

Title 48

INSURANCE

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48.01.010 Short title. Title 48 RCW constitutes the insurance code. [1975 1st ex.s. c 266 § 2; 1947 c 79 § .01.01; Rem. Supp. 1947 § 45.01.01.]

Additional notes found at www.leg.wa.gov

48.01.020 Scope of code. All insurance and insurance transactions in this state, or affecting subjects located wholly or in part or to be performed within this state, and all persons having to do therewith are governed by this code. [1947 c 79 § .01.02; Rem. Supp. 1947 § 45.01.02.]

48.01.030 Public interest. The business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, their providers, and their representatives rests the duty of preserving inviolate the integrity of insurance. [1995 c 285 § 16; 1947 c 79 § .01.03; Rem. Supp. 1947 § 45.01.03.]

Additional notes found at www.leg.wa.gov

48.01.035 "Developmental disability" defined. The term "developmental disability" as used in this title means a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological condition closely related to an intellectual disability or to require treatment similar to that required for persons with intellectual disabilities, which disability originates before such individual attains age eighteen, which has continued or can be expected to continue indefinitely, and which constitutes a substantial limitation to such individual. [2010 c 94 § 14; 1985 c 264 § 1.]

Purpose—2010 c 94: See note following RCW 44.04.280.

48.01.040 "Insurance" defined. Insurance is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies. [1947 c 79 § .01.04; Rem. Supp. 1947 § 45.01.04.]

48.01.050 "Insurer" defined. "Insurer" as used in this code includes every person engaged in the business of making contracts of insurance, other than a fraternal benefit society. A reciprocal or interinsurance exchange is an "insurer" as used in this code. Two or more hospitals that join and organize as a mutual corporation pursuant to chapter 24.06 RCW for the purpose of insuring or self-insuring against liability claims, including medical liability, through a contributing trust fund are not an "insurer" under this code. Two or more local governmental entities, under any provision of law, that join together and organize to form an organization for the purpose of jointly self-insuring or self-funding are not an "insurer" under this code. Two or more affordable housing entities that join together and organize to form an organization for the purpose of jointly self-insuring or self-funding under chapter 48.64 RCW are not an "insurer" under this code. Two or more persons engaged in the business of commercial fishing who enter into an arrangement with other such persons for the pooling of funds to pay claims or losses arising out of loss or damage to a vessel or machinery used in the business of commercial fishing and owned by a member of the pool are not an "insurer" under this code. Two or more nonprofit corporations that join together and organize to form an organization for the purpose of jointly self-insuring or self-funding for property and liability risks under chapter 48.180 RCW are not an "insurer" under this code. [2015 c 109 § 1; 2009 c 314 § 19; 2003 c 248 § 1; 1990 c 130 § 1; 1985 c 277 § 9; 1979 ex.s. c 256 § 13; 1975-'76 2nd ex.s. c 13 § 1; 1947 c 79 § .01.05; Rem. Supp. 1947 § 45.01.05.]

"Domestic," "foreign," "alien" insurers defined: RCW 48.05.010.

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Additional notes found at www.leg.wa.gov

48.01.053 "Issuer" defined. "Issuer" as used in this title and chapter 26.18 RCW means insurer, fraternal benefit society, certified health plan, health maintenance organization, and health care service contractor. [1995 c 34 § 1.]

48.01.060 "Insurance transaction" defined. "Insurance transaction" includes any:

- (1) Solicitation.
- (2) Negotiations preliminary to execution.
- (3) Execution of an insurance contract.
- (4) Transaction of matters subsequent to execution of the contract and arising out of it.
- (5) Insuring. [1947 c 79 § .01.06; Rem. Supp. 1947 § 45.01.06.]

48.01.070 "Person" defined. "Person" means any individual, company, insurer, association, organization, reciprocal or interinsurance exchange, partnership, business trust, or corporation. [1947 c 79 § .01.07; Rem. Supp. 1947 § 45.01.07.]

48.01.080 Penalties. Except as otherwise provided in this code, any person violating any provision of this code is guilty of a gross misdemeanor and will, upon conviction, be fined not less than ten dollars nor more than one thousand dollars, or imprisoned for not more than three hundred sixty-four days, or both, in addition to any other penalty or forfeiture provided herein or otherwise by law. [2011 c 96 § 37; 2003 c 250 § 1; 1947 c 79 § .01.08; Rem. Supp. 1947 § 45.01.08.]

Findings—Intent—2011 c 96: See note following RCW 9A.20.021.

Additional notes found at www.leg.wa.gov

48.01.100 Existing officers. Continuation by this code of any office existing under any act repealed herein preserves the tenure of the individual holding the office at the effective date of this code. [1947 c 79 § .01.10; Rem. Supp. 1947 § 45.01.10.]

48.01.110 Existing licenses. Every license or certificate of authority in force immediately prior to the effective date of this code and existing under any act herein repealed is valid until its original expiration date, unless earlier terminated in accordance with this code. [1947 c 79 § .01.11; Rem. Supp. 1947 § 45.01.11.]

48.01.120 Existing insurance forms. Every form of insurance document in use at the effective date of this code in accordance with the commissioner's approval pursuant to any act herein repealed, may continue to be so used unless the commissioner otherwise prescribes in accordance with this code. [1947 c 79 § .01.12; Rem. Supp. 1947 § 45.01.12.]

48.01.130 Existing actions, violations. No action or proceeding commenced, and no violation of law existing, under any act herein repealed is affected by the repeal, but all procedure hereafter taken in reference thereto shall conform to this code as far as possible. [1947 c 79 § .01.13; Rem. Supp. 1947 § 45.01.13.]

48.01.140 Headings. The meaning or scope of any provision is not affected by chapter, section, or paragraph headings. [1947 c 79 § .01.14; Rem. Supp. 1947 § 45.01.14.]

48.01.150 Particular provisions prevail. Provisions of this code relating to a particular kind of insurance or a particular type of insurer or to a particular matter prevail over provisions relating to insurance in general or insurers in general

or to such matter in general. [1947 c 79 § .01.15; Rem. Supp. 1947 § 45.01.15.]

48.01.160 Repealed acts not revived. Repeal by this code of any act shall not revive any law heretofore repealed or superseded. [1947 c 79 § .01.16; Rem. Supp. 1947 § 45.01.16.]

48.01.170 Effective date—1947 c 79. This code shall become effective on the first day of October, 1947. [1947 c 79 § .01.17; Rem. Supp. 1947 § 45.01.17.]

48.01.180 Adopted children—Insurance coverage.

(1) A child of an insured, subscriber, or enrollee shall be considered a dependent child for insurance purposes under this title upon assumption by the insured, subscriber, or enrollee of a legal obligation for total or partial support of a child in anticipation of adoption of the child. Upon the termination of such legal obligations, the child shall not be considered a dependent child for insurance purposes.

(2) Every policy or contract providing coverage for health benefits to a resident of this state shall provide coverage for dependent children placed for adoption under the same terms and conditions as apply to the natural, dependent children of the insured, subscriber, or enrollee whether or not the adoption has become final.

(3) No policy or contract may restrict coverage of any dependent child adopted by, or placed for adoption with, an insured, subscriber, or enrollee solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan if the adoption or placement for adoption occurs while the insured, subscriber, or enrollee is eligible for coverage under the plan. [1995 c 34 § 4; 1986 c 140 § 1.]

Additional notes found at www.leg.wa.gov

48.01.190 Immunity from civil liability. (1) Any person who files reports, or furnishes other information, required under Title 48 RCW, required by the commissioner under authority granted by Title 48 RCW, useful to the commissioner in the administration of Title 48 RCW, or furnished to the National Association of Insurance Commissioners at the request of the commissioner or pursuant to 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 commissioner or the National Association of Insurance Commissioners, unless actual malice, fraud, or bad faith is shown.

(2) The commissioner and the National Association of Insurance Commissioners, 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 bulletin or dissemination of information related to the official activities of the commissioner or the National Association of Insurance Commissioners, unless actual malice, fraud, or bad faith is shown.

(3) Any licensee under chapter 48.17 RCW and any trade association of the licensees under chapter 48.15 RCW, and any officer, director, employee, agent, or committee of the licensee or association who furnishes information to or for the commissioner or to or for the association regarding unauthorized insurers or regarding attempts by any person to place

or actual placement by any person of business with the insurers, whether in compliance with chapter 48.15 RCW or not, shall be immune from each and every kind of liability in any civil action or suit arising in whole or in part from the information or from the furnishing of the information.

(4) 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. [1995 c 10 § 1; 1987 c 51 § 1.]

48.01.220 Behavioral health administrative services organizations—Exemption. The activities and operations of behavioral health administrative services organizations, as defined in RCW 71.24.025, are exempt from the requirements of this title. [2019 c 325 § 5017; 2014 c 225 § 69; 1993 c 462 § 104.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

48.01.230 Eligibility for coverage or making payments may not be contingent on eligibility for medical assistance. An issuer and an employee welfare benefit plan, whether insured or self funded, as defined in the employee retirement income security act of 1974, 29 U.S.C. Sec. 1101 et seq. may not consider the availability of eligibility for medical assistance in this state under medical assistance, RCW 74.09.500, or any other state under 42 U.S.C. Sec. 1396a, section 1902 of the social security act, in considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders, or certificate holders. [1995 c 34 § 2.]

48.01.235 Enrollment of a child under the health plan of the child's parent—Requirements—Restrictions.

(1) An issuer and an employee welfare benefit plan, whether insured or self funded, as defined in the employee retirement income security act of 1974, 29 U.S.C. Sec. 1101 et seq. may not deny enrollment of a child under the health plan of the child's parent on the grounds that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the parent or in the issuer's, or insured or self funded employee welfare benefit plan's service area.

(2) Where a child has health coverage through an issuer, or an insured or self funded employee welfare benefit plan of a noncustodial parent, the issuer, or insured or self funded employee welfare benefit plan, shall:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the provider or the custodial parent to submit claims for covered services without the approval of the noncustodial parent. If the provider submits the claim, the provider will obtain the custodial parent's assignment of insurance benefits or otherwise secure the custodial parent's approval.

For purposes of this subsection the health care authority as the state medicaid agency under RCW 74.09.500 may reassign medical insurance rights to the provider for custodial parents whose children are eligible for services under RCW 74.09.500; and

(c) Make payments on claims submitted in accordance with (b) of this subsection directly to the custodial parent, to the provider, or to the health care authority as the state medicaid agency under RCW 74.09.500.

(3) Where a child does not reside in the issuer's service area, an issuer shall cover no less than urgent and emergent care. Where the issuer offers broader coverage, whether by policy or reciprocal agreement, the issuer shall provide such coverage to any child otherwise covered that does not reside in the issuer's service area.

(4) Where a parent is required by a court order to provide health coverage for a child, and the parent is eligible for family health coverage, the issuer, or insured or self funded employee welfare benefit plan, shall:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) Enroll the child under family coverage upon application of the child's other parent, health care authority as the state medicaid agency under RCW 74.09.500, or child support enforcement program, if the parent is enrolled but fails to make application to obtain coverage for such child; and

(c) Not disenroll, or eliminate coverage of, such child who is otherwise eligible for the coverage unless the issuer or insured or self funded employee welfare benefit plan is provided satisfactory written evidence that:

(i) The court order is no longer in effect; or

(ii) The child is or will be enrolled in comparable health coverage through another issuer, or insured or self funded employee welfare benefit plan, which will take effect not later than the effective date of disenrollment.

(5) An issuer, or insured or self funded employee welfare benefit plan, that has been assigned the rights of an individual eligible for medical assistance under medicaid and coverage for health benefits from the issuer, or insured or self funded employee welfare benefit plan, may not impose requirements on the health care authority that are different from requirements applicable to an agent or assignee of any other individual so covered. [2011 1st sp.s. c 15 § 76; 2003 c 248 § 2; 1995 c 34 § 3.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

48.01.250 Assistance or services in exchange for dues, assessments, or periodic or lump sum payments—Certificate of authority required—Certain travel or automobile services excepted—Violations. (1) Any person, firm, partnership, corporation, or association promising, in exchange for dues, assessments, or periodic or lump sum payments, to furnish members or subscribers with assistance in matters relating to trip cancellation, bail bond service or any accident, sickness, or death insurance benefit program must:

(a) Have a certificate of authority, issued by the insurance commissioner, authorizing the person, firm, partnership,

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corporation, or association to sell that coverage in this state; or

(b) Purchase the service or insurance from a company that holds a certificate of authority, issued by the insurance commissioner, authorizing the company to sell that coverage in this state. If coverage cannot be procured from an authorized insurer holding a certificate of authority issued by the insurance commissioner, insurance may be procured from an unauthorized insurer subject to chapter 48.15 RCW.

(2) Travel or automobile related products or assistance including but not limited to community traffic safety service, travel and touring service, theft or reward service, map service, towing service, emergency road service, lockout or lost key service, reimbursement of emergency expenses due to a vehicle disabling accident, or legal fee reimbursement service in the defense of traffic offenses shall not be considered to be insurance for the purposes of Title 48 RCW.

(3) Violation of this section is subject to the enforcement provisions of RCW 48.02.080 and to the hearing and appeal provisions of chapter 48.04 RCW. [1998 c 303 § 1.]

48.01.260 Health benefit plans—Carriers—Clarification. (1) Except as required in RCW 48.21.045, 48.44.023, and 48.46.066, nothing in this title shall be construed to require a carrier, as defined in RCW 48.43.005, to offer any health benefit plan for sale.

(2) Nothing in this title shall prohibit a carrier as defined in RCW 48.43.005 from ceasing sale of any or all health benefit plans to new applicants if the closed plans are closed to all new applicants.

(3) This section is intended to clarify, and not modify, existing law. [2000 c 79 § 40.]

Additional notes found at www.leg.wa.gov

48.01.270 PACE programs—Exemption. The activities and operations of PACE programs, as defined in RCW 74.09.523 and as authorized under sections 1894, 1905(a), and 1934 of the social security act, when registered, certified, licensed, or otherwise recognized or designated as a PACE program by the Washington state department of social and health services, are exempt from the requirements of this title. [2001 c 191 § 3.]

Finding—Effective date—2001 c 191: See notes following RCW 74.09.523.

48.01.280 Private air ambulance service—Subscription service—Exempt when conditions are met. (1) A private air ambulance service that solicits membership subscriptions, accepts membership applications, charges membership fees, and provides air ambulance services, to subscription members and designated members of their household is not an insurer under RCW 48.01.050, a health carrier under chapter 48.43 RCW, a health care services contractor under chapter 48.44 RCW, or a health maintenance organization under chapter 48.46 RCW if the private air ambulance service:

(a) Is licensed in accordance with RCW 18.73.130;

(b) Attains and maintains accreditation by the commission on accreditation of medical transport services or another accrediting organization approved by the department of health as having equivalent requirements as the commission for aeromedical transport;

(c) Has been in operation in Washington for at least two years; and

(d) Has submitted evidence of its compliance with this section, the licensing requirements of RCW 18.73.130, and accreditation from the commission or another accrediting organization approved by the department of health as having equivalent requirements as the commission for aeromedical transport to the commissioner.

(2) A subscription service that solicits membership subscriptions, charges membership fees, and provides rescue, evacuation, emergency transport, and crisis management and consulting services related to an emergency while traveling more than one hundred miles away from home, to its members or designated members of a member's household is not an insurer under RCW 48.01.050, a health carrier under chapter 48.43 RCW, a health care services contractor under chapter 48.44 RCW, or a health maintenance organization under chapter 48.46 RCW. Rescue, evacuation, emergency transport, and crisis management and consulting services related to an emergency, include the following:

(a) Providing rescue, evacuation, and emergency transport and crisis management services related to the emergency;

(b) Locator services for medical and legal professionals;

(c) Visa and passport services;

(d) Emergency message services;

(e) Emergency-related travel and emergency-related services and information;

(f) Transport of human remains; and

(g) Other services established by rule of the commissioner.

(3) A subscription service that provides rescue, evacuation, emergency transport, and crisis management and consulting services related to an emergency as described in subsection (2) of this section must satisfy, or contract with a service provider which satisfies, the licensing requirements, if any, of the jurisdiction in which the services are provided. The requirements of subsection (1) of this section must be satisfied when providing air ambulance services within the state of Washington.

(4) It is not required that a subscription service under subsection (1) or (2) of this section own the vehicles, planes, helicopters, other aircraft, maritime vessels, or other means of transportation that will be used to provide the contracted services. [2012 c 93 § 1; 2006 c 61 § 1.]

Chapter 48.02 RCW

INSURANCE COMMISSIONER

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48.02.220	Pharmacy benefit managers—Registration—Enforcement authority—Rules.
48.02.230	Health insurance market stability program—Confidentiality—Definitions—Reports—Commissioner's responsibilities.
48.02.240	Natural disaster and resiliency work group.
48.02.250	Living organ donors—Discrimination prohibited.

Commissioner to prepare annuity tables for calculation of reserve fund in cases of death or permanent disability under workers' compensation: RCW 51.44.070.

Public bodies may retain collection agencies to collect public debts—Fees: RCW 19.16.500.

Salary of insurance commissioner: RCW 43.03.010.

48.02.010 Insurance commissioner. (1) There shall be an insurance commissioner of this state who shall be elected at the time and in the manner that other state officers are elected.

(2) The commissioner in office at the effective date of this code shall continue in office for the remainder of the term for which he or she was elected and until his or her successor is duly elected and qualified.

(3) "Commissioner," where used in this code, means the insurance commissioner of this state. [2009 c 549 § 7001; 1947 c 79 § .02.01; Rem. Supp. 1947 § 45.02.01.]

48.02.020 Term of office. The term of office of the commissioner shall be four years, commencing on the Wednesday after the second Monday in January after his or her election. [2009 c 549 § 7002; 1947 c 79 § .02.02; Rem. Supp. 1947 § 45.02.02.]

48.02.030 Bond. Before entering upon his or her duties the commissioner shall execute a bond to the state in the sum of twenty-five thousand dollars, to be approved by the state treasurer and the attorney general, conditioned upon the faithful performance of the duties of his or her office. [2009 c 549 § 7003; 1947 c 79 § .02.03; Rem. Supp. 1947 § 45.02.03.]

48.02.050 Seal. The official seal of the commissioner shall be a vignette of George Washington, with the words "Insurance Commissioner, State of Washington" surrounding the vignette. [1947 c 79 § .02.05; Rem. Supp. 1947 § 45.02.05.]

48.02.060 General powers and duties—State of emergency. (1) The commissioner has the authority expressly conferred upon him or her by or reasonably implied from the provisions of this code.

(2) The commissioner must execute his or her duties and must enforce the provisions of this code.

(3) The commissioner may:

(a) Make reasonable rules for effectuating any provision of this code, except those relating to his or her election, qualifications, or compensation. Rules are not effective prior to their being filed for public inspection in the commissioner's office.

(b) Conduct investigations to determine whether any person has violated any provision of this code.

(c) Conduct examinations, investigations, hearings, in addition to those specifically provided for, useful and proper for the efficient administration of any provision of this code.

(4) When the governor proclaims a state of emergency under RCW 43.06.010(12), the commissioner may issue an order that addresses any or all of the following matters related to insurance policies issued in this state:

(a) Reporting requirements for claims;

(b) Grace periods for payment of insurance premiums and performance of other duties by insureds;

(c) Temporary postponement of cancellations and nonrenewals; and

(d) Medical coverage to ensure access to care.

(5) An order by the commissioner under subsection (4) of this section may remain effective for not more than sixty days unless the commissioner extends the termination date for the order for an additional period of not more than thirty days. The commissioner may extend the order if, in the commissioner's judgment, the circumstances warrant an extension. An order of the commissioner under subsection (4) of this section is not effective after the related state of emergency is terminated by proclamation of the governor under RCW 43.06.210. The order must specify, by line of insurance:

(a) The geographic areas in which the order applies, which must be within but may be less extensive than the geographic area specified in the governor's proclamation of a state of emergency and must be specific according to an appropriate means of delineation, such as the United States postal service zip codes or other appropriate means; and

(b) The date on which the order becomes effective and the date on which the order terminates.

(6) The commissioner may adopt rules that establish general criteria for orders issued under subsection (4) of this section and may adopt emergency rules applicable to a specific proclamation of a state of emergency by the governor.

(7) The rule-making authority set forth in subsection (6) of this section does not limit or affect the rule-making authority otherwise granted to the commissioner by law. [2010 c 27 § 1; 2009 c 335 § 1; 1947 c 79 § .02.06; Rem. Supp. 1947 § 45.02.06.]

48.02.062 Mental health services—Rules. The insurance commissioner may adopt rules to implement RCW 48.21.241, 48.44.341, and 48.46.291, except that the rules do not apply to health benefit plans administered or operated under chapter 41.05 or 70.47 RCW. [2005 c 6 § 10.]

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

48.02.065 Confidentiality of documents, materials, or other information—Public disclosure. (1) Documents, materials, or other information as described in either subsection (5) or (6), or both, of this section are confidential by law

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and privileged, are not subject to public disclosure under chapter 42.56 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(8) applies only to the commissioner, any person acting under the authority of the commissioner, 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 is permitted or 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) The commissioner:

(a) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (1) of this section, with (i) the national association of insurance commissioners and its affiliates and subsidiaries, and (ii) regulatory and law enforcement officials of other states and nations, the federal government, and international authorities, if the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

(b) May receive documents, materials, or information, including otherwise either confidential or privileged, or both, documents, materials, or information, from (i) the national association of insurance commissioners and its affiliates and subsidiaries, and (ii) regulatory and law enforcement officials of other states and nations, the federal government, and international authorities and shall maintain as confidential and privileged any document, material, or information received that is either confidential or privileged, or both, under the laws of the jurisdiction that is the source of the document, material, or information; and

(c) May enter into agreements governing the sharing and use of information consistent with this subsection.

(4) 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 as authorized in subsection (3) of this section.

(5) Documents, materials, or information, which is either confidential or privileged, or both, which has been provided to the commissioner by (a) the national association of insurance commissioners and its affiliates and subsidiaries, (b) regulatory or law enforcement officials of other states and nations, the federal government, or international authorities, or (c) agencies of this state, is confidential and privileged only if the documents, materials, or information is protected from disclosure by the applicable laws of the jurisdiction that is the source of the document, material, or information.

(6) Working papers, documents, materials, or information produced by, obtained by, or disclosed to the commissioner or any other person in the course of a financial or mar-

ket conduct examination, or in the course of financial analysis or market conduct desk audit, are not required to be disclosed by the commissioner unless cited by the commissioner in connection with an agency action as defined in RCW 34.05.010(3). The commissioner shall notify a party that produced the documents, materials, or information five business days before disclosure in connection with an agency action. The notified party may seek injunctive relief in any Washington state superior court to prevent disclosure of any documents, materials, or information it believes is confidential or privileged. In civil actions between private parties or in criminal actions, disclosure to the commissioner under this section does not create any privilege or claim of confidentiality or waive any existing privilege or claim of confidentiality.

(7)(a) After receipt of a public disclosure request, the commissioner shall disclose the documents, materials, or information under subsection (6) of this section that relate to a financial or market conduct examination undertaken as a result of a proposed change of control of a nonprofit or mutual health insurer governed in whole or in part by chapter 48.31B RCW.

(b) The commissioner is not required to disclose the documents, materials, or information in (a) of this subsection if:

- (i) The documents, materials, or information are otherwise privileged or exempted from public disclosure; or
- (ii) The commissioner finds that the public interest in disclosure of the documents, materials, or information is outweighed by the public interest in nondisclosure in that particular instance.

(8) Any person may petition a Washington state superior court to allow inspection of information exempt from public disclosure under subsection (6) of this section when the information is connected to allegations of negligence or malfeasance by the commissioner related to a financial or market conduct examination. 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 regular hearing, the court may order that the information can be disclosed publicly if the court finds that there is a public interest in the disclosure of the information and the exemption of the information from public disclosure is clearly unnecessary to protect any individual's right of privacy or any vital governmental function. [2015 c 122 § 15; 2007 c 126 § 1. Prior: 2005 c 274 § 309; 2005 c 126 § 1; 2001 c 57 § 1.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.02.068 Confidentiality of personal health information—Public disclosure. (1) All nonpublic personal health information obtained by, disclosed to, or in the custody of the commissioner, regardless of the form or medium, is confidential and is not subject to public disclosure under chapter 42.56 RCW. The commissioner shall not disclose nonpublic personal health information except in the furtherance of regulatory or legal action brought as a part of the commissioner's official duties.

(2) The following definitions apply only for the purposes of this section:

(a) "Health information" means any information or data, except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or a patient, or a policyholder or enrollee, that relates to:

- (i) The past, present, or future physical, mental, or behavioral health or condition of an individual;
- (ii) The provision of health care to an individual; or
- (iii) Payment for the provision of health care to an individual.

(b) "Health care" means preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, services, procedures, tests, or counseling that:

- (i) Relates to the physical, mental, or behavioral condition of an individual;
- (ii) Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or
- (iii) Prescribes, dispenses, or furnishes to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

(c) "Nonpublic personal health information" means health information:

- (i) That identifies an individual who is the subject of the information; or
- (ii) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(d) "Patient" means an individual who is receiving, has received, or has sought health care. The term includes a deceased individual who has received health care.

(e) "Policyholder" or "enrollee" means a person who is covered by, enrolled in, has applied for, or purchased, an insurance policy, a health plan as defined in RCW 48.43.005, a group plan, or any other product regulated by the insurance commissioner. "Policyholder" or "enrollee" may include, without limitation, a subscriber, member, annuitant, beneficiary, spouse, or dependent.

(3) The commissioner may:

(a) Share documents, materials, or other information, including the confidential documents, materials, or information subject to subsection (1) of this section, with (i) the national association of insurance commissioners and its affiliates and subsidiaries, and (ii) regulatory and law enforcement officials of this and other states and nations, the federal government, and international authorities, if the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

(b) Receive documents, materials, or information, including otherwise either confidential or privileged documents, materials, or information, from (i) the national association of insurance commissioners and its affiliates and subsidiaries, and (ii) regulatory and law enforcement officials of this and other states and nations, the federal government, and international authorities and must maintain as confidential or privileged any document, material, or information received that is either confidential or privileged, or both, under the laws of the jurisdiction that is the source of the document, material, or information; and

(c) Enter into agreements governing the sharing and use of information consistent with this subsection.

(4) No waiver of an existing claim of confidentiality or privilege 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 as authorized in subsection (3) of this section.

(5) The commissioner shall add language in large font to the release consumers use when filing complaints with the office, whether online or in writing, informing them that the office may share their personal health information with other entities and for the purposes authorized under subsection (3) of this section, and that the information will only be shared if it is to be held confidential by the other entity. Consumers shall be provided the opportunity to opt out at the time of filing their complaint, indicating that their personal health information may not be shared under subsection (3) of this section. [2017 c 193 § 1.]

48.02.080 Enforcement. (1) The commissioner may prosecute an action in any court of competent jurisdiction to enforce any order made by him or her pursuant to any provision of this code.

(2) If the commissioner has cause to believe that any person has violated any penal provision of this code or of other laws relating to insurance he or she shall certify the facts of the violation to the public prosecutor of the jurisdiction in which the offense was committed.

(3) If the commissioner has cause to believe that any person is violating or is about to violate any provision of this code or any regulation or order of the commissioner, he or she 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.

(4) The attorney general and the several prosecuting attorneys throughout the state shall prosecute or defend all proceedings brought pursuant to the provisions of this code when requested by the commissioner. [2009 c 549 § 7005; 1967 c 150 § 1; 1947 c 79 § .02.08; Rem. Supp. 1947 § 45.02.08.]

48.02.090 Deputies—Employees. (1) The commissioner may appoint a chief deputy commissioner, who shall have power to perform any act or duty conferred upon the commissioner. The chief deputy commissioner shall take and subscribe the same oath of office as the commissioner, which oath shall be endorsed upon the certificate of his or her appointment and filed in the office of the secretary of state.

(2) The commissioner may appoint additional deputy commissioners for such purposes as he or she may designate.

(3) The commissioner shall be responsible for the official acts of his or her deputies, and may revoke at will the appointment of any deputy.

(4) The commissioner may employ examiners, and such actuarial, technical, and administrative assistants and clerks as he or she may need for proper discharge of his or her duties.

(5) The commissioner, or any deputy or employee of the commissioner, shall not be interested, directly or indirectly,

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in any insurer except as a policyholder; except, that as to such matters wherein a conflict of interests does not exist on the part of any such person, the commissioner may employ insurance actuaries or other technicians who are independently practicing their professions even though such persons are similarly employed by insurers.

(6) The commissioner may require any deputy or employee to be bonded as he or she shall deem proper but not to exceed in amount the sum of twenty-five thousand dollars. The cost of any such bond shall be borne by the state. [2009 c 549 § 7006; 1949 c 190 § 1; 1947 c 79 § .02.09; Rem. Supp. 1949 § 45.02.09.]

48.02.093 Health care authority ombuds—Retirees—Volunteer position. There is established, within the office of the insurance commissioner, the volunteer position of health care authority ombuds to assist retirees enrolled in the public employees' benefits board program. The volunteer position shall be trained as part of the existing volunteer training provided to the statewide health insurance benefit advisors. The position shall help retirees with questions and concerns, assist the public employees' benefits board program with identification of retiree concerns, and maintain access to updated program information. [2013 c 23 § 101; 2012 c 150 § 1.]

48.02.100 Commissioner may delegate authority. Any power or duty vested in the commissioner by any provision of this code may be exercised or discharged by any deputy, assistant, examiner, or employee of the commissioner acting in his or her name and by his or her authority. [2009 c 549 § 7007; 1947 c 79 § .02.10; Rem. Supp. 1947 § 45.02.10.]

48.02.110 Office. The commissioner shall have an office at the state capital, and may maintain such offices elsewhere in this state as he or she may deem necessary. [2009 c 549 § 7008; 1947 c 79 § .02.11; Rem. Supp. 1947 § 45.02.11.]

48.02.120 Records—Public inspection. (Effective until January 1, 2022.) (1) The commissioner shall preserve in permanent form records of his or her proceedings, hearings, investigations, and examinations, and shall file such records in his or her office.

(2) The records of the commissioner and insurance filings in his or her office shall be open to public inspection, except as otherwise provided by this code.

(3) Except as provided in subsection (4) of this section, actuarial formulas, statistics, and assumptions submitted in support of a rate or form filing by an insurer, health care service contractor, or health maintenance organization or submitted to the commissioner upon his or her request shall be withheld from public inspection in order to preserve trade secrets or prevent unfair competition.

(4) For individual and small group health benefit plan rate filings submitted on or after July 1, 2011, subsection (3) of this section applies only to the numeric values of each small group rating factor used by a health carrier as authorized by RCW 48.21.045(3)(a), 48.44.023(3)(a), and 48.46.066(3)(a). Subsection (3) of this section may continue

to apply for a period of one year from the date a new individual or small group product filing is submitted or until the next rate filing for the product, whichever occurs earlier, if the commissioner determines that the proposed rate filing is for a new product that is distinct and unique from any of the carrier's currently or previously offered health benefit plans. Carriers must make a written request for a product classification as a new product under this subsection and must receive subsequent written approval by the commissioner for this subsection to apply.

(5) Unless the commissioner has determined that a filing is for a new product pursuant to subsection (4) of this section, for all individual or small group health benefit rate filings submitted on or after July 1, 2011, the health carrier must submit part I rate increase summary and part II written explanation of the rate increase as set forth by the department of health and human services at the time of filing, and the commissioner must:

(a) Make each filing and the part I rate increase summary and part II written explanation of the rate increase available for public inspection on the tenth calendar day after the commissioner determines that the rate filing is complete and accepts the filing for review through the electronic rate and form filing system; and

(b) Prepare a standardized rate summary form, to explain his or her findings after the rate review process is completed. The commissioner's summary form must be included as part of the rate filing documentation and available to the public electronically. [2011 c 312 § 1; 1985 c 264 § 2; 1979 ex.s. c 130 § 1; 1947 c 79 § .02.12; Rem. Supp. 1947 § 45.02.12.]

48.02.120 Records—Public inspection. (Effective January 1, 2022.) (1) The commissioner shall preserve in permanent form records of his or her proceedings, hearings, investigations, and examinations, and shall file such records in his or her office.

(2) The records of the commissioner and insurance filings in his or her office shall be open to public inspection, except as otherwise provided by RCW 48.200.040 and 48.43.731 and this code.

(3) Except as provided in subsection (4) of this section, actuarial formulas, statistics, and assumptions submitted in support of a rate or form filing by an insurer, health care service contractor, or health maintenance organization or submitted to the commissioner upon his or her request shall be withheld from public inspection in order to preserve trade secrets or prevent unfair competition.

(4) For individual and small group health benefit plan rate filings submitted on or after July 1, 2011, subsection (3) of this section applies only to the numeric values of each small group rating factor used by a health carrier as authorized by RCW 48.21.045(3)(a), 48.44.023(3)(a), and 48.46.066(3)(a). Subsection (3) of this section may continue to apply for a period of one year from the date a new individual or small group product filing is submitted or until the next rate filing for the product, whichever occurs earlier, if the commissioner determines that the proposed rate filing is for a new product that is distinct and unique from any of the carrier's currently or previously offered health benefit plans. Carriers must make a written request for a product classification as a new product under this subsection and must receive

subsequent written approval by the commissioner for this subsection to apply.

(5) Unless the commissioner has determined that a filing is for a new product pursuant to subsection (4) of this section, for all individual or small group health benefit rate filings submitted on or after July 1, 2011, the health carrier must submit part I rate increase summary and part II written explanation of the rate increase as set forth by the department of health and human services at the time of filing, and the commissioner must:

(a) Make each filing and the part I rate increase summary and part II written explanation of the rate increase available for public inspection on the tenth calendar day after the commissioner determines that the rate filing is complete and accepts the filing for review through the electronic rate and form filing system; and

(b) Prepare a standardized rate summary form, to explain his or her findings after the rate review process is completed. The commissioner's summary form must be included as part of the rate filing documentation and available to the public electronically. [2020 c 240 § 7; 2011 c 312 § 1; 1985 c 264 § 2; 1979 ex.s. c 130 § 1; 1947 c 79 § .02.12; Rem. Supp. 1947 § 45.02.12.]

Rule making—Effective date—2020 c 240: See RCW 48.200.900 and 48.200.901.

48.02.122 Filings or actions affecting corporate or company name—Notice to secretary of state. Whenever any documents are filed with the insurance commissioner which affect a corporate or company name, the insurance commissioner shall immediately notify the secretary of state of the filing. If any other action is taken by the insurance commissioner which affects a corporate or company name, the insurance commissioner shall immediately notify the secretary of state of the action. The insurance commissioner shall cooperate with the secretary of state to ascertain that there is no duplication of corporate or company names. [1998 c 23 § 19.]

48.02.130 Certificates—Copies—Evidentiary effect. (1) Any certificate or license issued by the commissioner shall bear the seal of his or her office.

(2) Copies of records or documents in his or her office certified to by the commissioner shall be received as evidence in all courts in the same manner and to the same effect as if they were the originals.

(3) When required for evidence in court, the commissioner shall furnish his or her certificate as to the authority of an insurer or other licensee in this state on any particular date, and the court shall receive the certificate in lieu of the commissioner's testimony. [2009 c 549 § 7009; 1947 c 79 § .02.13; Rem. Supp. 1947 § 45.02.13.]

48.02.140 Interstate cooperation. (1) The commissioner shall to the extent he or she deems useful for the proper discharge of his or her responsibilities under the provisions of this code:

(a) Consult and cooperate with the public officials having supervision over insurance in other states.

(b) Share jointly with other states in the employment of actuaries, statisticians, and other insurance technicians whose

services or the products thereof are made available and are useful to the participating states and to the commissioner.

(c) Share jointly with other states in establishing and maintaining offices and clerical facilities for purposes useful to the participating states and to the commissioner.

(2) All arrangements made jointly with other states under items (b) and (c) of subsection (1) of this section shall be in writing executed on behalf of this state by the commissioner. Any such arrangement, as to participation of this state therein, shall be subject to termination by the commissioner at any time upon reasonable notice.

(3) For the purposes of this code "National Association of Insurance Commissioners" means that voluntary organization of the public officials having supervision of insurance in the respective states, districts, and territories of the United States, whatever other name such organization may hereafter adopt, and in the affairs of which each of such public officials is entitled to participate subject to the constitution and bylaws of such organization. [2009 c 549 § 7010; 1947 c 79 § .02.14; Rem. Supp. 1947 § 45.02.14.]

48.02.150 Supplies. The commissioner must purchase at the expense of the state, and in the manner provided by law, printing, books, reports, furniture, equipment, and supplies as he or she deems necessary to the proper discharge of his or her duties under this code. [2011 c 47 § 2; 2009 c 549 § 7011; 1947 c 79 § .02.15; Rem. Supp. 1947 § 45.02.15.]

48.02.160 Special duties. The commissioner shall:

(1) Obtain and publish for the use of courts and appraisers throughout the state, tables showing the average expectancy of life and values of annuities and of life and term estates.

(2) Disseminate information concerning the insurance laws of this state.

(3) Provide assistance to members of the public in obtaining information about insurance products and in resolving complaints involving insurers and other licensees. [1988 c 248 § 1; 1947 c 79 § .02.16; Rem. Supp. 1947 § 45.02.16.]

48.02.170 Annual report. The commissioner shall, as soon as accurate preparation enables, prepare a report of his or her official transactions during the preceding fiscal year, containing information relative to insurance as the commissioner deems proper. [2009 c 549 § 7012; 1987 c 505 § 53; 1977 c 75 § 69; 1947 c 79 § .02.17; Rem. Supp. 1947 § 45.02.17.]

48.02.180 Publication of insurance code and related statutes, manuals, etc.—Distribution—Sale. (1) The commissioner may periodically prepare and publish:

(a) Title 48 RCW, Title 284 WAC, insurance bulletins and technical assistance advisories, and other laws, rules, and regulations relevant to the regulation of insurance;

(b) Manuals and other material relating to examinations for licensure; and

(c) Any other publications authorized under Title 48 RCW.

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(2) The commissioner may provide copies of the publications referred to in subsection (1)(a) of this section free of charge to:

(a) Public offices and officers in this state;

(b) Public officials of other states and jurisdictions that regulate insurance;

(c) The library of congress; and

(d) Officers of the armed forces of the United States of America located at military installations in this state who are concerned with insurance transactions at or involving the military installations.

(3) Except as provided in subsection (2) of this section, the commissioner shall sell the publications referred to in subsection (1) of this section. The commissioner may charge a reasonable price that is not less than the cost of publication, handling, and distribution. The commissioner shall promptly deposit all funds received under this subsection with the state treasurer to the credit of the insurance commissioner's regulatory account. For appropriation purposes, the funds received and deposited by the commissioner are a recovery of a previous expenditure. [2005 c 223 § 1; 1981 c 339 § 1; 1977 c 75 § 70; 1959 c 225 § 1.]

48.02.190 Operating costs of office—Insurance commissioner's regulatory account—Insurance commissioner's fraud account—Regulatory and insurance fraud surcharges. (1) As used in this section:

(a) "Insurance fraud surcharge" means the fees imposed by subsection (2)(b) of this section.

(b) "Organization" means every insurer, as defined in RCW 48.01.050, having a certificate of authority to do business in this state, every health care service contractor, as defined in RCW 48.44.010, every health maintenance organization, as defined in RCW 48.46.020, or self-funded multiple employer welfare arrangement, as defined in RCW 48.125.010, registered to do business in this state. "Class one" organizations consist of all insurers as defined in RCW 48.01.050. "Class two" organizations consist of all organizations registered under provisions of chapters 48.44 and 48.46 RCW. "Class three" organizations consist of self-funded multiple employer welfare arrangements as defined in RCW 48.125.010.

(c)(i) "Receipts" means (A) net direct premiums consisting of direct gross premiums, as defined in RCW 48.18.170, paid for insurance written or renewed upon risks or property resident, situated, or to be performed in this state, less return premiums and premiums on policies not taken, dividends paid or credited to policyholders on direct business, and premiums received from policies or contracts issued in connection with qualified plans as defined in RCW 48.14.021, and (B) prepayments to health care service contractors, as defined in RCW 48.44.010, health maintenance organizations, as defined in RCW 48.46.020, or participant contributions to self-funded multiple employer welfare arrangements, as defined in RCW 48.125.010, less experience rating credits, dividends, prepayments returned to subscribers, and payments for contracts not taken.

(ii) Participant contributions, under chapter 48.125 RCW, used to determine the receipts in this state under this section are determined in the same manner as premiums taxable in this state are determined under RCW 48.14.090.

(d) "Regulatory surcharge" means the fees imposed by subsection (2)(a) of this section.

(2) The annual cost of operating the office of the insurance commissioner is determined by legislative appropriation.

(a) A pro rata share of the cost, except for the cost of the insurance fraud program, is charged to all organizations as a regulatory surcharge. Each class of organization must contribute a sufficient amount to the insurance commissioner's regulatory account to pay the reasonable costs, including overhead, of regulating that class of organization.

(b) The annual cost of operating the insurance fraud program is charged to all organizations as an insurance fraud surcharge. Each class of organization must contribute a sufficient amount to the insurance commissioner's fraud account to pay the reasonable costs of the program, including overhead.

(3)(a) The regulatory surcharge is calculated separately for each class of organization. The regulatory surcharge collected from each organization is that portion of the cost of operating the insurance commissioner's office, except for the cost of operating the insurance fraud program, for that class of organization, for the ensuing fiscal year that is represented by the organization's portion of the receipts collected or received by all organizations within that class on business in this state during the previous calendar year. However, the regulatory surcharge must not exceed one-eighth of one percent of receipts and the minimum regulatory surcharge is one thousand dollars.

(b) The insurance fraud surcharge collected from each organization is the cost of operating the insurance fraud program for the ensuing fiscal year that is represented by the organization's portion of the receipts collected or received on business in this state during the previous calendar year. However, the insurance fraud surcharge may not exceed one one-hundredths of one percent of receipts and the minimum insurance fraud surcharge is one hundred dollars.

(4) The commissioner must annually, on or before July 1st, calculate and bill each organization for the amount of the regulatory and insurance fraud surcharges. The surcharges are due and payable no later than July 15th of each year. However, if the necessary financial records are not available or if the amount of the legislative appropriation is not determined in time to carry out such calculations and bill the surcharges within the time specified, the commissioner may use the surcharge factors for the prior year as the basis for the surcharges and, if necessary, the commissioner may impose supplemental fees to fully and properly charge the organizations. Any organization failing to pay the surcharges by July 31st must pay the same penalties as the penalties for failure to pay taxes when due under RCW 48.14.060. The surcharges required by this section are in addition to all other taxes and fees now imposed or that may be subsequently imposed.

(5)(a) All moneys collected for the regulatory surcharge must be deposited in the insurance commissioner's regulatory account in the state treasury which is hereby created.

(b) All moneys collected for the insurance fraud surcharge must be deposited in the insurance commissioner's fraud account in the state treasury which is hereby created.

(6) Unexpended funds in the insurance commissioner's regulatory and fraud accounts at the close of a fiscal year are

carried forward to the succeeding fiscal year and are used to reduce future regulatory and insurance fraud surcharges.

(7)(a) Each insurer may annually collect regulatory and insurance fraud surcharges remitted in preceding years by means of a policyholder surcharge on premiums charged for all kinds of insurance. The recoupment is at a uniform rate reasonably calculated to collect the regulatory and insurance fraud surcharges remitted by the insurer.

(b) If an insurer fails to collect the entire amount of the recoupment in the first year under this section, it may repeat the recoupment procedure provided for in this subsection (7) in succeeding years until the regulatory and insurance fraud surcharges are fully collected or a de minimis amount remains uncollected. Any such de minimis amount may be collected as provided in (d) of this subsection.

(c) The amount and nature of any recoupment must be separately stated on either a billing or policy declaration sent to an insured. The amount of the recoupment must not be considered a premium for any purpose, including the premium tax or agents' commissions.

(d) An insurer may elect not to collect the regulatory and insurance fraud surcharges from its insured. In such a case, the insurer may recoup the regulatory and insurance fraud surcharges through its rates, if the following requirements are met:

(i) The insurer remits the amount of the surcharges not collected by election under this subsection; and

(ii) The surcharges are not considered a premium for any purpose, including the premium tax or agents' commission. [2020 c 195 § 2; 2011 c 47 § 3; 2009 c 161 § 1; 2008 c 328 § 6003. Prior: 2007 c 468 § 1; 2007 c 153 § 3; 2004 c 260 § 22; 2003 1st sp.s. c 25 § 923; 2002 c 371 § 913; 1987 c 505 § 54; 1986 c 296 § 7.]

Findings—2020 c 195: "The legislature finds that insurance fraud is not a victimless crime. The national insurance crime bureau has recognized as much as seven hundred dollars per year may be added to the average Washington household's insurance premium costs due to fraudulent insurance claims. For the 2017-2019 biennium, the insurance commissioner's insurance fraud program, known as its criminal investigations unit, reviewed over four thousand five hundred referrals from over one hundred fifty companies. The adjudicated cases from this review resulted in almost two million dollars of restitution and projected insurance claim savings.

The legislature finds it is critical to continue protecting Washington state insurance consumers from the cost of insurance fraud by funding the insurance fraud program through an insurance fraud surcharge and creating the insurance commissioner's fraud account to better manage the accountability of the funds." [2020 c 195 § 1.]

Effective date—2020 c 195: "This act takes effect July 1, 2020." [2020 c 195 § 4.]

Additional notes found at www.leg.wa.gov

48.02.200 When legal process against a person is served on the commission. (1) Legal process against a person (a) for whom the commissioner has been appointed attorney for service of process, or (b) who may be served by service of process upon the commissioner, must be served upon the commissioner either by a person competent to serve a summons or by registered mail. At the time of service, the plaintiff must pay to the commissioner ten dollars, taxable as costs in the action.

(2) As soon as practicable, the commissioner must send or make available a copy of the process to the person on whose behalf he or she has been served by mail, electronic

means, or other means reasonably calculated to give notice. The copy must be sent or made available in a manner that is secure and with a receipt that is verifiable.

(3) The commissioner must keep a record of the day and hour of service upon him or her of all legal process.

(4) Proceedings must not be had against the person, and the person must not be required to appear, plead, or answer until the expiration of forty days after the date of service upon the commissioner.

(5) The commissioner may adopt rules to implement this section. [2010 c 18 § 5.]

Additional notes found at www.leg.wa.gov

48.02.220 Pharmacy benefit managers—Registration—Enforcement authority—Rules. (Effective until January 1, 2022.) (1) The commissioner shall accept registration of pharmacy benefit managers as established in RCW 19.340.030 and receipts shall be deposited in the insurance commissioner's regulatory account.

(2) The commissioner shall have enforcement authority over chapter 19.340 RCW consistent with requirements established in RCW 19.340.110.

(3) The commissioner may adopt rules to implement chapter 19.340 RCW and to establish registration and renewal fees that ensure the registration, renewal, and oversight activities are self-supporting. [2016 c 210 § 5.]

48.02.220 Health care benefit managers—Registration—Enforcement authority—Rules. (Effective January 1, 2022.) (1) The commissioner shall accept registration of health care benefit managers as established in RCW 48.200.030 and receipts shall be deposited in the insurance commissioner's regulatory account.

(2) The commissioner shall have enforcement authority over chapter 48.200 RCW consistent with requirements established in RCW 48.200.290.

(3) The commissioner may adopt rules to implement chapter 48.200 RCW and to establish registration and renewal fees that ensure the registration, renewal, and oversight activities are self-supporting. [2020 c 240 § 8; 2016 c 210 § 5.]

Rule making—Effective date—2020 c 240: See RCW 48.200.900 and 48.200.901.

48.02.230 Health insurance market stability program—Confidentiality—Definitions—Reports—Commissioner's responsibilities. (1) For the purposes of developing or implementing an individual health insurance market stability program, any reports, data, documents, or materials that health carriers submit to or receive from the United States department of health and human services as part of any health and human services operated risk adjustment or reinsurance program, or that the Washington state health insurance pool, established under chapter 48.41 RCW, prepares for purposes of this section that are obtained by, disclosed to, or in the custody of the commissioner, regardless of the form or medium, are confidential and are not subject to public disclosure under chapter 42.56 RCW. The commissioner shall not disclose these reports, data, documents, or materials except in the furtherance of developing and implementing an individual health insurance market stability program.

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(2) For the purposes of this section:

(a) A health and human services operated risk adjustment or reinsurance program is any of the health insurance risk adjustment or reinsurance programs established under 42 U.S.C. Secs. 18061 and 18063. The reports, data, documents, and materials that are confidential under this section include all data and information carriers are required to provide to health and human services through the dedicated data environments required by 45 C.F.R. Sec. 153.700 et seq. for all health carriers participating in any health and human services health insurance risk adjustment or reinsurance program; and

(b) "Health carrier" has the same meaning as in RCW 48.43.005.

(3) The commissioner may:

(a) Share documents, materials, or other information, including the confidential documents, materials, or information subject to subsection (1) of this section, with contractors conducting actuarial, economic, or other analyses necessary to develop or implement an individual health insurance market stability program.

(b) Enter into agreements governing the sharing and use of information consistent with this subsection.

(4) No waiver of an existing claim of confidentiality or privilege 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 as authorized in subsection (3) of this section.

(5) Nothing in this section may be construed to authorize the commissioner to submit a complete application to the federal government for a waiver of any provision of federal law, including the federal patient protection and affordable care act, P.L. 111-148, as amended by the federal health care and education reconciliation act, P.L. 111-152, or federal regulations or guidance issued under the affordable care act. The commissioner shall provide the joint select committee on health care oversight established by RCW 44.82.010 with a progress report prior to submitting a draft waiver application to the federal government.

(6) Reports, data, documents, and materials subject to this section are those obtained by the commissioner as of December 31, 2019.

(7) The study conducted under this section to examine individual market stability options must be conducted one time only, and the data requested for purposes of the study must be mutually agreed on between the commissioner and the carriers. [2017 3rd sp.s. c 30 § 1.]

Effective date—2017 3rd sp.s. c 30: "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 [July 7, 2017]." [2017 3rd sp.s. c 30 § 3.]

48.02.240 Natural disaster and resiliency work group. (1) A work group to study and make recommendations on natural disaster and resiliency activities is hereby created. The work group membership shall be composed of:

(a) The insurance commissioner or his or her designee, who shall serve as the chair of the work group;

(b) One member from each of the two largest caucuses of the house of representatives, appointed by the speaker of the house of representatives;

(c) One member from each of the two largest caucuses of the senate, appointed by the president of the senate;

(d) A representative from the governor's resilient Washington work group;

(e) A representative from the Washington state association of counties;

(f) A representative from the association of Washington cities;

(g) A representative from the state building code council;

(h) The commissioner of the department of natural resources or his or her designee;

(i) The director of the Washington state military department or his or her designee;

(j) The superintendent of public instruction or his or her designee;

(k) The secretary of the state department of transportation or his or her designee;

(l) The director of the department of ecology or his or her designee;

(m) The director of the department of commerce or his or her designee;

(n) A representative from the Washington association of building officials;

(o) A representative from the building industry association of Washington;

(p) Two representatives from the property and casualty insurance industry, to be selected by the insurance commissioner or his or her designee, through an application process;

(q) A representative of emergency and transitional housing providers, to be appointed by the office of the insurance commissioner;

(r) A representative from public utility districts to be selected by a state association of public utility districts;

(s) A representative of water and sewer districts to be selected by a state association of water and sewer districts;

(t) A representative selected by the Washington state commission on African American affairs, the Washington state commission on Hispanic affairs, the governor's office of Indian affairs, and the Washington state commission on Asian Pacific American affairs to represent the entities on the work group;

(u) A representative from the state department of agriculture;

(v) A representative from the state conservation commission as defined in RCW 89.08.030;

(w) A representative of a federally recognized Indian tribe with a reservation located east of the crest of the Cascade mountains, to be appointed by the governor;

(x) A representative of a federally recognized Indian tribe with a reservation located west of the crest of the Cascade mountains, to be appointed by the governor; and

(y) Other state agency representatives or stakeholder group representatives, at the discretion of the work group, for the purpose of participating in specific topic discussions or subcommittees.

(2) The work group shall engage in the following activities:

(a) Review disaster mitigation and resiliency activities being done in this state by public and private entities;

(b) Review disaster mitigation and resiliency activities being done in other states and at the federal level;

(c) Review information on uptake in this state for disaster related insurance, such as flood and earthquake insurance;

(d) Review information on how other states are coordinating disaster mitigation and resiliency work including, but not limited to, the work of entities such as the California earthquake authority;

(e) Review how other states and the federal government fund their disaster mitigation and resiliency activities and programs; and

(f) Make recommendations to the legislature and office of the insurance commissioner regarding:

(i) Whether this state should create an ongoing disaster resiliency program;

(ii) What activities the program should engage in;

(iii) How the program should coordinate with state agencies and other entities engaged in disaster mitigation and resiliency work;

(iv) Where the program should be housed; and

(v) How the program should be funded.

(3) The work group shall submit, in compliance with RCW 43.01.036, a preliminary report of recommendations to the legislature, the office of the insurance commissioner, the governor, the office of the superintendent of public instruction, and the commissioner of public lands by November 1, 2019, and a final report by December 1, 2020. [2019 c 388 § 2.]

Findings—2019 c 388: "The legislature finds that residents of this state have been impacted by natural disasters such as floods, landslides, wildfires, and earthquakes and continue to be at risk from these and other natural disasters. In 2016, insured losses from natural disasters in the United States totaled almost twenty-four billion dollars. In 2015, Washington state had the largest wildfire season in state history, with more than one million acres burned and costing more than two hundred fifty-three million dollars. In 2017, four hundred four thousand two hundred twenty-three acres burned in Washington state and there were more than four hundred thirty national flood insurance program claims filed, totaling over seven million dollars.

The legislature finds that Washington state has the second highest earthquake risk in the nation, estimated by the federal emergency management agency to exceed four hundred thirty-eight million dollars per year. The 2001 Nisqually earthquake caused more than two billion dollars in damage. A Seattle fault earthquake will cause an estimated thirty-three billion dollars in damage, and a Cascadia subduction zone earthquake will cause an estimated amount of over forty-nine billion dollars in damage.

The legislature finds that it is critical to better prepare this state for disasters and to put in place strategies to mitigate the impacts of disasters. To address this critical need, the legislature is creating a work group to review disaster mitigation and preparation projects in this state and other states, make recommendations regarding how to coordinate and expand state efforts to mitigate the impacts of natural disasters, and evaluate whether an ongoing disaster resiliency program should be created." [2019 c 388 § 1.]

48.02.250 Living organ donors—Discrimination prohibited. (1) Notwithstanding any other provision of law, all insurers, fraternal benefit societies, health carriers including disability insurers, health maintenance organizations, and health care service contractors, and limited health care service contractors may not:

(a) Decline or limit coverage of a person under a policy or contract solely due to the status of the person as a living organ donor;

(b) Preclude a person from donating all or part of an organ as a condition of receiving or continuing to receive a policy or contract; or

(c) Otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price, or any other condition

of a policy or contract for a person based solely and without any additional actuarial risks upon the status of the person as a living organ donor. Except as provided in RCW 48.43.0128, 48.44.220, or 48.46.370, this subsection does not prohibit fair discrimination on the basis of sex, or marital status, or the presence of any sensory, mental, or physical handicap when bona fide statistical differences in risk or exposure have been substantiated.

(2) The commissioner shall make educational materials available to the health plans and the public on the access of living organ donors to insurance.

(3) The commissioner may adopt rules to implement this section.

(4) For purposes of this section, "living organ donor" means an individual who has donated all or part of an organ and is not deceased. [2021 c 172 § 1.]

Chapter 48.03 RCW EXAMINATIONS

Sections

48.03.005	Application.
48.03.010	Examination of insurers, bureaus.
48.03.020	Examination of producers, surplus line brokers, adjusters, title insurance agents, managers, or promoters.
48.03.025	Examiners—Scope of examination—Examiners' handbook.
48.03.030	Access to records on examination—Correction of accounts.
48.03.040	Examination reports—Consideration by commissioner—Orders—Confidentiality.
48.03.050	Reports withheld.
48.03.060	Examination expense.
48.03.065	Appointments by commissioner—Examiners—Exceptions.
48.03.070	Witnesses—Subpoenas—Depositions—Oaths.
48.03.075	Legal protection for commissioner, authorized representatives, and examiners—Good faith—Attorneys' fees—Payment by commissioner.

48.03.005 Application. This chapter applies to the financial analysis and examination of insurers and other regulated entities. [2007 c 82 § 1.]

48.03.010 Examination of insurers, bureaus. (1) The commissioner shall examine the affairs, transactions, accounts, records, documents, and assets of each authorized insurer as often as he or she deems advisable. The commissioner shall so examine each insurer holding a certificate of authority or certificate of registration not less frequently than every five years. Examination of an alien insurer may be limited to its insurance transactions in the United States. In scheduling and determining the nature, scope, and frequency of an examination, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the examiner's handbook adopted by the National Association of Insurance Commissioners and in effect when the commissioner exercises discretion under this section.

(2) As often as the commissioner deems advisable and at least once in five years, the commissioner shall fully examine each rating organization and examining bureau licensed in this state. As often as he or she deems it advisable the commissioner may examine each advisory organization, any statistical reporting agent designated by the commissioner under

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RCW 48.29.017, and each joint underwriting or joint reinsurance group, association, or organization.

(3) The commissioner shall in like manner examine each insurer or rating organization applying for authority to do business in this state.

(4) In lieu of making an examination under this chapter, the commissioner may accept a full report of the last recent examination of a nondomestic rating or advisory organization, or joint underwriting or joint reinsurance group, association or organization, as prepared by the insurance supervisory official of the state of domicile or of entry. In lieu of an examination under this chapter of a foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, an examination report may be accepted only if: (a) That insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' financial regulation standards and accreditation program; or (b) the examination was performed either under the supervision of an accredited insurance department or with the participation of one or more examiners employed by an accredited state insurance department who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(5) The commissioner may elect to accept and rely on an audit report made by an independent certified public accountant for the insurer 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.

(6) For the purposes of completing an examination of any company under this chapter, the commissioner may examine or investigate any managing general agent or any other person, or the business of any managing general agent or other person, insofar as that examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company. [2013 c 65 § 3; 1993 c 462 § 43; 1982 c 181 § 1; 1979 c 139 § 1; 1947 c 79 § .03.01; Rem. Supp. 1947 § 45.03.01.]

Additional notes found at www.leg.wa.gov

48.03.020 Examination of producers, surplus line brokers, adjusters, title insurance agents, managers, or promoters. For the purpose of ascertaining its condition, or compliance with this code, the commissioner may as often as he or she deems advisable examine the accounts, records, documents, and transactions of:

(1) Any insurance producer, surplus line broker, adjuster, or title insurance agent.

(2) Any person having a contract under which he or she enjoys in fact the exclusive or dominant right to manage or control a stock or mutual insurer.

(3) Any person holding the shares of capital stock or policyholder proxies of a domestic insurer for the purpose of control of its management either as voting trustee or otherwise.

(4) Any person engaged in or proposing to be engaged in or assisting in the promotion or formation of a domestic

insurer, or an insurance holding corporation, or a stock corporation to finance a domestic mutual insurer or the production of its business, or a corporation to be attorney-in-fact for a domestic reciprocal insurer. [2009 c 162 § 1; 2008 c 217 § 1; 1947 c 79 § .03.02; Rem. Supp. 1947 § 45.03.02.]

Additional notes found at www.leg.wa.gov

48.03.025 Examiners—Scope of examination—Examiners' handbook. Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the National Association of Insurance Commissioners. The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate. [1993 c 462 § 44.]

Additional notes found at www.leg.wa.gov

48.03.030 Access to records on examination—Correction of accounts. (1) Every person being examined, its officers, employees, and representatives shall produce and make freely accessible to the commissioner the accounts, records, documents, and files in his or her possession or control relating to the subject of the examination, and shall otherwise facilitate the examination.

(2) If the commissioner finds the accounts to be inadequate, or improperly kept or posted, he or she may employ experts to rewrite, post or balance them at the expense of the person being examined. [2009 c 549 § 7013; 1947 c 79 § .03.03; Rem. Supp. 1947 § 45.03.03.]

48.03.040 Examination reports—Consideration by commissioner—Orders—Confidentiality. (1) No later than sixty days after completion of each examination, the commissioner shall make a full written report of each examination made by him or her containing only facts ascertained from the accounts, records, and documents examined and from the sworn testimony of individuals, and such conclusions and recommendations as may reasonably be warranted from such facts.

(2) The report shall be certified by the commissioner or by his or her examiner in charge of the examination, and shall be filed in the commissioner's office subject to subsection (3) of this section.

(3) The commissioner shall furnish a copy of the examination report to the person examined not less than ten days and, unless the time is extended by the commissioner, not more than thirty days prior to the filing of the report for public inspection in the commissioner's office. If such person so requests in writing within such period, the commissioner shall hold a hearing to consider objections of such person to the report as proposed, and shall not so file the report until after such hearing and until after any modifications in the report deemed necessary by the commissioner have been made.

(4) Within thirty days of the end of the period described in subsection (3) of this section, unless extended by order of the commissioner, the commissioner shall consider the report, together with any written submissions or rebuttals and

any relevant portions of the examiner's workpapers and enter an order:

(a) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, rule, or order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure that violation;

(b) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information, and refiling under this section; or

(c) Calling for an investigatory hearing with no less than twenty days' notice to the company for purposes of obtaining additional documentation, data, information, and testimony.

(5) All orders entered under subsection (4) of this section must be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers, and any written submissions or rebuttals. Such an order is considered a final administrative decision and may be appealed under the Administrative Procedure Act, chapter 34.05 RCW, and must be served upon the company by certified mail or certifiable electronic means, together with a copy of the adopted examination report. A copy of the adopted examination report must be sent by certified mail or certifiable electronic means to each director at the director's residence address or to a personal email account.

(6)(a) Upon the adoption of the examination report under subsection (4) of this section, the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of five days except that the order may be disclosed to the person examined. Thereafter, the commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

(b) Nothing in this title prohibits the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as the agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this chapter.

(c) If the commissioner determines that regulatory action is appropriate as a result of any examination, he or she may initiate any proceedings or actions as provided by law.

(d) Nothing contained in this section requires the commissioner to disclose any information or records that would indicate or show the existence or content of any investigation or activity of a criminal justice agency. [2008 c 100 § 1; 1993 c 462 § 45; 1965 ex.s. c 70 § 1; 1947 c 79 § .03.04; Rem. Supp. 1947 § 45.03.04.]

Additional notes found at www.leg.wa.gov

48.03.050 Reports withheld. The commissioner may withhold from public inspection any examination or investigation report for so long as he or she deems it advisable, subject to RCW 48.32.080. [1993 c 462 § 46; 1947 c 79 § .03.05; Rem. Supp. 1947 § 45.03.05.]

Additional notes found at www.leg.wa.gov

48.03.060 Examination expense. (1) Examinations within this state of any insurer or self-funded multiple employer welfare arrangement as defined in RCW 48.125.010 domiciled or having its home offices in this state, other than a title insurer, made by the commissioner or the commissioner's examiners and employees must, except as to fees, mileage, and expense incurred as to witnesses, be at the expense of the state.

(2) Every other examination, whatsoever, or any part of the examination of any person domiciled or having its home offices in this state requiring travel and services outside this state, must be made by the commissioner or by examiners designated by the commissioner and must be at the expense of the person examined; but a domestic insurer must not be liable for the compensation of examiners employed by the commissioner for such services outside this state.

(3) When making an examination under this chapter, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the cost of which must be borne by the person who is the subject of the examination, except as provided in subsection (1) of this section.

(4) The person examined and liable must reimburse the state upon presentation of an itemized statement 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 examining insurers domiciled outside the state of Washington must 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 state director of personnel, and the expense schedule established by the office of financial management, whichever is higher. A domestic title insurer must pay the examination expense and costs to the commissioner as itemized and billed by the commissioner.

The commissioner or the commissioner's examiners must not receive or accept any additional emolument on account of any examination.

(5) Nothing contained in this chapter limits the commissioner's authority to terminate or suspend any examination 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 examination are prima facie evidence in any legal or regulatory action.

(6) The expense of the examination of any statistical reporting agent designated by the commissioner under RCW 48.29.017 must be borne by and apportioned among all authorized title insurance companies and licensed title insurance agents in this state. [2013 c 65 § 4; 2011 c 47 § 4; 2004 c 260 § 23; 1995 c 152 § 2. Prior: 1993 c 462 § 47; 1993 c 281 § 55; 1981 c 339 § 2; 1979 ex.s. c 35 § 1; 1947 c 79 § .03.06; Rem. Supp. 1947 § 45.03.06.]

Intent—1995 c 152: "The only intent of the legislature in chapter 152, Laws of 1995 is to correct double amendments. It is not the intent of the legislature to change the substance or effect of any statute previously enacted." [1995 c 152 § 1.]

Additional notes found at www.leg.wa.gov

48.03.065 Appointments by commissioner—Examiners—Exceptions. (1) No examiner may be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in a person subject to examination under this chapter. This section does not automatically preclude an examiner from being:

(a) A policyholder or claimant under an insurance policy;

(b) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(c) An investment owner in shares of regulated diversified investment companies; or

(d) A settlor or beneficiary of a blind trust into which any otherwise impermissible holdings have been placed.

(2) Notwithstanding the requirements of subsection (1) of this section, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though those persons may from time to time be similarly employed or retained by persons subject to examination under this chapter. [1993 c 462 § 48.]

Additional notes found at www.leg.wa.gov

48.03.070 Witnesses—Subpoenas—Depositions—Oaths. (1) The commissioner may take depositions, may subpoena witnesses or documentary evidence, administer oaths, and examine under oath any individual relative to the affairs of any person being examined, or relative to the subject of any hearing or investigation: PROVIDED, That the provisions of RCW 34.05.446 shall apply in lieu of the provisions of this section as to subpoenas relative to hearings in rule-making and adjudicative proceedings.

(2) The subpoena shall be effective if served within the state of Washington and shall be served in the same manner as if issued from a court of record.

(3) Witness fees and mileage, if claimed, shall be allowed the same as for testimony in a court of record. Witness fees, mileage, and the actual expense necessarily incurred in securing attendance of witnesses and their testimony shall be itemized, and shall be paid by the person as to whom the examination is being made, or by the person if other than the commissioner, at whose request the hearing is held.

(4) Enforcement of subpoenas shall be in accord with RCW 34.05.588. [1989 c 175 § 112; 1967 c 237 § 15; 1963 c 195 § 1; 1949 c 190 § 2; 1947 c 79 § .03.07; Rem. Supp. 1949 § 45.03.07.]

Additional notes found at www.leg.wa.gov

48.03.075 Legal protection for commissioner, authorized representatives, and examiners—Good faith—Attorneys' fees—Payment by commissioner. (1) No cause of action may arise nor may any liability be imposed against the commissioner, the commissioner's authorized representa-

tives, or an examiner appointed by the commissioner for statements made or conduct performed in good faith while carrying out this chapter.

(2) No cause of action may arise nor may any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this chapter, if that act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(3) This section does not modify a privilege or immunity previously enjoyed by a person identified in subsection (1) of this section.

(4) A person identified in subsection (1) of this section is 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 tort arising out of activities in carrying out 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.

(5) If a claim is made or threatened of the sort described in subsection (1) of this section, the commissioner shall provide or pay for the defense of himself or herself, the examiner or representative, and shall pay a judgment or settlement, until it is determined that the person did not act in good faith or did act with fraudulent intent or the intent to deceive.

(6) The immunity, indemnification, and other protections under this section are in addition to those now or hereafter existing under other law. [1993 c 462 § 49.]

Additional notes found at www.leg.wa.gov

Chapter 48.04 RCW HEARINGS AND APPEALS

Sections

48.04.010	Hearings—Waiver—Administrative law judge.
48.04.020	Stay of action.
48.04.030	Place of hearing.
48.04.050	Show cause notice.
48.04.060	Adjourned hearings.
48.04.070	Nonattendance, effect of.
48.04.140	Stay of action on appeal.

48.04.010 Hearings—Waiver—Administrative law judge. (1) The commissioner may hold a hearing for any purpose within the scope of this code as he or she may deem necessary. The commissioner shall hold a hearing:

(a) If required by any provision of this code; or

(b) Except under RCW 48.13.475, upon written demand for a hearing made by any person aggrieved by any act, threatened act, or failure of the commissioner to act, if such failure is deemed an act under any provision of this code, or by any report, promulgation, or order of the commissioner other than an order on a hearing of which such person was given actual notice or at which such person appeared as a party, or order pursuant to the order on such hearing.

(2) Any such demand for a hearing shall specify in what respects such person is so aggrieved and the grounds to be relied upon as basis for the relief to be demanded at the hearing.

(3) Unless a person aggrieved by a written order of the commissioner demands a hearing thereon within ninety days after receiving notice of such order, or in the case of a licensee under Title 48 RCW within ninety days after the commissioner has mailed the order to the licensee at the most recent address shown in the commissioner's licensing records for the licensee, the right to such hearing shall conclusively be deemed to have been waived.

(4) If a hearing is demanded by a licensee whose license has been temporarily suspended pursuant to RCW 48.17.540, the commissioner shall hold such hearing demanded within thirty days after receipt of the demand or within thirty days of the effective date of a temporary license suspension issued after such demand, unless postponed by mutual consent.

(5) A licensee under this title may request that a hearing authorized under this section be presided over by an administrative law judge assigned under chapter 34.12 RCW. Any such request shall not be denied.

(6) Any hearing held relating to RCW 48.20.025, 48.44.017, or 48.46.062 shall be presided over by an administrative law judge assigned under chapter 34.12 RCW. [2000 c 221 § 8; 2000 c 79 § 1; 1990 1st ex.s. c 3 § 1; 1988 c 248 § 2; 1967 c 237 § 16; 1963 c 195 § 2; 1947 c 79 § .04.01; Rem. Supp. 1947 § 45.04.01.]

Reviser's note: This section was amended by 2000 c 79 § 1 and by 2000 c 221 § 8, 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).

Additional notes found at www.leg.wa.gov

48.04.020 Stay of action. (1) Such demand for a hearing received by the commissioner prior to the effective date of action taken or proposed to be taken by him or her shall stay such action pending the hearing, except as to action taken or proposed

(a) under an order on hearing, or

(b) under an order pursuant to an order on hearing, or

(c) under an order to make good an impairment of the assets of an insurer, or

(d) under an order of temporary suspension of license issued pursuant to RCW 48.17.540 as now or hereafter amended.

(2) In any case where an automatic stay is not provided for, and if the commissioner after written request therefor fails to grant a stay, the person aggrieved thereby may apply to the superior court for Thurston county for a stay of the commissioner's action.

(3) A stay of action is not available for actions taken by the commissioner under RCW 48.13.475. [2000 c 221 § 9; 1982 c 181 § 2; 1949 c 190 § 3; 1947 c 79 § .04.02; Rem. Supp. 1949 § 45.04.02.]

Additional notes found at www.leg.wa.gov

48.04.030 Place of hearing. The hearing shall be held at the place designated by the commissioner, and at his or her discretion it may be open to the public. [2009 c 549 § 7014; 1947 c 79 § .04.03; Rem. Supp. 1947 § 45.04.03.]

48.04.050 Show cause notice. If any person is entitled to a hearing by any provision of this code before any proposed action is taken, the notice of the proposed action may

be in the form of a notice to show cause stating that the proposed action may be taken unless such person shows cause at a hearing to be held as specified in the notice, why the proposed action should not be taken, and stating the basis of the proposed action. [1947 c 79 § .04.05; Rem. Supp. 1947 § 45.04.05.]

48.04.060 Adjourned hearings. The commissioner may adjourn any hearing from time to time and from place to place without other notice of the adjourned hearing than announcement thereof at the hearing. [1947 c 79 § .04.06; Rem. Supp. 1947 § 45.04.06.]

48.04.070 Nonattendance, effect of. The validity of any hearing held in accordance with the notice thereof shall not be affected by failure of any person to attend or to remain in attendance. [1947 c 79 § .04.07; Rem. Supp. 1947 § 45.04.07.]

48.04.140 Stay of action on appeal. (1) The taking of an appeal shall not stay any action taken or proposed to be taken by the commissioner under the order appealed from unless a stay is granted by the court at a hearing held as part of the proceedings on appeal.

(2) A stay shall not be granted by the court in any case where the granting of a stay would tend to injure the public interest. In granting a stay, the court may require of the person taking the appeal such security or other conditions as it deems proper. [1988 c 248 § 3; 1947 c 79 § .04.14; Rem. Supp. 1947 § 45.04.14.]

Chapter 48.05 RCW

INSURERS—GENERAL REQUIREMENTS

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Deposit of insurers: Chapter 48.16 RCW.

Federal home loan bank as depository: RCW 30A.32.040.

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Unfair practices: Chapter 48.30 RCW.

48.05.010 "Domestic," "foreign," "alien" insurers defined. (1) A "domestic" insurer is one formed under the laws of this state.

(2) A "foreign" insurer is one 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.

(3) An "alien" insurer is one formed under the laws of a nation other than the United States.

(4) For the purposes of this code, "United States," when used to signify place, means only the states of the United States, the government of Puerto Rico and the District of

Columbia. [1961 c 194 § 1; 1947 c 79 § .05.01; Rem. Supp. 1947 § 45.05.01.]

"Insurer" defined: RCW 48.01.050.

48.05.030 Certificate of authority required. (1) No person shall act as an insurer and no insurer shall transact insurance in this state other than as authorized by a certificate of authority issued to it by the commissioner and then in force; except, as to such transactions as are expressly otherwise provided for in this code.

(2) Every certificate of authority shall specify the name of the insurer, the location of its principal office, the name and location of the principal office of its attorney-in-fact if a reciprocal insurer, and the kind or kinds of insurance it is authorized to transact in this state.

(3) The investigation and adjustment of any claim in this state arising under an insurance contract issued by an unauthorized insurer, shall not be deemed to constitute the transacting of insurance in this state. [1947 c 79 § .05.03; Rem. Supp. 1947 § 45.05.03.]

48.05.040 Certificate of authority—Qualifications. To qualify for and hold a certificate of authority an insurer must:

(1) Be a stock, mutual, or reciprocal insurer of the same general type as may be formed as a domestic insurer under the provisions of chapter 48.06 RCW of this code, but this requirement shall not apply as to domestic mutual property insurers which, as of January 1, 1957, were lawfully transacting insurance on the assessment plan; and

(2) Have capital funds as required by this code, based upon the type and domicile of the insurer and the kinds of insurance proposed to be transacted; and

(3) Transact or propose to transact in this state insurances authorized by its charter, and only such insurance as meets the standards and requirements of this code; and

(4) Fully comply with, and qualify according to, the other provisions of this code. [1957 c 193 § 1; 1947 c 79 § .05.04; Rem. Supp. 1947 § 45.05.04.]

48.05.045 Certificate of authority not to be issued to governmentally owned insurer. No certificate of authority shall be issued to or exist with respect to any insurer which is owned and controlled, in whole or in substantial part, by any government or governmental agency. [1957 c 193 § 2.]

48.05.050 "Charter" defined. "Charter" means articles of incorporation, articles of agreement, articles of association of a corporation, or other basic constituent document of a corporation, or subscribers' agreement and attorney-in-fact agreement of a reciprocal insurer. [1947 c 79 § .05.05; Rem. Supp. 1947 § 45.05.05.]

48.05.060 "Capital funds" defined. "Capital funds" means the excess of the assets of an insurer over its liabilities. Capital stock, if any, shall not be deemed to be a liability for the purposes of this section. [1947 c 79 § .05.06; Rem. Supp. 1947 § 45.05.06.]

48.05.070 Application for certificate of authority. To apply for an original certificate of authority an insurer shall:

(1) File with the commissioner its request therefor showing:

(a) Its name, home office location, type of insurer, organization date, and state or country of its domicile.

(b) The kinds of insurance it proposes to transact.

(c) Additional information as the commissioner may reasonably require.

(2) File with the commissioner:

(a) A copy of its charter as amended, certified, if a foreign or alien insurer, by the proper public officer of the state or country of domicile.

(b) A copy of its bylaws, certified by its proper officer.

(c) A statement of its financial condition, management, and affairs on a form satisfactory to or furnished by the commissioner.

(d) If a foreign or alien insurer, or a domestic reciprocal insurer, an appointment of the commissioner as its attorney to receive service of legal process.

(e) If an alien insurer, a copy of the appointment and authority of its United States manager, certified by its proper officer.

(f) If a foreign or alien insurer, a certificate from the proper public official of its state or country of domicile showing that it is duly organized and is authorized to transact the kinds of insurance proposed to be transacted.

(g) If a domestic reciprocal insurer, the declaration required by RCW 48.10.090 of this code.

(h) Other documents or stipulations as the commissioner may reasonably require to evidence compliance with the provisions of this code.

(3) Deposit with the commissioner the fees required by this code to be paid for filing the accompanying documents, and for the certificate of authority, if granted. [1947 c 79 § .05.07; Rem. Supp. 1947 § 45.05.07.]

48.05.073 Filing of financial statements. Every insurer holding a certificate of authority from the commissioner shall file its financial statements as required by this code 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. [1999 c 33 § 1.]

48.05.080 Foreign insurers—Deposit. (1) Prior to the issuance of a certificate of authority to a foreign insurer, it shall make a deposit of assets with the commissioner for the protection of all its policyholders, or of all of its policyholders and obligees or its policyholders and obligees within the United States, in amount and kind, subject to RCW 48.14.040, the same as is required of a like domestic insurer transacting like kinds of insurance.

(2) In lieu of such deposit or part thereof the commissioner may accept the certificate of the public official having supervision over insurers in any other state to the effect that a like deposit by such insurer or like part thereof in equal or greater amount is held in public custody in such state. [1955 c 86 § 1; 1947 c 79 § .05.08; Rem. Supp. 1947 § 45.05.08.]

Additional notes found at www.leg.wa.gov

48.05.090 Alien insurers—Assets required—Trust deposit. (1) An alien insurer shall not be authorized to trans-

act insurance in this state unless it maintains within the United States assets in amount not less than its outstanding liabilities arising out of its insurance transactions in the United States, nor unless it maintains a trust deposit in an amount not less than the required reserves under its policies resulting from such transactions (after deducting, in the case of a life insurer, the amount of outstanding policy loans on such policies) plus assets equal to the larger of the following sums:

(a) The largest amount of deposit required under this title to be made in this state by any type of domestic insurer transacting like kinds of insurance; or

(b) Two hundred thousand dollars.

(2) The trust deposit shall be for the security of all policyholders or policyholders and obligees of the insurer in the United States. It shall not be subject to diminution below the amount currently determined in accordance with subsection (1) of this section so long as the insurer has outstanding any liabilities arising out of its business transacted in the United States.

(3) The trust deposit shall be maintained with public depositaries or trust institutions within the United States approved by the commissioner. [1949 c 190 § 4; 1947 c 79 § .05.09; Rem. Supp. 1949 § 45.05.09.]

48.05.100 Alien insurers—Deposit resolution. An alien insurer shall file with the commissioner a certified copy of the resolution of its governing board by which the trust deposit was established, together with a certified copy of any trust agreement under which the deposit is held. [1947 c 79 § .05.10; Rem. Supp. 1947 § 45.05.10.]

48.05.105 Foreign or alien insurers—Three years active transacting required—Exception. (1) No certificate of authority shall be granted to a foreign or alien applicant that has not actively transacted for three years the classes of insurance for which it seeks to be admitted.

(2) Subsection (1) of this section does not apply to the following:

(a) Any subsidiary of a seasoned, reputable insurer that has held a certificate of authority in this state for at least three years; or

(b) Any applicant that:

(i) Has surplus of not less than twenty-five million dollars; and

(ii) Has made a deposit with the commissioner in the amount of one million dollars for the sole benefit of the applicant's Washington policyholders.

(3) The commissioner shall release the deposit to an authorized insurer who originally met the requirement in subsection (2)(b)(ii) of this section, in accordance with chapter 48.16 RCW, if:

(a) The certificate of authority was issued at least three years prior to application for release of the deposit; and

(b) The insurer is in good standing with the commissioner. [2010 c 93 § 1; 1967 c 150 § 2.]

48.05.110 Issuance of certificate of authority. If the commissioner finds that an insurer has met the requirements for and is fully entitled thereto under this code, he or she shall issue to it a proper certificate of authority. If the commis-

sioner does not so find, the authority shall be refused within a reasonable length of time following completion by the insurer of the application therefor. [2009 c 549 § 7015; 1947 c 79 § .05.11; Rem. Supp. 1947 § 45.05.11.]

48.05.120 Certificate of authority—Duration, renewal, amendment. (1) All certificates of authority shall continue in force until suspended, revoked, or not renewed. A certificate shall be subject to renewal annually on the first day of July upon application of the insurer and payment of the fee therefor. If not so renewed, the certificate shall expire as of the thirtieth day of June next preceding.

(2) The commissioner may amend a certificate of authority at any time in accordance with changes in the insurer's charter or insuring powers. [1957 c 193 § 3; 1955 c 31 § 1; 1947 c 79 § .05.12; Rem. Supp. 1947 § 45.05.12.]

48.05.130 Certificate of authority—Mandatory refusal, revocation, suspension. The commissioner shall refuse to renew or shall revoke or suspend an insurer's certificate of authority, in addition to other grounds therefor in this code, if the insurer:

(1) Is a foreign or alien insurer and no longer qualifies or meets the requirements for the authority; or, is a domestic mutual or domestic reciprocal insurer, and fails to make good a deficiency of assets as required by the commissioner.

(2) Is a domestic stock insurer and has assets less in amount than its liabilities, including its capital stock as a liability, and has failed to make good such deficiency as required by the commissioner.

(3) Knowingly exceeds its charter powers or its certificate of authority. [1947 c 79 § .05.13; Rem. Supp. 1947 § 45.05.13.]

48.05.140 Certificate of authority—Discretionary refusal, revocation, suspension. The commissioner may refuse, suspend, or revoke an insurer's certificate of authority, in addition to other grounds therefor in this code, if the insurer:

(1) Fails to comply with any provision of this code other than those for violation of which refusal, suspension, or revocation is mandatory, or fails to comply with any proper order or regulation of the commissioner.

(2) Is found by the commissioner to be in such condition that its further transaction of insurance in this state would be hazardous to policyholders and the people in this state.

(3) Refuses to remove or discharge a director or officer who has been convicted of any crime involving fraud, dishonesty, or like moral turpitude.

(4) Usually compels claimants under policies either to accept less than the amount due them or to bring suit against it to secure full payment of the amount due.

(5) Is affiliated with and under the same general management, or interlocking directorate, or ownership as another insurer which transacts insurance in this state without having a certificate of authority therefor, except as is permitted by this code.

(6) Refuses to be examined, or if its directors, officers, employees or representatives refuse to submit to examination or to produce its accounts, records, and files for examination

by the commissioner when required, or refuse to perform any legal obligation relative to the examination.

(7) Fails to pay any final judgment rendered against it in this state upon any policy, bond, recognizance, or undertaking issued or guaranteed by it, within thirty days after the judgment became final or within thirty days after time for taking an appeal has expired, or within thirty days after dismissal of an appeal before final determination, whichever date is the later.

(8) Is found by the commissioner, after investigation or upon receipt of reliable information, to be managed by persons, whether by its directors, officers, or by any other means, who are incompetent or untrustworthy or so lacking in insurance company managerial experience as to make a proposed operation hazardous to the insurance-buying public; or that there is good reason to believe it is affiliated directly or indirectly through ownership, control, reinsurance or other insurance or business relations, with any person or persons whose business operations are or have been marked, to the detriment of policyholders or stockholders or investors or creditors or of the public, by bad faith or by manipulation of assets, or of accounts, or of reinsurance.

(9) Does business through insurance producers or title insurance agents in this state or in any other state who are not properly licensed under applicable laws and duly enacted regulations adopted pursuant thereto. [2008 c 217 § 2; 1973 1st ex.s. c 152 § 1; 1969 ex.s. c 241 § 3; 1967 c 150 § 4; 1947 c 79 § .05.14; Rem. Supp. 1947 § 45.04.14.]

Additional notes found at www.leg.wa.gov

48.05.150 Notice of intention to refuse, revoke, or suspend. The commissioner shall give an insurer notice of his or her intention to suspend, revoke, or refuse to renew its certificate of authority not less than ten days before the order of suspension, revocation or refusal is to become effective; except that no advance notice of intention is required where the order results from a domestic insurer's failure to make good a deficiency of assets as required by the commissioner. [2009 c 549 § 7016; 1947 c 79 § .05.15; Rem. Supp. 1947 § 45.05.15.]

48.05.160 Period of suspension. The commissioner shall not suspend an insurer's certificate of authority for a period in excess of one year, and he or she shall state in his or her order of suspension the period during which it shall be effective. [2009 c 549 § 7017; 1947 c 79 § .05.16; Rem. Supp. 1947 § 45.05.16.]

48.05.170 Reauthorization, limitation upon. No insurer whose certificate of authority has been suspended, revoked, or refused shall subsequently be authorized unless the grounds for such suspension, revocation, or refusal no longer exist and the insurer is otherwise fully qualified. [1947 c 79 § .05.17; Rem. Supp. 1947 § 45.05.17.]

48.05.180 Notice of refusal, revocation, suspension—Effect upon insurance producers' or title insurance agents' authority. Upon the suspension, revocation or refusal of an insurer's certificate of authority, the commissioner shall give notice thereof to the insurer and shall likewise suspend, revoke or refuse the authority of its appointed

insurance producers or title insurance agents to represent it in this state and give notice thereof to these insurance producers or title insurance agents. [2008 c 217 § 3; 1947 c 79 § .05.18; Rem. Supp. 1947 § 45.05.18.]

Additional notes found at www.leg.wa.gov

48.05.185 Fine in addition or in lieu of suspension, revocation, or refusal. After hearing or with the consent of the insurer and in addition to or in lieu of the suspension, revocation, or refusal to renew any certificate of authority the commissioner may levy a fine upon the insurer in an amount not less than two hundred 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 certificate of authority of the insurer if not already revoked, and the fine shall be recovered in a civil action brought in 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. [1980 c 102 § 1; 1975 1st ex.s. c 266 § 3; 1965 ex.s. c 70 § 3.]

Additional notes found at www.leg.wa.gov

48.05.190 Name of insurer. (1) Every insurer shall conduct its business in its own legal name.

(2) No insurer shall assume or use a name deceptively similar to that of any other authorized insurer. [1947 c 79 § .05.19; Rem. Supp. 1947 § 45.05.19.]

48.05.200 Commissioner as attorney for service of process—Exception. (1) Each authorized foreign or alien insurer 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 insurer. Service of legal process against the insurer can be had only by service upon the commissioner, except actions upon contractor bonds pursuant to RCW 18.27.040, where service may be upon the department of labor and industries.

(2) With the appointment the insurer 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 insurer may change the person by filing a new designation.

(3) The insurer must keep the designation, address, and email address filed with the commissioner current.

(4) The appointment of the commissioner as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the insurer, and remains in effect as long as there is in force in this state any contract made by the insurer or liabilities or duties arising therefrom.

(5) The service of process must be accomplished and processed in the manner prescribed under RCW 48.02.200. [2011 c 47 § 5; 1985 c 264 § 3; 1947 c 79 § .05.20; Rem. Supp. 1947 § 45.05.20.]

48.05.215 Unauthorized foreign or alien insurers—Jurisdiction of state courts—Service of process—Proce-

dure. (1) Any foreign or alien insurer not authorized by the commissioner, whether it be a surplus lines insurer operating under chapter 48.15 RCW or not, who, by mail or otherwise, solicits insurance business in this state or transacts insurance business in this state as defined by RCW 48.01.060, thereby submits itself to the jurisdiction of the courts of this state in any action, suit, or proceeding instituted by or on behalf of an insured, beneficiary or the commissioner arising out of an unauthorized solicitation of insurance business, including, but not limited to, an action for injunctive relief by the commissioner.

(2) In any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary, service of legal process against an unauthorized foreign or alien insurer must be accomplished and processed in the manner prescribed under RCW 48.02.200. The defendant insurer has forty days from the date of the service on the commissioner within which to plead, answer, or otherwise defend the action.

(3) In any such action, suit, or proceeding by the commissioner, service of legal process against an unauthorized foreign or alien insurer may be made by personal service of legal process upon any officer of such insurer at its last known principal place of business outside the state of Washington. The summons upon an unauthorized foreign or alien insurer must contain the same requisites and be served in like manner as personal summons within the state of Washington; except, the insurer has forty days from the date of personal service within which to plead, answer, or otherwise defend the action. [2011 c 47 § 6; 1981 c 339 § 4; 1967 c 150 § 3.]

48.05.220 Venue of actions against insurer. Suit upon causes of action arising within this state against an insurer upon an insurance contract shall be brought in the county where the cause of action arose. [1947 c 79 § .05.22; Rem. Supp. 1947 § 45.05.22.]

48.05.250 Annual statement. (1) Each domestic insurer 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 preceding. The statement forms shall be in general form and context as approved by the National Association of Insurance Commissioners for the kinds of insurance to be reported upon, and as supplemented for additional information required by this code and by the commissioner. The statement shall be verified by the oaths of at least two of the insurer's officers.

(2) The annual statement of an alien insurer shall relate only to its transactions and affairs in the United States unless the commissioner requires otherwise. The statement shall be verified by the insurer's United States manager or by its officers duly authorized.

(3) The commissioner shall suspend or revoke the certificate of authority of any insurer failing to file its annual statement when due or during any extension of time therefor which the commissioner, for good cause, may grant. [2006 c 25 § 5; 1983 c 85 § 1; 1947 c 79 § .05.25; Rem. Supp. 1947 § 45.05.25.]

Advertising of financial condition: RCW 48.30.070.

Assets and liabilities: Chapter 48.12 RCW.

False financial statements: RCW 48.30.030.

(2021 Ed.)

48.05.270 Alien insurer—Capital funds, determination. (1) The capital funds of an alien insurer shall be deemed to be the amount by which its assets, deposited and otherwise held as provided in RCW 48.05.090 exceed its liabilities with respect to its business transacted in the United States.

(2) Assets of such insurer held in any state for the special protection of policyholders and obligees in such state shall not constitute assets of the insurer for the purposes of this code. Liabilities of the insurer so secured by such assets, but not exceeding the amount of such assets, may be deducted in computing the insurer's liabilities for the purpose of this section. [1947 c 79 § .05.27; Rem. Supp. 1947 § 45.05.27.]

48.05.280 Records and accounts of insurers. Every insurer shall keep full and adequate accounts and records of its assets, obligations, transactions, and affairs. [1947 c 79 § .05.28; Rem. Supp. 1947 § 45.05.28.]

48.05.290 Withdrawal of insurer—Reinsurance. (1) No insurer shall withdraw from this state until its direct liability to its policyholders and obligees under all its insurance contracts then in force in this state has been assumed by another authorized insurer under an agreement approved by the commissioner. In the case of a life insurer, its liability pursuant to contracts issued in this state in settlement of proceeds under its policies shall likewise be so assumed.

(2) The commissioner may waive this requirement if he or she finds upon examination that a withdrawing insurer is then fully solvent and that the protection to be given its policyholders in this state will not be impaired by the waiver.

(3) The assuming insurer shall within a reasonable time replace the assumed insurance contracts with its own, or by endorsement thereon acknowledge its liability thereunder. [2009 c 549 § 7019; 1947 c 79 § .05.29; Rem. Supp. 1947 § 45.05.29.]

48.05.320 Reports of fire losses. (1) Each authorized insurer shall promptly report to the chief of the Washington state patrol, through the director of fire protection, upon forms as prescribed and furnished by him or her, each fire loss of property in this state reported to it and whether the loss is due to criminal activity or to undetermined causes.

(2) Each such insurer shall likewise report to the chief of the Washington state patrol, through the director of fire protection, upon claims paid by it for loss or damage by fire in this state. Copies of all reports required by this section shall be promptly transmitted to the state insurance commissioner. [1995 c 369 § 24; 1986 c 266 § 66; 1985 c 470 § 16; 1947 c 79 § .05.32; Rem. Supp. 1947 § 45.05.32.]

Additional notes found at www.leg.wa.gov

48.05.330 Insurers—Combination of kinds of insurance authorized—Exceptions. An insurer which otherwise qualifies therefor may be authorized to transact any one kind or combinations of kinds of insurance as defined in chapter 48.11 RCW, except:

(1) A life insurer may grant annuities and may be authorized to transact in addition only disability insurance; except, that the commissioner may, if the insurer otherwise qualifies therefor, continue so to authorize any life insurer which

immediately prior to June 13, 1963 was lawfully authorized to transact in this state a kind or kinds of insurance in addition to life and disability insurances and annuity business.

(2) A reciprocal insurer shall not transact life insurance.

(3) A title insurer shall be a stock insurer and shall not transact any other kind of insurance. This provision shall not prohibit the ceding of reinsurance by a title insurer to insurers other than mutual or reciprocal insurers. [1963 c 195 § 6.]

48.05.340 Capital and surplus requirements. (1) Subject to RCW 48.05.350 to qualify for authority to transact any one kind of insurance as defined in chapter 48.11 RCW or combination of kinds of insurance as set forth in this subsection, a foreign or alien insurer, whether stock or mutual, or a domestic insurer must possess unimpaired paid-in capital stock, if a stock insurer, or unimpaired surplus if a mutual insurer, and additional funds in surplus, as follows, and must thereafter maintain unimpaired a combined total of: (a) The paid-in capital stock if a stock insurer or surplus if a mutual insurer, plus (b) additional funds in surplus equal to the total of the following initial requirements:

Kind or kinds of insurance	Paid-in capital stock or basic surplus	Additional surplus
Life	\$2,000,000	\$2,000,000
Disability	2,000,000	2,000,000
Life and disability . .	2,400,000	2,400,000
Property	2,000,000	2,000,000
Marine & transportation	2,000,000	2,000,000
General casualty . . .	2,400,000	2,400,000
Vehicle	2,000,000	2,000,000
Surety	2,000,000	2,000,000
Ocean marine and foreign trade	2,000,000	2,000,000
Any two of the following kinds of insurance: Property, marine & transportation, general casualty, vehicle, surety, ocean marine and foreign trade, disability	3,000,000	3,000,000
Multiple lines (all insurances except life and title insurance)	3,000,000	3,000,000
Title	2,000,000	2,000,000

(2) Capital and surplus requirements are based upon all the kinds of insurance transacted by the insurer wherever it operates or proposes to operate, whether or not only a portion of the kinds are to be transacted in this state.

(3) Until December 31, 1996, a foreign or alien insurer holding a certificate of authority to transact insurance in this state immediately prior to June 9, 1994, may continue to be authorized to transact the same kinds of insurance as long as

it is otherwise qualified for that authority. A domestic insurer, except a title insurer, holding a certificate of authority to transact insurance in this state immediately prior to June 9, 1994, may continue to be authorized to transact the same kinds of insurance as long as it is otherwise qualified for such an authority and thereafter maintains unimpaired the amount of paid-in capital stock, if a stock insurer, or basic surplus, if a mutual or reciprocal insurer, and special or additional surplus as required of it under laws in force immediately prior to June 9, 1994. A domestic insurer that is acquired or merged must, immediately after completion of an acquisition or merger, meet the capital and surplus requirements of subsection (1) of this section. A domestic insurer, upon attaining the capital and surplus requirements of subsection (1) of this section, may not return to the capital and surplus requirements existing before June 9, 1994. [2007 c 127 § 1; 2005 c 223 § 2; 1995 c 83 § 14; 1994 c 171 § 1; 1993 c 462 § 50; 1991 sp.s. c 5 § 1; 1982 c 181 § 3; 1980 c 135 § 1; 1967 c 150 § 5; 1963 c 195 § 7.]

Additional notes found at www.leg.wa.gov

48.05.350 General casualty insurer combining disability, fidelity, insurance. An insurer authorized to transact general casualty insurance shall be authorized to transact disability insurance and fidelity insurance without requiring additional financial qualifications. [1963 c 195 § 8.]

48.05.370 Fiduciary relationship to insurer of officers, directors or corporation holding controlling interest. Officers and directors of an insurer or a corporation holding a controlling interest in an insurer shall be deemed to stand in a fiduciary relation to the insurer, and shall discharge the duties of their respective positions in good faith, and with that diligence, care and skill which ordinary prudent persons would exercise under similar circumstances in like positions. [2009 c 549 § 7020; 1969 ex.s. c 241 § 1.]

48.05.380 Reports by property and casualty insurers—Rules. The insurance commissioner shall adopt rules requiring insurers who are authorized to write property and casualty insurance in the state of Washington to record and report their Washington state loss and expense experiences and other data, as required by RCW 48.05.390. These rules may not require a report to be submitted by any insurer that has no data or experience to report. [2002 c 22 § 1; 1986 c 148 § 1; 1985 c 238 § 1.]

Additional notes found at www.leg.wa.gov

48.05.383 Statement of actuarial opinion—Property and casualty insurance. (1) Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an appointed actuary entitled "Statement of Actuarial Opinion." This opinion shall be filed in accordance with the property and casualty annual statement instructions as adopted by the national association of insurance commissioners.

(2) Every property and casualty insurance company domiciled in this state that is required to submit a statement of actuarial opinion shall annually submit an actuarial opinion summary, written by the company's appointed actuary.

This actuarial opinion summary shall be filed in accordance with the property and casualty annual statement instructions as adopted by the national association of insurance commissioners and shall be considered as a document supporting the actuarial opinion required in subsection (1) of this section.

(3) An insurance company authorized but not domiciled in this state shall provide the actuarial opinion summary upon request.

(4) An actuarial report and underlying work papers as required by the property and casualty annual statement instructions as adopted by the national association of insurance commissioners shall be prepared to support each actuarial opinion.

(5) If the insurance company fails to provide either a supporting actuarial report or work papers, or both, at the request of the commissioner or the commissioner determines that the supporting actuarial report or work papers provided by the insurance company 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 actuarial report or work papers.

(6) The appointed actuary is not liable for damages to any person, other than the insurance company, the commissioner, or both, for any act, error, omission, decision, or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the appointed actuary. [2006 c 25 § 1.]

Additional notes found at www.leg.wa.gov

48.05.385 Statement of actuarial opinion—Property and casualty insurance—Confidentiality. (1) The statement of actuarial opinion shall be provided with the annual statement in accordance with the property and casualty annual statement instructions as adopted by the national association of insurance commissioners and shall be treated as a public document.

(2) Documents, materials or other information in the possession or control of the commissioner that are considered an actuarial report, work papers, or actuarial opinion summary provided in support of the opinion, and any other material provided by the insurance company to the commissioner in connection with the actuarial report, work papers, or actuarial opinion summary, is confidential by law and privileged, is not subject to chapter *42.17 or 42.56 RCW, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action.

(3) Subsection (2) of this section does not limit the commissioner's authority to release the documents to the actuarial board for counseling and discipline so long as the material is required for the purpose of professional disciplinary proceedings and the board establishes procedures satisfactory to the commissioner for preserving the confidentiality of the documents. Subsection (2) of this section does not limit the commissioner's authority to use the documents, materials, or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(4) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner is permitted or required to testify in any private civil action concerning

any confidential documents, materials, or information subject to subsection (2) of this section.

(5) In order to assist in the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (2) of this section with other state, federal, and international regulatory agencies, with the national association of insurance commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information and has the legal authority to maintain confidentiality;

(b) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the national association of insurance commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or 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, or information; and

(c) May enter into agreements governing the sharing and use of information consistent with this subsection.

(6) A waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information may not occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (5) of this section. [2006 c 25 § 2.]

*Reviser's note: Provisions in chapter 42.17 RCW relating to public disclosure were recodified in chapter 42.56 RCW by 2005 c 274.

Additional notes found at www.leg.wa.gov

48.05.390 Reports by various insurers—Contents.

(1) The report required by RCW 48.05.380 shall include the types of insurance written by the insurer for policies pertaining to:

(a) Medical malpractice for physicians and surgeons, hospitals, other health care professions, and other health care facilities individually;

(b) Products liability. However, if comparable information is included in the annual statement required by RCW 48.05.250, products liability data must not be reported under RCW 48.05.380;

(c) Attorneys' malpractice;

(d) Architects' and engineers' malpractice;

(e) Municipal liability; and

(f) Day care center liability.

(2) The report shall include the following data by the type of insurance for the previous year ending on the thirty-first day of December:

(a) Direct premiums written;

(b) Direct premiums earned;

(c) Net investment income, including net realized capital gain and losses, using appropriate estimates where necessary;

(d) Incurred claims, development as the sum of the following:

(i) Dollar amount of claims closed with payments; plus

- (ii) Reserves for reported claims at the end of the current year; minus
 - (iii) Reserves for reported claims at the end of the previous year; plus
 - (iv) Reserves for incurred but not reported claims at the end of the current year; minus
 - (v) Reserves for incurred but not reported claims at the end of the previous year; plus
 - (vi) Reserves for loss adjustment expense at the end of the current year; minus
 - (vii) Reserves for loss adjustment expense at the end of the previous year.
 - (e) Actual incurred expenses allocated separately to loss adjustment, commissions, other acquisition costs, advertising, general office expenses, taxes, licenses and fees, and all other expenses;
 - (f) Net underwriting gain or loss;
 - (g) Net operation gain or loss, including net investment income; and
 - (h) Other information requested by the insurance commissioner.
- (3) The report shall be filed annually with the commissioner, no later than the first day of May. [1994 c 131 § 7; 1988 c 248 § 6; 1986 c 148 § 2; 1985 c 238 § 2.]

Additional notes found at www.leg.wa.gov

48.05.400 Annual filing and fee to National Association of Insurance Commissioners—Penalty. (1) Each domestic, foreign, and alien insurer that is authorized to transact insurance in this state shall annually, on or before March 1 of each year, file with the National Association of Insurance Commissioners a copy of its annual statement convention blank, along with such additional filings as prescribed by the commissioner 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.

(2) Coincident with the filing of its annual statement convention blank and other filings, each such insurer 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 convention blank.

(3) Foreign insurers that are domiciled in a state which has a law substantially similar to subsection (1) of this section shall be considered to be in compliance with this section.

(4) 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 dissimulating the information developed from the filing of the annual statement convention blanks 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, and analysis or

dissimilation of the data and information collected for the filings required under this section.

(5) The commissioner may suspend, revoke, or refuse to renew the certificate of authority of any insurer failing to file its annual statement or pay the fees when due or within any extension of time which the commissioner, for good cause, may have granted. [1987 c 132 § 1.]

48.05.410 Health care practitioner risk management training. Effective July 1, 1994, each health care provider, facility, or health maintenance organization that self-insures for liability risks related to medical malpractice and employs physicians or other independent health care practitioners in Washington state shall condition each physician's and practitioner's liability coverage by that entity upon that physician's or practitioner's participation in risk management training offered by the provider, facility, or health maintenance organization to its employees. The risk management training shall provide information related to avoiding adverse health outcomes resulting from substandard practice and minimizing damages associated with those adverse health outcomes that do occur. For purposes of this section, "independent health care practitioner" means those health care practitioner licensing classifications designated by the department of health in rule pursuant to *RCW 18.130.330. [1993 c 492 § 414.]

*Reviser's note: RCW 18.130.330 was repealed by 1995 c 265 § 27, effective July 1, 1995.

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

Additional notes found at www.leg.wa.gov

48.05.430 Definitions. As used in RCW 48.05.430 through *48.05.490, these terms have the following meanings:

- (1) "RBC" means risk-based capital.
- (2) "NAIC" means the national association of insurance commissioners.
- (3) "Domestic insurer" means any insurance company domiciled in this state.
- (4) "Foreign or alien insurer" means any insurance company that is licensed to do business in this state under this chapter but is not domiciled in this state.
- (5) "Life and disability insurer" means any insurance company authorized to write only life insurance, disability insurance, or both, as defined in chapter 48.11 RCW.
- (6) "Property and casualty insurer" means any insurance company authorized to write only property insurance, marine and transportation insurance, general casualty insurance, vehicle insurance, or any combination thereof, including disability insurance, as defined in chapter 48.11 RCW.
- (7) "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.
- (8) "Negative trend" means, with respect to a life insurer, a disability insurer, or a life and disability insurer, the negative trend over a period of time, as determined in accordance with the trend test calculation included in the RBC instructions.
- (9) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with RCW 48.05.435(5).

(10) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC.

(11) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(a) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(b) "Regulatory action level RBC" means the product [of] 1.5 and its authorized control level RBC;

(c) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions; and

(d) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(12) "RBC plan" means a comprehensive financial plan containing the elements specified in RCW 48.05.440(2). If the commissioner rejects the RBC plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

(13) "RBC report" means the report required in RCW 48.05.435.

(14) "Total adjusted capital" means the sum of:

(a) An insurer's statutory capital and surplus as determined in accordance with statutory accounting applicable to the annual financial statements required to be filed under RCW 48.05.250; and

(b) Other items, if any, as the RBC instructions may provide. [1995 c 83 § 1.]

*Reviser's note: RCW 48.05.490 was repealed by 2006 c 25 § 11.

48.05.435 Report of RBC levels—Formula for determining levels—Inaccurate reports adjusted by commissioner. (1) Every domestic insurer shall, on or prior to the filing date, which is hereby established as March 1, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing that information required by the RBC instructions. In addition, every domestic insurer shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and

(b) With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) Fifteen days from the receipt of notice to file its RBC report with that state; or

(ii) The filing date.

(2) A life and disability insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

(a) The risk with respect to the insurer's assets;

(b) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) The interest rate risk with respect to the insurer's business; and

(d) All other business risks and other relevant risks as set forth in the RBC instructions; determined in each case by

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applying the factors in the manner set forth in the RBC instructions.

(3) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and other relevant risks as are set forth in the RBC instructions; determined in each case by applying the factors in the manner set forth in the RBC instructions.

(4) An excess of capital over the amount produced by the RBC requirements and the formulas, schedules, and instructions under RCW 48.05.430 through *48.05.490 is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the RBC requirements.

(5) If a domestic insurer files an RBC report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. [1995 c 83 § 2.]

*Reviser's note: RCW 48.05.490 was repealed by 2006 c 25 § 11.

48.05.440 Company action level event—Definition—RBC plan—Commissioner's review. (1) "Company action level event" means any of the following events:

(a) The filing of an RBC report by an insurer indicating that:

(i) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC, but less than its company action level RBC;

(ii) If a life and disability insurer, the insurer has total adjusted capital that is greater than or equal to its company action level RBC, but less than the product of its authorized control level RBC and 3 and has a negative trend; or

(iii) If a property and casualty insurer, the insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and met the trend test determined in accordance with the trend test calculation included in the RBC instructions;

(b) The notification by the commissioner to the insurer of an adjusted RBC report that indicates an event in (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under RCW 48.05.460; or

(c) If, under RCW 48.05.460, an insurer challenges an adjusted RBC report that indicates an event in (a) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan that:

(a) Identifies the conditions that contribute to the company action level event;

(b) Contains proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the company action level event;

(c) Provides projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(d) Identifies the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) Identifies the quality of, and problems associated with, the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(3) The RBC plan shall be submitted:

(a) Within forty-five days of the company action level event; or

(b) If the insurer challenges an adjusted RBC report under RCW 48.05.460, within forty-five days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) Within sixty days after the submission by an insurer of an RBC plan to the commissioner, the commissioner shall notify the insurer whether the RBC plan may be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions that will render the RBC plan satisfactory. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan, that may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) Within forty-five days after the notification from the commissioner; or

(b) If the insurer challenges the notification from the commissioner under RCW 48.05.460, within forty-five days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(5) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, subject to the insurer's rights to a hearing under RCW 48.05.460, specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(a) The state has an RBC provision substantially similar to RCW 48.05.465(1); and

(b) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) Fifteen days after the receipt of notice to file a copy of its RBC plan or revised plan with the state; or

(ii) The date on which the RBC plan or revised RBC plan is filed under subsections (3) and (4) of this section. [2012 c 211 § 2; 2006 c 25 § 6; 1995 c 83 § 3.]

48.05.445 Regulatory action level event—Definition—Commissioner's duties—Corrective actions. (1) "Regulatory action level event" means, with respect to any insurer, any of the following events:

(a) The filing of an RBC report by the insurer indicating that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) The notification by the commissioner to an insurer of an adjusted RBC report that indicates the event in (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under RCW 48.05.460;

(c) If, under RCW 48.05.460, the insurer challenges an adjusted RBC report that indicates the event in (a) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(d) The failure of the insurer to file an RBC report by the filing date, unless the insurer has provided an explanation for such failure that is satisfactory to the commissioner and has cured the failure within ten days after the filing date;

(e) The failure of the insurer to submit an RBC plan to the commissioner within the time period set forth in RCW 48.05.440(3);

(f) Notification by the commissioner to the insurer that:

(i) The RBC plan or revised RBC plan submitted by the insurer is, in the judgment of the commissioner, unsatisfactory; and

(ii) The notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under RCW 48.05.460;

(g) If, under RCW 48.05.460, the insurer challenges a determination by the commissioner under (f) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge;

(h) Notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the insurer has not challenged the determination under RCW 48.05.460; or

(i) If, under RCW 48.05.460, the insurer challenges a determination by the commissioner under (h) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge.

(2) In the event of a regulatory action level event the commissioner shall:

(a) Require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform the examination or analysis the commissioner deems necessary of the assets, liabilities, and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying those corrective actions the commissioner determines are required.

(3) In determining corrective actions, the commissioner may take into account those factors deemed relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken under the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within forty-five days after the occurrence of the regulatory action level event;

(b) If the insurer challenges an adjusted RBC report under RCW 48.05.460, and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(c) If the insurer challenges a revised RBC plan under RCW 48.05.460, and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the insurer's RBC plan or revised RBC plan, examine or analyze the assets, liabilities, and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants shall be borne by the affected insurer or other party as directed by the commissioner. [1995 c 83 § 4.]

48.05.450 Authorized control level event—Definition—Commissioner's duties. (1) "Authorized control level event" means any of the following events:

(a) The filing of an RBC report by the insurer indicating that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) The notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under RCW 48.05.460;

(c) If, under RCW 48.05.460, the insurer challenges an adjusted RBC report that indicates the event in (a) of this subsection, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(d) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the insurer has not challenged the corrective order under RCW 48.05.460; or

(e) If the insurer has challenged a corrective order under RCW 48.05.460 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to

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the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(a) Take those actions required under RCW 48.05.445 regarding an insurer with respect to which a regulatory action level event has occurred; or

(b) If the commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take those actions necessary to cause the insurer to be placed under regulatory control under chapter 48.31 RCW. In the event the commissioner takes these actions, the authorized control level event is sufficient grounds for the commissioner to take action under chapter 48.31 RCW, and the commissioner has the rights, powers, and duties with respect to the insurer as are set forth in chapter 48.31 RCW. In the event the commissioner takes actions under this subsection pursuant to an adjusted RBC report, the insurer is entitled to those protections afforded to insurers under RCW 48.31.121 pertaining to summary proceedings. [1995 c 83 § 5.]

48.05.455 Mandatory control level event—Definition—Commissioner's duties. (1) "Mandatory control level event" means any of the following events:

(a) The filing of an RBC report indicating that the insurer's total adjusted capital is less than its mandatory control level RBC;

(b) Notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under RCW 48.05.460; or

(c) If, under RCW 48.05.460, the insurer challenges an adjusted RBC report that indicates the event in (a) of this subsection, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(2) In the event of a mandatory control level event:

(a) With respect to a life and disability insurer, the commissioner shall take those actions necessary to place the insurer under regulatory control under chapter 48.31 RCW. In that event, the mandatory control level event is sufficient grounds for the commissioner to take action under chapter 48.31 RCW, and the commissioner has the rights, powers, and duties with respect to the insurer as are set forth in chapter 48.31 RCW. If the commissioner takes actions pursuant to an adjusted RBC report, the insurer is entitled to the protections of RCW 48.31.121 pertaining to summary proceedings. However, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

(b) With respect to a property and casualty insurer, the commissioner shall take those actions necessary to place the insurer under regulatory control under chapter 48.31 RCW, or, in the case of an insurer that is writing no business and that is running off its existing business, may allow the insurer to continue its runoff under the supervision of the commissioner. In either event, the mandatory control level event is sufficient grounds for the commissioner to take action under

chapter 48.31 RCW and the commissioner has the rights, powers, and duties with respect to the insurer as are set forth in chapter 48.31 RCW. If the commissioner takes actions pursuant to an adjusted RBC report, the insurer is entitled to the protections of RCW 48.31.121 pertaining to summary proceedings. However, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period. [1995 c 83 § 6.]

48.05.460 Insurer's right to a hearing—Request—Commissioner sets date. (1) Upon notification to an insurer by the commissioner of any of the following, the insurer shall have the right to a hearing, in accordance with chapters 48.04 and 34.05 RCW, at which the insurer may challenge any determination or action by the commissioner:

- (a) Of an adjusted RBC report; or
- (b)(i) That the insurer's RBC plan or revised RBC plan is unsatisfactory; and
- (ii) The notification constitutes a regulatory action level event with respect to such insurer; or
- (c) That the insurer has failed to adhere to its RBC plan or revised RBC plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or
- (d) Of a corrective order with respect to the insurer.

(2) The insurer shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under this section. Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing. The date shall be no less than ten nor more than thirty days after the date of the insurer's request. [1995 c 83 § 7.]

48.05.465 Confidentiality of RBC reports and plans—Use of information for comparative purposes—Use of information to monitor solvency. (1) All RBC reports, to the extent the information is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of an insurer and any corrective order issued by the commissioner, with respect to any domestic insurer or foreign insurer that are filed with the commissioner constitute information that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential by the commissioner. This information shall 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.

(2) The comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer, and is not a means to rank insurers generally. Therefore, except as otherwise required under the provisions of RCW 48.05.430 through 48.05.485, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice,

circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any insurer, or of any component derived in the calculation, by any insurer, insurance producer, title insurance agent, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. However, if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels, or any of them, or an inappropriate comparison of any other amount to the insurer's RBC levels is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(3) The RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans are solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the commissioner for rate-making nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that an insurer or any affiliate is authorized to write. [2008 c 217 § 4; 1995 c 83 § 8.]

Additional notes found at www.leg.wa.gov

48.05.470 Regulation of capital and surplus requirements is supplemental—Commissioner may grant exemptions. (1) The provisions of RCW 48.05.430 through *48.05.490 are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the commissioner under those laws, including, but not limited to, chapter 48.31 RCW.

(2) The commissioner may exempt any domestic property and casualty insurer from RCW 48.05.430 through *48.05.490, if the insurer:

- (a) Writes direct business only in this state;
- (b) Writes direct annual premiums of two million dollars or less; and
- (c) Assumes no reinsurance in excess of five percent of direct premiums written. [1995 c 83 § 9.]

*Reviser's note: RCW 48.05.490 was repealed by 2006 c 25 § 11.

48.05.475 RBC report from foreign or alien insurers—Request of commissioner—Commissioner's options. (1) Any foreign or alien insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended by the later of:

- (a) The date an RBC report would be required to be filed by a domestic insurer under RCW 48.05.435; or
- (b) Fifteen days after the request is received by the foreign or alien insurer. Any foreign or alien insurer shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(2) In the event of a company action level event, regulatory action level event, or authorized control level event with respect to any foreign or alien insurer as determined under the RBC statute applicable in the state of domicile of the insurer or, if no RBC statute is in force in that state, under the provisions of RCW 48.05.430 through *48.05.490, if the insurance commissioner of the state of domicile of the foreign or alien insurer fails to require the foreign or alien insurer to file an RBC plan in the manner specified under that state's RBC statute, the commissioner may require the foreign or alien insurer to file an RBC plan. In this event, the failure of the foreign or alien insurer to file an RBC plan is grounds to order the insurer to cease and desist from writing new insurance business in this state.

(3) In the event of a mandatory control level event with respect to any foreign or alien insurer, if no domiciliary receiver has been appointed with respect to the foreign or alien insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign or alien insurer, the commissioner may apply for an order under RCW 48.31.080 or 48.31.090 to conserve the assets within this state of foreign or alien insurers, and the occurrence of the mandatory control level event is considered adequate grounds for the application. [1995 c 83 § 10.]

*Reviser's note: RCW 48.05.490 was repealed by 2006 c 25 § 11.

48.05.480 No liability for regulation of capital and surplus requirements. There is no liability on the part of, and no cause of action may arise against, the commissioner or insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under RCW 48.05.430 through *48.05.490. [1995 c 83 § 11.]

*Reviser's note: RCW 48.05.490 was repealed by 2006 c 25 § 11.

48.05.485 Notices by commissioner—When effective. All notices by the commissioner to an insurer that may result in regulatory action are effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission are effective upon the insurer's receipt of the notice. [1995 c 83 § 12.]

48.05.510 Disclosure of certain material transactions—Insurer's report—Information is confidential. (1) Every insurer 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 48.05.515 through 48.05.535 are exempt from public inspection and copying and are not 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 insurer to which it pertains unless the commissioner, after giving the insurer that would be affected by disclosure notice and a hearing under chapter 48.04 RCW, determines that the interest of policyholders, 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 § 1.]

48.05.515 Material acquisitions or dispositions. No acquisitions or dispositions of assets need be reported under RCW 48.05.510 if the acquisitions or dispositions are not material. For purposes of RCW 48.05.510 through 48.05.535, 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 insurer's total assets as reported in its most recent statutory statement filed with the commissioner. [1995 c 86 § 2.]

48.05.520 Asset acquisitions—Asset dispositions. (1) Asset acquisitions subject to RCW 48.05.510 through 48.05.535 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 insurer or the acquisition of materials for such a purpose.

(2) Asset dispositions subject to RCW 48.05.510 through 48.05.535 include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, abandonment, destruction, other disposition, or assignment, whether the assignment is for the benefit of creditors or otherwise. [1995 c 86 § 3.]

48.05.525 Report of a material acquisition or disposition of assets—Information required. (1) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

- (a) Date of the transaction;
- (b) Manner of acquisition or disposition;
- (c) Description of the assets involved;
- (d) Nature and amount of the consideration given or received;
- (e) Purpose of or reason for the transaction;
- (f) Manner by which the amount of consideration was determined;
- (g) Gain or loss recognized or realized as a result of the transaction; and
- (h) Names of the persons from whom the assets were acquired or to whom they were disposed.

(2) Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that utilizes a pool-

ing arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such an insurer ceded substantially all of its direct and assumed business to the pool. An insurer has ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus. [1995 c 86 § 4.]

48.05.530 Material nonrenewals, cancellations, or revisions of ceded reinsurance agreements. (1) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements need be reported under RCW 48.05.510 if the nonrenewals, cancellations, or revisions are not material. For purposes of RCW 48.05.510 through 48.05.535, a material nonrenewal, cancellation, or revision is one that affects:

(a) More than fifty percent of a property and casualty insurer's total ceded written premium;

(b) More than fifty percent of the property and casualty insurer's total ceded indemnity and loss adjustment reserves;

(c) More than fifty percent of a nonproperty and casualty insurer's total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement;

(d) More than ten percent of an insurer's total cession when it is replaced by one or more unauthorized reinsurers; or

(e) 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) A property and casualty insurer's total ceded written premium represents, on an annualized basis, less than ten percent of its total written premium for direct and assumed business; or

(b) A nonproperty and casualty insurer'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 § 5.]

48.05.535 Report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements—Information required. (1) The following is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

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

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

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

(d) If applicable, the identity of the replacement reinsurers.

(2) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or one hundred percent reinsurance agreement

that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer has ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus. [1995 c 86 § 6.]

Chapter 48.05A RCW

RISK MANAGEMENT AND SOLVENCY ASSESSMENT

Sections

48.05A.005 Purpose—Application—Findings—Intent.

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48.05A.045 Failure to report—Fines.

48.05A.900 Short title.

48.05A.901 Effective dates—2015 c 17.

48.05A.005 Purpose—Application—Findings—Intent. (1) The purpose of this chapter is to provide the requirements for maintaining a risk management framework and completing an own risk and solvency assessment and provide guidance and instructions for filing an ORSA summary report with the insurance commissioner of this state.

(2) The requirements of this chapter apply to all insurers domiciled in this state unless exempt pursuant to RCW 48.05A.030.

(3) The legislature finds and declares that the ORSA summary report contains confidential and sensitive information related to an insurer or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information includes proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. It is the intent of this legislature that the ORSA summary report is a confidential document filed with the commissioner, that the ORSA summary report may be shared only as stated in this chapter and to assist the commissioner in the performance of his or her duties, and that in no event may the ORSA summary report be subject to public disclosure. [2015 c 17 § 1.]

48.05A.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Insurance group" means, for the purposes of conducting an ORSA, those insurers and affiliates included within an insurance holding company system as defined in RCW 48.31B.005.

(2) "Insurer" includes an insurer authorized under chapter 48.05 RCW, a fraternal mutual insurer or society holding a license under RCW 48.36A.290, a health care service contractor registered under chapter 48.44 RCW, a health maintenance organization registered under chapter 48.46 RCW, and a self-funded multiple employer welfare arrangement under chapter 48.125 RCW, as well as all persons engaged as, or purporting to be engaged as insurers, fraternal benefit societies, health care service contractors, health maintenance organizations, or self-funded multiple employer welfare arrangements in this state, and to persons in process of organization to become insurers, fraternal benefit societies, health care service contractors, health maintenance organizations, or self-funded multiple employer welfare arrangements, except that it does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(3) "ORSA guidance manual" means the own risk and solvency assessment guidance manual developed and adopted by the national association of insurance commissioners.

(4) "ORSA summary report" means a confidential high-level ORSA summary of an insurer or insurance group.

(5) "Own risk and solvency assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurance group's current business plan, and the sufficiency of capital resources to support those risks. [2015 c 17 § 2.]

48.05A.015 Risk management framework required.

An insurer must maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement is satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer. [2015 c 17 § 3.]

48.05A.020 Must conduct an ORSA at least annually.

Subject to RCW 48.05A.030, an insurer, or the insurance group of which the insurer is a member, must regularly conduct an ORSA consistent with a process comparable to the ORSA guidance manual. The ORSA must be conducted annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member. [2015 c 17 § 4.]

48.05A.025 Submission of ORSA summary reports—Frequency—Requirements.

(1) Upon the commissioner's request, and no more than once each year, an insurer must submit to the commissioner an ORSA summary report or any combination of reports that together contain the information described in the ORSA guidance manual, applicable to the insurer or the insurance group of which it is a member. Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer must submit the report or set of reports required by this subsection if the commissioner is the lead state commis-

sioner of the insurance group as determined by the procedures within the financial analysis handbook adopted by the national association of insurance commissioners.

(2) The report must include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his or her belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA summary report and that a copy of the report has been provided to the insurer's board of directors or the appropriate governing committee.

(3) An insurer may comply with subsection (1) of this section by providing the most recent and substantially similar report or reports provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA guidance manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language. [2015 c 17 § 5.]

48.05A.030 Insurer exemptions from chapter—Qualifying conditions—Reports.

(1) An insurer is exempt from the requirements of this chapter, if:

(a) The insurer has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premium reinsured with the federal crop insurance corporation and federal flood program, less than five hundred million dollars; and

(b) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premium reinsured with the federal crop insurance corporation and federal flood program, less than one billion dollars.

(2) If an insurer qualifies for exemption pursuant to subsection (1)(a) of this section, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to subsection (1)(b) of this section, then the ORSA summary report that may be required pursuant to RCW 48.05A.025 must include every insurer within the insurance group. This requirement is satisfied by the submission of more than one ORSA summary report for any combination of insurers, provided any combination of reports includes every insurer within the insurance group.

(3) If an insurer does not qualify for exemption pursuant to subsection (1)(a) of this section, but the insurance group of which the insurer is a member does qualify for exemption pursuant to subsection (1)(b) of this section, then the only ORSA summary report that may be required pursuant to RCW 48.05A.025 is the report applicable to that insurer.

(4) If an insurer does not qualify for exemption pursuant to subsection (1)(a) of this section, the insurer may apply to the commissioner for a waiver from the requirements of this chapter based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is

a part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(5) Notwithstanding the exemptions stated in this section, the commissioner may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report (a) based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests; and (b) if the insurer has risk-based capital at the company action level event as set forth in RCW 48.05.440 or 48.43.310, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in WAC 284-16-310, or otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(6) If an insurer that qualifies for exemption pursuant to subsection (1)(a) of this section subsequently no longer qualifies for that exemption due to changes in premium reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer has one year following the year the threshold is exceeded to comply with the requirement of this chapter. [2015 c 17 § 6.]

48.05A.035 ORSA summary report must be consistent with ORSA guidance manual. (1) The ORSA summary report shall be prepared consistent with the ORSA guidance manual, subject to the requirements of subsection (2) of this section. Documentation and supporting information must be maintained and made available upon examination or upon the request of the commissioner.

(2) The review of the ORSA summary report, and any additional requests for information, must be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups. [2015 c 17 § 7.]

48.05A.040 Documents, materials, or other ORSA-related information considered confidential and privileged—Exceptions—Permitted uses. (1) Documents, materials, or other information, including the ORSA summary report, 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, is recognized by this state as being proprietary and to contain trade secrets. All such documents, materials, or other 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 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 may not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

(2) Neither the commissioner nor any person who received documents, materials, or other ORSA-related information, through examination or otherwise, while acting

under the authority of the commissioner or with whom such documents, materials, or other information are [is] shared pursuant to this chapter, is 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 share documents, materials, or other ORSA-related information, including the 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 regulatory agencies, including members of any supervisory college recognized by the national association of insurance commissioners, with the national association of insurance commissioners, and with any third-party consultants designated by the commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(b) May receive documents, materials, or ORSA-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college recognized by the national association of insurance commissioners, from the national association of insurance commissioners, and must maintain as confidential or privileged any document, material, or 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, or information;

(c) Shall enter into written agreements with the national association of insurance commissioners or a third-party consultant governing sharing and use of information provided pursuant to this chapter, consistent with this subsection that shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the national association of insurance commissioners or third-party consultant pursuant to this chapter, including procedures and protocols for sharing by the national association of insurance commissioners 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 ORSA-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(ii) Specify that ownership of information shared with the national association of insurance commissioners or third-party consultants pursuant to this chapter remains with the commissioner and the national association of insurance commissioners' or a third-party consultant's use of the information is subject to the direction of the commissioner;

(iii) Prohibit the national association of insurance commissioners or third-party consultant from storing the informa-

tion shared pursuant to this chapter in a permanent database after the underlying analysis is completed;

(iv) Require prompt notice to be given to an insurer whose confidential information in the possession of the national association of insurance commissioners or a third-party consultant pursuant to this chapter is subject to a request or subpoena to the national association of insurance commissioners or a third-party consultant for disclosure or production;

(v) Require the national association of insurance commissioners or a third-party consultant to 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 a third-party consultant pursuant to this chapter; and

(vi) In the case of an agreement involving a third-party consultant, provide the insurer's written consent.

(4) The sharing of information by the commissioner pursuant to 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 the provisions of this chapter.

(5) A waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information does not occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in this chapter.

(6) Documents, materials, or other information in the possession or control of the national association of insurance commissioners or a third-party consultant pursuant to this chapter are [is] confidential by law and privileged, are [is] not subject to chapter 42.56 RCW, are [is] not subject to subpoena, and are [is] not subject to discovery or admissible in evidence in any private civil action. [2015 c 17 § 8.]

48.05A.045 Failure to report—Fines. The commissioner must require any insurer failing, without just cause, to file the ORSA summary report as required in this chapter, after notice and hearing, to pay a fine of five hundred dollars for each day's delay, to be recovered by the commissioner and the fine collected must be transferred to the treasurer for deposit into the state general fund. The maximum fine under this section is one hundred thousand dollars. The commissioner may reduce the fine if the insurer demonstrates to the commissioner that the imposition of the fine would constitute a financial hardship to the insurer. [2015 c 17 § 9.]

48.05A.900 Short title. This chapter may be known and cited as the risk management and solvency assessment act. [2015 c 17 § 14.]

48.05A.901 Effective dates—2015 c 17. Except for section 11 of this act, which takes effect July 1, 2017, this act takes effect January 1, 2016. [2015 c 17 § 15.]

(2021 Ed.)

**Chapter 48.06 RCW
ORGANIZATION OF DOMESTIC INSURERS**

Sections

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48.06.180	Subsequent financing.
48.06.190	Penalty for exhibiting false accounts, etc.
48.06.200	Incorporation, articles of—Contents.

48.06.010 Types of domestic insurers permitted. An insurer formed in this state shall be either

- (1) An incorporated stock insurer, or
- (2) An incorporated mutual insurer, or
- (3) An incorporated specific risks mutual property insurer, or
- (4) An incorporated mutual assessment property insurer only, or
- (5) An incorporated farm mutual assessment property insurer only, or
- (6) A reciprocal insurer, with respective powers, duties, and restrictions as provided in this code. [1947 c 79 § .06.01; Rem. Supp. 1947 § 45.06.01.]

48.06.020 Assessment mutuals prohibited—Exceptions. No insurer shall be formed or be authorized in this state to issue contracts of insurance the performance of which is contingent upon the payment of assessments, assessment premiums, or calls made upon its members. Mutual assessment property insurers and farm mutual assessment property insurers shall be the only exception to this provision. [1947 c 79 § .06.02; Rem. Supp. 1947 § 45.06.02.]

48.06.030 Solicitation permit. (1) No person forming or proposing to form in this state an insurer, or insurance holding corporation, or stock corporation to finance an insurer or insurance production therefor, or corporation to manage an insurer, or corporation to be attorney-in-fact for a reciprocal insurer, or a syndicate for any of such purposes, shall advertise, or solicit or receive any funds, agreement, stock subscription, or membership on account thereof unless he or she has applied for and has received from the commissioner a solicitation permit.

(2) Any person violating this section is guilty of a class B felony and shall be subject to a fine of not more than ten thousand dollars or imprisonment for not more than ten years, or by both fine and imprisonment. [2003 c 53 § 267; 1947 c 79 § .06.03; Rem. Supp. 1947 § 45.06.03.]

Intent—Effective date—2003 c 53: See notes following RCW 2.48.180.

48.06.040 Application for solicitation permit. To apply for a solicitation permit the person shall:

(1) File with the commissioner a request showing:

(a) Name, type, and purpose of insurer, corporation, or syndicate proposed to be formed;

(b) 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 insurer, corporation, or syndicate to be formed;

(c) Third-party verification reports from a vendor authorized by the national association of insurance commissioners to perform a state, national, and international background history check of any person who exercises control over the financial dealings and operations of the insurer, corporation, or syndicate;

(d) Full disclosure of the terms of all understandings and agreements existing or proposed among persons so associated relative to the proposed insurer, corporation, or syndicate, or the formation thereof;

(e) The plan according to which solicitations are to be made; and

(f) Additional information as the commissioner may reasonably require.

(2) File with the commissioner:

(a) Original and copies in triplicate of proposed articles of incorporation, or syndicate agreement; or, if the proposed insurer is a reciprocal, original and duplicate of the proposed subscribers' agreement and attorney-in-fact agreement;

(b) Original and duplicate copy of any proposed bylaws;

(c) Copy of any security proposed to be issued and copy of application or subscription agreement for that security;

(d) Copy of any insurance contract proposed to be offered and copy of application for that contract;

(e) Copy of any prospectus, advertising, or literature proposed to be used; and

(f) Copy of proposed form of any escrow agreement required.

(3) Deposit with the commissioner the fees required by law to be paid for the application including fees associated with the state and national criminal history background check, for filing of the articles of incorporation of an insurer, for filing the subscribers' agreement and attorney-in-fact agreement if the proposed insurer is a reciprocal, for the solicitation permit, if granted, and for filing articles of incorporation with the secretary of state. [2012 c 211 § 3; 2002 c 227 § 1; 1967 c 150 § 6; 1947 c 79 § .06.04; Rem. Supp. 1947 § 45.06.04.]

Additional notes found at www.leg.wa.gov

48.06.050 Procedure upon application. The commissioner shall expeditiously examine the application for a solicitation permit and make any investigation relative thereto deemed necessary. If the commissioner finds that

(1) the application is complete; and

(2) the documents therewith filed are equitable in terms and proper in form; and

(3) the management of the company, whether by its directors, officers, or by any other means is competent and trustworthy and not so lacking in managerial experience as to make a proposed operation hazardous to the insurance-buying public; and that there is no reason to believe the company

is affiliated, directly or indirectly, through ownership, control, reinsurance, or other insurance or business relations, with any other person or persons whose business operations are or have been marked, to the detriment of the policyholders or stockholders or investors or creditors or of the public, by bad faith or by manipulation of assets, or of accounts, or of reinsurance; and

(4) the agreements made or proposed are equitable to present and future shareholders, subscribers, members or policyholders, he or she shall give notice to the applicant that he or she will issue a solicitation permit, stating the terms to be contained therein, upon the filing of the bond required by RCW 48.06.110 of this code.

If the commissioner does not so find, he or she shall give notice to the applicant that the permit will not be granted, stating the grounds therefor, and shall refund to the applicant all sums so deposited except the application fee. [2009 c 549 § 7021; 1967 c 150 § 7; 1947 c 79 § .06.05; Rem. Supp. 1947 § 45.06.05.]

48.06.060 Issuance of permit—Bond. Upon the filing of the bond required by RCW 48.06.110 after notice by the commissioner, the commissioner shall:

(1) File the articles of incorporation of the proposed incorporated insurer or other corporation; and

(2) Issue to the applicant a solicitation permit. [1998 c 23 § 1; 1947 c 79 § .06.06; Rem. Supp. 1947 § 45.06.06.]

48.06.070 Duration of permit—Contents. Every solicitation permit issued by the commissioner shall:

(1) Be for a period of not over two years, subject to the right of the commissioner to grant a reasonable extension for good cause.

(2) State the securities for which subscriptions are to be solicited, the number, classes, par value, and selling price thereof, or identify the insurance contract for which applications and advance premiums or deposits are to be solicited.

(3) Limit the portion of funds received on account of stock or syndicate subscriptions, if any are proposed to be taken, which may be used for promotion and organization expenses to such amount as he or she deems adequate, but in no event to exceed fifteen percent of such funds as and when actually received.

(4) If to be a mutual or reciprocal insurer, limit the portion of funds received on account of applications for insurance which may be used for promotion or organization expenses to a reasonable commission upon such funds, giving consideration to the kind of insurance and policy involved and to the costs incurred by insurers generally in the production of similar business, and provide that no such commission shall be deemed to be earned nor be paid until the insurer has received its certificate of authority and the policies applied for and upon which such commission is to be based, have been actually issued and delivered.

(5) Contain such other information required by this chapter or reasonable conditions relative to accounting and reports or otherwise as the commissioner deems necessary. [2009 c 549 § 7022; 1953 c 197 § 1; 1947 c 79 § .06.07; Rem. Supp. 1947 § 45.06.07.]

48.06.080 Permit as inducement. The granting of a solicitation permit is permissive only and shall not constitute an endorsement by the commissioner of any person or thing related to the proposed insurer, corporation, or syndicate and the existence of the permit shall not be advertised or used as an inducement in any solicitation. The substance of this section in bold faced type not less than ten point shall be printed at the top of each solicitation permit. [1947 c 79 § .06.08; Rem. Supp. 1947 § 45.06.08.]

48.06.090 Solicitors' licenses. Solicitation for sale of securities to members of the public under a solicitation permit shall be made only by individuals licensed therefor pursuant to the provisions of the securities act. [1949 c 190 § 5; 1947 c 79 § .06.09; Rem. Supp. 1949 § 45.06.09.]

48.06.100 Modification, revocation of permit. (1) The commissioner may, for cause, modify a solicitation permit, or may, after a hearing, revoke any solicitation permit for violation of any provision of this code, or of the terms of the permit, or of any proper order of the commissioner, or for misrepresentation.

(2) The commissioner shall revoke a solicitation permit if requested in writing by a majority of the syndicate members, or by a majority of the incorporators and two-thirds of the subscribers to stock or applicants for insurance in the proposed incorporated insurer or corporation, or if he or she is so requested by a majority of the subscribers of a proposed reciprocal insurer. [2009 c 549 § 7023; 1947 c 79 § .06.10; Rem. Supp. 1947 § 45.06.10.]

48.06.110 Bond—Cash deposit. (1) The commissioner shall not issue a solicitation permit until the person applying therefor files with him or her a corporate surety bond in the penalty of fifty thousand dollars, in favor of the state and for the use and benefit of the state and of subscribers and creditors of the proposed organization.

The bond shall be conditioned upon the payment of costs incurred by the state in event of any legal proceedings for liquidation or dissolution of the proposed organization before completion of organization or in event a certificate of authority is not granted; and upon a full accounting for funds received until the proposed insurer has been granted its certificate of authority, or until the proposed corporation or syndicate has completed its organization as defined in the solicitation permit.

(2) In lieu of filing such bond, the person may deposit with the commissioner fifty thousand dollars in cash or in United States government bonds at par value, to be held in trust upon the same conditions as required for the bond.

(3) The commissioner may waive the requirement for a bond or deposit in lieu thereof if the permit provides that:

(a) The proposed securities are to be distributed solely and finally to those few persons who are the active promotors intimate to the formation of the insurer, or other corporation or syndicate, or

(b) The securities are to be issued in connection with subsequent financing as provided in RCW 48.06.180.

(4) Any bond filed or deposit or remaining portion thereof held under this section shall be released and discharged upon settlement or termination of all liabilities

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against it. [2009 c 549 § 7024; 1969 ex.s. c 241 § 2; 1955 c 86 § 2; 1953 c 197 § 2; 1947 c 79 § .06.11; Rem. Supp 1947 § 45.06.11.]

Additional notes found at www.leg.wa.gov

48.06.120 Escrow of funds. (1) All funds received pursuant to a solicitation permit shall be deposited and held in escrow in a bank or trust company under an agreement approved by the commissioner. No part of any such deposit shall be withdrawn, except:

(a) For the payment of promotion and organization expenses as authorized by the solicitation permit; or

(b) for the purpose of making any deposit with the commissioner required for the issuance of a certificate of authority to an insurer; or

(c) if the proposed organization is not to be an insurer, upon completion of payments on stock or syndicate subscriptions made under the solicitation permit and deposit or appropriation of such funds to the purposes specified in the solicitation permit; or

(d) for making of refunds as provided in RCW 48.06.170.

(2) When the commissioner has issued a certificate of authority to an insurer any such funds remaining in escrow for its account shall be released to the insurer. [1947 c 79 § .06.12; Rem. Supp. 1947 § 45.06.12.]

48.06.130 Liability of organizers—Organization expense. (1) The incorporators of any insurer or other corporation, or the persons proposing to form a reciprocal insurer, or a syndicate, shall be jointly and severally liable for its debts or liabilities until it has secured a certificate of authority, if an insurer, or has completed its organization if a corporation other than an insurer or a syndicate.

(2) Any portion of funds received on account of stock or syndicate subscriptions which is allowed therefor under the solicitation permit, may be applied concurrently toward the payment of promotion and organization expense theretofore incurred. [1947 c 79 § .06.13; Rem. Supp. 1947 § 45.06.13.]

48.06.150 Payment for subscriptions—Forfeiture. (1) No such proposed stock insurer, corporation, or syndicate shall issue any share of stock or participation agreement except for payment in cash or in securities eligible for investment of funds of insurers. No such shares or agreement shall be issued until all subscriptions received under the solicitation permit have been so fully paid, nor, if an insurer, until a certificate of authority has been issued to it.

(2) Every subscription contract to shares of a stock insurer or other corporation calling for payment in installments, together with all amounts paid thereon may be forfeited at the option of the corporation, upon failure to make good a delinquency in any installment upon not less than forty-five days' notice in writing, and every such contract shall so provide. [1947 c 79 § .06.15; Rem. Supp. 1947 § 45.06.15.]

48.06.160 Insurance applications—Mutual and reciprocal insurers. All applications for insurance obtained in forming a mutual or reciprocal insurer shall provide that:

(1) Issuance of the policy is contingent upon completion of organization of the insurer and issuance to it of a certificate of authority; and

(2) the prepaid premium or deposit will be refunded in full to the applicant if the organization is not completed and certificate of authority issued prior to the solicitation permit's date of expiration; and

(3) the agreement for insurance is not effective until a policy has been issued under it. [1947 c 79 § .06.16; Rem. Supp. 1947 § 45.06.16.]

48.06.170 Procedure on failure to complete organization or to qualify. The commissioner shall withdraw all funds held in escrow and refund to subscribers or applicants all sums paid in on stock or syndicate subscriptions, less that part of such sums paid in on subscriptions as has been allowed and used for promotion and organization expenses, and all sums paid in on insurance applications, and shall dissolve the proposed insurer, corporation or syndicate if

(1) the proposed insurer, corporation or syndicate fails to complete its organization and obtain full payment for subscriptions and applications, and, if an insurer, it fails to secure its certificate of authority, all before expiration of the solicitation permit; or

(2) the commissioner revokes the solicitation permit. [1947 c 79 § .06.17; Rem. Supp. 1947 § 45.06.17.]

48.06.180 Subsequent financing. (1) No domestic insurer, or insurance holding corporation, or stock corporation for financing operations of a mutual insurer, or attorney-in-fact corporation of a reciprocal insurer, after

(a) it has received a certificate of authority, if an insurer, or

(b) it has completed its initial organization and financing if a corporation other than an insurer, shall solicit or receive funds in exchange for any new issue of its corporate securities, other than through a stock dividend, until it has applied to the commissioner for, and has been granted, a solicitation permit.

(2) The commissioner shall issue such a permit unless he or she finds that:

(a) The funds proposed to be secured are excessive in amount for the purpose intended, or

(b) the proposed securities or the manner of their distribution are inequitable, or

(c) the issuance of the securities would jeopardize the interests of policyholders or the holders of other securities of the insurer or corporation.

(3) Any such solicitation permit granted by the commissioner shall be for such duration, and shall contain such terms and be issued upon such conditions as the commissioner may reasonably specify or require. [2009 c 549 § 7025; 1949 c 190 § 6; 1947 c 79 § .06.18; Rem. Supp. 1949 § 45.06.18.]

48.06.190 Penalty for exhibiting false accounts, etc. Every person who, with intent to deceive, knowingly exhibits any false account, or document, or advertisement, relative to the affairs of any insurer, or of any corporation or syndicate of the kind enumerated in RCW 48.06.030, formed or proposed to be formed, is guilty of a class B felony punishable

according to chapter 9A.20 RCW. [2003 c 53 § 268; 1947 c 79 § .06.19; Rem. Supp. 1947 § 45.06.19.]

Intent—Effective date—2003 c 53: See notes following RCW 2.48.180.

48.06.200 Incorporation, articles of—Contents. (1)

This section applies to insurers incorporated in this state, but no insurer heretofore lawfully incorporated in this state is required to reincorporate or change its articles of incorporation by reason of any provisions of this section.

(2) The incorporators shall be individuals who are United States citizens, of whom two-thirds shall be residents of this state. The number of incorporators shall be not less than five if a stock insurer, nor less than ten if a mutual insurer.

(3) The incorporators shall execute articles of incorporation in duplicate, acknowledge their signatures thereunto before an officer authorized to take acknowledgments of deeds, and file both copies with the commissioner.

(4) After approval of the articles by the commissioner, one copy shall be filed in the office of the commissioner and the other copy shall be returned to the insurer.

(5) The articles of incorporation shall state:

First: The names and addresses of the incorporators.

Second: The name of the insurer. If a mutual insurer the name shall include the word "mutual."

Third: (a) The objects for which the insurer is formed;

(b) whether it is a stock or mutual insurer, and if a mutual property insurer only, whether it will insure on the cash premium or assessment plan;

(c) the kinds of insurance it will issue, according to the designations made in this code.

Fourth: If a stock insurer, the amount of its capital, the aggregate number of shares, and the par value of each share, which par value shall be not less than ten dollars, except that after the corporation has transacted business as an authorized insurer in the state for five years or more, its articles of incorporation may be amended, at the option of its stockholders, to provide for a par value of not less than one dollar per share. If a mutual insurer, the maximum contingent liability of its policyholders for the payment of its expenses and losses occurring under its policies.

Fifth: The duration of its existence, which may be perpetual.

Sixth: The names and addresses of the directors, not less than five in number, who shall constitute the board of directors of the insurer for the initial term, not less than two nor more than six months, as designated in the articles of incorporation.

Seventh: The name of the city or town of this state in which the insurer's principal place of business is to be located.

Eighth: Other provisions not inconsistent with law as may be deemed proper by the incorporators. [1998 c 23 § 2; 1981 c 302 § 37; 1963 c 60 § 1; 1949 c 190 § 7; 1947 c 79 § .06.20; Rem. Supp. 1949 § 45.06.20.]

Additional notes found at www.leg.wa.gov

Chapter 48.07 RCW
DOMESTIC INSURERS—POWERS

Sections

48.07.010	Application of code to existing insurers.
48.07.020	Principal office.
48.07.030	Application of general corporation laws.
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48.07.050	Directors—Qualifications—Removal.
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Business corporations: Title 23B RCW.

Dissolution and winding up business corporation: Chapter 23B.14 RCW.

Interlocking ownership, management: RCW 48.30.250.

Merger or consolidation: RCW 48.31.010.

Organization of domestic insurers: Chapter 48.06 RCW.

48.07.010 Application of code to existing insurers.

Existing authorized domestic insurers shall continue to insure only in accordance with the provisions of this code. [1947 c 79 § .07.01; Rem. Supp. 1947 § 45.07.01.]

48.07.020 Principal office. Every domestic insurer shall establish and maintain in this state its principal office and place of business. [1947 c 79 § .07.02; Rem. Supp. 1947 § 45.07.02.]

48.07.030 Application of general corporation laws.

The laws of this state relating to private corporations, except where inconsistent with the express provisions of this code, shall govern the corporate powers, duties, and relationships of incorporated domestic insurers and insurance holding corporations formed under the laws of the state of Washington. [1985 c 364 § 1; 1947 c 79 § .07.03; Rem. Supp. 1947 § 45.07.03.]

Provisions as to general business corporations: Title 23B RCW.

Additional notes found at www.leg.wa.gov

48.07.040 Annual, special meetings. Each incorporated domestic insurer shall hold an annual meeting of its shareholders or members at such time and place as may be stated in or fixed in accordance with its bylaws for the purpose of receiving reports of its affairs and to elect directors. Each domestic insurance holding corporation shall hold an annual meeting of its shareholders at such time and place as may be stated in or fixed in accordance with its bylaws. Special meetings of the shareholders of an incorporated domestic insurer or domestic insurance holding corporation shall be called and held by such persons and in such a manner as

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stated in the articles of incorporation or bylaws. [2002 c 300 § 5; 1985 c 364 § 2; 1965 ex.s. c 70 § 4; 1947 c 79 § .07.04; Rem. Supp. 1947 § 45.07.04.]

Additional notes found at www.leg.wa.gov

48.07.050 Directors—Qualifications—Removal. Not less than three-fourths of the directors of an incorporated domestic insurer shall be United States or Canadian citizens, and a majority of the board of directors of a mutual life insurer shall be residents of this state. The directors of a domestic insurer or domestic insurance holding corporation may be removed with cause by a vote of a majority of its voting capital stock or members (if a mutual insurer) at a valid meeting and said directors may be removed without cause by a vote of sixty-seven percent of its voting capital stock or members (if a mutual insurer) at a valid meeting. [1989 c 24 § 1; 1985 c 364 § 3; 1957 c 193 § 21; 1947 c 79 § .07.05; Rem. Supp. 1947 § 45.07.05.]

Additional notes found at www.leg.wa.gov

48.07.060 Corrupt practices—Penalty. No person shall buy or sell or barter a vote or proxy, relative to any meeting of shareholders or members of an incorporated domestic insurer, or engage in any corrupt or dishonest practice in or relative to the conduct of any such meeting. Violation of this section shall constitute a gross misdemeanor. [1947 c 79 § .07.06; Rem. Supp. 1947 § 45.07.06.]

48.07.070 Amendment of articles of incorporation.

(1) Unless a vote of a greater proportion of directors or shares is required by its articles of incorporation, amendments to the articles of incorporation of a domestic insurer or a domestic insurance holding corporation shall be made by a majority vote of its board of directors and the vote or written assent of a majority of its voting capital stock, or two-thirds of the members (if a mutual insurer) voting at a valid meeting of members.

(2) The president and secretary of the insurer shall, under the corporate seal, certify the amendment in duplicate, and file both copies in the office of the commissioner as required under this code for original articles of incorporation. Thereupon, subject to the requirements of RCW 48.08.010 relative to increase of capital stock of a stock insurer, the amendment shall become effective. [1998 c 23 § 3; 1985 c 364 § 4; 1981 c 302 § 38; 1947 c 79 § .07.07; Rem. Supp. 1947 § 45.07.07.]

Additional notes found at www.leg.wa.gov

48.07.080 Guarantee of officers' obligations prohibited. No domestic insurer or its affiliates or subsidiaries shall guarantee the financial obligation of any director or officer of such insurer or affiliate or subsidiary in his or her personal capacity, and any such guaranty attempted shall be void.

This prohibition shall not apply to obligations of the insurer under surety bonds or insurance contracts issued in the regular course of business. [2009 c 549 § 7026; 1947 c 79 § .07.08; Rem. Supp. 1947 § 45.07.08.]

48.07.100 Vouchers for expenditures. (1) No domestic insurer shall make any disbursement of twenty-five dollars or more, unless evidenced by a voucher correctly describing the consideration for the payment and supported

by a check or receipt endorsed or signed by or on behalf of the person receiving the money.

(2) If the disbursement is for services and reimbursement, the voucher shall describe the services and itemize the expenditures.

(3) If the disbursement is in connection with any matter pending before any legislature or public body or before any public official, the voucher shall also correctly describe the nature of the matter and of the insurer's interest therein. [1947 c 79 § .07.10; Rem. Supp. 1947 § 45.07.10.]

48.07.110 Depositories. The funds of a domestic insurer shall not be deposited in any bank or banking institution which has not first been approved as a depository by the insurer's board of directors or by a committee thereof designated for the purpose. [1947 c 79 § .07.11; Rem. Supp. 1947 § 45.07.11.]

48.07.130 Pecuniary interest of officer or director, restrictions upon. (1) No person having any authority in the investment or disposition of the funds of a domestic insurer and no officer or director of an insurer shall accept, except for the insurer, or be the beneficiary of any fee, brokerage, gift, commission, or other emolument because of any sale of insurance or of any investment, loan, deposit, purchase, sale, payment, or exchange made by or for the insurer, or be pecuniarily interested therein in any capacity; except, that such a person may procure a loan from the insurer direct upon approval by two-thirds of its directors and upon the pledge of securities eligible for the investment of the insurer's funds under this code.

(2) This section does not prohibit a life insurer from making a policy loan to such person on a life insurance contract issued by it and in accordance with the terms thereof.

(3) The commissioner may permit additional exceptions to the prohibition contained in subsection (1) of this section to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the insurer, 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 insurer in the ordinary course of the insurer's business and in the usual private professional or business capacity of such director or such corporation or firm.

In addition, the commissioner may permit exceptions to the prohibitions contained in subsection (1) of this section where the payment of a fee, brokerage, gift, commission, or other emolument is fully disclosed to the insurer's officers and directors and is reasonable in relation to the service performed. [1989 c 228 § 1; 1981 c 339 § 5; 1947 c 79 § .07.13; Rem. Supp. 1947 § 45.07.13.]

48.07.140 Compliance with foreign laws. Any domestic insurer doing business in another state, territory or sovereignty may design and issue insurance contracts and transact insurance in such state, territory or sovereignty as required or permitted by the laws thereof, any provision of the insurer's articles of incorporation or bylaws notwithstanding. [1947 c 79 § .07.14; Rem. Supp. 1947 § 45.07.14.]

48.07.150 Solicitations in other states. (1) No domestic insurer shall knowingly solicit insurance business in any

reciprocating state in which it is not then licensed as an authorized insurer.

(2) This section shall not prohibit advertising through publications and radio broadcasts originating outside such reciprocating state, if the insurer is licensed in a majority of the states in which such advertising is disseminated, and if such advertising is not specifically directed to residents of such reciprocating state.

(3) This section shall not prohibit insurance, covering persons or risks located in a reciprocating state, under contracts solicited and issued in states in which the insurer is then licensed. Nor shall it prohibit insurance effectuated by the insurer as an unauthorized insurer in accordance with the laws of the reciprocating state. Nor shall it prohibit renewal or continuance in force, with or without modification, of contracts otherwise lawful and which were not originally executed in violation of this section.

(4) A "reciprocating" state, as used herein, is one under the laws of which a similar prohibition is imposed upon and is enforced against insurers domiciled in that state.

(5) The commissioner shall suspend or revoke the certificate of authority of a domestic insurer found by him or her, after a hearing, to have violated this section. [2009 c 549 § 7027; 1988 c 248 § 4; 1947 c 79 § .07.15; Rem. Supp. 1947 § 45.07.15.]

48.07.160 Continuing operation in event of emergency—Declaration of purpose—"Insurer" defined. It is desirable for the general welfare and in particular for the welfare of insurance beneficiaries, policyholders, claimants, subscribers, and others that the business of domestic insurers be continued notwithstanding the event of a local, state, or national emergency. The purpose of this section, RCW 48.07.170 through 48.07.200, and 48.07.203 is to facilitate the continued operation of domestic insurers in the event that a local, state, or national emergency is so disruptive of normal business and commerce as to make it impossible or impracticable for a domestic insurer to conduct its business in accord with applicable provisions of law, its bylaws, or its charter. When used in this section, RCW 48.07.170 through 48.07.200, and 48.07.203 the word "insurer" means the same as defined in RCW 48.01.053 [48.01.050]. [2009 c 150 § 1; 1963 c 195 § 25.]

Additional notes found at www.leg.wa.gov

48.07.170 Continuing operation in event of emergency—Emergency bylaws. The board of directors of any domestic insurer may at any time adopt emergency bylaws, subject to repeal or change by action of those having power to adopt regular bylaws for such insurer, which shall be operative during such a local, state, or national emergency and which may, notwithstanding any different provisions of the regular bylaws, or of the applicable statutes, or of such insurer's charter, make any provision that may be reasonably necessary for the operation of such insurer during the period of such emergency. [2009 c 150 § 2; 1963 c 195 § 26.]

Additional notes found at www.leg.wa.gov

48.07.180 Continuing operation in event of emergency—Directors. In the event that the board of directors of a domestic insurer has not adopted emergency bylaws, the

following provisions shall become effective upon the occurrence of such a local, state, or national emergency as described in this chapter:

(1) Three directors shall constitute a quorum for the transaction of business at all meetings of the board.

(2) Any vacancy in the board may be filled by a majority of the remaining directors, though less than a quorum, or by a sole remaining director.

(3) If there are no surviving directors, but at least three vice presidents of such insurer survive, the three vice presidents with the longest term of service shall be the directors and shall possess all of the powers of the previous board of directors and such powers as are granted in this chapter or by subsequently enacted legislation. By majority vote, such emergency board of directors may elect other directors. If there are not at least three surviving vice presidents, the commissioner or duly designated person exercising the powers of the commissioner shall appoint three persons as directors who shall include any surviving vice presidents and who shall possess all of the powers of the previous board of directors and such powers as are granted in this chapter or by subsequently enacted legislation, and these persons by majority vote may elect other directors. [2009 c 150 § 3; 1963 c 195 § 27.]

Additional notes found at www.leg.wa.gov

48.07.190 Continuing operation in event of emergency—Officers. At any time the board of directors of a domestic insurer may, by resolution, provide that in the event of such a local, state, or national emergency and in the event of the death or incapacity of the president, the secretary, or the treasurer of such insurer, such officers, or any of them, shall be succeeded in the office by the person named or described in a succession list adopted by the board of directors. Such list may be on the basis of named persons or position titles, shall establish the order of priority and may prescribe the conditions under which the powers of the office shall be exercised. [2009 c 150 § 4; 1963 c 195 § 28.]

Additional notes found at www.leg.wa.gov

48.07.200 Continuing operation in event of emergency—Principal office and place of business. At any time the board of directors of a domestic insurer may, by resolution, provide that in the event of such a local, state, or national emergency the principal office and place of business of such insurer shall be at such location as is named or described in the resolution. Such resolution may provide for alternate locations and establish an order of preference. [2009 c 150 § 5; 1963 c 195 § 29.]

Additional notes found at www.leg.wa.gov

48.07.203 Continuing operation in event of emergency—Written plan required. Each domestic insurer must create and maintain a written business continuity plan identifying procedures relating to a local, state, or national emergency or significant business disruption. [2009 c 150 § 6.]

Additional notes found at www.leg.wa.gov

48.07.205 Continuing operation in event of emergency—Planning standards—Rules. After considering rel-

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evant standards adopted by the national association of insurance commissioners, other states, and other regulatory authorities that regulate financial institutions, the commissioner shall adopt, by rule, standards for insurers and insurance producers to follow for business continuity planning. [2009 c 150 § 7.]

Additional notes found at www.leg.wa.gov

48.07.210 Conversion to domestic insurer. (1)(a) Any insurer duly organized under the laws of any other state and admitted to transact insurance business in this state may become a domestic insurer upon complying with all requirements of law for the organization of a domestic insurer in this state and by designating its principal place of business at a location in this state. Such domestic insurer is entitled to a certificate of authority to transact insurance in this state, subject to the conditions set forth in (b) of this subsection, and is subject to the authority and the jurisdiction of this state.

(b) Before being eligible to become a domestic insurer under this section, an admitted insurer shall advise the commissioner, in writing, thirty days in advance of the proposed date of its plan to become a domestic insurer. The commissioner must approve the plan in advance of the proposed date. The commissioner shall not approve any such plan unless, after a hearing, pursuant to such notice as the commissioner may require, the commissioner finds that the plan is consistent with law, and that no reasonable objection to the plan exists. If the commissioner fails to approve the plan, the commissioner shall state his or her reasons for failure to approve the plan in an order issued at the hearing.

(2) After providing thirty days' advance written notice of its plan to the commissioner and upon the written approval of the commissioner in advance of the proposed transfer date, any domestic insurer of this state may transfer its domicile to any other state in which it is admitted to transact the business of insurance. Upon transfer of domicile, the insurer ceases to be a domestic insurer of this state. If otherwise qualified under the laws of this state, the commissioner shall admit the insurer to do business in this state as a foreign insurer. The commissioner shall approve any proposed transfer of domicile unless the commissioner determines after a hearing, pursuant to such notice as the commissioner may require, that the transfer is not in the best interests of the public or the insurer's policyholders in this state. If the commissioner fails to approve a proposed transfer of domicile, the commissioner shall state his or her reasons for failure to approve the transfer in an order issued at the hearing.

(3) When a foreign insurer, admitted to transact business in this state, transfers its corporate domicile to this state or to any other state, the certificate of authority, appointment of statutory agent, and all approved licenses, policy forms, rates, filings, and other authorizations and approvals in existence at the time the foreign insurer transfers its corporate domicile shall continue in effect.

(4) Any insurer transferring its corporate domicile under this section shall file any amendments to articles of incorporation, bylaws, or other corporate documents that are required to be filed in this state before the insurer may receive approval of its proposed plan by the commissioner. [1988 c 248 § 5.]

Chapter 48.08 RCW
DOMESTIC STOCK INSURERS

Sections

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Merger or consolidation: RCW 48.31.010.

Organization of domestic insurers: Chapter 48.06 RCW.

Superadded liability of shareholders of domestic stock insurance companies: State Constitution Art. 12 § 11.

48.08.010 Increase of capital stock. (1) Increase of the capital stock of a domestic stock insurer shall be by amendment to its articles of incorporation.

(2) If the increased capital stock is to be distributed as a stock dividend, such increased capital stock may be fully paid in out of any available surplus funds as is provided in RCW 48.08.030, and such payment shall be effected by a transfer on the insurer's books from its surplus account to its capital account.

(3) When the increased capital has been fully paid in, a certificate to such effect shall be made in quadruplicate under oath and the corporate seal by the insurer's president and secretary and filed in the public offices named in RCW 48.07.070. [1953 c 197 § 4; 1947 c 79 § .08.01; Rem. Supp. 1947 § 45.08.01.]

48.08.020 Reduction of capital stock. (1) Reduction of the capital stock of a domestic stock insurer shall be by amendment of its articles of incorporation. No such reduction shall be made which results in capital stock less in amount than the minimum required by this code for the kinds of insurance thereafter to be transacted by the insurer.

(2) No surplus funds of the insurer resulting from a reduction of its capital stock shall be distributed to stockholders, except as a stock dividend on a subsequent increase of capital stock, or upon dissolution of the insurer, or upon approval of the commissioner of a distribution upon proof satisfactory to him or her that the distribution will not impair the interests of policyholders or the insurer's solvency.

(3) Upon such reduction of capital stock, the insurer's directors shall call in any outstanding stock certificates required to be changed pursuant thereto, and issue proper certificates in their stead. [2009 c 549 § 7028; 1947 c 79 § .08.02; Rem. Supp. 1947 § 45.08.02.]

48.08.030 Dividends to stockholders. (1) No domestic stock insurer shall pay any cash dividend to stockholders except out of earned surplus. For the purpose of this section, "earned surplus" means that part of its available surplus funds which is derived from any realized net profits on its business, and does not include unrealized capital gains or reevaluation of assets.

(2) Such an insurer may pay a stock dividend out of any available surplus funds.

(3) Payment of any dividend to stockholders of a domestic stock insurer shall also be subject to all the limitations and requirements governing the payment of dividends by other private corporations.

(4) No dividend shall be declared or paid which would reduce the insurer's surplus to an amount less than the minimum required for the kinds of insurance thereafter to be transacted.

(5) For the purposes of this chapter "surplus funds" means the excess of the insurer's assets over its liabilities, including its capital stock as a liability.

(6) Available surplus means the excess over the minimum amount of surplus required for the kinds of insurance the insurer is authorized to transact. [1993 c 462 § 52; 1947 c 79 § .08.03; Rem. Supp. 1947 § 45.08.03.]

Additional notes found at www.leg.wa.gov

48.08.040 Illegal dividends, reductions—Penalty against directors. Any director of a domestic stock insurer who votes for or concurs in the declaration or payment of any dividend to stockholders or a reduction of capital stock not authorized by law shall, in addition to any other liability imposed by law, be guilty of a gross misdemeanor. [1947 c 79 § .08.04; Rem. Supp. 1947 § 45.08.04.]

48.08.050 Impairment of capital. (1) If the capital stock of a domestic stock insurer becomes impaired, the commissioner shall at once determine the amount of the deficiency and serve notice upon the insurer to require its stockholders to make good the deficiency within ninety days after service of such notice.

(2) The deficiency shall be made good in cash, or in assets eligible under this code for the investment of the insurer's funds, or by reduction of the insurer's capital stock to an amount not below the minimum required for the kinds of insurance to be thereafter transacted.

(3) If the deficiency is not made good and proof thereof filed with the commissioner within such ninety-day period, the insurer shall be deemed insolvent and shall be proceeded against as authorized by this code.

(4) If the deficiency is not made good the insurer shall not issue or deliver any policy after the expiration of such ninety-day period. Any officer or director who violates or knowingly permits the violation of this provision shall be subject to a fine of from fifty dollars to one thousand dollars for each violation. [1947 c 79 § .08.05; Rem. Supp. 1947 § 45.08.05.]

48.08.060 Repayment of contributions to surplus. Contributions to the surplus of a domestic stock insurer other than resulting from sale of its capital stock, shall not be subject to repayment except out of surplus in excess of the mini-

mum surplus initially required of such an insurer transacting like kinds of insurance. [1947 c 79 § .08.06; Rem. Supp. 1947 § 45.08.06.]

48.08.070 Participating policies. (1) Any domestic stock insurer may, if its charter so provides, issue policies entitled to participate from time to time in the earnings of the insurer through dividends.

(2) Any classification of its participating policies and of risks assumed thereunder which the insurer may make shall be reasonable. No dividend shall be paid which is inequitable or which unfairly discriminates as between such classifications or as between policies within the same classification.

(3) No such insurer shall issue in this state both participating and nonparticipating policies for the same class of risks; except, that both participating and nonparticipating life insurance policies may be issued if the right or absence of the right to participate is reasonably related to the premium charged.

(4) Dividends to participating life insurance policies issued by such insurer shall be paid only out of its surplus funds as defined in subsection (5) of RCW 48.08.030. Dividends to participating policies for other kinds of insurance shall be paid only out of that part of such surplus funds which is derived from any realized net profits from the insurer's business.

(5) No dividend, otherwise earned, shall be made contingent upon the payment of renewal premium on any policy. [1947 c 79 § .08.07; Rem. Supp. 1947 § 45.08.07.]

48.08.080 Mutualization of stock insurers. (1) Any domestic stock insurer may become a domestic mutual insurer pursuant to such plan and procedure as are approved by the commissioner in advance of such mutualization.

(2) The commissioner shall not approve any such plan, procedure, or mutualization unless:

(a) It is equitable to both shareholders and policyholders.

(b) It is approved by vote of the holders of not less than three-fourths of the insurer's capital stock having voting rights, and by vote of not less than two-thirds of the insurer's policyholders who vote on such plan, pursuant to such notice and procedure as may be approved by the commissioner. Such vote may be registered in person, by proxy, or by mail.

(c) If a life insurer, the right to vote thereon is limited to those policyholders whose policies have face amounts of not less than one thousand dollars and have been in force one year or more.

(d) Mutualization will result in retirement of shares of the insurer's capital stock at a price not in excess of the fair value thereof as determined by competent disinterested appraisers.

(e) The plan provides for appraisal and purchase of the shares of any nonconsenting stockholder in accordance with the laws of this state relating to the sale or exchange of all the assets of a private corporation.

(f) The plan provides for definite conditions to be fulfilled by a designated early date upon which such mutualization will be deemed effective.

(g) The mutualization leaves the insurer with surplus funds reasonably adequate to preserve the security of its policyholders and its ability to continue successfully in business

in the states in which it is then authorized, and in the kinds of insurance it is then authorized to transact. [1947 c 79 § .08.08; Rem. Supp. 1947 § 45.08.08.]

48.08.090 Stockholder meetings—Duty to inform stockholders of matters to be presented—Proxies. (1) This section shall apply to all domestic stock insurers except:

(a) A domestic stock insurer having less than one hundred stockholders; except, that if ninety-five percent or more of the insurer's stock is owned or controlled by a parent or affiliated insurer, this section shall not apply to such insurer unless its remaining shares are held by five hundred or more stockholders.

(b) Domestic stock insurers which file with the Securities and Exchange Commission forms of proxies, consents and authorizations pursuant to the Securities and Exchange Act of 1934, as amended.

(2) Every such insurer shall seasonably furnish its stockholders in advance of stockholder meetings, information in writing reasonably adequate to inform them relative to all matters to be presented by the insurer's management for consideration of stockholders at such meeting.

(3) No person shall solicit a proxy, consent, or authorization in respect of any stock of such an insurer unless he or she furnishes the person so solicited with written information reasonably adequate as to

(a) The material matters in regard to which the powers so solicited are proposed to be used, and

(b) The person or persons on whose behalf the solicitation is made, and the interest of such person or persons in relation to such matters.

(4) No person shall so furnish to another, information which the informer knows or has reason to believe, is false or misleading as to any material fact, or which fails to state any material fact reasonably necessary to prevent any other statement made from being misleading.

(5) The form of all such proxies shall:

(a) Conspicuously state on whose behalf the proxy is solicited;

(b) Provide for dating the proxy;

(c) Impartially identify each matter or group of related matters intended to be acted upon;

(d) Provide means for the principal to instruct the vote of his or her shares as to approval or disapproval of each matter or group, other than election to office; and

(e) Be legibly printed, with context suitably organized.

Except, that a proxy may confer discretionary authority as to matters as to which choice is not specified pursuant to (d) of this subsection, if the form conspicuously states how it is intended to vote the proxy or authorization in each such case; and may confer discretionary authority as to other matters which may come before the meeting but unknown for a reasonable time prior to the solicitation by the persons on whose behalf the solicitation is made.

(6) No proxy shall confer authority (a) to vote for election of any person to any office for which a bona fide nominee is not named in the proxy statement, or (b) to vote at any annual meeting (or adjournment thereof) other than the annual meeting next following the date on which the proxy statement and form were furnished stockholders.

(7) The commissioner shall have authority to make and promulgate reasonable rules and regulations for the effectuation of this section, and in so doing shall give due consideration to rules and regulations promulgated for similar purposes by the insurance supervisory officials of other states. [2010 c 8 § 11001; 2009 c 549 § 7029; 1965 ex.s. c 70 § 5.]

Exemption from federal registration: 15 U.S.C. § 78 l(g)(2)(G).

48.08.100 Equity security—Defined. The term "equity security" when used in RCW 48.08.100 through 48.08.160 means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the commissioner shall deem to be of similar nature and consider necessary or appropriate, by such rules and regulations as he or she may prescribe in the public interest or for the protection of investors, to treat as an equity security. [2009 c 549 § 7030; 1965 ex.s. c 70 § 11.]

48.08.110 Equity security—Duty to file statement of ownership. Every person who is directly or indirectly the beneficial owner of more than ten percent of any class of any equity security of a domestic stock insurer, or who is a director or an officer of such insurer, shall file with the commissioner on or before the 30th day of September, 1965, or within ten days after he or she becomes such beneficial owner, director or officer, a statement, in such form as the commissioner may prescribe, of the amount of all equity securities of such insurer of which he or she is the beneficial owner, and within ten days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file with the commissioner a statement, in such form as the commissioner may prescribe, indicating his or her ownership at the close of the calendar month and such changes in his or her ownership as have occurred during such calendar month. [2009 c 549 § 7031; 1965 ex.s. c 70 § 6.]

48.08.120 Equity security—Profits from short term transactions—Remedies—Limitation of actions. For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director or officer by reason of his or her relationship to such insurer, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such insurer within any period of less than six months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the insurer, irrespective of any intention on the part of such beneficial owner, director or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the insurer, or by the owner of any security of the insurer in the name and in behalf of the insurer if the insurer shall fail or refuse to bring such suit within sixty days after request or shall fail diligently to prosecute the same thereafter: PROVIDED, That no such suit shall be brought more than two years after the date such profit was realized. This section shall not be construed to cover any

transaction where such beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the commissioner by rules and regulations may exempt as not comprehended within the purpose of this section. [2009 c 549 § 7032; 1965 ex.s. c 70 § 7.]

Exemption from federal registration: 15 U.S.C. § 78 l(g)(2)(G).

48.08.130 Equity security—Sales, unlawful practices. It shall be unlawful for any such beneficial owner, director or officer, directly or indirectly, to sell any equity security of such insurer if the person selling the security or his or her principal (1) does not own the security sold, or (2) if owning the security, does not deliver it against such sale within twenty days thereafter, or does not within five days after such sale deposit it in the mails or other usual channels of transportation: PROVIDED, That no person shall be deemed to have violated this section if he or she proves that notwithstanding the exercise of good faith he or she was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense. [2010 c 8 § 11002; 2009 c 549 § 7033; 1965 ex.s. c 70 § 8.]

48.08.140 Equity security—Exemptions—Sales by dealer. The provisions of RCW 48.08.120 shall not apply to any purchase and sale, or sale and purchase, and the provisions of RCW 48.08.130 shall not apply to any sale of an equity security of a domestic stock insurer not then or theretofore held by him or her in an investment account, by a dealer in the ordinary course of his or her business and incident to the establishment or maintenance by him or her of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The commissioner may, by such rules and regulations as he or she deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market. [2009 c 549 § 7034; 1965 ex.s. c 70 § 9.]

48.08.150 Equity security—Exemptions—Foreign or domestic arbitrage transactions. The provisions of RCW 48.08.110, 48.08.120 and 48.08.130 shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the commissioner may adopt in order to carry out the purposes of RCW 48.08.100 through 48.08.160. [1965 ex.s. c 70 § 10.]

48.08.160 Equity security—Exemptions—Securities registered or required to be, or no class held by one hundred or more persons. The provisions of RCW 48.08.110, 48.08.120, and 48.08.130 shall not apply to equity securities of a domestic stock insurer if (1) such securities shall be registered, or shall be required to be registered, pursuant to section 12 of the Securities Exchange Act of 1934, as amended, or if (2) such domestic stock insurer shall not have any class of its equity securities held of record by one hundred or more persons on the last business day of the year next preceding the year in which equity securities of the insurer would be subject to the provisions of RCW 48.08.110, 48.08.120, and

48.08.130 except for the provisions of this subsection (2). [1965 ex.s. c 70 § 12.]

48.08.170 Equity security—Rules and regulations.

The commissioner shall have the power to make such rules and regulations as may be necessary for the execution of the functions vested in him or her by RCW 48.08.100 through 48.08.160, and may for such purpose classify domestic stock insurers, securities, and other persons or matters within his jurisdiction. No provision of RCW 48.08.110, 48.08.120, and 48.08.130 imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the commissioner, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason. [2009 c 549 § 7035; 1965 ex.s. c 70 § 13.]

48.08.190 Failure to file required information, documents, or reports—Forfeiture. Any person who fails to file information, documents, or reports required to be filed under chapter 241, Laws of 1969 ex. sess. or any rule or regulation thereunder shall forfeit to the state of Washington the sum of one hundred dollars for each and every day such failure to file shall continue. Such forfeiture, which shall be in lieu of any criminal penalty for such failure to file which might be deemed to arise under this title, shall be payable to the treasurer of the state of Washington and shall be recoverable in a civil suit in the name of the state of Washington. [1969 ex.s. c 241 § 18.]

**Chapter 48.09 RCW
MUTUAL INSURERS**

Sections

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Dividends not to be guaranteed: RCW 48.30.100.

Merger or consolidation: RCW 48.31.010.

Organization of domestic insurers: Chapter 48.06 RCW.

Policy dividends are payable to real party in interest: RCW 48.18.340.

(2021 Ed.)

48.09.010 Initial qualifications. (1) The commissioner shall not issue a certificate of authority to a domestic mutual insurer unless it has fully qualified therefor under this code, and unless it has met the minimum requirements for the kind of insurance it proposes to transact as provided in this chapter.

(2) All applications for insurance submitted by such an insurer as fulfilling qualification requirements shall be bona fide applications from persons resident in this state covering lives, property, or risks resident or located in this state.

(3) All qualifying premiums collected and initial surplus funds of such an insurer shall be in cash. Any deposit made by such an insurer in lieu of applications, premiums, and initial surplus funds, shall be in cash or in securities eligible for the investment of the capital of a domestic stock insurer transacting the same kind of insurance. [1947 c 79 § .09.01; Rem. Supp. 1947 § 45.09.01.]

48.09.090 Additional kinds of insurance. A domestic mutual insurer may be authorized to transact kinds of insurance in addition to that for which it was originally authorized, if it has otherwise complied with the provisions of this code therefor, and while it possesses and maintains surplus funds in aggregate amount not less than the minimum amount of capital and surplus required under this code of a domestic stock insurer authorized to transact like kinds of insurance pursuant to RCW 48.05.340. [1980 c 135 § 2; 1957 c 193 § 5; 1947 c 79 § .09.09; Rem. Supp. 1947 § 45.09.09.]

48.09.100 Minimum surplus. A domestic mutual insurer on the cash premium plan shall at all times have and maintain surplus funds, representing the excess of its assets over its liabilities, in amount not less than the aggregate of

(1) the amount of any surplus funds deposited by it with the commissioner to qualify for its original certificate of authority, and

(2) the amount of any additional surplus required of it pursuant to RCW 48.09.090 for authority to transact additional kinds of insurance. [1963 c 195 § 3; 1947 c 79 § .09.10; Rem. Supp. 1947 § 45.09.10.]

48.09.110 Membership. (1) Each holder of one or more insurance contracts issued by a domestic mutual insurer, other than a contract of reinsurance, is a member of the insurer, with the rights and obligations of such membership, and each insurance contract so issued shall effectively so stipulate.

(2) Any person, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, estate, trustee or fiduciary, may be a member of a mutual insurer. [1947 c 79 § .09.11; Rem. Supp. 1947 § 45.09.11.]

48.09.120 Rights of members. (1) A domestic mutual insurer is owned by and shall be operated in the interest of its members.

(2) Each member is entitled to one vote in the election of directors and on matters coming before corporate meetings of members, subject to such reasonable minimum requirements as to duration of membership and amount of insurance held as may be made in the insurer's bylaws. The person named as

the policyholder in any group insurance policy issued by such insurer shall be deemed the member, and shall have but one such vote regardless of the number of individuals insured by such policy.

(3) With respect to the management, records, and affairs of the insurer, a member shall have the same character of rights and relationship as a stockholder has toward a domestic stock insurer. [1947 c 79 § .09.12; Rem. Supp. 1947 § 45.09.12.]

48.09.130 Bylaws. A domestic mutual insurer shall adopt bylaws for the conduct of its affairs. Such bylaws, or any modification thereof, shall forthwith be filed with the commissioner. The commissioner shall disapprove any such bylaws, or as so modified, if he or she finds after a hearing thereon, that it is not in compliance with the laws of this state, and he or she shall forthwith communicate such disapproval to the insurer. No such bylaw, or modification, so disapproved shall be effective during the existence of such disapproval. [2009 c 549 § 7036; 1947 c 79 § .09.13; Rem. Supp. 1947 § 45.09.13.]

48.09.140 Notice of annual meeting. (1) Notice of the time and place of the annual meeting of members of a domestic mutual insurer shall be given by imprinting such notice plainly on the policies issued by the insurer.

(2) Any change of the date or place of the annual meeting shall be made only by an annual meeting of members. Notice of such change may be given:

(a) By imprinting such new date or place on all policies which will be in effect as of the date of such changed meeting; or

(b) Unless the commissioner otherwise orders, notice of the new date or place need be given only through policies issued after the date of the annual meeting at which such change was made and in premium notices and renewal certificates issued during the twenty-four months immediately following such meeting. [1947 c 79 § .09.14; Rem. Supp. 1947 § 45.09.14.]

48.09.150 Voting—Proxies. (1) A member of a domestic mutual insurer may vote in person or by proxy given another member on any matter coming before a corporate meeting of members.

(2) An officer of the insurer shall not hold or vote the proxy of any member.

(3) No such proxy shall be valid beyond the earlier of the following dates:

(a) The date of expiration set forth in the proxy; or

(b) the date of termination of membership; or

(c) five years from the date of execution of the proxy.

(4) No member's vote upon any proposal to divest the insurer of its business and assets, or the major part thereof, shall be registered or taken except in person or by a proxy newly executed and specific as to the matter to be voted upon. [1947 c 79 § .09.15; Rem. Supp. 1947 § 45.09.15.]

48.09.160 Directors—Disqualification. No individual shall be a director of a domestic mutual insurer by reason of his or her holding public office. Adjudication as a bankrupt or taking the benefit of any insolvency law or making a general

assignment for the benefit of creditors disqualifies an individual from being or acting as a director. [2009 c 549 § 7037; 1947 c 79 § .09.16; Rem. Supp. 1947 § 45.09.16.]

48.09.180 Limitation of expenses as to property and casualty insurance. (1) For any calendar year after its first two full calendar years of operation, no domestic mutual insurer on the cash premium plan, other than one issuing non-assessable policies, shall incur any costs or expense in the writing or administration of property, disability, and casualty insurances (other than boiler and machinery or elevator) transacted by it which, exclusive of losses paid, loss adjustment expenses, investment expenses, dividends, and taxes exceeds the sum of

(a) forty percent of the net premium income during that year after deducting therefrom net earned reinsurance premiums for such year, plus

(b) all of the reinsurance commissions received on reinsurance ceded by it.

(2) The bylaws of every domestic mutual property insurer on the assessment premium plan shall impose a reasonable limitation upon its expenses. [1949 c 190 § 8; 1947 c 79 § .09.18; Rem. Supp. 1949 § 45.09.18.]

48.09.190 Procedure upon violation of limitation. The officers and directors of an insurer violating RCW 48.09.180 shall be jointly and severally liable to the insurer for any excess of expenses incurred. If the insurer fails to exercise reasonable diligence or refuses to enforce such liability, the commissioner may prosecute action thereon for the benefit of the insurer. Such failure or refusal constitutes grounds for revocation of the insurer's certificate of authority. [1947 c 79 § .09.19; Rem. Supp. 1947 § 45.09.19.]

48.09.210 Limitation of action on officer's salary. No action to recover, or on account of, any salary or other compensation due or claimed to be due any officer or director of a domestic mutual insurer, or on any note or agreement relative thereto, shall be brought against such insurer after twelve months after the date on which such salary or compensation, or any installment thereof, first accrued. [1947 c 79 § .09.21; Rem. Supp. 1947 § 45.09.21.]

48.09.220 Contingent liability of members. (1) Each member of a domestic mutual insurer, except as otherwise provided in this chapter, shall have a contingent liability, pro rata and not one for another, for the discharge of its obligations. The contingent liability shall be in such maximum amount as is stated in the insurer's articles of incorporation, but shall be not less than one, nor more than five, additional premiums for the member's policy at the annual premium rate and for a term of one year.

(2) Every policy issued by the insurer shall contain a statement of the contingent liability.

(3) Termination of the policy of any such member shall not relieve the member of contingent liability for his or her proportion of the obligations of the insurer which accrued while the policy was in force. [2009 c 549 § 7038; 1949 c 190 § 9; 1947 c 79 § .09.22; Rem. Supp. 1949 § 45.09.22.]

48.09.230 Assessment of members. (1) If at any time the assets of a domestic mutual insurer doing business on the cash premium plan are less than its liabilities and the minimum surplus, if any, required of it by this code as prerequisite for continuance of its certificate of authority, and the deficiency is not cured from other sources, its directors may, if approved by the commissioner, make an assessment only on its members who at any time within the twelve months immediately preceding the date such assessment was authorized by its directors held policies providing for contingent liability.

(2) Such an assessment shall be for such an amount of money as is required, in the opinion of the commissioner, to render the insurer fully solvent, but not to result in surplus in excess of five percent of the insurer's liabilities as of the date of the assessment.

(3) A member's proportionate part of any such assessment shall be computed by applying to the premium earned, during the period since the deficiency first appeared, on his or her contingently liable policy or policies the ratio of the total assessment to the total premium earned during such period on all contingently liable policies which are subject to the assessment.

(4) No member shall have an offset against any assessment for which he or she is liable on account of any claim for unearned premium or losses payable. [2009 c 549 § 7039; 1949 c 190 § 10; 1947 c 79 § .09.23; Rem. Supp. 1949 § 45.09.23.]

48.09.235 Issuing a capital call—Notice—Insurer's duties—Rules. (1) In addition to authority granted by RCW 48.09.220 and 48.09.230, a domestic mutual insurer meeting all the requirements of this section may increase its surplus by issuing a capital call. A capital call requires policyholders or applicants for insurance to pay a sum, in addition to premium, to be eligible to renew a policy or be issued a new policy. A policyholder that does not pay the amount of a call cannot be canceled or denied the benefits of an existing policy.

(2) Prior to issuing a capital call, the insurer must have:

(a) Adopted articles of incorporation or other organizational documents authorizing capital calls; and

(b) For any capital call issued on or after January 1, 2006, included information concerning the insurer's authority to issue a capital call in the policy of every policyholder. This information must be provided at least one full policy renewal cycle prior to a capital call.

(3) The insurer must notify the commissioner of its intent to issue a capital call at least ninety days prior to the capital call. The notice to the commissioner must include:

(a) A statement of each of the following:

(i) The specific purpose or purposes of the capital call;

(ii) The total amount intended to be raised by issuance of the capital call;

(iii) The amount intended to be raised for each stated purpose;

(iv) The grounds relied upon by the insurer in deciding that the capital call is the best option available to the insurer for raising capital; and

(v) Each of the alternative methods of raising capital the insurer considered and the reasons the insurer rejected each alternative in favor of the capital call;

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(b) For the ten years immediately preceding the filing of the notice, a year by year accounting of:

(i) All rate filings and actions;

(ii) The total of all underwriting losses; and

(iii) The total amount of dividends paid to policyholders; and

(c) A complete application for a solicitation permit as required in RCW 48.06.030.

(4) Before an insurer may issue a capital call, the insurer must:

(a) Notify the commissioner and provide information as required in subsection (3) of this section;

(b) Provide any and all additional information that the commissioner may determine is useful or necessary in evaluating the merits of the proposed capital call;

(c) Receive approval of the policy or insuring instrument from the commissioner; and

(d) Receive approval of the commissioner for the capital call and the solicitation permit.

The commissioner may disapprove a capital call if he or she does not believe it is in the best interest of the insurer, the policyholders, or the citizens of the state of Washington. In making this determination, the commissioner may consider the financial health of the insurer, the impact on the marketplace, the possible use of other means to raise capital, the frequency of previous capital calls by the insurer, the effect of raising premiums instead of a capital call, the impact on state revenue, or any other factor the commissioner deems proper.

(5) The funds raised by an approved capital call are not premiums for the purposes of RCW 48.14.020.

(6) The commissioner may adopt rules to implement this section. [2004 c 89 § 2.]

Additional notes found at www.leg.wa.gov

48.09.240 Contingent liability of members of assessment insurer. The contingent liability of members of a domestic mutual insurer doing business on the assessment premium plan shall be called upon and enforced by its directors as provided in its bylaws. [1947 c 79 § .09.24; Rem. Supp. 1947 § 45.09.24.]

48.09.250 Contingent liability as asset. Any contingent liability of members of a domestic mutual insurer to assessment does not constitute an asset of the insurer in any determination of its financial condition. [1949 c 190 § 11; 1947 c 79 § .09.25; Rem. Supp. 1949 § 45.09.25.]

48.09.260 Liability as lien on policy reserves. As to life insurance, any portion of an assessment of contingent liability upon a policyholder which remains unpaid following notice of such assessment, demand for payment, and lapse of a reasonable waiting period as specified in such notice, may, if approved by the commissioner, be secured by placing a lien on the reserves held by the insurer to the credit of such policyholder. [1949 c 190 § 12; 1947 c 79 § .09.26; Rem. Supp. 1949 § 45.09.26.]

48.09.270 Nonassessable policies. (1) A domestic mutual insurer on the cash premium plan, after it has established a surplus not less in amount than the minimum capital funds required of a domestic stock insurer to transact like

kinds of insurance, and for so long as it maintains such surplus, may extinguish the contingent liability of its members to assessment and omit provisions imposing contingent liability in all policies currently issued.

(2) Any deposit made with the commissioner as a prerequisite to the insurer's certificate of authority may be included as part of the surplus required in this section.

(3) When the surplus has been so established and the commissioner has so ascertained, he or she shall issue to the insurer, at its request, his or her certificate authorizing the extinguishment of the contingent liability of its members and the issuance of policies free therefrom.

(4) While it maintains surplus funds in amount not less than the minimum capital required of a domestic stock insurer authorized to transact like kinds of insurance, and subject to the requirements of *RCW 48.05.360 as to special surplus, a foreign or alien mutual insurer on the cash premium plan may, if consistent with its charter and the laws of its domicile, issue nonassessable policies covering subjects located, resident, or to be performed in this state. [2009 c 549 § 7040; 1963 c 195 § 4; 1947 c 79 § .09.27; Rem. Supp. 1947 § 45.09.27.]

*Reviser's note: RCW 48.05.360 was repealed by 2005 c 223 § 35.

48.09.280 Qualification on issuance of nonassessable policies. The commissioner shall not authorize a domestic mutual insurer so to extinguish the contingent liability of any of its members or in any of its policies to be issued, unless it qualifies to and does extinguish such liability of all its members and in all such policies for all kinds of insurance transacted by it. Except, that if required by the laws of another state in which such an insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its members as may acquire such policies in such state, and need not extinguish the contingent liability applicable to policies theretofore in force in such state. [1947 c 79 § .09.28; Rem. Supp. 1947 § 45.09.28.]

48.09.290 Revocation of right to issue nonassessable policies. (1) The commissioner shall revoke the authority of a domestic mutual insurer so to extinguish the contingent liability of its members if

(a) at any time the insurer's assets are less than the sum of its liabilities and the surplus required for such authority, or

(b) the insurer, by resolution of its directors approved by its members, requests that the authority be revoked.

(2) Upon revocation of such authority for any cause, the insurer shall not thereafter issue any policies without contingent liability, nor renew any policies then in force without written endorsement thereon providing for contingent liability. [1947 c 79 § .09.29; Rem. Supp. 1947 § 45.09.29.]

48.09.300 Dividends. (1) The directors of a domestic mutual insurer on the cash premium plan may from time to time apportion and pay to its members as entitled thereto, dividends only out of that part of its surplus funds which are in excess of its required minimum surplus and which represent net realized savings and net realized earnings from its business.

(2) Any classification of its participating policies and of risks assumed thereunder which the insurer may make shall be reasonable. No dividend shall be paid which is inequitable, or which unfairly discriminates as between such classifications or as between policies within the same classification.

(3) No dividend, otherwise earned, shall be made contingent upon the payment of renewal premium on any policy. [1947 c 79 § .09.30; Rem. Supp. 1947 § 45.09.30.]

48.09.310 Nonparticipating policies. (1) If its articles of incorporation so provide, a domestic mutual insurer on the cash premium plan may, while it is authorized to issue policies without contingent liability to assessment, issue policies not entitled to participate in the insurer's savings and earnings.

(2) Such insurer shall not issue in this state both participating and nonparticipating policies for the same class of risks; except, that both participating and nonparticipating life insurance policies may be issued if the right or absence of the right to participate is reasonably related to the premium charged. [1947 c 79 § .09.31; Rem. Supp. 1947 § 45.09.31.]

48.09.320 Borrowed capital. (1) A domestic mutual insurer may, with the commissioner's advance approval and without the pledge of any of its assets, borrow money to defray the expenses of its organization or for any purpose required by its business, upon an agreement that such money and such fair and reasonable interest thereon as may be agreed upon, shall be repaid only out of the insurer's earned surplus in excess of its required minimum surplus.

(2) An insurer borrowing funds under this section must comply with the national association of insurance commissioner's - accounting practices and procedures manual which sets forth requirements for borrowed money to be treated as surplus notes for financial accounting purposes.

(3) The commissioner's approval of such borrowed funds, if granted, shall specify the amount to be borrowed, the purpose for which the money is to be used, the terms and form of the loan agreement, the date by which the loan must be completed, fair and reasonable commissions or promotional expenses to be incurred or to be paid, and such other related matters as the commissioner shall deem proper. If the money is to be borrowed upon multiple agreements, the agreements shall be serially numbered. No loan agreement or series thereof shall have or be given any preferential rights over any other such loan agreement or series. [2003 c 249 § 1; 1947 c 79 § .09.32; Rem. Supp. 1947 § 45.09.32.]

48.09.330 Repayment of borrowed capital. (1) The insurer may repay any loan received pursuant to RCW 48.09.320, or any part thereof as approved by the commissioner, only out of its funds which represent such loan or realized net earned surplus. No repayment shall be made which reduces the insurer's surplus below the minimum surplus required for the kinds of insurance transacted.

(2) The insurer shall repay any such loan or the largest possible part thereof when the purposes for which such funds were borrowed have been fulfilled and when the insurer's surplus is adequate to so repay without unreasonable impairment of the insurer's operations.

(3) No repayment of such loan shall be made unless approved by the commissioner. The insurer shall notify the commissioner in writing not less than sixty days in advance of its intention to repay such loan or any part thereof, and the commissioner shall forthwith ascertain whether the insurer's financial condition is such that the repayment can properly be made.

(4) Upon dissolution and liquidation of the insurer, after the retirement of all its other outstanding obligations the holders of any such loan agreements then remaining unpaid shall be entitled to payment before any distribution of surplus is made to the insurer's members. [1949 c 190 § 13; 1947 c 79 § .09.33; Rem. Supp. 1949 § 45.09.33.]

48.09.340 Impairment of surplus. (1) If the assets of a domestic mutual insurer on the cash premium plan fall below the amount of its liabilities, plus the amount of any surplus required by this code for the kinds of insurance authorized to be transacted, the commissioner shall at once ascertain the amount of the deficiency and serve notice upon the insurer to cure the deficiency within ninety days after such service of notice.

(2) If the deficiency is not made good in cash or in assets eligible under this code for the investment of the insurer's funds, and proof thereof filed with the commissioner within such ninety-day period, the insurer shall be deemed insolvent and shall be proceeded against as authorized by this code.

(3) If the deficiency is not made good the insurer shall not issue or deliver any policy after the expiration of such ninety-day period. Any officer or director who violates or knowingly permits the violating of this provision shall be subject to a fine of from fifty dollars to one thousand dollars for each violation. [1949 c 190 § 14; 1947 c 79 § 09.34; Rem. Supp. 1949 § 45.09.34.]

48.09.350 Reorganization of mutual as stock insurer—Reinsurance—Approval. (1) Upon satisfaction of the requirements applicable to the formation of a domestic stock insurer, a domestic mutual insurer may be reorganized as a stock corporation, pursuant to a plan of reorganization as approved by the commissioner.

(2) A domestic mutual insurer may be wholly reinsured in and its assets transferred to and its liabilities assumed by another mutual or stock insurer under such terms and conditions as are approved by the commissioner in advance of such reinsurance.

(3) The commissioner shall not approve any such reorganization plan or reinsurance agreement which does not determine the amount of and make adequate provision for paying to members of such mutual insurer, reasonable compensation for their equities as owners of such insurer, such compensation to be apportioned to members as identified and in the manner prescribed in RCW 48.09.360. The procedure for approval by the commissioner of any such reorganization plan or reinsurance agreement shall be the same as the procedure for approval by the commissioner of a plan of merger or consolidation under RCW 48.31.010.

Approval at a corporate meeting of members by two-thirds of the then members of a domestic mutual insurer who vote on the plan or agreement pursuant to such notice and procedure as was approved by the commissioner shall consti-

tute approval of any such reorganization plan or reinsurance agreement by the insurer's members. [1984 c 23 § 1; 1983 1st ex.s. c 32 § 1; 1947 c 79 § .09.35; Rem. Supp. 1947 § 45.09.35.]

48.09.360 Distribution of assets and ownership equities upon liquidation. (1) Upon the liquidation of a domestic mutual insurer, its assets remaining after discharge of its indebtedness and policy obligations shall be distributed to its members who were such within the thirty-six months prior to the last termination of its certificate of authority.

(2) Upon the reorganization of a domestic mutual insurer as a domestic stock insurer under RCW 48.09.350(1) or upon reinsurance of the whole of the liabilities and transfer of all the assets of a domestic mutual insurer under RCW 48.09.350(2), the ownership equities of members of the domestic mutual insurer shall be distributed to its members who were such on an eligibility date stated in the reorganization plan or reinsurance agreement, or who were such within the thirty-six months prior to such eligibility date. Such eligibility date shall be either the date on which the reorganization plan or reinsurance agreement is adopted by resolution of the board of directors of the domestic mutual insurer, or the date on which the reorganization plan or reinsurance agreement is approved by a vote of the members, or the date which ends a calendar quarter during which either of such actions is taken.

(3) Upon the liquidation of a domestic mutual insurer, the distributive share of each such member shall be in the proportion that the aggregate premiums earned by the insurer on the policies of the member during the thirty-six months before the last termination of the insurer's certificate of authority, bear to the aggregate of all premiums so earned on the policies of all such members during the same thirty-six months.

(4) Upon the reorganization of a domestic mutual insurer as a domestic stock insurer under RCW 48.09.350(1) or upon reinsurance of the whole of the liabilities and transfer of all the assets of a domestic mutual insurer under RCW 48.09.350(2), the distributive share of each member entitled thereto shall be in the proportion that the aggregate premiums earned by the insurer on the policies in force of that member during the thirty-six months before the eligibility date established under RCW 48.09.360(2) bear to the aggregate of all premiums so earned during the same thirty-six months on all the policies in force of all such members who are entitled to a distributive share.

(5) If a life insurer, the insurer shall make a reasonable classification of its life insurance policies so held by such members entitled to a distributive share and a formula based upon such classification for determining the equitable distributive share of each such member. Such classification and formula shall be subject to the commissioner's approval. [1984 c 23 § 2; 1947 c 79 § .09.36; Rem. Supp. 1947 § 45.09.36.]

**Chapter 48.10 RCW
RECIPROCAL INSURERS**

Sections

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48.10.330	Merger—Conversion to stock or mutual insurer.
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Dividends not to be guaranteed: RCW 48.30.100.

Merger or consolidation: RCW 48.31.010.

Organization of domestic insurers: Chapter 48.06 RCW.

Policy dividends are payable to real party in interest: RCW 48.18.340.

48.10.010 "Reciprocal insurance" defined. "Reciprocal insurance" is that resulting from an interexchange among persons, known as "subscribers," of reciprocal agreements of indemnity, the interexchange being effectuated through an "attorney-in-fact" common to all such persons. [1947 c 79 § .10.01; Rem. Supp. 1947 § 45.10.01.]

48.10.020 "Reciprocal insurer" defined. A "reciprocal insurer" means an unincorporated aggregation of subscribers operating individually and collectively through an attorney-in-fact to provide reciprocal insurance among themselves. [1947 c 79 § .10.02; Rem. Supp. 1947 § 45.10.02.]

48.10.030 Scope of chapter. All authorized reciprocal insurers shall be governed by those sections of this chapter not expressly made applicable to domestic reciprocal insurers. [1947 c 79 § .10.03; Rem. Supp. 1947 § 45.10.03.]

48.10.050 Insuring powers of reciprocals. (1) A reciprocal insurer may, upon qualifying therefor as provided by this code, transact any kind or kinds of insurance defined by this code, other than life or title insurances.

(2) A reciprocal insurer may purchase reinsurance upon the risk of any subscriber, and may grant reinsurance as to any kind of insurance which it is authorized to transact direct. [1947 c 79 § .10.05; Rem. Supp. 1947 § 45.10.05.]

48.10.055 Real property—Attorney's duty. A reciprocal insurer may purchase, sell, mortgage, encumber, lease, or otherwise affect the title to real property for the purposes and objects of the reciprocal insurer. All deeds, notes, mortgages, or other documents relating to the real property may be executed in the name of the reciprocal insurer by its attorney. [1991 c 266 § 1.]

48.10.060 Name—Suits. A reciprocal insurer shall:

(1) Have and use a business name. The name shall include the word "reciprocal," or "interinsurer," or "interinsurance," or "exchange," or "underwriters," or "underwriting."

(2) Sue and be sued in its own name. [1947 c 79 § .10.06; Rem. Supp. 1947 § 45.10.06.]

48.10.070 Surplus funds required. (1) A domestic reciprocal insurer hereafter formed, if it has otherwise complied with the provisions of this code, may be authorized to transact insurance if it initially possesses surplus in an amount equal to or exceeding the capital and surplus requirements required under RCW 48.05.340(1) plus special surplus, if any, required under *RCW 48.05.360 and thereafter possesses, and maintains surplus funds equal to the paid-in capital stock required under RCW 48.05.340 of a stock insurer transacting like kinds of insurance, and the special surplus, if any, required under *RCW 48.05.360.

(2) A domestic reciprocal insurer which under prior laws held authority to transact insurance in this state may continue to be so authorized so long as it otherwise qualifies therefor and maintains surplus funds in amount not less than as required under laws of this state in force at the time such authority to transact insurance in this state was granted.

(3) A domestic reciprocal insurer heretofore formed shall maintain on deposit with the commissioner surplus funds of not less than the sum of one hundred thousand dollars, and to transact kinds of insurance transacted by it in addition to that authorized by its original certificate of authority, shall have and maintain surplus (including the amount of such deposit) in amount not less than the paid-in capital stock required under RCW 48.05.340(1) plus special surplus, if any, required under *RCW 48.05.360, of a domestic stock insurer formed after 1967 and transacting the same kinds of insurance. Such additional surplus funds need not be deposited with the commissioner. [1985 c 264 § 4; 1975 1st ex.s. c 266 § 5; 1963 c 195 § 5; 1947 c 79 § .10.07; Rem. Supp. 1947 § 45.10.07.]

*Reviser's note: RCW 48.05.360 was repealed by 2005 c 223 § 35.

Additional notes found at www.leg.wa.gov

48.10.080 Attorney. (1) "Attorney" as used in this chapter refers to the attorney-in-fact of a reciprocal insurer. The attorney may be an individual, firm, or corporation.

(2) The attorney of a foreign or alien reciprocal insurer, which insurer is duly authorized to transact insurance in this state, shall not, by virtue of discharge of its duties as such attorney with respect to the insurer's transactions in this state, be thereby deemed to be doing business in this state within the meaning of any laws of this state applying to foreign persons, firms, or corporations.

(3) The subscribers and the attorney-in-fact comprise a reciprocal insurer and a single entity for the purposes of chapter 48.14 RCW as to all operations under the insurer's certificate of authority. [1965 ex.s. c 70 § 35; 1947 c 79 § .10.08; Rem. Supp. 1947 § 45.10.08.]

48.10.090 Organization of reciprocal. (1) Twenty-five or more persons domiciled in this state may organize a domestic reciprocal insurer and in compliance with this code

make application to the commissioner for a certificate of authority to transact insurance.

(2) When applying for a certificate of authority, the original subscribers and the proposed attorney shall fulfill the requirements of and shall execute and file with the commissioner a declaration setting forth:

- (a) the name of the insurer;
- (b) the location of the insurer's principal office, which shall be the same as that of the attorney and shall be maintained within this state;
- (c) the kinds of insurance proposed to be transacted;
- (d) the names and addresses of the original subscribers;
- (e) the designation and appointment of the proposed attorney and a copy of the power of attorney;
- (f) the names and addresses of the officers and directors of the attorney, if a corporation, or of its members, if a firm;
- (g) the powers of the subscribers' advisory committee and the names and terms of office of the members thereof;
- (h) that all moneys paid to the reciprocal, after deducting therefrom any sum payable to the attorney, shall be held in the name of the insurer and for the purposes specified in the subscriber's agreement;
- (i) a copy of the subscriber's agreement;
- (j) a statement that each of the original subscribers has in good faith applied for insurance of the kind proposed to be transacted, and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than six months at the rate theretofore filed with and approved by the commissioner;
- (k) a statement of the financial condition of the insurer, a schedule of its assets, and a statement that the surplus as required by RCW 48.10.070 is on hand;
- (l) a copy of each policy, endorsement, and application form it then proposes to issue or use.

Such declaration shall be acknowledged by each such subscriber and by the attorney in the manner required for the acknowledgment of deeds to real estate. [1947 c 79 § .10.09; Rem. Supp. 1947 § 45.10.09.]

48.10.100 Policies of original subscribers, effective when. Any policy applied for by an original subscriber shall become effective coincidentally with the issuance of a certificate of authority to the reciprocal insurer. [1947 c 79 § .10.10; Rem. Supp. 1947 § 45.10.10.]

48.10.110 Certificate of authority. (1) The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

(2) The commissioner may refuse, suspend, or revoke the certificate of authority, in addition to other grounds therefor, for failure of its attorney to comply with any provision of this code. [1947 c 79 § .10.11; Rem. Supp. 1947 § 45.10.11.]

48.10.120 Power of attorney. (1) The rights and powers of the attorney of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

- (2) The power of attorney must set forth:
 - (a) The powers of the attorney;
 - (b) that the attorney is empowered to accept service of process on behalf of the insurer and to authorize the commis-

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sioner to receive service of process in actions against the insurer upon contracts exchanged;

(c) the services to be performed by the attorney in general;

(d) the maximum amount to be deducted from advance premiums or deposits to be paid to the attorney;

(e) except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount which amount shall be not less than one nor more than ten times the premium or premium deposit stated in the policy.

(3) The power of attorney may:

(a) Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;

(b) impose such restrictions upon the exercise of the power as are agreed upon by the subscribers;

(c) provide for the exercise of any right reserved to the subscribers directly or through their advisory committee;

(d) contain other lawful provisions deemed advisable.

(4) The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement or any amendment thereof, shall be used or be effective in this state until approved by the commissioner. [1949 c 190 § 15; 1947 c 79 § .10.12; Rem. Supp. 1949 § 45.10.12.]

48.10.130 Modification of subscriber's agreement or power of attorney. Modification of the terms of the subscriber's agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. No such modification shall be effective retroactively, nor as to any insurance contract issued prior thereto. [1947 c 79 § .10.13; Rem. Supp. 1947 § 45.10.13.]

48.10.140 Attorney's bond. (1) Concurrently with the filing of the declaration provided for in RCW 48.10.090, (or, if an existing domestic reciprocal insurer, within ninety days after the effective date of this code) the attorney of a domestic reciprocal shall file with the commissioner a bond running to the state of Washington. The bond shall be executed by the attorney and by an authorized corporate surety, and shall be subject to the commissioner's approval.

(2) The bond shall be in the penal sum of twenty-five thousand dollars, conditioned that the attorney will faithfully account for all moneys and other property of the insurer coming into his or her hands, and that he or she will not withdraw or appropriate for his or her own use from the funds of the insurer any moneys or property to which he or she is not entitled under the power of attorney.

(3) The bond shall provide that it is not subject to cancellation unless thirty days advance notice in writing of intent to cancel is given to both the attorney and the commissioner. [2009 c 549 § 7041; 1947 c 79 § .10.14; Rem. Supp. 1947 § 45.10.14.]

48.10.150 Deposit in lieu of bond. In lieu of such bond, the attorney may maintain on deposit with the commissioner a like amount in cash or in value of securities qualified under this code as insurers' investments, and subject to the same

conditions as the bond. [1947 c 79 § .10.15; Rem. Supp. 1947 § 45.10.15.]

48.10.160 Actions on bond. Action on the attorney's bond or to recover against any such deposit made in lieu thereof may be brought at any one time by one or more subscribers suffering loss through a violation of the conditions thereof or by a receiver or liquidator of the insurer. Amounts so recovered shall be deposited in and become part of the insurer's funds. [1947 c 79 § .10.16; Rem. Supp. 1947 § 45.10.16.]

48.10.170 Service of legal process. (1) Each authorized reciprocal insurer must appoint the commissioner as its attorney to receive service of, and upon whom service 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 insurer.

(2) With the appointment the insurer must designate the person to whom the commissioner must forward legal process so served upon him or her.

(3) The appointment of the commissioner as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the insurer, and remains in effect as long as there is in force in this state any contract made by the insurer or liabilities or duties arising under that contract.

(4) The service of process must be accomplished and processed in the manner prescribed under RCW 48.02.200.

(5) In lieu of service on the commissioner, legal process may be served upon a domestic reciprocal insurer by serving the insurer's attorney at his or her principal offices.

(6) Any judgment against the insurer based upon legal process so served is binding upon each of the insurer's subscribers as their respective interests may appear and in an amount not exceeding their respective contingent liabilities. [2011 c 47 § 7; 2009 c 549 § 7042; 1947 c 79 § .10.17; Rem. Supp. 1947 § 45.10.17.]

48.10.180 Annual statement. The annual statement of a reciprocal insurer shall be made and filed by the attorney. [1947 c 79 § .10.18; Rem. Supp. 1947 § 45.10.18.]

48.10.190 Attorney's contribution—Repayment. No contribution to a domestic reciprocal insurer's surplus by the attorney shall be retrievable by the attorney except under such terms and in such circumstances as the commissioner approves. [1947 c 79 § .10.19; Rem. Supp. 1947 § 45.10.19.]

48.10.200 Determination of financial condition. In determining the financial condition of a reciprocal insurer the commissioner shall apply the following rules:

(1) He or she shall charge as liabilities the same reserves as are required of incorporated insurers issuing nonassessable policies on a reserve basis.

(2) The surplus deposits of subscribers shall be allowed as assets, except that any premium deposit delinquent for ninety days shall first be charged against such surplus deposit.

(3) The surplus deposits of subscribers shall not be charged as a liability.

(4) All premium deposits delinquent less than ninety days shall be allowed as assets.

(5) An assessment levied upon subscribers, and not collected, shall not be allowed as an asset.

(6) The contingent liability of subscribers shall not be allowed as an asset.

(7) The computation of reserves shall be based upon premium deposits other than membership fees and without any deduction for the compensation of the attorney. [2009 c 549 § 7043; 1947 c 79 § .10.20; Rem. Supp. 1947 § 45.10.20.]

48.10.220 Who may become subscriber. Any person, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, estate, trustee, or fiduciary may be a subscriber of a reciprocal insurer. [1947 c 79 § .10.22; Rem. Supp. 1947 § 45.10.22.]

48.10.230 Subscribers' advisory committee. (1) The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under such rules as the subscribers adopt.

(2) Not less than three-fourths of such committee shall be composed of subscribers other than the attorney, or any person employed by, representing, or having a financial interest in the attorney.

(3) The committee shall:

(a) Supervise the finances of the insurer;

(b) supervise the insurer's operations to such extent as to assure their conformity with the subscribers' agreement and power of attorney;

(c) procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer;

(d) have such additional powers and functions as may be conferred by the subscribers' agreement. [1947 c 79 § .10.23; Rem. Supp. 1947 § 45.10.23.]

48.10.250 Assessment liability of subscriber. (1) The liability of each subscriber subject to assessment for the obligations of the reciprocal insurer shall not be joint, but shall be individual and several.

(2) Each subscriber who is subject to assessment shall have a contingent assessment liability, in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while his or her policy was in force. Such contingent liability may be at the rate of not less than one nor more than ten times the premium or premium deposit stated in the policy, and the maximum aggregate thereof shall be computed in the manner set forth in RCW 48.10.290.

(3) Each assessable policy issued by the insurer shall plainly set forth a statement of the contingent liability. [2009 c 549 § 7044; 1947 c 79 § .10.25; Rem. Supp. 1947 § 45.10.25.]

48.10.260 Action against subscriber requires judgment against insurer. (1) No action shall lie against any subscriber upon any obligation claimed against the insurer until a final judgment has been obtained against the insurer and remains unsatisfied for thirty days.

(2) Any such judgment shall be binding upon each subscriber only in such proportion as his or her interests may appear and in an amount not exceeding his or her contingent liability, if any. [2009 c 549 § 7045; 1947 c 79 § .10.26; Rem. Supp. 1947 § 45.10.26.]

48.10.270 Assessments. (1) Assessments may be levied from time to time upon the subscribers of a domestic reciprocal insurer, other than as to nonassessable policies, by the attorney upon approval in advance by the subscribers' advisory committee and the commissioner; or by the commissioner in liquidation of the insurer.

(2) Each such subscriber's share of a deficiency for which an assessment is made, not exceeding in any event his or her aggregate contingent liability as computed in accordance with RCW 48.10.290, shall be computed by applying to the premium earned on the subscriber's policy or policies during the period to be covered by the assessment, the ratio of the total deficiency to the total premiums earned during such period upon all policies subject to the assessment.

(3) In computing the earned premiums for the purposes of this section, the gross premium received by the insurer for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the renewal or extension of the policy.

(4) No subscriber shall have an offset against any assessment for which he or she is liable, on account of any claim for unearned premium or losses payable. [2009 c 549 § 7046; 1947 c 79 § .10.27; Rem. Supp. 1947 § 45.10.27.]

48.10.280 Time limit for assessment. Every subscriber of a domestic reciprocal insurer having contingent liability shall be liable for, and shall pay his or her share of any assessment, as computed and limited in accordance with this chapter, if:

(1) While his or her policy is in force or within one year after its termination, he or she is notified by either the attorney or the commissioner of his or her intention to levy such assessment; or

(2) If an order to show cause why a receiver, conservator, rehabilitator, or liquidator of the insurer should not be appointed is issued pursuant to RCW 48.31.190 while his or her policy is in force or within one year after its termination. [2009 c 549 § 7047; 1947 c 79 § .10.28; Rem. Supp. 1947 § 45.10.28.]

48.10.290 Aggregate liability. No one policy or subscriber as to such policy, shall be assessed or be charged with an aggregate of contingent liability as to obligations incurred by a domestic reciprocal insurer in any one calendar year, in excess of the number of times the premium as stated in the policy as computed solely upon premium earned on such policy during that year. [1947 c 79 § .10.29; Rem. Supp. 1947 § 45.10.29.]

48.10.300 Nonassessable policies. (1) Subject to the special surplus requirements of *RCW 48.05.360, if a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital stock required of a domestic stock insurer authorized to transact like kinds of insurance, upon application of the attorney and as approved by the sub-

scribers' advisory committee the commissioner shall issue his or her certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this state, and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this state for so long as all such surplus remains unimpaired.

(2) Upon impairment of such surplus, the commissioner shall forthwith revoke the certificate. No policy shall thereafter be issued or renewed without providing for the contingent assessment liability of subscribers.

(3) The commissioner shall not authorize a domestic reciprocal insurer so to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued, unless it qualifies to and does extinguish such liability of all its subscribers and in all such policies for all kinds of insurance transacted by it. Except, that if required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its subscribers as may acquire such policies in such state, and need not extinguish the contingent liability applicable to policies theretofore in force in such state. [2009 c 549 § 7048; 1983 c 3 § 148; 1947 c 79 § .10.30; Rem. Supp. 1947 § 45.10.30.]

*Reviser's note: RCW 48.05.360 was repealed by 2005 c 223 § 35.

48.10.310 Return of savings to subscribers. A reciprocal insurer may from time to time return to its subscribers any savings or credits accruing to their accounts. Any such distribution shall not unfairly discriminate between classes of risks, or policies, or between subscribers. [1947 c 79 § .10.31; Rem. Supp. 1947 § 45.10.31.]

48.10.320 Distribution of assets upon liquidation. Upon the liquidation of a domestic reciprocal insurer, its assets remaining after discharge of its indebtedness and policy obligations, the return of any contribution of the attorney to its surplus made as provided in RCW 48.10.190, and the return of any unused deposits, savings, or credits, shall be distributed to its subscribers who were such within the twelve months prior to the last termination of its certificate of authority according to such formula as may have been approved by the commissioner. [1947 c 79 § .10.32; Rem. Supp. 1947 § 45.10.32.]

48.10.330 Merger—Conversion to stock or mutual insurer. (1) A domestic reciprocal insurer, upon affirmative vote of not less than two-thirds of the subscribers who vote upon such merger pursuant to such notice as may be approved by the commissioner and with the approval of the commissioner of the terms therefor, may merge with another reciprocal insurer or be converted to a stock or mutual insurer.

(2) Such a stock or mutual insurer shall be subject to the same capital requirements and shall have the same rights as a like domestic insurer transacting like kinds of insurance.

(3) The commissioner shall not approve any plan for such merger or conversion which is inequitable to subscribers, or which, if for conversion to a stock insurer, does not give each subscriber preferential right to acquire stock of the proposed insurer proportionate to his or her interest in the reciprocal insurer as determined in accordance with RCW

48.10.320 and a reasonable length of time within which to exercise such right. [2009 c 549 § 7049; 1947 c 79 § .10.33; Rem. Supp. 1947 § 45.10.33.]

48.10.340 Impairment of assets—Procedure. (1) If the assets of a domestic reciprocal insurer are at any time insufficient to discharge its liabilities other than any liability on account of funds contributed by the attorney, and to maintain the surplus required for the kinds of insurance it is authorized to transact, its attorney shall forthwith levy an assessment upon subscribers made subject to assessment by the terms of their policies for the amount needed to make up the deficiency.

(2) If the attorney fails to make the assessment within thirty days after the commissioner orders him or her to do so, or if the deficiency is not fully made up within sixty days after the date the assessment was made, the insurer shall be deemed insolvent and shall be proceeded against as authorized by this code.

(3) If liquidation of such an insurer is ordered, an assessment shall be levied upon the subscribers for such an amount, subject to limits as provided by this chapter, as the commissioner determines to be necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney, but including the reasonable cost of the liquidation. [2009 c 549 § 7050; 1947 c 79 § .10.34; Rem. Supp. 1947 § 45.10.34.]

Chapter 48.11 RCW INSURING POWERS

Sections

48.11.020	"Life insurance" defined.
48.11.030	"Disability insurance" defined—"Stop loss insurance" defined.
48.11.040	"Property insurance" defined.
48.11.050	"Marine and transportation insurance" defined.
48.11.060	"Vehicle insurance" defined.
48.11.070	"General casualty insurance" defined.
48.11.080	"Surety insurance" defined.
48.11.100	"Title insurance" defined.
48.11.105	"Ocean marine and foreign trade insurances" defined.
48.11.130	Reinsurance powers.
48.11.140	Limitation of single risk.

Workers' compensation: Title 51 RCW.

48.11.020 "Life insurance" defined. "Life insurance" is insurance on human lives and insurances appertaining thereto or connected therewith. For the purposes of this code the transacting of life insurance includes the granting of annuities and endowment benefits; additional benefits in event of death by accident; additional benefits in event of the total and permanent disability of the insured; and optional modes of settlement of proceeds. [1947 c 79 § .11.02; Rem. Supp. 1947 § 45.11.02.]

48.11.030 "Disability insurance" defined—"Stop loss insurance" defined. "Disability insurance" is insurance against bodily injury, disablement or death by accident, against disablement resulting from sickness, and every insurance appertaining thereto including stop loss insurance. "Stop loss insurance" is insurance against the risk of economic loss assumed under a self-funded employee disability benefit

plan. [1992 c 226 § 1; 1947 c 79 § .11.03; Rem. Supp. 1947 § 45.11.03.]

Additional notes found at www.leg.wa.gov

48.11.040 "Property insurance" defined. "Property insurance" is insurance against loss of or damage to real or personal property of every kind and any interest therein, from any or all hazard or cause, and against loss consequential upon such loss or damage. [1947 c 79 § .11.04; Rem. Supp. 1947 § 45.11.04.]

48.11.050 "Marine and transportation insurance" defined. "Marine and transportation insurance" is:

(1) Insurance against loss of or damage to:

(a) Vessels, craft, aircraft, vehicles, goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, securities, choses in action, evidences of debt, valuable papers, bottomry, and respondentia interests and all other kinds of property and interests therein, in respect to, appertaining to or in connection with any and all risks or perils of navigation, transit or transportation, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting shipment, or during any delays, storage, transshipment, or reshipment incident thereto, including war risks, marine builder's risks, and all personal property floater risks.

(b) Person or property in connection with or appertaining to a marine, transit or transportation insurance, including liability for loss of or damage to either incident to the construction, repair, operation, maintenance or use of the subject matter of such insurance (but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to any person arising out of the ownership, maintenance, or use of automobiles).

(c) Precious stones, jewels, jewelry, precious metals, whether in course of transportation or otherwise.

(d) Bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage); piers, wharves, docks and slips, and other aids to navigation and transportation, including dry docks and marine railways, dams and appurtenant facilities for the control of waterways.

(2) "Marine protection and indemnity insurance," meaning insurance against, or against legal liability of the insured for, loss, damage, or expense incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person. [1947 c 79 § .11.05; Rem. Supp. 1947 § 45.11.05.]

48.11.060 "Vehicle insurance" defined. (1) "Vehicle insurance" is insurance against loss or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, and against any loss or liability resulting from or incident to ownership, maintenance, or use of any such vehicle or aircraft or animal.

(2) Insurance against accidental death or accidental injury to individuals while in, entering, alighting from, adjusting, repairing, cranking, or caused by being struck by a vehicle, aircraft, or draft or riding animal, if such insurance is issued as part of insurance on the vehicle, aircraft, or draft or riding animal, shall be deemed to be vehicle insurance. [1947 c 79 § .11.06; Rem. Supp. 1947 § 45.11.06.]

48.11.070 "General casualty insurance" defined. "General casualty insurance" includes vehicle insurance as defined in RCW 48.11.060, and in addition is insurance:

(1) Against legal liability for the death, injury, or disability of any human being, or for damage to property.

(2) Of medical, hospital, surgical and funeral benefits to persons injured, irrespective of legal liability of the insured, when issued with or supplemental to insurance against legal liability for the death, injury or disability of human beings.

(3) Of the obligations accepted by, imposed upon, or assumed by employers under law for workers' compensation.

(4) Against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation or wrongful conversion, disposal or concealment, or from any attempt of any of the foregoing; also insurance against loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances or any other valuable papers or documents, resulting from any cause, except while in the custody or possession of and being transported by any carrier for hire or in the mail.

(5) Upon personal effects against loss or damage from any cause.

(6) Against loss or damage to glass, including its lettering, ornamentation and fittings.

(7) Against any liability and loss or damage to property resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery, or apparatus and to make inspection of and issue certificates of inspection upon elevators, boilers, machinery, and apparatus of any kind.

(8) Against loss or damage to any property caused by the breakage or leakage of sprinklers, water pipes and containers, or by water entering through leaks or openings in buildings.

(9) Against loss or damage resulting from failure of debtors to pay their obligations to the insured (credit insurance).

(10) Against any other kind of loss, damage, or liability properly the subject of insurance and not within any other kind or kinds of insurance as defined in this chapter, if such insurance is not contrary to law or public policy. [1987 c 185 § 18; 1953 c 197 § 5; 1947 c 79 § .11.07; Rem. Supp. 1947 § 45.11.07.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

48.11.080 "Surety insurance" defined. "Surety insurance" includes:

(1) Credit insurance as defined in subdivision (9) of RCW 48.11.070.

(2) Bail bond insurance.

(3) Fidelity insurance, which is insurance guaranteeing the fidelity of persons holding positions of public or private trust.

(2021 Ed.)

(4) Guaranteeing the performance of contracts, other than insurance policies, and guaranteeing and executing bonds, undertakings, and contracts of suretyship.

(5) Indemnifying banks, bankers, brokers, financial or moneyed corporations or associations against loss resulting from any cause of bills of exchange, notes, bonds, securities, evidence of debts, deeds, mortgages, warehouse receipts, or other valuable papers, documents, money, precious metals and articles made therefrom, jewelry, watches, necklaces, bracelets, gems, precious and semiprecious stones, including any loss while the same are being transported in armored motor vehicles, or by messenger, but not including any other risks of transportation or navigation; also against loss or damage to such an insured's premises, or to his or her furnishings, fixtures, equipment, safes and vaults therein, caused by burglary, robbery, theft, vandalism or malicious mischief, or any attempt thereat. [2009 c 549 § 7051; 1967 c 150 § 8; 1947 c 79 § .11.08; Rem. Supp. 1947 § 45.11.08.]

48.11.100 "Title insurance" defined. "Title insurance" is insurance of owners of property or others having an interest in real property, against loss by encumbrance, or defective titles, or adverse claim to title, and associated services. [2005 c 223 § 3; 1947 c 79 § .11.10; Rem. Supp. 1947 § 45.11.10.]

48.11.105 "Ocean marine and foreign trade insurances" defined. For the purposes of this code other than as to chapter 48.19 RCW "ocean marine and foreign trade insurances" shall include only:

(1) Insurances upon vessels, crafts, hulls, and of interests therein or with relation thereto;

(2) Insurance of marine builders' risks, marine war risks, and contracts of marine protection and indemnity insurance;

(3) Insurance of freights and disbursements pertaining to a subject of insurance coming within this definition;

(4) Insurance of personal property and interests therein, in course of exportation from or importation into any country, or in course of transportation coastwise, including transportation by land, water, or air from point of origin to final destination, in respect to, appertaining to, or in connection with, any and all risks or perils of navigation, transit, or transportation, and while being prepared for and while awaiting shipment, and during any delays, storage, transshipment, or reshipment incident thereto. [2007 c 80 § 5.]

48.11.130 Reinsurance powers. A domestic mutual assessment insurer shall not have authority to accept reinsurance. Any other domestic insurer may accept reinsurance only of such kinds of insurance as it is authorized to transact direct. [1947 c 79 § .11.13; Rem. Supp. 1947 § 45.11.13.]

48.11.140 Limitation of single risk. (1) An insurer may not retain any risk on any one subject of insurance, whether located or to be performed in this state or elsewhere, in an amount exceeding ten percent of its surplus to policyholders.

(2) For the purposes of this section, a "subject of insurance" as to insurance against fire includes all properties insured by the same insurer that are reasonably subject to loss or damage from the same fire.

(3) Reinsurance in an alien reinsurer not qualified under *RCW 48.12.166 may not be deducted in determining risk retained for the purposes of this section.

(4) In the case of surety insurance, the net retention shall be computed after deduction of reinsurances, the amount assumed by any co-surety, the value of any security deposited, pledged, or held subject to the consent of the surety and for the protection of the surety.

(5) This section does not apply to life insurance, disability insurance, title insurance, or insurance of marine risks or marine protection and indemnity risks. [2005 c 223 § 4; 1993 c 462 § 53; 1983 c 3 § 149; 1959 c 225 § 2; 1947 c 79 § .11.14; Rem. Supp. 1947 § 45.11.14.]

*Reviser's note: RCW 48.12.166 was recodified as RCW 48.12.475 pursuant to 2015 c 63 § 17.

Additional notes found at www.leg.wa.gov

Chapter 48.12 RCW ASSETS AND LIABILITIES

Sections

48.12.010	"Assets" defined.
48.12.020	Nonallowable assets.
48.12.030	Liabilities.
48.12.040	Unearned premium reserve, property, casualty, and surety insurance.
48.12.050	Unearned premium reserve, marine and transportation insurance.
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48.12.070	Loss records.
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48.12.475	Assuming alien reinsurer—Registration—Requirements—Duties of commissioner—Costs.
48.12.480	Rules.
48.12.499	Application of chapter 63, Laws of 2015.

48.12.010 "Assets" defined. In any determination of the financial condition of any insurer there shall be allowed as assets only such assets as belong wholly and exclusively to the insurer, which are registered, recorded, or held under the insurer's name, and which consist of:

(1) Cash in the possession of the insurer or in transit under its control, and the true balance of any deposit of the insurer in a solvent bank or trust company;

(2) Investments, securities, properties, and loans acquired or held in accordance with this code, and in connection therewith the following items:

(a) Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.

(b) Declared and unpaid dividends on stocks and shares unless such amount has otherwise been allowed as an asset.

(c) Interest due or accrued upon a collateral loan in an amount not to exceed one year's interest thereon.

(d) Interest due or accrued on deposits in solvent banks and trust companies, and interest due or accrued on other assets if such interest is in the judgment of the commissioner a collectible asset.

(e) Interest due or accrued on a mortgage loan, in amount not exceeding in any event the amount, if any, of the difference between the unpaid principal and the value of the property less delinquent taxes thereon; but if any interest on the loan is in default more than one hundred eighty days, or if any interest on the loan is in default and any taxes or any installment thereof on the property are and have been due and unpaid for more than one hundred eighty days, no allowance shall be made for any interest on the loan.

(f) Rent due or accrued on real property if such rent is not in arrears for more than three months;

(3) Premium notes, policy loans, and other policy assets and liens on policies of life insurance, in amount not exceeding the legal reserve and other policy liabilities carried on each individual policy;

(4) The net amount of uncollected and deferred premiums in the case of a life insurer which carries the full annual mean tabular reserve liability;

(5) Premiums in the course of collection, other than for life insurance, not more than ninety days past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by the United States government or any of its instrumentalities;

(6) Installment premiums other than life insurance premiums, in accordance with regulations prescribed by the commissioner consistent with practice formulated or adopted by the National Association of Insurance Commissioners;

(7) Notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on such basis, to the extent of the unearned premium reserves carried thereon and unless otherwise required by regulation prescribed by the commissioner;

(8) Reinsurance recoverable subject to *RCW 48.12.160;

(9) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty;

(10) Deposits or equities recoverable from underwriting associations, syndicates and reinsurance funds, or from any

suspended banking institution, to the extent deemed by the commissioner available for the payment of losses and claims and at values to be determined by him or her;

(11) Electronic and mechanical machines constituting a data processing and accounting system if the cost of such system is at least twenty-five thousand dollars, which cost shall be amortized in full over a period not to exceed three calendar years; and

(12) Other assets, not inconsistent with the foregoing provisions, deemed by the commissioner available for the payment of losses and claims, at values to be determined by him or her. [2009 c 549 § 7052; 2007 c 80 § 2; 1977 ex.s. c 180 § 2; 1963 c 195 § 11; 1947 c 79 § .12.01; Rem. Supp. 1947 § 45.12.01.]

*Reviser's note: RCW 48.12.160 was repealed by 2015 c 63 § 19.

48.12.020 Nonallowable assets. In addition to assets impliedly excluded under RCW 48.12.010, the following expressly shall not be allowed as assets in any determination of the financial condition of an insurer:

(1) Goodwill, except in accordance with regulations prescribed by the commissioner, trade names, agency plants and other like intangible assets.

(2) Prepaid or deferred charges for expenses and commissions paid by the insurer.

(3) Advances to officers (other than policy loans or loans made pursuant to RCW 48.07.130), whether secured or not, and advances to employees, agents and other persons on personal security only.

(4) Stock of such insurer, owned by it, or any equity therein or loans secured thereby, or any proportionate interest in such stock through the ownership by such insurer of an interest in another firm, corporation or business unit.

(5) Furniture, furnishings, fixtures, safes, equipment, vehicles, library, stationery, literature, and supplies; except, electronic and mechanical machines authorized by subsection (11) of RCW 48.12.010, or such personal property as the insurer is permitted to hold pursuant to paragraph (e) of subsection (2) of *RCW 48.13.160, or which is acquired through foreclosure of chattel mortgages acquired pursuant to *RCW 48.13.150, or which is reasonably necessary for the maintenance and operation of real estate lawfully acquired and held by the insurer other than real estate used by it for home office, branch office, and similar purposes.

(6) The amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value thereof as determined under this code. [1982 c 218 § 1; 1963 c 195 § 12; 1947 c 79 § .12.02; Rem. Supp. 1947 § 45.12.02.]

*Reviser's note: RCW 48.13.150 and 48.13.160 were repealed by 2011 c 188 § 22, effective July 1, 2012.

Additional notes found at www.leg.wa.gov

48.12.030 Liabilities. In any determination of the financial condition of an insurer, liabilities to be charged against its assets shall include:

(1) The amount of its capital stock outstanding, if any; and

(2) The amount, estimated consistent with the provisions of this chapter, necessary to pay all of its unpaid losses and claims incurred on or prior to the date of statement, whether

reported or unreported, together with the expense of adjustment or settlement thereof; and

(3) With reference to life and disability insurance, and annuity contracts,

(a) the amount of reserves on life insurance policies and annuity contracts in force (including disability benefits for both active and disabled lives, and accidental death benefits, in or supplementary thereto) and disability insurance, valued according to the tables of mortality, tables of morbidity, rates of interest, and methods adopted pursuant to this chapter which are applicable thereto; and

(b) any additional reserves which may be required by the commissioner, consistent with practice formulated or approved by the National Association of Insurance Commissioners, on account of such insurances; and

(4) With reference to insurances other than those specified in subdivision (3) of this section, and other than title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this chapter; and

(5) Taxes, expenses, and other obligations accrued at the date of the statement; and

(6) Any additional reserve set up by the insurer for a specific liability purpose or required by the commissioner consistent with practices adopted or approved by the National Association of Insurance Commissioners. [1973 1st ex.s. c 162 § 1; 1947 c 79 § .12.03; Rem. Supp. 1947 § 45.12.03.]

48.12.040 Unearned premium reserve, property, casualty, and surety insurance. (1) With reference to insurances against loss or damage to property, except as provided in RCW 48.12.050, and with reference to all general casualty insurances, and surety insurances, every insurer shall maintain an unearned premium reserve on all policies in force.

(2) The commissioner may require that such reserve shall be equal to the unearned portions of the gross premiums in force after deducting authorized reinsurance, as computed on each respective risk from the policy's date of issue. If the commissioner does not so require, the portions of the gross premiums in force, less authorized reinsurance, to be held as a premium reserve, shall be computed according to the following table:

Term for which policy was written	Reserve for unearned premium
One year, or less	1/2
Two years	First year 3/4 Second year 1/4
Three years	First year 5/6 Second year 1/2 Third year 1/6
Four years	First year 7/8 Second year 5/8 Third year 3/8 Fourth year 1/8
Five years	First year 9/10 Second year 7/10 Third year 1/2

Term for which policy was written	Reserve for unearned premium	
	Fourth year	3/10
	Fifth year	1/10
Over five years	Pro rata	

(3) In lieu of computation according to such table, all of such reserves may be computed, at the insurer's option, on a monthly pro rata basis.

(4) After adopting any one of the methods for computing such reserve an insurer shall not change methods without the commissioner's approval.

(5) If, for certain policies, the insurer's exposure to loss is uneven over the policy term, the commissioner may grant permission to the insurer to use a different method of calculating the unearned premium reserve on those certain policies. [1995 c 35 § 1; 1973 1st ex.s. c 162 § 2; 1947 c 79 § .12.04; Rem. Supp. 1947 § 45.12.04.]

48.12.050 Unearned premium reserve, marine and transportation insurance. With reference to marine and transportation insurances, premiums on trip risks not terminated shall be deemed unearned and the commissioner may require the insurer to carry a reserve thereon equal to one hundred percent on trip risks written during the month ended as of the date of statement; and computed upon a pro rata basis or, with the commissioner's consent, in accordance with the alternative methods provided in RCW 48.12.040 for all other risks. [1947 c 79 § .12.05; Rem. Supp. 1947 § 45.12.05.]

48.12.060 Reserve—Disability insurance. For all disability insurance policies the insurer shall maintain an active life reserve which shall place a sound value on its liabilities under such policies and be not less than the reserve according to appropriate standards set forth in regulations issued by the commissioner and, in no event, less in the aggregate than the pro rata gross unearned premiums for such policies. [1973 1st ex.s. c 162 § 3; 1947 c 79 § .12.06; Rem. Supp. 1947 § 45.12.06.]

48.12.070 Loss records. An insurer shall maintain a complete and itemized record showing all losses and claims as to which it has received notice, including with regard to property, casualty, surety, and marine and transportation insurances, all notices received of the occurrence of any event which may result in a loss. [1947 c 79 § .12.07; Rem. Supp. 1947 § 45.12.07.]

48.12.080 Increased reserves. (1) If the commissioner determines that an insurer's unearned premium reserves, however computed, are inadequate, he or she may require the insurer to compute such reserves or any part thereof according to such other method or methods as are prescribed in this chapter.

(2) If the loss experience of an insurer shows that its loss reserves, however estimated, are inadequate, the commissioner shall require the insurer to maintain loss reserves in such increased amount as is needed to make them adequate.

[2009 c 549 § 7053; 1947 c 79 § .12.08; Rem. Supp. 1947 § 45.12.08.]

48.12.090 Loss reserves—Liability insurance. The reserves for outstanding losses and loss expenses under policies of personal injury liability insurance and under policies of employer's liability insurance shall be computed as follows:

(1) The reserves for outstanding losses and loss expenses under policies of personal injury liability insurance and under policies of employer's liability insurance shall be computed in accordance with accepted loss-reserving standards and principles and shall make a reasonable provision for all unpaid loss and loss expense obligations of the insurer under the terms of such policies.

(2) Reserves under liability policies written during the three years immediately preceding the date of determination shall include any additional reserves required by the annual statement instructions of the national association of insurance commissioners. [1995 c 35 § 2; 1947 c 79 § .12.09; Rem. Supp. 1947 § 45.12.09.]

48.12.100 Unallocated liability loss expense. Subject to any restrictions contained in the annual statement instructions or accounting practices and procedures manuals of the national association of insurance commissioners, all unallocated liability loss expense payments shall be distributed as follows:

(1) All payments associated with particular claims shall be distributed to the year in which the claim was covered; and

(2) All other payments shall be distributed by year in a reasonable manner. [1995 c 35 § 3; 1947 c 79 § .12.10; Rem. Supp. 1947 § 45.12.10.]

48.12.110 Schedule of experience. Any insurer transacting any liability or workers' compensation insurances shall include in its annual statement filed with the commissioner, a schedule of its experience thereunder in such form as the commissioner may prescribe. [1987 c 185 § 19; 1947 c 79 § .12.11; Rem. Supp. 1947 § 45.12.11.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

48.12.140 "Loss payments," "loss expense" defined. "Loss payments" and "loss expense payments" as used with reference to liability and workers' compensation insurances shall include all payments to claimants, payments for medical and surgical attendance, legal expenses, salaries and expenses of investigators, adjusters and claims field representatives, rents, stationery, telegraph and telephone charges, postage, salaries and expenses of office employees, home office expenses and all other payments made on account of claims, whether such payments are allocated to specific claims or are unallocated. [2009 c 549 § 7054; 1987 c 185 § 22; 1947 c 79 § .12.14; Rem. Supp. 1947 § 45.12.14.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

48.12.170 Valuation of bonds. (1) All bonds or other evidences of debt having a fixed term and rate held by any

insurer may, if amply secured and not in default as to principal or interest, be valued as follows:

(a) If purchased at par, at the par value.

(b) If purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at the earliest date callable at par or maturing at par and so as to yield in the meantime the effective rate of interest at which the purchase was made; or in lieu of such method, according to such accepted method of valuation as is approved by the commissioner.

(c) Purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase.

(d) Unless otherwise provided by a valuation established or approved by the National Association of Insurance Commissioners, no such security shall be carried at above call price for the entire issue during any period within which the security may be so called.

(2) Such securities not amply secured or in default as to principal or interest shall be carried at market value.

(3) The commissioner shall have full discretion in determining the method of calculating values according to the rules set forth in this section, and not inconsistent with any such methods then currently formulated or approved by the National Association of Insurance Commissioners. [1947 c 79 § .12.17; Rem. Supp. 1947 § 45.12.17.]

48.12.180 Valuation of stocks. (1) Securities, other than those referred to in RCW 48.12.170, held by an insurer shall be valued, in the discretion of the commissioner, at their market value, or at their appraised value, or at prices determined by him or her as representing their fair market value.

(2) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, at the discretion of the commissioner and in accordance with such method of computation as he or she may approve.

(3) The stock of a subsidiary of an insurer shall be valued on the basis of the greater of (a) the value of only such of the assets of such subsidiary as would constitute lawful investments for the insurer if acquired or held directly by the insurer or (b) such other value determined pursuant to rules and cumulative limitations which shall be promulgated by the commissioner to effectuate the purposes of this chapter.

(4) The commissioner has full discretion in determining the method of calculating values according to the rules set forth in this section, and consistent with such methods as then adopted by the National Association of Insurance Commissioners. [1993 c 462 § 54; 1973 c 151 § 1; 1947 c 79 § .12.18; Rem. Supp. 1947 § 45.12.18.]

Additional notes found at www.leg.wa.gov

48.12.190 Valuation of property. (1) Real property acquired pursuant to a mortgage loan or a contract for a deed, in the absence of a recent appraisal deemed by the commissioner to be reliable, shall not be valued at an amount greater than the unpaid principal of the defaulted loan or contract at the date of such acquisition, together with any taxes and expenses paid or incurred in connection with such acquisition, and the cost of improvements thereafter made by the insurer and any amounts thereafter paid by the insurer on

assessments levied for improvements in connection with the property.

(2) Other real property held by an insurer shall not be valued at any amount in excess of fair value, less reasonable depreciation based on the estimated life of the improvements.

(3) Personal property acquired pursuant to chattel mortgages made under *RCW 48.13.150 shall not be valued at an amount greater than the unpaid balance of principal on the defaulted loan at date of acquisition together with taxes and expenses incurred in connection with such acquisition, or the fair value of such property, whichever amount is the lesser.

(4) The commissioner has full discretion in determining the method of calculating values according to the rules set forth in this section, and consistent with such methods as then adopted by the National Association of Insurance Commissioners. [1993 c 462 § 55; 1967 ex.s. c 95 § 10; 1947 c 79 § .12.19; Rem. Supp. 1947 § 45.12.19.]

*Reviser's note: RCW 48.13.150 was repealed by 2011 c 188 § 22, effective July 1, 2012.

Additional notes found at www.leg.wa.gov

48.12.200 Valuation of purchase money mortgages.

(1) Purchase money mortgages shall be valued in an amount not exceeding the acquisition cost of the real property covered thereby or ninety percent of the fair value of such real property, whichever is less.

(2) The commissioner has full discretion in determining the method of calculating values according to the rules set forth in this section, and consistent with such methods as then adopted by the National Association of Insurance Commissioners. [1993 c 462 § 56; 1947 c 79 § .12.20; Rem. Supp. 1947 § 45.12.20.]

Additional notes found at www.leg.wa.gov

CREDIT FOR REINSURANCE

48.12.400 Purpose—Intent—Declaration. The purpose of this subchapter is to protect the interest of insureds, claimants, ceding insurers, assuming insurers, and the public generally. The legislature intends to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. Therefore, the legislature provides a mandate that upon the insolvency of a non-United States insurer or reinsurer that provides security to fund its United States obligations in accordance with this subchapter, the assets representing the security must be maintained in the United States and claims must be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets distributed, in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The legislature declares that the matters contained in this subchapter are fundamental to the business of insurance in accordance with 15 U.S.C. Secs. 1011-1012. [2015 c 63 § 1.]

48.12.405 Domestic ceding insurer—Asset or reduction from liability—Requirements. Credit for reinsurance is allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of RCW

48.12.410, 48.12.415, 48.12.420, 48.12.425, 48.12.430, 48.12.462, or 48.12.435. Credit is allowed under RCW 48.12.410, 48.12.415, or 48.12.420 only as respects cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of the alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit is allowed under RCW 48.12.420 or 48.12.425 only if the applicable requirements of RCW 48.12.440 have been satisfied. [2021 c 138 § 1; 2015 c 63 § 2.]

48.12.410 Assuming insurer—Licensed. Credit is allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state. [2015 c 63 § 3.]

48.12.415 Accredited as reinsurer—Assuming insurer—Requirements. Credit is allowed when the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state. In order to be eligible for accreditation, a reinsurer must:

- (1) File with the commissioner evidence of its submission to this state's jurisdiction;
- (2) Submit to this state's authority to examine its books and records;
- (3) Be licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state;
- (4) File annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and
- (5) Demonstrate to the satisfaction of the commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer meets this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than twenty million dollars and its accreditation has not been denied by the commissioner within ninety days after submission of its application. [2015 c 63 § 4.]

48.12.420 Assuming insurer—Domiciled in this state or state with similar statutes. (1) Credit is allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a United States branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or United States branch of an alien assuming insurer:

- (a) Maintains a surplus as regards policyholders in an amount not less than twenty million dollars; and
 - (b) Submits to the authority of this state to examine its books and records.
- (2) Subsection (1)(a) of this section does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. [2015 c 63 § 5.]

48.12.425 Assuming insurer maintains a trust fund—Payment of valid claims—Requirements. (1) Credit is allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in RCW 48.12.465(2), for the payment of the valid claims of its United States ceding insurers, their assigns, and successors in interest. To enable the commissioner to determine the sufficiency of the trust fund, the assuming insurer must report annually to the commissioner information substantially the same as that required to be reported on the national association of insurance commissioners annual statement form by licensed insurers. The assuming insurer must submit to examination of its books and records by the commissioner and bear the expense of examination.

(2)(a) Credit for reinsurance shall not be granted under this section unless the form of the trust and any amendments to the trust have been approved by:

- (i) The commissioner of the state where the trust is domiciled; or
- (ii) The commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(b) The form of the trust and any trust amendments also must be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns, and successors in interest. The trust and the assuming insurer are subject to examination as determined by the commissioner.

(c) The trust remains in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. By February 28th of each year the trustee of the trust must report to the commissioner in writing the balance of the trust and listing the trust's investments at the preceding year end and certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31st.

(3) The following requirements apply to the following categories of assuming insurer:

(a) The trust fund for a single assuming insurer consists of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer must maintain a trustee surplus of not less than twenty million dollars, except as provided in (b) of this subsection.

(b) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trustee surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an

independent analysis of reserves and cash flows, and must consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trustee surplus may not be reduced to an amount less than thirty percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(c)(i) In the case of a group including incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after January 1, 1993, the trust must consist of a trustee account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group;

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this subchapter, the trust must consist of a trustee account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

(C) In addition to these trusts, the group must maintain in trust a trustee surplus of which one hundred million dollars is held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(ii) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(iii) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, the group must provide to the commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

(d) In the case of a group of incorporated underwriters under common administration, the group must:

(i) Have continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation;

(ii) Maintain aggregate policyholders' surplus of at least ten billion dollars;

(iii) Maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

(iv) In addition, maintain a joint trustee surplus of which one hundred million dollars is held jointly for the benefit of United States domiciled ceding insurers of any member of the group as additional security for these liabilities; and

(v) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner an annual certification of each underwriter member's solvency by the member's domiciliary

regulator and financial statements of each underwriter member of the group prepared by its independent public accountant. [2015 c 63 § 6.]

48.12.430 Assuming insurer—Certified as reinsurer—Eligibility requirements—Insurer obligations—Commissioner's duties. Credit is allowed when the reinsurance is ceded to an assuming insurer that has been certified by the commissioner as a reinsurer in this state and secures its obligations in accordance with the requirements of this section.

(1) In order to be eligible for certification, the assuming insurer must meet the following requirements:

(a) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to subsection (3) of this section;

(b) The assuming insurer must maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner by rule;

(c) The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner by rule;

(d) The assuming insurer must agree to submit to the jurisdiction of this state, appoint the commissioner as its agent for service of process in this state, and agree to provide security for one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

(e) The assuming insurer must agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis; and

(f) The assuming insurer must satisfy any other requirements for certification deemed relevant by the commissioner.

(2) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying the requirements of subsection (1) of this section:

(a) The association must satisfy its minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and its members, which includes a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the commissioner to provide adequate protection;

(b) The incorporated members of the association must not be engaged in any business other than underwriting as a member of the association and must be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(c) Within ninety days after its financial statements are due to be filed with the association's domiciliary regulator, the association must provide to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(3) The commissioner must create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such a jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer.

(a) In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner must evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction must agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the commissioner.

(b) A list of qualified jurisdictions shall be published through the national association of insurance commissioners' committee process. The commissioner must consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner must provide thoroughly documented justification in accordance with criteria to be developed by rule.

(c) United States jurisdictions that meet the requirement for accreditation under the national association of insurance commissioners' financial standards and accreditation program must be recognized as qualified jurisdictions.

(d) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner has the discretion to suspend the reinsurer's certification indefinitely in lieu of revocation.

(4) The commissioner must assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the commissioner by rule. The commissioner must publish a list of all certified reinsurers and their ratings.

(5) A certified reinsurer must secure obligations assumed from United States ceding insurers under this section at a level consistent with its rating, as specified in rules adopted by the commissioner.

(a) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer must maintain security in a form acceptable to the commissioner and consistent with the provisions of RCW 48.12.460, or in a multibeneficiary trust in accordance with RCW 48.12.425, except as otherwise provided in this section.

(b) If a certified reinsurer maintains a trust to fully secure its obligations under RCW 48.12.425, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer must maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer

with reduced security as permitted by this section or comparable laws of other United States jurisdictions and for its obligations under RCW 48.12.425. It is a condition to the grant of certification under this section that the certified reinsurer must have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any trust account, out of the remaining surplus of the trust any deficiency of any other trust account.

(c) The minimum trustee surplus requirements provided in RCW 48.12.425 are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this section, except that the trust must maintain a minimum trustee surplus of ten million dollars.

(d) With respect to obligations incurred by a certified reinsurer under this section, if the security is insufficient, the commissioner must reduce the allowable credit by an amount proportionate to the deficiency, and has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(e) For purposes of this section, a certified reinsurer whose certification has been terminated for any reason must be treated as a certified reinsurer required to secure one hundred percent of its obligations.

(i) As used in this section, "terminated" means revocation, suspension, voluntary surrender, and inactive status.

(ii) If the commissioner continues to assign a higher rating as permitted by this section, this subsection (5)(e) does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(6) If an applicant for certification has been certified as a reinsurer in a national association of insurance commissioners accredited jurisdiction, the commissioner has the discretion to defer to that jurisdiction's certification, and has the discretion to defer to the rating assigned by that jurisdiction, and the assuming insurer must be considered to be a certified reinsurer in this state.

(7) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer must continue to comply with all applicable requirements of this section, and the commissioner must assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business. [2015 c 63 § 7.]

48.12.435 Assuming insurer not meeting certain requirements—Credit restricted. Credit is allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of RCW 48.12.410, 48.12.415, 48.12.420, 48.12.425, 48.12.462, or 48.12.430, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction. [2021 c 138 § 3; 2015 c 63 § 8.]

48.12.440 Assuming insurer not licensed, accredited, or certified—No credit—Exceptions. If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this state, the credit permitted by

RCW 48.12.420 and 48.12.425 must not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(1)(a) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, must submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(b) To designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(2) This section is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement. [2015 c 63 § 9.]

48.12.445 Assuming insurer does not meet certain requirements—Trust agreements—Necessary conditions. If the assuming insurer does not meet the requirements of RCW 48.12.410, 48.12.415, or 48.12.420, the credit permitted by RCW 48.12.425, 48.12.462, or 48.12.430 must not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(1) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by RCW 48.12.425(3), or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee must comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(2) The assets must be distributed by and claims must be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(3) If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof must be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

(4) The grantor must waive any right otherwise available to it under United States law that is inconsistent with this provision. [2021 c 138 § 4; 2015 c 63 § 10.]

48.12.450 Accredited or certified reinsurer does not meet requirements—Commissioner may suspend or revoke. If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

(1) The commissioner must give the reinsurer notice and opportunity for hearing. The suspension or revocation may

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not take effect until after the commissioner's order on hearing, unless:

(a) The reinsurer waives its right to hearing;

(b) The commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under RCW 48.12.430(6); or

(c) The commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(2) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with RCW 48.12.460. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with RCW 48.12.430(5) or 48.12.460. [2015 c 63 § 11.]

48.12.455 Ceding insurer—Reinsurance program.

(1) A ceding insurer must take steps to manage its reinsurance recoverable proportionate to its own book of business. A domestic ceding insurer must notify the commissioner within thirty days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds fifty percent of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification must demonstrate that the exposure is safely managed by the domestic ceding insurer.

(2) A ceding insurer must take steps to diversify its reinsurance program. A domestic ceding insurer must notify the commissioner within thirty days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty percent of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification must demonstrate that the exposure is safely managed by the domestic ceding insurer. [2015 c 63 § 12.]

48.12.460 Reinsurance ceded by domestic insurer to assuming insurer not meeting requirements—When asset or reduction from liability allowed.

An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of RCW 48.12.405 through 48.12.455 must be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United

States financial institution, as defined in RCW 48.12.465(2). This security may be in the form of:

- (1) Cash;
- (2) Securities listed by the securities valuation office of the national association of insurance commissioners, including those deemed exempt from filing as defined by the purposes and procedures manual of the securities valuation office, and qualifying as admitted assets;
- (3)(a) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in RCW 48.12.465(1), effective no later than December 31st of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement;
- (b) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) must, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs; or
- (4) Any other form of security acceptable to the commissioner. [2015 c 63 § 13.]

48.12.462 Reinsurance ceded to an assuming insurer—Reciprocal jurisdictions—Commissioner's duties. (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that:

- (a) Is located and licensed in a reciprocal jurisdiction;
- (b) Has and maintains, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in rule;
- (c) Has and maintains, on an ongoing basis, a minimum solvency or capital ratio, as applicable, to be established in rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed;
- (d) Provides adequate assurance to the commissioner, in a form specified by the commissioner in rule, as follows:
 - (i) The assuming insurer must provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in (b) or (c) of this subsection, or if any regulatory action is taken against it for serious noncompliance with applicable law;
 - (ii) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement. Nothing in this provision limits, or in any way alters, the capacity of parties to a reinsurance agreement

to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(iii) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(iv) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded under that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

(v) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement which involves this state's ceding insurers, and agree to notify the ceding insurer and the commissioner and to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. This security must be in a form consistent with RCW 48.12.430 and 48.12.460 and as specified by the commissioner in rule;

(e) Provides, if requested by the commissioner, on behalf of itself and any legal predecessors, documentation to the commissioner, as specified by the commissioner in rule;

(f) Maintains a practice of prompt payment of claims under reinsurance agreements, under criteria established in rule; and

(g) Requires its supervisory authority to confirm to the commissioner on an annual basis, as of the preceding December 31st or at the date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer is in compliance with (b) and (c) of this subsection.

(2) Nothing in subsection (1) of this section precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

(3) The commissioner must create and publish a list of reciprocal jurisdictions.

(a) The commissioner's list must include any reciprocal jurisdiction as defined in subsection (9)(b)(i) and (ii) of this section, and consider any other reciprocal jurisdiction included on the list of reciprocal jurisdictions published through the national association of insurance commissioners' committee process. The commissioner may approve a jurisdiction that does not appear on the national association of insurance commissioners' list of reciprocal jurisdictions in accordance with the commissioner's rules.

(b) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with the commissioner's rules, except that the commissioner shall not remove from the list a reciprocal jurisdiction as defined under subsection (9)(b)(i) and (ii) of this section. Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an

assuming insurer that is located in that jurisdiction shall be allowed if otherwise allowed under this chapter.

(4) The commissioner must create and publish a list of assuming insurers that have satisfied the conditions set forth in this section and to which cessions shall be granted credit. The commissioner may add a [an] assuming insurer to the list if a national association of insurance commissioners' accredited jurisdiction has added the assuming insurer to a list of assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner required under subsection (1)(d) of this section and complies with any additional requirements that the commissioner adopts in rule, except to the extent that they conflict with an applicable covered agreement.

(5) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this subsection, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection in accordance with procedures adopted in rule.

(a) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with RCW 48.12.460.

(b) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into before the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of RCW 48.12.460.

(6) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(7) This subsection does not limit or alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this chapter.

(8)(a) Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after July 25, 2021, and only with respect to losses incurred and reserves reported on or after the later of:

(i) The date on which the assuming insurer has met all eligibility requirements; and

(ii) The effective date of the new reinsurance agreement, amendment, or renewal.

(b) This subsection does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this subsection, as long as the reinsurance qualifies for credit under any other applicable provision of this chapter.

(c) Nothing in this section authorizes an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

(d) Nothing in this section limits, or in any way alters, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

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

(a) "Covered agreement" is an agreement entered into under the Dodd-Frank wall street reform and consumer protection act, 31 U.S.C. Secs. 313 and 314, that is currently in effect or is in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.

(b) "Reciprocal jurisdiction" means a jurisdiction that is:

(i) Located outside the United States and is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union;

(ii) Located within a United States jurisdiction that meets the requirements for accreditation under the national association of insurance commissioners' financial standards and accreditation program; or

(iii) A qualified jurisdiction, as determined by the commissioner under RCW 48.12.430(3), which is not otherwise described in (b)(i) or (ii) of this subsection and which meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the commissioner in rule. [2021 c 138 § 2.]

48.12.464 Reinsurance agreements—Commissioner may adopt rules. (1) The commissioner may adopt rules applicable to reinsurance agreements as provided in this section.

(2) A rule adopted under this section may only apply to reinsurance relating to:

(a) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(b) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(c) Variable annuities with guaranteed death or living benefits;

(d) Long-term care insurance policies; or

(e) Such other life and health insurance and annuity products as to which the national association of insurance commissioners adopts model regulatory requirements with respect to credit for reinsurance.

(3) A rule adopted under subsection (2)(a) or (b) of this section may apply to any treaty containing:

(a) Policies issued on or after January 1, 2015; and

(b) Policies issued before January 1, 2015, if risk pertaining to these policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

(4) A rule adopted under this section may require the ceding insurer, in calculating the amounts or forms of security required to be held under rule, to use the valuation manual adopted by the national association of insurance commissioners under RCW 48.74.100(2)(a), including all amendments adopted by the national association of insurance

commissioners and in effect on the date as of which the calculation is made, to the extent applicable.

(5) A rule adopted under this section shall not apply to cessions to an assuming insurer that:

(a) Meets the conditions set forth in RCW 48.12.462;

(b) Is certified under RCW 48.12.430 in this state; or

(c) Maintains at least two hundred fifty million dollars in capital and surplus when determined in accordance with the national association of insurance commissioners' accounting practices and procedures manual, including all amendments adopted by the national association of insurance commissioners as of July 25, 2021, excluding the impact of any permitted or prescribed practices, and:

(i) Is licensed in at least twenty-six states; or

(ii) Is either licensed or accredited in a total of at least thirty-five states and maintains licensure in at least ten states under this subsection (5)(c)(ii).

(6) The authority to adopt rules under this section does not limit the commissioner's general authority to adopt rules under RCW 48.12.480. [2021 c 138 § 5.]

48.12.465 Definitions—Apply to RCW 48.12.460(3).

(1) For the purposes of RCW 48.12.460(3), a "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 the 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.

(2) A "qualified United States financial institution" means, for the purposes of those provisions of this subchapter specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(a) Is organized, or, in the case of a United States branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(b) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies. [2015 c 63 § 14.]

48.12.470 Credit for reinsurance—Accounting or financial statement—After December 31, 1996. Credit for reinsurance, as either an asset or a deduction, is prohibited in an accounting or financial statement of the ceding insurer in respect to the reinsurance contract unless, in such contract, the reinsurer undertakes to indemnify the ceding insurer against all or a part of the loss or liability arising out of the original insurance. This section only applies to those reinsurance contracts entered into after December 31, 1996. [1997 c 379 § 5. Formerly RCW 48.12.164.]

Purpose—Intent—1997 c 379: "(1) The purpose of this act is to protect the interest of insureds, claimants, ceding insurers, assuming insurers, and the public generally.

(2) It is the intent of the legislature to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations.

(3) It is also the intent of the legislature to declare that the matters contained in this act are fundamental to the business of insurance and to exercise its powers and privileges under 15 U.S.C. Secs. 1011 and 1012." [1997 c 379 § 1.]

48.12.475 Assuming alien reinsurer—Registration—Requirements—Duties of commissioner—Costs. (1) The assuming alien reinsurer must register with the commissioner and must:

(a) File with the commissioner evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records under chapter 48.03 RCW;

(b) Designate the commissioner as its lawful attorney upon whom service of all papers may be made for an action, suit, or proceeding instituted by or on behalf of the ceding insurer;

(c) File with the commissioner a certified copy of a letter or a certificate of authority or a certificate of compliance issued by the assuming alien insurer's domiciliary jurisdiction and the domiciliary jurisdiction of its United States reinsurance trust;

(d) Submit a statement, signed and verified by an officer of the assuming alien insurer to be true and correct, that discloses whether the assuming alien insurer or an affiliated person who owns or has a controlling interest in the assuming alien insurer is currently known to be the subject of one or more of the following:

(i) An order or proceeding regarding conservation, liquidation, or receivership;

(ii) An order or proceeding regarding the revocation or suspension of a license or accreditation to transact insurance or reinsurance in any jurisdiction; or

(iii) An order or proceeding brought by an insurance regulator in any jurisdiction seeking to restrict or stop the assuming alien insurer from transacting insurance or reinsurance based upon a hazardous financial condition.

The assuming alien insurer shall provide the commissioner with copies of all orders or other documents initiating proceedings subject to disclosure under this subsection. The statement must affirm that no actions, proceedings, or orders subject to this subsection are outstanding against the assuming alien insurer or an affiliated person who owns or has a controlling interest in the assuming alien insurer, except as disclosed in the statement;

(e) File other information, financial or otherwise, which the commissioner reasonably requests.

(2) A registration continues in force until suspended, revoked, or not renewed. A registration is subject to renewal annually on the first day of July upon application of the assuming alien insurer and payment of the fee in the same amount as an insurer pays for renewal of a certificate of authority.

(3) The commissioner shall give an assuming alien insurer notice of his or her intention to revoke or refuse to renew its registration at least ten days before the order of revocation or refusal is to become effective.

(4) The commissioner shall, consistent with chapters 48.04 and 34.05 RCW, deny or revoke an assuming alien insurer's registration if the assuming alien insurer no longer qualifies or meets the requirements for registration.

(5) The commissioner may, consistent with chapters 48.04 and 34.05 RCW, deny or revoke an assuming alien insurer's registration if the assuming alien insurer:

(a) Fails to comply with a provision of this chapter or fails to comply with an order or regulation of the commissioner;

(b) Is found by the commissioner to be in such a condition that its further transaction of reinsurance would be hazardous to ceding insurers, policyholders, or the people in this state;

(c) Refuses to remove or discharge a trustee, director, or officer who has been convicted of a crime involving fraud, dishonesty, or moral turpitude;

(d) Usually compels policy-holding claimants either to accept less than the amount due them or to bring suit against the assuming alien insurer to secure full payment of the amount due;

(e) Refuses to be examined, or its trustees, directors, officers, employees, or representatives refuse to submit to examination or to produce its accounts, records, and files for examination by the commissioner when required, or refuse to perform a legal obligation relative to the examination;

(f) Refuses to submit to the jurisdiction of the United States courts;

(g) Fails to pay a final judgment rendered against it:

(i) Within thirty days after the judgment became final;

(ii) Within thirty days after time for taking an appeal has expired; or

(iii) Within thirty days after dismissal of an appeal before final determination;
whichever date is later;

(h) Is found by the commissioner, after investigation or upon receipt of reliable information:

(i) To be managed by persons, whether by its trustees, directors, officers, or by other means, who are incompetent or untrustworthy or so lacking in insurance company management experience as to make proposed operation hazardous to the insurance-buying public; or

(ii) That there is good reason to believe it is affiliated directly or indirectly through ownership, control, or business relations, with a person or persons whose business operations are, or have been found to be, in violation of any law or rule, to the detriment of policyholders, stockholders, investors, creditors, or of the public, by bad faith or by manipulation of the assets, accounts, or reinsurance;

(i) Does business through reinsurance intermediaries or other representatives in this state or in any other state, who are not properly licensed under applicable laws and rules; or

(j) Fails to pay, by the date due, any amounts required by this code.

(6) A domestic ceding insurer is not allowed credit with respect to reinsurance ceded, if the assuming alien insurer's registration has been revoked by the commissioner.

(7) The actual costs and expenses incurred by the commissioner for an examination of a registered alien insurer must be charged to and collected from the alien reinsurer.

(8) A registered alien reinsurer is included as a "class one" organization for the purposes of RCW 48.02.190. [1997 c 379 § 7. Formerly RCW 48.12.166.]

Purpose—Intent—1997 c 379: See note following RCW 48.12.470.

48.12.480 Rules. The commissioner may adopt rules and regulations implementing the provisions of this subchapter. [2015 c 63 § 15.]

48.12.499 Application of chapter 63, Laws of 2015. Chapter 63, Laws of 2015 applies to all cessions after July 24, 2015, under reinsurance agreements that have an inception, anniversary, or renewal date not less than six months after July 24, 2015. [2015 c 63 § 16.]

Chapter 48.13 RCW INVESTMENTS

Sections

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48.13.490	Safeguarding securities—Rules.
48.13.900	Effective date—2011 c 188.

Valuation of investments: RCW 48.12.170 through 48.12.200.

48.13.005 Purpose—Application. (1) The purpose of chapter 188, Laws of 2011 is to protect and to further the interests of insureds, creditors, and the general public by providing, with minimum interference with management initiative and judgment, prudent standards for the development and administration of insurer investment programs.

(2) Chapter 188, Laws of 2011 and the rules adopted to interpret and implement it apply to domestic insurers, United States branches of alien insurers entered through this state, alien insurers admitted and using this state as their port of entry, domestic fraternal benefit societies formed pursuant to chapter 48.36A RCW, domestic health care service contractors formed pursuant to chapter 48.44 RCW, domestic health maintenance organizations formed pursuant to chapter 48.46 RCW, and domestic self-funded multiple employer welfare arrangements formed pursuant to chapter 48.125 RCW.

(3) Separate accounts established in accordance with RCW 48.18A.020 shall be evaluated separately pursuant to that section. [2011 c 188 § 1.]

48.13.009 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Derivative instrument" means an item appropriately reported in schedule DB (derivative instruments) or schedule DC (insurance futures and insurance futures options) of an insurer's statutory financial statement or successor schedules, pursuant to applicable annual statement instructions or statutory accounting guidelines.

(2) "Derivative transaction" means a transaction involving the use of one or more derivative instruments.

(3) "Income generation" means a derivative transaction involving the writing of covered options, caps, or floors that is intended to generate income or enhance return.

(4) "Leverage" means the relationship of insurance and investment risks to capital and surplus as defined by the national association of insurance commissioners insurance regulatory information system and its other financial analysis solvency tools and reports.

(5) "Lower grade investment" means a rated credit instrument or debt-like preferred stock rated 4, 5, or 6 by the securities valuation office of the national association of insurance commissioners or any successor office.

(6) "Medium grade investment" means a rated credit instrument or debt-like preferred stock rated 3 by the securities valuation office of the national association of insurance commissioners or any successor office.

(7) "Minimum asset requirement" is the sum of an insurer's liabilities and its minimum financial security benchmark.

(8) "Minimum financial security benchmark" is the amount an insurer is required to have under RCW 48.13.021.

(9) "Mutual fund" means a mutual fund or exchange traded fund registered with the securities and exchange commission of the United States under the investment company act of 1940.

(10) "Rated by the securities valuation office" means any security that is directly rated by the securities valuation office or that is given an equivalent filing exempt rating as prescribed in the purposes and procedures manual of the national association of insurance commissioners securities valuation office.

(11) "Replication" means a derivative transaction involving one or more derivative instruments being used to modify the cash flow characteristics of one or more investments held by an insurer in a manner so that the aggregate cash flows of the derivative instruments and investments

reproduce the cash flows of another investment having a higher risk-based capital charge than the risk-based capital charge of the original instruments or investments.

(12) "Securities valuation office listed mutual fund" means a money market mutual fund or short-term bond fund that is registered with the United States securities and exchange commission under the investment company act of 1940, and that has been determined by the national association of insurance commissioners securities valuation office to be eligible for special reserve and reporting treatment, other than as common stock.

(13) "Surplus" means the excess of admitted assets over all liabilities.

(14) "United States government securities" means any security defined in the purposes and procedures manual of the national association of insurance commissioners securities valuation office as a United States government security. [2011 c 188 § 2.]

48.13.021 Minimum financial security benchmark—Determination of amount. (1) Minimum financial security benchmark.

(a) Unless otherwise established in accordance with (b) and (c) of this subsection, the amount of the minimum financial security benchmark for an insurer shall be the greater of:

(i) The authorized control level risk-based capital applicable to the insurer as set forth by RCW 48.05.450 or 48.43.320; or

(ii) The minimum capital or minimum surplus required by statute or rule for maintenance of an insurer's certificate of authority, certificate of registration, or other form of authorization to transact business pursuant to Title 48 RCW.

(b) The commissioner may, in accordance with the factors in subsection (2)(b) of this section, establish by order a minimum financial security benchmark to apply to a specific insurer provided it is not less than the amount determined by (a) of this subsection, in the event the insurer falls below three and one-half times the authorized control level risk-based capital applicable to the insurer as set forth by RCW 48.05.450 or 48.43.320.

(c) The commissioner may establish by rule a minimum financial security benchmark that is a multiple of authorized control level risk-based capital to apply to any class of insurers provided the amount established by the rule is not less than the amount determined in (a) of this subsection.

(2) The commissioner shall determine the amount of surplus that shall constitute an insurer's minimum financial security benchmark, as an amount that will provide reasonable security against contingencies affecting the insurer's financial position that are not fully covered by reserves or by reinsurance.

(a) Types of contingencies. The commissioner shall consider the risks of:

(i) Increases in the frequency or severity of losses beyond the levels contemplated by the rates charged;

(ii) Increases in expenses beyond those contemplated by the rates charged;

(iii) Decreases in the value of or the return on invested assets below those planned on;

(iv) Changes in economic conditions that would make liquidity more important than contemplated and would force untimely sale of assets or prevent timely investments;

(v) Currency devaluation to which the insurer may be subject;

(vi) Diminished prospects for performance of reinsurers' or other counter parties' obligations; and

(vii) Any other contingencies the commissioner can identify that may affect the insurer's operations.

(b) Controlling factors. In making the determination under this subsection, the commissioner shall take into account the following factors:

(i) The most reliable information available as to the magnitude of the various risks under (a) of this subsection;

(ii) The extent to which the risks in (a) of this subsection are independent of each other or are related, and whether any dependency is direct or inverse;

(iii) The insurer's recent history of profits or losses;

(iv) The extent to which the insurer has provided protection against the contingencies in other ways than the establishment of surplus; including redundancy of premiums, adjustability of contracts under their terms, investment valuation reserves whether voluntary or mandatory, appropriate reinsurance, the use of conservative actuarial assumptions to provide a margin of security, reserve adjustments in recognition of previous rate inadequacies, contingency or catastrophe reserves, diversification of assets, and underwriting risks;

(v) Independent judgments of the soundness of the insurer's operations, as evidenced by the ratings of reliable professional financial reporting services; and

(vi) Any other relevant factors. [2011 c 188 § 3.]

48.13.031 Investment of funds—Board of directors—Judgment and care—Internal controls and procedures.

(1) Subject to the provisions of this chapter, an insurer may loan or invest its funds, and may buy, sell, hold title to, possess, occupy, pledge, convey, manage, protect, insure, and deal with its investments, property, and other assets to the same extent as any other person or corporation under the laws of this state and of the United States.

(2) With respect to all of the insurer's investments, the board of directors of an insurer shall exercise the judgment and care, under the circumstances then prevailing, that persons of reasonable prudence, discretion, and intelligence exercise in the management of a like enterprise, not in regard to speculating but in regard to the permanent disposition of their funds, considering the probable income as well as the probable safety of their capital. Investments shall be of sufficient value, liquidity, and diversity to assure the insurer's ability to meet its outstanding obligations based on reasonable assumptions as to new business production for current lines of business. As part of its exercise of judgment and care, the board of directors shall take into account the prudence evaluation criteria of RCW 48.13.041.

(3) The insurer shall establish and implement internal controls and procedures to assure compliance with investment policies and procedures to assure that:

(a) The insurer's investment staff and any consultants used are reputable and capable;

(b) A periodic evaluation and monitoring process occurs for assessing the effectiveness of investment policy and strategies;

(c) Management's performance is assessed in meeting the stated objectives within the investment policy; and

(d) Appropriate analyses are undertaken of the degree to which asset cash flows are adequate to meet liability cash flows under different economic environments. These analyses shall be conducted at least annually and make specific reference to economic conditions. [2011 c 188 § 4.]

48.13.041 Determining whether an investment portfolio or investment policy is prudent.

The following factors shall be evaluated by the insurer and considered along with its business in determining whether an investment portfolio or investment policy is prudent; the commissioner shall consider the following factors prior to making a determination that an insurer's investment portfolio or investment policy is not prudent:

(1) General economic conditions;

(2) The possible effect of inflation or deflation;

(3) The expected tax consequences of investment decisions or strategies;

(4) The fairness and reasonableness of the terms of an investment considering its probable risk and reward characteristics and relationship to the investment portfolio as a whole;

(5) The extent of the diversification of the insurer's investments among:

(a) Individual investments;

(b) Classes of investments;

(c) Industry concentrations;

(d) Dates of maturity; and

(e) Geographic areas;

(6) The quality and liquidity of investments in affiliates;

(7) The investment exposure to the following risks, quantified in a manner consistent with the insurer's acceptable risk level identified in RCW 48.13.051(8):

(a) Liquidity;

(b) Credit and default;

(c) Systemic (market);

(d) Interest rate;

(e) Call, prepayment, and extension;

(f) Currency;

(g) Foreign sovereign; and

(h) Leverage;

(8) The amount of the insurer's assets, capital, and surplus, premium writings, insurance in force, and other appropriate characteristics;

(9) The amount and adequacy of the insurer's reported liabilities;

(10) The relationship of the expected cash flows of the insurer's assets and liabilities, and the risk of adverse changes in the insurer's assets and liabilities;

(11) The adequacy of the insurer's capital and surplus to secure the risks and liabilities of the insurer; and

(12) Any other factors relevant to whether an investment is prudent. [2011 c 188 § 5.]

48.13.051 Written investment policy required—Annual review—Contents.

In acquiring, investing,

exchanging, holding, selling, and managing investments, an insurer shall establish and follow a written investment policy that shall be reviewed and approved by the insurer's board of directors at least annually. The content and format of an insurer's investment policy are at the insurer's discretion, but shall include written guidelines appropriate to the insurer's business as to the following:

(1) The delegation and monitoring of policies, procedures, and controls covering all aspects of the investing function;

(2) Quantified goals and objectives regarding the composition of classes of investments, including maximum internal limits;

(3) Periodic evaluation of the investment portfolio as to its risk and reward characteristics. This subsection shall not preclude an insurer from the use of modern portfolio theory to manage its investments;

(4) Professional standards for the individuals making day-to-day investment decisions to assure that investments are managed in an ethical and capable manner;

(5) The types of investments to be made and those to be avoided, based on their risk and reward characteristics and the insurer's level of experience with the investments;

(6) The relationship of classes of investments to the insurer's insurance products and liabilities;

(7) The manner in which the insurer intends to implement RCW 48.13.041; and

(8) The level of risk, based on quantitative measures, appropriate for the insurer given the level of capitalization and expertise available to the insurer. [2011 c 188 § 6.]

48.13.061 Classes of investments—Description—

Rules. The following classes of investments may be counted for the purposes specified in RCW 48.13.101, whether they are made directly or as a participant in a partnership, joint venture, or limited liability company. Investments in partnerships, joint ventures, and limited liability companies are authorized investments only pursuant to subsection (12) of this section:

(1) Cash in the direct possession of the insurer or on deposit with a financial institution regulated by any federal or state agency of the United States;

(2) Bonds, debt-like preferred stock, and other evidences of indebtedness of governmental units in the United States or Canada, or the instrumentalities of the governmental units, or private business entities domiciled in the United States or Canada, including asset-backed securities and securities valuation office listed mutual funds;

(3) Loans secured by first mortgages, first trust deeds, or other first security interests in real property located in the United States or Canada or secured by insurance against default issued by a government insurance corporation of the United States or Canada or by an insurer authorized to do business in this state;

(4) Common stock or equity-like preferred stock or equity interests in any United States or Canadian business entity, or shares of mutual funds registered with the securities and exchange commission of the United States under the investment company act of 1940, other than securities valuation office listed mutual funds, and, subsidiaries, as defined

in RCW 48.31B.005, engaged exclusively in the following businesses:

(a) Acting as an insurance producer, surplus line broker, or title insurance agent for its parent or for any of its parent's insurer subsidiaries or affiliates;

(b) Investing, reinvesting, or trading in securities or acting as a securities broker or dealer for its own account, that of its parent, any subsidiary of its parent, or any affiliate or subsidiary;

(c) Rendering management, sales, or other related services to any investment company subject to the federal investment company act of 1940, as amended;

(d) Rendering investment advice;

(e) Rendering services related to the functions involved in the operation of an insurance business including, but not limited to, actuarial, loss prevention, safety engineering, data processing, accounting, claims appraisal, and collection services;

(f) Acting as administrator of employee welfare benefit and pension plans for governments, government agencies, corporations, or other organizations or groups;

(g) Ownership and management of assets which the parent could itself own and manage: PROVIDED, that the aggregate investment by the insurer and its subsidiaries acquired pursuant to this subsection (4)(g) shall not exceed the limitations otherwise applicable to such investments by the parent;

(h) Acting as administrative agent for a government instrumentality which is performing an insurance function or is responsible for a health or welfare program;

(i) Financing of insurance premiums;

(j) Any other business activity reasonably ancillary to an insurance business;

(k) Owning one or more subsidiary;

(i) Insurers, health care service contractors, or health maintenance organizations to the extent permitted by this chapter;

(ii) Businesses specified in (a) through (k) of this subsection inclusive; or

(iii) Any combination of such insurers and businesses;

(5) Real property necessary for the convenient transaction of the insurer's business;

(6) Real property, together with the fixtures, furniture, furnishings, and equipment pertaining thereto in the United States or Canada, which produces or after suitable improvement can reasonably be expected to produce income;

(7) Loans, securities, or other investments of the types described in subsections (1) through (6) of this section in national association of insurance commissioners securities valuation office 1 debt rated countries other than the United States and Canada;

(8) Bonds or other evidences of indebtedness of international development organizations of which the United States is a member;

(9) Loans upon the security of the insurer's own policies in amounts that are adequately secured by the policies and that in no case exceed the surrender values of the policies;

(10) Tangible personal property under contract of sale or lease under which contractual payments may reasonably be expected to return the principal of and provide earnings on the investment within its anticipated useful life;

(11) Other investments the commissioner authorizes by rule; and

(12) Investments not otherwise permitted by this section, and not specifically prohibited by statute, to the extent of not more than five percent of the first five hundred million dollars of the insurer's admitted assets plus ten percent of the insurer's admitted assets exceeding five hundred million dollars. [2015 c 122 § 16; 2011 c 188 § 7.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.13.071 Limitations on investments—Special rules for certain investments. (1) Class limitations. For the purposes of RCW 48.13.101, the following limitations on classes of investments apply:

(a) Investments authorized by RCW 48.13.061(2), and investments authorized by RCW 48.13.061(7) that are of the types described in RCW 48.13.061(2);

(i) The aggregate amount of medium and lower grade investments, twenty percent of its admitted assets;

(ii) The aggregate amount of lower grade investments, ten percent of its admitted assets;

(iii) The aggregate amount of investments rated 5 or 6 by the securities valuation office, five percent of its admitted assets;

(iv) The aggregate amount of investments rated 6 by the securities valuation office, one percent of its admitted assets; or

(v) The aggregate amount of medium and lower grade investments that receive as cash income less than the equivalent yield for treasury issues with a comparative average life, one percent of its admitted assets;

(b) Investments authorized by RCW 48.13.061(3), forty-five percent of admitted assets in the case of life insurers and twenty-five percent of admitted assets in the case of nonlife insurers;

(c) Investments authorized by RCW 48.13.061(4), other than subsidiaries of the types authorized under RCW 48.13.061(4) (a) through (k), twenty percent of admitted assets in the case of life insurers and twenty-five percent of admitted assets in the case of nonlife insurers;

(i) Individual investments authorized by RCW 48.13.061(4), except for subsidiaries, shall be limited to ten percent of the voting interest in any one entity;

(ii) Investments authorized in RCW 48.13.061(4) in one or more subsidiaries shall be limited to the lesser of ten percent of admitted assets or fifty percent of surplus;

(d) Investments authorized by RCW 48.13.061(5), ten percent of admitted assets;

(e) Investments authorized by RCW 48.13.061(6), twenty percent of admitted assets in the case of life insurers, and ten percent of admitted assets in the case of nonlife insurers;

(f) Investments authorized by RCW 48.13.061(7), twenty percent of admitted assets;

(g) Investments authorized by RCW 48.13.061(8), two percent of admitted assets; and

(h) Investments authorized by RCW 48.13.061(10), two percent of admitted assets.

(2) Individual limitations. For purposes of determining compliance with RCW 48.13.101, securities of a single issuer and its affiliates, other than United States government securi-

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ties and subsidiaries authorized by RCW 48.13.061(4), shall not exceed three percent of admitted assets in the case of life insurers, and five percent in the case of nonlife insurers. Investments in the voting securities of a depository institution, or any company that controls a depository institution, shall not exceed five percent of the insurer's admitted assets.

(3) Investment subsidiaries. For purposes of determining compliance with the limitations of this section, the admitted portion of assets of subsidiaries authorized by RCW 48.13.061(4) shall be deemed to be owned directly by the insurer and any other investors in proportion to the market value or if there is no market, the reasonable value, of their interest in the subsidiaries.

(4) Effect of quantity limitations. To the extent that investments exceed the limitations specified in subsections (1) and (2) of this section, the excess may be assigned to the investment class authorized in RCW 48.13.061(12), until that limit is exhausted.

(5) Special rule for mutual funds, pooled investment vehicles, and other investment companies, excluding mutual funds listed on the securities valuation office's United States direct obligations/full faith and credit exempt list, class 1 list, and/or bond fund list (securities valuation office listed mutual funds). At the discretion of the commissioner, as may be deemed necessary in order to determine compliance with this chapter in relation to limitations of particular classes of investments, the commissioner may require that investments in mutual funds, pooled investment vehicles, or other investment companies be treated for purposes of this chapter as if the investor owned directly its proportional share of the assets owned by the mutual fund, pooled investment vehicle, or investment company to the extent such individual nonsecurities valuation office listed mutual funds, pooled investment vehicles, and other investment companies exceed two percent of admitted assets or, in aggregate, ten percent of admitted assets.

(6) Unless otherwise specified, an investment limitation computed on the basis of an insurer's admitted assets or capital and surplus shall relate to the amount required to be shown on the statutory balance sheet of the insurer most recently required to be filed with the commissioner.

(7) Investments authorized by RCW 48.13.061(3) shall not exceed eighty percent of the fair value of the particular property at the time of the investment, unless guaranteed or insured.

(a) The fair value shall be determined by a competent appraiser at the time of the investment.

(b) Buildings and other improvements shall be kept insured for the benefit of the mortgagee. [2011 c 188 § 8.]

48.13.081 Investments in securities of different currencies. An insurer doing business that requires it to make payment in different currencies shall have investments in securities in each of these currencies in an amount that independently of all other investments meets the requirements of this chapter as applied separately to the insurer's obligations in each currency. The commissioner may by order exempt an insurer, or by rule a class of insurers, from this requirement if the obligations in other currencies are small enough that no significant problem for financial stability would be created

by substantial fluctuations in relative currency values. [2011 c 188 § 9.]

48.13.091 Prohibited investments. (1)(a) An insurer shall not invest in investments that are prohibited for an insurer by statutes or rules of this state.

(b) The use of a derivative instrument for replication, speculative, or for any purposes other than hedging or income generation, is prohibited.

(c) Investment in real property for speculative, ranching, farming, mining, gaming, amusement, oil, gas, or mineral exploration, or club purposes, is prohibited.

(d) Investment in issued shares of its own capital stock, held directly or indirectly, except for the purpose of mutualization in accordance with RCW 48.08.080, is prohibited.

(e) Investment in securities issued by any corporation if a majority of its stock having voting power is owned directly or indirectly by or for the benefit of any one or more of the insurer's officers and directors, is prohibited.

(f) Investment in securities issued by any insolvent corporation, is prohibited.

(g) Investment in any instrument or security which is found by the commissioner to be designed to evade any limitation or prohibition of this code, is prohibited.

(2) A reasonable time, not in excess of five years, shall be allowed for disposal of a prohibited investment in hardship cases if the investment is demonstrated by the insurer to have been legal when made, or the result of a mistake made in good faith, or if the commissioner deems that the sale of the asset would be contrary to the interests of insureds, creditors, or the general public. [2011 c 188 § 10.]

48.13.101 Satisfaction of the minimum asset requirement—When assets may be counted. (1) Invested assets may be counted toward satisfaction of the minimum asset requirement only so far as they are invested in compliance with this chapter and applicable rules adopted and orders issued by the commissioner pursuant to this chapter. Assets other than invested assets may be counted toward satisfaction of the minimum asset requirement at admitted annual statement value.

(2) An investment held as an admitted asset by an insurer on July 1, 2012, which qualified under this chapter shall remain qualified as an admitted asset under this chapter.

(3) Assets acquired in the bona fide enforcement of creditors' rights or in bona fide workouts or settlements of disputed claims may be counted for the purposes of subsection (1) of this section for five years after acquisition if real property and three years if not real property, even if they could not otherwise be counted under this chapter. The commissioner may allow reasonable extensions of these periods if replacement of the assets within the periods would not be possible without substantial loss.

(4) If an insurer does not own, or is unable to apply toward compliance with this chapter, an amount of assets equal to its minimum asset requirement, the commissioner may deem it to be financially hazardous under chapter 48.31 RCW. [2011 c 188 § 11.]

48.13.111 Commissioner's powers—Requirements of persons subject to regulation. (1) The commissioner may

require any of the following from a person subject to regulation under this chapter:

(a) Statements, reports, answers to questionnaires, and other information, and evidence thereof, in whatever reasonable form the commissioner designates, and at such reasonable intervals as the commissioner chooses;

(b) Full explanation of the programming of any data storage or communication system in use;

(c) That information from any books, records, electronic data processing systems, computers, or any other information storage system be made available to the commissioner at a reasonable time and in a reasonable manner.

(2) The commissioner may prescribe forms for the reports under subsection (1) of this section and specify who shall execute or certify the reports. The forms for the reports required under subsection (1) of this section shall be consistent, so far as practicable, with those prescribed by other jurisdictions.

(3) The commissioner may prescribe reasonable minimum standards and techniques of accounting and data handling to ensure that timely and reliable information will exist and will be available to the commissioner.

(4) Any officer, manager or general agent of an insurer subject to this chapter, any person controlling or having a contract under which the person has a right to control the insurer, whether exclusively or otherwise, or a person with executive authority over or in charge of any segment of the insurer's affairs, shall reply promptly in writing or in other reasonably designated form, to a written inquiry from the commissioner requesting a reply. A timely response is one that is received by the commissioner within fifteen business days from receipt of the inquiry. Failure to make a timely response constitutes a violation of this section.

(5) The commissioner may require that any communication made to the commissioner under this section be verified.

(6) A communication to the commissioner, or to an expert or consultant retained by the commissioner, required by the provisions of this chapter shall not subject the person making it to an action for damages for the communication in the absence of actual malice.

(7) Notwithstanding the provisions of subsection (6) of this section, the commissioner may bring suit against any person providing information required under this chapter that is not truthful and accurate. [2011 c 188 § 12.]

48.13.121 Commissioner may retain experts—Insurer's expense. The commissioner may retain at the insurer's expense attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist in reviewing the insurer's investments. Persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity. [2011 c 188 § 13.]

48.13.131 When investment practices are not in compliance—Commissioner's authority. (1) If the commissioner determines that an insurer's investment practices do not meet the provisions of this chapter, the commissioner may, after notification to the insurer of the commissioner's findings, order the insurer to make changes necessary to comply with the provisions of this chapter.

(2) If the commissioner determines that by reason of the financial condition, current investment practice, or current investment plan of an insurer, the interests of insureds, creditors, or the general public are or may be endangered, the commissioner may impose reasonable additional restrictions upon the admissibility or valuation of investments or may impose restrictions on the investment practices of an insurer, including prohibition or divestment.

(3) The commissioner may count toward satisfaction of the minimum asset requirement any assets in which an insurer is required to invest under the laws of a country other than the United States as a condition for doing business in that country if the commissioner finds that counting them does not endanger the interests of insureds, creditors, or the general public.

(4) If the commissioner is satisfied by evidence of the financial stability of an insurer and the competence of management and its investment advisors, the commissioner, after a hearing, may by order adjust the class limitations in RCW 48.13.071, for that insurer, to the extent that the commissioner is satisfied that the interests of insureds, creditors, and the public of this state are sufficiently protected in other ways. Adjustments granted with respect to RCW 48.13.071, in aggregate, are limited to an amount equal to ten percent of the insurer's liabilities. [2011 c 188 § 14.]

48.13.141 Aggrieved insurer—Request for hearing.

An insurer aggrieved by an order or any other act or failure to act of the commissioner regarding compliance with this chapter or rules adopted under this chapter may request a hearing by following the procedures of chapters 48.04 and 34.05 RCW. [2011 c 188 § 15.]

48.13.151 Confidentiality of investment policy information. The investment policy, or information related to the investment policy provided to the commissioner for review under this chapter shall be considered confidential and shall not be a public record or subject to subpoena. [2011 c 188 § 16.]

48.13.161 Chapter prevails over other statutes—Valuation of assets. (1) This chapter prevails over any other statute purporting to authorize an insurer to make a particular investment if the other statute was enacted before July 1, 2012, and prevails over any statute enacted after July 1, 2012, unless the latter specifically includes amendments made to this chapter.

(2) An insurer shall value its assets in accordance with the valuation standards of the national association of insurance commissioners to the extent those standards are consistent with the statutes of this state or rules or orders of the commissioner. [2011 c 188 § 17.]

48.13.171 Rule making—Special investment restrictions. (1) The commissioner may, in accordance with chapter 34.05 RCW, adopt rules interpreting and implementing the provisions of this chapter.

(2) The commissioner may, in accordance with chapter 34.05 RCW, adopt special investment restrictions as follows:

(a) The commissioner may by rule prescribe for defined classes of insurers special procedural requirements including

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special reports, prior approval, or subsequent disapproval of investments.

(b) The commissioner may by rule prescribe substantive restrictions on investments of defined classes of insurers, including:

(i) Specification of classes of assets that may not be counted toward satisfaction of the minimum asset requirement even though they may be counted for unrestricted insurers;

(ii) Specification of maximum amounts of assets that may be invested in a single investment, or an issue, a class or a group of classes of investments, expressed as percentages of total assets, capital, surplus, legal reserves, or other variables;

(iii) Prescription of qualitative tests for investments and conditions under which investments may be made, including requirements of specified ratings from investment advisory services, listing on specified stock exchanges, collateral, marketability, currency matching, and the financial and legal status of the issuer and its earnings capacity.

(3) If the commissioner is satisfied by evidence of the financial stability of an insurer and the competence of management and its investment advisors, the commissioner, after a hearing, may by order grant an exemption to that insurer from any restriction under subsection (2) of this section to the extent that the commissioner is satisfied that the interests of insureds, creditors, and the general public of this state are protected in other ways. [2011 c 188 § 18.]

48.13.350 Written record of investments—Contents.

A written record of each investment or loan of the funds of a domestic insurer shall contain:

(1) In the case of loans: The name of the borrower; the location and legal description of the property; a physical description, and the appraised value of the security; the amount of the loan, rate of interest and terms of repayment.

(2) In the case of securities: The name of the obligor; a description of the security and the record of earnings; the amount invested, the rate of interest or dividend, the maturity and yield based upon the purchase price.

(3) In the case of real estate: The location and legal description of the property; a physical description and the appraised value; the purchase price and terms.

(4) In the case of all investments:

(a) The amount of expenses and commissions if any incurred on account of any investment or loan and by whom and to whom payable if not covered by contracts with mortgage loan representatives or correspondents which are part of the insurer's records.

(b) The name of any officer or director of the insurer having any direct, indirect, or contingent interest in the securities or loan representing the investment, or in the assets of the person in whose behalf the investment or loan is made, and the nature of such interest. [2011 c 188 § 20; 2009 c 549 § 7055; 1949 c 190 § 20; 1947 c 79 § .13.35; Rem. Supp. 1949 § 45.13.35.]

48.13.360 Investments of foreign and alien insurers.

The investments of a foreign or alien insurer shall be as permitted by the laws of its domicile but shall be of a quality substantially as high as those required under this chapter for

similar funds of like domestic insurers. [1947 c 79 § .13.36; Rem. Supp. 1947 § 45.13.36.]

48.13.450 Safeguarding securities—Definitions. The definitions in this section apply throughout RCW 48.13.450 through 48.13.475 unless the context clearly requires otherwise.

(1) "Agent" means a national bank, state bank, trust company, or broker/dealer that maintains an account in its name in a clearing corporation or that is a member of the federal reserve system and through which a custodian participates in a clearing corporation, including the treasury/reserve automated debt entry securities system (TRADES) or treasury direct systems; except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet the deposit requirements pursuant to laws of a foreign country as a condition of doing business therein, "agent" may include a corporation that is organized or existing under the laws of a foreign country and that is legally qualified under those laws to accept custody of securities.

(2) "Broker/dealer" means a broker or dealer as defined in RCW 62A.8-102(1)(c), that is registered with and subject to the jurisdiction of the securities and exchange commission, maintains membership in the securities investor protection corporation, and has a tangible net worth equal to or greater than two hundred fifty million dollars.

(3) "Clearing corporation" means a corporation as defined in RCW 62A.8-102(1)(e) that is organized for the purpose of effecting transactions in securities by computerized book-entry, except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "clearing corporation" may include a corporation that is organized or existing under the laws of any foreign country and is legally qualified under such laws to effect transactions in securities by computerized book-entry. "Clearing corporation" also includes treasury/reserve automated debt entry securities system and treasury direct book-entry securities systems established pursuant to 31 U.S.C. Sec. 3100 et seq., 12 U.S.C. pt. 391, and 5 U.S.C. pt. 301.

(4) "Commissioner" means the insurance commissioner of the state of Washington.

(5) "Custodian" means:

(a) A national bank, state bank, or trust company that shall, at all times acting as a custodian, be no less than adequately capitalized as determined by the standards adopted by United States banking regulators and that is regulated by either state banking laws or is a member of the federal reserve system and that is legally qualified to accept custody of securities; except that with respect to securities issued by institutions organized or existing under the laws of a foreign country, or securities used to meet the deposit requirements pursuant to laws of a foreign country as a condition of doing business therein, "custodian" may include a bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as such by that country's government or an agency thereof that shall at all times acting as a custodian be no less than adequately cap-

italized as determined by the standards adopted by the international banking authorities and legally qualified to accept custody of securities; or

(b) A broker/dealer.

(6) "Custodied securities" means securities held by the custodian or its agent or in a clearing corporation, including the treasury/reserve automated debt entry securities system (TRADES) or treasury direct systems.

(7) "Securities" means instruments as defined in RCW 62A.8-102(1)(o).

(8) "Securities certificate" has the same meaning as in RCW 62A.8-102(1)(d).

(9) "Tangible net worth" means shareholders equity, less intangible assets, as reported in the broker/dealer's most recent annual or transition report pursuant to section 13 or 15(d) of the securities exchange act of 1934 (S.E.C. Form 10-K) filed with the securities and exchange commission.

(10) "Treasury/reserve automated debt entry securities system" ("TRADES") and "treasury direct" mean book-entry securities systems established pursuant to 31 U.S.C. Sec. 3100 et seq., 12 U.S.C. pt. 391, and 5 U.S.C. pt. 301, with the operation of TRADES and treasury direct subject to 31 C.F.R. pt. 357 et seq. [2009 c 161 § 2; 2008 c 234 § 1; 2000 c 221 § 1.]

48.13.455 Safeguarding securities—Deposit in a clearing corporation—Certificates—Records. Notwithstanding any other provision of law, a domestic insurance company may deposit or arrange for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation. When securities are deposited with a clearing corporation, securities certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and securities certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of any custodian through which an insurance company holds securities shall at all times show that such securities are held for such insurance company and for which accounts thereof. Ownership of, and other interests in, such securities may be transferred by bookkeeping entry on the books of such clearing corporation without physical delivery of securities certificates representing such securities. [2008 c 234 § 2; 2000 c 221 § 2.]

48.13.460 Safeguarding securities—Authorized methods of holding securities. The following are the only authorized methods of holding securities:

(1) A domestic insurance company may hold securities in definitive certificates;

(2) A domestic insurance company may, pursuant to an agreement, designate a custodian through which it can transact and maintain book-entry securities on behalf of the insurance company; or

(3) A domestic insurance company may, pursuant to an agreement, participate in depository systems of clearing corporations directly or through a custodian. [2008 c 234 § 3; 2000 c 221 § 3.]

48.13.465 Safeguarding securities—Requirement to receive a confirmation. A domestic insurance company using the methods of holding securities under RCW 48.13.460 (2) or (3) is required to receive a confirmation from:

(1) The custodian whenever securities are received or surrendered pursuant to the domestic insurance company's instructions to a securities broker; or

(2) The securities broker provided that the domestic insurance company has given the custodian and the securities broker matching instructions authorizing the transaction, which have been confirmed by the custodian prior to surrendering funds or securities to conduct the transaction. [2008 c 234 § 4; 2000 c 221 § 4.]

48.13.470 Safeguarding securities—Broker executing a trade—Time limits. (1) A broker executing a securities trade pursuant to an order from a domestic insurance company shall send confirmation to the domestic insurance company or the clearing corporation confirming the order has been executed within twenty-four hours after order completion.

(2) A broker may not hold in its own account for longer than seventy-two hours any securities bought or sold pursuant to an order from a domestic insurance company. [2000 c 221 § 5.]

48.13.475 Safeguarding securities—Maintenance with a custodian—Commissioner may order transfer—Challenge to order—Standing at hearing or for judicial review. (1) Notwithstanding the maintenance of securities with a custodian pursuant to agreement, if the commissioner:

(a) Has reasonable cause to believe that the domestic insurer:

(i) Is conducting its business and affairs in such a manner as to threaten to render it insolvent;

(ii) Is in a hazardous condition or is conducting its business and affairs in a manner that is hazardous to its policyholders, creditors, or the public; or

(iii) Has committed or is committing or has engaged or is engaging in any act that would constitute grounds for rendering it subject to rehabilitation or liquidation proceedings; or

(b) Determines that irreparable loss and injury to the property and business of the domestic insurer has occurred or may occur unless the commissioner acts immediately; then the commissioner may, without hearing, order the insurer and the custodian promptly to effect the transfer of the securities to another custodian approved by the commissioner. Upon receipt of the order, the custodian shall promptly effect the transfer of the securities. Notwithstanding the pendency of any hearing or request for hearing, the order shall be complied with by those persons subject to that order. Any challenge to the validity of the order shall be made under chapter 48.04 RCW, however, the stay of action provisions of RCW 48.04.020 do not apply. It is the responsibility of both the insurer and the custodian to oversee that compliance with the order is completed as expeditiously as possible. Upon receipt of an order, there shall be no trading of the securities without specific instructions from the commissioner until the securities are received by the new custodian, except to the extent trading transactions are in process on the day the

order is received by the insurer and the failure to complete the trade may result in loss to the insurer's account. Issuance of an order does not affect the custodian's liabilities with regard to the securities that are the subject of the order.

(2) No person other than the insurer has standing at the hearing by the commissioner or for any judicial review of the order. [2008 c 234 § 5; 2000 c 221 § 6.]

48.13.480 Safeguarding securities—Insurance company's securities—Written agreement with custodian—Required terms. (1) An insurance company may, by written agreement with a custodian, provide for the custody of its securities with that custodian. The securities that are the subject of the agreement may be held by the custodian or its agent or in a clearing corporation.

(2) The agreement shall be in writing and shall be authorized by a resolution of the board of directors of the insurance company or of an authorized committee of the board. The terms of the agreement shall comply with the following:

(a) Securities certificates held by the custodian shall be held separate from the securities certificates of the custodian and all of its customers;

(b) Securities held indirectly by the custodian and securities in a clearing corporation shall be separately identified on the custodian's official records as being owned by the insurance company. The records shall identify which securities are held by the custodian or by its agent and which securities are in a clearing corporation. If the securities are in a clearing corporation, the records shall also identify where the securities are and the name of the clearing corporation; and if the securities are held by an agent, the records shall also identify the name of the agent;

(c) All custodied securities that are registered shall be registered in the name of the company or in the name of the nominee of the company or in the name of the custodian or its nominee, or, if in a clearing corporation, in the name of the clearing corporation or its nominee;

(d) Custodied securities shall be held subject to the instructions of the insurance company and shall be withdrawable upon the demand of the insurance company, except custodied securities used to meet the deposit requirements;

(e) The custodian shall be required to send or cause to be sent to the insurance company a confirmation of all transfers of custodied securities to or from the account of the insurance company. Confirmation of all transfers shall be provided to the insurance company in hard copy or electronic format. In addition, the custodian shall be required to furnish, no less than monthly, the insurance company with reports of various holdings of custodied securities at times and containing information reasonably requested by the insurance company. The custodian's trust committee's annual reports of its review of the insurer trust accounts shall also be provided to the insurer. Reports and verifications may be transmitted in electronic or paper format;

(f) During the course of the custodian's regular business hours, an officer or employee of the insurance company, an independent accountant selected by the insurance company, and a representative of an appropriate regulatory body shall be entitled to examine, on the premise of the custodian, the custodian's records relating to the custodied securities, but only upon furnishing the custodian with written instructions

to that effect from an appropriate officer of the insurance company;

(g) The custodian and its agents shall be required to send to the insurance company:

(i) All reports that they receive from a clearing corporation on their respective systems of internal accounting control; and

(ii) Reports prepared by outside auditors on the custodians or its agents internal accounting control of custodied securities that the insurance company may reasonably request;

(h) The custodian shall maintain records sufficient to determine and verify information relating to custodied securities that may be reported in the insurance company's annual statement and supporting schedules and information required in an audit of the financial statements of the insurance company;

(i) The custodian shall provide, upon written request from an appropriate officer of the insurance company, the appropriate affidavits;

(j) A national bank, state bank, or trust company shall secure and maintain insurance protection in an adequate amount covering the bank's or trust company's duties and activities as custodian for the insurer's assets, and shall state in the custody agreement that the protection is in compliance with the requirements of the custodian's banking regulator. A broker/dealer shall secure and maintain insurance protection for each insurance company's custodied securities in excess of that provided by the securities investor protection corporation in an amount equal to or greater than the market value of each respective insurance company's custodied securities. The commissioner may determine whether the type of insurance is appropriate and whether the amount of coverage is adequate;

(k) The custodian shall be obligated to indemnify the insurance company for any loss of custodied securities occasioned by the negligence or dishonesty of the custodian's officers or employees or agents, or burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction;

(l) In the event that there is a loss of custodied securities for which the custodian shall be obligated to indemnify the insurance company as provided in (k) of this subsection, the custodian shall promptly replace the securities of the value thereof and the value of any loss of rights or privileges resulting from the loss of securities;

(m) The custodian will not be liable for a failure to take an action required under the agreement in the event and to the extent that the taking of the action is prevented or delayed by war (whether declared or not, including existing wars), revolution, insurrection, riot, civil commotion, accident, fire, explosion, labor stoppage and strikes, laws, regulations, orders, or other acts of any governmental authority, which are beyond its reasonable control;

(n) In the event that the custodian gains entry in a clearing corporation through an agent, there shall be an agreement between the custodian and the agent under which the agent shall be subject to the same liability for loss of custodied securities as the custodian. However, if the agent is subject to regulation under the laws of a jurisdiction that are different from the laws of the jurisdiction that regulates the custodian,

the commissioner may accept a standard of liability applicable to the agent that is different from the standard of liability applicable to the custodian;

(o) The custodian shall provide written notification to the office of the insurance commissioner if the custodial agreement with the insurer has been terminated or if one hundred percent of the account assets in any one custody account have been withdrawn. This notification shall be remitted to the commissioner within three business days of the withdrawal of one hundred percent of the account assets. [2008 c 234 § 7.]

48.13.490 Safeguarding securities—Rules. The commissioner may adopt rules governing the deposit by insurance companies of securities with clearing corporations, including establishing standards for national banks, state banks, trust companies, and brokers/dealers to qualify as custodians for insurance company securities. [2008 c 234 § 6; 2000 c 221 § 7.]

48.13.900 Effective date—2011 c 188. This act takes effect July 1, 2012. [2011 c 188 § 24.]

**Chapter 48.14 RCW
FEES AND TAXES**

Sections

48.14.010	Fee schedule.
48.14.020	Premium taxes.
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48.14.010 Fee schedule. (1) The commissioner shall collect in advance the following fees:

(a) For filing charter documents:

- (i) Original charter documents, bylaws or record of organization of insurers, or certified copies thereof, required to be filed \$250.00
- (ii) Amended charter documents, or certified copy thereof, other than amendments of bylaws. \$ 10.00
- (iii) No additional charge or fee shall be required for filing any of such documents in the office of the secretary of state.

(b) Certificate of authority:

- (i) Issuance \$ 25.00
- (ii) Renewal \$ 25.00

(c) Annual statement of insurer, filing	\$ 20.00
(d) Organization or financing of domestic insurers and affiliated corporations:	
(i) Application for solicitation permit, filing	\$100.00
(ii) Issuance of solicitation permit	\$ 25.00
(e) Insurance producer licenses:	
(i) License application	\$ 55.00
(ii) License renewal, every two years	\$ 55.00
(iii) Initial appointment and renewal of appointment of each insurance producer, every two years	\$ 20.00
(iv) Limited line insurance producer license application and renewal, every two years	\$ 20.00
(f) Title insurance agent licenses:	
(i) License application	\$ 50.00
(ii) License renewal, every two years	\$ 50.00
(g) Reinsurance intermediary licenses:	
(i) Reinsurance intermediary-broker, each year	\$ 50.00
(ii) Reinsurance intermediary-manager, each year	\$100.00
(h) Surplus line broker license application and renewal, every two years	\$200.00
(i) Adjusters' licenses:	
(i) Independent adjuster: (A) License application	\$ 50.00
(B) License renewal, every two years	\$ 50.00
(ii) Public adjuster: (A) License application	\$ 50.00
(B) License renewal, every two years	\$ 50.00
(iii) Crop adjuster: (A) License application	\$ 50.00
(B) License renewal, every two years	\$50.00
(j) Managing general agent appointment, every two years	\$200.00
(k) Examination for license, each examination:	
All examinations, except examinations administered by an independent testing service, the fees for which are to be approved by the commissioner and collected directly by and retained by such independent testing service	\$ 20.00
(l) Miscellaneous services:	
(i) Filing other documents.	\$ 5.00
(ii) Commissioner's certificate under seal	\$ 5.00

(iii) Copy of documents filed in the commissioner's office, reasonable charge therefor as determined by the commissioner.

(m) Self-service storage specialty insurance producer license application and renewal:

Every two years, \$130.00 for an owner with under fifty employees or \$375.00 for an owner with fifty or more employees; plus a location fee of \$35.00 for each additional location of an owner.

(2) All fees so collected shall be remitted by the commissioner to the state treasurer not later than the first business day following, and shall be placed to the credit of the general fund.

(a) Fees for examinations administered by an independent testing service that are approved by the commissioner under subsection (1)(k) of this section shall be collected directly by the independent testing service and retained by it.

(b) Fees for copies of documents filed in the commissioner's office shall be remitted by the commissioner to the state treasurer not later than the first business day following, and shall be placed to the credit of the insurance commissioner's regulatory account. [2010 c 67 § 1. Prior: 2009 c 162 § 2; 2009 c 119 § 10; 2007 c 117 § 37; 2005 c 223 § 5; 1994 c 131 § 2; 1993 c 462 § 57; 1988 c 248 § 7; 1981 c 111 § 1; 1979 ex.s. c 269 § 1; 1977 ex.s. c 182 § 1; 1969 ex.s. c 241 § 8; 1967 c 150 § 12; 1955 c 303 § 4; 1947 c 79 § .14.01; Rem. Supp. 1947 § 45.14.01.]

Additional notes found at www.leg.wa.gov

48.14.020 Premium taxes. (1) Subject to other provisions of this chapter, each authorized insurer except title insurers and registered eligible captive insurers as defined in RCW 48.201.020 shall on or before the first day of March of each year pay to the state treasurer through the commissioner's office a tax on premiums. Except as provided in subsection (3) of this section, such tax shall be in the amount of two percent of all premiums, excluding amounts returned to or the amount of reductions in premiums allowed to holders of industrial life policies for payment of premiums directly to an office of the insurer, collected or received by the insurer under RCW 48.14.090 during the preceding calendar year other than ocean marine and foreign trade insurances, after deducting premiums paid to policyholders as returned premiums, upon risks or property resident, situated, or to be performed in this state. For tax purposes, the reporting of premiums shall be on a written basis or on a paid-for basis consistent with the basis required by the annual statement. For the purposes of this section the consideration received by an insurer for the granting of an annuity shall not be deemed to be a premium.

(2)(a) The taxes imposed in this section do not apply to amounts received by any life and disability insurer for health care services included within the definition of practice of dentistry under RCW 18.32.020 except amounts received for pediatric oral services that qualify as coverage for the minimum essential coverage requirement under P.L. 111-148 (2010), as amended, and for stand-alone family dental plans as defined in RCW 43.71.080(4)(a), only when offered in the

individual market, as defined in RCW 48.43.005, or to a small group, as defined in RCW 48.43.005.

(b) Beginning January 1, 2014, moneys collected for premiums written on qualified health benefit plans and qualified dental plans offered through the health benefit exchange under chapter 43.71 RCW must be deposited in the health benefit exchange account under RCW 43.71.060.

(3) In the case of insurers which require the payment by their policyholders at the inception of their policies of the entire premium thereon in the form of premiums or premium deposits which are the same in amount, based on the character of the risks, regardless of the length of term for which such policies are written, such tax shall be in the amount of two percent of the gross amount of such premiums and premium deposits upon policies on risks resident, located, or to be performed in this state, in force as of the thirty-first day of December next preceding, less the unused or unabsorbed portion of such premiums and premium deposits computed at the average rate thereof actually paid or credited to policyholders or applied in part payment of any renewal premiums or premium deposits on one-year policies expiring during such year.

(4) Each authorized insurer shall with respect to all ocean marine and foreign trade insurance contracts written within this state during the preceding calendar year, on or before the first day of March of each year pay to the state treasurer through the commissioner's office a tax of ninety-five one-hundredths of one percent on its gross underwriting profit. Such gross underwriting profit shall be ascertained by deducting from the net premiums (i.e., gross premiums less all return premiums and premiums for reinsurance) on such ocean marine and foreign trade insurance contracts the net losses paid (i.e., gross losses paid less salvage and recoveries on reinsurance ceded) during such calendar year under such contracts. In the case of insurers issuing participating contracts, such gross underwriting profit shall not include, for computation of the tax prescribed by this subsection, the amounts refunded, or paid as participation dividends, by such insurers to the holders of such contracts.

(5) The state does hereby preempt the field of imposing excise or privilege taxes upon insurers or their appointed insurance producers, other than title insurers, and no county, city, town or other municipal subdivision shall have the right to impose any such taxes upon such insurers or these insurance producers.

(6) If an authorized insurer collects or receives any such premiums on account of policies in force in this state which were originally issued by another insurer and which other insurer is not authorized to transact insurance in this state on its own account, such collecting insurer shall be liable for and shall pay the tax on such premiums. [2021 c 281 § 7; 2016 c 133 § 1; 2013 2nd sp.s. c 6 § 6; 2013 c 325 § 4; 2009 c 161 § 3; 2008 c 217 § 6; 1986 c 296 § 1; 1983 2nd ex.s. c 3 § 7; 1982 2nd ex.s. c 10 § 1; 1982 1st ex.s. c 35 § 15; 1979 ex.s. c 233 § 2; 1969 ex.s. c 241 § 9; 1947 c 79 § .14.02; Rem. Supp. 1947 § 45.14.02.]

Effective date—2021 c 281: See note following RCW 48.201.010.

Intent—1979 ex.s. c 233: "It is the intent of the legislature to eliminate existing tax discrimination between qualified and nonqualified pension plans which are effectuated by annuity contracts, by excluding the consideration

paid for such contracts from premiums subject to the premium tax." [1979 ex.s. c 233 § 1.]

Credit against premium tax for assessments paid pursuant to RCW 48.32.060(1)(c): RCW 48.32.145.

*Portion of state taxes on fire insurance premiums to be deposited in firefighters' pension fund: RCW 41.16.050.
volunteer firefighters' and reserve officers' relief and pension principal fund: RCW 41.24.030.*

Additional notes found at www.leg.wa.gov

48.14.0201 Premiums and prepayments tax—Health care services—Exemptions—State preemption. (1) As used in this section, "taxpayer" means a health maintenance organization as defined in RCW 48.46.020, a health care service contractor as defined in chapter 48.44 RCW, or a self-funded multiple employer welfare arrangement as defined in RCW 48.125.010.

(2) Each taxpayer must pay a tax on or before the first day of March of each year to the state treasurer through the insurance commissioner's office. The tax must be equal to the total amount of all premiums and prepayments for health care services collected or received by the taxpayer under RCW 48.14.090 during the preceding calendar year multiplied by the rate of two percent. For tax purposes, the reporting of premiums and prepayments must be on a written basis or on a paid-for basis consistent with the basis required by the annual statement.

(3) Taxpayers must prepay their tax obligations under this section. The minimum amount of the prepayments is the percentages of the taxpayer's tax obligation for the preceding calendar year recomputed using the rate in effect for the current year. For the prepayment of taxes due during the first calendar year, the minimum amount of the prepayments is the percentages of the taxpayer's tax obligation that would have been due had the tax been in effect during the previous calendar year. The tax prepayments must be paid to the state treasurer through the commissioner's office by the due dates and in the following amounts:

- (a) On or before June 15, forty-five percent;
- (b) On or before September 15, twenty-five percent;
- (c) On or before December 15, twenty-five percent.

(4) For good cause demonstrated in writing, the commissioner may approve an amount smaller than the preceding calendar year's tax obligation as recomputed for calculating the health maintenance organization's, health care service contractor's, self-funded multiple employer welfare arrangement's, or certified health plan's prepayment obligations for the current tax year.

(5)(a) Except as provided in (b) of this subsection, moneys collected under this section are deposited in the general fund.

(b) Beginning January 1, 2014, moneys collected from taxpayers for premiums written on qualified health benefit plans and qualified dental plans offered through the health benefit exchange under chapter 43.71 RCW must be deposited in the health benefit exchange account under RCW 43.71.060.

(6) The taxes imposed in this section do not apply to:

(a) Amounts received by any taxpayer from the United States or any instrumentality thereof as prepayments for health care services provided under Title XVIII (medicare) of the federal social security act.

(b) Amounts received by any taxpayer from the state of Washington as prepayments for health care services provided under:

(i) The medical care services program as provided in RCW 74.09.035; or

(ii) The Washington basic health plan on behalf of subsidized enrollees as provided in chapter 70.47 RCW.

(c) Amounts received by any health care service contractor as defined in chapter 48.44 RCW, or any health maintenance organization as defined in chapter 48.46 RCW, as prepayments for health care services included within the definition of practice of dentistry under RCW 18.32.020, except amounts received for pediatric oral services that qualify as coverage for the minimum essential coverage requirement under P.L. 111-148 (2010), as amended, and for stand-alone family dental plans as defined in RCW 43.71.080(4)(a), only when offered in the individual market, as defined in *RCW 48.43.005(27), or to a small group, as defined in *RCW 48.43.005(33).

(d) Participant contributions to self-funded multiple employer welfare arrangements that are not taxable in this state.

(7) Beginning January 1, 2000, the state preempts the field of imposing excise or privilege taxes upon taxpayers and no county, city, town, or other municipal subdivision has the right to impose any such taxes upon such taxpayers. This subsection is limited to premiums and payments for health benefit plans offered by health care service contractors under chapter 48.44 RCW, health maintenance organizations under chapter 48.46 RCW, and self-funded multiple employer welfare arrangements as defined in RCW 48.125.010. The preemption authorized by this subsection must not impair the ability of a county, city, town, or other municipal subdivision to impose excise or privilege taxes upon the health care services directly delivered by the employees of a health maintenance organization under chapter 48.46 RCW.

(8)(a) The taxes imposed by this section apply to a self-funded multiple employer welfare arrangement only in the event that they are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the commissioner must initially request an advisory opinion from the United States department of labor or obtain a declaratory ruling from a federal court on the legality of imposing state premium taxes on these arrangements. Once the legality of the taxes has been determined, the multiple employer welfare arrangement certified by the insurance commissioner must begin payment of these taxes.

(b) If there has not been a final determination of the legality of these taxes, then beginning on the earlier of (i) the date the fourth multiple employer welfare arrangement has been certified by the insurance commissioner, or (ii) April 1, 2006, the arrangement must deposit the taxes imposed by this section into an interest bearing escrow account maintained by the arrangement. Upon a final determination that the taxes are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq., all funds in the interest bearing escrow account must be transferred to the state treasurer.

(9) The effect of transferring contracts for health care services from one taxpayer to another taxpayer is to transfer the tax prepayment obligation with respect to the contracts.

(10) On or before June 1st of each year, the commissioner must notify each taxpayer required to make prepayments in that year of the amount of each prepayment and must provide remittance forms to be used by the taxpayer. However, a taxpayer's responsibility to make prepayments is not affected by failure of the commissioner to send, or the taxpayer to receive, the notice or forms. [2016 c 133 § 2; 2013 2nd sp.s. c 6 § 5; 2013 c 325 § 3; 2011 c 47 § 8; 2009 c 479 § 41. Prior: 2005 c 405 § 1; 2005 c 223 § 6; 2005 c 7 § 1; 2004 c 260 § 24; 1998 c 323 § 1; 1997 c 154 § 1; 1993 sp.s. c 25 § 601; 1993 c 492 § 301.]

*Reviser's note: RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsections (27) and (33) to subsections (28) and (34), and effective January 1, 2020, changing subsections (27) and (33) to subsections (30) and (41).

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

Additional notes found at www.leg.wa.gov

48.14.021 Reduction of tax—Policies connected with pension, etc., plans exempt or qualified under internal revenue code. As to premiums received from policies or contracts issued in connection with a pension, annuity or profit-sharing plan exempt or qualified under sections 401, 403(b), 404, 408(b), or 501(a) of the United States internal revenue code, the rate of tax specified in RCW 48.14.020 shall be reduced twelve and one-half percent with respect to the tax payable in 1964, twenty-five percent with respect to the tax payable in 1965, thirty-seven and one-half percent with respect to the tax payable in 1966, fifty percent with respect to the tax payable in 1967, sixty-two and one-half percent with respect to the tax payable in 1968, seventy-five percent with respect to the tax payable in 1969, eighty-seven and one-half percent with respect to the tax payable in 1970, and one hundred percent with respect to the tax payable in 1971 and annually thereafter. [1975-'76 2nd ex.s. c 119 § 1; 1974 ex.s. c 132 § 1; 1963 c 166 § 1.]

48.14.022 Taxes—Exemptions and deductions. (1) The taxes imposed in RCW 48.14.020 and 48.14.0201 do not apply to premiums and prepayments collected or received for policies of insurance issued under RCW 48.41.010 through 48.41.210.

(2) In computing tax due under RCW 48.14.020 and 48.14.0201, there may be deducted from taxable premiums and prepayments the amount of any assessment against the taxpayer under RCW 48.41.010 through 48.41.210. Any portion of the deduction allowed in this section which cannot be deducted in a tax year without reducing taxable premiums below zero may be carried forward and deducted in successive years until the deduction is exhausted. [1995 c 304 § 1; 1987 c 431 § 23.]

Additional notes found at www.leg.wa.gov

48.14.025 Prepayment of tax obligations under RCW 48.14.020. (1) Every insurer with a tax obligation under RCW 48.14.020 shall make prepayment of the tax obligations under RCW 48.14.020 for the current calendar year's business, if the sum of the tax obligations under RCW

48.14.020 for the preceding calendar year's business is four hundred dollars or more.

(2) The commissioner shall credit the prepayment toward the appropriate tax obligations of the insurer for the current calendar year under RCW 48.14.020.

(3) The minimum amounts of the prepayments shall be percentages of the insurer's preceding calendar year's tax obligation recomputed using the rate in effect for the current year and shall be paid to the state treasurer through the commissioner's office by the due dates and in the following amounts:

- (a) On or before June 15, forty-five percent;
- (b) On or before September 15, twenty-five percent; and
- (c) On or before December 15, twenty-five percent.

For good cause demonstrated in writing, the commissioner may approve an amount smaller than the preceding calendar year's tax obligation as recomputed for calculating the insurer's prepayment obligations.

(4) The effect of transferring policies of insurance from one insurer to another insurer is to transfer the tax prepayment obligation with respect to the policies.

(5) On or before June 1 of each year, the commissioner shall notify each insurer required to make prepayments in that year of the amount of each prepayment and shall provide remittance forms to be used by the insurer. However, an insurer's responsibility to make prepayments is not affected by failure of the commissioner to send, or the insurer to receive, the notice or forms. [1986 c 296 § 2; 1982 c 181 § 4; 1981 c 6 § 1.]

Additional notes found at www.leg.wa.gov

48.14.027 Exemption for state health care premiums before July 1, 1990. The taxes imposed in RCW 48.14.020 do not apply to premiums collected or received before July 1, 1990, for medical and dental coverage purchased under chapter 41.05 RCW. [1988 c 107 § 32.]

Additional notes found at www.leg.wa.gov

48.14.030 Tax statement. The insurer shall file with the commissioner as part of its annual statement a statement of premiums so collected or received according to such form as shall be prescribed and furnished by the commissioner. In every such statement the reporting of premiums for tax purposes shall be on a written basis or on a paid-for basis consistent with the basis required by the annual statement. [1947 c 79 § .14.03; Rem. Supp. 1947 § 45.14.03.]

48.14.040 Retaliatory provision. (1) If pursuant to the laws of any other state or country, any taxes, licenses, fees, deposits, or other obligations or prohibitions, in the aggregate, or additional to or at a net rate in excess of any such taxes, licenses, fees, deposits or other obligations or prohibitions imposed by the laws of this state upon like foreign or alien insurers and their appointed insurance producers or title insurance agents, are imposed on insurers of this state and their appointed insurance producers or title insurance agents doing business in such other state or country, a like rate, obligation or prohibition may be imposed by the commissioner, as to any item or combination of items involved, upon all insurers of such other state or country and their appointed insurance producers or title insurance agents doing business

in this state, so long as such laws remain in force or are so applied.

(2) For the purposes of this section, an alien insurer may be deemed to be domiciled in the state wherein it has established its principal office or agency in the United States. If no such office or agency has been established, the domicile of the alien insurer shall be deemed to be the country under the laws of which it is formed.

(3) For the purposes of this section, the regulatory and insurance fraud surcharges imposed by RCW 48.02.190 shall not be included in the calculation of any retaliatory taxes, licenses, fees, deposits, or other obligations or prohibitions imposed under this section. [2020 c 195 § 3; 2008 c 217 § 7; 2007 c 153 § 4; 1988 c 248 § 8; 1949 c 190 § 21, part; 1947 c 79 § .14.04; Rem. Supp. 1949 § 45.14.04.]

Findings—Effective date—2020 c 195: See notes following RCW 48.02.190.

Additional notes found at www.leg.wa.gov

48.14.060 Failure to pay tax—Penalty. (1) Any insurer or taxpayer, as defined in RCW 48.14.0201, failing to file its tax statement and to pay the specified tax or prepayment of tax on premiums and prepayments for health care services by the last day of the month in which the tax becomes due shall be assessed a penalty of five percent of the amount of the tax; and if the tax is not paid within forty-five days after the due date, the insurer will be assessed a total penalty of ten percent of the amount of the tax; and if the tax is not paid within sixty days of the due date, the insurer will be assessed a total penalty of twenty percent of the amount of the tax. The tax may be collected by distraint, and the penalty recovered by any action instituted by the commissioner in any court of competent jurisdiction. The amount of any penalty collected must be paid to the state treasurer and credited to the general fund.

(2) In addition to the penalties set forth in subsection (1) of this section, interest will accrue on the amount of the unpaid tax or prepayment at the maximum legal rate of interest permitted under RCW 19.52.020 commencing sixty-one days after the tax is due until paid. This interest will not accrue on taxes imposed under RCW 48.15.120.

(3) The commissioner may revoke the certificate of authority or registration of any delinquent insurer or taxpayer, and the certificate of authority or registration will not be reissued until all taxes, prepayments of tax, interest, and penalties have been fully paid and the insurer or taxpayer has otherwise qualified for the certificate of authority or registration. [2003 c 341 § 1; 1981 c 6 § 2; 1947 c 79 § .14.06; Rem. Supp. 1947 § 45.14.06.]

48.14.070 Refunds. In event any person has paid to the commissioner any tax, license fee or other charge in error or in excess of that which he or she is lawfully obligated to pay, the commissioner shall upon written request made to him or her make a refund thereof. A person may only request a refund of taxes within six years from the date the taxes were paid. A person may only request a refund of fees or charges other than taxes within thirteen months of the date the fees or charges were paid. Refunds may be made either by crediting the amount toward payment of charges due or to become due from such person, or by making a cash refund. To facilitate

such cash refunds the commissioner may establish a revolving fund out of funds appropriated by the legislature for his use. [2009 c 549 § 7056; 1979 ex.s. c 130 § 2; 1947 c 79 § 14.07; Rem. Supp. 1947 § 45.14.07.]

48.14.080 Premium tax in lieu of other forms—Exceptions—Definition. (1) As to insurers, other than title insurers and taxpayers under RCW 48.14.0201, the taxes imposed by this title are in lieu of all other taxes, except as otherwise provided in this section.

(2) Subsection (1) of this section does not apply with respect to:

(a) Taxes on real and tangible personal property;

(b) Excise taxes on the sale, purchase, use, or possession of (i) real property; (ii) tangible personal property; (iii) extended warranties; (iv) services, including digital automated services as defined in RCW 82.04.192; and (v) digital goods and digital codes as those terms are defined in RCW 82.04.192; and

(c) The tax imposed in *RCW 82.04.260(9), regarding public and nonprofit hospitals.

(3) For the purposes of this section, the term "taxes" includes taxes imposed by the state or any county, city, town, municipal corporation, quasi-municipal corporation, or other political subdivision. [2010 1st sp.s. c 23 § 520; 2009 c 535 § 1102; 2006 c 278 § 2; 1998 c 312 § 1; 1993 sp.s. c 25 § 602; 1993 c 492 § 302; 1949 c 190 § 21, part; Rem. Supp. 1949 § 45.14.08.]

*Reviser's note: RCW 82.04.260 was amended by 2011 c 2 § 203 (Initiative Measure No. 1107), changing subsection (9) to subsection (10).

Findings—Intent—2010 1st sp.s. c 23: See notes following RCW 82.04.220.

Intent—Construction—2009 c 535: See notes following RCW 82.04.192.

Findings—Intent—2006 c 278: "The legislature finds that the insurance premiums tax is intended to be in lieu of any other tax imposed on insurers. However, insurers are not exempt from taxes on real and tangible personal property, or excise taxes on the sale, purchase, or use of such property. These provisions, enacted in 1949, have not been reviewed or altered in light of significant expansion of sales and use taxes to include taxation of many service activities. Some insurers have interpreted their obligation to pay retail sales and use taxes to be limited to those taxes imposed on the sale or use of tangible personal property. These insurers claim exemption from retail sales tax, use tax, or any other excise tax on the purchase or sale of services, such as telephone service, credit bureau services, construction services, landscape services, and repair services. Other insurers have consistently paid excise taxes imposed on these services.

The legislature further finds exempting insurers from excise taxes on the purchase or sale of services is inequitable and results from the inadvertent failure to revise insurance premiums tax statutes to be consistent with other excise tax statutes. The legislature declares its intent to require insurers to pay retail sales and use taxes on purchases of both tangible personal property or services, on the same terms as other taxpayers. This act is intended to apply both prospectively and retrospectively." [2006 c 278 § 1.]

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

Additional notes found at www.leg.wa.gov

48.14.090 Determining amount of direct premium taxable in this state. In determining the amount of direct premium taxable in this state other than for policies issued by an eligible captive insurer as defined in RCW 48.201.020, all such premiums written, procured, or received in this state shall be deemed written upon risks or property resident, situated, or to be performed in this state except such premiums as are properly allocated or apportioned and reported as taxable

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premiums of any other state or states. For tax purposes, the reporting of premiums shall be on a written basis or on a paid-for basis consistent with the basis required by the annual statement. [2021 c 281 § 11; 2009 c 161 § 4; 1963 c 195 § 14.]

Application—2021 c 281 §§ 8-11: See note following RCW 48.14.095.

Effective date—2021 c 281: See note following RCW 48.201.010.

48.14.095 Unlawful or delinquent insurers or taxpayers—Computing the tax payable—Risks, exposures, or enrolled participants only partially in state. (1) This section applies to any insurer or taxpayer, as defined in RCW 48.14.0201, violating or failing to comply with RCW 48.05.030(1), 48.17.060, 48.36A.290(1), 48.44.015(1), or 48.46.027(1).

(2) Except as provided in subsections (7) and (8) of this section, RCW 48.14.020, 48.14.0201, and 48.14.060 apply to insurers or taxpayers identified in subsection (1) of this section.

(3) If an insurance contract, health care services contract, or health maintenance agreement covers risks or exposures, or enrolled participants only partially in this state, the tax payable is computed on the portion of the premium that is properly allocated to a risk or exposure located in this state, or enrolled participants residing in this state.

(4) In determining the amount of taxable premiums under subsection (3) of this section, all premiums, other than premiums properly allocated or apportioned and reported as taxable premiums of another state, that are written, procured, or received in this state, or that are for a policy or contract negotiated in this state, are considered to be written on risks or property resident, situated, or to be performed in this state, or for health care services to be provided to enrolled participants residing in this state.

(5) Insurance on risks or property resident, situated, or to be performed in this state, or health coverage for the provision of health care services for residents of this state, is considered to be insurance procured, continued, renewed, or performed in this state, regardless of the location from which the application is made, the negotiations are conducted, or the premiums are remitted.

(6) Premiums on risks or exposures that are properly allocated to federal waters or international waters or under the jurisdiction of a foreign government are not taxable by this state.

(7) This section does not apply to premiums on insurance procured by a licensed surplus line broker under chapter 48.15 RCW.

(8) This section does not apply to premiums on insurance that is issued by a registered eligible captive insurer under chapter 48.201 RCW. [2021 c 281 § 8; 2008 c 217 § 8; 2003 c 341 § 3.]

Application—2021 c 281 §§ 8-11: "Sections 8 through 11 of this act apply both retroactively and prospectively." [2021 c 281 § 14.]

Effective date—2021 c 281: See note following RCW 48.201.010.

Additional notes found at www.leg.wa.gov

48.14.100 Foreign or alien insurers, continuing liability for taxes. Any foreign or alien insurer authorized to do business in this state which hereafter either withdraws from the state or has its certificate of authority suspended or

revoked shall continue to pay premium taxes pursuant to this chapter as to policies upon risks or property resident, situated, or to be performed in this state, which policies were issued during the time the insurer was authorized in this state. [1963 c 195 § 15.]

Chapter 48.15 RCW UNAUTHORIZED INSURERS

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48.15.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Affiliate" means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.

(2) "Affiliated group" means any group of entities that are all affiliated.

(3) With respect to an insured, an entity has "control" over another entity when:

(a) The entity directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote twenty-five percent or more of any class of voting securities of the other entity; or

(b) The entity controls in any manner the election of a majority of the directors or trustees of the other entity.

(4)(a) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(i) The person employs or retains a qualified risk manager to negotiate insurance coverage;

(ii) The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars in the immediately preceding twelve months; and

(iii) The person meets at least one of the following criteria:

(A) The person possesses a net worth in excess of twenty million dollars, as the amount is adjusted under (b) of this subsection;

(B) The person generates annual revenues in excess of fifty million dollars, as the amount is adjusted under (b) of this subsection;

(C) The person employs more than five hundred full-time or full-time equivalent employees per insured or is a member of an affiliated group employing more than one thousand employees in the aggregate;

(D) The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars, as the amount is adjusted under (b) of this subsection; or

(E) The person is a municipality with a population in excess of fifty thousand persons.

(b) The amounts in (a)(iii)(A), (B), and (D) of this subsection must be adjusted to reflect the percentage change for the five-year period in the consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor.

(c) For the purpose of this subsection, "commercial insurance" means property and casualty insurance pertaining to a business, profession, occupation, nonprofit organization, or public entity.

(5)(a) Except as provided in (b) of this subsection, "insured's home state" means, with respect to an insured:

(i) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(ii) If one hundred percent of the insured risk is located out of the state referred to in this subsection, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(b) If more than one insured from an affiliated group are named insureds on a single insurance contract issued by an unauthorized insurer, the term "insured's home state" means the insured's home state, as determined pursuant to (a) of this subsection, of the member of the affiliated group that has the largest percentage of premium attributed to it under the insurance contract.

(c) To determine the home state of the insured, the principal place of business is the state where the insured maintains its headquarters and where the insured's high-level officers direct, control, and coordinate the business activities of the insured.

(6) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

(a) The person is an employee of, or third-party consultant retained by, the commercial policyholder;

(b) The person provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance; and

(c) The person:

(i)(A) Has a bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field deter-

mined by the commissioner to demonstrate minimum competence in risk management; and

(B)(I) Has three years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance; or

(II) Has one of the following designations:

(AA) A designation as a chartered property and casualty underwriter (CPCU) issued by the American institute for CPCU/insurance institute of America;

(BB) A designation as an associate in risk management issued by the American institute for CPCU/insurance institute of America;

(CC) A designation as [a] certified risk manager issued by the national alliance for insurance education and research;

(DD) A designation as a RIMS fellow issued by the global risk management institute; or

(EE) Any other designation, certification, or license determined by the commissioner to demonstrate minimum competency in risk management;

(ii)(A) Has at least seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and

(B) Has any one of the designations specified in (c)(i)(B)(II)(AA) through (EE) of this subsection;

(iii) Has at least ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; or

(iv) Has a graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the commissioner to demonstrate minimum competence in risk management. [2011 c 31 § 1.]

Effective date—2011 c 31: "Sections 1, 2, and 4 through 9 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing institutions, and take effect July 21, 2011." [2011 c 31 § 12.]

48.15.015 Rules. The commissioner may adopt rules to implement and administer this chapter. [2009 c 162 § 12.]

Additional notes found at www.leg.wa.gov

48.15.020 Solicitation by unauthorized insurer prohibited—Personal liability. (1) An insurer that is not authorized by the commissioner may not solicit insurance business in this state or transact insurance business in this state, except as provided in this chapter.

(2)(a) A person may not, in this state, represent an unauthorized insurer except as provided in this chapter. This subsection does not apply to any adjuster or attorney-at-law representing an unauthorized insurer from time to time in this state in his or her professional capacity.

(b) A person, other than a duly licensed surplus line broker acting in good faith under his or her license, who makes a contract of insurance in this state, directly or indirectly, on behalf of an unauthorized insurer, without complying with the provisions of this chapter, is personally liable for the performance of such contract.

(3) Each violation of subsection (2) of this section constitutes a separate offense punishable by a fine of not more

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than twenty-five thousand dollars, and the commissioner, at the commissioner's discretion, may order replacement of policies improperly placed with an unauthorized insurer with policies issued by an authorized insurer. Violations may result in suspension or revocation of a license. [2003 c 250 § 2; 1992 c 149 § 1; 1983 1st ex.s. c 32 § 3; 1980 c 102 § 2; 1947 c 79 § .15.02; Rem. Supp. 1947 § 45.15.02.]

Additional notes found at www.leg.wa.gov

48.15.023 Unauthorized 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 an insurance contract.

(3) Any person who knowingly violates RCW 48.15.020(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 48.15.020(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 § 3.]

Additional notes found at www.leg.wa.gov

48.15.025 Application of other chapters to surplus line brokers. (1) A surplus line broker shall not engage in any act prohibited by RCW 48.05.465(2), 48.43.335(2), and chapter 48.30 RCW.

(2) A surplus line broker is entitled to the immunities granted under RCW 48.43.105 and 48.50.070.

(3) The rights and prohibitions applicable to insurance producers contained in RCW 48.30.260, 48.30.270, and 48.62.121 also apply to surplus line brokers.

(4) The exemption for taxes and fees in RCW 48.62.151 does not apply to surplus line brokers. [2009 c 162 § 8.]

Additional notes found at www.leg.wa.gov

48.15.030 Validity of contracts illegally effectuated. A contract of insurance effectuated by an unauthorized insurer in violation of the provisions of this code shall be voidable except at the instance of the insurer. [1947 c 79 § .15.03; Rem. Supp. 1947 § 45.15.03.]

48.15.039 National database—Surplus line brokers. When a national insurance producer database of the national association of insurance commissioners, or other equivalent uniform national database, for the licensure of surplus line

brokers is created, the commissioner may participate in the database. [2011 c 31 § 4.]

Effective date—2011 c 31: See note following RCW 48.15.010.

48.15.040 "Surplus line" coverage. If certain insurance coverages cannot be procured from authorized insurers, such coverages, hereinafter designated as "surplus lines," may be procured from unauthorized insurers subject to the following conditions:

(1) The insurance must be procured through a licensed surplus line broker under this chapter. If the insurance is property and casualty insurance, except industrial insurance under Title 51 RCW, then the insurance must be procured under the laws and rules of the insured's home state.

(2) The insurance must not be procurable, after diligent effort has been made to do so from among a majority of the insurers authorized to transact that kind of insurance in this state.

(3) Coverage shall not be procured from an unauthorized insurer for the purpose of securing a lower premium rate than would be accepted by any authorized insurer nor to secure any other competitive advantage.

(4) The commissioner may by regulation establish the degree of effort required to comply with subsections (2) and (3) of this section.

(5) At the time of procuring the insurance the surplus line broker must certify to the accuracy of the facts supporting the surplus line broker's diligent effort required in subsections (2) and (3) of this section.

(a) The certification must set forth the facts supporting the surplus line broker's diligent effort.

(b) The certification must state that under the penalty of suspension or revocation of the surplus line broker's license the facts contained in the certification are true and correct.

(c) The certification may be in electronic, digital, or another format as designated by the commissioner.

(d) The certification must be filed with the commissioner within sixty days after the insurance is procured. [2011 c 31 § 3; (2011 c 31 § 2 expired December 31, 2016); (2010 c 230 § 17 expired December 31, 2016); 1983 1st ex.s. c 32 § 4; 1947 c 79 § .15.04; Rem. Supp. 1947 § 45.15.04.]

Effective date—2011 c 31 § 3: "Section 3 of this act takes effect December 31, 2016." [2011 c 31 § 11.]

Expiration date—2011 c 31 § 2: "Section 2 of this act expires December 31, 2016." [2011 c 31 § 10.]

Effective date—2011 c 31: See note following RCW 48.15.010.

48.15.043 Diligent effort requirement—Exempt commercial purchaser. A surplus line broker seeking to procure from or place insurance with an unauthorized insurer for an exempt commercial purchaser is not required to satisfy the diligent effort requirement set forth in RCW 48.15.040 when:

(1) The surplus line broker or referring insurance producer procuring or placing the surplus line insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(2) The exempt commercial purchaser has subsequently requested in writing the surplus line broker or referring insur-

ance producer to procure or place such insurance from an unauthorized insurer.

(3) Records of the surplus line broker's satisfaction of the requirements of this section must be maintained in compliance with RCW 48.15.100. [2011 c 31 § 5.]

Effective date—2011 c 31: See note following RCW 48.15.010.

48.15.050 Endorsement of contract. Every insurance contract procured and delivered as a surplus line coverage pursuant to this chapter must have stamped upon it and be initialed by or bear the name of the surplus line broker who procured it, the following:

"This contract is registered and delivered as a surplus line coverage under the insurance code of the state of Washington, Title 48 RCW." [2015 c 132 § 1; 1947 c 79 § .15.05; Rem. Supp. 1947 § 45.15.05.]

48.15.060 Validity of contracts. Insurance contracts procured as surplus line coverage from unauthorized insurers in accordance with this chapter shall be fully valid and enforceable as to all parties, and shall be given recognition in all matters and respects to the same effect as like contracts issued by authorized insurers. [1947 c 79 § .15.06; Rem. Supp. 1947 § 45.15.06.]

48.15.070 Surplus line brokers—Licensing—Bond—Renewal. Any individual while a resident of this state, or any firm, corporation, or other business entity that has in its employ a qualified individual who is a resident of this state and who is authorized to exercise the powers of the firm or corporation, deemed by the commissioner to be competent and trustworthy, and while maintaining an office at a designated location in this state, may be licensed as a surplus line broker in accordance with this section.

(1) An applicant and a licensee for a resident surplus line broker license must have and maintain a license from the commissioner as a resident insurance producer with property and casualty lines of authority.

(2) Each applicant for a resident surplus line broker's license must pass the required examination and pay the required fee when applying for a license.

(3) If a nonresident that is licensed as a resident surplus line broker in another state moves to this state and wishes to become licensed as a resident surplus line broker in this state, then the examination requirement is waived if the application is received by the commissioner within ninety days of the cancellation of the surplus line broker's resident license in the other state.

(4) Application to the commissioner for the license must be made on forms furnished by the commissioner. As part of, or in connection with, this application, the applicant must 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. If in the process of verifying fingerprints, 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 must be paid to the commissioner's office by the applicant.

(5) Every resident surplus line broker licensed under this chapter must maintain a bond in favor of the state of Washington in the penal sum of twenty thousand dollars, with authorized corporate sureties approved by the commissioner, conditioned that the licensee will conduct business under the license in accordance with the provisions of this chapter and that the licensee will promptly remit the taxes provided by RCW 48.15.120. The licensee must maintain such bond in force for as long as the license remains in effect.

(6) Every resident surplus line broker licensed under this chapter must maintain in force while so licensed a bond in favor of the people of the state of Washington or a named insured such that the people of the state are covered by the bond, executed by an authorized corporate surety approved by the commissioner, in the amount of two thousand five hundred dollars, or five percent of the premiums from placement of coverage with surplus line insurers in the previous calendar year, whichever is greater, but not to exceed one hundred thousand dollars total aggregate liability. The bond may be continuous in form, and total aggregate liability on the bond may be limited to the required amount of the bond. The bond must be contingent on the accounting by the resident surplus line broker to any person requesting the broker to obtain insurance, for moneys or premiums collected in connection therewith. A bond issued in accordance with RCW 48.17.250 or with this subsection will satisfy the requirements of both RCW 48.17.250 and this subsection if the limit of liability is not less than the greater of the requirement of RCW 48.17.250 or the requirement of this subsection.

(7) Authorized surplus line brokers of a business entity may meet the requirements of subsection (6) of this section with a bond in the name of the business entity, continuous in form, and in the amount set forth in subsection (6) of this section.

(8) Surplus line brokers may meet the requirements of this section with a bond in the name of an association. The association must have been in existence for five years, have common membership, and have been formed for a purpose other than obtaining a bond. An individual surplus line broker remains responsible for assuring that a bond is in effect and is for the correct amount.

(9) Members of an association may meet the requirements of subsection (6) of this section with a bond in the name of the association that is continuous in form and in the amounts set forth in subsection (6) of this section for each participating member.

(10) The surety may cancel the bond and be released from further liability thereunder upon thirty days' written notice in advance to the principal. The cancellation does not affect any liability incurred or accrued under the bond before the termination of the thirty-day period.

(11) Failure to have and maintain the bonds required under subsections (5) and (6) of this section is grounds for revocation of a license under RCW 48.15.140.

(12) If a party injured under the terms of the bond required under subsection (6) of this section requests the surplus line broker to provide the name of the surety and the

bond number, the surplus line broker must provide the information within three working days after receiving the request.

(13) All records relating to the bonds required by this section must be kept available and open to the inspection of the commissioner at any business time.

(14) A surplus line broker's license expires if not timely renewed. Surplus line broker licenses are valid for the time period established by the commissioner unless suspended or revoked at an earlier date.

(15) Subject to the right of the commissioner to suspend, revoke, or refuse to renew any surplus line broker's license as provided in this title, the license may be renewed into another like period by filing with the commissioner by any means acceptable to the commissioner on or before the expiration date a request, by or on behalf of the licensee, for the renewal accompanied by payment of the renewal fee as specified in RCW 48.14.010.

(16) If the request and fee for renewal of a surplus line broker's license are filed with the commissioner prior to expiration of the existing license, the licensee may continue to act under the license, unless sooner revoked or suspended, until the issuance of a renewal license, or until the expiration of fifteen days after the commissioner has refused to renew the license and has mailed notification of the refusal to the licensee. If the request and fee for the license are not received by the expiration date, the authority conferred by the license ends on the expiration date.

(17) If the request for renewal of a surplus line broker's license and payment of the fee are not received by the commissioner prior to the expiration date, the applicant for renewal must pay to the commissioner in addition to the renewal fee, a surcharge as follows:

(a) For the first thirty days or part thereof of delinquency, the surcharge is fifty percent of the renewal fee; and

(b) For the next thirty days or part thereof of delinquency, the surcharge is one hundred percent of the renewal fee.

(18) If the request for renewal of a surplus line broker's license and payment of the renewal fee are not received by the commissioner after sixty days but prior to twelve months after the expiration date, the application must be for reinstatement of the license and the applicant for reinstatement must pay to the commissioner the license fee and a surcharge of two hundred percent of the license fee.

(19) Subsections (17) and (18) of this section do not exempt any person from any penalty provided by law for transacting business without a valid and subsisting license.

(20) An individual surplus line broker who allows his or her license to lapse may, within twelve months after the expiration date, reinstate the same license without the necessity of passing a written examination.

(21) For the purposes of this section, a "qualified individual" is a natural person who has met all the requirements that must be met by an individual surplus line broker.

(22) The commissioner may require any documents reasonably necessary to verify the information contained in an application and may, from time to time, require any licensed surplus line broker to produce the information called for in an application for license. [2017 c 49 § 1; 2010 c 18 § 1; 2009 c 162 § 3; 2002 c 227 § 3; 1994 c 131 § 3; 1983 1st ex.s. c 32 § 24; 1982 c 181 § 5; 1981 c 199 § 1; 1980 c 102 § 3; 1979 ex.s.

c 130 § 3; 1977 ex.s. c 182 § 2; 1959 c 225 § 4; 1947 c 79 § .15.07; Rem. Supp. 1947 § 45.15.07.]

Effective date—2017 c 49: "This act takes effect January 1, 2018." [2017 c 49 § 3.]

Additional notes found at www.leg.wa.gov

48.15.073 Nonresident surplus line brokers—Licensing—Reciprocity—Service of process. (1) The commissioner may license a nonresident person as a surplus line broker who is not a resident of this state if the person's resident state issues nonresident surplus line broker licenses to residents of this state on the same basis.

(2) A nonresident that holds a surplus line broker's license, or the equivalent, in the applicant's home state, and that license is in good standing is deemed qualified and meets the minimum standards of this state for licensing as a nonresident surplus line broker.

(3) Once a person has been issued a nonresident surplus line broker's license by the commissioner, the licensee must fulfill all the same responsibilities as a resident surplus line broker, except for bonding, and is subject to the (a) commissioner's supervision as though resident in this state and (b) rules adopted under this chapter.

(4) A nonresident surplus line broker's license expires if not timely renewed. A nonresident surplus line broker's license is valid for the time period established by the commissioner unless suspended or revoked at an earlier date. The request and fee for the renewal of the license is the same as the renewal and fee requirements for a resident surplus line broker licensed under RCW 48.15.070.

(5) Each licensed nonresident surplus line broker, by application for and issuance of a license, is deemed to have appointed the commissioner as the surplus line broker's attorney to receive service of legal process issued against the surplus line broker in this state upon causes of action arising within this state. Service upon the commissioner as attorney constitutes effective legal service upon the surplus line broker.

(a) The appointment of the commissioner as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the surplus line broker, and remains in effect for as long as there could be any cause of action against the surplus line broker arising out of the surplus line broker's insurance transactions in this state.

(b) Service of legal process must be accomplished and processed in the manner prescribed in RCW 48.02.200. [2017 c 49 § 2; 2010 c 18 § 2; 2009 c 162 § 4; 2001 c 91 § 1.]

Effective date—2017 c 49: See note following RCW 48.15.070.

Additional notes found at www.leg.wa.gov

48.15.080 Licensed surplus line broker may accept business. A licensed surplus line broker may accept and place surplus line business for any insurance producer licensed in this state for the kind of insurance involved, and may compensate that insurance producer therefor. [2008 c 217 § 9; 1947 c 79 § .15.08; Rem. Supp. 1947 § 45.15.08.]

Additional notes found at www.leg.wa.gov

48.15.085 Liability of insurer assuming direct risk.

(1) If pursuant to the surplus lines provisions of this chapter an insurer has assumed direct risk under a coverage and the

premium therefor has been paid to the broker who placed such insurance, the insurer shall be liable to the insured for unearned premiums payable upon cancellation of the insurance, whether or not the broker is indebted to the insurer for such premium or otherwise. This provision shall not affect rights as between the insurer and the broker.

(2) Each such insurer shall be deemed to have subjected itself to this section by acceptance of such direct risk. [1959 c 225 § 5.]

48.15.090 Solvent insurer required—Rules. (1) A surplus line broker must not knowingly place surplus line insurance with insurers unsound financially. The surplus line broker must ascertain the financial condition of the unauthorized insurer, and maintain written evidence thereof, before placing insurance therewith. The surplus line broker may only so insure with:

(a)(i) Any foreign insurer:

(A) That is authorized to write the kind of insurance in its domiciliary jurisdiction; and

(B) Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

(I) The minimum capital and surplus requirements under the laws of this state; or

(II) Fifteen million dollars.

(ii) The requirements of (a)(i)(B) of this subsection may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding must be based upon factors such as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. The commissioner is prohibited from making an affirmative finding of acceptability when the foreign insurer's capital and surplus is less than four million five hundred thousand dollars; or

(b) Any alien insurer that is listed on the quarterly listing of alien insurers maintained by the international insurers department of the national association of insurance commissioners.

(2) The commissioner may, by rule, prescribe the terms under which the foregoing financial requirements may be waived in circumstances where insurance cannot be otherwise procured on risks located in this state.

(3) For any violation of this section the surplus line broker may be fined not less than one hundred dollars or more than five thousand dollars, and in addition to or in lieu thereof the surplus line broker's license may be revoked, suspended, or nonrenewed. [2011 c 31 § 6; 1997 c 89 § 1; 1994 c 86 § 2; 1991 sp.s. c 5 § 2; 1980 c 102 § 4; 1975 1st ex.s. c 266 § 6; 1969 ex.s. c 241 § 10; 1955 c 303 § 5; 1947 c 79 § .15.09; Rem. Supp. 1947 § 45.15.09.]

Effective date—2011 c 31: See note following RCW 48.15.010.

Additional notes found at www.leg.wa.gov

48.15.100 Record of surplus line broker. (1) Each licensed surplus line broker shall keep a full and true record of each surplus line contract procured by him or her including a copy of the daily report, if any, showing such of the following items as may be applicable:

- (a) Amount of the insurance;
- (b) Gross premiums charged;
- (c) Return premium paid, if any;
- (d) Rate of premium charged upon the several items of property;
- (e) Effective date of the contract, and the terms thereof;
- (f) Name and address of the insurer;
- (g) Name and address of the insured;
- (h) Brief general description of property insured and where located;
- (i) Other information as may be required by the commissioner.

(2) All such records as to any particular transaction shall be kept available and open to the inspection of the commissioner at any business time during the five years next following the date of completion of such transaction.

(3) For the purpose of ascertaining its condition, or compliance with this title, the commissioner may as often as he or she deems advisable, examine the accounts, records, documents, and transactions of any surplus line broker as set forth in chapter 48.03 RCW. [2009 c 162 § 5; 1955 c 303 § 6; 1947 c 79 § .15.10; Rem. Supp. 1947 § 45.15.10.]

Additional notes found at www.leg.wa.gov

48.15.103 Use of business name—Place of business—Duties of surplus line broker. (1) A surplus line broker doing business under any name other than the surplus line broker's legal name is required to register the name in accordance with chapter 19.80 RCW and notify the commissioner before using the assumed name.

(2) Every licensed surplus line broker shall have and maintain in this state, or, if a nonresident surplus line broker, in this state or in the state of the licensee's domicile, a place of business accessible to the public. The place of business is where the surplus line broker principally conducts transactions under that person's license. A licensee maintaining more than one place of business in this state shall obtain a duplicate license or licenses for each additional place, and shall pay the full fee therefor.

(3) Any notice, order, or written communication from the commissioner to a person licensed under this chapter which directly affects the person's license shall be sent by mail to the person's last address of record with the commissioner.

(4) The license or licenses of each surplus line broker shall be displayed in a conspicuous place in that part of the place of business which is customarily open to the public.

(5) If a surplus line broker is dealing directly with the insured in any capacity, the surplus line broker must comply with the disclosure requirements contained in RCW 48.17.270.

(6) Every surplus line broker or other person licensed under this chapter shall promptly reply in writing to an inquiry of the commissioner relative to the business of insurance. A timely response is one that is received by the commissioner within fifteen business days from receipt of the inquiry. Failure to make a timely response constitutes a violation of this section.

(7) A surplus line broker shall report to the commissioner any administrative action taken against the surplus line broker in another jurisdiction or by another governmental

agency in this state within thirty days of the final disposition of the matter. This report must include a copy of the order, consent to order, or other relevant legal documents.

(8) Within thirty days of the initial pretrial hearing date, a surplus line broker shall report to the commissioner any criminal prosecution of the surplus line broker taken in any jurisdiction. The report must include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents. [2009 c 162 § 6.]

Additional notes found at www.leg.wa.gov

48.15.110 Broker's annual statement. (1) Each surplus line broker must on or before the first day of March of each year file with the commissioner a verified statement of all surplus line insurance transacted by him or her during the preceding calendar year.

(2) The statement must be in a form and format as prescribed by the commissioner and must show:

- (a) Aggregate of net premiums; and
- (b) Additional information as required by the commissioner.

(3) This section does not apply to property and casualty insurance procured by the surplus line broker when the insured's home state is a state other than this state. [2011 c 31 § 7; 2009 c 549 § 7058; 1955 c 303 § 7; 1947 c 79 § .15.11; Rem. Supp. 1947 § 45.15.11.]

Effective date—2011 c 31: See note following RCW 48.15.010.

48.15.120 Premium tax—Surplus lines. (1) On or before the first day of March of each year each surplus line broker must remit to the state treasurer through the commissioner a tax on the premiums, exclusive of sums collected to cover federal and state taxes and examination fees, on surplus line insurance subject to tax transacted by him or her during the preceding calendar year as shown by his or her annual statement filed with the commissioner, and at the same rate as is applicable to the premiums of authorized foreign insurers under this code. The tax when collected must be credited to the general fund.

(2) For property and casualty insurance other than industrial insurance under Title 51 RCW, when this state is the insured's home state:

(a) If the surplus line insurance covers risks or exposures located inside the United States, its territories, or both, the tax so payable must be computed upon the entire premium under subsection (1) of this section, without regard to whether the policy covers risks or exposures that are located in this state; and

(b) If the surplus line insurance covers risks or exposures located outside of the United States and its territories, no tax under subsection (1) of this section is due or payable for the premium properly allocable to the risks and exposures located outside the United States and its territories.

(3) For all other lines of insurance, if a surplus line policy covers risks or exposures only partially in this state, the tax so payable must be computed upon the proportion of the premium that is properly allocable to the risks or exposures located in this state. [2015 c 132 § 2; 2011 c 31 § 8; 2009 c 549 § 7059; 1947 c 79 § .15.12; Rem. Supp. 1947 § 45.15.12.]

Application—2011 c 31 § 8: "Section 8 of this act applies to all surplus line insurance policies with an effective date on or after July 21, 2011." [2011 c 31 § 9.]

Effective date—2011 c 31: See note following RCW 48.15.010.

48.15.130 Penalty for default. If any surplus line broker fails to file his or her annual statement, or fails to remit the tax provided by RCW 48.15.120, by the last day of the month in which the tax becomes due, the surplus line broker must pay the penalties provided in RCW 48.14.060(1). 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. [2003 c 341 § 2; 1983 1st ex.s. c 32 § 5; 1980 c 102 § 5; 1947 c 79 § .15.13; Rem. Supp. 1947 § 45.15.13.]

48.15.140 Revocation, suspension, or failure to renew surplus line broker's license—Civil penalty. (1) The commissioner may place on probation, revoke, suspend, or refuse to renew any surplus line broker's license, or may levy a civil penalty in accordance with RCW 48.17.560 or any combination of actions, for any one or more of the following causes:

(a) If the surplus line broker fails to file the licensee's annual statement or to remit the tax as required by this chapter; or

(b) If the surplus line broker fails to maintain an office in this state, or to keep the records, or to allow the commissioner to examine the licensee's records as required by this chapter; or

(c) For any of the causes for which an insurance producer's license may be revoked under chapter 48.17 RCW.

(2) The commissioner may suspend or revoke any such license whenever he or she deems suspension or revocation to be for the best interests of the people of this state.

(3) The procedures provided by this code for the suspension or revocation of insurance producers' licenses shall be applicable to suspension or revocation of a surplus line broker's license.

(4) A surplus line broker whose license has been so revoked shall not again be so licensed within one year thereafter, nor until any fines or delinquent taxes owing by the formal licensee have been paid. [2009 c 162 § 7; 2008 c 217 § 10; 1980 c 102 § 6; 1947 c 79 § .15.14; Rem. Supp. 1947 § 45.15.14.]

Additional notes found at www.leg.wa.gov

48.15.142 Suspension for failure to comply with support order. The commissioner shall immediately suspend the license or certificate of a person issued under this chapter who has been certified pursuant to RCW 74.20A.320 by the department of social and health services as a person who is not in compliance with a support order. If the person has continued to meet all other requirements for reinstatement during the suspension, reissuance of the license or certificate shall be automatic upon the commissioner's receipt of a release issued by the department of social and health services stating that the licensee is in compliance with the order. [2009 c 162 § 10.]

Additional notes found at www.leg.wa.gov

48.15.150 Legal process against surplus line insurer.

(1) For any cause of action arising in this state under any contract issued as a surplus line contract under this chapter, an unauthorized insurer must be sued in the superior court of the county in which the cause of action arose.

(2) An unauthorized insurer issuing a policy under this chapter has authorized service of process against it in the manner prescribed under RCW 48.02.200. Any policy must contain a provision designating the commissioner as the person upon whom service of process may be made.

(3) The insurer has forty days from the date of the service upon the commissioner within which to plead, answer, or otherwise defend the action. Upon service of process upon the commissioner in accordance with this section, the court has jurisdiction in personam of the insurer. [2011 c 47 § 9; 1979 ex.s. c 199 § 4; 1963 c 195 § 16; 1955 c 303 § 8; 1947 c 79 § .15.15; Rem. Supp. 1947 § 45.15.15.]

48.15.160 Exemptions from surplus line requirements. (1) The provisions of this chapter controlling the placing of insurance with unauthorized insurers shall not apply to reinsurance, to insurance issued by a registered eligible captive insurer under chapter 48.201 RCW, or to the following insurances when so placed by licensed insurance producers of this state:

(a) Ocean marine and foreign trade insurances.

(b) Insurance on subjects located, resident, or to be performed wholly outside of this state, or on vehicles or aircraft owned and principally garaged outside this state.

(c) Insurance on operations of railroads engaged in transportation in interstate commerce and their property used in such operations.

(d) Insurance of aircraft owned or operated by manufacturers of aircraft, or of aircraft operated in schedule interstate flight, or cargo of such aircraft, or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance or use of such aircraft.

(2) Insurance producers so placing any such insurance with an unauthorized insurer shall keep a full and true record of each such coverage in detail as required of surplus line insurance under this chapter and shall meet the requirements imposed upon a surplus line broker pursuant to RCW 48.15.090 and any regulations adopted thereunder. The record shall be preserved for not less than five years from the effective date of the insurance and shall be kept available in this state and open to the examination of the commissioner. The insurance producer shall furnish to the commissioner at the commissioner's request and on forms as designated and furnished by him or her a report of all such coverages so placed in a designated calendar year. [2021 c 281 § 9; 2008 c 217 § 11; 1987 c 185 § 23; 1985 c 264 § 5; 1949 c 190 § 22; 1947 c 79 § .15.16; Rem. Supp. 1949 § 45.15.16.]

Application—2021 c 281 §§ 8-11: See note following RCW 48.14.095.

Effective date—2021 c 281: See note following RCW 48.201.010.

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

Additional notes found at www.leg.wa.gov

48.15.170 Records of insureds—Inspection. Every person for whom insurance has been placed with an unauthorized insurer pursuant to or in violation of this chapter shall,

upon the commissioner's order, produce for his or her examination all policies and other documents evidencing the insurance, and shall disclose to the commissioner the amount of the gross premiums paid or agreed to be paid for the insurance. For each refusal to obey such order, such person shall be liable to a fine of not more than five hundred dollars. [2009 c 549 § 7060; 1947 c 79 § .15.17; Rem. Supp. 1947 § 45.15.17.]

48.15.180 Surplus line broker's fiduciary capacity—Violations. (1) A surplus line broker, its representative, or any person licensed under this chapter involved in the procuring or issuance of an insurance contract and who receives any funds representing premiums or return premiums which belong to or should be paid to another person as a result of or in connection with an insurance transaction is deemed to have been received in the surplus line broker's fiduciary capacity and shall:

(a) Report to the insurer the exact amount of consideration charged as premium for the contract, and the amount shall likewise be shown in the contract and in the records of the surplus line broker;

(b) Be promptly accounted for and paid to the insured, insurer, or person entitled to the funds;

(c) Be accounted for and maintained in a separate account from all other business and personal funds and not commingle or otherwise combine premiums with any other moneys, except a surplus line broker may commingle with premium funds any additional funds as the surplus line broker may deem prudent for the purpose of advancing premiums, establishing reserves for the paying of return premiums, or for any contingencies as may arise in the surplus line broker's business of receiving and transmitting premium or return premium funds.

(2) Each willful violation of this section constitutes a misdemeanor.

(3) Any surplus line broker or other person licensed under this chapter who, not being lawfully entitled thereto, diverts or appropriates funds received in a fiduciary capacity or any portion thereof to his or her own use, is guilty of theft under chapter 9A.56 RCW. [2009 c 162 § 9.]

Additional notes found at www.leg.wa.gov

48.15.185 Determination of qualifications and competence by state—Unlawful use of questions. It is unlawful for any unauthorized person to remove, reproduce, duplicate, or distribute in any form, any question used by the state of Washington to determine the qualifications and competence of surplus line brokers required by this title to be licensed. This section does not prohibit an insurance education provider from creating and using sample test questions in courses approved by the commissioner.

Any person violating this section is subject to penalties as provided by RCW 48.01.080 and 48.15.140. [2009 c 162 § 11.]

Additional notes found at www.leg.wa.gov

(2021 Ed.)

Chapter 48.16 RCW DEPOSITS OF INSURERS

Sections

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48.16.030	Securities eligible for deposit.
48.16.050	Commissioner's receipt—Records.
48.16.060	Transfer of securities.
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48.16.090	Dividends and substitutions.
48.16.100	Release of deposits—Generally.
48.16.110	Release of existing deposits.
48.16.120	Voluntary excess deposits.
48.16.130	Immunity from levy.

48.16.010 Deposits of insurers—In general. The commissioner shall accept deposits of securities or funds by insurers as follows:

(1) Deposits in amount as required to be made as prerequisite to a certificate of authority to transact insurance in this state.

(2) Deposits of domestic or alien insurers in amount as required to be made by the laws of other states as prerequisite for authority to transact insurance in such other states.

(3) Deposits in amounts as result from application of the retaliatory provision, RCW 48.14.040.

(4) Deposits in other additional amounts permitted to be made by this code. [1955 c 86 § 3; 1947 c 79 § .16.01; Rem. Supp. 1947 § 45.16.01.]

Additional notes found at www.leg.wa.gov

48.16.020 Deposits to be held in trust. Each such deposit shall be held by the commissioner in trust for the protection of all policyholders in the United States of the insurer making it; except that deposits of alien insurers shall be so held for the security of such insurer's obligations arising out of its insurance transactions in the United States, and except as to deposits the purpose of which may be further limited pursuant to the retaliatory provision, RCW 48.14.040. [1955 c 86 § 4; 1947 c 79 § .16.02; Rem. Supp. 1947 § 45.16.02.]

Additional notes found at www.leg.wa.gov

48.16.030 Securities eligible for deposit. All such deposits shall consist of cash funds or public obligations as specified in *RCW 48.13.040; except, that with respect to deposits held on account of registered policies heretofore issued, the commissioner may accept deposit of such other kinds of securities as are expressly required to be deposited by the terms of such policies. [1955 c 86 § 5; 1947 c 79 § .16.03; Rem. Supp. 1947 § 45.16.03.]

*Reviser's note: RCW 48.13.040 was repealed by 2011 c 188 § 22, effective July 1, 2012.

Additional notes found at www.leg.wa.gov

48.16.050 Commissioner's receipt—Records. (1) The commissioner shall deliver to the insurer a receipt for all funds and securities so deposited by it.

(2) The commissioner or the designated depository shall keep a record in permanent form of all funds and securities so deposited. [1955 c 86 § 6; 1947 c 79 § .16.05; Rem. Supp. 1947 § 45.16.05.]

Additional notes found at www.leg.wa.gov

48.16.060 Transfer of securities. (1) No transfer of any funds or security so held on deposit, whether voluntary or by operation of law, shall be valid unless approved in writing by the commissioner.

(2) A statement of each such transfer shall be entered on the records of the commissioner or designated depository, showing the name of the insurer from whose deposit such transfer is made, the name of the transferee, and the par value of the securities so transferred. [1955 c 86 § 7; 1947 c 79 § .16.06; Rem. Supp. 1947 § 45.16.06.]

Additional notes found at www.leg.wa.gov

48.16.070 Depositories—Designation. The commissioner may designate any solvent trust company or other solvent financial institution having trust powers as the commissioner's depository to receive and hold any deposit of securities. Any deposit so held shall be at the expense of the insurer. Any solvent financial institution having trust powers, the deposits of which are insured by the Federal Deposit Insurance Corporation, may be designated as the commissioner's depository to receive and hold any deposit of funds. All funds deposited shall be fully insured by the Federal Deposit Insurance Corporation. For purposes of this section, "solvent financial institution" means any national or state-chartered commercial bank or trust company, savings bank, or savings association, or branch or branches thereof, having trust powers located in this state and lawfully engaged in business. [1998 c 25 § 1; 1985 c 264 § 6; 1955 c 86 § 8; 1947 c 79 § .16.07; Rem. Supp. 1947 § 45.16.07.]

Additional notes found at www.leg.wa.gov

48.16.080 Liability for safekeeping. The state of Washington shall be responsible for the safekeeping and return of all funds and securities deposited pursuant to this chapter with the commissioner or in any such depository so designated by him or her. [2009 c 549 § 7061; 1955 c 86 § 9; 1947 c 79 § .16.08; Rem. Supp. 1947 § 45.16.08.]

Additional notes found at www.leg.wa.gov

48.16.090 Dividends and substitutions. While solvent and complying with this code an insurer shall be entitled:

(1) To collect and receive interest and dividends accruing on the securities so held on deposit for its account, and

(2) From time to time exchange and substitute for any of such securities, other securities eligible for deposit and of at least equal value. [1947 c 79 § .16.09; Rem. Supp. 1947 § 45.16.09.]

48.16.100 Release of deposits—Generally. (1) Any such required deposit shall be released in these instances only:

(a) Upon extinguishment of all liabilities of the insurer for the security of which the deposit is held, by reinsurance contract or otherwise.

(b) If any such deposit or portion thereof is no longer required under this code.

(c) If the deposit has been made pursuant to the retaliatory provision, RCW 48.14.040, it shall be released in whole or in part when no longer so required.

(d) Upon proper order of a court of competent jurisdiction the deposit shall be released to the receiver, conservator,

rehabilitator, or liquidator of the insurer for whose account the deposit is held.

(2) No such release shall be made except on application to and written order of the commissioner made upon proof satisfactory to him or her of the existence of one of such grounds therefor. The commissioner shall have no personal liability for any such release of any deposit or part thereof so made by him or her in good faith.

(3) All releases of deposits or any part thereof shall be made to the person then entitled thereto upon proof of title satisfactory to the commissioner.

(4) Deposits held on account of title insurers are subject further to the provisions of chapter 48.29 RCW. [2009 c 549 § 7062; 1947 c 79 § .16.10; Rem. Supp. 1947 § 45.16.10.]

48.16.110 Release of existing deposits. Any part of any deposit of an insurer held by the commissioner which is in amount in excess of the deposit required or permitted to be made by such insurer under this code, shall, upon written order of the commissioner, be released; except, that no deposit held on account of any registered policies heretofore issued by the insurer shall be released except in accordance with the conditions under which such deposit was made. [1955 c 86 § 10; 1947 c 79 § .16.11; Rem. Supp. 1947 § 45.16.11.]

Additional notes found at www.leg.wa.gov

48.16.120 Voluntary excess deposits. An insurer may deposit and maintain on deposit with the commissioner funds and eligible securities in amount exceeding its required deposit under this code by not more than one hundred thousand dollars, for the purpose of absorbing fluctuations in the value of securities held in its required deposit, and to facilitate the exchange and substitution of such required securities. During the solvency of the insurer any such excess deposit or any part thereof shall be released to it upon its request. During the insolvency of the insurer such excess deposit shall be released only as provided in RCW 48.16.100. [1955 c 86 § 11; 1947 c 79 § .16.12; Rem. Supp. 1947 § 45.16.12.]

Additional notes found at www.leg.wa.gov

48.16.130 Immunity from levy. No judgment creditor or other claimant of an insurer shall levy upon any deposit held pursuant to this chapter, or upon any part thereof. [1947 c 79 § .16.13; Rem. Supp. 1947 § 45.16.13.]

Chapter 48.17 RCW

INSURANCE PRODUCERS, TITLE INSURANCE AGENTS, AND ADJUSTERS

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- 48.17.902 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

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48.17.005 Rule making. The commissioner may adopt rules to implement and administer this chapter. [2007 c 117 § 35.]

48.17.010 Definitions. The definitions in this section apply throughout this title unless the context clearly requires otherwise.

(1) "Adjuster" means any person who either investigates and negotiates settlement relative to insurance claims, or

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applies the factual circumstances of an insurance claim to the insurance policy provisions, or both, arising under property and casualty insurance contracts. An attorney-at-law who adjusts insurance losses from time to time incidental to the practice of his or her profession or an adjuster of marine losses is not deemed to be an "adjuster" for the purpose of this chapter. A salaried employee of an insurer or of a managing general agent is not deemed to be an "adjuster" for the purpose of this chapter, except when acting as a crop adjuster. An appraiser or umpire functioning under the appraisal clause in an insurance contract is not deemed to be an "adjuster" for the purpose of this chapter.

(a) "Independent adjuster" means an adjuster representing the interests of the insurer.

(b) "Public adjuster" means an adjuster employed by and representing solely the financial interests of the insured named in the policy.

(c) "Crop adjuster" means an adjuster, including (i) an independent adjuster, (ii) a public adjuster, and (iii) an employee of an insurer or managing general agent, who acts as an adjuster for claims arising under crop insurance. A salaried employee of an insurer or of a managing general agent who is certified by a crop adjuster program approved by the risk management agency of the United States department of agriculture is not a "crop adjuster" for the purposes of this chapter. Proof of certification must be provided to the commissioner upon request.

(d) For the purposes of this chapter:

(i) "Appraiser" means a person selected by the insurer or the insured to place a value on or estimate the amount of loss under an appraisal clause in an insurance contract.

(ii) "Umpire" means a person selected by the appraisers representing the insurer and the insured, or, if the appraisers cannot agree, by the court, who is charged with resolving issues that the appraisers are unable to agree upon during the course of an appraisal.

(2) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(3) "Crop insurance" means insurance coverage for damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease, or other yield-reducing conditions or perils provided by the private insurance market, or multiple peril crop insurance reinsured by the federal crop insurance corporation, including but not limited to revenue insurance.

(4) "Home state" means the District of Columbia and any state or territory of the United States or province of Canada in which an insurance producer or adjuster maintains the insurance producer's or adjuster's principal place of residence or principal place of business, and is licensed to act as an insurance producer or adjuster.

(5) "Insurance education provider" means any insurer, health care service contractor, health maintenance organization, professional association, educational institution created by Washington statutes, or vocational school licensed under Title 28C RCW, or independent contractor to which the commissioner has granted authority to conduct and certify completion of a course satisfying the insurance education requirements of RCW 48.17.150.

(6) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance. "Insurance producer" does not include title insurance agents as defined in subsection (16) of this section or surplus line brokers licensed under chapter 48.15 RCW.

(7) "Insurer" has the same meaning as in RCW 48.01.050, and includes a health care service contractor as defined in RCW 48.44.010 and a health maintenance organization as defined in RCW 48.46.020.

(8) "License" means a document issued by the commissioner authorizing a person to act as an insurance producer or title insurance agent for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit to an insurer.

(9) "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, automobile dealer gap insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing the credit obligation that the commissioner determines should be designated a form of limited line credit insurance.

(10) "NAIC" means national association of insurance commissioners.

(11) "Negotiate" means the act of conferring directly with, or offering advice directly to, a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(12) "Person" means an individual or a business entity.

(13) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer.

(14) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular insurer.

(15) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of an insurance producer's authority to transact insurance.

(16) "Title insurance agent" means a business entity licensed under the laws of this state and appointed by an authorized title insurance company to sell, solicit, or negotiate insurance on behalf of the title insurance company.

(17) "Uniform application" means the current version of the NAIC uniform application for individual insurance producers for resident and nonresident insurance producer licensing.

(18) "Uniform business entity application" means the current version of the NAIC uniform application for business entity insurance license or registration for resident and nonresident business entities. [2021 c 22 § 1; 2012 c 211 § 4; 2010 c 67 § 2; 2009 c 162 § 13; 2007 c 117 § 1; 1985 c 264 § 7; 1981 c 339 § 9; 1947 c 79 § .17.01; Rem. Supp. 1947 § 45.17.01.]

Additional notes found at www.leg.wa.gov

48.17.060 License required. (1) A person shall not sell, solicit, or negotiate insurance in this state for any line or lines of insurance unless the person is licensed for that line of authority in accordance with this chapter.

(2) A person may not act as or hold himself or herself out to be an adjuster in this state unless licensed by the commissioner or otherwise authorized to act as an adjuster under this chapter.

(3) A person may not act as or hold himself or herself out to be a crop adjuster in this state unless licensed by the commissioner or otherwise authorized to act as a crop adjuster under this chapter. [2010 c 67 § 3; 2009 c 162 § 14; 2007 c 117 § 2; 2003 c 250 § 4; 1995 c 214 § 1; 1975 1st ex.s. c 266 § 7; 1955 c 303 § 9; 1947 c 79 § .17.06; Rem. Supp. 1947 § 45.17.06.]

Additional notes found at www.leg.wa.gov

48.17.062 Insurance producer license not required under chapter 117, Laws of 2007. (1) Nothing in chapter 117, Laws of 2007 shall be construed to require an insurer to obtain an insurance producer license. In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

(2) A license as an insurance producer is not required of the following:

(a) An officer, director, or employee of an insurer or of an insurance producer, provided that the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this state, and:

(i) The officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance; or

(ii) The officer, director, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(iii) The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers, and do not include the sale, solicitation, or negotiation of insurance;

(b) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and disability insurance; or for the purpose of enrolling individuals under plans; or issuing certificates under plans or otherwise assisting in administering plans; or performs administrative services related to mass marketed property and casualty insurance; where no commission is paid to the person for the service;

(c) An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, director, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers,

directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(d) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks, or in the supervision of the training of insurance producers, and who are not individually engaged in the sale, solicitation, or negotiation of insurance;

(e) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communication in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state;

(f) A person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that the person is otherwise licensed as an insurance producer to sell, solicit, or negotiate the insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state;

(g) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer, provided that the employee does not sell or solicit insurance or receive a commission; or

(h) Any person securing and forwarding information required for the purposes of group credit life and credit disability insurance or credit casualty insurance against loss or damage resulting from failure of debtors to pay their obligations in connection with an extension of credit and such other credit life and disability insurance or credit casualty insurance against loss or damage resulting from failure of debtors to pay their obligations as the commissioner shall determine, and where no commission or other compensation is payable on account of the securing and forwarding of such information. However, the reimbursement of a creditor's actual expenses for securing and forwarding information required for the purposes of such group insurance will not be considered a commission or other compensation if such reimbursement does not exceed three dollars per certificate issued, or in the case of a monthly premium plan extending beyond twelve months, not to exceed three dollars per loan transaction revision per year. [2007 c 117 § 3.]

48.17.063 Unlicensed activities—Acts committed in this state—Sanctions. (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 the state and relates to or involves an insurance contract, health care services contract, or health maintenance agreement.

(2) Any person who knowingly violates RCW 48.17.060 is guilty of a class B felony punishable under chapter 9A.20 RCW.

(3) 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.

(4)(a) If the commissioner has cause to believe that any person has violated the provisions of RCW 48.17.060, the commissioner may:

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

(ii) Suspend or revoke a license; and/or

(iii) 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. [2007 c 117 § 4; 2003 c 250 § 5.]

Additional notes found at www.leg.wa.gov

48.17.065 Application of chapter to insurance producers appointed by health care service contractors, health maintenance organizations, or both. The provisions of this chapter shall apply to insurance producers appointed by either health care service contractors or health maintenance organizations, or both. [2007 c 117 § 5; 1983 c 202 § 7.]

48.17.067 Determining whether authorization exists—Burden on insurance producer or title insurance agent. Any insurance producer or title insurance agent soliciting, negotiating, or procuring an application for insurance or health care services in this state must make a good faith effort to determine whether the entity that is issuing the coverage is:

(1) Authorized to transact insurance or health coverage in this state; or

(2) Conducting business through a surplus line broker licensed under chapter 48.15 RCW. [2007 c 117 § 6; 2003 c 250 § 6.]

Additional notes found at www.leg.wa.gov

48.17.071 Portable electronics—Application of chapter to adjusters—Duties of independent adjuster—Commissioner's authority. (1) An individual who collects claim information from, or furnishes claim information to, insureds or claimants, and who enters data is not an "adjuster" for the purpose of this chapter if both of the following are satisfied:

(a) The individual's claim-related activity is limited exclusively to claims originating from policies of insurance issued through a portable electronics insurance program as defined in RCW 48.120.005(6); and

(b) The individual is an employee of, and is supervised by, a person that is licensed as an independent adjuster. For purposes of this section, "employee" includes employees of entities under common ownership with the licensed person.

(2) The person that is licensed as an independent adjuster must maintain complete records of its employees engaged in the activity described in subsection (1) of this section and must comply with either (a) or (b) of this subsection:

(a) The person must submit a list of the names of all such employees to the commissioner on forms prescribed by the commissioner annually and must keep the list current by

reporting all changes, deletions, or additions within thirty days after the change, deletion, or addition occurred. Each list must be retained by the licensed independent adjuster for a period of three years from submission; or

(b) The person must maintain a system to track and document in the claim records each employee engaged in the activity described in subsection (1) of this section and, upon request of the commissioner, must identify the employee who has engaged in the activity.

(3) The person licensed as an independent adjuster must provide a training and education program for each employee engaged in the activity described in subsection (1) of this section prior to allowing the employee to engage in the activity. The training must include a section on compliance with applicable insurance laws for which a syllabus outlining the content of this section must be submitted to the commissioner for approval prior to use, and resubmitted for approval of any changes prior to use.

(4) The licensed independent adjuster that supervises the persons engaged in the activity described in subsection (1) of this section is responsible for their conduct. The commissioner may place on probation, revoke, suspend, or refuse to renew the adjuster's license of the independent adjuster, levy a civil penalty in accordance with RCW 48.17.560, or any combination of actions for any of the causes for which an adjuster's license may be revoked under chapter 48.17 RCW for the violation of any insurance laws, or any rule, subpoena, or order of the commissioner by a person engaged in the activity described in subsection (1) of this section who is employed by the licensed adjuster. [2012 c 154 § 6.]

48.17.090 Application for license—Commissioner's findings. (1) An individual applying for a resident insurance producer license shall make application to the commissioner on the uniform application and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. As a part of or in connection with the application, the individual applicant shall furnish information concerning the applicant's 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. If, in the process of verifying fingerprints, 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 commissioner's office by the applicant.

(2) Before approving the application, the commissioner shall find that the individual:

- (a) Is at least eighteen years of age;
- (b) Has not committed any act that is a ground for denial, suspension, or revocation set forth in RCW 48.17.530;
- (c) Has completed a preclicensing course of study for the lines of authority for which the person has applied;
- (d) Has paid the fees set forth in RCW 48.14.010; and
- (e) Has successfully passed the examinations for the lines of authority for which the person has applied.

(3) A resident business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the uniform business entity application, and the individual signing the application shall declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall find that:

(a) The business entity has paid the fees set forth in RCW 48.14.010;

(b) The business entity has designated a licensed insurance producer responsible for the business entity's compliance with the insurance laws and rules of this state; and

(c) The business entity has not committed any act that is a ground for denial, suspension, or revocation set forth in RCW 48.17.530.

(4) A resident business entity acting as a title insurance agent is required to obtain a title insurance agent license. Application shall be made to the commissioner on the uniform business entity application, and the individual submitting the application shall declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall find that the business entity:

(a) Has paid the fees set forth in RCW 48.14.010;

(b) Maintains a lawfully established place of business in this state;

(c) Is empowered to be a title insurance agent under a members' agreement, if a limited liability company, or by its articles of incorporation;

(d) Is appointed as an agent by one or more authorized title insurance companies; and

(e) Has complied with RCW 48.29.155 and 48.29.160.

(5) The commissioner may require any documents reasonably necessary to verify the information contained in an application and may, from time to time, require any licensed insurance producer or title insurance agent to produce the information called for in an application for license. [2009 c 162 § 15; 2007 c 117 § 7; 2002 c 227 § 2; 2001 c 56 § 1; 1982 c 181 § 6; 1981 c 339 § 10; 1967 c 150 § 15; 1947 c 79 § .17.09; Rem. Supp. 1947 § 45.17.09.]

Additional notes found at www.leg.wa.gov

48.17.110 Examination of applicants—Exemptions—Rules. (1) A resident individual applying for an insurance producer license or an individual applying for an adjuster, including crop adjuster, license shall pass a written examination unless exempt under this section or RCW 48.17.175. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer or adjuster, and the insurance laws and rules of this state. Examinations required by this section shall be developed and conducted under the rules prescribed by the commissioner.

(2) The following are exempt from the examination requirement:

(a) Applicants for licenses under RCW 48.17.170(1) (g), (h), and (i), at the discretion of the commissioner;

(b) With the exception of crop adjusters, applicants for an adjuster's license who for a period of one year, a portion of which was in the year next preceding the date of application, have been a full-time salaried employee of an insurer or of a managing general agent to adjust, investigate, or report claims arising under insurance contracts;

(c) With the exception of crop adjusters, applicants for a license as a nonresident adjuster who are duly licensed in another state and who are deemed by the commissioner to be fully qualified and competent for a similar license in this state; and

(d) Applicants for a license as a nonresident crop adjuster, who must:

(i) Be duly licensed as a crop adjuster, or hold a valid substantially similar license in another state; and

(ii) Have completed preclicensing education and passed an examination substantially similar to the preclicensing education and examination required for licensure as a resident crop adjuster in this state; or

(iii) If their state of residence does not license crop adjusters, complete preclicensing education and pass an examination that are substantially similar to the preclicensing education and examination required to be licensed as a resident crop adjuster in this state.

(3) The commissioner may make arrangements, including contracting with an outside testing service, for administering examinations.

(4) The commissioner may, at any time, require any licensed insurance producer, adjuster[,], or crop adjuster to take and successfully pass an examination testing the licensee's competence and qualifications as a condition to the continuance or renewal of a license, if the licensee has been guilty of violating this title, or has so conducted affairs under an insurance license as to cause the commissioner to reasonably desire further evidence of the licensee's qualifications.

(5) The commissioner may by rule establish requirements for crop adjusters to:

(a) Successfully complete preclicensing education;

(b) Pass a written examination to obtain a license; and

(c) Renew their license. [2010 c 67 § 4; 2009 c 162 § 16; 2007 c 117 § 8; 1990 1st ex.s. c 3 § 2; 1977 ex.s. c 182 § 3; 1967 c 150 § 16; 1965 ex.s. c 70 § 19; 1963 c 195 § 17; 1955 c 303 § 10; 1949 c 190 § 23; 1947 c 79 § .17.11; Rem. Supp. 1949 § 45.17.11.]

Additional notes found at www.leg.wa.gov

48.17.125 Examination questions—Confidentiality—Penalties. It is unlawful for any unauthorized person to remove, reproduce, duplicate, or distribute in any form, any question(s) used by the state of Washington to determine the qualifications and competence of insurance producers or adjusters required by Title 48 RCW to be licensed. This section shall not prohibit an insurance education provider from creating and using sample test questions in courses approved pursuant to RCW 48.17.150.

Any person violating this section shall be subject to penalties as provided by RCW 48.01.080, 48.17.530, and 48.17.560. [2007 c 117 § 9; 1989 c 323 § 1.]

Additional notes found at www.leg.wa.gov

(2021 Ed.)

48.17.150 Continuing education courses and requirements—Rules. (1) The commissioner shall by rule establish minimum continuing education requirements for the renewal or reissuance of a license to an insurance producer.

(2) The commissioner may by rule establish minimum continuing education requirements for the renewal or reissuance of a license to a crop adjuster, an independent adjuster, and a public adjuster.

(3) The commissioner shall require that continuing education courses will be made available on a statewide basis in order to ensure that persons residing in all geographical areas of this state will have a reasonable opportunity to attend such courses.

(4) The continuing education requirements must be appropriate to the license for the lines of authority specified in RCW 48.17.170 or by rule. [2021 c 22 § 2; 2010 c 67 § 5; 2009 c 162 § 17; 2007 c 117 § 10; 2005 c 223 § 7; 1994 c 131 § 4; 1988 c 248 § 9; 1979 ex.s. c 269 § 7; 1971 ex.s. c 292 § 47; 1967 c 150 § 19; 1961 c 194 § 4; 1947 c 79 § .17.15; Rem. Supp. 1947 § 45.17.15.]

Additional notes found at www.leg.wa.gov

48.17.153 Agents selling federal flood insurance policies—Training requirements. (1) All Washington state licensed insurance agents who sell federal flood insurance policies must comply with the minimum training requirements of section 207 of the flood insurance reform act of 2004, and basic flood education as outlined at 70 C.F.R. Sec. 52117, or such later requirements as are published by the federal emergency management agency.

(2) Licensed insurers shall demonstrate to the commissioner, upon request, that their licensed and appointed agents who sell federal flood insurance policies have complied with the minimum federal flood insurance training requirements. [2006 c 25 § 15.]

48.17.160 Appointment of agents—Approval—Termination—Fees. (1) An insurance producer or title insurance agent shall not act as an agent of an insurer unless the insurance producer or title insurance agent becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(2) To appoint an insurance producer or title insurance agent as its agent, the appointing insurer shall file, in a format approved by the commissioner, a notice of appointment within fifteen days from the date the agency contract is executed or the first insurance application is submitted, whichever is earlier.

(3) Upon receipt of the notice of appointment, the commissioner shall verify within a reasonable time, not to exceed thirty days, that the insurance producer or title insurance agent is eligible for appointment. If the insurance producer or title insurance agent is determined to be ineligible for appointment, the commissioner shall notify the insurer within ten days of the determination.

(4) An insurer shall pay an appointment fee, in the amount and method of payment set forth in RCW 48.14.010, for each insurance producer or title insurance agent appointed by the insurer.

[Title 48 RCW—page 95]

(5) Contingent upon payment of the appointment renewal fee as set forth in RCW 48.14.010, an appointment shall be effective until terminated by the insurer, insurance producer, or title insurance agent and notice has been given to the commissioner as required by RCW 48.17.595. [2009 c 162 § 18; 2007 c 117 § 11; 1994 c 131 § 5; 1990 1st ex.s. c 3 § 3; 1979 ex.s. c 269 § 2; 1967 c 150 § 20; 1959 c 225 § 6; 1955 c 303 § 13; 1947 c 79 § .17.16; Rem. Supp. 1947 § 45.17.16.]

Additional notes found at www.leg.wa.gov

48.17.170 Insurance producers', title insurance agents', and adjusters' licenses—Authorized lines of authority—Definitions—Form and content of licenses.

(1) Unless denied licensure under RCW 48.17.530, persons who have met the requirements of RCW 48.17.090 and 48.17.110 shall be issued an insurance producer license. An insurance producer may receive a license in one or more of the following lines of authority:

(a) "Life," which is insurance coverage on human lives, including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income;

(b) "Disability," which is insurance coverage for accident, health, and disability or sickness, bodily injury, or accidental death, and may include benefits for disability income;

(c) "Property," which is insurance coverage for the direct or consequential loss or damage to property of every kind;

(d) "Casualty," which is insurance coverage against legal liability, including that for death, injury, or disability or damage to real or personal property;

(e) "Variable life and variable annuity products," which is insurance coverage provided under variable life insurance contracts, variable annuities, or any other life insurance or annuity product that reflects the investment experience of a separate account;

(f) "Personal lines," which is property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;

(g) Limited lines:

(i) Surety;

(ii) Limited line credit insurance;

(iii) Travel;

(h) Specialty lines:

(i) Portable electronics;

(ii) Rental car;

(iii) Self-service storage; or

(i) Any other line of insurance permitted under state laws or rules.

(2) Unless denied licensure under RCW 48.17.530, persons who have met the requirements of RCW 48.17.090(4) shall be issued a title insurance agent license.

(3) All insurance producers', title insurance agents', and adjusters' licenses issued by the commissioner shall be valid for the time period established by the commissioner unless suspended or revoked at an earlier date.

(4) Subject to the right of the commissioner to suspend, revoke, or refuse to renew any insurance producer's, title insurance agent's, or adjuster's license as provided in this title, the license may be renewed into another like period by filing with the commissioner by any means acceptable to the

commissioner on or before the expiration date a request, by or on behalf of the licensee, for such renewal accompanied by payment of the renewal fee as specified in RCW 48.14.010.

(5) If the request and fee for renewal of an insurance producer's, title insurance agent's, or adjuster's license are filed with the commissioner prior to expiration of the existing license, the licensee may continue to act under such license, unless sooner revoked or suspended, until the issuance of a renewal license, or until the expiration of fifteen days after the commissioner has refused to renew the license and has mailed notification of such refusal to the licensee. If the request and fee for the license renewal are not received by the expiration date, the authority conferred by the license ends on the expiration date.

(6) If the request for renewal of an insurance producer's, title insurance agent's, or adjuster's license and payment of the fee are not received by the commissioner prior to the expiration date, the applicant for renewal shall pay to the commissioner, in addition to the renewal fee, a surcharge as follows:

(a) For the first thirty days or part thereof of delinquency, the surcharge is fifty percent of the renewal fee;

(b) For the next thirty days or part thereof of delinquency, the surcharge is one hundred percent of the renewal fee.

(7) If the request for renewal of an insurance producer's, title insurance agent's, or adjuster's license and fee for the renewal are received by the commissioner after sixty days but prior to twelve months after the expiration date, the application is for reinstatement of the license and the applicant for reinstatement must pay to the commissioner the license fee and a surcharge of two hundred percent of the license fee.

(8) Subsections (6) and (7) of this section do not exempt any person from any penalty provided by law for transacting business without a valid and subsisting license or appointment.

(9) An individual insurance producer, title insurance agent, or adjuster who allows his or her license to lapse may, within twelve months after the expiration date, reinstate the same license without the necessity of passing a written examination.

(10) A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance such as a long-term medical disability, may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

(11) The license shall contain the licensee's name, address, personal identification number, and the date of issuance, lines of authority, expiration date, and any other information the commissioner deems necessary.

(12) Licensees shall inform the commissioner by any means acceptable to the commissioner of a change of address within thirty days of the change. Failure to timely inform the commissioner of a change in legal name or address may result in a penalty under either RCW 48.17.530 or 48.17.560, or both. [2012 c 154 § 5. Prior: 2009 c 162 § 19; 2009 c 119 § 11; 2007 c 117 § 12; 1979 ex.s. c 269 § 3; 1947 c 79 § .17.17; Rem. Supp. 1947 § 45.17.17.]

Additional notes found at www.leg.wa.gov

48.17.173 Nonresident license request—Conditions for approval—Service of legal process. (1) Unless denied licensure under RCW 48.17.530, a nonresident person must receive a nonresident producer license for the line or lines of authority under RCW 48.17.170 which is substantially equivalent to the line or lines of authority granted to the nonresident person in the person's home state if:

- (a) The person is currently licensed as a resident and in good standing in the person's home state;
- (b) The person has submitted the proper request for licensure and has paid the fees required by RCW 48.14.010;
- (c) The person has submitted or transmitted to the commissioner a completed uniform application;
- (d) The person's home state awards nonresident producer licenses to residents of this state on the same basis; and
- (e) A business entity, it has designated an individual licensed insurance producer responsible for the business entity's compliance with the insurance laws and rules of this state.

(2) An individual, as part of the request for licensure, must furnish information concerning the individual's identity 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. If, in the process of verifying 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 must be paid to the commissioner's office by the applicant.

(3) A nonresident business entity acting as a title insurance agent is required to obtain a title insurance agent license. Application must be made to the commissioner on the uniform business entity application, and the individual submitting the application must declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner must find that the business entity:

- (a) Has paid the fees set forth in RCW 48.14.010;
- (b) Maintains a lawfully established place of business in its home state and holds a corresponding license issued by the state of its principal place of business, and has complied with the laws of this state governing the admission of foreign corporations;
- (c) Is empowered to be a title agent under a members' agreement, if a limited liability company, or by its articles of incorporation;
- (d) Is appointed as an agent by one or more authorized title insurance companies;
- (e) Has complied with RCW 48.29.155 and 48.29.160; and
- (f) Has designated an individual officer of the title insurance agent to be responsible for the business entity's compliance with the insurance laws and rules of this state.

(4) If the nonresident insurance producer applicant (a) has a valid license from the applicant's home state and (b) the applicant's home state awards nonresident insurance producer licenses to residents of this state on the same basis, the

commissioner must waive any license application requirements, except those imposed under this section.

(5) A nonresident insurance producer's satisfaction of the nonresident insurance producer's home state's continuing education requirements for licensed insurance producers constitutes satisfaction of this state's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis.

(6) The commissioner may verify the nonresident insurance producer's licensing status through the producer database maintained by the NAIC, its affiliates, or subsidiaries.

(7) A nonresident insurance producer who moves from one state to another state or a resident producer who moves from this state to another state must file a change of address and provide certification from the new resident state within thirty days of the change of legal residence. No fee or license application is required.

(8) A person licensed as a limited line credit insurance or other type of limited lines insurance producer in the person's home state and who complies with the requirements of subsection (1) of this section must receive a nonresident limited lines insurance producer license, under subsection (1) of this section, granting the same scope of authority as granted under the license issued by the insurance producer's home state. For the purpose of this subsection, "limited lines insurance" is any authority granted by the home state which restricts the authority of the license to the lines set out in RCW 48.17.170(1) (g) or (h).

(9) Each licensed nonresident insurance producer or title insurance agent, by application for and issuance of a license, is deemed to have appointed the commissioner as the insurance producer's or title insurance agent's attorney to receive service of legal process issued against the insurance producer or title insurance agent in this state upon causes of action arising within this state. Service upon the commissioner as attorney constitutes effective legal service upon the insurance producer or title insurance agent.

(a) The appointment of the commissioner as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the insurance producer or title insurance agent, and remains in effect for as long as there could be any cause of action against the insurance producer or title insurance agent arising out of the insurance producer's or title insurance agent's insurance transactions in this state.

(b) Service of legal process must be accomplished and processed in the manner prescribed in RCW 48.02.200.

(10) The commissioner may require any documents reasonably necessary to verify the information contained in an application and may, from time to time, require any licensed insurance producer or title insurance agent to produce the information called for in an application for license. [2010 c 18 § 3; 2009 c 162 § 20; 2007 c 117 § 13.]

Additional notes found at www.leg.wa.gov

48.17.175 In-state applicant has license in another state. (1) An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any preclicensing education or examination. This

exemption is only available if the person is currently licensed in that state or if the application is received within ninety days of the cancellation of the applicant's previous license, and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer database records, maintained by the NAIC, its affiliates, or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

(2) A person licensed as an insurance producer in another state who moves to this state shall make application within ninety days of establishing legal residence to become a resident licensee under RCW 48.17.090. No prelicensing education or examination shall be required of that person to obtain any line of authority previously held in the prior state except where the commissioner determines otherwise by rule. [2007 c 117 § 14.]

48.17.180 Doing business under any name other than legal name. An insurance producer or title insurance agent doing business under any name other than the insurance producer's or title insurance agent's legal name is required to register the name in accordance with chapter 19.80 RCW and notify the commissioner before using the assumed name. [2007 c 117 § 15; 1990 1st ex.s. c 3 § 4; 1979 ex.s. c 269 § 4; 1947 c 79 § .17.18; Rem. Supp. 1947 § 45.17.18.]

Title insurance agents, separate licenses for individuals not required: RCW 48.29.170.

Additional notes found at www.leg.wa.gov

48.17.250 Insurance producer's bond. (1) Every resident insurance producer licensed under this chapter on or after July 1, 2009, who places insurance either directly or indirectly with an insurer with which the insurance producer is not appointed as an agent must maintain in force while so licensed a bond in favor of the people of the state of Washington or a named insured such that the people of Washington are covered by the bond, executed by an authorized corporate surety approved by the commissioner, in the amount of two thousand five hundred dollars, or five percent of the premiums brokered in the previous calendar year, whichever is greater, but not to exceed one hundred thousand dollars total aggregate liability. The bond may be continuous in form, and total aggregate liability on the bond may be limited to the required amount of the bond. The bond must be contingent on the accounting by the resident insurance producer to any person requesting the resident insurance producer to obtain insurance, for moneys or premiums collected in connection therewith.

(2) Authorized insurance producers of a business entity may meet the requirements of this section with a bond in the name of the business entity, continuous in form, and in the amounts set forth in subsection (1) of this section. Insurance producers may meet the requirements of this section with a bond in the name of an association. The association must have been in existence for five years, have common membership, and have been formed for a purpose other than obtaining a bond. An individual insurance producer remains responsible for assuring that a bond is in effect and is for the correct amount.

(3) The surety may cancel the bond and be released from further liability thereunder upon thirty days' written notice in advance to the principal. The cancellation does not affect any liability incurred or accrued under the bond before the termination of the thirty-day period.

(4) The insurance producer's license may be revoked if the insurance producer acts without a bond that is required under this section.

(5) If a party injured under the terms of the bond requests the insurance producer to provide the name of the surety and the bond number, the insurance producer must provide the information within three working days after receiving the request.

(6) Members of an association may meet the requirements of this section with a bond in the name of the association that is continuous in form and in the amounts set forth in subsection (1) of this section for each participating member.

(7) All records relating to the bond required by this section must be kept available and open to the inspection of the commissioner at any business time. [2010 c 18 § 4; 2009 c 162 § 21; 2007 c 117 § 16; 1979 ex.s. c 269 § 8; 1977 ex.s. c 182 § 4; 1947 c 79 § .17.25; Rem. Supp. 1947 § 45.17.25.]

Additional notes found at www.leg.wa.gov

48.17.270 Insurance producer as insurer's agent—Compensation—Disclosure. (1) The sole relationship between an insurance producer and an insurer as to which the insurance producer is appointed as an agent shall, as to transactions arising during the existence of such agency appointment, be that of insurer and agent.

(2) Unless the agency-insurer agreement provides to the contrary, an insurance producer may receive the following compensation:

(a) A commission paid by the insurer;

(b) A fee paid by the insured; or

(c) A combination of commission paid by the insurer and a fee paid by the insured from which an insurance producer may offset or reimburse the insured for all or part of the fee.

(3) If the compensation received by an insurance producer who is dealing directly with the insured includes a fee, for each policy, the insurance producer must disclose in writing to the insured:

(a) The full amount of the fee paid by the insured;

(b) The full amount of any commission paid to the insurance producer by the insurer, if one is received;

(c) An explanation of any offset or reimbursement of fees or commissions as described in subsection (2)(c) of this section;

(d) When the insurance producer may receive additional commission, notice that states the insurance producer:

(i) May receive additional commission in the form of future incentive compensation from the insurer, including contingent commissions and other awards and bonuses based on factors that typically include the total sales volume, growth, profitability, and retention of business placed by the insurance producer with the insurer, and incentive compensation is only paid if the performance criteria established in the agency-insurer agreement is met by the insurance producer or the business entity with which the insurance producer is affiliated; and

(ii) Will furnish to the insured or prospective insured specific information relating to additional commission upon request; and

(e) The full name of the insurer that may pay any commission to the insurance producer.

(4) Written disclosure of compensation as required by subsection (3) of this section shall be provided by the insurance producer to the insured prior to the sale of the policy.

(5) Written disclosure as required by subsection (3) of this section must be signed by the insurance producer and the insured, and the writing must be retained by the insurance producer for five years. For the purposes of this section, written disclosure means the insured's written consent obtained prior to the insured's purchase of insurance. In the case of a purchase over the telephone or by electronic means for which written consent cannot be reasonably obtained, consent documented by the insurance producer shall be acceptable. [2009 c 162 § 22; 2007 c 117 § 17; 1994 c 203 § 1; 1993 c 455 § 1; 1981 c 339 § 13; 1947 c 79 § .17.27; Rem. Supp. 1947 § 45.17.27.]

Additional notes found at www.leg.wa.gov

48.17.380 Adjusters—Application form—Qualifications for license—Bond. (1) Application for a license to be an adjuster must be made to the commissioner upon forms furnished by the commissioner.

(a) As a part of or in connection with the application, each resident applicant, and nonresident applicant designating Washington as the applicant's home state must 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 record, purposes, and other pertinent facts, as the commissioner may reasonably require. If, in the process of verifying fingerprints, 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 must be paid to the commissioner's office by the applicant.

(b) A nonresident person holding an adjuster's license or equivalent in a state other than Washington that is the applicant's home state, or is designated as the applicant's home state, must comply with the requirements of this section, with the exception of the fingerprint requirement contained in (a) of this subsection.

(2) Any person willfully misrepresenting any fact required to be disclosed in any application shall be liable to penalties as provided by this code.

(3) The commissioner licenses as an adjuster only an individual or business entity which has otherwise complied with this code and the individual or responsible officer of the business entity has furnished evidence satisfactory to the commissioner that the individual or responsible officer of the business entity is qualified as follows:

(a) Is eighteen or more years of age;

(b) Is a bona fide resident of this state, or is a resident of a state which will permit residents of this state to act as adjusters in such other state;

(c) Is a trustworthy person;

(d) Has had experience or special education or training with reference to the handling of loss claims under insurance contracts, of sufficient duration and extent reasonably to make the individual or responsible officer of the business entity competent to fulfill the responsibilities of an adjuster;

(e) Has successfully passed any examination as required under this chapter;

(f) If for a public adjuster's license, has filed the bond required by RCW 48.17.430;

(g) If a nonresident business entity, has designated an individual licensed adjuster responsible for the business entity's compliance with the insurance laws and rules of this state.

(4) If an applicant's principal place of residence or principal place of business is located in a state or province that does not have laws governing adjusters substantially similar to those of this state, the applicant may designate this state or another state or province in which the applicant is licensed and acts as an adjuster to be the applicant's home state for the purposes of this chapter.

(5) If the applicant designates this state or another state or province as the applicant's home state, to be eligible for licensure in this state, the applicant must have satisfied the requirements for licensure as a resident adjuster under the laws of the applicant's designated home state.

(6)(a) Each licensed nonresident adjuster, by application for and issuance of a license, has appointed the commissioner as the adjuster's attorney to receive service of legal process against the adjuster in this state upon causes of action arising within this state. Service upon the commissioner as attorney constitutes effective legal service on the adjuster.

(b) The appointment of the commissioner as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the adjuster, and remains in effect for as long as there could be any cause of action against the adjuster arising out of the adjuster's transactions in this state. The service of process must be accomplished and processed in the manner prescribed under RCW 48.02.200.

(7) The commissioner may require any documents reasonably necessary to verify the information contained in an application and may, from time to time, require any licensed adjuster to produce the information called for in an application for a license. [2012 c 211 § 12; 2011 c 47 § 10; 2009 c 162 § 23; 2007 c 117 § 18; 1981 c 339 § 15; 1971 ex.s. c 292 § 48; 1947 c 79 § .17.38; Rem. Supp. 1947 § 45.17.38.]

Additional notes found at www.leg.wa.gov

48.17.390 Independent, public, or crop adjusters—Separate licenses. (1)(a) The commissioner may license:

(i) An individual or business entity as an independent adjuster or as a public adjuster;

(ii) An individual as a crop adjuster; and

(b) Separate licenses shall be required for each type of adjuster.

(2) An individual or business entity may be concurrently licensed under separate licenses as an independent adjuster and as a public adjuster.

(3) An individual may be concurrently licensed under separate licenses as an independent adjuster, a public adjuster, or a crop adjuster.

(4) The full license fee shall be paid for each such license. [2010 c 67 § 6; 2007 c 117 § 19; 1981 c 339 § 16; 1947 c 79 § .17.39; Rem. Supp. 1947 § 45.17.39.]

Additional notes found at www.leg.wa.gov

48.17.410 Authority of adjuster. An adjuster shall have authority under an adjuster's license only to either investigate and negotiate settlement relative to insurance claims, or apply the factual circumstances of an insurance claim to the insurance policy provisions, or both, to the adjuster's principal upon claims as limited under RCW 48.17.010(1) on behalf only of the insurers if licensed as an independent adjuster, or on behalf only of insureds if licensed as a public adjuster. An adjuster licensed concurrently as both an independent and a public adjuster shall not represent both the insurer and the insured in the same transaction. [2021 c 22 § 3; 2007 c 117 § 20; 1947 c 79 § .17.41; Rem. Supp. 1947 § 45.17.41.]

48.17.420 Appointed agent may adjust—When license or certification is required—Nonresident adjusters or crop adjusters. (1) An insurance producer or title insurance agent may from time to time act as an adjuster on behalf of and as authorized by an insurer for which an insurance producer or title insurance agent has been appointed as an agent and investigate and report upon claims without being required to be licensed as an adjuster. An insurance producer or title insurance agent must not act as a crop adjuster or investigate or report upon claims arising under crop insurance without first obtaining a crop adjuster license or, if a salaried employee of an insurer or of a managing general agent, without first being certified by a crop adjuster proficiency program approved by the risk management agency of the United States department of agriculture.

(2) Except for losses arising under crop insurance, a license by this state is not required of a nonresident independent adjuster, for the adjustment in this state of a single loss, or of losses arising out of a catastrophe common to all such losses from which the governor proclaims a state of emergency, if the nonresident independent adjuster registers with the commissioner as an emergency adjuster and includes:

- (a) The nonresident independent adjuster's name;
- (b) The nonresident independent adjuster's contact information;
- (c) The nonresident independent adjuster's home state and license number;
- (d) The single loss or specific proclamation from the governor that details the emergency; and
- (e) The insurers the nonresident independent adjuster is representing.

(3) An emergency adjuster:

- (a) Must not operate longer than one hundred eighty days, unless extended by the commissioner;
- (b) Is subject to all the disciplinary provisions and penalties of this title and Title 284 WAC; and
- (c) Is subject to the jurisdiction of the courts of the state of Washington concerning civil liability for all acts in any way related to the emergency adjuster's actions in Washington state.

(4) For losses arising under crop insurance, a license by this state is not required of a nonresident crop adjuster, for the

adjustment in this state of a single loss, or of losses arising out of a catastrophe common to all such losses, if the nonresident crop adjuster is:

- (a) Licensed as a crop adjuster in another state;
- (b) Certified by the risk management agency of the United States department of agriculture; or
- (c) A salaried employee of an insurer or of a managing general agent who is certified by a crop adjuster proficiency program approved by the risk management agency of the United States department of agriculture. [2021 c 22 § 4; 2010 c 67 § 7; 2007 c 117 § 21; 1947 c 79 § .17.42; Rem. Supp. 1947 § 45.17.42.]

Additional notes found at www.leg.wa.gov

48.17.430 Public adjuster's bond. (1) Prior to the issuance of a license as public adjuster, the applicant therefor shall file with the commissioner and shall thereafter maintain in force while so licensed a surety bond in favor of the people of the state of Washington, executed by an authorized corporate surety approved by the commissioner, in the amount of five thousand dollars. The bond may be continuous in form, and total aggregate liability on the bond may be limited to the payment of five thousand dollars. The bond shall be contingent on the accounting by the adjuster to any insured whose claim he or she is handling, for moneys or any settlement received in connection therewith.

(2) Any such bond shall remain in force until the surety is released from liability by the commissioner, or until canceled by the surety. Without prejudice to any liability accrued prior to cancellation, the surety may cancel a bond upon thirty days advance notice in writing filed with the commissioner.

(3) Such bond shall be required of any adjuster acting as a public adjuster as of the effective date of this code, or thereafter under any unexpired license heretofore issued. [2009 c 549 § 7063; 1977 ex.s. c 182 § 5; 1947 c 79 § .17.43; Rem. Supp. 1947 § 45.17.43.]

48.17.450 Place of business. (1) Every licensed insurance producer, title insurance agent, and adjuster, other than an insurance producer licensed for life or disability insurances only, shall have and maintain in this state, or, if a nonresident insurance producer or title insurance agent, in this state or in the state of the licensee's domicile, a place of business accessible to the public. Such place of business shall be that wherein the insurance producer or title insurance agent principally conducts transactions under that person's licenses. A licensee maintaining more than one place of business in this state shall obtain a duplicate license or licenses for each additional such place, and shall pay the full fee therefor.

(2) Any notice, order, or written communication from the commissioner to a person licensed under this chapter which directly affects the person's license shall be sent by mail to the person's last address of record with the commissioner. [2007 c 117 § 22; 1990 1st ex.s. c 3 § 5; 1988 c 248 § 11; 1953 c 197 § 6; 1947 c 79 § .17.45; Rem. Supp. 1947 § 45.17.45.]

48.17.460 Display of license. The license or licenses of each insurance producer, title insurance agent, or adjuster shall be displayed in a conspicuous place in that part of the

place of business which is customarily open to the public. [2007 c 117 § 23; 1947 c 79 § .17.46; Rem. Supp. 1947 § 45.17.46.]

48.17.470 Records of insurance producers, title insurance agents, adjusters. (1) Every insurance producer, title insurance agent, or adjuster shall retain a record of all transactions consummated under the license. This record shall be in organized form and shall include:

(a) If an insurance producer or title insurance agent:

(i) A record of each insurance contract procured or issued, together with the names of the insurers and insureds, the amount of premium paid or to be paid, and a statement of the subject of the insurance;

(ii) The names of any other licensees from whom business is accepted, and of persons to whom commissions or allowances of any kind are promised or paid.

(b) If an adjuster, a record of each investigation or adjustment undertaken or consummated, and a statement of any fee, commission, or other compensation received or to be received by the adjuster on account of such investigation or adjustment.

(c) Such other and additional information as shall be customary, or as may reasonably be required by the commissioner.

(2) All such records as to any particular transaction shall be kept available and open to the inspection of the commissioner at any business time during the five years immediately after the date of the completion of such transaction.

(3) This section shall not apply as to life or disability insurances. [2007 c 117 § 24; 1947 c 79 § .17.47; Rem. Supp. 1947 § 45.17.47.]

48.17.475 Licensee to reply promptly to inquiry by commissioner. Every insurance producer, title insurance agent, adjuster, or other person licensed under this chapter shall promptly reply in writing to an inquiry of the commissioner relative to the business of insurance. A timely response is one that is received by the commissioner within fifteen business days from receipt of the inquiry. Failure to make a timely response constitutes a violation of this section. [2007 c 117 § 25; 1967 c 150 § 13.]

48.17.480 Reporting and accounting for premiums.

(1) An insurance producer, title insurance agent, or any other representative of an insurer involved in the procuring or issuance of an insurance contract shall report to the insurer the exact amount of consideration charged as premium for such contract, and such amount shall likewise be shown in the contract and in the records of the insurance producer, title insurance agent, or other representative. Each willful violation of this provision is a misdemeanor.

(2) All funds representing premiums or return premiums received by an insurance producer or title insurance agent shall be so received in the insurance producer's or title insurance agent's fiduciary capacity, and shall be promptly accounted for and paid to the insured, insurer, title insurance agent, or insurance producer as entitled thereto.

(3) Any person licensed under this chapter who receives funds which belong to or should be paid to another person as a result of or in connection with an insurance transaction is

deemed to have received the funds in a fiduciary capacity. The licensee shall promptly account for and pay the funds to the person entitled to the funds.

(4) Any insurance producer, title insurance agent, adjuster, or other person licensed under this chapter who, not being lawfully entitled thereto, diverts or appropriates funds received in a fiduciary capacity or any portion thereof to his or her own use, is guilty of theft under chapter 9A.56 RCW. [2007 c 117 § 26; 2003 c 53 § 269; 1988 c 248 § 12; 1947 c 79 § .17.48; Rem. Supp. 1947 § 45.17.48.]

Intent—Effective date—2003 c 53: See notes following RCW 2.48.180.

48.17.490 Must be licensed to receive a commission, service fee, or other valuable consideration. (1) An insurance company, insurance producer, or title insurance agent shall not pay a commission, service fee, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter or chapter 48.15 RCW and is not so licensed.

(2) A person shall not accept a commission, service fee, or other valuable consideration for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter or chapter 48.15 RCW and is not so licensed.

(3) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this state if the person was required to be licensed under this chapter or chapter 48.15 RCW at the time of the sale, solicitation, or negotiation, and was so licensed at that time.

(4) An insurer, except a title insurer, or insurance producer may pay or assign commissions, service fees, or other valuable consideration to an insurance agency, or to persons who do not sell, solicit, or negotiate insurance in this state, unless the payment would violate RCW 48.30.140, 48.30.150, 48.30.155, 48.30.157, or 48.30.170. [2007 c 117 § 27; 1988 c 248 § 13; 1947 c 79 § .17.49; Rem. Supp. 1947 § 45.17.49.]

48.17.510 Temporary licenses—Restrictions—Commissioner's discretion. (1) The commissioner may issue a temporary insurance producer license for a period not to exceed one hundred eighty days without requiring an examination if the commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(a) To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the insurance producer or for the recovery or return of the insurance producer to the business, or to provide for the training and licensing of new personnel to operate the insurance producer's business;

(b) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license;

(c) To the designee of a licensed insurance producer entering active service in the armed forces of the United States; or

(d) In any other circumstance where the commissioner deems that the public interest will best be served by the issuance of this license.

(2) The commissioner may, by order, limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The commissioner may require the temporary licensee to have a suitable sponsor who is a licensed insurance producer or insurer and who assumes responsibility for all acts of the temporary licensee, and may impose other similar requirements designed to protect insureds and the public. The commissioner may, by order, revoke a temporary license if the interest of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representatives dispose of the business. [2007 c 117 § 28; 1982 c 181 § 7; 1955 c 303 § 15; 1953 c 197 § 8; 1947 c 79 § .17.51; Rem. Supp. 1947 § 45.17.51.]

Additional notes found at www.leg.wa.gov

48.17.530 Commissioner may place on probation, suspend, revoke, or refuse to issue or renew a license. (1) The commissioner may place on probation, suspend, revoke, or refuse to issue or renew an adjuster's license, an insurance producer's license, a title insurance agent's license, or any surplus line broker's license, or may levy a civil penalty in accordance with RCW 48.17.560 or any combination of actions, for any one or more of the following causes:

(a) Providing incorrect, misleading, incomplete, or materially untrue information in the license application;

(b) Violating any insurance laws, or violating any rule, subpoena, or order of the commissioner or of another state's insurance commissioner;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing insurance business;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(f) Having been convicted of a felony;

(g) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(h) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in this state or elsewhere;

(i) Having an insurance producer license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(j) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(k) Improperly using notes or any other reference material to complete an examination for an insurance license;

(l) Knowingly accepting insurance business from a person who is required to be licensed under this title and is not so licensed, other than orders for issuance of title insurance on property located in this state placed by a nonresident title insurance agent authorized to act as a title insurance agent in the title insurance agent's home state; or

(m) Obtaining a loan from an insurance client that is not a financial institution and who is not related to the insurance producer by birth, marriage, or adoption, except the commissioner may, by rule, define and permit reasonable arrangements.

(2) The license of a business entity may be suspended, revoked, or refused if the commissioner finds that an individual licensee's violation was known or should have been known by one or more of the partners, officers, or managers acting on behalf of the partnership or corporation, and the violation was neither reported to the commissioner nor corrective action taken.

(3) The commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this chapter and this title against any person who is under investigation for or charged with a violation of this chapter or this title, even if the person's license or registration has been surrendered or has lapsed by operation of law.

(4) The holder of any license which has been revoked or suspended shall surrender the license certificate to the commissioner at the commissioner's request.

(5) The commissioner may probate a suspension or revocation of a license under reasonable terms determined by the commissioner. In addition, the commissioner may require a licensee who is placed on probation to:

(a) Report regularly to the commissioner on matters that are the basis of the probation;

(b) Limit practice to an area prescribed by the commissioner; or

(c) Continue or renew continuing education until the licensee attains a degree of skill satisfactory to the commissioner in the area that is the basis of the probation.

(6) At any time during a probation term where the licensee has violated the probation order, the commissioner may:

(a) Rescind the probation and enforce the commissioner's original order; and

(b) Impose any disciplinary action permitted under this section in addition to or in lieu of enforcing the original order. [2007 c 117 § 29; 1973 1st ex.s. c 152 § 2; 1969 ex.s. c 241 § 11; 1967 c 150 § 23; 1947 c 79 § .17.53; Rem. Supp. 1947 § 45.17.53.]

Additional notes found at www.leg.wa.gov

48.17.535 License or certificate suspension—Non-compliance with support order—Reissuance. The commissioner shall immediately suspend the license or certificate of a person who has been certified pursuant to RCW 74.20A.320 by the department of social and health services as a person who is not in compliance with a support order or a *residential or visitation order. If the person has continued to meet all other requirements for reinstatement during the suspension, reissuance of the license or certificate shall be automatic upon the commissioner's receipt of a release issued by the department of social and health services stating that the licensee is in compliance with the order. [1997 c 58 § 857.]

*Reviser's note: 1997 c 58 § 886 requiring a court to order certification of noncompliance with residential provisions of a court-ordered parenting plan was vetoed. Provisions ordering the department of social and health ser-

vices to certify a responsible parent based on a court order to certify for non-compliance with residential provisions of a parenting plan were vetoed. See RCW 74.20A.320.

Effective dates—Intent—1997 c 58: See notes following RCW 74.20A.320.

Additional notes found at www.leg.wa.gov

48.17.540 Procedure to suspend, revoke, or refuse—Effect of conviction of felony. (1) The commissioner may revoke or refuse to renew any license issued under this chapter, or any surplus line broker's license, immediately and without hearing, upon sentencing of the licensee for conviction of a felony by final judgment of any court of competent jurisdiction, if the facts giving rise to such conviction demonstrate the licensee to be untrustworthy to maintain any such license.

(2) The commissioner may suspend, revoke, or refuse to renew any such license:

(a) By an order served by mail or personal service upon the licensee not less than fifteen days prior to the effective date thereof, subject to the right of the licensee to have a hearing as provided in RCW 48.04.010; or

(b) By an order on hearing made as provided in chapter 34.05 RCW, the Administrative Procedure Act, effective not less than ten days after the date of the service of the order, subject to the right of the licensee to appeal to the superior court.

(3) The commissioner may temporarily suspend such license by an order served by mail or by personal service upon the licensee not less than three days prior to the effective date thereof, provided the order contains a notice of revocation and includes a finding that the public safety or welfare imperatively requires emergency action. Such suspension shall continue only until proceedings for revocation are concluded. The commissioner also may temporarily suspend such license in cases where proceedings for revocation are pending if he or she finds that the public safety or welfare imperatively requires emergency action.

(4) Service by mail under this section shall mean 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. [1990 1st ex.s. c 3 § 6; 1989 c 175 § 113; 1988 c 248 § 14; 1982 c 181 § 8; 1973 1st ex.s. c 107 § 2; 1967 c 150 § 24; 1947 c 79 § .17.54; Rem. Supp. 1947 § 45.17.54.]

Additional notes found at www.leg.wa.gov

48.17.550 Duration of suspension. Every order suspending any such license shall specify the period during which suspension will be effective, and which period shall in no event exceed twelve months. [1947 c 79 § .17.55; Rem. Supp. 1947 § 45.17.55.]

48.17.560 Fines may be imposed. After hearing or upon stipulation by the licensee or insurance education provider, and in addition to or in lieu of the suspension, revocation, or refusal to renew any such license or insurance education provider approval, the commissioner may levy a fine upon the licensee or insurance education provider. (1) For each offense the fine shall be an amount not more than one

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thousand dollars. (2) The order levying such fine shall specify that the fine shall be fully paid not less than fifteen nor more than thirty days from the date of the order. (3) Upon failure to pay any such fine when due, the commissioner shall revoke the licenses of the licensee or the approval(s) of the insurance education provider, if not already revoked. 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. [1989 c 323 § 3; 1975 1st ex.s. c 266 § 8; 1967 c 150 § 25; 1947 c 79 § .17.56; Rem. Supp. 1947 § 45.17.56.]

Additional notes found at www.leg.wa.gov

48.17.563 Insurance education providers—Commissioner's approval—Renewal fee. (1) The commissioner may require insurance education providers to furnish specific information regarding their curricula, faculty, methods of monitoring attendance, and other matters reasonably related to providing insurance education under this chapter. The commissioner may grant approvals to such providers who demonstrate the ability to conduct and certify completion of one or more courses satisfying the insurance education requirements of RCW 48.17.150.

(2) Provider and course approvals are valid for the time period established by the commissioner and shall expire if not timely renewed. Each provider shall pay the renewal fee set forth in *RCW 48.14.010(1)(n). [2017 3rd sp.s. c 25 § 15; 1994 c 131 § 6; 1989 c 323 § 7.]

*Reviser's note: The reference to RCW 48.14.010(1)(n) appears to be erroneous. See RCW 48.14.010.

Additional notes found at www.leg.wa.gov

48.17.565 Insurance education providers—Violations—Costs awarded. If an investigation of any insurance education provider culminates in a finding by the commissioner or by any court of competent jurisdiction, that the insurance education provider has failed to comply with or has violated any statute or regulation pertaining to insurance education, the insurance education provider shall pay the expenses reasonably attributable and allocable to such investigation.

(1) The commissioner shall calculate such expenses and render a bill therefor by registered mail to the insurance education provider. Within thirty days after receipt of such bill, the insurance education provider shall pay the full amount to the commissioner. The commissioner shall transmit such payment to the state treasurer. The state treasurer shall credit the payment to the office of the insurance commissioner regulatory account, treating such payment as recovery of a prior expenditure.

(2) In any action brought under this section, if the commissioner prevails, the court may award to the office of the commissioner all costs of the action, including a reasonable attorneys' fee to be fixed by the court. [2009 c 162 § 24; 2007 c 117 § 30; 1989 c 323 § 4.]

Additional notes found at www.leg.wa.gov

48.17.568 Insurance education providers—Bond. In addition to the regulatory requirements imposed pursuant to RCW 48.17.150, the commissioner may require each insur-

ance education provider to post a bond, cash deposit, or irrevocable letter of credit. Every insurance education provider, other than an insurer, health care service contractor, health maintenance organization, or educational institution established by Washington statutes, is subject to the requirement.

(1) The provider shall file with each request for course approval and shall maintain in force while so approved, the bond, cash deposit, or irrevocable letter of credit in favor of the state of Washington, according to criteria which the commissioner shall establish by regulation. The amount of such bond, cash deposit, or irrevocable letter of credit, shall not exceed five thousand dollars for the provider's first approved course and one thousand dollars for each additional approved course.

(2) Proceeds from the bond, cash deposit, or irrevocable letter of credit shall inure to the commissioner for payment of investigation expenses or for payment of any fine ordered per Washington statutes or regulations governing insurance education: PROVIDED, That recoverable investigation expenses or fines shall not be limited to the amount of such required bond, cash deposit, or irrevocable letter of credit. [1989 c 323 § 5.]

Additional notes found at www.leg.wa.gov

48.17.591 Termination of agency contract—Effect on insured—Definition—Application of section. (1) No insurer authorized to do business in this state may cancel or refuse to renew any policy because that insurer's contract with the independent insurance producer through whom such policy is written has been terminated by the insurer, the insurance producer, or by mutual agreement.

(2) If an insurer intends to terminate a written agency contract with an independent insurance producer, the insurer shall give the insurance producer not less than one hundred twenty days' advance written notice of the intent, unless the reason for termination is one of the reasons set forth in RCW 48.17.530. During the notice period the insurer shall not amend the existing contract without the consent of the insurance producer.

(a) Unless the agency contract provides otherwise, during the one hundred twenty day notice period the independent insurance producer shall not write or bind any new business on behalf of the terminating insurer without specific written approval. However, routine adjustments by insureds are permitted. The terminating insurer shall permit renewal of all its policies in the insurance producer's book of business for a period of one year following the effective date of the termination, to the extent the policies meet the insurer's underwriting standards and the insurer has no other reason for non-renewal. The rate of commission for any policies renewed under this provision shall be the same as the insurance producer would have received had the agency agreement not been terminated.

(b) An independent insurance producer whose agency contract has been terminated shall have a reasonable opportunity to transfer affected policies to other insurers with which the insurance producer has an appointment: PROVIDED, HOWEVER, That prior to the conclusion of the one-year renewal period following the effective date of the termination, an insurer without a reason for not renewing an insured's policy and which has not received notification of the place-

ment of such policy with another insurer shall provide its insured with appropriate written notice of an offer to continue the policy. In such cases, except where the terminated insurance producer has placed the policy with another agent of the insurer, the insurer shall, where practical, assign the policy to an appointed insurance producer located reasonably near the insured willing to accept the assignment.

(c) An insurer is not required to continue the appointment of a terminated independent insurance producer during or after the one year renewal period. However, an insurance producer whose contract has been terminated by the insurer remains an agent of the terminating insurer as to actions associated with the policies subject to this section just as if the insurance producer were appointed by the insurer as its agent.

(3) In the absence of receipt of notice from the insured that coverage will not be continued with the existing insurer, an insurer whose agency contract has been terminated by an independent insurance producer, or by the mutual agreement of the insurer and the insurance producer, that elects to renew or lacks a reason not to renew, shall give the renewal notice required by chapter 48.18 RCW to affected insureds, and continue renewed coverage in accordance with the methods specified in subsection (2)(b) of this section. Insurance producers affected by this subsection may provide the notice to an insurer that an insured does not intend to continue existing coverage with the insurer, after receiving written authority to do so from an insured.

(4) For purposes of this section an "independent insurance producer" is a licensed insurance producer representing an insurer on an independent contractor basis and not as an employee. This term includes only those insurance producers not obligated by contract to place insurance accounts with a particular insurer or group of insurers.

(5) This section does not apply to:

(a) Insurance producers or policies of an insurer or group of insurers if the business is not owned by the insurance producer and the termination of any such contractual agreement does not result in the cancellation or nonrenewal of any policies of insurance;

(b) Managing general agents, to the extent that they are acting in that capacity;

(c) Life, disability, surety, ocean marine and foreign trade, and title insurance policies;

(d) Situations where the termination of the agency contract results from the insolvency or liquidation of the terminating insurer.

(6) No insurer may terminate its agency contract with an appointed insurance producer unless it complies with this section.

(7) Nothing contained in this section excuses an insurer from giving cancellation and renewal notices that may be required by chapter 48.18 RCW. [2007 c 117 § 31; 1990 c 121 § 1. Formerly RCW 48.18.285.]

48.17.595 Termination of business relationship with an insurance producer or title insurance agent—Notice—Confidentiality of information—Immunity from civil liability. (1) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract, or other insurance business relationship with an insurance producer or title insurance agent shall notify the com-

missioner within thirty days following the effective date of the termination, using a format prescribed by the commissioner, if the reason for termination is one of the reasons set forth in RCW 48.17.530 or the insurer has knowledge the insurance producer or title insurance agent was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in RCW 48.17.530. Upon the written request of the commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the insurance producer or title insurance agent.

(2) An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with an insurance producer or title insurance agent for any reason not set forth in RCW 48.17.530, shall notify the commissioner within thirty days following the effective date of the termination, using a format prescribed by the commissioner. Upon written request of the commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination.

(3) The insurer or the authorized representative of the insurer shall promptly notify the commissioner in a format acceptable to the commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the commissioner in accordance with subsection (1) of this section had the insurer then known of its existence.

(4) A copy of the notification to the commissioner shall be provided to the insurance producer or title insurance agent.

(a) Within fifteen days after making the notification required by subsections (1), (2), and (3) of this section, the insurer shall mail a copy of the notification to the insurance producer or title insurance agent at the insurance producer's or title insurance agent's last known address. If the insurance producer or title insurance agent is terminated for cause for any of the reasons listed in RCW 48.17.530, the insurer shall provide a copy of the notification to the insurance producer or title insurance agent at the insurance producer's or title insurance agent's last known address by certified mail, return receipt requested, postage prepaid, or by overnight delivery using a nationally recognized carrier.

(b) Within thirty days after the insurance producer or title insurance agent has received the original or additional notification, the insurance producer or title insurance agent may file written comments concerning the substance of the notification with the commissioner. The insurance producer or title insurance agent shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the insurance producer or title insurance agent as permitted under subsection (6) of this section.

(5) Immunities shall apply as follows:

(a) In the absence of actual malice, an insurer, the authorized representative of the insurer, an insurance producer, title insurance agent, the commissioner, or an organization of which the commissioner is a member and that compiles the information and makes it available to other insurance commissioners or regulatory or law enforcement agencies shall not be subject to civil liability, and a civil cause of action of

any nature shall not arise against these entities or their respective agents or employees, as a result of any statement or information required by or provided under this section, or any information relating to any statement that may be requested in writing by the commissioner, from an insurer, insurance producer, or title insurance agent; or a statement by a terminating insurer, insurance producer, or title insurance agent to an insurer, insurance producer, or title insurance agent limited solely and exclusively to whether a termination for cause under subsection (1) of this section was reported to the commissioner, provided that the propriety of any termination for cause under subsection (1) of this section is certified in writing by an officer or authorized representative of the insurer, insurance producer, or title insurance agent terminating the relationship.

(b) In any action brought against a person that may have immunity under (a) of this subsection for making any statement required by this section or providing any information relating to any statement that may be requested by the commissioner, the party bringing the action shall plead specifically in any allegation that (a) of this subsection does not apply because the person making the statement or providing the information did so with actual malice.

(c) Subsection (5)(a) or (b) of this section shall not abrogate or modify any existing statutory or common law privileges or immunities.

(6) Information provided under this section is confidential.

(a) Any documents, materials, or other information in the control or possession of the commissioner that is furnished by an insurer, insurance producer, title insurance agent, or an employee or agent thereof acting on behalf of the insurer, insurance producer, or title insurance agent, or obtained by the commissioner in an investigation pursuant to this section shall be confidential by law and privileged, shall not be subject to disclosure under chapter 42.56 RCW, shall not be subject to subpoena, and shall not be 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 duties.

(b) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential or privileged documents, materials, or information subject to (a) of this subsection.

(c) In order to assist in the performance of the commissioner's duties under chapter 117, Laws of 2007 and in accordance with RCW 48.02.065, the commissioner:

(i) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to (a) of this subsection, with other state, federal, and international regulatory agencies, with the NAIC, its affiliates, or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

(ii) May receive documents, materials, or information, including otherwise confidential and privileged documents,

materials, or information, from the NAIC, its affiliates, or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or 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, or information; and

(iii) May enter into agreements governing sharing and use of information consistent with this subsection.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (5)(c) of this section.

(e) Nothing in this chapter shall prohibit the commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to chapter 42.56 RCW to a database or other clearinghouse service maintained by the NAIC, its affiliates, or subsidiaries.

(7) An insurer, the authorized representative of the insurer, insurance producer, or title insurance agent that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked, and may be fined in accordance with this title. [2007 c 117 § 32.]

48.17.597 Administrative action taken against a licensee in another jurisdiction or governmental agency—Report to commissioner. (1) An insurance producer, title insurance agent, or adjuster shall report to the commissioner any administrative action taken against the insurance producer, title insurance agent, or adjuster in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

(2) Within thirty days of the initial pretrial hearing date, an insurance producer, title insurance agent, or adjuster shall report to the commissioner any criminal prosecution of the insurance producer, title insurance agent, or adjuster taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents. [2007 c 117 § 34.]

48.17.600 Separation of premium funds. (1) All funds representing premiums or return premiums received by an insurance producer or title insurance agent in the insurance producer's or title insurance agent's fiduciary capacity shall be accounted for and maintained in a separate account from all other business and personal funds.

(2) An insurance producer or title insurance agent shall not commingle or otherwise combine premiums with any other moneys, except as provided in subsection (3) of this section.

(3) An insurance producer or title insurance agent may commingle with premium funds any additional funds as the insurance producer or title insurance agent may deem prudent for the purpose of advancing premiums, establishing reserves for the paying of return premiums, or for any contingencies

as may arise in the insurance producer's or title insurance agent's business of receiving and transmitting premium or return premium funds.

(4) Each willful violation of this section shall constitute a misdemeanor. [2007 c 117 § 33; 1988 c 248 § 15; 1986 c 69 § 1.]

Additional notes found at www.leg.wa.gov

48.17.901 Effective date—2007 c 117. This act takes effect July 1, 2009. [2007 c 117 § 40.]

48.17.902 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 § 113.]

Chapter 48.18 RCW THE INSURANCE CONTRACT

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Exemptions of proceeds of insurance on exempt property: RCW 6.15.030.

False claims or proof: RCW 48.30.230.

Misrepresentation in application: RCW 48.30.210.

48.18.010 Scope of chapter. This chapter applies to insurances other than ocean marine and foreign trade insurances. [2005 c 337 § 2; 1947 c 79 § .18.01; Rem. Supp. 1947 § 45.18.01.]

Finding—Intent—2005 c 337: See note following RCW 48.18.030.

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48.18.020 Power to contract. (1) Any person eighteen years or older shall be considered of full legal age and may contract for or with respect to insurance. Any person seven-teen years or younger shall be considered a minor for purposes of Title 48 RCW.

(2) A minor not less than fifteen years of age as at nearest birthday may, notwithstanding such minority, contract for life or disability insurance on his or her own life or body, for his or her own benefit or for the benefit of his or her father, mother, spouse, child, brother, sister, or grandparent, and may exercise all rights and powers with respect to or under the contract as though of full legal age, and may surrender his or her interest therein and give a valid discharge for any benefit accruing or money payable thereunder. The minor shall not, by reason of his minority, be entitled to rescind, avoid, or repudiate the contract, or any exercise of a right or privilege thereunder, except, that such minor, not otherwise emancipated, shall not be bound by any unperformed agreement to pay, by promissory note or otherwise any premium on any such insurance contract. [2009 c 549 § 7064; 1973 1st ex.s. c 163 § 2; 1970 ex.s. c 17 § 4; 1947 c 79 § .18.02; Rem. Supp. 1947 § 45.18.02.]

48.18.030 Insurable interest—Personal insurances—Nonprofit organizations—Rules. (1) Any individual of competent legal capacity may insure his or her own life or body for the benefit of any person. A person may not insure the life or body of another individual unless the benefits under the contract are payable to the individual insured or the individual's personal representative, or to a person having, at the time when the contract was made, an insurable interest in the individual insured.

(2) If the beneficiary, assignee or other payee under any contract made in violation of this section receives from the insurer any benefits accruing upon the death, disability, or injury of the individual insured, the individual insured or the individual's executor or administrator may maintain an action to recover any benefits from the person receiving them.

(3)(a) "Insurable interest" as used in this section and in RCW 48.18.060 includes only the following interests:

(i) In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection; and

(ii) In the case of other persons, a lawful and substantial economic interest in having the life, health, or bodily safety of the individual insured continue, as distinguished from an interest that would arise only by, or would be enhanced in value by, the death, disability, or injury of the individual insured.

(b) An individual who is party to a contract or option for the purchase or sale of an interest in a business partnership or firm, or of shares of stock of a close corporation or of an interest in those shares, has an insurable interest in the life of each individual party to the contract and for the purposes of that contract only, in addition to any insurable interest that may otherwise exist as to the life of such individual.

(c) A guardian, trustee, or other fiduciary has an insurable interest in the life of any person for whose benefit the fiduciary holds property, and in the life of any other individual in whose life the person has an insurable interest.

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(d) Subject to rules adopted under subsection (4) of this section, upon joint application with a nonprofit organization for, or transfer to a nonprofit organization of, an insurance policy on the life of a person naming the organization as owner and beneficiary, a nonprofit organization's interest in the life of a person if:

(i) The nonprofit organization was established exclusively for religious, charitable, scientific, literary, or educational purposes, or to promote amateur athletic competition, to conduct testing for public safety, or to prevent cruelty to children or animals; and

(ii) The nonprofit organization:

(A) Has existed for a minimum of five years; or

(B) Has been issued a certificate of exemption to conduct a charitable gift annuity business under RCW 48.38.010, or is authorized to conduct a charitable gift annuity business under RCW 28B.10.485; or

(C) Has been organized, and at all times has been operated, exclusively for benefit of, to perform the functions of, or to carry out the purposes of one or more nonprofit organizations described in (d)(ii)(A) or (B) of this subsection and is operated, supervised, or controlled by or in connection with one or more of those nonprofit organizations; and

(iii) For a joint application, the person is not an employee, officer, or director of the organization who receives significant compensation from the organization and who became affiliated with the organization in that capacity less than one year before the joint application.

(4) The commissioner may adopt rules governing joint applications for, and transfers of, life insurance under subsection (3)(d) of this section. The rules may include:

(a) Standards for full and fair disclosure that set forth the manner, content, and required disclosure for the sale of life insurance issued under subsection (3)(d) of this section; and

(b) For joint applications, a grace period of thirty days during which the insured person may direct the nonprofit organization to return the policy and the insurer to refund any premium paid to the party that, directly or indirectly, paid the premium; and

(c) Standards for granting an exemption from the five-year existence requirement of subsection (3)(d)(ii)(A) of this section to a private foundation that files with the insurance commissioner documents, stipulations, and information as the insurance commissioner may require to carry out the purpose of subsection (3)(d) of this section.

(5) Nothing in this section permits the personal representative of the insured's estate to recover the proceeds of a policy on the life of a deceased insured person that was applied for jointly by, or transferred to, an organization covered by subsection (3)(d) of this section, where the organization was named owner and beneficiary of the policy.

This subsection applies to all life insurance policies applied for by, or transferred to, an organization covered by subsection (3)(d) of this section, regardless of the time of application or transfer and regardless of whether the organization would have been covered at the time of application or transfer. [2005 c 337 § 3; 1992 c 51 § 1; 1973 1st ex.s. c 89 § 3; 1947 c 79 § .18.03; Rem. Supp. 1947 § 45.18.03.]

Finding—Intent—2005 c 337: "The legislature finds that there is a long-standing principle that corporations have an insurable interest in the lives of key personnel. Nationally, some corporations have begun to insure

the lives of personnel that have not met the insurable interest standard of Washington. Entry-level workers have been insured by their corporate employer for the benefit of the corporate employer. The legislature intends to clarify this subject and preclude corporations from insuring the lives of employees when the employees are not key personnel and the corporations have no insurable interest in the lives of those employees." [2005 c 337 § 1.]

Use of trust funds by fiduciaries for life insurance: RCW 11.110.120.

48.18.040 Insurable interest—Property insurances.

(1) No contract of insurance on property or of any interest therein or arising therefrom shall be enforceable except for the benefit of persons having an insurable interest in the things insured.

(2) "Insurable interest" as used in this section means any lawful and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage. [1947 c 79 § .18.04; Rem. Supp. 1947 § 45.18.04.]

48.18.050 Named insured—Interest insured.

When the name of a person intended to be insured is specified in the policy, such insurance can be applied only to his or her own proper interest. This section shall not apply to life and disability insurances. [2009 c 549 § 7065; 1947 c 79 § .18.05; Rem. Supp. 1947 § 45.18.05.]

48.18.060 Application—Consent—When required.

A life or disability insurance contract upon an individual may not be made or take effect unless at the time the contract is made the individual insured applies for or consents to the contract in writing, except in the following cases:

(1) A spouse may insure the life of the other spouse.

(2) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may insure the life of the minor.

(3) A contract of group or blanket disability insurance may be effectuated upon an individual.

(4) A contract of group life insurance may be effectuated upon an individual, except as otherwise provided in RCW 48.18.580. [2005 c 337 § 5; 1947 c 79 § .18.06; Rem. Supp. 1947 § 45.18.06.]

Finding—Intent—2005 c 337: See note following RCW 48.18.030.

48.18.070 Alteration of application. (1) Any application for insurance in writing by the applicant shall be altered solely by the applicant or by his or her written consent, except that insertions may be made by the insurer for administrative purposes only in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant. Violation of this provision shall be a misdemeanor.

(2) Any insurer issuing an insurance contract upon such an application unlawfully altered by its officer, employee, or agent shall not have available in any action arising out of such contract, any defense which is based upon the fact of such alteration, or as to any item in the application which was so altered. [2009 c 549 § 7066; 1947 c 79 § .18.07; Rem. Supp. 1947 § 45.18.07.]

48.18.080 Application as evidence. (1) No application for the issuance of any insurance policy or contract shall be admissible in evidence in any action relative to such policy or contract, unless a true copy of the application was attached to

or otherwise made a part of the policy when issued and delivered. This provision shall not apply to policies or contracts of industrial life insurance.

(2) If any policy of life or disability insurance delivered in this state is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within fifteen days after receipt of such request at its home office or at any of its branch offices, deliver or mail to the person making such request, a copy of such application. If such copy is not so delivered or mailed, the insurer shall be precluded from introducing the application as evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal. [1947 c 79 § .18.08; Rem. Supp. 1947 § 45.18.08.]

48.18.090 Warranties and misrepresentations, effect of. (1) Except as provided in subsection (2) of this section, no oral or written misrepresentation or warranty made in the negotiation of an insurance contract, by the insured or in his or her behalf, shall be deemed material or defeat or avoid the contract or prevent it attaching, unless the misrepresentation or warranty is made with the intent to deceive.

(2) In any application for life or disability insurance made in writing by the insured, all statements therein made by the insured shall, in the absence of fraud, be deemed representations and not warranties. The falsity of any such statement shall not bar the right to recovery under the contract unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. [2009 c 549 § 7067; 1947 c 79 § .18.09; Rem. Supp. 1947 § 45.18.09.]

48.18.100 Forms of policies—Filing, certification, and approval—Exceptions. (1) No insurance policy form or application form where written application is required and is to be attached to the policy, or printed life or disability rider or endorsement form may be issued, delivered, or used unless it has been filed with and approved by the commissioner. This section does not apply to:

- (a) Surety bond forms;
- (b) Forms filed under RCW 48.18.103;
- (c) Forms exempted from filing requirements by the commissioner under RCW 48.18.103;
- (d) Manuscript policies, riders, or endorsements of unique character designed for and used with relation to insurance upon a particular subject;
- (e) Contracts of insurance procured under the provisions of chapter 48.15 RCW; or
- (f) Forms filed under the requirements of RCW 48.43.733.

(2) Every such filing containing a certification, in a form approved by the commissioner, by either the chief executive officer of the insurer or by an actuary who is a member of the American academy of actuaries, attesting that the filing complies with Title 48 RCW and Title 284 of the Washington Administrative Code, may be used by the insurer immediately after filing with the commissioner. The commissioner may order an insurer to cease using a certified form upon the grounds set forth in RCW 48.18.110. This subsection does

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not apply to certain types of policy forms designated by the commissioner by rule.

(3) Except as provided in RCW 48.18.103 and 48.43.733, every filing that does not contain a certification pursuant to subsection (2) of this section must be made not less than thirty days in advance of issuance, delivery, or use. At the expiration of the thirty days, the filed form 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 form, by giving notice of the extension before expiration of the initial thirty-day period. At the expiration of the period that has been extended, and in the absence of prior affirmative approval or disapproval, the form shall be deemed approved. The commissioner may withdraw any approval at any time for cause. By approval of any form for immediate use, the commissioner may waive any unexpired portion of the initial thirty-day waiting period.

(4) The commissioner's order disapproving any form or withdrawing a previous approval must state the grounds for disapproval.

(5) No form may knowingly be issued or delivered as to which the commissioner's approval does not then exist.

(6) The commissioner may, by rule, exempt from the requirements of this section any class or type of insurance policy forms if filing and approval is not desirable or necessary for the protection of the public.

(7) Every member or subscriber to a rating organization must adhere to the form filings made on its behalf by the organization. Deviations from the organization are permitted only when filed with the commissioner in accordance with this chapter.

(8) Medical malpractice insurance form filings are subject to the provisions of this section.

(9) Variable contract forms; disability insurance policy forms; individual life insurance policy forms; life insurance policy illustration forms; industrial life insurance contract, individual medicare supplement insurance policy, and long-term care insurance policy forms, which are amended solely to comply with the changes in nomenclature required by RCW 48.18A.035, 48.20.013, 48.20.042, 48.20.072, 48.23.380, 48.23A.040, 48.23A.070, 48.25.140, 48.66.120, and 48.76.090 are exempt from this section. [2015 c 19 § 2; 2008 c 217 § 12; 2006 c 8 § 214; 2005 c 223 § 8; 1997 c 428 § 3; 1989 c 25 § 1; 1982 c 181 § 16; 1947 c 79 § .18.10; Rem. Supp. 1947 § 45.18.10.]

Intent—2015 c 19: "It is the intent of the legislature to enhance competition and create regulatory uniformity in the filing requirements for group health benefit plans other than small group plans, as well as stand-alone dental plan and stand-alone vision plan rates and forms in order to increase competition among carriers and provide a more competitive market for these products." [2015 c 19 § 1.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

Format of disability policies: RCW 48.20.012.

Additional notes found at www.leg.wa.gov

48.18.103 Forms of commercial property casualty policies—Legislative intent—Issuance prior to filing—Disapproval by commissioner—Definition. (1) It is the

intent of the legislature to assist the purchasers of commercial property casualty insurance by allowing policies to be issued more expeditiously and provide a more competitive market for forms.

(2) Commercial property casualty policies may be issued prior to filing the forms.

(3) All commercial property casualty forms must be filed with the commissioner within thirty days after an insurer issues any policy using them. This subsection does not apply to:

(a) Types or classes of forms that the commissioner exempts from filing by rule; and

(b) Manuscript policies, riders, or endorsements of unique character designed for and used with relation to insurance upon a particular subject.

(4) If, within thirty days after a commercial property casualty form has been filed, the commissioner finds that the form does not meet the requirements of this chapter, the commissioner shall disapprove the form and give notice to the insurer or rating organization that made the filing, specifying how the form fails to meet the requirements and stating when, within a reasonable period thereafter, the form shall be deemed no longer effective. The commissioner may extend the time for review an additional fifteen days by giving notice to the insurer prior to the expiration of the original thirty-day period.

(5) Upon a final determination of a disapproval of a policy form under subsection (4) of this section, the insurer must amend any previously issued disapproved form by endorsement to comply with the commissioner's disapproval.

(6) For purposes of this section, "commercial property casualty" means insurance pertaining to a business, profession, occupation, nonprofit organization, or public entity for the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, or 48.11.070, but does not mean medical malpractice insurance or portable electronics insurance as defined in RCW 48.120.005.

(7) Except as provided in subsection (5) of this section, the disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice of disapproval.

(8) Every member or subscriber to a rating organization must adhere to the form filings made on its behalf by the organization. An insurer may deviate from forms filed on its behalf by an organization only if the insurer files the forms with the commissioner in accordance with this chapter.

(9) In the event a hearing is held on the actions of the commissioner under subsection (4) of this section, the burden of proof shall be on the commissioner. [2013 c 152 § 1; 2006 c 8 § 215; 2005 c 223 § 9; 2003 c 248 § 4; 1997 c 428 § 1.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

48.18.110 Grounds for disapproval. (1) The commissioner shall disapprove any such form of policy, application, rider, or endorsement, or withdraw any previous approval thereof, only:

(a) If it is in any respect in violation of or does not comply with this code or any applicable order or regulation of the commissioner issued pursuant to the code; or

(b) If it does not comply with any controlling filing theretofore made and approved; or

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

(d) If it has any title, heading, or other indication of its provisions which is misleading; or

(e) If purchase of insurance thereunder is being solicited by deceptive advertising.

(2) In addition to the grounds for disapproval of any such form as provided in subsection (1) of this section, the commissioner may disapprove any form of disability insurance policy if the benefits provided therein are unreasonable in relation to the premium charged. 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 insurer has filed the documents required in RCW 48.20.025(2) and any rules adopted pursuant thereto, the filing shall be deemed approved. [2008 c 303 § 1; 2000 c 79 § 2; 1985 c 264 § 9; 1982 c 181 § 9; 1947 c 79 § .18.11; Rem. Supp. 1947 § 45.18.11.]

Additional notes found at www.leg.wa.gov

48.18.120 Standard forms. (1) The commissioner shall, after hearing, from time to time promulgate such rules and regulations as may be necessary to define and effect reasonable uniformity in all basic contracts of fire insurance which are commonly known as the standard form fire policies and may be so referred to in this code, and the usual supplemental coverages, riders, or endorsements thereon or thereto, to the end that such definitions shall be applied in the construction of the various sections of this code wherein such terms are used and that there be a reasonable concurrency of contract where two or more insurers insure the same subject and risk. All such forms heretofore approved by the commissioner and for use as of immediately prior to the effective date of this code, may continue to be so used until the further order of the commissioner made pursuant to this subsection or pursuant to any other provision of this code.

(2) The commissioner may from time to time, after hearing, promulgate such rules and regulations as he or she deems necessary to establish reasonable minimum standard conditions and terminology for basic benefits to be provided by disability insurance contracts which are subject to chapters 48.20 and 48.21 RCW, for the purpose of expediting his or her approval of such contracts pursuant to this code. No such promulgation shall be inconsistent with standard provisions as required pursuant to RCW 48.18.130, nor contain requirements inconsistent with requirements relative to the same benefit provision as formulated or approved by the National Association of Insurance Commissioners. [2009 c 549 § 7068; 1957 c 193 § 10; 1947 c 79 § .18.12; Rem. Supp. 1947 § 45.18.12.]

48.18.125 Loss payable and mortgagee clauses for property and automobile physical damage insurances—Requirement to use adopted forms. The commissioner is

hereby authorized, and shall within a reasonable time following July 30, 1967, adopt standard forms for loss payable and mortgagee clauses for property and automobile physical damage insurances, pursuant to the procedures set forth in RCW 48.18.120(1). Following the adoption of such forms, no insurer authorized to do business in the state shall use any form other than those so adopted. [1967 ex.s. c 12 § 1.]

48.18.130 Standard provisions. (1) Insurance contracts shall contain such standard provisions as are required by the applicable chapters of this code pertaining to contracts of particular kinds of insurance. The commissioner may waive the required use of a particular standard provision in a particular insurance contract form if

(a) he or she finds such provision unnecessary for the protection of the insured, and inconsistent with the purposes of the contract, and

(b) the contract is otherwise approved by him or her.

(2) No insurance contract shall contain any provision inconsistent with or contradictory to any such standard provision used or required to be used, but the commissioner may, except as to the standard provisions of individual disability insurance contracts as required under chapter 48.20 RCW, approve any provision which is in his or her opinion more favorable to the insured than the standard provision or optional standard provision otherwise required. No endorsement, rider, or other documents attached to such contract shall vary, extend, or in any respect conflict with any such standard provision, or with any modification thereof so approved by the commissioner as being more favorable to the insured.

(3) In lieu of the standard provisions required by this code for contracts for particular kinds of insurance, substantially similar standard provisions required by the law of a foreign or alien insurer's domicile may be used when approved by the commissioner. [2009 c 549 § 7069; 1947 c 79 § .18.13; Rem. Supp. 1947 § 45.18.13.]

Standard provisions

disability: Chapter 48.20 RCW.

group and blanket disability: Chapter 48.21 RCW.

group life and annuities: Chapter 48.24 RCW.

industrial life: Chapter 48.25 RCW.

life insurance and annuities: Chapter 48.23 RCW.

48.18.140 Contents of policies in general. (1) The written instrument, in which a contract of insurance is set forth, is the policy.

(2) A policy shall specify:

(a) The names of the parties to the contract. The insurer's name shall be clearly shown in the policy.

(b) The subject of the insurance.

(c) The risk insured against.

(d) The time at which the insurance thereunder takes effect and the period during which the insurance is to continue.

(e) A statement of the premium, and if other than life, disability, or title insurance, the premium rate where applicable.

(f) The conditions pertaining to the insurance.

(3) If under the contract the exact amount of premiums is determinable only at termination of the contract, a statement

of the basis and rates upon which the final premium is to be determined and paid shall be specified in the policy.

(4)(a) Periodic payment plans for private passenger automobile insurance shall allow a specific day of the month for a due date for payment of premiums. A late charge may not be required if payment is received within five days of the date payment is due.

(b) The commissioner shall adopt rules to implement this subsection and shall take no disciplinary action against an insurer until ninety days after the effective date of the rule.

(5) This section shall not apply to surety insurance contracts. [2002 c 344 § 1; 1989 c 25 § 2; 1957 c 193 § 11; 1947 c 79 § .18.14; Rem. Supp. 1947 § 45.18.14.]

Additional notes found at www.leg.wa.gov

48.18.150 Additional contents. A policy may contain additional provisions, which are not inconsistent with this code, and which are

(1) required to be so inserted by the laws of the insurer's state of domicile; or

(2) necessary, on account of the manner in which the insurer is constituted or operated, to state the rights and obligations of the parties to the contract. [1947 c 79 § .18.15; Rem. Supp. 1947 § 45.18.15.]

48.18.160 Charter or bylaw provisions. No policy shall contain any provision purporting to make any portion of the charter, bylaws, or other constituent document of the insurer a part of the contract unless such portion is set forth in full in the policy. Any policy provision in violation of this section shall be invalid. [1947 c 79 § .18.16; Rem. Supp. 1947 § 45.18.16.]

48.18.170 "Premium" defined. "Premium" as used in this code means all sums charged, received, or deposited as consideration for an insurance contract or the continuance thereof. "Premium" does not include a regulatory surcharge imposed by RCW 48.02.190, except as otherwise provided in this section. Any assessment, or any "membership," "policy," "survey," "inspection," "service" or similar fee or charge made by the insurer in consideration for an insurance contract is deemed part of the premium. [2007 c 153 § 1; 1947 c 79 § .18.17; Rem. Supp. 1947 § 45.18.17.]

48.18.180 Stated premium must include all charges.

(1) The premium stated in the policy shall be inclusive of all fees, charges, premiums, or other consideration charged for the insurance or for the procurement thereof.

(2) No insurer or its officer, employee, appointed insurance producer, or other representative shall charge or receive any fee, compensation, or consideration for insurance which is not included in the premium specified in the policy.

(3) Each violation of this section is a gross misdemeanor.

(4) This section does not apply to:

(a) A fee paid to an insurance producer by an insured as provided in RCW 48.17.270; or

(b) A regulatory surcharge imposed by RCW 48.02.190. [2008 c 217 § 13; 2007 c 153 § 2; 1994 c 203 § 2; 1947 c 79 § .18.18; Rem. Supp. 1947 § 45.18.18.]

Additional notes found at www.leg.wa.gov

48.18.190 Policy must contain entire contract. No agreement in conflict with, modifying, or extending any contract of insurance shall be valid unless in writing and made a part of the policy. [1947 c 79 § .18.19; Rem. Supp. 1947 § 45.18.19.]

48.18.200 Limiting actions, jurisdiction. (1) Except as provided by subsection (3) of this section, no insurance contract delivered or issued for delivery in this state and covering subjects located, resident, or to be performed in this state, shall contain any condition, stipulation, or agreement

(a) requiring it to be construed according to the laws of any other state or country except as necessary to meet the requirements of the motor vehicle financial responsibility laws of such other state or country; or

(b) depriving the courts of this state of the jurisdiction of action against the insurer; or

(c) limiting right of action against the insurer to a period of less than one year from the time when the cause of action accrues in connection with all insurances other than property and marine and transportation insurances. In contracts of property insurance, or of marine and transportation insurance, such limitation shall not be to a period of less than one year from the date of the loss.

(2) Any such condition, stipulation, or agreement in violation of this section shall be void, but such voiding shall not affect the validity of the other provisions of the contract.

(3) For purposes of out-of-network payment disputes between a health carrier and health care provider covered under the provisions of chapter 48.49 RCW, the arbitration provisions of chapter 48.49 RCW apply. [2019 c 427 § 29; 1947 c 79 § .18.20; Rem. Supp. 1947 § 45.18.20.]

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

48.18.210 Execution of policies. (1) Every insurance contract shall be executed in the name of and on behalf of the insurer by its officer, employee, or representative duly authorized by the insurer.

(2) A facsimile signature of any such executing officer, employee or representative may be used in lieu of an original signature.

(3) No insurance contract heretofore or hereafter issued and which is otherwise valid shall be rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of any individual not authorized so to execute as of the date of the policy, if the policy is countersigned with the original signature of an individual then so authorized to countersign. [1947 c 79 § .18.21; Rem. Supp. 1947 § 45.18.21.]

48.18.220 Receipt of premium to bind coverage—Contents of receipt. Where an insurance producer, title insurance agent, or other representative of an insurer receipts premium money at the time that the insurance producer, title insurance agent, or representative purports to bind coverage, the receipt shall state: (a) That it is a binder, (b) a brief description of the coverage bound, and (c) the identity of the insurer in which the coverage is bound. This section does not apply as to life and disability insurances. [2008 c 217 § 14; 1967 ex.s. c 12 § 2.]

48.18.230 Binders—Duration—Premium. (1) A "binder" is used to bind insurance temporarily pending the issuance of the policy. No binder shall be valid beyond the issuance of the policy as to which it was given, or beyond ninety days from its effective date, whichever period is the shorter.

(2) If the policy has not been issued a binder may be extended or renewed beyond such ninety days upon the commissioner's written approval, or in accordance with such rules and regulations relative thereto as the commissioner may promulgate.

(3) Where the premium used in the binder differs from the actual policy premium by less than ten dollars, the insurer shall not be required to notify the insured and may use the actual policy premium. [1996 c 95 § 1; 1947 c 79 § .18.23; Rem. Supp. 1947 § 45.18.23.]

48.18.240 Binders—Insurance producer's or title insurance agent's liability. The commissioner may suspend or revoke the license of any insurance producer or title insurance agent issuing or purporting to issue any binder as to any insurer named therein as to which he or she is not then authorized so to bind. [2008 c 217 § 15; 1947 c 79 § .18.24; Rem. Supp. 1947 § 45.18.24.]

48.18.250 Underwriters' and combination policies. (1) Two or more authorized insurers may jointly issue, and shall be jointly and severally liable on, an underwriters' policy bearing their names. Any one insurer may issue policies in the name of an underwriter's department and such policies shall plainly show the true name of the insurer.

(2) Two or more authorized insurers may, with the commissioner's approval, issue a combination policy which shall contain provisions substantially as follows:

(a) That the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy.

(b) That service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing the policy, shall constitute service upon all such insurers.

(3) This section shall not apply to co-surety obligations. [1947 c 79 § .18.25; Rem. Supp. 1947 § 45.18.25.]

48.18.260 Delivery of policy. (1) Subject to the insurer's requirements as to payment of premium, every policy shall be delivered to the insured or to the person entitled thereto within a reasonable period of time after its issuance.

(2) In event the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle or aircraft, and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to such vehicle or aircraft is insured, a duplicate of such policy, or memorandum thereof setting forth the type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, shall be delivered by the vendor, mortgagee, or pledgee to each such

vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a conspicuous statement of such fact shall be printed, written, or stamped on the face of such duplicate policy or memorandum. [1947 c 79 § .18.26; Rem. Supp. 1947 § 45.18.26.]

Vehicle seller must furnish buyer itemized statement of insurance and other charges: RCW 46.70.130.

48.18.278 Terms for cancellation, nonrenewal, or modification of portable electronics policy—Application of RCW 48.18.290 and 48.18.2901 to portable electronics insurance. (1) The cancellation provisions in RCW 48.18.290 and the nonrenewal provisions in RCW 48.18.2901 apply to portable electronics insurance policies issued under chapter 48.120 RCW, unless inconsistent with this section in which case this section controls.

(2) An insurer may cancel, nonrenew, modify, or otherwise change the terms and conditions of a policy of portable electronics only:

(a) Upon providing the policyholder and enrolled customers with at least thirty days' notice; or

(b) As provided in subsections (5) through (7) of this section.

(3) An insurer may not increase premiums or deductibles or otherwise restrict benefits more than once in any six-month period.

(4) If an insurer changes the terms and conditions, then the insurer must provide:

(a) The vendor policyholder with a revised policy endorsement; and

(b) Each enrolled customer with:

(i) A revised certificate or endorsement and a summary of material changes; or

(ii) If the change is limited to a change in premium, a revised certificate, endorsement, updated brochure, or other evidence indicating a change in premium.

(5) An insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim.

(6) An insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon ten days' notice for nonpayment of premium.

(7) An insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(a) Without notice, if the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(b) Without prior notice if an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within thirty calendar days after exhaustion of the limit. However, if notice is not timely sent, coverage continues notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(8) If a policy of portable electronics insurance is being canceled or terminated by the insurer, the notice must include the insurer's actual reason for cancellation or termination.

(9) When a portable electronics insurance policy is terminated by a policyholder, the insurer must mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice must be mailed or delivered to the enrolled customer at least thirty days prior to the termination. The written notice must include the actual reason for the termination. However, if the policyholder is a vendor licensed as a specialty producer pursuant to RCW 48.120.010, the notice required by this subsection must be mailed or delivered by the vendor.

(10) Any notice or correspondence with respect to a policy of portable electronics insurance required under this section or otherwise required by law must be in writing. Notice or correspondence may be sent either by mail or by electronic means. If the notice or correspondence is mailed, it must be sent to the vendor of portable electronics at the vendor's mailing address specified for that purpose and to its affected enrolled customers' last known mailing addresses on file with the insurer.

The insurer or vendor of portable electronics must maintain proof of mailing in a form authorized or accepted by the United States postal service or other commercial mail delivery service. If a notice or correspondence is sent by electronic means, it must be sent to the vendor of portable electronics at the vendor's electronic mail address specified for that purpose and to its affected enrolled customers' last known electronic mail address as provided by each enrolled customer to the insurer or vendor of portable electronics, as the case may be.

For purposes of this subsection, an enrolled customer's provision of an electronic mail address to the insurer, supervising person, or vendor of portable electronics means that the enrolled customer consents to receive notices and correspondence by electronic mail as long as a disclosure to that effect is provided to the consumer at the time the consumer provides an electronic mail address. The insurer or vendor of portable electronics, as the case may be, must maintain proof that the notice or correspondence was sent.

(11) Notice or correspondence required by this section or otherwise required by law may be sent by the supervising person appointed by the insurer on behalf of an insurer or a vendor. [2013 c 152 § 8.]

48.18.280 Renewal of policy. Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable, may be renewed or extended at the option of the insurer and upon a currently authorized policy form and at the premium rate then required therefor for a specific additional period or periods by a certificate or by endorsement of the policy, and without requiring the issuance of a new policy. [1947 c 79 § .18.28; Rem. Supp. 1947 § 45.18.28.]

48.18.289 Cancellation, nonrenewal, renewal offer—Notice to insurance producer or title insurance agent. Whenever a notice of cancellation or nonrenewal or an offer to renew is furnished to an insured in accord with any provision of this chapter, a copy of such notice or offer shall be

provided within five working days to the insurance producer or title insurance agent on the account. When possible, the copy to the insurance producer or title insurance agent may be provided electronically. [2008 c 217 § 16; 2000 c 220 § 1; 1988 c 249 § 1; 1987 c 14 § 1.]

Additional notes found at www.leg.wa.gov

48.18.290 Cancellation by insurer. (1) Cancellation by the insurer of any policy which by its terms is cancellable at the option of the insurer, or of any binder based on such policy which does not contain a clearly stated expiration date, may be effected as to any interest only upon compliance with the following:

(a) For all insurance policies other than medical malpractice insurance policies or fire insurance policies canceled under RCW 48.53.040:

(i) The insurer must deliver or mail written notice of cancellation to the named insured at least forty-five days before the effective date of the cancellation; and

(ii) The cancellation notice must include the insurer's actual reason for canceling the policy.

(b) For medical malpractice insurance policies:

(i) The insurer must deliver or mail written notice of the cancellation to the named insured at least ninety days before the effective date of the cancellation; and

(ii) The cancellation notice must include the insurer's actual reason for canceling the policy and describe the significant risk factors that led to the insurer's underwriting action, as defined under RCW 48.18.547(1)(e).

(c) If an insurer cancels a policy described under (a) or (b) of this subsection for nonpayment of premium, the insurer must deliver or mail the cancellation notice to the named insured at least ten days before the effective date of the cancellation.

(d) If an insurer cancels a fire insurance policy under RCW 48.53.040, the insurer must deliver or mail the cancellation notice to the named insured at least five days before the effective date of the cancellation.

(e) Like notice must also be so delivered or mailed to each mortgagee, pledgee, or other person shown by the policy to have an interest in any loss which may occur thereunder. For purposes of this subsection (1)(e), "delivered" includes electronic transmittal, facsimile, or personal delivery.

(2) The mailing of any such notice shall be effected by depositing it in a sealed envelope, directed to the addressee at his or her last address as known to the insurer or as shown by the insurer's records, with proper prepaid postage affixed, in a letter depository of the United States post office. The insurer shall retain in its records any such item so mailed, together with its envelope, which was returned by the post office upon failure to find, or deliver the mailing to, the addressee.

(3) The affidavit of the individual making or supervising such a mailing, shall constitute prima facie evidence of such facts of the mailing as are therein affirmed.

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

mailed to the insured or such person as soon as possible, and no later than forty-five days after the date of notice of cancellation to the insured for homeowners', dwelling fire, and private passenger auto. Any such payment may be made by cash, or by check, bank draft, or money order.

(5) This section shall not apply to contracts of life or disability insurance without provision for cancellation prior to the date to which premiums have been paid, or to contracts of insurance procured under the provisions of chapter 48.15 RCW. [2006 c 8 § 212; 1997 c 85 § 1; 1988 c 249 § 2; 1986 c 287 § 1; 1985 c 264 § 17; 1982 c 110 § 7; 1980 c 102 § 7; 1979 ex.s. c 199 § 5; 1975-'76 2nd ex.s. c 119 § 2; 1947 c 79 § .18.29; Rem. Supp. 1947 § 45.18.29.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

Additional notes found at www.leg.wa.gov

48.18.2901 Renewal required—Exceptions. (1) Each insurer must renew any insurance policy subject to RCW 48.18.290 unless one of the following situations exists:

(a)(i) For all insurance policies subject to RCW 48.18.290(1)(a):

(A) The insurer must deliver or mail written notice of nonrenewal to the named insured at least forty-five days before the expiration date of the policy; and

(B) The notice must include the insurer's actual reason for refusing to renew the policy.

(ii) For medical malpractice insurance policies subject to RCW 48.18.290(1)(b):

(A) The insurer must deliver or mail written notice of the nonrenewal to the named insured at least ninety days before the expiration date of the policy; and

(B) The notice must include the insurer's actual reason for refusing to renew the policy and describe the significant risk factors that led to the insurer's underwriting action, as defined under RCW 48.18.547(1)(e);

(b) At least twenty days prior to its expiration date, the insurer has communicated, either directly or through its agent, its willingness to renew in writing to the named insured and has included in that writing a statement of the amount of the premium or portion thereof required to be paid by the insured to renew the policy, and the insured fails to discharge when due his or her obligation in connection with the payment of such premium or portion thereof;

(c) The insured has procured equivalent coverage prior to the expiration of the policy period;

(d) The contract is evidenced by a written binder containing a clearly stated expiration date which has expired according to its terms; or

(e) The contract clearly states that it is not renewable, and is for a specific line, subclassification, or type of coverage that is not offered on a renewable basis. This subsection (1)(e) does not restrict the authority of the insurance commissioner under this code.

(2) Any insurer failing to include in the notice required by subsection (1)(b) of this section the amount of any increased premium resulting from a change of rates and an explanation of any change in the contract provisions shall renew the policy if so required by that subsection according to the rates and contract provisions applicable to the expiring policy. However, renewal based on the rates and contract pro-

visions applicable to the expiring policy shall not prevent the insurer from making changes in the rates and/or contract provisions of the policy once during the term of its renewal after at least twenty days' advance notice of such change has been given to the named insured.

(3) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal, or with respect to cancellation of fire policies under chapter 48.53 RCW.

(4) "Renewal" or "to renew" means the issuance and delivery by an insurer of a contract of insurance replacing at the end of the contract period a contract of insurance previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a contract beyond its policy period or term. However, (a) any contract of insurance with a policy period or term of six months or less whether or not made continuous for successive terms upon the payment of additional premiums shall for the purpose of RCW 48.18.290 and 48.18.293 through 48.18.295 be considered as if written for a policy period or term of six months; and (b) any policy written for a term longer than one year or any policy with no fixed expiration date, shall, for the purpose of RCW 48.18.290 and 48.18.293 through 48.18.295, be considered as if written for successive policy periods or terms of one year.

(5) A midterm blanket reduction in rate, approved by the commissioner, for medical malpractice insurance shall not be considered a renewal for purposes of this section. [2006 c 8 § 213; 2002 c 347 § 1; 1993 c 186 § 1; 1988 c 249 § 3; 1986 c 287 § 2; 1985 c 264 § 20.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

Additional notes found at www.leg.wa.gov

48.18.291 Cancellation of private automobile insurance by insurer—Notice—Requirements. (1) A contract of insurance predicated wholly or in part upon the use of a private passenger automobile may not be terminated by cancellation by the insurer until at least twenty days after mailing written notice of cancellation to the named insured at the latest address filed with the insurer by or on behalf of the named insured, accompanied by the reason therefor. If cancellation is for nonpayment of premium, or is within the first thirty days after the contract has been in effect, at least ten days notice of cancellation, accompanied by the reason therefor, shall be given. In case of a contract evidenced by a written binder which has been delivered to the insured, if the binder contains a clearly stated expiration date, no additional notice of cancellation or nonrenewal is required.

(2)(a) A notice of cancellation by the insurer as to a contract of insurance to which subsection (1) of this section applies is not valid if sent more than sixty days after the contract has been in effect unless:

(i) The named insured fails to discharge when due any of his or her obligations in connection with the payment of premium for the policy or any installment thereof, whether payable directly to the insurer or to its agent or indirectly under any premium finance plan or extension of credit; or

(ii) The driver's license of the named insured, or of any other operator who customarily operates an automobile

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insured under the policy, has been suspended, revoked, or canceled during the policy period or, if the policy is a renewal, during its policy period or the one hundred eighty days immediately preceding the effective date of the renewal policy.

(b) Modification by the insurer of automobile physical damage coverage by the inclusion of a deductible not exceeding one hundred dollars is not a cancellation of the coverage or of the policy.

(3) The substance of subsections (1) and (2)(a) of this section must be set forth in each contract of insurance subject to the provisions of subsection (1) of this section, and may be in the form of an attached endorsement.

(4) A notice of cancellation of a policy that may be canceled only pursuant to subsection (2) of this section is not effective unless the reason therefor accompanies or is included in the notice of cancellation. [2003 c 248 § 5; 1985 c 264 § 18; 1979 ex.s. c 199 § 6; 1969 ex.s. c 241 § 19.]

Additional notes found at www.leg.wa.gov

48.18.292 Refusal to renew private automobile insurance by insurer—Change in amount of premium or deductibles. (1) Each insurer shall be required to renew any contract of insurance subject to RCW 48.18.291 unless one of the following situations exists:

(a) The insurer gives the named insured at least twenty days' notice in writing as provided for in RCW 48.18.291(1), that it proposes to refuse to renew the insurance contract upon its expiration date; and sets forth therein the actual reason for refusing to renew; or

(b) At least twenty days prior to its expiration date, the insurer has communicated its willingness to renew in writing to the named insured, and has included therein a statement of the amount of the premium or portion thereof required to be paid by the insured to renew the policy, including the amount by which the premium or deductibles have changed from the previous policy period, and the date by which such payment must be made, and the insured fails to discharge when due his or her obligation in connection with the payment of such premium or portion thereof; or

(c) The insured's insurance producer has procured other coverage acceptable to the insured prior to the expiration of the policy period.

(2) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

(3) "Renewal" or "to renew" means the issuance and delivery by an insurer of a contract of insurance replacing at the end of the contract period a contract of insurance previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a contract beyond its policy period or term: PROVIDED, HOWEVER, That any contract of insurance with a policy period or term of six months or less whether or not made continuous for successive terms upon the payment of additional premiums shall for the purpose of RCW 48.18.291 through 48.18.297 be considered as if written for a policy period or term of six months: PROVIDED, FURTHER, That any policy written for a term longer than one year or any policy with no fixed expiration date, shall, for the purpose of RCW

48.18.291 through 48.18.297, be considered as if written for successive policy periods or terms of one year.

(4) On and after January 1, 1980, no policy of insurance subject to RCW 48.18.291 shall be issued for a policy period or term of less than six months.

(5) No insurer shall refuse to renew the liability and/or collision coverage of an automobile insurance policy on the basis that an insured covered by the policy of the insurer has submitted one or more claims under the comprehensive, road service, or towing coverage of the policy. Nothing in this subsection shall prohibit the nonrenewal of comprehensive, road service, or towing coverage on the basis of one or more claims submitted by an insured. [2008 c 217 § 17; 1985 c 264 § 19; 1981 c 339 § 17; 1979 ex.s. c 199 § 7; 1973 1st ex.s. c 152 § 3; 1969 ex.s. c 241 § 20.]

Additional notes found at www.leg.wa.gov

48.18.293 Nonliability of commissioner, agents, insurer for information giving reasons for cancellation or refusal to renew—Proof of mailing of notice. (1) There shall be no liability on the part of, and no cause of action of any nature shall arise against, the insurance commissioner, his or her agents, or members of his or her staff, or against any insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or refusal to renew, for any statement made by any of them in any written notice of cancellation or refusal to renew, or in any other communications, oral or written, specifying the reasons for cancellation or refusal to renew or the providing of information pertaining thereto, or for statements made or evidence submitted in any hearing conducted in connection therewith.

(2) Proof of mailing of notice of cancellation or refusal to renew or of reasons for cancellation, to the named insured, at the latest address filed with the insurer by or on behalf of the named insured shall be sufficient proof of notice. [2009 c 549 § 7070; 1969 ex.s. c 241 § 21.]

Additional notes found at www.leg.wa.gov

48.18.295 RCW 48.18.290 through 48.18.297 not to prevent cancellation or nonrenewal, when. Nothing in RCW 48.18.290 through 48.18.297 shall be construed to prevent the cancellation or nonrenewal of any such insurance where:

(1) Such cancellation or nonrenewal is ordered by the commissioner under a statutory delinquency proceeding commenced under the provisions of chapter 48.31 RCW, or

(2) Permission for such cancellation or nonrenewal has been given by the commissioner on a showing that the continuation of such coverage can reasonably be expected to create a condition in the company hazardous to its policyholder, or to its creditors, or to its members, subscribers, or stockholders, or to the public. [1985 c 264 § 21; 1969 ex.s. c 241 § 22; 1967 ex.s. c 95 § 2.]

Additional notes found at www.leg.wa.gov

48.18.296 Contracts to which RCW 48.18.291 through 48.18.297 inapplicable. The provisions of RCW 48.18.291 through 48.18.297 shall not apply to:

(1) Contracts of insurance issued under the assigned risk plan;

(2) Any policy covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards; and

(3) Contracts of insurance procured under the provisions of chapter 48.15 RCW. [1986 c 287 § 3; 1985 c 264 § 22; 1983 1st ex.s. c 32 § 6; 1969 ex.s. c 241 § 23.]

Additional notes found at www.leg.wa.gov

48.18.297 Private passenger automobile defined. A private passenger automobile as used in RCW 48.18.291 through 48.18.297 shall mean:

(1) An individually owned motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others.

(2) Any other individually owned four-wheel motor vehicle with a load capacity of fifteen hundred pounds or less which is not used in the occupation, profession, or business of the insured. [1969 ex.s. c 241 § 24.]

Additional notes found at www.leg.wa.gov

48.18.298 Disability insurance—Refusal to renew by insurer. No insurer shall refuse to renew any policy of individual disability insurance issued after July 1, 1973 because of a change in the physical or mental condition or health of any person covered thereunder: PROVIDED, That after approval of the insurance commissioner, an insurer may discharge its obligation to renew the contract by obtaining for the insured coverage with another insurer which is comparable in terms of premiums and benefits. [1973 1st ex.s. c 188 § 1.]

Additional notes found at www.leg.wa.gov

48.18.299 Disability insurance—Cancellation by insurer. No contract of insurance enumerated in RCW 48.18.298 shall be terminated by cancellation by the insurer during the period of contract except for nonpayment of premium. This section shall not be deemed to affect the right of the insurer to rescind the policy as limited and defined in RCW 48.18.090. [1973 1st ex.s. c 188 § 2.]

Additional notes found at www.leg.wa.gov

48.18.300 Cancellation by insured. (1) Cancellation by the insured of any policy which by its terms is cancellable at the insured's option or of any binder based on such policy may be effected by written notice thereof to the insurer or surrender of the policy or binder for cancellation prior to or on the effective date of such cancellation. In [the] event the policy or binder has been lost or destroyed and cannot be so surrendered, the insurer may in lieu of such surrender accept and in good faith rely upon the insured's written statement setting forth the fact of such loss or destruction.

(2) As soon as possible, and no later than thirty days after the receipt of the notice of cancellation from the policyholder for homeowners', dwelling fire, and private passenger auto insurance, the insurer shall pay to the insured or to the person entitled thereto as shown by the insurer's records, any unearned portion of any premium paid on the policy as computed on the customary short rate or as otherwise specified in the policy: PROVIDED, That the refund of any unearned

portion of any premium paid on a contract of dwelling fire insurance, homeowners' insurance, or insurance predicated upon the use of a private passenger automobile (as defined in RCW 48.18.297 and excluding contracts of insurance and policies enumerated in RCW 48.18.296) shall be computed on a pro rata basis and the insurer shall refund not less than ninety percent of any unearned portion not exceeding one hundred dollars, plus ninety-five percent of any unearned portion over one hundred dollars but not exceeding five hundred dollars, and not less than ninety-seven percent of the amount of any unearned portion in excess of five hundred dollars. If the amount of any refund is less than two dollars, no refund need be made. If no premium has been paid on the policy, the insured shall be liable to the insurer for premium for the period during which the policy was in force.

(3) The surrender of a policy to the insurer for any cause by any person named therein as having an interest insured thereunder shall create a presumption that such surrender is concurred in by all persons so named.

(4) This section shall not apply to life insurance policies or to annuity contracts. [1980 c 102 § 8; 1979 ex.s. c 199 § 8; 1955 c 303 § 16; 1947 c 79 § .18.30; Rem. Supp. 1947 § 45.18.30.]

48.18.310 Cancellation by commissioner. The commissioner may order the immediate cancellation of any policy the procuring or effectuation of which was accomplished through or accompanied by a violation of this code, except in cases where the policy by its terms is not cancellable by the insurer and the insured did not knowingly participate in any such violation. [1947 c 79 § .18.31; Rem. Supp. 1947 § 45.18.31.]

48.18.320 Annulment of liability policies. No insurance contract insuring against loss or damage through legal liability for the bodily injury or death by accident of any individual, or for damage to the property of any person, shall be retroactively annulled by any agreement between the insurer and insured after the occurrence of any such injury, death, or damage for which the insured may be liable, and any such annulment attempted shall be void. [1947 c 79 § .18.32; Rem. Supp. 1947 § 45.18.32.]

48.18.340 Dividends payable to real party in interest.

(1) Every insurer issuing participating policies, shall pay dividends, unused premium refunds or savings distributed on account of any such policy, only to the real party in interest entitled thereto as shown by the insurer's records, or to any person to whom the right thereto has been assigned in writing of record with the insurer, or given in the policy by such real party in interest.

(2) Any person who is shown by the insurer's records to have paid for his or her own account, or to have been ultimately charged for, the premium for insurance provided by a policy in which another person is the nominal insured, shall be deemed such real party in interest proportionate to premium so paid or so charged. This subsection shall not apply as to any such dividend, refund, or distribution which would amount to less than one dollar.

(3) This section shall not apply to contracts of group life insurance, group annuities, or group disability insurance.

[2009 c 549 § 7071; 1947 c 79 § .18.34; Rem. Supp. 1947 § 45.18.34.]

48.18.350 Breach of warranty prior to loss—Effect.

If any breach of a warranty or condition in any insurance contract occurs prior to a loss under the contract, such breach shall not avoid the contract nor avail the insurer to avoid liability, unless the breach exists at the time of the loss. [1947 c 79 § .18.35; Rem. Supp. 1947 § 45.18.35.]

48.18.360 Assignment of policies—Life and disability.

Subject to the terms of the policy relating to its assignment, life insurance policies, other than industrial or group life insurance policies, and disability policies providing benefits for accidental death, whether such policies were heretofore or are hereafter issued, and under the terms of which the beneficiary may be changed upon the sole request of the insured, may be assigned either by pledge or transfer of title, by an assignment executed by the insured alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Industrial life insurance policies may be made assignable only to a bank or trust company. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment. [1947 c 79 § .18.36; Rem. Supp. 1947 § 45.18.36.]

48.18.370 Payment discharges insurer—Life and disability.

Whenever the proceeds of, or payments under a life or disability insurance policy, heretofore or hereafter issued, become payable and the insurer makes payment thereof in accordance with the terms of the policy, or in accordance with any written assignment thereof pursuant to RCW 48.18.360, the person then designated in the policy or by such assignment as being entitled thereto, shall be entitled to receive such proceeds or payments and to give full acquittance therefor, and such payment shall fully discharge the insurer from all claims under the policy unless, before payment is made, the insurer has received at its home office, written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy. [1947 c 79 § .18.37; Rem. Supp. 1947 § 45.18.37.]

48.18.375 Assignment of interests under group insurance policy.

A person whose life is insured under a group insurance policy may, subject and pursuant to the terms of the policy, or pursuant to an arrangement between the insured, the group policyholder and the insurer, assign to any or all his or her spouse, children, parents, or a trust for the benefit of any or all of them, all or any part of his or her incidents of ownership, rights, title, and interests, both present and future, under such policy including specifically, but not by way of limitation, the right to designate a beneficiary or beneficiaries thereunder and the right to have an individual policy issued to him in case of termination of employment or of said group insurance policy. Such an assignment by the insured, made

either before or after July 16, 1973, is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is to be effective, all of such incidents of ownership, rights, title, and interests so assigned, but without prejudice to the insurer on account of any payment it may make or individual policy it may issue prior to receipt of notice of the assignment. This section acknowledges, declares, and codifies the existing right of assignment of interests under group insurance policies. [2009 c 549 § 7072; 1973 1st ex.s. c 163 § 3.]

48.18.390 Simultaneous deaths—Payment of proceeds—Life insurance. Where the individual insured and the beneficiary designated in a life insurance policy or policy insuring against accidental death have died and there is not sufficient evidence that they have died otherwise than simultaneously, the proceeds of the policy shall be distributed as if the insured had survived the beneficiary, unless otherwise expressly provided in the policy. [1947 c 79 § .18.39; Rem. Supp. 1947 § 45.18.39.]

Simultaneous death, uniform act: Chapter 11.05A RCW.

48.18.400 Exemption of proceeds—Disability. The proceeds or avails of all contracts of disability insurance and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance or annuity contracts heretofore or hereafter effected shall be exempt from all liability for any debt of the insured, and from any debt of the beneficiary existing at the time the proceeds are made available for his or her use. [2009 c 549 § 7073; 1947 c 79 § .18.40; Rem. Supp. 1947 § 45.18.40.]

48.18.410 Exemption of proceeds—Life. (1) The lawful beneficiary, assignee, or payee of a life insurance policy, other than an annuity, heretofore or hereafter effected by any person on his or her own life, or on the life of another, in favor of a person other than himself or herself, shall be entitled to the proceeds and avails of the policy against the creditors and representatives of the insured and of the person effecting the insurance, and such proceeds and avails shall also be exempt from all liability for any debt of such beneficiary, existing at the time the proceeds or avails are made available for his or her own use.

(2) The provisions of subsection (1) of this section shall apply

(a) whether or not the right to change the beneficiary is reserved or permitted in the policy; or

(b) whether or not the policy is made payable to the person whose life is insured or to his or her estate if the beneficiary, assignee or payee shall predecease such person; except, that this subsection shall not be construed so as to defeat any policy provision which provides for disposition of proceeds in the event the beneficiary shall predecease the insured.

(3) The exemptions provided by subsection (1) of this section, subject to the statute of limitations, shall not apply

(a) to any claim to or interest in such proceeds or avails by or on behalf of the insured, or the person so effecting the insurance, or their administrators or executors, in whatever capacity such claim is made or such interest is asserted; or

(b) to any claim to or interest in such proceeds or avails by or on behalf of any person to whom rights thereto have

been transferred with intent to defraud creditors; but an insurer shall be liable to all such creditors only as to amounts aggregating not to exceed the amount of such proceeds or avails remaining in the insurer's possession at the time the insurer receives at its home office written notice by or on behalf of such creditors, of claims to recover for such transfer, with specification of the amounts claimed; or

(c) to so much of such proceeds or avails as equals the amount of any premiums or portion thereof paid for the insurance with intent to defraud creditors, with interest thereon, and if prior to the payment of such proceeds or avails the insurer has received at its home office written notice by or on behalf of the creditor, of a claim to recover for premiums paid with intent to defraud creditors, with specification of the amount claimed.

(4) For the purposes of subsection (1) of this section a policy shall also be deemed to be payable to a person other than the insured if and to the extent that a facility-of-payment clause or similar clause in the policy permits the insurer to discharge its obligation after the death of the individual insured by paying the death benefits to a person as permitted by such clause.

(5) No person shall be compelled to exercise any rights, powers, options or privileges under any such policy. [2009 c 549 § 7074; 1947 c 79 § .18.41; Rem. Supp. 1947 § 45.18.41.]

48.18.420 Exemption of proceeds—Group life. (1) A policy of group life insurance or the proceeds thereof payable to the individual insured or to the beneficiary thereunder, shall not be liable, either before or after payment, to be applied to any legal or equitable process to pay any liability of any person having a right under the policy. The proceeds thereof, when not made payable to a named beneficiary or to a third person pursuant to a facility-of-payment clause, shall not constitute a part of the estate of the individual insured for the payment of his or her debts.

(2) This section shall not apply to group life insurance policies issued under RCW 48.24.040 (debtor groups) to the extent that such proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued. [2009 c 549 § 7075; 1947 c 79 § .18.42; Rem. Supp. 1947 § 45.18.42.]

48.18.430 Exemption of proceeds, commutation—Annuities. (1) The benefits, rights, privileges, and options under any annuity contract that are due the annuitant who paid the consideration for the annuity contract are not subject to execution and the annuitant may not be compelled to exercise those rights, powers, or options, and creditors are not allowed to interfere with or terminate the contract, except:

(a) As to amounts paid for or as premium on an annuity with intent to defraud creditors, with interest thereon, and of which the creditor has given the insurer written notice at its home office prior to making the payments to the annuitant out of which the creditor seeks to recover. The notice must specify the amount claimed or the facts that will enable the insurer to determine the amount, and must set forth the facts that will enable the insurer to determine the insurance or annuity contract, the person insured or annuitant and the payments sought to be avoided on the basis of fraud.

(b) The total exemption of benefits presently due and payable to an annuitant periodically or at stated times under all annuity contracts may not at any time exceed three thousand dollars per month for the length of time represented by the installments, and a periodic payment in excess of three thousand dollars per month is subject to garnishee execution to the same extent as are wages and salaries.

(c) If the total benefits presently due and payable to an annuitant under all annuity contracts at any time exceeds payment at the rate of three thousand dollars per month, then the court may order the annuitant to pay to a judgment creditor or apply on the judgment, in installments, the portion of the excess benefits that the court determines to be just and proper, after due regard for the reasonable requirements of the judgment debtor and the judgment debtor's dependent family, as well as any payments required to be made by the annuitant to other creditors under prior court orders.

(2) The benefits, rights, privileges, or options accruing under an annuity contract to a beneficiary or assignee are not transferable or subject to commutation, and if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained in this section for the annuitant apply to the beneficiary or assignee.

(3) An annuity contract within the meaning of this section is any obligation to pay certain sums at stated times, during life or lives, or for a specified term or terms, issued for a valuable consideration, regardless of whether or not the sums are payable to one or more persons, jointly or otherwise, but does not include payments under life insurance contracts at stated times during life or lives, or for a specified term or terms. [2011 c 162 § 4; 2005 c 223 § 10; 1949 c 190 § 25; 1947 c 79 § .18.43; Rem. Supp. 1949 § 45.18.43.]

48.18.440 Spouse's rights in life insurance policy. (1) Every life insurance policy heretofore or hereafter made payable to or for the benefit of the spouse of the insured, and every life insurance policy heretofore or hereafter assigned, transferred, or in any way made payable to a spouse or to a trustee for the benefit of a spouse, regardless of how such assignment or transfer is procured, shall, unless contrary to the terms of the policy, inure to the separate use and benefit of such spouse: PROVIDED, That the beneficial interest of a spouse in a policy upon the life of a child of the spouses, however such interest is created, shall be deemed to be a community interest and not a separate interest, unless expressly otherwise provided by the policy.

(2) In any life insurance policy heretofore or hereafter issued upon the life of a spouse the designation heretofore or hereafter made by such spouse of a beneficiary in accordance with the terms of the policy, shall create a presumption that such beneficiary was so designated with the consent of the other spouse, but only as to any beneficiary who is the child, parent, brother, or sister of either of the spouses. The insurer may in good faith rely upon the representations made by the insured as to the relationship to him or her of any such beneficiary. [2009 c 549 § 7076; 1947 c 79 § .18.44; Rem. Supp. 1947 § 45.18.44.]

48.18.450 Life insurance payable to trustee named as beneficiary in the policy. Life insurance may be made payable to a trustee to be named as beneficiary in the policy and

the proceeds of such insurance paid to such trustee shall be held and disposed of by the trustee as provided in a trust agreement or declaration of trust made by the insured during his or her lifetime. It shall not be necessary to the validity of any such trust agreement or declaration of trust that it have a trust corpus other than the right of the trustee to receive such insurance proceeds as beneficiary, and any such trustee may also receive assets, other than insurance proceeds, by testamentary disposition and administer them according to the terms of the trust agreement or declaration of trust as they exist at the death of the testator. [2009 c 549 § 7077; 1963 c 227 § 1.]

48.18.452 Life insurance designating as beneficiary a trustee named by will. A policy of life insurance may designate as beneficiary a trustee or trustees named or to be named by will, if the designation is made in accordance with the provisions of the policy and the requirements of the insurance company. Immediately after the proving of the will the proceeds of such insurance shall be paid to the trustee or trustees named therein to be held and disposed of under the terms of the will as they exist at the death of the testator, but if no qualified trustee makes claim to the proceeds from the insurance company within one year after the death of the insured, or if satisfactory evidence is furnished the insurance company within such one-year period showing that no trustee can qualify to receive the proceeds, payment shall be made by the insurance company to those thereafter entitled. The proceeds of the insurance as collected by the trustee or trustees shall not be subject to debts of the insured and inheritance tax to any greater extent than if such proceeds were payable to any other named beneficiary other than the estate of the insured. Enactment of this section shall not invalidate previous life insurance policy beneficiary designations naming trustees of trusts established by will. [1963 c 227 § 2.]

48.18.460 Proof of loss—Furnishing forms—May require oath. An insurer shall furnish, upon request of any person claiming to have a loss under any insurance contract, forms of proof of loss for completion by such person. But such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion. If a person makes a claim under a policy of insurance, the insurer may require that the person be examined under an oath administered by a person authorized by state or federal law to administer oaths. [1995 c 285 § 17; 1949 c 190 § 26; 1947 c 79 § .18.46; Rem. Supp. 1949 § 45.18.46.]

Additional notes found at www.leg.wa.gov

48.18.470 Claims administration—Not waiver. None of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder:

(a) Acknowledgment of the receipt of notice of loss or of claim under the policy.

(b) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted.

(c) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim. [1947 c 79 § .18.47; Rem. Supp. 1947 § 45.18.47.]

48.18.480 Discrimination prohibited. No insurer shall make or permit any unfair discrimination between insureds or subjects of insurance having substantially like insuring, risk, and exposure factors, and expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor, or in the benefits payable or in any other rights or privileges accruing thereunder. This provision shall not prohibit fair discrimination by a life insurer as between individuals having unequal expectation of life. [1957 c 193 § 12; 1947 c 79 § .18.48; Rem. Supp. 1947 § 45.18.480.]

48.18.510 Validity of noncomplying forms. Any insurance policy, rider, or endorsement hereafter issued and otherwise valid, which contains any condition or provision not in compliance with the requirements of this code, shall not be rendered invalid thereby, but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy, rider, or endorsement been in full compliance with this code. [1947 c 79 § .18.51; Rem. Supp. 1947 § 45.18.51.]

48.18.520 Construction of policies. Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy, and as amplified, extended, or modified by any rider, endorsement, or application attached to and made a part of the policy. [1947 c 79 § .18.52; Rem. Supp. 1947 § 45.18.52.]

48.18.540 Cancellations, denials, refusals to renew—Written notification. Every insurer upon canceling, denying, or refusing to renew any disability policy, shall, upon written request, directly notify in writing the applicant or insured, as the case may be, of the reasons for the action by the insurer and to any person covered under a group contract. Any benefits, terms, rates, or conditions of such a contract that are restricted, excluded, modified, increased, or reduced shall, upon written request, be set forth in writing and supplied to the insured and to any person covered under a group contract. The written communications required by this section shall be phrased in simple language that is readily understandable to a person of average intelligence, education, and reading ability. [1993 c 492 § 281.]

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

Additional notes found at www.leg.wa.gov

48.18.543 Single premium credit insurance—Residential mortgage loan—Restrictions—Definitions. (1) For the purposes of this section:

(a) "Licensee" means every insurance producer licensed under chapter 48.17 RCW.

(b) "Residential mortgage loan" means any loan primarily for personal, family, or household use secured by a mortgage or deed of trust on residential real estate upon which is constructed or intended to be constructed a single-family dwelling or multiple-family dwelling of four or less units.

(c) "Single premium credit insurance" means credit insurance purchased with a single premium payment at inception of coverage.

(2) An insurer or licensee may not issue or sell any single premium credit insurance product in connection with a residential mortgage loan unless:

(a) The term of the single premium credit insurance policy is the same as the term of the loan;

(b) The debtor is given the option to buy credit insurance paid with monthly premiums; and

(c) The single premium credit insurance policy provides for a full refund of premiums to the debtor if the credit insurance is canceled within sixty days of the date of the loan.

(3) This section does not apply to residential mortgage loans if:

(a) The loan amount does not exceed ten thousand dollars, exclusive of fees;

(b) The repayment term of the loan does not exceed five years; and

(c) The term of the single premium credit insurance does not exceed the repayment term of the loan. [2008 c 217 § 18; 2003 c 116 § 1.]

Additional notes found at www.leg.wa.gov

48.18.545 Underwriting restrictions that apply to personal insurance—Credit history or insurance score—Rules. (1) For the purposes of this section:

(a) "Adverse action" has the same meaning as defined in the fair credit reporting act, 15 U.S.C. Sec. 1681 et seq. Adverse actions include, but are not limited to:

(i) Cancellation, denial, or nonrenewal of personal insurance coverage;

(ii) Charging a higher insurance premium for personal insurance than would have been offered if the credit history or insurance score had been more favorable, whether the charge is by:

(A) Application of a rating rule;

(B) Assignment to a rating tier that does not have the lowest available rates; or

(C) Placement with an affiliate company that does not offer the lowest rates available to the consumer within the affiliate group of insurance companies; or

(iii) Any reduction, adverse, or unfavorable change in the terms of coverage or amount of any personal insurance due to a consumer's credit history or insurance score. A reduction, adverse, or unfavorable change in the terms of coverage occurs when:

(A) Coverage provided to the consumer is not as broad in scope as coverage requested by the consumer but available to other insureds of the insurer or any affiliate; or

(B) The consumer is not eligible for benefits such as dividends that are available through affiliate insurers.

(b) "Affiliate" has the same meaning as defined in RCW 48.31B.005(1).

(c) "Consumer" means an individual policyholder or applicant for insurance.

(d) "Consumer report" has the same meaning as defined in the fair credit reporting act, 15 U.S.C. Sec. 1681 et seq.

(e) "Credit history" means any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's creditworthiness, credit

standing, or credit capacity that is used or expected to be used, or collected in whole or in part, for the purpose of serving as a factor in determining personal insurance premiums or eligibility for coverage.

(f) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit history.

(g) "Personal insurance" means:

- (i) Private passenger automobile coverage;
- (ii) Homeowner's coverage, including mobile homeowners, manufactured homeowners, condominium owners, and renter's coverage;
- (iii) Dwelling property coverage;
- (iv) Earthquake coverage for a residence or personal property;
- (v) Personal liability and theft coverage;
- (vi) Personal inland marine coverage; and
- (vii) Mechanical breakdown coverage for personal auto or home appliances.

(h) "Tier" means a category within a single insurer into which insureds with substantially like insuring, risk or exposure factors, and expense elements are placed for purposes of determining rate or premium.

(2) An insurer that takes adverse action against a consumer based in whole or in part on credit history or insurance score shall provide written notice to the applicant or named insured. The notice must state the significant factors of the credit history or insurance score that resulted in the adverse action. The insurer shall also inform the consumer that the consumer is entitled to a free copy of their consumer report under the fair credit reporting act.

(3) An insurer shall not cancel or nonrenew personal insurance based in whole or in part on a consumer's credit history or insurance score. An offer of placement with an affiliate insurer does not constitute cancellation or nonrenewal under this section.

(4) An insurer may use credit history to deny personal insurance only in combination with other substantive underwriting factors. For the purposes of this subsection:

- (a) "Deny" means an insurer refuses to offer insurance coverage to a consumer;
- (b) An offer of placement with an affiliate insurer does not constitute denial of coverage; and
- (c) An insurer may reject an application when coverage is not bound or cancel an insurance contract within the first sixty days after the effective date of the contract.

(5) Insurers shall not deny personal insurance coverage based on:

- (a) The absence of credit history or the inability to determine the consumer's credit history, if the insurer has received accurate and complete information from the consumer;
- (b) The number of credit inquiries;
- (c) Credit history or an insurance score based on collection accounts identified with a medical industry code;
- (d) The initial purchase or finance of a vehicle or house that adds a new loan to the consumer's existing credit history, if evident from the consumer report; however, an insurer may consider the bill payment history of any loan, the total number of loans, or both;

(e) The consumer's use of a particular type of credit card, charge card, or debit card; or

(f) The consumer's total available line of credit; however, an insurer may consider the total amount of outstanding debt in relation to the total available line of credit.

(6)(a) If disputed credit history is used to determine eligibility for coverage and a consumer is placed with an affiliate that charges higher premiums or offers less favorable policy terms:

- (i) The insurer shall reissue or rerate the policy retroactive to the effective date of the current policy term; and
- (ii) The policy, as reissued or rerated, shall provide premiums and policy terms the consumer would have been eligible for if accurate credit history had been used to determine eligibility.

(b) This subsection only applies if the consumer resolves the dispute under the process set forth in the fair credit reporting act and notifies the insurer in writing that the dispute has been resolved.

(7) The commissioner may adopt rules to implement this section.

(8) This section applies to all personal insurance policies issued or renewed after January 1, 2003. [2002 c 360 § 1.]

Additional notes found at www.leg.wa.gov

48.18.547 Underwriting restrictions that apply to medical malpractice insurance—Rules. (1) For the purposes of this section:

- (a) "Affiliate" has the same meaning as in RCW 48.31B.005(1).
- (b) "Claim" means a demand for monetary damages by a claimant.
- (c) "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.
- (d) "Tier" has the same meaning as in RCW 48.18.545(1)(h).

(e) "Underwrite" or "underwriting" means the process of selecting, rejecting, or pricing a risk, and includes each of these activities:

- (i) Evaluation, selection, and classification of risk, including placing a risk with an affiliate insurer that has higher rates and/or rating plan components that will result in higher premiums;
- (ii) Application of classification plans, rates, rating rules, and rating tiers to an insured risk; and
- (iii) Determining eligibility for:
 - (A) Insurance coverage provisions;
 - (B) Higher policy limits; or
 - (C) Premium payment plans.

(2) During each underwriting process, an insurer may consider the following factors only in combination with other substantive underwriting factors:

- (a) An insured has inquired about the nature or scope of coverage under a medical malpractice insurance policy;
- (b) An insured has notified their insurer about an incident that may be covered under the terms of their medical malpractice insurance policy, and that incident does not result in a claim; or
- (c) A claim made against an insured was closed by the insurer without payment. An insurer may consider the effect

of multiple claims if they have a significant effect on the insured's risk profile.

(3) If any underwriting activity related to the insured's risk profile results in higher premiums as described under subsection (1)(e)(i) and (ii) of this section or reduced coverage as described under subsection (1)(e)(iii) of this section, the insurer must provide written notice to the insured, in clear and simple language, that describes the significant risk factors which led to the underwriting action. The commissioner must adopt rules that define the components of a risk profile that require notice under this subsection. [2006 c 8 § 211.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

Additional notes found at www.leg.wa.gov

48.18.550 Victims of domestic abuse—Prohibition on certain cancellations, denials, refusals to renew, and different rates—Domestic abuse defined. (Effective until July 1, 2022.) (1) No insurer shall deny or refuse to accept an application for insurance, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of insurance, or charge a different rate for the same coverage on the basis that the applicant or insured person is, has been, or may be a victim of domestic abuse.

(2) Nothing in this section shall prevent an insurer from taking any of the actions set forth in subsection (1) of this section on the basis of loss history or medical condition or for any other reason not otherwise prohibited by this section, any other law, regulation, or rule.

(3) Any form filed or filed after June 11, 1998, subject to RCW 48.18.120(1) or subject to a rule adopted under RCW 48.18.120(1) may exclude coverage for losses caused by intentional or fraudulent acts of any insured. Such an exclusion, however, shall not apply to deny an insured's otherwise-covered property loss if the property loss is caused by an act of domestic abuse by another insured under the policy, the insured claiming property loss files a police report and cooperates with any law enforcement investigation relating to the act of domestic abuse, and the insured claiming property loss did not cooperate in, or contribute to, the creation of the property loss. Payment by the insurer to an insured may be limited to the person's insurable interest in the property less payments made to a mortgagee or other party with a legal secured interest in the property. An insurer making payment to an insured under this section has all rights of subrogation to recover against the perpetrator of the act that caused the loss.

(4) Nothing in this section prohibits an insurer from investigating a claim and complying with chapter 48.30A RCW.

(5) For the purposes of this section, the following definitions apply:

(a) "Domestic abuse" means: (i) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members or intimate partners; (ii) sexual assault of one family or household member by another or of one intimate partner by another; (iii) stalking as defined in RCW 9A.46.110 of one family or household member by another or of one intimate partner by another; or (iv) intentionally, knowingly, or recklessly causing damage to property so as to intimidate or

attempt to control the behavior of another family or household member or of another intimate partner.

(b) "Family or household member" has the same meaning as in RCW 26.50.010.

(c) "Intimate partner" has the same meaning as in RCW 26.50.010. [2020 c 29 § 15; 1998 c 301 § 1.]

Effective date—2020 c 29: See note following RCW 7.77.060.

48.18.550 Victims of domestic abuse—Prohibition on certain cancellations, denials, refusals to renew, and different rates—Domestic abuse defined. (Effective July 1, 2022.) (1) No insurer shall deny or refuse to accept an application for insurance, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of insurance, or charge a different rate for the same coverage on the basis that the applicant or insured person is, has been, or may be a victim of domestic abuse.

(2) Nothing in this section shall prevent an insurer from taking any of the actions set forth in subsection (1) of this section on the basis of loss history or medical condition or for any other reason not otherwise prohibited by this section, any other law, regulation, or rule.

(3) Any form filed or filed after June 11, 1998, subject to RCW 48.18.120(1) or subject to a rule adopted under RCW 48.18.120(1) may exclude coverage for losses caused by intentional or fraudulent acts of any insured. Such an exclusion, however, shall not apply to deny an insured's otherwise-covered property loss if the property loss is caused by an act of domestic abuse by another insured under the policy, the insured claiming property loss files a police report and cooperates with any law enforcement investigation relating to the act of domestic abuse, and the insured claiming property loss did not cooperate in, or contribute to, the creation of the property loss. Payment by the insurer to an insured may be limited to the person's insurable interest in the property less payments made to a mortgagee or other party with a legal secured interest in the property. An insurer making payment to an insured under this section has all rights of subrogation to recover against the perpetrator of the act that caused the loss.

(4) Nothing in this section prohibits an insurer from investigating a claim and complying with chapter 48.30A RCW.

(5) For the purposes of this section, the following definitions apply:

(a) "Domestic abuse" means: (i) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members or intimate partners; (ii) sexual assault of one family or household member by another or of one intimate partner by another; (iii) stalking as defined in RCW 9A.46.110 of one family or household member by another or of one intimate partner by another; or (iv) intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another family or household member or of another intimate partner.

(b) "Family or household member" has the same meaning as in RCW 10.99.020.

(c) "Intimate partner" has the same meaning as in RCW 10.99.020. [2021 c 215 § 151; 2020 c 29 § 15; 1998 c 301 § 1.]

Effective date—2021 c 215: See note following RCW 7.105.900.

Effective date—2020 c 29: See note following RCW 7.77.060.

48.18.553 Victims of hate crime offenses—Restrictions of underwriting actions—Definitions. (1) For the purposes of this section:

(a) "Insured" means a current policyholder or a person or entity that is covered under the insurance policy.

(b) "Hate crime offense" has the same meaning as RCW 9A.36.080. Under this section, the perpetrator does not have to be identified for a hate crime offense to have occurred.

(c) "Underwriting action" means an insurer:

(i) Cancels or refuses to renew an insurance policy; or

(ii) Changes the terms or benefits in an insurance policy.

(2) This section applies to property insurance policies if the insured is:

(a) An individual;

(b) A religious organization;

(c) An educational organization; or

(d) Any other nonprofit organization that is organized and operated for religious, charitable, or educational purposes.

(3) An insurer may not take an underwriting action on a policy described in subsection (2) of this section because an insured has made one or more insurance claims for any loss that occurred during the preceding sixty months that is the result of a hate crime offense. An insurer may take an underwriting action due to other factors that are not prohibited by this subsection.

(4) If an insured sustains a loss that is the result of a hate crime offense, the insured must file a report with the police or other law enforcement authority within thirty days of discovery of the incident, and a law enforcement authority must determine that a crime has occurred. The report must contain sufficient information to provide an insurer with reasonable notice that the loss was the result of a hate crime offense. The insured has a duty to cooperate with any law enforcement official or insurer investigation.

(5) Annually, each insurer must report underwriting actions to the commissioner if the insurer has taken an underwriting action against any insured who has filed a claim during the preceding sixty months that was the result of a hate crime offense. The report must include the policy number, name of the insured, location of the property, and the reason for the underwriting action. [2019 c 271 § 11; 2003 c 117 § 1.]

48.18.555 Property insurance—Actions resulting from arson or malicious mischief—Definitions. (1) For the purposes of this section:

(a) "Arson" has the same meaning as in chapter 9A.48 RCW.

(b) "Health care facility" has the same meaning as defined in RCW 48.43.005.

(c) "Health care provider" has the same meaning as defined in RCW 48.43.005.

(d) "Insured" means a current policyholder or a person or entity that is covered under the insurance policy.

(e) A perpetrator does not have to be identified for an act of arson or malicious mischief to have occurred.

(f) "Malicious mischief" has the same meaning as in chapter 9A.48 RCW.

(g) "Underwriting action" means an insurer:

(i) Cancels or refuses to renew an insurance policy; or

(ii) Changes the terms or benefits in an insurance policy.

(2) This section applies to property insurance policies if the insured is:

(a) A health care facility;

(b) A health care provider; or

(c) A religious organization.

(3) An insurer may not take an underwriting action on a policy described in subsection (2) of this section because an insured has made one or more insurance claims for any loss that occurred during the preceding sixty months that is the result of arson or malicious mischief. An insurer may take an underwriting action due to other factors that are not prohibited by this subsection.

(4) If an insured sustains a loss that is the result of arson or malicious mischief, the insured must file a report with the police or other law enforcement authority within thirty days of discovery of the incident, and a law enforcement authority must determine that a crime has occurred. The report must contain sufficient information to provide an insurer with reasonable notice that the loss was the result of arson or malicious mischief. The insured has a duty to cooperate with any law enforcement official or insurer investigation.

(5) Annually, each insurer must report underwriting actions to the commissioner if the insurer has taken an underwriting action against any insured who has filed a claim during the preceding sixty months that was the result of arson or malicious mischief. The report must include the policy number, name of the insured, location of the property, and the reason for the underwriting action. [2006 c 145 § 2.]

Finding—Intent—2006 c 145: "The legislature finds that access to insurance can be imperiled by the response of insurers to criminal acts. Rather than allow criminals to achieve their objectives, it is the intent of the legislature that criminals, through criminal acts, should not dictate insurance underwriting decisions. It is the intent of the legislature that courts should use restitution from perpetrators of intentional property crimes to make property owners and insurers whole." [2006 c 145 § 1.]

48.18.558 Property insurers—Assistance to prevent or reduce severity of claims or losses—Prior approval of commissioner—Pilot program permitted. (1) With the prior approval of the commissioner, a property insurer may include the following either goods or services, or both, intended to reduce either the probability of loss, or the extent of loss, or both, from a covered event as part of a policy of property insurance, except commercial property insurance:

(a) Goods, including a water monitor;

(b) Foundation strapping to mitigate losses due to earthquake;

(c) Ongoing services, including home safety monitoring or brush clearing to mitigate losses due to wildfire; and

(d) Other either goods or services, or both, as the commissioner may identify by rule.

(2) Any goods provided are owned by the insured, even if the insurance is subsequently canceled.

(3) The value of goods and services to be provided is limited to one thousand five hundred dollars in value in the aggregate in any twelve-month period.

(4) In order to receive prior approval of the commissioner, and except as provided in subsection (6) of this section, the property insurer must include the following in its rate filing:

(a) A description of either the specific goods or services, or both, to be offered;

(b) A description of the method of delivering either the specific goods or services, or both, being offered; and

(c) The selection criteria for insureds receiving either the specific goods or services, or both, being offered.

(5) This section does not require the commissioner to approve any particular proposed benefit. The commissioner may disapprove any proposed noninsurance benefit that the commissioner determines may tend to promote or facilitate the violation of any other section of this title. However, if the commissioner approves the inclusion of either the goods or services, or both, in a policy of property insurance, except commercial property insurance, it does not constitute a violation of RCW 48.30.140 or 48.30.150.

(6)(a) A property insurer may conduct a pilot program as either a risk mitigation or prevention, or both, strategy through which the insurer offers or provides risk mitigation and/or prevention goods and/or services identified in subsection (1) of this section in connection with an insurance policy covering property risks, except commercial property insurance, in accordance with rules adopted by the commissioner.

(b) A property insurer offering or providing risk mitigation and/or prevention goods and/or services through a pilot program under this subsection is exempt from including information about the risk mitigation and/or prevention goods and/or services in its rate filing as is otherwise required under subsection (4) of this section and RCW 48.19.530.

(c) A property insurer's pilot program may last no longer than two years.

(7) This section does not apply to disaster or emergency response activities of a property insurer. [2018 c 239 § 2.]

Findings—2018 c 239: "The legislature finds that allowing property insurers to assist their insureds with risk mitigation and/or prevention goods and/or services could help prevent, or reduce the severity of claims and losses. The legislature further finds that property insurers engage in supporting insureds through disaster or emergency response activities when there is an imminent threat of damage to insured property, such as wildfire prevention defense efforts that provide fire retardants to homes in a wildfire area or send crews to combat wildfires to protect insureds' homes. The legislature further finds that assisting insureds with risk mitigation and prevention and providing disaster or emergency response activities are both useful in preventing economic loss, and should be exempt from the prohibition against inducements under RCW 48.30.140 and 48.30.150." [2018 c 239 § 1.]

48.18.559 Property insurers—Rules addressing assistance to prevent or reduce severity of claims or losses. The commissioner may adopt rules as necessary to implement RCW 48.18.558 and 48.19.530, including but not limited to:

(1) Rules requiring a notice to insureds or potential insureds regarding their ability to opt out of receiving any risk mitigation and/or prevention goods and/or services;

(2) Rules increasing the value of either the goods or services, or both, permitted under RCW 48.18.558(1);

(3) Rules establishing requirements for pilot programs authorized under RCW 48.18.558(6); and

(4) Rules identifying which insurer disaster or emergency response activities are exempt from RCW 48.18.558

and 48.19.530 and RCW 48.30.140 and 48.30.150. [2018 c 239 § 4.]

Findings—2018 c 239: See note following RCW 48.18.558.

48.18.565 Homeowner's insurance—Foster parent.

An insurer licensed to write homeowner's insurance in this state shall not deny an application for a homeowner's insurance policy, or cancel, refuse to renew, or modify an existing homeowner's insurance policy for the principal reason that the applicant or insured is a foster parent licensed under chapter 74.15 RCW. [2004 c 84 § 1.]

48.18.570 Life insurance—Lawful travel destinations. (1) No life insurer may deny or refuse to accept an application for insurance, or refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of insurance, or charge a different rate for the same coverage, based upon the applicant's or insured person's past or future lawful travel destinations.

(2) Nothing in this section prohibits a life insurer from excluding or limiting coverage of specific lawful travel, or charging a differential rate for such coverage, when bona fide statistical differences in risk or exposure have been substantiated. [2005 c 441 § 1.]

48.18.580 Employer-owned life insurance—Requirements. (1) "Employer-owned life insurance policy" as used in this section and RCW 48.18.583 means an insurance policy purchased by an employer on the life of an employee, for the benefit of a person other than the employee or the employee's personal representative.

(2) An employer-owned life insurance policy may not be made or take effect unless at the time the contract is made the individual insured consents to the contract in writing.

(3) An employer may not retaliate in any manner against an employee for providing written notice that he or she does not want to be insured under an employer-owned life insurance policy.

(4) No later than thirty days after the date on which an employer purchases an employer-owned life insurance policy on the life of an employee, the employer must provide to the employee a written notice that contains the following information:

(a) A statement that the employer carries an employer-owned life insurance policy on the life of the employee;

(b) The identity of the insurance carrier of the policy;

(c) The maximum face amount of the policy at issue; and

(d) The identity of the beneficiary of the policy. [2005 c 337 § 4.]

Finding—Intent—2005 c 337: See note following RCW 48.18.030.

48.18.583 Employer-owned life insurance—Application to policies. With respect to employer-owned life insurance policies, chapter 337, Laws of 2005 shall apply only to policies issued and delivered after July 24, 2005. [2005 c 337 § 6.]

Finding—Intent—2005 c 337: See note following RCW 48.18.030.

48.18.586 Employer-owned life insurance—Rules. The commissioner shall adopt rules to implement RCW

48.18.010, 48.18.030, 48.18.060, 48.18.580, and 48.18.583. [2005 c 337 § 7.]

Finding—Intent—2005 c 337: See note following RCW 48.18.030.

48.18.600 Usage-based insurance—Restrictions on information collected. (1) For the purposes of this section, "usage-based insurance" has the same meaning as defined in RCW 48.19.040.

(2) Location data may not be collected without:

(a) Disclosure to the insured that such information is being collected as required by RCW 46.35.020; and

(b) The insured's consent.

(3) Individually identifiable usage information retrieved from a recording device may only be used and/or retained:

(a) For purposes of determining premiums; or

(b) As allowed by law in RCW 46.35.030.

(4) Individually identifiable usage information retrieved from a recording device may not be disclosed to any third party except as allowed by RCW 46.35.030. [2012 c 222 § 3.]

48.18.610 Customer satisfaction benefits. (1) An insurer may include contractual benefits based on customer satisfaction as part of an insurance policy. The insurer must file the policy or endorsement for approval as required by RCW 48.18.100. The contractual benefits may include sums of money provided or credited to a policyholder if the policyholder is dissatisfied with the service provided by their insurer. A sum that is provided to or credited to a policyholder as part of an approved contractual benefit based on customer satisfaction is not "premium" for the purposes of RCW 48.18.170. A policy premium reduced by such a credit will be taxed on the full cost of the premium before application of the customer satisfaction credit.

(2) This section applies only to personal insurance as defined in RCW 48.18.545(1)(g). [2016 c 121 § 1.]

48.18.900 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 § 114.]

Chapter 48.18A RCW VARIABLE CONTRACT ACT

Sections

48.18A.010 Short title—Intent.
48.18A.020 Separate accounts authorized—Allocations—Benefits—Limitations—Valuation—Sale, transfer, or exchange of assets.

48.18A.030 Statements required in contracts—Payment on death, incidental benefit provision.

48.18A.035 Return of policy and refund of premium—Notice required—Effect of return.

48.18A.040 Requirements for operation under this chapter—Considerations—Authorization of subsidiary or affiliate—Exceptions.

48.18A.050 Applicability of other code provisions—Contract requirements.

48.18A.060 Licensing requirement.

48.18A.070 Authority of commissioner.

48.18A.900 Effective date—1969 c 104.

Reviser's note: Powers, duties, and functions of the department of licensing relating to securities were transferred to the department of financial institutions by 1993 c 472, effective October 1, 1993. See RCW 43.320.011.

48.18A.010 Short title—Intent. This chapter shall be known as the "Variable Contract Act" and is intended to authorize the sale of both individual and group variable contracts. [1969 c 104 § 1.]

48.18A.020 Separate accounts authorized—Allocations—Benefits—Limitations—Valuation—Sale, transfer, or exchange of assets. A domestic life insurer may, by or pursuant to resolution of its board of directors, establish one or more separate accounts, and may allocate thereto amounts (including without limitation proceeds applied under optional modes of settlement or under dividend options) to provide for life insurance or annuities (and other benefits incidental thereto), payable in fixed or variable amounts or both, subject to the following:

(1) The income, gains, and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains, or losses of the insurer.

(2)(a) Except as hereinafter provided, amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurers: PROVIDED, That to the extent that the insurer's reserve liability with regard to (i) benefits guaranteed as to dollar amount and duration, and (ii) funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of such separate account at least equal to such reserve liability shall be invested under such conditions as the commissioner may prescribe. The investments in such separate account or accounts shall not be taken into account in applying the investment limitations applicable to the investments of the insurer.

(b) With respect to seventy-five percent of the market value of the total assets in a separate account no insurer shall purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal or interest by the United States, if immediately after such purchase or acquisition the market value of such investment, together with prior investments of such separate account in such security taken at market value, would exceed ten percent of the market value of the assets of such separate account: PROVIDED, That the commissioner may waive such limitation if, in his or her opinion, such waiver will not render the operation of such separate account hazardous to the public or the policyholders in this state.

(c) Unless otherwise permitted by law or approved by the commissioner, no insurer shall purchase or otherwise acquire for its separate accounts the voting securities of any issuer if as a result of such acquisition the insurer and its separate accounts, in the aggregate, will own more than ten percent of the total issued and outstanding voting securities of such issuer: PROVIDED, That the foregoing shall not apply with respect to securities held in separate accounts, the voting rights in which are exercisable only in accordance with instructions from persons having interests in such accounts.

(d) The limitations provided in paragraphs (b) and (c) of this subsection shall not apply to the investment with respect to a separate account in the securities of an investment company registered under the United States Investment Company Act of 1940: PROVIDED, That the investments of such investment company shall comply in substance therewith.

(3) Unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account: PROVIDED, That unless otherwise approved by the commissioner, the portion, if any, of the assets of such separate account equal to the insurer's reserve liability with regard to the guaranteed benefits and funds referred to in subsection (2) of this section shall be valued in accordance with the rules otherwise applicable to the insurer's assets.

(4) Amounts allocated to a separate account in the exercise of the power granted by this chapter shall be owned by the insurer and the insurer shall not be, nor hold itself out to be, a trustee with respect to such amounts. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the insurer may conduct.

(5) No sale, exchange or other transfer of assets may be made by an insurer between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made (a) by a transfer of cash, or (b) by a transfer of securities having a readily determinable market value: PROVIDED, That such transfer of securities is approved by the commissioner. The commissioner may approve other transfers among such accounts, if, in his or her opinion, such transfers would not be inequitable.

(6) To the extent such insurer deems it necessary to comply with any applicable federal or state law, such insurer, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having interest therein, as may be appropriate, voting and other rights and special procedures for the conduct of the business of such account, including without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of independent public

accountants, and the selection of a committee, the members of which need not be otherwise affiliated with such insurer, to manage the business of such account. [2009 c 549 § 7078; 1973 1st ex.s. c 163 § 4; 1969 c 104 § 2.]

48.18A.030 Statements required in contracts—Payment on death, incidental benefit provision. (1) Every variable contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurer in determining the dollar amount of such variable benefits. Any such contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will so vary and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

(2) Variable annuity contracts delivered or issued for delivery in this state may include as an incidental benefit provision for payment on death during the deferred period of an amount not in excess of the greater of the sum of the premiums or stipulated payments paid under the contract or the value of the contract at time of death. For this purpose such benefit shall not be deemed to be life insurance and therefore not subject to any statutory provisions governing life insurance contracts. A provision for any other benefits on death during the deferred period will be subject to such insurance law provisions. [1973 1st ex.s. c 163 § 5; 1969 c 104 § 3.]

48.18A.035 Return of policy and refund of premium—Notice required—Effect of return. Every individual variable contract issued shall have printed on its face or attached thereto a notice stating in substance that the policy owner shall be permitted to return the policy within ten days after it is received by the policy owner and to have the market value of the assets purchased by its premium, less taxes and investment brokerage commissions, if any, refunded, if, after examination of the policy, the policy owner 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 policy owner pursuant to such notice returns the policy 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 had been issued. [2017 3rd sp.s. c 25 § 16; 2008 c 217 § 19; 1983 1st ex.s. c 32 § 7; 1982 c 181 § 15.]

Additional notes found at www.leg.wa.gov

48.18A.040 Requirements for operation under this chapter—Considerations—Authorization of subsidiary or affiliate—Exceptions. No insurer shall deliver or issue, for delivery within this state, contracts under this chapter unless it is licensed or organized to do a life insurance or annuity business in this state, and unless the commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this

state. In this connection, the commissioner shall consider among other things:

- (1) The history and financial condition of the insurer;
- (2) The character, responsibility and fitness of the officers and directors of the insurer; and
- (3) The law and regulation under which the insurer is authorized in the state of domicile to issue variable contracts.

An insurer which issues variable contracts and which is a subsidiary of, or affiliated through common management or ownership with, another life insurer authorized to do business in this state may be deemed to have met the provisions of this section if either it or the parent or affiliated company meets the requirements hereof: PROVIDED, That no insurer may provide variable benefits in its contracts unless it is an admitted insurer having and continually maintaining a combined capital and surplus of at least five million dollars. [1982 c 181 § 10; 1969 c 104 § 4.]

Additional notes found at www.leg.wa.gov

48.18A.050 Applicability of other code provisions—Contract requirements. The provisions of RCW 48.23.020, 48.23.030, 48.23.080 through 48.23.120, 48.23.140, 48.23.150, 48.23.200 through 48.23.240, 48.23.310, and 48.23.360, and the provisions of chapters 48.24 and 48.76 RCW are inapplicable to variable contracts. Any provision in the code requiring contracts to be participating is not applicable to variable contracts. Except as otherwise provided in this chapter, all pertinent provisions of the insurance code apply to separate accounts and contracts relating thereto. Any individual variable life insurance or individual variable annuity contract delivered or issued for delivery in this state must contain grace, reinstatement, and nonforfeiture provisions appropriate to those contracts, and any variable life insurance contract must provide that the investment experience of the separate account may not operate to reduce the death benefit below an amount equal to the face amount of the contract at the time the contract was issued. Any individual variable life insurance contract may contain a provision for deduction from the death proceeds of amounts of due and unpaid premiums or of indebtedness which are appropriate to that contract. The reserve liability for variable annuities must be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees. [2003 c 248 § 6; 1983 c 3 § 150; 1979 c 157 § 2; 1973 1st ex.s. c 163 § 6; 1969 c 104 § 5.]

48.18A.060 Licensing requirement. No person shall be or act as an insurance producer for the solicitation or sale of variable contracts except while duly appointed and licensed under the insurance code as a variable life and variable annuity products insurance producer with respect to the insurer, and while duly licensed as a security salesperson or securities broker under a license issued by the director of financial institutions pursuant to the securities act of this state; except that any person who participates only in the sale or offering for sale of variable contracts which fund corporate plans meeting the requirements for qualification under sections 401 or 403 of the United States internal revenue code need not be licensed pursuant to the securities act of this state. [2010 c 8 § 11003; 2008 c 217 § 20; 1994 c 92 § 502; 1973 1st ex.s. c 163 § 7; 1969 c 104 § 6.]

(2021 Ed.)

Additional notes found at www.leg.wa.gov

48.18A.070 Authority of commissioner. Notwithstanding any other provision of law, the commissioner shall have sole and exclusive authority to regulate the issuance and sale of variable contracts; except for the examination, issuance or renewal, suspension or revocation, of a security salesperson's license issued to persons selling variable contracts. To carry out the purposes and provisions of this chapter, he or she may independently, and in concert with the director of financial institutions, issue such reasonable rules and regulations as may be appropriate. [2013 c 23 § 102; 1994 c 92 § 503; 1969 c 104 § 7.]

48.18A.900 Effective date—1969 c 104. This 1969 act shall take effect July 1, 1969. [1969 c 104 § 10.]

Chapter 48.19 RCW RATES

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Anti-compact law: RCW 48.30.020.

Discrimination prohibited: RCW 48.18.480.

Rate wars prohibited: RCW 48.30.240.

48.19.010 Scope of chapter. (1) Except as is otherwise expressly provided the provisions of this chapter apply to all insurances upon subjects located, resident or to be performed in this state except:

- (a) Life insurance;
- (b) Disability insurance;
- (c) Reinsurance except as to joint reinsurance as provided in RCW 48.19.360;
- (d) Insurance against loss of or damage to aircraft, their hulls, accessories, and equipment, or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance[,] or use of aircraft;
- (e) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection[,] and indemnity; and such other risks commonly insured under marine, as distinguished from inland marine, insurance contracts as may be defined by ruling of the commissioner for the purposes of this provision;
- (f) Title insurance.

(2) Except, that every insurer shall, as to disability insurance, before using file with the commissioner its manual of classification, manual of rules and rates, and any modifications thereof except as provided under RCW 48.43.733 or rate filing requirements established by a specific statute or federal law. [2015 c 19 § 4; 1987 c 185 § 24; 1947 c 79 § .19.01; Rem. Supp. 1947 § 45.19.01.]

Intent—2015 c 19: See note following RCW 48.18.100.

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

48.19.020 Rate standard. Premium rates for insurance shall not be excessive, inadequate, or unfairly discriminatory. [1983 1st ex.s. c 32 § 13; 1947 c 79 § .19.02; Rem. Supp. 1947 § 45.19.02.]

48.19.030 Making of rates—Criteria. Rates shall be used, subject to the other provisions of this chapter, only if made in accordance with the following provisions:

(1) In the case of insurances under standard fire policies and that part of marine and transportation insurances not exempted under RCW 48.19.010, manual, minimum, class or classification rates, rating schedules or rating plans, shall be made and adopted; except as to specific rates on inland marine risks individually rated, which risks are not reasonably susceptible to manual or schedule rating, and which risks by general custom of the business are not written according to manual rates or rating plans.

(2) In the case of casualty and surety insurances:

(a) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with

respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(b) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

(3) Due consideration in making rates for all insurances shall be given to:

(a) Past and prospective loss experience within this state for experience periods acceptable to the commissioner. If the information is not available or is not statistically credible, an insurer may use loss experience in those states which are likely to produce loss experience similar to that in this state.

(b) Conflagration and catastrophe hazards, where present.

(c) A reasonable margin for underwriting profit and contingencies.

(d) Dividends, savings and unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.

(e) Past and prospective operating expenses.

(f) Past and prospective investment income.

(g) All other relevant factors within and outside this state.

(4) In addition to other factors required by this section, rates filed by an insurer on its own behalf may also be related to the insurer's plan of operation and plan of risk classification.

(5) Except to the extent necessary to comply with RCW 48.19.020 uniformity among insurers in any matter within the scope of this section is neither required nor prohibited. [1989 c 25 § 3; 1947 c 79 § .19.03; Rem. Supp. 1947 § 45.19.03.]

Additional notes found at www.leg.wa.gov

48.19.035 Making of rates—Definitions—Personal insurance—Use of credit history or insurance scores—Rules. (1) For the purposes of this section:

(a) "Affiliate" has the same meaning as defined in RCW 48.31B.005(1).

(b) "Consumer" means an individual policyholder or applicant for insurance.

(c) "Credit history" means any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's creditworthiness, credit standing, or credit capacity that is used or expected to be used, or collected in whole or in part, for the purpose of serving as a factor in determining personal insurance premiums or eligibility for coverage.

(d) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit history.

(e) "Personal insurance" means:

(i) Private passenger automobile coverage;

(ii) Homeowner's coverage, including mobile homeowners, manufactured homeowners, condominium owners, and renter's coverage;

(iii) Dwelling property coverage;

(iv) Earthquake coverage for a residence or personal property;

(v) Personal liability and theft coverage;

(vi) Personal inland marine coverage; and

(vii) Mechanical breakdown coverage for personal auto or home appliances.

(2)(a) Credit history shall not be used to determine personal insurance rates, premiums, or eligibility for coverage unless the insurance scoring models are filed with the commissioner. Insurance scoring models include all attributes and factors used in the calculation of an insurance score. RCW 48.19.040(5) does not apply to any information filed under this subsection, and the information shall be withheld from public inspection and kept confidential by the commissioner. All information filed under this subsection shall be considered trade secrets under RCW 48.02.120(3). Information filed under this subsection may be made public by the commissioner for the sole purpose of enforcement actions taken by the commissioner.

(b) Each insurer that uses credit history or an insurance score to determine personal insurance rates, premiums, or eligibility for coverage must file all rates and rating plans for that line of coverage with the commissioner. This requirement applies equally to a single insurer and two or more affiliated insurers. RCW 48.19.040(5) applies to information filed under this subsection except that any eligibility rules or guidelines shall be withheld from public inspection under RCW 48.02.120(3) from the date that the information is filed and after it becomes effective.

(3) Insurers shall not use the following types of credit history to calculate a personal insurance score or determine personal insurance premiums or rates:

(a) The absence of credit history or the inability to determine the consumer's credit history, unless the insurer has filed actuarial data segmented by demographic factors in a manner prescribed by the commissioner that demonstrates compliance with RCW 48.19.020;

(b) The number of credit inquiries;

(c) Credit history or an insurance score based on collection accounts identified with a medical industry code;

(d) The initial purchase or finance of a vehicle or house that adds a new loan to the consumer's existing credit history, if evident from the consumer report; however, an insurer may consider the bill payment history of any loan, the total number of loans, or both;

(e) The consumer's use of a particular type of credit card, charge card, or debit card; or

(f) The consumer's total available line of credit; however, an insurer may consider the total amount of outstanding debt in relation to the total available line of credit.

(4) If a consumer is charged higher premiums due to disputed credit history, the insurer shall rerate the policy retroactive to the effective date of the current policy term. As rerated, the consumer shall be charged the same premiums they would have been charged if accurate credit history was used to calculate an insurance score. This subsection applies only if the consumer resolves the dispute under the process

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set forth in the fair credit reporting act and notifies the insurer in writing that the dispute has been resolved.

(5) The commissioner may adopt rules to implement this section.

(6) This section applies to all personal insurance policies issued or renewed on or after June 30, 2003. [2004 c 86 § 1; 2002 c 360 § 2.]

Additional notes found at www.leg.wa.gov

48.19.040 Filing required—Contents—Definition.

(1) Every insurer or rating organization shall, before using, file with the commissioner every classifications manual, manual of rules and rates, rating plan, rating schedule, minimum rate, class rate, and rating rule, and every modification of any of the foregoing which it proposes. The insurer need not so file any rate on individually rated risks as described in subdivision (1) of RCW 48.19.030; except that any such specific rate made by a rating organization shall be filed.

(2) Every such filing shall indicate the type and extent of the coverage contemplated and must be accompanied by sufficient information to permit the commissioner to determine whether it meets the requirements of this chapter. An insurer or rating organization shall offer in support of any filing:

(a) The experience or judgment of the insurer or rating organization making the filing;

(b) An exhibit detailing the major elements of operating expense for the types of insurance affected by the filing;

(c) An explanation of how investment income has been taken into account in the proposed rates; and

(d) Any other information which the insurer or rating organization deems relevant.

(3) If an insurer has insufficient loss experience to support its proposed rates, it may submit:

(a) Loss experience for similar exposures of other insurers or of a rating organization; or

(b) A complete and logical explanation of how it has developed its proposed rates, including the insurer's analysis of any relevant information and showing why the proposed rates should be considered to meet the requirements of RCW 48.19.020.

(4) Every such filing shall state its proposed effective date.

(5)(a) A filing made pursuant to this chapter shall be exempt from the provisions of RCW 48.02.120(3). However, the filing and all supporting information accompanying it shall be open to public inspection only after the filing becomes effective, except as provided in (b) of this subsection.

(b) For the purpose of this section, "usage-based insurance" means private passenger automobile coverage that uses data gathered from any recording device as defined in RCW 46.35.010, or a system, or business method that records and preserves data arising from the actual usage of a motor vehicle to determine rates or premiums. Information in a filing of usage-based insurance about the usage-based component of the rate is confidential and must be withheld from public inspection.

(6) Where a filing is required no insurer shall make or issue an insurance contract or policy except in accordance with its filing then in effect, except as is provided by RCW 48.19.090. [2013 c 152 § 2; 2012 c 222 § 1; 1994 c 131 § 8;

1989 c 25 § 4; 1983 1st ex.s. c 32 § 14; 1947 c 79 § .19.04; Rem. Supp. 1947 § 45.19.04.]

Additional notes found at www.leg.wa.gov

48.19.043 Forms of commercial property casualty policies—Legislative intent—Issuance prior to filing—Disapproval by commissioner—Definition. (1) It is the intent of the legislature to assist the purchasers of commercial property casualty insurance by allowing policies to be issued more expeditiously and provide a more competitive market for rates.

(2) Notwithstanding the provisions of RCW 48.19.040(1), commercial property casualty policies may be issued prior to filing the rates. All commercial property casualty rates shall be filed with the commissioner within thirty days after an insurer issues any policy using them.

(3) If, within thirty days after a commercial property casualty rate has been filed, the commissioner finds that the rate does not meet the requirements of this chapter, the commissioner shall disapprove the filing and give notice to the insurer or rating organization that made the filing, specifying how the filing fails to meet the requirements and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. The commissioner may extend the time for review another fifteen days by giving notice to the insurer prior to the expiration of the original thirty-day period.

(4) Upon a final determination of a disapproval of a rate filing under subsection (3) of this section, the insurer shall issue an endorsement changing the rate to comply with the commissioner's disapproval from the date the rate is no longer effective.

(5) For purposes of this section, "commercial property casualty" means insurance pertaining to a business, profession, occupation, nonprofit organization, or public entity for the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, or 48.11.070, but does not mean medical malpractice insurance or portable electronics insurance as defined in RCW 48.120.005.

(6) Except as provided in subsection (4) of this section, the disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice of disapproval.

(7) In the event a hearing is held on the actions of the commissioner under subsection (3) of this section, the burden of proof is on the commissioner. [2013 c 152 § 3; 2006 c 8 § 216; 2003 c 248 § 7; 1997 c 428 § 2.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

48.19.050 Filings by rating bureau. (1) If so authorized by an insurer, the commissioner shall accept, in lieu of filings by the insurer, filings on its behalf made by a rating organization then licensed as provided in this chapter.

(2) As to fire insurance under a standard form fire policy, and the following insurances (other than vehicle insurance coverages) when issued as part of a standard form fire policy, an insurer may so authorize a rating organization to make all [of] its filings only, and may not make a portion of such filings upon its own behalf and authorize a rating organization to make other such filings:

(a) Additional property insurance coverages; or

(b) Coverages including any kind of insurance in addition to fire for a single undivided premium.

(3) Except, that notwithstanding the provisions of subsection (2) an insurer which prior to the first day of January, 1947, made its own filings in this state as to a particular class of fire risks, and its filings in this state as to other classes of fire risks were made by a rating organization authorized by the insurer so to do, may:

(a) Continue to make all [of] its own filings as to such specific class of risks or authorize a rating organization to make its filings as to such specific class of risks or any part thereof; and

(b) Authorize a different rating organization to make all only of its filings [all of its filings only] as to all other classes of risks insured by it in this state against fire under the standard form fire policy; or

(c) Make all [of] its own filings as to all classes of risks insured by it against fire under the standard form fire policy, or make all [of] its own such filings except as to any which may relate to any such specific class of risks, which filings so excepted the insurer may authorize a rating organization to make; or

(d) Authorize a rating organization to make all only of its filings [all of its filings only] as to all classes or risks insured by it against fire in this state under the standard form fire policy. [1957 c 193 § 13; 1947 c 79 § .19.05; Rem. Supp. 1947 § 45.19.05.]

48.19.060 Filings—Review, waiting period, disapproval. (1) The commissioner shall review a filing as soon as reasonably possible after made, to determine whether it meets the requirements of this chapter.

(2) Except as provided in RCW 48.19.070 and 48.19.043:

(a) No such filing shall become effective within thirty days after the date of filing with the commissioner, which period may be extended by the commissioner for an additional period not to exceed fifteen days if he or she gives notice within such waiting period to the insurer or rating organization which made the filing that he or she needs such additional time for the consideration of the filing. The commissioner may, upon application and for cause shown, waive such waiting period or part thereof as to a filing that he or she has not disapproved.

(b) A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

(3) Medical malpractice insurance rate filings are subject to the provisions of this section. [2006 c 8 § 217; 1997 c 428 § 4; 1989 c 25 § 5; 1947 c 79 § .19.06; Rem. Supp. 1947 § 45.19.06.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

Additional notes found at www.leg.wa.gov

48.19.070 Special filings. The following special filings, when not covered by a previous filing, shall become effective when filed and shall be deemed to meet the requirements of this chapter until such time as the commissioner reviews the filing and for so long thereafter as the filing remains in effect:

(1) Special filings with respect to surety or guaranty bonds required by law or by court or executive order or by order, rule or regulation of a public body.

(2) Specific rates on inland marine risks individually rated by a rating organization, which risks are not reasonably susceptible to manual or schedule rating, and which risks by general custom of the business are not written according to manual rates or rating plans. [1947 c 79 § .19.07; Rem. Supp. 1947 § 45.19.07.]

48.19.080 Waiver of filing. Under such rules and regulations as he or she shall adopt the commissioner may, by order, suspend or modify the requirement of filing as to any kind of insurance. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The commissioner may make such examination as he or she may deem advisable to ascertain whether any rates affected by such order meet the standard prescribed in RCW 48.19.020. [2009 c 549 § 7079; 1981 c 339 § 18; 1947 c 79 § .19.08; Rem. Supp. 1947 § 45.19.08.]

48.19.090 Excess rates on specific risks. Upon written application of the insured, stating his or her reasons therefor, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk. [2009 c 549 § 7080; 1947 c 79 § .19.09; Rem. Supp. 1947 § 45.19.09.]

48.19.100 Disapproval of filing. If within the waiting period or any extension thereof as provided in RCW 48.19.060, the commissioner finds that a filing does not meet the requirements of this chapter, he or she shall disapprove such filing, and shall give notice of such disapproval, specifying the respect in which he or she finds the filing fails to meet such requirements, and stating that the filing shall not become effective, to the insurer or rating organization which made the filing. [2009 c 549 § 7081; 1989 c 25 § 6; 1947 c 79 § .19.10; Rem. Supp. 1947 § 45.19.10.]

Additional notes found at www.leg.wa.gov

48.19.110 Disapproval of special filing. (1) If within thirty days after a special filing subject to RCW 48.19.070 has become effective, the commissioner finds that the filing does not meet the requirements of this chapter, he or she shall disapprove the filing and shall give notice to the insurer or rating organization which made the filing, specifying in what respects he or she finds that the filing fails to meet such requirements and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective.

(2) Such disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice of disapproval. [2009 c 549 § 7082; 1947 c 79 § .19.11; Rem. Supp. 1947 § 45.19.11.]

48.19.120 Subsequent disapproval. (1) If at any time subsequent to the applicable review period provided in RCW 48.19.060 or 48.19.110, the commissioner finds that a filing does not meet the requirements of this chapter, he or she shall, after a hearing, notice of which was given to every insurer and rating organization which made such filing, issue his or her order specifying in what respect he or she finds that

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such filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, the filings shall be deemed no longer effective.

(2) Such order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(3) Any person aggrieved with respect to any filing then in effect, other than the insurer or rating organization which made the filing, may make written application to the commissioner for a hearing thereon. The application shall specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if his or her grounds are established, and that such grounds otherwise justify holding the hearing, he or she shall, within thirty days after receipt of the application, hold a hearing as required in subsection (1) of this section. [2009 c 549 § 7083; 1989 c 25 § 7; 1983 1st ex.s. c 32 § 15; 1947 c 79 § .19.12; Rem. Supp. 1947 § 45.19.12.]

Additional notes found at www.leg.wa.gov

48.19.140 Rating organizations—Discrimination—"Subscriber" defined. (1) Every rating organization operating in this state shall furnish its services without discrimination as between its subscribers.

(2) "Subscriber," for the purposes of this chapter and where the context does not otherwise specify, means any insurer which employs the services of a rating organization for the purpose of making filings, whether or not the insurer is a "member" of such rating organization.

(3) This chapter is not intended to and does not govern or affect the "membership" relation as such between a rating organization and insurers who are its "members." [1947 c 79 § .19.14; Rem. Supp. 1947 § 45.19.14.]

48.19.150 Subscribership not required. No provision of this code shall require, or be deemed to require, any insurer to be a subscriber of, or in any other respect affiliated with, any rating organization. [1947 c 79 § .19.15; Rem. Supp. 1947 § 45.19.15.]

48.19.160 Rating organization license. No rating organization shall do business in this state or make filings with the commissioner unless then licensed by the commissioner as a rating organization. [1947 c 79 § .19.16; Rem. Supp. 1947 § 45.19.16.]

48.19.170 Application for license. (1) Any person, whether domiciled within or outside this state, except as provided in subsection (2) of this section, may make application to the commissioner for a license as a rating organization for such kinds of insurance or subdivisions thereof, if for casualty or surety insurances, or for such subdivision, class of risks or a part or combination thereof, if for other insurances, as are specified in its application, and shall file therewith:

(a) A copy of its constitution, its articles of agreement or association, or its certificate of incorporation, or trust agreement, and of its bylaws, rules and regulations governing the conduct of its business;

(b) A list of its members and a list of its subscribers;

(c) The name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served, and

(d) A statement of its qualifications as a rating organization.

(2) Any rating organization proposing to act as such as to insurance under standard form fire policies, shall be licensed only if all the following conditions are complied with:

(a) The applicant and the operators of such rating organization shall be domiciled in and shall actually reside in this state.

(b) The ownership of such rating organization shall be vested in trustees for all its subscribers under such trust agreement as is approved by the commissioner, and the rating organization shall be and shall be conducted as a nonprofit public service institution.

(c) Such rating organization shall not be connected with any insurer or insurers except to the extent that any such insurer may be a subscriber to its services. [1947 c 79 § .19.17; Rem. Supp. 1947 § 45.19.17.]

48.19.180 Issuance of license. (1) If the commissioner finds that the applicant for a license as a rating organization is competent, trustworthy and otherwise qualified so to act, and that its constitution, articles of agreement or association or certificate of incorporation or trust agreement, and its bylaws, rules and regulations governing the conduct of its business conform to the requirements of law, he or she shall, upon payment of a license fee of twenty-five dollars, issue a license specifying the kinds of insurance, or subdivisions or class of risk or part or combination thereof for which the applicant is authorized to act as a rating organization.

(2) The commissioner shall grant or deny in whole or in part every such application within sixty days of the date of its filing with him or her.

(3) A license issued pursuant to this section shall remain in effect for three years unless sooner suspended or revoked by the commissioner. [2009 c 549 § 7084; 1947 c 79 § .19.18; Rem. Supp. 1947 § 45.19.18.]

48.19.190 Suspension or revocation of license. (1) The commissioner may, after a hearing, suspend or revoke the license issued to a rating organization for any of the following causes:

(a) If he or she finds that the licensee no longer meets the qualifications for the license.

(b) For failure to comply with an order of the commissioner within the time limited by the order, or any extension thereof which the commissioner may grant.

(2) The commissioner shall not so suspend or revoke a license for failure to comply with an order until the time prescribed by this code for an appeal from such order to the superior court has expired or if such appeal has been taken, until such order has been affirmed.

(3) The commissioner may determine when a suspension or revocation of license shall become effective. A suspension of license shall remain in effect for the period fixed by him or her, unless he or she modifies or rescinds the suspension, or until the order, failure to comply with which constituted grounds for the suspension, is modified, rescinded or

reversed. [2009 c 549 § 7085; 1947 c 79 § .19.19; Rem. Supp. 1947 § 45.19.19.]

48.19.200 Notice of changes. Every rating organization shall notify the commissioner promptly of every change in

(1) its constitution, its articles of agreement or association, or its certificate of incorporation, or trust agreement, and its bylaws, rules and regulations governing the conduct of its business;

(2) its list of members and subscribers;

(3) the name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting such rating organization may be served. [1947 c 79 § .19.20; Rem. Supp. 1947 § 45.19.20.]

48.19.210 Subscribers—Rights, limitations. (1) Subject to rules and regulations which have been approved by the commissioner as reasonable, each rating organization shall permit any insurer to subscribe to its rating services for any kind of insurance or subdivision thereof, for which it is authorized to act as a rating organization, subject to subsection (2) of RCW 48.19.050.

(2) Notice of proposed changes in such rules and regulations shall be given to each subscriber.

(3) An insurer shall not concurrently be a subscriber to the services of more than one rating organization as to the same subdivision, class of risk or part or combination of a kind of insurance.

(4) As to fire insurance under standard form fire policies, an insurer may not concurrently be a subscriber to the services of more than one rating organization except as provided in subsection (2) of RCW 48.19.050. [1947 c 79 § .19.21; Rem. Supp. 1947 § 45.19.21.]

48.19.220 Review of rules and refusal to admit insurers. (1) The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the commissioner at a hearing held upon notice to the rating organization, and to the subscriber or insurer.

(2) If the commissioner finds that such rule or regulation is unreasonable in its application to subscribers, he or she shall order that such rule or regulation shall not be applicable to subscribers who are not members of the rating organization.

(3) If a rating organization fails to grant or reject an insurer's application for subscribership within thirty days after it was made, the insurer may request a review by the commissioner as if the application had been rejected. If the commissioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, he or she shall order the rating organization to admit the insurer as a subscriber. If he or she finds that the action of the rating organization was justified, he or she shall make an order affirming its action. [2009 c 549 § 7086; 1947 c 79 § .19.22; Rem. Supp. 1947 § 45.19.22.]

48.19.230 Subscriber committees. The subscribers of any rating organization may, from time to time, individually or through committees representing various subscribers, con-

sult with the rating organization with respect to matters within this chapter which affect such subscribers. [1947 c 79 § .19.23; Rem. Supp. 1947 § 45.19.23.]

48.19.240 Rules cannot affect dividends. No rating organization shall adopt any rule the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers. [1947 c 79 § .19.24; Rem. Supp. 1947 § 45.19.24.]

48.19.250 Cooperative activities. (1) Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this chapter is hereby authorized, if the filings resulting from such cooperation are subject to all the provisions of this chapter which are applicable to filings generally.

(2) The commissioner may review such cooperative activities and practices and if, after a hearing, he or she finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this code, he or she may issue a written order specifying in what respect such activity or practice is so unfair, unreasonable, or inconsistent, and requiring the discontinuance of such activity or practice. [2009 c 549 § 7088; 1947 c 79 § .19.25; Rem. Supp. 1947 § 45.19.25.]

48.19.260 Technical services. Any rating organization may subscribe for or purchase actuarial, technical or other services, and such services shall be available to all subscribers without discrimination. [1947 c 79 § .19.26; Rem. Supp. 1947 § 45.19.26.]

48.19.270 Records—Examinations. Each rating organization shall keep an accurate and complete record of all work performed by it, and of all its receipts and disbursements. Such rating organization and its records shall be examined by the commissioner at such times and in such manner as is provided in chapter 48.03 RCW of this code. [1947 c 79 § .19.27; Rem. Supp. 1947 § 45.19.27.]

48.19.280 Deviations. (1) Every member or subscriber to a rating organization shall adhere to the filings made on its behalf by such organization. Deviations from the organization's filings are permitted only when filed with the commissioner in accordance with this chapter.

(2) Every such deviation shall terminate upon a material change of the basic rate from which the deviation is made. The commissioner shall determine whether a change of the basic rate is so material as to require such termination of deviations. [1989 c 25 § 8; 1957 c 193 § 14; 1947 c 79 § .19.28; Rem. Supp. 1947 § 45.19.28.]

Additional notes found at www.leg.wa.gov

48.19.290 Appeal from rating organization's action. (1) Any subscriber to a rating organization may appeal to the commissioner from the rating organization's action or decision in approving or rejecting any proposed change in or addition to the rating organization's filings. The commissioner shall, after a hearing on the appeal:

(a) Issue an order approving the rating organization's action or decision or directing it to give further consideration to such proposal; or

(b) If the appeal is from the rating organization's action or decision in rejecting a proposed addition to its filings, he or she may, in event he or she finds that the action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filings, on behalf of its subscribers, in a manner consistent with his or her findings, within a reasonable time after the issuance of such order.

(2) If such appeal is based upon the rating organization's failure to make a filing on behalf of such subscriber which is based on a system of expense provisions which differs, in accordance with the right granted in subdivision (2) of RCW 48.19.030, from the system of expense provisions included in a filing made by the rating organization, the commissioner shall, if he or she grants the appeal, order the rating organization to make the requested filing for use by the appellant. In deciding the appeal the commissioner shall apply the standards set forth in RCW 48.19.020 and 48.19.030. [2009 c 549 § 7088; 1947 c 79 § .19.29; Rem. Supp. 1947 § 45.19.29.]

48.19.300 Service to insureds. Every rating organization and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate. [1947 c 79 § .19.30; Rem. Supp. 1947 § 45.19.30.]

48.19.310 Complaints of insureds. Every rating organization and every insurer which makes its own rates shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by his or her authorized representative, on his or her written request to review the manner in which such rating system has been applied in connection with the insurance afforded him or her. If the rating organization or insurer fails to grant or reject such request within thirty days after it is made, the applicant may proceed in the same manner as if his or her application had been rejected. Any party affected by the action of such rating organization or such insurer on such request may, within thirty days after written notice of such action, appeal to the commissioner, who, after a hearing held upon notice to the appellant and to the rating organization or insurer, may affirm or reverse such action. [2009 c 549 § 7089; 1947 c 79 § .19.31; Rem. Supp. 1947 § 45.19.31.]

48.19.320 Advisory organizations—Definition. (1) Every group, association or other organization of insurers, whether located within or outside this state, which assists insurers which make their own filings or rating organizations in rate making, by the collection and furnishing of loss or expense statistics, or by the submission of recommendations, but which does not make filings under this chapter, shall be known as an advisory organization.

(2) This section does not apply to subscribers' committees provided for in RCW 48.19.230. [1947 c 79 § .19.32; Rem. Supp. 1947 § 45.19.32.]

48.19.330 Requisites of advisory organization. Every advisory organization before serving as such to any rating organization or independently filing insurer doing business in this state, shall file with the commissioner:

(1) A copy of its constitution, its articles of agreement or association or its certificate of incorporation and of its bylaws, rules and regulations governing its activities;

(2) A list of its members;

(3) The name and address of a resident of this state upon whom notices or orders of the commissioner or process issued at his or her direction may be served; and

(4) An agreement that the commissioner may examine such advisory organization in accordance with the provisions of RCW 48.03.010. [2009 c 549 § 7090; 1947 c 79 § .19.33; Rem. Supp. 1947 § 45.19.33.]

48.19.340 Desist orders. If, after a hearing, the commissioner finds that the furnishing of information or assistance by an advisory organization, as referred to in RCW 48.19.320, involves any act or practice which is unfair or unreasonable or otherwise inconsistent with the provisions of this code, he or she may issue a written order specifying in what respect such act or practice is unfair or unreasonable or so otherwise inconsistent, and requiring the discontinuance of such act or practice. [2009 c 549 § 7091; 1947 c 79 § .19.34; Rem. Supp. 1947 § 45.19.34.]

48.19.350 Disqualification of data. No insurer which makes its own filing nor any rating organization shall support its filings by statistics or adopt rate making recommendations, furnished to it by an advisory organization which has not complied with this chapter or with any order of the commissioner involving such statistics or recommendations issued under RCW 48.19.340. If the commissioner finds such insurer or rating organization to be in violation of this section he or she may issue an order requiring the discontinuance of the violation. [2009 c 549 § 7092; 1947 c 79 § .19.35; Rem. Supp. 1947 § 45.19.35.]

48.19.360 Joint underwriting or joint reinsurance.

(1) Every group, association or other organization of insurers which engages in joint underwriting or joint reinsurance, shall be subject to regulation with respect thereto as is provided in this section, subject, however, with respect to joint underwriting, to all other provisions of this chapter, and, with respect to joint reinsurance, to RCW 48.19.270, 48.01.080 and 48.19.430; and to chapter 48.03 RCW of this code.

(2) If, after a hearing, the commissioner finds that any activity or practice of any such group, association or other organization is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he or she may issue a written order specifying in what respects such activity or practice is unfair, or unreasonable or so inconsistent, and requiring the discontinuance of the activity or practice. [2009 c 549 § 7093; 1947 c 79 § .19.36; Rem. Supp. 1947 § 45.19.36.]

48.19.370 Recording and reporting of loss and expense experience. (1) The commissioner shall promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with him or her, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him or her in determining whether rating systems comply with the standards set forth in RCW 48.19.020 and 48.19.030. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience.

(2) In promulgating such rules and plans, the commissioner shall give due consideration to the rating systems on file with him or her and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states.

(3) No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it.

(4) The commissioner may designate one or more rating organizations or other agencies to assist him or her in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations.

(5) Reasonable rules and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans. [2009 c 549 § 7094; 1947 c 79 § .19.37; Rem. Supp. 1947 § 45.19.37.]

48.19.380 Exchange of information. Every rating organization and insurer may exchange information and experience data with insurers and rating organizations in this and other states and may consult with them with respect to rate making and the application of rating systems. [1947 c 79 § .19.38; Rem. Supp. 1947 § 45.19.38.]

48.19.390 False or misleading information. No person shall wilfully withhold information from, or knowingly give false or misleading information to, the commissioner, any statistical agency designated by the commissioner, any rating organization, or any insurer, which will affect the rates or premiums chargeable under this chapter. [1947 c 79 § .19.39; Rem. Supp. 1947 § 45.19.39.]

48.19.400 Assigned risks. Agreements may be made among casualty insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the commissioner. [1947 c 79 § .19.40; Rem. Supp. 1947 § 45.19.40.]

48.19.410 Examination of contracts. (1) The commissioner may permit the organization and operation of examining bureaus for the examination of policies, daily reports, binders, renewal certificates, endorsements, and other evidences of insurance or of the cancellation thereof, for the purpose of ascertaining that lawful rates are being charged.

(2) A bureau shall examine documents with regard to such kinds of insurance as the commissioner may, after hearing, reasonably require to be submitted for examination. A bureau may examine documents as to such other kinds of insurance as the issuing insurers may voluntarily submit for examination. Upon request of the commissioner, a bureau shall also examine affidavits filed pursuant to RCW 48.15.040, surplus lines contracts and related documents, and shall make recommendations to the commissioner to assist the commissioner in determining whether surplus lines have been procured in accordance with chapter 48.15 RCW and rules issued thereunder.

(3) No bureau shall operate unless licensed by the commissioner as to the kinds of insurance as to which it is permitted so to examine. To qualify for a license a bureau shall:

(a) Be owned in trust for the benefit of all the insurers regularly using its services, under a trust agreement approved by the commissioner.

(b) Make its services available without discrimination to all authorized insurers applying therefor, subject to such reasonable rules and regulations as to the obligations of insurers using its services, as to the conduct of its affairs, and as to the correction of errors and omissions in documents examined by it as are approved by the commissioner.

(c) Have no manager or other employee who is an employee of an insurer other than to the extent that he or she is an employee of the bureau owned by insurers through such trust agreement.

(d) Pay to the commissioner a fee of ten dollars for issuance of its license.

(4) Such license shall be of indefinite duration and shall remain in force until revoked by the commissioner or terminated at the request of the bureau. The commissioner may revoke the license, after hearing,

(a) if the bureau is no longer qualified therefor;

(b) if the bureau fails to comply with a proper order of the commissioner;

(c) if the bureau violates or knowingly participates in the violation of any provision of this code.

(5) Any person aggrieved by any rule, regulation, act or omission of a bureau may appeal to the commissioner therefrom. The commissioner shall hold a hearing upon such appeal, and shall make such order upon the hearing as he or she deems to be proper.

(6) Every such bureau operating in this state shall be subject to the supervision of the commissioner, and the commissioner shall examine it as provided in chapter 48.03 RCW of this code.

(7) Every examining bureau shall keep adequate records of the outstanding errors and omissions found in coverages examined by it and of its receipts and disbursements, and shall hold as confidential all information contained in documents submitted to it for examination.

(8) The commissioner shall not license an additional bureau for the examination of documents relative to a kind of

insurance if such documents are being examined by a then existing licensed bureau. Any examining bureau operating in this state immediately prior to the effective date of this code under any law of this state repealed as of such date, shall have prior right to apply for and secure a license under this section. [2009 c 549 § 7095; 1983 1st ex.s. c 32 § 8; 1947 c 79 § .19.41; Rem. Supp. 1947 § 45.19.41.]

48.19.420 Rate agreements. Two or more insurers mutually may agree to adhere to rates, rating plans, rating systems or underwriting practices or uniform modifications thereof, all subject to the following conditions:

(1) All of the terms of the agreements shall be in writing executed on behalf of each such insurer.

(2) An executed copy of every such written agreement and of every modification thereof shall be filed with the commissioner.

(3) Within a reasonable length of time after every such filing, the commissioner shall either approve or disapprove such agreement or modification. No such agreement or modification shall be effective unless and until approved by the commissioner.

(4) The commissioner shall not approve any such agreement or modification which:

(a) Constitutes or would tend to result in an unreasonable restraint upon free competition;

(b) contains terms otherwise tending to injure the public interest.

(5) No cause of action shall lie in favor of any insurer which is party to any such agreement against any other insurer party thereto on account of any breach thereof.

(6) All rate filings covered by such agreement shall be subject to the provisions of this chapter or of other applicable law.

(7) The commissioner may after a hearing thereon and for cause withdraw any approval previously given any such agreement or modification. [1947 c 79 § .19.42; Rem. Supp. 1947 § 45.19.42.]

48.19.430 Penalties. Any person violating any provision of this chapter shall be subject to a penalty of not more than fifty dollars for each such violation, but if such violation is found to be wilful a penalty of not more than five hundred dollars for each such violation may be imposed. Such penalties may be in addition to any other penalty provided by law. [1947 c 79 § .19.43; Rem. Supp. 1947 § 45.19.43.]

48.19.460 Automobile insurance—Premium reductions for older insureds completing accident prevention course. Any schedule of rates or rating plan for automobile liability and physical damage insurance submitted to or filed with the commissioner shall provide for an appropriate reduction in premium charges except for underinsured motorist coverage for those insureds who are fifty-five years of age and older, for a two-year period after successfully completing a motor vehicle accident prevention course meeting the criteria of the department of licensing with a minimum of eight hours, or additional hours as determined by rule of the department of licensing. The classroom course may be conducted by a public or private agency approved by the department. An eight-hour course meeting the criteria of the department of

licensing may be offered via an alternative delivery method of instruction, which may include internet, video, or other technology-based delivery methods. An agency seeking approval from the department to offer an alternative delivery method course of instruction is not required to conduct classroom courses under this section. The department of licensing may adopt rules to ensure that insureds who seek certification for taking a course offered via an alternative delivery method have completed the course. [2007 c 258 § 1; 1987 c 377 § 1; 1986 c 235 § 1.]

48.19.470 Automobile insurance—Premium reductions for persons eligible under RCW 48.19.460. All insurance companies writing automobile liability and physical damage insurance in this state shall allow an appropriate reduction in premium charges except for underinsured motorist coverage to all eligible persons subject to RCW 48.19.460. [1986 c 235 § 2.]

48.19.480 Automobile insurance—Completion of accident prevention course, certificate. Upon successfully completing the approved course, each participant shall be issued by the course's sponsoring agency, a certificate that shall be the basis of qualification for the discount on insurance. [1986 c 235 § 3.]

48.19.490 Automobile insurance—Continued eligibility for discount. Each participant shall take an approved course every two years to continue to be eligible for the discount on insurance. [1986 c 235 § 4.]

48.19.500 Motor vehicle insurance—Seat belts, etc. Due consideration in making rates for motor vehicle insurance shall be given to any anticipated change in losses that may be attributable to the use of seat belts, child restraints, and other lifesaving devices. An exhibit detailing these changes and any credits or discounts resulting from any such changes shall be included in each filing pertaining to private passenger automobile (or motor vehicle) insurance. [1989 c 11 § 20; 1987 c 310 § 1.]

Additional notes found at www.leg.wa.gov

48.19.501 Motor vehicle insurance—Anti-theft devices—Lights—Multiple vehicles. Due consideration in making rates for motor vehicle insurance shall be given to:

(1) Any anticipated change in losses that may be attributable to the use of properly installed and maintained anti-theft devices in the insured private passenger automobile. An exhibit detailing these losses and any credits or discounts resulting from any such changes shall be included in each filing pertaining to private passenger automobile (or motor vehicle) insurance.

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

(3) Any anticipated change in losses per vehicle covered that may be attributable to the fact that the insured has more vehicles covered under the policy than there are insured drivers in the same household. An exhibit detailing these changes and any credits or discounts resulting from any such changes shall be included in each filing pertaining to private passenger automobile (or motor vehicle) insurance. [1989 c 11 § 21; 1987 c 320 § 1.]

Additional notes found at www.leg.wa.gov

48.19.530 Property insurers—Assistance to prevent or reduce severity of claims or losses—Impact on rates.

(1) Except as provided in subsection (2) of this section, in addition to other information required by this chapter, a rate filing by a property insurer for a policy, except commercial property insurance, that includes risk mitigation and/or prevention goods and/or services under RCW 48.18.558, must demonstrate that its rates account for the expected costs of the goods and services and the reduction in expected claims costs resulting from either the goods or services, or both.

(2) This section does not apply to:

(a) A property insurer offering or providing risk mitigation and/or prevention goods and/or services through a pilot program established in RCW 48.18.558(6); or

(b) Disaster or emergency response activities of a property insurer. [2018 c 239 § 3.]

Findings—2018 c 239: See note following RCW 48.18.558.

48.19.540 Fire alarms and smoke detection devices—Impact on dwelling unit insurance rates—Report to legislature.

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

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

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

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

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

(3) For the purposes of this section:

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

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

operated from a power supply either in the unit or obtained at the point of installation.

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

(4) This section applies to rate filings for coverage for dwelling units filed on or after January 1, 2020. [2019 c 455 § 4.]

Short title—2019 c 455: See note following RCW 43.44.110.

**Chapter 48.20 RCW
DISABILITY INSURANCE**

Sections

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- 48.20.520 Phenylketonuria.
- 48.20.525 Prescriptions—Preapproval of individual claims—Subsequent rejection prohibited—Written record required.
- 48.20.530 Nonresident pharmacies.
- 48.20.550 Fixed payment insurance—Standard disclosure form.
- 48.20.555 Fixed payment insurance—Benefit restrictions.
- 48.20.580 Mental health services—Definition—Coverage required, when.
- 48.20.900 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

Approval of policy forms: RCW 48.18.100.

Assignment of policies: RCW 48.18.360.

Exemption of proceeds: RCW 48.18.400.

General provisions regarding filing, approval, contents of policies, execution, applications, etc.: Chapter 48.18 RCW.

Grounds for disapproval of policy forms: RCW 48.18.110.

Insurable interest, personal insurance, nonprofit organizations: RCW 48.18.030.

Minimum standard conditions and terminology for disability policies, established by commissioner: RCW 48.18.120(2).

Minor contracting for life or disability insurance: RCW 48.18.020.

Payment to person designated in policy or by assignment discharges insurer: RCW 48.18.370.

Rates, manuals, classifications—Filing: RCW 48.19.010(2).

Refusal to renew or cancellation of disability insurance: RCW 48.18.298, 48.18.299.

48.20.002 Scope of chapter. Nothing in this chapter shall apply to or affect (1) any policy of workers' compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein; or (2) any policy or contract of reinsurance; or (3) any blanket or group policy of insurance; or (4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract. [1987 c 185 § 25; 1951 c 229 § 1.]

Reviser's note: For prior laws governing standard provision requirements for individual accident or health insurance policies see 1947 c 79 §§ .20.01 through .20.33 and .20.37 and Rem. Supp. 1947 §§ 45.20.01 through 45.20.33 and 45.20.37.

Many of the sections enacted in 1951 c 229 are in substance amendatory of sections previously appearing in chapter 48.20 RCW, although they appear in 1951 c 229 as new sections. To assist those using the code, the

prior enactment on the same subject is shown in the history note following the new section wherever practical.

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

48.20.012 Format of disability policies. No disability policy shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

(1) It shall purport to insure only one person, except as to family expense insurance written pursuant to RCW 48.20.340.

(2) The style, arrangement and over-all appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than one hundred and twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and caption and subcaptions).

(3) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in RCW 48.20.042 to *48.20.272, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(4) Each such form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof.

(5) It shall contain no provision purporting to make any portion of the insurer's charter, rules, constitution, or bylaws a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner. [1951 c 229 § 2; 1947 c 79 § .20.02; formerly Rem. Supp. 1949 § 45.20.02.]

*Reviser's note: RCW 48.20.272 was repealed by 2004 c 112 § 6.

48.20.013 Return of policy and refund of premium—Notice required—Effect of return. Every individual disability insurance policy issued after January 1, 1968, except single premium nonrenewable policies, shall have printed on its face or attached thereto a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within ten days of its delivery to the purchaser and to have the premium paid refunded if, after examination of the policy, 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 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 had been issued. [2008 c 217 § 21; 1983 1st ex.s. c 32 § 9; 1967 c 150 § 26.]

Additional notes found at www.leg.wa.gov

48.20.015 Endorsements. If a contract is issued on any basis other than as applied for, an endorsement setting forth such modification(s) must accompany and be attached to the policy; and no endorsement shall be effective unless signed by the policyowner, and a signed copy thereof returned to the insurer. [1975 1st ex.s. c 266 § 9.]

Additional notes found at www.leg.wa.gov

48.20.022 Policies issued by domestic insurer for delivery in another state. If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public official of such other state has advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the applicable standards set forth in this chapter and in chapter 48.18 RCW. [1951 c 229 § 3.]

48.20.025 Schedule of rates for individual health benefit plans—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 insurer of health care services, as defined in RCW 48.43.005, provided to a policyholder or paid to or on behalf of the policyholder 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 a policyholder.

(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 an insurer means the percentage of the total number of applicants for individual health benefit plans received by that insurer in the aggregate in the applicable year which are not accepted for enrollment by that insurer 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) An insurer must file supporting documentation of its method of determining the rates charged for its individual health benefit plans. At a minimum, the insurer must provide the following supporting documentation:

(a) A description of the insurer's rate-making methodology;

(b) An actuarially determined estimate of incurred claims which includes the experience data, assumptions, and justifications of the insurer'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 insurer's individual health benefit plans under RCW 48.14.020. [2011 c 314 § 10; 2008 c 303 § 4; 2003 c 248 § 8; 2001 c 196 § 1; 2000 c 79 § 3.]

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

Effective date—2011 c 314 §§ 10-12: "Sections 10 through 12 of this act take effect January 1, 2012." [2011 c 314 § 19.]

Additional notes found at www.leg.wa.gov

48.20.028 Calculation of premiums—Adjusted community rating method—Definitions. (1) Premiums for health benefit plans for individuals shall be calculated using the adjusted community rating method that spreads financial risk across the carrier's entire individual product population, except the individual product population covered under RCW 48.20.029. All such rates shall conform to the following:

(a) The insurer 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 insurer 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 not to exceed twenty percent.

(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

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(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 purchasing coverage, except individuals purchasing coverage under RCW 48.20.029, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.21.045.

(3) As used in this section, "health benefit plan," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

(4) This section shall not apply to premiums for health benefit plans covered under RCW 48.20.029. [2006 c 100 § 1; 2000 c 79 § 4; 1997 c 231 § 207; 1995 c 265 § 13.]

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

Additional notes found at www.leg.wa.gov

48.20.029 Calculation of premiums—Members of a purchasing pool—Adjusted community rating method—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. All such rates shall conform to the following:

(i) The insurer 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 insurer 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.

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(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 not to exceed twenty percent.

(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 experience of health benefit plans offered to small employers under RCW 48.21.045.

(3) As used in this section, "health benefit plan," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005. [2006 c 100 § 2.]

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

Additional notes found at www.leg.wa.gov

48.20.032 Standard provisions required—Substitutions—Captions. Except as provided in RCW 48.18.130, each such policy delivered or issued for delivery to any person in this state shall contain the provisions as specified in RCW 48.20.042 to 48.20.152, inclusive, in the words in which the same appear; except, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded by the applicable caption shown or, at the insurer's option, by such appropriate individual or group caption or subcaption as the commissioner may approve. [1951 c 229 § 4; 1947 c 79 § .20.03; formerly Rem. Supp. 1947 § 45.20.03.]

48.20.042 Standard provision No. 1—Entire contract; changes. There shall be a provision as follows:

ENTIRE CONTRACTS; CHANGES: This policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions. [2008 c

217 § 22; 1951 c 229 § 5. Prior law: (i) 1947 c 79 § .20.05; Rem. Supp. 1947 § 45.20.05. (ii) 1947 c 79 § .20.06; Rem. Supp. 1947 § 45.20.06.]

Additional notes found at www.leg.wa.gov

48.20.050 Standard provision No. 2—Misstatement of age or sex. There shall be a provision as follows:

"MISSTATEMENT OF AGE OR SEX: If the age or sex of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age or sex."

The amount of any underpayments which may have been made on account of any such misstatement under a disability income policy shall be paid the insured along with the current payment and the amount of any overpayment may be charged against the current or succeeding payments to be made by the insurer. Interest may be applied to such underpayments or overpayments as specified in the insurance policy form but not exceeding six percent per annum. [1983 1st ex.s. c 32 § 16.]

48.20.052 Standard provision No. 3—Time limit on certain defenses. There shall be a provision as follows:

"TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of RCW 48.20.050, 48.20.172, 48.20.192, 48.20.202, and 48.20.212 in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."

"(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(More stringent provisions may be required by the commissioner in connection with individual disability policies sold without any application or with minimal applications.) [1983 1st ex.s. c 32 § 17; 1975 1st ex.s. c 266 § 12; 1973 1st ex.s. c 152 § 4; 1969 ex.s. c 241 § 12; 1951 c 229 § 6.]

Additional notes found at www.leg.wa.gov

48.20.062 Standard provision No. 4—Grace period.

There shall be a provision as follows:

GRACE PERIOD: A grace period of . . . (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies, and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision: "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.")

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision: "Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his or her last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted." [2009 c 549 § 7096; 1951 c 229 § 7.]

48.20.072 Standard provision No. 5—Reinstatement.

There shall be a provision as follows:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any insurance producer duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: PROVIDED, HOWEVER, That if the insurer or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.) [2008 c 217 § 23; 1951 c 229 § 8; 1947 c 79 § .20.07; formerly Rem. Supp. 1947 § 45.20.07.]

Additional notes found at www.leg.wa.gov

48.20.082 Standard provision No. 6—Notice of claim.

There shall be a provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within twenty days after the occurrence

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or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he or she shall at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.") [2009 c 549 § 7097; 1951 c 229 § 9. Prior law: 1947 c 79 § .20.08; Rem. Supp. 1947 § 45.20.08.]

48.20.092 Standard provision No. 7—Claim forms.

There shall be a provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, the character and the extent of the loss for which claim is made. [1951 c 229 § 10; 1947 c 79 § .20.10; formerly Rem. Supp. 1947 § 45.20.10.]

Furnishing claim forms does not constitute waiver of any defense by insurer: RCW 48.18.470.

Insurer has no responsibility as to completion of claim forms: RCW 48.18.460.

48.20.102 Standard provision No. 8—Proofs of loss.

There shall be a provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. [1951 c 229 § 11. Prior: (i) 1947 c 79 § .20.11; Rem. Supp. 1947 §

45.20.11. (ii) 1947 c 79 § .20.09, part; Rem. Supp. 1947 § 45.20.09, part.]

48.20.112 Standard provision No. 9—Time of payment of claims. There shall be a provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. [1951 c 229 § 12. Prior: (i) 1947 c 79 § .20.13; Rem. Supp. 1947 § 45.20.13. (ii) 1947 c 79 § .20.14; Rem. Supp. 1947 § 45.20.14.]

48.20.122 Standard provision No. 10—Payment of claims. (1) There shall be a provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(2) The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

"If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding \$. (insert an amount which shall not exceed \$1000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment."

"Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person." [1951 c 229 § 13. Prior: 1947 c 79 § .20.15; Rem. Supp. 1947 § 45.20.15.]

Proceeds of disability policy are exempt from creditors: RCW 48.18.400.

48.20.132 Standard provision No. 11—Physical examination and autopsy. There shall be a provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often

as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law. [1951 c 229 § 14. Prior: 1947 c 79 § .20.12; Rem. Supp. 1947 § 45.20.12.]

48.20.142 Standard provision No. 12—Legal actions. There shall be a provision as follows:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. [1951 c 229 § 15. Prior: 1947 c 79 § .20.18; Rem. Supp. 1947 § 45.20.18.]

48.20.152 Standard provision No. 13—Change of beneficiary. There shall be a provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.) [1951 c 229 § 16. Prior: 1947 c 79 § .20.17; Rem. Supp. 1947 § 45.20.17.]

48.20.162 Optional standard provisions. Except as provided in RCW 48.18.130, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth in RCW 48.20.172 to *48.20.272, inclusive, unless such provisions are in the words in which the same appear in the applicable section; except, that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption or, at the insurer's option, by such appropriate individual or group caption or subcaption as the commissioner may approve. [1951 c 229 § 17. Prior: 1947 c 79 § .20.20; Rem. Supp. 1947 § 45.20.20.]

*Reviser's note: RCW 48.20.272 was repealed by 2004 c 112 § 6.

48.20.172 Optional standard provision No. 14—Change of occupation. There may be a provision as follows:

CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his or her occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of

such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation. [2009 c 549 § 7098; 1951 c 229 § 18.]

48.20.192 Optional standard provision No. 15—Other insurance in this insurer. There may be a provision as follows:

OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for (insert type of coverage or coverages) in excess of \$. (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

Or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his or her beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies. [2009 c 549 § 7099; 1951 c 229 § 20. Prior: 1947 c 79 § .20.24; Rem. Supp. 1947 § 45.20.24.]

48.20.202 Optional standard provision No. 16—Insurance with other insurers (Provision of service or expense incurred basis). (1) There may be a provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(2) If the foregoing policy provision is included in a policy which also contains the policy provision set out in RCW

48.20.212, there shall be added to the caption of the foregoing provision the phrase ". expense incurred benefits." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage." [1987 c 185 § 26; 1951 c 229 § 21. Prior: 1947 c 79 § .20.22; Rem. Supp. 1947 § 45.20.22.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

48.20.212 Optional standard provision No. 17—Insurance with other insurers. (1) There may be a provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

(2) If the foregoing policy provision is included in a policy which also contains the policy provision set out in RCW 48.20.202, there shall be added to the caption of the foregoing provision the phrase ". other benefits." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory

benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage." [1987 c 185 § 27; 1951 c 229 § 22. Prior: 1947 c 79 § .20.22; Rem. Supp. 1947 § 45.20.22.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

48.20.222 Optional standard provision No. 18—Relation of earnings to insurance. (1) There may be a provision as follows:

RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his or her average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(2) The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (a) until at least age 50 or, (b) in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations. [2009 c 549 § 7100; 1987 c 185 § 28; 1951 c 229 § 23.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

48.20.232 Optional standard provision No. 19—Unpaid premium. There may be a provision as follows:

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UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom. [1951 c 229 § 24. Prior: 1947 c 79 § .20.23; Rem. Supp. 1947 § 45.20.23.]

48.20.242 Optional standard provision No. 20—Cancellation. There may be a provision as follows:

CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his or her last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. [2009 c 549 § 7101; 1951 c 229 § 25. Prior: 1947 c 79 § .20.21; Rem. Supp. 1947 § 45.20.21.]

48.20.252 Optional standard provision No. 21—Conformity with state statutes. There may be a provision as follows:

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes. [1951 c 229 § 26.]

48.20.262 Optional standard provision No. 22—Illegal occupation. There may be a provision as follows:

ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation. [1951 c 229 § 27. Prior: 1947 c 79 § .20.26; Rem. Supp. 1947 § 45.20.26.]

48.20.282 Order of certain policy provisions. The provisions which are the subject of RCW 48.20.042 to *48.20.272, inclusive, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections or, at the insurer's option, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued. [1951 c 229 § 29.]

*Reviser's note: RCW 48.20.272 was repealed by 2004 c 112 § 6.

48.20.292 Third party ownership. The word "insured," as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein. [1951 c 229 § 30.]

Insurable interest defined, personal insurance, nonprofit organizations: RCW 48.18.030.

48.20.302 Requirements of other jurisdictions. (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or to the beneficiary than the provisions of this chapter and which is prescribed or required by the laws of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country. [1951 c 229 § 31.]

Domestic insurer may transact insurance in other state as permitted by laws thereof: RCW 48.07.140.

48.20.312 Age limit. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy. [1951 c 229 § 32. Prior: 1947 c 79 § .20.25; Rem. Supp. 1947 § 45.20.25.]

48.20.340 "Family expense disability insurance" defined. (1) Family expense disability insurance is that covering members of any one family including one or both spouses and dependents provided under a master policy issued to the head of the family.

(2) Any authorized disability insurer may issue family expense disability insurance.

(3) A disability policy providing such family expense coverage, in addition to other provisions required to be contained in disability policies under this chapter, shall contain the following provisions:

(a) A provision that the policy and the application of the head of the family shall constitute the entire contract between the parties.

(b) A provision that to the family group originally insured shall, on notice to the insurer, be added from time to time all new members of the family as they become eligible for insurance in such family group, and on the payment of such additional premium as may be required therefor. [1961 c 194 § 5; 1947 c 79 § .20.34; Rem. Supp. 1947 § 45.20.34.]

(2021 Ed.)

48.20.350 "Franchise plan" defined. (1) Disability insurance on a franchise plan is that issued to

(a) five or more employees of a common employer, or to

(b) ten or more members of any bona fide trade or professional association or labor union, which association or union was formed and exists for purposes other than that of obtaining insurance, and under which such employees or members, with or without their dependents, are issued individual policies which may vary as to amounts and kinds of coverage as applied for, under an arrangement whereby the premiums on the policies are to be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association, or by some designated employee or officer of the association acting on behalf of the employer or association members.

(2) An insurer may charge different rates, provide different benefits, or employ different underwriting procedure for individuals insured under a franchise plan, if such rates, benefits, or procedures as used do not discriminate as between franchise plans, and do not discriminate unfairly as between individuals insured under franchise plans and individuals otherwise insured under similar policies. [1947 c 79 § .20.35; Rem. Supp. 1947 § 45.20.35.]

48.20.360 Extended disability benefit. A disability insurance contract which provides a reasonable amount of disability indemnity for both accidental injuries and sickness, other than a contract of group or blanket insurance, may provide a benefit in amount not exceeding two hundred dollars payable in event of death from any causes. Such benefit shall be deemed to constitute the payment of disability benefits beyond the period for which otherwise payable, and shall not be deemed to constitute life insurance. [1947 c 79 § .20.36; Rem. Supp. 1947 § 45.20.36.]

48.20.380 Incontestability after reinstatement. The reinstatement of any policy of noncancellable disability insurance hereafter delivered or issued for delivery in this state shall be contestable only on account of fraud or misrepresentation of facts material to the reinstatement and only for the same period following reinstatement as is provided in the policy with respect to the contestability thereof after the original issuance of the policy. [1947 c 79 § .20.38; Rem. Supp. 1947 § 45.20.38.]

48.20.385 When injury caused by intoxication or use of narcotics. An insurer may not deny coverage for the treatment of an injury solely because the injury was sustained as a consequence of the insured's being intoxicated or under the influence of a narcotic. [2004 c 112 § 2.]

Finding—2004 c 112: "The legislature finds that an alcohol or drug-related injury that requires treatment in an emergency department can be a critical moment in the life of a person with a substance abuse problem. Studies have demonstrated that appropriate interventions by hospital staff at these times can reduce substance abuse and lower future health care costs. The perception among health care providers that they may be penalized by insurers for conducting these interventions prevents many of them from performing interventions which can make all the difference to a person at the crossroads of a substance abuse problem." [2004 c 112 § 1.]

Additional notes found at www.leg.wa.gov

48.20.389 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 § 19; 2011 c 159 § 3.]

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

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

48.20.390 Podiatric medicine and surgery. Notwithstanding any provision of any disability insurance contract, benefits shall not be denied thereunder for any medical or surgical service performed by a holder of a license issued pursuant to chapter 18.22 RCW provided that (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW. [1963 c 87 § 1.]

Additional notes found at www.leg.wa.gov

48.20.391 Diabetes coverage. 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 disability insurance contracts providing health care services, delivered or issued for delivery in this state and issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For disability insurance contracts that include 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 disability insurance contracts providing health care services, 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 insurer from restricting patients to seeing only health care providers who have signed participating provider agreements with the insurer or an insuring entity under contract with the insurer.

(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 insurer 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 plan that provides benefits identical to the schedule of services covered by the basic health plan, as required by RCW 48.20.028. [2020 c 346 § 7; 2020 c 245 § 3; 1997 c 276 § 2.]

Reviser's note: This section was amended by 2020 c 245 § 3 and by 2020 c 346 § 7, 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

48.20.392 Prostate cancer screening. (1) Each disability insurance policy 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) 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 an insurer 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 § 2.]

48.20.393 Mammograms—Insurance coverage. Each disability insurance policy issued or renewed after January 1, 1990, that provides coverage for hospital or medical expenses shall provide coverage 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.

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 an insurer 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 § 728; 1989 c 338 § 1.]

Additional notes found at www.leg.wa.gov

48.20.395 Reconstructive breast surgery. (1) Any disability insurance contract providing hospital and medical expenses and health care services delivered or issued in this state after July 24, 1983, shall provide coverage for reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness, or injury.

(2) Any disability insurance contract providing hospital and medical expenses and health care services delivered or issued in this state 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 § 5; 1983 c 113 § 1.]

Additional notes found at www.leg.wa.gov

48.20.397 Mastectomy, lumpectomy. No person engaged in the business of insurance under this chapter may refuse to issue any contract of insurance or cancel or decline to renew the contract 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 § 1.]

Additional notes found at www.leg.wa.gov

48.20.410 Optometry. Notwithstanding any provision of any disability insurance contract, benefits shall not be denied thereunder for any eye care service rendered by a holder of a license issued pursuant to chapter 18.53 RCW, provided, that (1) the service rendered was within the lawful scope of such person's license, and (2) such contract would have provided the benefits for such service if rendered by a holder of a license issued pursuant to chapter 18.71 RCW. [1965 c 149 § 2.]

Additional notes found at www.leg.wa.gov

48.20.411 Registered nurses or advanced registered nurses. Notwithstanding any provision of any disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health care service performed by a holder of a license for registered nursing practice or advanced registered nursing practice issued pursuant to chapter 18.79 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of

chapter 18.71 RCW shall be asserted to deny benefits under this section.

The provisions of this section are intended to be remedial and procedural to the extent they do not impair the obligation of any existing contract. [1994 sp.s. c 9 § 729; 1973 1st ex.s. c 188 § 3.]

Additional notes found at www.leg.wa.gov

48.20.412 Chiropractic. Notwithstanding any provision of any disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health care service performed by a holder of a license issued pursuant to chapter 18.25 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of chapter 18.71 RCW shall be asserted to deny benefits under this section.

The provisions of this section are intended to be remedial and procedural to the extent they do not impair the obligation of any existing contract. [1971 ex.s. c 13 § 1.]

48.20.414 Psychological services. Notwithstanding any provision of any disability insurance contract, benefits shall not be denied thereunder for any psychological service rendered by a holder of a license issued pursuant to chapter 18.83 RCW: PROVIDED, That (1) the service rendered was within the lawful scope of such person's license, and (2) such contract would have provided the benefits for such service if rendered by a holder of a license issued pursuant to chapter 18.71 RCW. [1971 ex.s. c 197 § 1.]

Additional notes found at www.leg.wa.gov

48.20.416 Dentistry. Notwithstanding any provision of any disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health care service performed by a holder of a license issued pursuant to chapter 18.32 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service has [had] been performed by a holder of a license issued [pursuant] to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of chapter 18.71 RCW shall be asserted to deny benefits under this section.

The provisions of this section are intended to be remedial and procedural to the extent they do not impair the obligation of any existing contract. [1974 ex.s. c 42 § 1.]

48.20.417 Dental services that are not subject to contract or provider agreement. (1) Notwithstanding any other provisions of law, no disability insurance policy of any disability insurer as provided in this chapter subject to the jurisdiction of the state of Washington that covers any dental services, and no contract or participating provider agreement with a dentist may:

(a) Require, directly or indirectly, that a dentist who is a participating provider provide services to a subscriber at a fee set by, or at a fee subject to the approval of, the disability insurer unless the dental services are covered services, including services that would be reimbursable but for the

application of contractual limitations such as benefit maximums, deductibles, coinsurance, waiting periods, or frequency limitations, under the applicable disability insurance policy; nor

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

(2) For the purposes of this section, "covered services" means dental services that are reimbursable under the applicable insurance policy or subscriber agreement or would be reimbursable but for the application of contractual limitations such as benefit maximums, deductibles, coinsurance, waiting periods or frequency limitations. [2010 c 228 § 1.]

48.20.418 Denturist services. Notwithstanding any provision of any disability insurance contract 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 contract would have provided benefits if such service had been performed by a dentist licensed under chapter 18.32 RCW. [1995 c 1 § 21 (Initiative Measure No. 607, approved November 8, 1994).]

Additional notes found at www.leg.wa.gov

48.20.420 Dependent child coverage—Continuation for incapacity. Any disability insurance contract providing health care services, delivered or issued for delivery in this state more than one hundred twenty days after August 11, 1969, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the contract, 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, provided proof of such incapacity and dependency is furnished to the insurer by the subscriber within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two year period following the child's attainment of the limiting age. [2020 c 274 § 30; 1985 c 264 § 10; 1969 ex.s. c 128 § 3.]

48.20.430 Dependent child coverage—From moment of birth—Congenital anomalies—Notification of birth.

(1) Any disability insurance contract providing hospital and medical expenses and health care services, delivered or issued for delivery in this state more than one hundred twenty days after February 16, 1974, which provides coverage for dependent children of the insured, shall provide coverage for newborn infants of the insured from and after the moment of birth. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

(2) If payment of an additional premium is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the

required premium must be furnished to the insurer. The notification period shall be no less than sixty days from the date of birth. This subsection applies to policies issued or renewed on or after January 1, 1984. [1983 1st ex.s. c 32 § 18; 1974 ex.s. c 139 § 1.]

48.20.435 Option to cover dependents under age twenty-six. (1) Each disability insurance contract 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 grandfathered disability insurance contract that provides coverage for a subscriber's child must offer the option of covering any child under the age of twenty-six unless the child is eligible to enroll in an eligible health plan sponsored by the child's employer or the child's spouse's employer.

(3) As used in this section, "grandfathered" has the same meaning as "grandfathered health plan" in RCW 48.43.005. [2012 c 211 § 15; 2011 c 314 § 1; 2007 c 259 § 19.]

Additional notes found at www.leg.wa.gov

48.20.450 Standardization and simplification of terms and coverages—Disclosure requirements. The commissioner shall issue regulations to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of individual policies of disability insurance which shall be in addition to and in accordance with applicable laws of this state, including RCW 48.20.450 through 48.20.480, which may cover but shall not be limited to:

- (1) Terms of renewability;
- (2) Initial and subsequent conditions of eligibility;
- (3) Nonduplication of coverage provisions;
- (4) Coverage of dependents;
- (5) Preexisting conditions;
- (6) Termination of insurance;
- (7) Probationary periods;
- (8) Limitations;
- (9) Exceptions;
- (10) Reductions;
- (11) Elimination periods;
- (12) Requirements for replacement;
- (13) Recurrent conditions; and

(14) The definition of terms including but not limited to the following: Hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable, and noncancellable. [1985 c 264 § 11; 1975 1st ex.s. c 266 § 16.]

Purpose—1975 1st ex.s. c 266: "The purpose of *sections 14 through 18 of this 1975 amendatory act is to provide reasonable standardization and simplification of terms and coverages of individual disability insurance policies to facilitate public understanding and comparison, to eliminate provisions contained in individual disability insurance policies which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of disability coverages." [1975 1st ex.s. c 266 § 15.]

***Reviser's note:** During the course of passage of 1975 1st ex.s. c 266 [Substitute House Bill No. 198], the section numbering was changed, but the internal references were not changed accordingly. Thus the reference "sections 14 through 18 of this 1975 amendatory act" appears to be erroneous. Reference to "sections 15 through 19," codified herein as this section and RCW 48.20.450 through 48.20.480, was apparently intended.

Additional notes found at www.leg.wa.gov

48.20.460 Standardization and simplification—Minimum standards for benefits and coverages. (1) The commissioner shall issue regulations to establish minimum standards for benefits under each of the following categories of coverage in individual policies, other than conversion policies issued pursuant to a contractual conversion privilege under a group policy, of disability insurance:

- (a) Basic hospital expense coverage;
- (b) Basic medical-surgical expense coverage;
- (c) Hospital confinement indemnity coverage;
- (d) Major medical expense coverage;
- (e) Disability income protection coverage;
- (f) Accident only coverage;
- (g) Specified disease or specified accident coverage;
- (h) Medicare supplemental coverage; and
- (i) Limited benefit coverage.

(2) Nothing in this section shall preclude the issuance of any policy which combines two or more of the categories of coverage enumerated in items (a) through (f) of subsection (1) of this section.

(3) No policy shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for the categories of coverage listed in items (a) through (i) of subsection (1) of this section, unless the commissioner finds such policy will be in the public interest and such policy meets the requirements set forth in RCW 48.18.110.

(4) The commissioner shall prescribe the method of identification of policies based upon coverages provided. [1981 c 339 § 19; 1975 1st ex.s. c 266 § 17.]

Additional notes found at www.leg.wa.gov

48.20.470 Standardization and simplification—Outline of coverage—Format and contents. (1) No policy of individual disability insurance shall be delivered or issued for delivery in this state unless an outline of coverage described in subsection (2) of this section is furnished to the applicant in accord with such rules or regulations as the commissioner shall prescribe.

(2) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (1) of this section. "Format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(a) A statement identifying the applicable category or categories of coverage provided by the policy as prescribed in RCW 48.20.450;

(b) A description of the principal benefits and coverage provided in the policy;

(c) A statement of the exceptions, reductions and limitations contained in the policy;

(d) A statement of the renewal provisions including any reservation by the insurer of a right to change premiums; and

(e) A statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions. [1985 c 264 § 12; 1975 1st ex.s. c 266 § 18.]

Additional notes found at www.leg.wa.gov

(2021 Ed.)

48.20.480 Standardization and simplification—Simplified application form—Coverage of loss from preexisting health condition. Notwithstanding the provisions of RCW 48.20.052, if an insurer elects to use a simplified application form, with or without a question as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy must cover any loss occurring after twelve months from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except as so provided, the policy shall not include wording that would permit a defense based upon preexisting conditions. [1975 1st ex.s. c 266 § 19.]

Additional notes found at www.leg.wa.gov

48.20.490 Continuation of coverage by former spouse and dependents. Every policy of disability insurance issued, amended, or renewed after June 12, 1980, for an individual and his/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 insured, shall have the right to continue the policy coverage without a physical examination, statement of health, or other proof of insurability. [1980 c 10 § 1.]

48.20.500 Coverage for adopted children. (1) Any disability insurance contract providing hospital and medical expenses and health care services, delivered or issued for delivery in this state, which provides coverage for dependent children, as defined in the contract of the insured, shall cover adoptive children placed with the insured 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 contract may require that notification of placement of a child for adoption and payment of the required premium must be furnished to the insurer. The notification period shall be no less than sixty days from the date of placement. [1986 c 140 § 2.]

Additional notes found at www.leg.wa.gov

48.20.510 Cancellation of rider. Upon application by an insured, a rider shall be canceled if at least five years after its issuance, no health care services have been received by the insured 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 insured from that condition, such agreement not to be unreasonably withheld. The option of the insured 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 § 1.]

48.20.520 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 disability insurance contract delivered or issued for delivery or renewed in this state on or after September 1, 1988, that insures for hospital or medical expenses shall provide coverage for the formulas necessary for the treatment of phenylketonuria. [1988 c 173 § 1.]

48.20.525 Prescriptions—Preapproval of individual claims—Subsequent rejection prohibited—Written record required. Disability insurance companies 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 § 2.]

Findings—1993 c 253: "The legislature finds that many health care insurance entities are initially approving claims as eligible under an identified program, over the telephone, but denying those same claims when they are submitted for payment. The legislature finds this to be an untenable situation for the providers." [1993 c 253 § 1.]

Additional notes found at www.leg.wa.gov

48.20.530 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, an insurer providing coverage of prescription drugs from nonresident pharmacies may only provide coverage from licensed nonresident pharmacies. The insurers 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 of health may request from the insurer the proof of current licensure for all nonresident pharmacies through which the insurer is providing coverage for prescription drugs to 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 § 310; 1991 c 87 § 7.]

Additional notes found at www.leg.wa.gov

48.20.550 Fixed payment insurance—Standard disclosure form. The commissioner shall adopt rules setting forth the content of a standard disclosure form to be provided to all applicants for individual, illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance. The standard disclosure shall provide information regarding the level, type, and amount of benefits provided and the limitations, exclusions, and exceptions under the policy, as well as additional information to enhance consumer understanding. The disclosure shall specifically disclose that the coverage is not comprehensive in nature and will not cover the cost of most hospital and other medical services. Such disclosure form must be filed for approval with the commissioner prior to use. The standard disclosure forms must be provided at the time of solicitation and completion of the application form. All advertising and marketing materials other than the standard disclosure form must be filed with the commissioner at least thirty days prior to use. [2007 c 296 § 2.]

48.20.555 Fixed payment insurance—Benefit restrictions. Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance policies are not considered to provide coverage for hospital or medical expenses under this chapter, if the benefits provided are a fixed dollar amount that is paid regardless of the amount charged. The benefits may not be related to, or be a percentage of, the amount charged by the provider of service and must be offered as an independent and noncoordinated benefit with any other health plan as defined in *RCW 48.43.005(19). [2007 c 296 § 3.]

***Reviser's note:** RCW 48.43.005 was amended by 2011 c 314 § 3 and by 2011 c 315 § 2, changing subsection (19) to subsection (24). RCW 48.43.005 was subsequently amended by 2012 c 87 § 1, changing subsection (24) to subsection (26). RCW 48.43.005 was subsequently alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (26) to subsection (27), and effective January 1, 2020, changing subsection (26) to subsection (29).

48.20.580 Mental health services—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 insurer'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, or to be a student-only health plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution, 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) Each disability insurance contract providing 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 disability insurance contract. 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 disability insurance contract 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 disability insurance contract 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 disability insurance contract.

(3) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable 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 benefit management requirement is applicable to medical and surgical services. [2020 c 228 § 2; 2007 c 8 § 1.]

Additional notes found at www.leg.wa.gov

48.20.900 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,

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rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 115.]

Chapter 48.21 RCW

GROUP AND BLANKET DISABILITY INSURANCE

Sections

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- 48.21.020 "Employees," "employer" defined.
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Irrigation district may contract for and pay premiums on group insurance for employees: RCW 87.03.160.

Minimum standards for disability policies may be promulgated by commissioner: RCW 48.18.120.

Payment to person designated in policy or by assignment discharges insurer: RCW 48.18.370.

Policy dividends are payable to real party in interest: RCW 48.18.340.

Policy forms, execution, filing, etc.: Chapter 48.18 RCW.

Refusal to renew or cancellation of disability insurance: RCW 48.18.298, 48.18.299.

48.21.010 "Group disability insurance" defined—Issuance. (1) Group disability insurance is that form of disability insurance, including stop loss insurance as defined in RCW 48.11.030, provided by a master policy issued to an employer, to a trustee appointed by an employer or employers, or to an association of employers formed for purposes other than obtaining such insurance, covering, with or without their dependents, the employees, or specified categories of the employees, of such employers or their subsidiaries or affiliates, or issued to a labor union, or to an association of employees formed for purposes other than obtaining such insurance, covering, with or without their dependents, the members, or specified categories of the members, of the labor union or association, or issued pursuant to RCW 48.21.030. Group disability insurance includes the following groups that qualify for group life insurance:

RCW 48.24.020, 48.24.035, 48.24.040, 48.24.045, 48.24.050, 48.24.060, 48.24.070, 48.24.080, 48.24.090, and 48.24.095. A group under RCW 48.24.027 does not qualify as a group for the purposes of this chapter.

(2) Group disability insurance for lines of coverage identified in *RCW 48.43.005(26) (e), (h), (k), and (m) offered to a resident of this state under a group disability insurance policy may be issued to a group other than the groups described in subsection (1) of this section subject to the requirements in this subsection.

(a) A group disability insurance policy offered under this subsection may not be delivered in this state unless the commissioner finds 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 premium charged.

(b) A group disability insurance coverage may not be offered under this subsection in this state by an insurer under a policy issued in another state unless the commissioner or the insurance commissioner of another state having requirements substantially similar to those contained in this subsection has made a determination that the requirements have been met. [2016 c 65 § 1; 2011 c 81 § 1; 2010 c 13 § 3; 1992 c 226 § 2; 1949 c 190 § 27; 1947 c 79 § .21.01; Rem. Supp. 1949 § 45.21.01.]

*Reviser's note: RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (26) to subsection (27), and effective January 1, 2020, changing subsection (26) to subsection (29).

Additional notes found at www.leg.wa.gov

48.21.015 "Group stop loss insurance" defined for the purpose of exemption—Scope of application. Group stop loss insurance is exempt from all sections of this chapter and chapter 48.32A RCW except for RCW 48.21.010 and this section. For the purpose of this exemption, group stop loss is further defined as follows:

(1) The policy must be issued to and insure the employer, the trustee or other sponsor of the plan, or the plan itself, but not the employees, members, or participants;

(2) Payment by the insurer must be made to the employer, the trustee, or other sponsor of the plan or the plan itself, but not to the employees, members, participants, or health care providers;

(3) The policy must contain a provision that establishes an aggregate attaching point or retention that is at the minimum one hundred twenty percent of the expected claims; and

(4) The policy may provide for an individual attaching point or retention that is not less than five percent of the expected claims or one hundred thousand dollars, whichever is less. [2000 c 80 § 8; 1992 c 226 § 3.]

Additional notes found at www.leg.wa.gov

48.21.020 "Employees," "employer" defined. The term "employees" as used in this chapter shall be deemed to include as employees of a single employer, the compensated officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used in this chapter shall be deemed to include any municipal corporation or governmental unit, agency or department thereof as well as private individuals, firms, corporations and other persons. [1947 c 79 § .21.02; Rem. Supp. 1947 § 45.21.02.]

48.21.030 Health care groups. A policy of group disability insurance may be issued to a corporation, as policyholder, existing primarily for the purpose of assisting individuals who are its subscribers in securing medical, hospital, dental, and other health care services for themselves and their dependents, covering all and not less than five hundred such subscribers and dependents, with respect only to medical, hospital, dental, and other health care services. [1947 c 79 § .21.03; Rem. Supp. 1947 § 45.21.03.]

48.21.040 "Blanket disability insurance" defined. (1) Any policy or contract of disability insurance which conforms with the description and complies with the requirements contained in one of the following six paragraphs shall be deemed a blanket disability insurance policy:

(a) A policy issued to any common carrier of passengers, which carrier shall be deemed the policyholder, covering a group defined as all persons who may become such passengers, and whereby such passengers shall be insured against

loss or damage resulting from death or bodily injury either while, or as a result of, being such passengers.

(b) A policy issued in the name of any volunteer fire department, first aid or ambulance squad or volunteer police organization, which shall be deemed the policyholder, and covering all the members of any such organization against loss from accidents resulting from hazards incidental to duties in connection with such organizations.

(c) A policy issued in the name of any established organization whether incorporated or not, having community recognition and operated for the welfare of the community and its members and not for profit, which shall be deemed the policyholder, and covering all volunteer workers who serve without pecuniary compensation and the members of the organization, against loss from accidents occurring while engaged in the actual performance of duties on behalf of such organization or in the activities thereof.

(d) A policy issued to an employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment, insuring such employees against death or bodily injury resulting while, or from, being exposed to such exceptional hazards.

(e) A policy covering students or employees issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder.

(f) A policy or contract issued to any other substantially similar group, which, in the commissioner's discretion, may be subject to the insurance of a blanket disability policy or contract.

(2) Nothing contained in this section shall be deemed to affect the liability of policyholders for the death of, or injury to, any such members of such group.

(3) Individual applications shall not be required from individuals covered under a blanket disability insurance contract. [1959 c 225 § 7; 1947 c 79 § .21.04; Rem. Supp. 1947 § 45.21.04.]

48.21.045 Health plan benefits for small employers—Coverage—Exemption from statutory requirements—Premium rates—Requirements for providing coverage for small employers—Definitions. (1)(a) An insurer 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 an insurer 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. An insurer offering a health benefit plan under this subsection shall clearly disclose all 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 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144,

48.21.146, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320.

(2) Nothing in this section shall prohibit an insurer 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 insurer 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 insurer 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 48.21.047, 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 small 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 an insurer 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) An insurer 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) An insurer 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) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer 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.

(7) As used in this section, "health benefit plan," "small employer," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005. [2010 c 292 § 7; 2009 c 131 § 1; 2008 c 143 § 6; 2007 c 260 § 7; 2004 c 244 § 1; 1995 c 265 § 14; 1990 c 187 § 2.]

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—1990 c 187: "The legislature finds that the rising cost of comprehensive group health coverage is exceeding the affordability of many small businesses and their employees. The legislature further finds that certain public policies have an adverse impact on the cost of such coverage. It is therefore the intent of the legislature to reduce costs by authorizing the development of basic hospital and medical coverage for small groups." [1990 c 187 § 1.]

Additional notes found at www.leg.wa.gov

48.21.047 Requirements for plans offered to small employers—Definitions. (1) An insurer may not offer any health benefit plan to any small employer without complying with RCW 48.21.045(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 the plans are not subject to RCW 48.21.045(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.

(4) For purposes of this section, "census date" has the same meaning as defined in RCW 48.44.010. [2010 c 292 § 8; 2005 c 223 § 11; 1995 c 265 § 22.]

Additional notes found at www.leg.wa.gov

48.21.050 Standard provisions required. Every policy of group or blanket disability insurance shall contain in substance the provisions as set forth in RCW 48.21.060 to 48.21.090, inclusive, or provisions which in the opinion of the commissioner are more favorable to the individuals insured, or at least as favorable to such individuals and more favorable to the policyholder. No such policy of group or blanket disability insurance shall contain any provision relative to notice or proof of loss, or to the time for paying benefits, or to the time within which suit may be brought upon the policy, which in the opinion of the commissioner is less favorable to the individuals insured than would be permitted by the standard provisions required for individual disability insurance policies. [1947 c 79 § .21.05; Rem. Supp. 1947 § 45.21.05.]

48.21.060 The contract—Representations. There shall be a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued; that all statements made by the policyholder or by the individuals insured shall in the absence of fraud be deemed representations and not warranties, and that no statement made by any individual insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such individual or to his or her beneficiary, if any. [2009 c 549 § 7102; 1947 c 79 § .21.06; Rem. Supp. 1947 § 45.21.06.]

48.21.070 Payment of premiums. There shall be a provision that all premiums due under the policy shall be remitted by the employer or employers of the persons insured, by the policyholder, or by some other designated person acting on behalf of the association or group insured, to the insurer on or before the due date thereof with such period of grace as may be specified therein. [1947 c 79 § .21.07; Rem. Supp. 1947 § 45.21.07.]

48.21.075 Payment of premiums by employee in event of suspension of compensation due to labor dispute. Any employee whose compensation includes group disability or blanket disability insurance providing health care services, the premiums for which are 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 premiums as they become due directly to the policyholder whenever the employee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute, for a period not exceeding six months and at the rate and coverages as the policy provides. During that period of time the policy may not be altered or changed. Nothing in this section shall be deemed to impair the right of the insurer to make normal decreases or increases of the premium rate upon expiration

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and renewal of the policy, in accordance with the provisions of the policy. Thereafter, if such insurance coverage is no longer available, then the employee shall be given the opportunity to purchase an individual policy at a rate consistent with rates filed by the insurer with the commissioner. When the employee's compensation is so suspended or terminated, the employee shall be notified immediately by the policyholder in writing, by mail addressed to the address last on record with the policyholder, that the employee may pay the premiums to the policyholder as they become due as provided in this section.

Payment of the premiums must be made when due or the insurance coverage may be terminated by the insurer.

The provisions of any insurance policy contrary to provisions of this section are void and unenforceable after May 29, 1975. [1975 1st ex.s. c 117 § 1.]

Additional notes found at www.leg.wa.gov

48.21.080 Certificates of coverage. In group disability insurance policies there shall be a provision that the insurer shall issue to the employer, the policyholder, or other person or association in whose name such policy is issued, for delivery to each insured employee or member, a certificate setting forth in summary form a statement of the essential features of the insurance coverage, and to whom the benefits thereunder are payable described by name, relationship, or reference to the insurance records of the policyholder or insurer. If family members are insured, only one certificate need be issued for each family. This section shall not apply to blanket disability insurance policies. [1961 c 194 § 6; 1947 c 79 § .21.08; Rem. Supp. 1947 § 45.21.08.]

48.21.090 Age limitations. There shall be a provision specifying the ages, if any there be, to which the insurance provided therein shall be limited; and the ages, if any there be, for which additional restrictions are placed on benefits, and the additional restrictions placed on the benefits at such ages. [1947 c 79 § .21.09; Rem. Supp. 1947 § 45.21.09.]

48.21.100 Examination and autopsy. There may be a provision that the insurer shall have the right and opportunity to examine the person of the insured employee, member or dependent when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law. [1947 c 79 § .21.10; Rem. Supp. 1947 § 45.21.10.]

48.21.110 Payment of benefits. The benefits payable under any policy or contract of group or blanket disability insurance shall be payable to the employee or other insured member of the group or to the beneficiary designated by him or her, other than the policyholder, employer or the association or any officer thereof as such, subject to provisions of the policy in the event there is no designated beneficiary as to all or any part of any sum payable at the death of the individual insured.

The policy may provide that any hospital, medical, or surgical benefits thereunder may be made payable jointly to the insured employee or member and the person furnishing such hospital, medical, or surgical services. [2009 c 549 §

7103; 1955 c 303 § 17; 1947 c 79 § .21.11; Rem. Supp. 1947 § 45.21.11.]

48.21.120 Readjustment of premiums—Dividends.

Any contract of group disability insurance may provide for the readjustment of the rate of premium based on the experience thereunder at the end of the first year or of any subsequent year of insurance thereunder, and such readjustment may be made retroactive only for such policy year. Any refund under any plan for readjustment of the rate of premium based on the experience under group policies heretofore or hereafter issued, and any dividend paid under such policies may be used to reduce the employer's share of the cost of the coverage, except that if the aggregate refunds or dividends under such group policy and any other group policy or contract issued to the policyholder exceed the aggregate contributions of the employer toward the cost of the coverages, such excess shall be applied by the policyholder for the sole benefit of insured employees. [1947 c 79 § .21.12; Rem. Supp. 1947 § 45.21.12.]

48.21.125 When injury caused by intoxication or use of narcotics. An insurer may not deny coverage for the treatment of an injury solely because the injury was sustained as a consequence of the insured's being intoxicated or under the influence of a narcotic. [2004 c 112 § 3.]

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

48.21.130 Podiatric medicine and surgery. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract, benefits shall not be denied thereunder for any medical or surgical service performed by a holder of a license issued pursuant to chapter 18.22 RCW provided that (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW. [1963 c 87 § 2.]

Additional notes found at www.leg.wa.gov

48.21.140 Optometry. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract, benefits shall not be denied thereunder for any eye care service rendered by a holder of a license issued pursuant to chapter 18.53 RCW, provided, that (1) the service rendered was within the lawful scope of such person's license, and (2) such contract would have provided the benefits for such service if rendered by a holder of a license issued pursuant to chapter 18.71 RCW. [1965 c 149 § 3.]

Additional notes found at www.leg.wa.gov

48.21.141 Registered nurses or advanced registered nurses. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health service performed by a holder of a license for registered nursing practice or advanced registered nursing practice issued pursuant to chapter 18.79 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided

benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of chapter 18.71 RCW shall be asserted to deny benefits under this section.

The provisions of this section are intended to be remedial and procedural to the extent they do not impair the obligation of any existing contract. [1994 sp.s. c 9 § 730; 1973 1st ex.s. c 188 § 4.]

Additional notes found at www.leg.wa.gov

48.21.142 Chiropractic. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health service performed by a holder of a license issued pursuant to chapter 18.25 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of chapter 18.71 RCW shall be asserted to deny benefits under this section.

The provisions of this section are intended to be remedial and procedural to the extent they do not impair the obligation of any existing contract. [1971 ex.s. c 13 § 2.]

48.21.143 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 group disability insurance contracts and blanket disability insurance contracts providing health care services, issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For group disability insurance contracts and blanket disability insurance contracts 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 group disability insurance contracts and blanket disability insurance contracts providing health care services, 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 insurer from restricting patients to seeing only health care providers who have signed participating provider agreements with the insurer or an insuring entity under contract with the insurer.

(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 insurer 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 plan that provides benefits identical to the schedule of services covered by the basic health plan. [2020 c 346 § 8; 2020 c 245 § 4; 2004 c 244 § 10; 1997 c 276 § 3.]

Reviser's note: This section was amended by 2020 c 245 § 4 and by 2020 c 346 § 8, 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

48.21.144 Psychological services. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract, benefits shall not be denied thereunder for any psychological service rendered by a holder of a license issued pursuant to chapter 18.83 RCW: PROVIDED, That (1) the service rendered was within the lawful scope of such person's license, and (2) such contract would have provided the benefits for such service if rendered by a holder of a license issued pursuant to chapter 18.71 RCW. [1971 ex.s. c 197 § 2.]

Additional notes found at www.leg.wa.gov

48.21.146 Dentistry. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health service performed by a holder of a license issued pursuant to chapter 18.32 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of chapter 18.71 RCW shall be asserted to deny benefits under this section.

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The provisions of this section are intended to be remedial and procedural to the extent they do not impair the obligation of any existing contract. [1974 ex.s. c 42 § 2.]

48.21.147 Dental services that are not subject to contract or provider agreement. (1) Notwithstanding any other provisions of law, no group disability insurance contract or blanket disability insurance contract of any disability insurer as provided for in this chapter subject to the jurisdiction of the state of Washington that covers any dental services, and no contract or participating provider agreement with a dentist may:

(a) Require, directly or indirectly, that a dentist who is a participating provider provide services to a subscriber at a fee set by, or at a fee subject to the approval of, the disability insurer unless the dental services are covered services, including services that would be reimbursable but for the application of contractual limitations such as benefit maximums, deductibles, coinsurance, waiting periods, or frequency limitations, under the applicable group plan or disability insurance policy; nor

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

(2) For the purposes of this section, "covered services" means dental services that are reimbursable under the applicable insurance policy, group plan, or subscriber agreement or would be reimbursable but for the application of contractual limitations such as benefit maximums, deductibles, coinsurance, waiting periods or frequency limitations. [2010 c 228 § 2.]

48.21.148 Denturist services. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract 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 contract would have provided benefits if such service had been performed by a dentist licensed under chapter 18.32 RCW. [1995 c 1 § 22 (Initiative Measure No. 607, approved November 8, 1994).]

Additional notes found at www.leg.wa.gov

48.21.150 Dependent child coverage—Continuation for incapacity. Any group disability insurance contract or blanket disability insurance contract, providing health care services, delivered or issued for delivery in this state more than one hundred twenty days after August 11, 1969, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the contract 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 employee or member for support and maintenance, provided proof of such incapacity and dependency is

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furnished to the insurer by the employee or member within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer, but not more frequently than annually after the two year period following the child's attainment of the limiting age. [2020 c 274 § 31; 1977 ex.s. c 80 § 32; 1969 ex.s. c 128 § 4.]

Purpose—Intent—Severability—1977 ex.s. c 80: See notes following RCW 4.16.190.

48.21.155 Dependent child coverage—From moment of birth—Congenital anomalies—Notification of birth.

(1) Any group disability insurance contract except blanket disability insurance contract, providing hospital and medical expenses and health care services, renewed, delivered or issued for delivery in this state more than one hundred twenty days after February 16, 1974, which provides coverage for the dependent children of persons in the insured group, shall provide coverage for newborn infant children of persons in the insured group from and after the moment of birth. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

(2) If payment of an additional premium is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium must be furnished to the insurer. The notification period shall be no less than sixty days from the date of birth. This subsection applies to policies issued or renewed on or after January 1, 1984. [1983 1st ex.s. c 32 § 20; 1974 ex.s. c 139 § 2.]

48.21.157 Option to cover dependents under age twenty-six. Any group disability insurance contract or blanket disability insurance contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any dependent under the age of twenty-six. [2011 c 314 § 17; 2007 c 259 § 20.]

Additional notes found at www.leg.wa.gov

48.21.160 Chemical dependency benefits—Legislative declaration. The legislature recognizes that chemical dependency is a disease and, as such, warrants the same attention from the health care industry as other similarly serious diseases warrant; the legislature further recognizes that health insurance contracts and contracts for health care services include inconsistent provisions providing benefits for the treatment of chemical dependency. In order to assist the many citizens of this state who suffer from the disease of chemical dependency, and who are presently effectively precluded from obtaining adequate coverage for medical assistance under the terms of their health insurance contract or health care service contract, the legislature hereby declares that provisions providing benefits for the treatment of chemical dependency shall be included in new contracts and that this section, RCW 48.21.180, 48.21.190, 48.44.240, 48.46.350, and RCW 48.21.195, 48.44.245, and 48.46.355 are necessary for the protection of the public health and safety. Nothing in this section, RCW 48.21.180, 48.21.190, 48.44.240, 48.46.350, and RCW 48.21.195, 48.44.245, and 48.46.355 shall be construed to relieve any person of any civil or criminal liability for any act or omission that is the

result of a chemical dependency or to grant any person with a chemical dependency any special right, privilege, or status under the law against discrimination, chapter 49.60 RCW. [1987 c 458 § 13; 1974 ex.s. c 119 § 1.]

Additional notes found at www.leg.wa.gov

48.21.180 Chemical dependency benefits—Contracts issued or renewed after January 1, 1988. Each group disability insurance contract which is delivered or issued for delivery or renewed, on or after January 1, 1988, and which insures for hospital or medical care must contain provisions providing benefits for the treatment of chemical dependency rendered to the insured by a provider which is an "approved substance use disorder treatment program" under *RCW 70.96A.020(2). [2018 c 201 § 8011; 2003 c 248 § 9; 1990 1st ex.s. c 3 § 7; 1987 c 458 § 14; 1974 ex.s. c 119 § 3.]

*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.

Additional notes found at www.leg.wa.gov

48.21.190 Chemical dependency benefits—RCW 48.21.160 through 48.21.190, 48.44.240 inapplicable, when. RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended shall not apply to the renewal of a contract in force prior to the pertinent date provided for such contract under RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended where there exists a right of renewal on the part of the insured or subscriber without any change in any provision of the contract: PROVIDED FURTHER, That RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended shall not apply to contracts which provide only accident coverage, nor to any contract 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 (commonly referred to as Medicare, Parts A and B), and amendments thereto. [1975 1st ex.s. c 266 § 10; 1974 ex.s. c 119 § 5.]

Additional notes found at www.leg.wa.gov

48.21.195 "Chemical dependency" defined. For the purposes of RCW 48.21.160 and 48.21.180 "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 § 15.]

Additional notes found at www.leg.wa.gov

48.21.197 Chemical dependency benefits—Rules. By September 1, 1987, the insurance commissioner shall adopt rules governing benefits for treatment of chemical dependency under medical plans issued under chapters 48.21,

48.44, and 48.46 RCW. These rules shall recognize that many persons are dependent on both alcohol and drugs; they shall prohibit the stacking of benefits and shall require that benefits for chemical dependency be equivalent to benefits previously required for alcoholism. [1987 c 458 § 21.]

Additional notes found at www.leg.wa.gov

48.21.200 Individual or group disability, health care service contract, health maintenance agreement—Reduction of benefits on basis of other existing coverages. (1) No individual or group disability insurance policy, health care service contract, or health maintenance agreement providing hospital, medical or surgical expense benefits and which contains a provision for the reduction of benefits otherwise payable or available thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount equal to one hundred percent of total allowable expenses.

(2) The commissioner shall by rule establish guidelines for the application of this section, including:

(a) The procedures by which persons covered under such policies, contracts, and agreements are to be made aware of the existence of such a provision;

(b) The benefits which may be subject to such a provision;

(c) The effect of such a provision on the benefits provided;

(d) Establishment of the order of benefit determination;

(e) Exceptions necessary to preserve policy, contract, or agreement requirements for use of particular health care facilities or providers; and

(f) Reasonable claim administration procedures to expedite claim payments and prevent duplication of payments or benefits under such a provision. [2007 c 80 § 3; 1993 c 492 § 282. Prior: 1983 c 202 § 16; 1983 c 106 § 24; 1975 1st ex.s. c 266 § 20.]

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

Additional notes found at www.leg.wa.gov

48.21.220 Home health care, hospice care, optional coverage required—Standards, limitations, restrictions—Rules—Medicare supplemental contracts excluded. (1) Every insurer entering into or renewing group or blanket disability insurance policies governed by this chapter shall offer optional coverage for home health care and hospice care for persons who are homebound and would otherwise require hospitalization. Such optional coverage need only be offered in conjunction with a policy that provides payment for hospitalization as a part of health care coverage. Persons seeking such services for palliative care in conjunction with treatment or management of serious or life-threatening illness need not be homebound in order to be eligible for coverage under this section.

(2) Home health care and hospice care coverage offered under subsection (1) of this section shall conform to the following standards, limitations, and restrictions in addition to those set forth in chapter 70.126 RCW:

(a) The coverage may include reasonable deductibles, coinsurance provisions, and internal maximums;

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(b) The coverage should be structured to create incentives for the use of home health care and hospice care as an alternative to hospitalization;

(c) The coverage may contain provisions for utilization review and quality assurance;

(d) The coverage may require that home health agencies and hospices have written treatment plans approved by a physician licensed under chapter 18.57 or 18.71 RCW, and may require such treatment plans to be reviewed at designated intervals;

(e) The coverage shall provide benefits for, and restrict benefits to, services rendered by home health and hospice agencies licensed by the department of social and health services;

(f) Hospice care coverage shall provide benefits for terminally ill patients for an initial period of care of not less than six months and may provide benefits for an additional six months of care in cases where the patient is facing imminent death or is entering remission if certified in writing by the attending physician;

(g) Home health care coverage shall provide benefits for a minimum of one hundred thirty health care visits per calendar year. However, a visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment constitutes one visit;

(h) The coverage may be structured so that services or supplies included in the primary contract are not duplicated in the optional home health and hospice coverage.

(3) The insurance commissioner shall adopt any rules necessary to implement this section.

(4) The requirements of this section shall not apply to contracts or policies governed by chapter 48.66 RCW.

(5) An insurer, as a condition of reimbursement, may require compliance with home health and hospice certification regulations established by the United States department of health and human services. [2015 c 22 § 1; 1988 c 245 § 31; 1984 c 22 § 1; 1983 c 249 § 1.]

Application—2015 c 22: "This act applies to plans issued or renewed after December 31, 2016." [2015 c 22 § 4.]

Home health care, hospice care, rules: Chapter 70.126 RCW.

Additional notes found at www.leg.wa.gov

48.21.223 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 § 20; 2011 c 159 § 4.]

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

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

48.21.225 Mammograms—Insurance coverage.

Each group disability insurance policy issued or renewed after January 1, 1990, that provides coverage for hospital or medical expenses shall provide coverage 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.

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 an insurer 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 § 731; 1989 c 338 § 2.]

Additional notes found at www.leg.wa.gov

48.21.227 Prostate cancer screening. (1) Each group disability insurance policy 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) 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 an insurer 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 § 3.]

48.21.230 Reconstructive breast surgery. (1) Each group disability insurance contract issued or renewed after July 24, 1983, which insures for hospital or medical care shall provide coverage for reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness, or injury.

(2) Each group disability insurance contract issued or renewed after January 1, 1986, which insures for hospital or medical care 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 § 6; 1983 c 113 § 2.]

Additional notes found at www.leg.wa.gov

48.21.235 Mastectomy, lumpectomy. No person engaged in the business of insurance under this chapter may refuse to issue any contract of insurance or cancel or decline to renew the contract 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 § 2.]

Additional notes found at www.leg.wa.gov

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

(a) For health benefit plans that provide coverage for medical and surgical services 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 insurer's medical director or designee determines the treatment to be medically necessary; and

(b) For health benefit plans that provide coverage for medical and surgical services 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) All group disability insurance contracts and blanket disability insurance contracts providing health benefit plans 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 comparable 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 § 3; 2007 c 8 § 2; 2006 c 74 § 1; 2005 c 6 § 3.]

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

Additional notes found at www.leg.wa.gov

48.21.242 Mental health treatment—Waiver of preauthorization for persons involuntarily committed. An insurer providing group disability insurance coverage for health care in this state shall waive a preauthorization requirement from the insurer before an insured or the insured's covered dependents receive mental health care and treatment rendered by a state hospital if the insured or any of the insured's covered dependents are involuntarily committed to a state hospital as defined in RCW 72.23.010. [1993 c 272 § 3.]

Additional notes found at www.leg.wa.gov

48.21.244 Benefits for prenatal diagnosis of congenital disorders—Contracts entered into or renewed on or after January 1, 1990. On or after January 1, 1990, every group disability contract entered into or renewed that covers hospital, medical, or surgical expenses on a group basis, 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 disability contractor in accord with standards set in rule by the board of health. Every group disability contractor shall communicate the availability of such coverage to all group disability contract holders and to all groups with whom they are negotiating. [1988 c 276 § 6.]

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

48.21.250 Continuation option to be offered. Every insurer that issues policies providing group coverage for hospital or medical expense shall offer the policyholder an option to include a policy provision granting a person who becomes ineligible for coverage under the group policy, the right to continue the group benefits for a period of time and at a rate agreed upon. The policy provision shall provide that when such coverage terminates, the covered person may convert to a policy as provided in RCW 48.21.260. [1984 c 190 § 2.]

Legislative intent—1984 c 190: "The legislature recognizes that when people covered by a group health insurance policy lose their group insurance benefits because they are no longer eligible, they need time to obtain a suitable form of replacement coverage or time to complete a reasonable course of medical treatment for a health condition that existed when the group benefits ended.

Spouses and dependents can lose their group insurance and may not have any other health insurance when one spouse covered under a group pol-

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icy dies, obtains a divorce, or becomes unemployed. Often the cost of an individual policy prevents these persons from obtaining any other health insurance.

The intent of this act is to require insurers, health care service contractors, and health maintenance organizations to:

(1) Offer to the contract holder the option to continue health and medical benefits for employees, members, spouses, or dependents whose eligibility for coverage under a group policy, contract, or agreement is terminated; and

(2) Provide a conversion policy, contract, or agreement to employees, members, spouses, or dependents whose eligibility for coverage under a group policy, contract, or agreement is terminated." [1984 c 190 § 1.]

Additional notes found at www.leg.wa.gov

48.21.260 Conversion policy to be offered—Exceptions, conditions. (1) Except as otherwise provided by this section, any group disability insurance policy that provides benefits for hospital or medical expenses must contain a provision granting a person covered by the group policy the right to obtain a conversion policy from the insurer upon termination of the person's eligibility for coverage under the group policy.

(2) An insurer need not offer a conversion policy to:

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

(4) If an insurer or group policyholder does not renew, cancels, or otherwise terminates the group policy, the insurer must offer a conversion policy to any person who was covered under the terminated policy unless the person is eligible to obtain group hospital or medical expense coverage within thirty-one days after such nonrenewal, cancellation, or termination of the group policy or thirty-one days after the date the person received notice of termination of coverage, whichever is later.

(5) The insurer shall determine the premium for the conversion policy in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under the policy and the type and amount of benefits provided. [2010 c 110 § 1; 1984 c 190 § 3.]

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

Additional notes found at www.leg.wa.gov

48.21.270 Conversion policy—Restrictions and requirements—Rules. (1) An insurer shall not require proof of insurability as a condition for issuance of the conversion policy.

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

(3) An insurer must offer at least three policy benefit plans that comply with the following:

(a) A major medical plan with a five thousand dollar deductible per person;

(b) A comprehensive medical plan with a five hundred dollar deductible per person; and

(c) A basic medical plan with a one thousand dollar deductible per person.

(4) The insurance commissioner may revise the deductible amounts in subsection (3) of this section from time to time to reflect changing health care costs.

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

(6) The commissioner shall adopt rules to establish specific standards for conversion policy 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 § 4; 2011 c 314 § 2; 1984 c 190 § 4.]

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.

48.21.280 Coverage for adopted children. (1) Any group disability insurance contract, except a blanket disability insurance contract, providing hospital and medical expenses and health care services, delivered or issued for delivery in this state, which provides coverage for dependent children, as defined in the contract of the insured, shall cover adoptive children placed with the insured 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 contract may require that notification of placement of a child for adoption and payment of the required premium must be furnished to the insurer. The notification period shall be no less than sixty days from the date of placement. [1986 c 140 § 3.]

Additional notes found at www.leg.wa.gov

48.21.290 Cancellation of rider. Upon application by an insured, a rider shall be canceled if at least five years after its issuance, no health care services have been received by the insured 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 insured from that condition, such agreement not to be unreasonably withheld. The option of the insured 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 § 2.]

48.21.300 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 group disability insurance contract delivered or issued for delivery or renewed in this state on or after September 1, 1988, that insures for hospital or medical expenses shall provide coverage for the formulas necessary for the treatment of phenylketonuria. [1988 c 173 § 2.]

48.21.310 Neurodevelopmental therapies—Employer-sponsored group contracts. (1) Each employer-sponsored group policy for comprehensive health insurance 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. Benefits shall be payable only where the services have been 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 covered services have been rendered by such licensee. Nothing in this section shall prohibit an insurer from negotiating rates with qualified providers.

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

(4) It is the intent of this section that employers purchasing comprehensive health insurance, including the benefits required by this section, together with the insurer, retain authority to design and employ utilization and cost controls. Therefore, benefits delivered under this section may be subject to contractual provisions regarding deductible amounts and/or copayments established by the employer purchasing insurance and the insurer. 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 insurance and the insurer. [1989 c 345 § 2.]

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

(a) Insurers offering medical coverage only may limit benefits in such coverages to medical services related to treatment of temporomandibular joint disorders. Insurers offering dental coverage only may limit benefits in such coverage to dental services related to treatment of temporomandibular joint disorders. No insurer offering medical coverage only may define all temporomandibular joint disorders as purely dental in nature, and no insurer offering dental coverage only may define all temporomandibular joint disorders as purely medical in nature.

(b) Insurers 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) An insurer 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 § 2.]

Legislative finding—1989 c 331: "The legislature finds that:

(1) Temporomandibular joint disorders are conditions for which treatment often is not covered in medical and dental group insurance contracts;

(2) Individuals with temporomandibular joint disorders experience substantial pain and financial hardship;

(3) Public awareness is needed concerning temporomandibular joint disorders and would be promoted by a mandated offering of temporomandibular joint disorders coverage to group purchasers; and

(4) A mandated offering of temporomandibular joint disorders coverage shall not prescribe minimum initial benefits so that the insurers and the purchasers are allowed broad flexibility in benefit design and application." [1989 c 331 § 1.]

Additional notes found at www.leg.wa.gov

48.21.325 Prescriptions—Preapproval of individual claims—Subsequent rejection prohibited—Written record required. Group disability insurance companies 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 § 3.]

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

(2021 Ed.)

48.21.330 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, an insurer providing coverage of prescription drugs from nonresident pharmacies may only provide coverage from licensed nonresident pharmacies. The insurers 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 insurer 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 § 311; 1991 c 87 § 8.]

Additional notes found at www.leg.wa.gov

48.21.370 Fixed payment insurance—Standard disclosure form. The commissioner shall adopt rules setting forth the content of a standard disclosure form to be delivered to all applicants for group illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance. The standard disclosure shall provide information regarding the level, type, and amount of benefits provided and the limitations, exclusions, and exceptions under the policy, as well as additional information to enhance consumer understanding. The disclosure shall specifically disclose that the coverage is not comprehensive in nature and will not cover the cost of most hospital and other medical services. Such disclosure form must be filed for approval with the commissioner prior to use. The standard disclosure form must be provided to the master policyholders at the time of solicitation and completion of the application and to all enrollees at the time of enrollment. All advertising and marketing materials other than the standard disclosure form must be filed with the commissioner at least thirty days prior to use. [2007 c 296 § 4.]

48.21.375 Fixed payment insurance—Benefit restrictions. Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance policies are not considered to provide coverage for hospital or medical expenses or care under this chapter, if the benefits provided are a fixed dollar amount that is paid regardless of the amount charged. The benefits may not be related to, or be a percentage of, the amount charged by the provider of service and must be offered as an independent and noncoordinated benefit with any other health plan as defined in *RCW 48.43.005(19). [2007 c 296 § 5.]

*Reviser's note: RCW 48.43.005 was amended by 2011 c 314 § 3 and by 2011 c 315 § 2, changing subsection (19) to subsection (24). RCW

48.43.005 was subsequently amended by 2012 c 87 § 1, changing subsection (24) to subsection (26). RCW 48.43.005 was subsequently alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (26) to subsection (27), and effective January 1, 2020, changing subsection (26) to subsection (29).

48.21.380 Noninsurance benefits. (1) A disability insurer may include the following noninsurance benefits as part of a policy or certificate of group disability insurance, with the prior approval of the commissioner and where such benefits bear a reasonable relationship to the disability insurance with which they are intended to be offered:

- (a) Will preparation services;
- (b) Financial planning and estate planning services;
- (c) Probate and estate settlement services;
- (d) Grief counseling;
- (e) Funeral planning and funeral services, but it must be disclosed that this noninsurance benefit does not constitute an insurance funded prearrangement contract, pursuant to RCW 18.39.255; and

(f) Such other services as the commissioner may identify by rule.

(2) The commissioner may adopt rules to regulate the disclosure of noninsurance benefits permitted under this section, including but not limited to guidelines regarding the coverage provided under the policy or certificate of insurance.

(3) Those providing the services listed in subsection (1) of this section must be appropriately licensed.

(4) This section does not require the commissioner to approve any particular proposed noninsurance benefit. The commissioner may disapprove any proposed noninsurance benefit that the commissioner determines may tend to promote or facilitate the violation of any other section of this title.

(5) This section does not expand, limit, or otherwise affect the authority and ethical obligations of those who are authorized by the state supreme court to practice law in this state. This section does not limit the prohibition against the unauthorized practice of law under chapter 2.48 RCW.

(6) This section does not affect the application of chapter 21.20 RCW.

(7) This section does not affect wellness programs as described in RCW 48.30.140(6). [2017 c 32 § 2; 2016 c 143 § 2.]

48.21.900 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 § 116.]

Chapter 48.21A RCW

DISABILITY INSURANCE—EXTENDED HEALTH

Sections

- 48.21A.010 Declaration of purpose.
- 48.21A.020 Definitions.
- 48.21A.030 Insurers may join—Policyholder—Reduced benefit provision—Master group policy—Offering—Cancellation.
- 48.21A.040 Insurance producers.
- 48.21A.050 Powers and duties of associations.
- 48.21A.060 Commissioner's powers—Forms—Rates—Standard provisions—Withdrawal of approval—Federal, state benefits—Annual reports.
- 48.21A.070 Documents to be filed—Deceptive name or advertising.
- 48.21A.080 Remedies.
- 48.21A.090 Home health care, hospice care, optional coverage required—Standards, limitations, restrictions—Rules—Medicare supplemental contracts excluded.
- 48.21A.900 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

Refusal to renew or cancellation of disability insurance: RCW 48.18.298, 48.18.299.

48.21A.010 Declaration of purpose. It is the purpose of this chapter to provide a means of more adequately meeting the needs of persons who are sixty-five years of age or older and their spouses for insurance coverage against financial loss from accident or disease through the combined resources and experience of a number of insurers; to make possible the fullest extension of such coverage by encouraging insurers to combine their resources and experience and to exercise their collective efforts in the development and offering of policies of such insurance to all applicants; and to regulate the joint activities herein authorized in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), as amended. [1965 ex.s. c 70 § 27.]

48.21A.020 Definitions. Wherever used in this chapter, the following terms shall have the meanings hereinafter set forth or indicated, unless the context otherwise requires:

(a) "Association" means a voluntary unincorporated association of insurers formed for the purpose of enabling cooperative action to provide disability insurance in accordance with this chapter in this or any other state having legislation enabling the issuance of insurance of the type provided in this chapter.

(b) "Insurer" means any insurance company which is authorized to transact disability insurance in this state.

(c) "Extended health insurance" means hospital, surgical and medical expense insurance provided by a policy issued as provided by this chapter. [1965 ex.s. c 70 § 28.]

48.21A.030 Insurers may join—Policyholder—Reduced benefit provision—Master group policy—Offering—Cancellation. Notwithstanding any other provision of this code or any other law which may be inconsistent herewith, any insurer may join with one or more other insurers, to plan, develop, underwrite, and offer and provide to any person who is sixty-five years of age or older and to the spouse of such person, extended health insurance against financial loss from accident or disease, or both. Such insurance may be offered, issued and administered jointly by two or more insurers by a group policy issued to a policyholder through an association formed for the purpose of offering, selling, issuing and administering such insurance. The policyholder may

be an association, a trustee, or any other person. Any such policy may provide, among other things, that the benefits payable thereunder are subject to reduction if the individual insured has any other coverage providing hospital, surgical or medical benefits whether on an indemnity basis or a provision of service basis resulting in such insured being eligible for more than one hundred percent of covered expenses which he or she is required to pay, and any insurer issuing individual policies providing extended hospital, surgical or medical benefits to persons sixty-five years of age and older and their spouses may also use such a policy provision. A master group policy issued to an association or to a trustee or any person appointed by an association for the purpose of providing the insurances described in this section shall be another form of group disability insurance.

Any form of policy approved by the commissioner for an association shall be offered throughout Washington to all persons sixty-five and older and their spouses, and the coverage of any person insured under such a form of policy shall not be cancellable except for nonpayment of premiums unless the coverage of all persons insured under such form of policy is also canceled. [2009 c 549 § 7104; 1965 ex.s. c 70 § 29.]

48.21A.040 Insurance producers. Any person licensed to transact disability insurance as an insurance producer may transact extended health insurance and may be paid a commission thereon. [2008 c 217 § 25; 1965 ex.s. c 70 § 30.]

Additional notes found at www.leg.wa.gov

48.21A.050 Powers and duties of associations. Any association formed for the purposes of this chapter may hold title to property, may enter into contracts, and may limit the liability of its members to their respective pro rata shares of the liability of such association. Any such association may sue and be sued in its associate name and for such purpose only shall be treated as a domestic corporation. Service of process against such association, made upon a managing agent, any member thereof or any agent authorized by appointment to receive service of process, shall have the same force and effect as if such service had been made upon all members of the association. Such association's books and records shall also be subject to examination under the provisions of RCW 48.03.010 through 48.03.070, inclusive, either separately or concurrently with examination of any of its member insurers. [1983 c 3 § 151; 1965 ex.s. c 70 § 31.]

48.21A.060 Commissioner's powers—Forms—Rates—Standard provisions—Withdrawal of approval—Federal, state benefits—Annual reports. The forms of the policies, applications, certificates or other evidence of insurance coverage and applicable premium rates relating thereto shall be filed with the commissioner. No such policy, contract, or other evidence of insurance, application or other form shall be sold, issued or used and no endorsement shall be attached to or printed or stamped thereon unless the form thereof shall have been approved by the commissioner or thirty days shall have expired after such filing without written notice from the commissioner of disapproval thereof. The commissioner shall disapprove the forms of such insurance if

he or she finds that they are unjust, unfair, inequitable, misleading or deceptive or that the rates are by reasonable assumption excessive in relation to the benefits provided. In determining whether such rates by reasonable assumptions are excessive in relation to the benefits provided, the commissioner shall give due consideration to past and prospective claim experience, within and outside this state, and to fluctuations in such claim experience, to a reasonable risk charge, to contribution to surplus and contingency funds, to past and prospective expenses, both within and outside this state, and to all other relevant factors within and outside this state including any differing operating methods of the insurers joining in the issue of the policy. In exercising the powers conferred upon him or her by this chapter, the commissioner shall not be bound by any other requirement of this code with respect to standard provisions to be included in disability policies or forms.

The commissioner may, after hearing upon written notice, withdraw an approval previously given, upon such grounds as in his or her opinion would authorize disapproval upon original submission thereof. Any such withdrawal of approval after hearing shall be by notice in writing specifying the ground thereof and shall be effective at the expiration of such period, not less than ninety days after the giving of notice of withdrawal, as the commissioner shall in such notice prescribe.

If and when a program of hospital, surgical and medical benefits is enacted by the federal government or the state of Washington, the extended health insurance benefits provided by policies issued under this chapter shall be adjusted to avoid any duplication of benefits offered by the federal or state programs and the premium rates applicable thereto shall be adjusted to conform with the adjusted benefits.

The association shall submit an annual report to the insurance commissioner which shall become public information and shall provide information as to the number of persons insured, the names of the insurers participating in the association with respect to insurance offered under this chapter and the calendar year experience applicable to such insurance offered under this chapter, including premiums earned, claims paid during the calendar year, the amount of claims reserve established, administrative expenses, commissions, promotional expenses, taxes, contingency reserve, other expenses, and profit and loss for the year. The commissioner shall require the association to provide any and all information concerning the operations of the association deemed relevant by him for inclusion in the report. [2009 c 549 § 7105; 1965 ex.s. c 70 § 32.]

48.21A.070 Documents to be filed—Deceptive name or advertising. The articles of association of any association formed in accordance with this chapter, all amendments and supplements thereto, a designation in writing of a resident of this state as agent for the service of process, and a list of insurers who are members of the association and all supplements thereto shall be filed with the commissioner.

The name of any association or any advertising or promotional material used in connection with extended health insurance to be sold, offered, or issued, pursuant to this chapter shall not be such as to mislead or deceive the public. [1965 ex.s. c 70 § 33.]

48.21A.080 Remedies. No act done, action taken or agreement made pursuant to the authority conferred by this chapter shall constitute a violation of or grounds for prosecution or civil proceedings under any other law of this state heretofore or hereafter enacted which does not specifically refer to insurance. [1965 ex.s. c 70 § 34.]

48.21A.090 Home health care, hospice care, optional coverage required—Standards, limitations, restrictions—Rules—Medicare supplemental contracts excluded. (1) Every insurer entering into or renewing extended health insurance governed by this chapter shall offer optional coverage for home health care and hospice care for persons who are homebound and would otherwise require hospitalization. Such optional coverage need only be offered in conjunction with a policy that provides payment for hospitalization as a part of health care coverage. Persons seeking such services for palliative care in conjunction with treatment or management of serious or life-threatening illness need not be homebound in order to be eligible for coverage under this section.

(2) Home health care and hospice care coverage offered under subsection (1) of this section shall conform to the following standards, limitations, and restrictions in addition to those set forth in chapters 70.126 and 70.127 RCW:

(a) The coverage may include reasonable deductibles, coinsurance provisions, and internal maximums;

(b) The coverage should be structured to create incentives for the use of home health care and hospice care as an alternative to hospitalization;

(c) The coverage may contain provisions for utilization review and quality assurance;

(d) The coverage may require that home health agencies and hospices have written treatment plans approved by a physician licensed under chapter 18.57 or 18.71 RCW, and may require such treatment plans to be reviewed at designated intervals;

(e) The coverage shall provide benefits for, and restrict benefits to, services rendered by home health and hospice agencies licensed under chapter 70.127 RCW;

(f) Hospice care coverage shall provide benefits for terminally ill patients for an initial period of care of not less than six months and may provide benefits for an additional six months of care in cases where the patient is facing imminent death or is entering remission if certified in writing by the attending physician;

(g) Home health care coverage shall provide benefits for a minimum of one hundred thirty health care visits per calendar year. However, a visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment constitutes one visit;

(h) The coverage may be structured so that services or supplies included in the primary contract are not duplicated in the optional home health and hospice coverage.

(3) The insurance commissioner shall adopt any rules necessary to implement this section.

(4) The requirements of this section shall not apply to contracts or policies governed by chapter 48.66 RCW.

(5) An insurer, as a condition of reimbursement, may require compliance with home health and hospice certification regulations established by the United States department

of health and human services. [2015 c 22 § 2; 1989 1st ex.s. c 9 § 220; 1988 c 245 § 32; 1984 c 22 § 2; 1983 c 249 § 2.]

Application—2015 c 22: See note following RCW 48.21.220.

Home health care, hospice care, rules: Chapter 70.126 RCW.

Additional notes found at www.leg.wa.gov

48.21A.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 § 117.]

Chapter 48.22 RCW CASUALTY INSURANCE

Sections

48.22.005	Definitions.
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48.22.030	Underinsured, hit-and-run, phantom vehicle coverage to be provided—Purpose—Definitions—Exceptions—Conditions—Deductibles—Information on motorcycle or motor-driven cycle coverage—Intended victims.
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48.22.050	Market assistance plans.
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48.22.080	Health care liability risk management training program.
48.22.085	Automobile liability insurance policy—Optional coverage for personal injury protection—Rejection by insured.
48.22.090	Personal injury protection coverage—Exceptions.
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48.22.105	Rule making.
48.22.110	Vendor single-interest or collateral protection coverage—Definitions.
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48.22.135	Vendor single-interest or collateral protection coverage—Application.
48.22.140	Driver's license suspension for nonpayment of child support—Exclusion of unlicensed driver from insurance coverage not applicable—Notation in driving record.
48.22.900	Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

Casualty rates, rating organization: Chapter 48.19 RCW.

Injured public assistance recipient, department has lien, payment to recipient does not discharge lien: RCW 74.09.180, 43.20B.040, and 43.20B.050.

Policy forms, execution, filing, etc.: Chapter 48.18 RCW.

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

(1) "Automobile" means a passenger car as defined in RCW 46.04.382 registered or principally garaged in this state other than:

- (a) A farm-type tractor or other self-propelled equipment designed for use principally off public roads;
- (b) A vehicle operated on rails or crawler-treads;
- (c) A vehicle located for use as a residence;
- (d) A motor home as defined in RCW 46.04.305; or
- (e) A moped as defined in RCW 46.04.304.

(2) "Bodily injury" means bodily injury, sickness, or disease, including death at any time resulting from the injury, sickness, or disease.

(3) "Income continuation benefits" means payments for the insured's loss of income from work, because of bodily injury sustained by the insured in an automobile accident, less income earned during the benefit payment period. The combined weekly payment an insured may receive under personal injury protection coverage, worker's compensation, disability insurance, or other income continuation benefits may not exceed eighty-five percent of the insured's weekly income from work. The benefit payment period begins fourteen days after the date of the automobile accident and ends at the earliest of the following:

- (a) The date on which the insured is reasonably able to perform the duties of his or her usual occupation;
 - (b) Fifty-four weeks from the date of the automobile accident; or
 - (c) The date of the insured's death.
- (4) "Insured automobile" means an automobile described on the declarations page of the policy.

(5) "Insured" means:

(a) The named insured or a person who is a resident of the named insured's household and is either related to the named insured by blood, marriage, or adoption, or is the named insured's ward, foster child, or stepchild; or

(b) A person who sustains bodily injury caused by accident while: (i) Occupying or using the insured automobile with the permission of the named insured; or (ii) a pedestrian accidentally struck by the insured automobile.

(6) "Loss of services benefits" means reimbursement for payment to others, not members of the insured's household, for expenses reasonably incurred for services in lieu of those the insured would usually have performed for his or her household without compensation, provided the services are actually rendered. The maximum benefit is forty dollars per day. Reimbursement for loss of services ends the earliest of the following:

- (a) The date on which the insured person is reasonably able to perform those services;
- (b) Fifty-two weeks from the date of the automobile accident; or
- (c) The date of the insured's death.

(7) "Medical and hospital benefits" means payments for all reasonable and necessary expenses incurred by or on behalf of the insured for injuries sustained as a result of an automobile accident for health care services provided by per-

sons licensed under Title 18 RCW, including pharmaceuticals, prosthetic devices and eyeglasses, and necessary ambulance, hospital, and professional nursing service. Medical and hospital benefits are payable for expenses incurred within three years from the date of the automobile accident.

(8) "Automobile liability insurance policy" means a policy insuring against loss resulting from liability imposed by law for bodily injury, death, or property damage suffered by any person and arising out of the ownership, maintenance, or use of an insured automobile. An automobile liability policy does not include:

- (a) Vendors single interest or collateral protection coverage;
- (b) General liability insurance; or
- (c) Excess liability insurance, commonly known as an umbrella policy, where coverage applies only as excess to an underlying automobile policy.

(9) "Named insured" means the individual named in the declarations of the policy and includes his or her spouse if a resident of the same household.

(10) "Occupying" means in or upon or entering into or alighting from.

(11) "Pedestrian" means a natural person not occupying a motor vehicle as defined in RCW 46.04.320.

(12) "Personal injury protection" means the benefits described in this section and RCW 48.22.085 through 48.22.100. Payments made under personal injury protection coverage are limited to the actual amount of loss or expense incurred. [2003 c 115 § 1; 1993 c 242 § 1.]

Additional notes found at www.leg.wa.gov

48.22.020 Assigned risk plans. The commissioner shall after consultation with the insurers licensed to write motor vehicle liability insurance in this state, approve a reasonable plan or plans for the equitable apportionment among such insurers of applicants for such insurance who are in good faith entitled to but are unable to procure insurance through ordinary methods and, when such plan has been approved, all such insurers shall subscribe thereto and shall participate therein. Any applicant for such insurance, any person insured under such plan and any insurer affected may appeal to the commissioner from any ruling or decision of the manager or committee designated to operate such plan. [1947 c 79 § .22.02; Rem. Supp. 1947 § 45.22.02.]

Rate modifications for assigned risks: RCW 48.19.400.

48.22.030 Underinsured, hit-and-run, phantom vehicle coverage to be provided—Purpose—Definitions—Exceptions—Conditions—Deductibles—Information on motorcycle or motor-driven cycle coverage—Intended victims. (1) "Underinsured motor vehicle" means a motor vehicle with respect to the ownership, maintenance, or use of which either no bodily injury or property damage liability bond or insurance policy applies at the time of an accident, or with respect to which the sum of the limits of liability under all bodily injury or property damage liability bonds and insurance policies applicable to a covered person after an accident is less than the applicable damages which the covered person is legally entitled to recover.

(2) No new policy or renewal of an existing policy insuring against loss resulting from liability imposed by law for

bodily injury, death, or property damage, suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle shall be issued with respect to any motor vehicle registered or principally garaged in this state unless coverage is provided therein or supplemental thereto for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of underinsured motor vehicles, hit-and-run motor vehicles, and phantom vehicles because of bodily injury, death, or property damage, resulting therefrom, except while operating or occupying a motorcycle or motor-driven cycle, and except while operating or occupying a motor vehicle owned or available for the regular use by the named insured or any family member, and which is not insured under the liability coverage of the policy. The coverage required to be offered under this chapter is not applicable to general liability policies, commonly known as umbrella policies, or other policies which apply only as excess to the insurance directly applicable to the vehicle insured.

(3) Except as to property damage, coverage required under subsection (2) of this section shall be in the same amount as the insured's third party liability coverage unless the insured rejects all or part of the coverage as provided in subsection (4) of this section. Coverage for property damage need only be issued in conjunction with coverage for bodily injury or death. Property damage coverage required under subsection (2) of this section shall mean physical damage to the insured motor vehicle unless the policy specifically provides coverage for the contents thereof or other forms of property damage.

(4) A named insured or spouse may reject, in writing, underinsured coverage for bodily injury or death, or property damage, and the requirements of subsections (2) and (3) of this section shall not apply. If a named insured or spouse has rejected underinsured coverage, such coverage shall not be included in any supplemental or renewal policy unless a named insured or spouse subsequently requests such coverage in writing. The requirement of a written rejection under this subsection shall apply only to the original issuance of policies issued after July 24, 1983, and not to any renewal or replacement policy. When a named insured or spouse chooses a property damage coverage that is less than the insured's third party liability coverage for property damage, a written rejection is not required.

(5) The limit of liability under the policy coverage may be defined as the maximum limits of liability for all damages resulting from any one accident regardless of the number of covered persons, claims made, or vehicles or premiums shown on the policy, or premiums paid, or vehicles involved in an accident.

(6) The policy may provide that if an injured person has other similar insurance available to him or her under other policies, the total limits of liability of all coverages shall not exceed the higher of the applicable limits of the respective coverages.

(7)(a) The policy may provide for a deductible of not more than three hundred dollars for payment for property damage when the damage is caused by a hit-and-run driver or a phantom vehicle.

(b) In all other cases of underinsured property damage coverage, the policy may provide for a deductible of not more than one hundred dollars.

(8) For the purposes of this chapter, a "phantom vehicle" shall mean a motor vehicle which causes bodily injury, death, or property damage to an insured and has no physical contact with the insured or the vehicle which the insured is occupying at the time of the accident if:

(a) The facts of the accident can be corroborated by competent evidence other than the testimony of the insured or any person having an underinsured motorist claim resulting from the accident; and

(b) The accident has been reported to the appropriate law enforcement agency within seventy-two hours of the accident.

(9) An insurer who elects to write motorcycle or motor-driven cycle insurance in this state must provide information to prospective insureds about the coverage.

(10) An insurer who elects to write motorcycle or motor-driven cycle insurance in this state must provide an opportunity for named insureds, who have purchased liability coverage for a motorcycle or motor-driven cycle, to reject underinsured coverage for that motorcycle or motor-driven cycle in writing.

(11) If the covered person seeking underinsured motorist coverage under this section was the intended victim of the tortfeasor, the incident must be reported to the appropriate law enforcement agency and the covered person must cooperate with any related law enforcement investigation.

(12) The purpose of this section is to protect innocent victims of motorists of underinsured motor vehicles. Covered persons are entitled to coverage without regard to whether an incident was intentionally caused. However, a person is not entitled to coverage if the insurer can demonstrate that the covered person intended to cause the event for which a claim is made under the coverage described in this section. As used in this section, and in the section of policies providing the underinsured motorist coverage described in this section, "accident" means an occurrence that is unexpected and unintended from the standpoint of the covered person.

(13) The coverage under this section may be excluded as provided for under RCW 48.177.010(6).

(14) "Underinsured coverage," for the purposes of this section, means coverage for "underinsured motor vehicles," as defined in subsection (1) of this section. [2015 c 236 § 7; 2009 c 549 § 7106; 2007 c 80 § 14. Prior: 2006 c 187 § 1; 2006 c 110 § 1; 2006 c 25 § 17; 2004 c 90 § 1; 1985 c 328 § 1; 1983 c 182 § 1; 1981 c 150 § 1; 1980 c 117 § 1; 1967 c 150 § 27.]

Additional notes found at www.leg.wa.gov

48.22.040 Underinsured motor vehicle coverage where liability insurer is insolvent—Extent of coverage—Rights of insurer upon making payment. (1) The term "underinsured motor vehicles" with reference to coverage offered under any insurance policy regulated under this chapter shall, subject to the terms and conditions of such coverage, be deemed to include an insured motor vehicle where the liability insurer thereof is unable to make payment with respect to the legal liability of its insured within the limits specified therein because of insolvency.

(2) An insurer's insolvency protection shall be applicable only to accidents occurring during a policy period in which its insured's underinsured motorist coverage is in effect where the liability insurer of the tort-feasor becomes insolvent within three years after such an accident. Nothing herein contained shall be construed to prevent any insurer from affording insolvency protection under terms and conditions more favorable to its insureds than is provided hereunder.

(3) In the event of payment to an insured under the coverage required by this chapter and subject to the terms and conditions of such coverage, the insurer making such payment shall, to the extent thereof, be entitled to the proceeds of any settlement or judgment resulting from the exercise of any rights of recovery of such insured against any person or organization legally responsible for the bodily injury, death, or property damage for which such payment is made, including the proceeds recoverable from the assets of the insolvent insurer. Whenever an insurer shall make payment under the coverage required by this section and which payment is occasioned by an insolvency, such insurer's right of recovery or reimbursement shall not include any rights against the insured of said insolvent insurer for any amounts which would have been paid by the insolvent insurer. Such paying insurer shall have the right to proceed directly against the insolvent insurer or its receiver, and in pursuance of such right such paying insurer shall possess any rights which the insured of the insolvent company might otherwise have had, if the insured of the insolvent insurer had personally made the payment. [1983 c 182 § 2; 1980 c 117 § 2; 1967 ex.s. c 95 § 3.]

Additional notes found at www.leg.wa.gov

48.22.050 Market assistance plans. The commissioner shall by regulation require insurers authorized to write casualty insurance in this state to form a market assistance plan to assist persons and other entities unable to purchase casualty insurance in an adequate amount from either the admitted market or nonadmitted market.

For the purpose of this section, a market assistance plan means a voluntary mechanism by insurers writing casualty insurance in this state in either the admitted or nonadmitted market to provide casualty insurance for a class of insurance designated in writing to the plan by the commissioner.

The bylaws and method of operation of any market assistance plan shall be approved by the commissioner prior to its operation.

A market assistance plan shall have a minimum of twenty-five insurers willing to insure risks within the class designated by the commissioner. If twenty-five insurers do not voluntarily agree to participate, the commissioner may require casualty insurers to participate in a market assistance plan as a condition of continuing to do business in this state. The commissioner shall make such a requirement to fulfill the quota of at least twenty-five insurers. The commissioner shall make his or her designation on the basis of the insurer's premium volume of casualty insurance in this state. [1986 c 305 § 906.]

Additional notes found at www.leg.wa.gov

48.22.060 Debt and financing coverage. Every insurer that writes collision and comprehensive coverage for loss or

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damage to "private passenger automobiles" or "motor homes," as those terms are defined in RCW 48.18.297 and 46.04.305, respectively, shall provide, upon the insured's request, coverage that will pay, in the event of total loss, an amount, in excess of the actual cash value of the vehicle, sufficient to satisfy any outstanding indebtedness secured by and incurred in conjunction with the financing of the purchase of a new private passenger automobile or motor home.

Nothing in this section prohibits an insurer from denying or excluding such coverage where the insured or someone acting on the insured's behalf acts in a fraudulent manner to obtain or file a claim under such coverage. [1988 c 248 § 16; 1987 c 240 § 1.]

Additional notes found at www.leg.wa.gov

48.22.070 Longshoreman's and harbor worker's compensation coverage—Rules—Plan creation.

(1) The commissioner shall adopt rules establishing a reasonable plan to insure that workers' compensation coverage as required by the United States longshore and harbor workers' compensation act, 33 U.S.C. Secs. 901 through 950, and maritime employer's liability coverage incidental to the workers' compensation coverage is available to those unable to purchase it through the normal insurance market. This plan shall require the participation of all authorized insurers writing primary or excess United States longshore and harbor workers' compensation insurance in the state of Washington and the Washington state industrial insurance fund as defined in RCW 51.08.175 which is authorized to participate in the plan and to make payments in support of the plan in accordance with this section. Any underwriting losses or surpluses incurred by the plan shall be determined by the governing committee of the plan and shall be shared by plan participants in accordance with the following ratios: The state industrial insurance fund, fifty percent; and authorized insurers writing primary or excess United States longshore and harbor workers' compensation insurance, fifty percent.

(2) The Washington state industrial insurance fund may obtain or provide reinsurance coverage for the plan created under subsection (1) of this section the terms of which shall be negotiated between the state fund and the plan. This coverage shall not be obtained or provided if the commissioner determines that the premium to be charged would result in unaffordable rates for coverage provided by the plan. In considering whether excess of loss coverage premiums would result in unaffordable rates for workers' compensation coverage provided by the plan, the commissioner shall compare the resulting plan rates to those provided under any similar pool or plan of other states.

(3) An applicant for plan insurance, a person insured under the plan, or an insurer, affected by a ruling or decision of the manager or committee designated to operate the plan may appeal to the commissioner for resolution of a dispute. In adopting rules under this section, the commissioner shall require that the plan use generally accepted actuarial principles for rate making. [1997 c 110 § 1; 1993 c 177 § 1; 1992 c 209 § 2.]

Finding—Declaration—1992 c 209: "The legislature finds and declares that the continued existence of a strong and healthy maritime industry in this state is threatened by the unavailability and excessive cost of workers' compensation coverage required by the United States longshoreman's

and harbor worker's compensation act. The legislature, therefore, acting under its authority to protect industry and employment in this state hereby establishes a commission to devise and implement both a near and long-term solution to this problem, for the purpose of maintaining employment for Washington workers and a vigorous maritime industry." [1992 c 209 § 1.]

Additional notes found at www.leg.wa.gov

48.22.080 Health care liability risk management training program. Effective July 1, 1994, a casualty insurer's issuance of a new medical malpractice policy or renewal of an existing medical malpractice policy to a physician or other independent health care practitioner shall be conditioned upon that practitioner's participation in, and completion of, an insurer-designed health care liability risk management training program once every three years. Completion of said training program during 1994 shall satisfy the first three-year training requirement. The risk management training shall provide information related to avoiding adverse health outcomes resulting from substandard practice and minimizing damages associated with the adverse health outcomes that do occur. For purposes of this section, "independent health care practitioners" means those health care practitioner licensing classifications designated by the department of health in rule pursuant to *RCW 18.130.330. [1994 c 102 § 2; 1993 c 492 § 413.]

*Reviser's note: RCW 18.130.330 was repealed by 1995 c 265 § 27, effective July 1, 1995.

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

Additional notes found at www.leg.wa.gov

48.22.085 Automobile liability insurance policy—Optional coverage for personal injury protection—Rejection by insured. (1) No new automobile liability insurance policy or renewal of such an existing policy may be issued unless personal injury protection coverage is offered as an optional coverage.

(2) A named insured may reject, in writing, personal injury protection coverage and the requirements of subsection (1) of this section shall not apply. If a named insured rejects personal injury protection coverage:

(a) That rejection is valid and binding as to all levels of coverage and on all persons who might have otherwise been insured under such coverage; and

(b) The insurer is not required to include personal injury protection coverage in any supplemental, renewal, or replacement policy unless a named insured subsequently requests such coverage in writing.

(3) The coverage under this section may be excluded as provided for under RCW 48.177.010(6). [2015 c 236 § 8; 2003 c 115 § 2; 1993 c 242 § 2.]

Additional notes found at www.leg.wa.gov

48.22.090 Personal injury protection coverage—Exceptions. An insurer is not required to provide personal injury protection coverage to or on behalf of:

(1) A person who intentionally causes injury to himself or herself;

(2) A person who is injured while participating in a pre-arranged or organized racing or speed contest or in practice or preparation for such a contest;

(3) A person whose bodily injury is due to war, whether or not declared, or to an act or condition incident to such circumstances;

(4) A person whose bodily injury results from the radioactive, toxic, explosive, or other hazardous properties of nuclear material;

(5) The named insured or a relative while occupying a motor vehicle owned by the named insured or furnished for the named insured's regular use, if such motor vehicle is not described on the declaration page of the policy under which a claim is made;

(6) A relative while occupying a motor vehicle owned by the relative or furnished for the relative's regular use, if such motor vehicle is not described on the declaration page of the policy under which a claim is made; or

(7) An insured whose bodily injury results or arises from the insured's use of an automobile in the commission of a felony. [2003 c 115 § 3; 1993 c 242 § 3.]

Additional notes found at www.leg.wa.gov

48.22.095 Automobile insurance policies—Minimum personal injury protection coverage. (1) Insurers providing automobile insurance policies must offer minimum personal injury protection coverage for each insured with benefit limits as follows:

(a) Medical and hospital benefits of ten thousand dollars;

(b) A funeral expense benefit of two thousand dollars;

(c) Income continuation benefits of ten thousand dollars, subject to a limit of two hundred dollars per week; and

(d) Loss of services benefits of five thousand dollars, subject to a limit of two hundred dollars per week.

(2) The coverage under this section may be excluded as provided for under RCW 48.177.010(6). [2015 c 236 § 9; 2003 c 115 § 4; 1993 c 242 § 4.]

Additional notes found at www.leg.wa.gov

48.22.100 Automobile insurance policies—Personal injury protection coverage—Request by named insured—Benefit limits. If requested by a named insured, an insurer providing automobile liability insurance policies must offer personal injury protection coverage for each insured with benefit limits as follows:

(1) Medical and hospital benefits of thirty-five thousand dollars;

(2) A funeral expense benefit of two thousand dollars;

(3) Income continuation benefits of thirty-five thousand dollars, subject to a limit of seven hundred dollars per week; and

(4) Loss of services benefits of fourteen thousand six hundred dollars. [2003 c 115 § 5; 1993 c 242 § 5.]

Additional notes found at www.leg.wa.gov

48.22.105 Rule making. The commissioner may adopt such rules as are necessary to implement RCW 48.22.005 and 48.22.085 through 48.22.100. [1993 c 242 § 9.]

Additional notes found at www.leg.wa.gov

48.22.110 Vendor single-interest or collateral protection coverage—Definitions. Unless the context clearly requires otherwise, the definitions in this section apply

throughout this section and RCW 48.22.115 through 48.22.135.

(1) "Borrower" means a person who receives a loan or enters into a retail installment contract under chapter 63.14 RCW to purchase a motor vehicle or vessel in which the secured party holds an interest.

(2) "Motor vehicle" means a motor vehicle in this state subject to registration under *chapter 46.16 RCW, except motor vehicles governed by RCW 46.16A.170 or registered with the Washington utilities and transportation commission as common or contract carriers.

(3) "Secured party" means a person, corporation, association, partnership, or venture that possesses a bona fide security interest in a motor vehicle or vessel.

(4) "Vendor single-interest" or "collateral protection coverage" means insurance coverage insuring primarily or solely the interest of a secured party but which may include the interest of the borrower in a motor vehicle or vessel serving as collateral and obtained by the secured party or its agent after the borrower has failed to obtain or maintain insurance coverage required by the financing agreement for the motor vehicle or vessel. Vendor single-interest or collateral protection coverage does not include insurance coverage purchased by a secured party for which the borrower is not charged.

(5) "Vessel" means a vessel as defined in RCW 88.02.310 and includes personal watercraft as defined in RCW 79A.60.010. [2010 c 161 § 1148; 2003 c 248 § 10; 1994 c 186 § 1.]

***Reviser's note:** Although directed to be recodified within chapter 46.16 RCW pursuant to chapter 161, Laws of 2010, a majority of chapter 46.16 RCW was recodified under chapter 46.16A RCW pursuant to RCW 1.08.015 (2)(k) and (3).

Effective date—Intent—Legislation to reconcile chapter 161, Laws of 2010 and other amendments made during the 2010 legislative session—2010 c 161: See notes following RCW 46.04.013.

Additional notes found at www.leg.wa.gov

48.22.115 Vendor single-interest or collateral protection coverage—Warning. In a contract or loan agreement, or on a separate document accompanying the contract or loan agreement and signed by the borrower, that provides financing for a motor vehicle or vessel and authorizes a secured party to purchase vendor single interest or collateral protection coverage, the following or substantially similar warning must be set forth in ten-point print:

WARNING

UNLESS YOU PROVIDE US WITH EVIDENCE OF THE INSURANCE COVERAGE AS REQUIRED BY OUR LOAN AGREEMENT, WE MAY PURCHASE INSURANCE AT YOUR EXPENSE TO PROTECT OUR INTEREST. THIS INSURANCE MAY, BUT NEED NOT, ALSO PROTECT YOUR INTEREST. IF THE COLLATERAL BECOMES DAMAGED, THE COVERAGE WE PURCHASE MAY NOT PAY ANY CLAIM YOU MAKE OR ANY CLAIM MADE AGAINST YOU. YOU MAY LATER CANCEL THIS COVERAGE BY PROVIDING EVIDENCE THAT YOU HAVE OBTAINED PROPER COVERAGE ELSEWHERE.

YOU ARE RESPONSIBLE FOR THE COST OF ANY INSURANCE PURCHASED BY US. THE COST OF THIS INSURANCE MAY BE ADDED TO YOUR LOAN BALANCE. IF THE COST IS ADDED TO THE LOAN BALANCE, THE INTEREST RATE ON THE UNDERLYING LOAN WILL APPLY TO THIS ADDED AMOUNT. THE EFFECTIVE DATE OF COVERAGE MAY BE THE DATE YOUR PRIOR COVERAGE LAPSED OR THE DATE YOU FAILED TO PROVIDE PROOF OF COVERAGE.

THE COVERAGE WE PURCHASE MAY BE CONSIDERABLY MORE EXPENSIVE THAN INSURANCE YOU CAN OBTAIN ON YOUR OWN AND MAY NOT SATISFY WASHINGTON'S MANDATORY LIABILITY INSURANCE LAWS.

[1994 c 186 § 2.]

Additional notes found at www.leg.wa.gov

48.22.120 Vendor single-interest or collateral protection coverage—Final notice and warning—No requirement to purchase—Effective date of coverage. (1) A secured party shall not impose charges, that may include but are not limited to interest, finance, and premium charges, on a borrower for vendor single interest or collateral protection coverage for the motor vehicle or vessel as provided in subsection (2) of this section until the following or a substantially similar warning printed in ten-point type is sent to the borrower:

FINAL NOTICE AND WARNING

UNLESS YOU PROVIDE US WITH EVIDENCE OF THE INSURANCE COVERAGE AS REQUIRED BY OUR LOAN AGREEMENT WITHIN FIVE DAYS AFTER THE POSTMARK ON THIS LETTER, WE WILL PURCHASE INSURANCE AT YOUR EXPENSE TO PROTECT OUR INTEREST. THIS INSURANCE MAY, BUT NEED NOT, ALSO PROTECT YOUR INTEREST. IF THE COLLATERAL BECOMES DAMAGED, THE COVERAGE WE PURCHASE MAY NOT PAY ANY CLAIM YOU MAKE OR ANY CLAIM MADE AGAINST YOU. YOU MAY LATER CANCEL THIS COVERAGE BY PROVIDING EVIDENCE THAT YOU HAVE OBTAINED PROPER COVERAGE ELSEWHERE OR HAVE PAID OFF THE LOAN ON THE COLLATERAL IN ITS ENTIRETY.

YOU ARE RESPONSIBLE FOR THE COST OF THE INSURANCE PURCHASED BY US. THE COST OF THIS INSURANCE MAY BE ADDED TO YOUR LOAN BALANCE. IF THE COST IS ADDED TO THE LOAN BALANCE, THE INTEREST RATE ON THE UNDERLYING LOAN WILL APPLY TO THIS ADDED AMOUNT. THE EFFECTIVE DATE OF COVERAGE MAY BE THE DATE YOUR COVERAGE

LAPSED OR THE DATE YOU FAILED TO PROVIDE PROOF OF COVERAGE.

THE COVERAGE WE PURCHASE WILL COST YOU A TOTAL OF APPROXIMATELY \$ (PLUS INTEREST) AND MAY BE CONSIDERABLY MORE EXPENSIVE THAN INSURANCE YOU CAN OBTAIN ON YOUR OWN.

The final notice and warning shall identify whether the coverage to be purchased is vendor single interest or collateral protection coverage and disclose the extent of the borrower's coverage, if any, including a statement of whether the coverage satisfies Washington's mandatory liability insurance laws.

(2) If reasonable efforts to provide the borrower with the notice required under subsection (1) of this section fail to produce evidence of the required insurance, the secured party may proceed to impose charges for vendor single interest or collateral protection coverage no sooner than eight days after giving notice as required under this chapter. Reasonable efforts to provide notice under this section means:

(a) Within thirty days before the secured party is required to send the final notice and warning in compliance with subsection (1) of this section, the secured party shall mail a notice by first-class mail to the borrower's last known address as contained in the secured party's records. The notice shall state that the secured party intends to charge the borrower for vendor single interest or collateral protection coverage on the collateral if the borrower fails to provide evidence of proper insurance to the lender; and

(b) The secured party shall send the final notice and warning notice in compliance with subsection (1) of this section by certified mail to the borrower's last known address as contained in the secured party's records at least eight days before the insurance is charged to the borrower by the insurer.

(3) The secured party is responsible for complying with subsection (2)(a) and (b) of this section. However, a secured party may seek the services of other entities to fulfill the requirements of subsection (2)(a) and (b) of this section.

(4) Nothing contained in this chapter, or a secured party's compliance with or failure to comply with this chapter, shall be construed to require the secured party to purchase vendor single interest or collateral protection coverage, and the secured party shall not be liable to the borrower or any third party as a result of its failure to purchase vendor single interest or collateral protection coverage.

(5) Substantial compliance by a secured party with RCW 48.22.110 through 48.22.130 constitutes a complete defense to any claim arising under the laws of this state challenging the secured party's placement of vendor single interest or collateral protection coverage.

(6) The effective date of vendor single interest or collateral protection coverage placed under this chapter shall be either the date that the borrower's prior coverage lapsed or the date that the borrower failed to provide proof of coverage on the vehicle or vessel as required under the contract or loan agreement. Premiums for vendor single interest or collateral protection coverage placed under this chapter shall be calculated on a basis that does not exceed the outstanding credit balance as of the effective date of the coverage even though

the coverage may limit liability to the outstanding balance, actual cash value, or cost of repair.

(7) If the secured party has purchased the contract or loan agreement relating to the motor vehicle or vessel from the seller of the motor vehicle or vessel under an agreement that the seller must repurchase the contract or loan agreement in the event of a default by the borrower, the secured party shall send a copy of the notice provided under subsection (2)(a) of this section by first-class mail to the seller at the seller's last known address on file with the secured party when such notice is sent to the borrower under subsection (2)(a) of this section. [1994 c 186 § 3.]

Additional notes found at www.leg.wa.gov

48.22.125 Vendor single-interest or collateral protection coverage—Cancellation when borrower has obtained insurance—Interest rate for financing. (1) The secured party shall cancel vendor single interest or collateral protection coverage charged to the borrower effective the date of receipt of proper evidence from the borrower that the borrower has obtained insurance to protect the secured party's interest. Proper evidence includes an insurance binder that is no older than ninety days from the date of issuance and that contains physical damage coverage as provided in the borrower's loan agreement with respect to the motor vehicle or vessel.

(2) If the underlying loan or extension of credit for the underlying loan is satisfied, the secured party may not require the borrower to maintain vendor single interest or collateral protection coverage that has been purchased.

(3) The interest rate for financing the cost of vendor single interest or collateral protection coverage may not exceed the interest rate applied to the underlying loan obligation. [1994 c 186 § 4.]

Additional notes found at www.leg.wa.gov

48.22.130 Vendor single-interest or collateral protection coverage—Canceled or discontinued—Premium refund. If vendor single interest or collateral protection coverage is canceled or discontinued under RCW 48.22.125 (1) or (2), the amount of unearned premium must be refunded to the borrower. At the option of the secured party, this refund may take the form of a credit against the borrower's obligation to the secured party. If the refund is taken as a credit against the borrower's obligation to the secured party, the secured party shall provide the borrower with an itemized statement that indicates the amount of the credit and where the credit has been applied. [1994 c 186 § 5.]

Additional notes found at www.leg.wa.gov

48.22.135 Vendor single-interest or collateral protection coverage—Application. The failure of a secured party prior to January 1, 1995, to provide notice as contemplated in this chapter, or otherwise to administer a vendor single interest or collateral protection coverage program in a manner similar to that required under this chapter, shall not be admissible in any court or arbitration proceeding or otherwise used to prove that a secured party's actions with respect to vendor single interest or collateral protection coverage or similar coverage were unlawful or otherwise improper. A secured party shall not be liable to the borrower or any other party for

placing vendor single interest or collateral protection coverage in accordance with the terms of an otherwise legal loan or other written agreement with the borrower entered prior to January 1, 1995. The provisions of this section shall be applicable with respect to actions pending or commenced on or after June 9, 1994. [1994 c 186 § 7.]

48.22.140 Driver's license suspension for nonpayment of child support—Exclusion of unlicensed driver from insurance coverage not applicable—Notation in driving record. In the event that the department of licensing suspends a driver's license solely for the nonpayment of child support as provided in chapter 74.20A RCW or for noncompliance with a *residential or visitation order as provided in chapter 26.09 RCW, any provision in the driver's motor vehicle liability insurance policy excluding insurance coverage for an unlicensed driver shall not apply to the driver for ninety days from the date of suspension. When a driver's license is suspended under chapter 74.20A RCW, the driving record for the suspended driver shall include a notation that explains the reason for the suspension. [1997 c 58 § 808.]

***Reviser's note:** 1997 c 58 § 886 requiring a court to order certification of noncompliance with residential provisions of a court-ordered parenting plan was vetoed. Provisions ordering the department of social and health services to certify a responsible parent based on a court order to certify for noncompliance with residential provisions of a parenting plan were vetoed. See RCW 74.20A.320.

Effective dates—Intent—1997 c 58: See notes following RCW 74.20A.320.

Additional notes found at www.leg.wa.gov

48.22.900 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 § 118.]

Chapter 48.23 RCW

LIFE INSURANCE AND ANNUITIES

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48.23.525	Individual life insurance—Noninsurance benefits—Rules.
48.23.900	Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

Assignment of policies: RCW 48.18.360.

Charitable gift annuity business: Chapter 48.38 RCW.

Exemption of proceeds

commutation, annuities: RCW 48.18.430.

life insurance: RCW 48.18.410.

Insurable interest, personal insurance, nonprofit organizations: RCW 48.18.030.

Minor may contract for life or disability insurance: RCW 48.18.020.

Payment to person designated in policy or by assignment discharges insurer: RCW 48.18.370.

Policy forms, execution, filing, etc.: Chapter 48.18 RCW.

Simultaneous deaths: RCW 48.18.390.

Spouses' rights in life insurance policy: RCW 48.18.440.

48.23.010 Scope of chapter. This chapter applies to contracts of life insurance and annuities other than group life insurance, group annuities, and, except for RCW 48.23.260, 48.23.270, and 48.23.340, other than industrial life insurance. However, Title 48 RCW does not apply to charitable gift annuities issued by a board of a state university, regional university, or a state college, nor to the issuance thereof. [2005 c 223 § 12; 1979 c 130 § 2; 1947 c 79 § .23.01; Rem. Supp. 1947 § 45.23.01.]

Additional notes found at www.leg.wa.gov

48.23.015 Purchase or exchange of annuities—Definitions—Standards—Requirements—Conduct—Records—Penalties—Rules. (1) For the purposes of this section:

(a) "Annuity" means a fixed annuity or variable annuity that is individually solicited, whether the product is classified as an individual or group annuity.

(b) "Recommendation" means advice provided by an insurance producer, or an insurer when no producer is involved, to an individual consumer that results in a purchase or exchange of an annuity in accordance with that advice.

(2) Insurers and insurance producers must comply with the following requirements in recommending and executing a purchase or exchange of an annuity:

(a) In recommending the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions to a consumer, the insurance producer, or the insurer when no producer is involved, must have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer about their investments and other insurance products and as to their financial situation and needs.

(b) Prior to the execution of a purchase or exchange of an annuity resulting from a recommendation, an insurance producer, or an insurer when no producer is involved, shall make reasonable efforts to obtain information concerning:

- (i) The consumer's financial status;
- (ii) The consumer's tax status;
- (iii) The consumer's investment objectives; and
- (iv) Other information used or considered to be reasonable by the insurance producer, or the insurer when no producer is involved, in making recommendations to the consumer.

(3) An insurer or insurance producer's recommendation must be reasonable under all circumstances actually known to the insurer or insurance producer at the time of the recommendation. Neither an insurance producer nor an insurer when no producer is involved, has any obligation to a consumer under subsection (2) of this section related to any recommendation if a consumer:

- (a) Refuses to provide relevant information requested by the insurer or insurance producer;
- (b) Decides to enter into an insurance transaction that is not based on a recommendation of the insurer or insurance producer; or
- (c) Fails to provide complete or accurate information.

(4) An insurer must assure that a system to supervise recommendations, reasonably designed to achieve compliance with this section, is established and maintained. The system must include, but is not limited to, written procedures and conducting periodic review of its records that are reasonably designed to assist in detecting and preventing violations of this section.

(a) An insurer may contract with a third party, including insurance producers, a general agent, or independent agency, to establish and maintain a system of supervision as required in this subsection with respect to insurance producers under contract with or employed by the third party. An insurer must make reasonable inquiry to assure that the third party is performing the functions required in this subsection and must

take action as is reasonable under the circumstances to enforce the contractual obligation to perform the functions. An insurer may comply with its obligation to make reasonable inquiry by doing all of the following:

(i) Annually obtaining a certification from a third party senior manager with responsibility for the delegated functions that the manager has a reasonable basis to represent, and does represent, that the third party is performing the required functions; and

(ii) Based on reasonable selection criteria, periodically selecting third parties contracting under this subsection for a review to determine whether the third parties are performing the required functions. The insurer shall perform those procedures to conduct the review that are reasonable under the circumstances.

(b) An insurer, or the contracted third party if a general agent or independent agency, is not required to:

(i) Review, or provide for review of, all insurance producer solicited transactions; or

(ii) Include in its system of supervision an insurance producer's recommendations to consumers of products other than the annuities offered by the insurer, general agent, or independent agency.

(c) A general agent or independent agency contracting with an insurer to supervise compliance with this section shall promptly, when requested by the insurer, give a certification of compliance or give a clear statement that it is unable to meet the certification criteria. A person may not provide a certification unless the person:

- (i) Is a senior manager with responsibility for the delegated functions; and
- (ii) Has a reasonable basis for making the certification.

(5) Compliance with the financial industry regulatory authority conduct rules pertaining to suitability satisfies the requirements under this section for the recommendation of annuities registered under the securities act of 1933 (15 U.S.C. Sec. 77(a) et seq. or as hereafter amended). The insurance commissioner must notify the appropriate committees of the house of representatives and senate if there are changes regarding the registration of annuities under the securities act of 1933 that affect the application of this subsection. This subsection does not limit the insurance commissioner's ability to enforce this section.

(6) The commissioner may order an insurer, an insurance producer, or both, to take reasonably appropriate corrective action for any consumer harmed by the insurer's or insurance producer's violation of this section.

(a) Any applicable penalty under this or other sections of Title 48 RCW may be reduced or eliminated by the commissioner if corrective action for the consumer was taken promptly after a violation was discovered.

(b) This subsection does not limit the commissioner's ability to enforce this section or other applicable sections of Title 48 RCW.

(7) Insurers and insurance producers must maintain or be able to make available to the commissioner records of the information collected from the consumer and other information used in making the recommendations that were the basis for the insurance transaction for five years after the insurance transaction is completed by the insurer, or for five years after the annuity begins paying benefits, whichever is longer. An

insurer is permitted, but is not required, to maintain documentation on behalf of an insurance producer. This section does not relieve an insurance producer of the obligation to maintain records of insurance transactions as required by RCW 48.17.470.

(8) The commissioner may adopt rules to implement and administer this section.

(9) Unless otherwise specifically included, this section does not apply to recommendations involving:

(a) Direct response solicitations when there is no recommendation based on information collected from the consumer under this section; or

(b) Contracts used to fund:

(i) An employee pension or welfare benefit plan that is covered by the employment and income security act;

(ii) A plan described by sections 401(a), 401(k), 403(b), 408(k), or 408(p) of the internal revenue code, as amended, if established or maintained by an employer;

(iii) A government or church plan defined in section 414 of the internal revenue code, a government or church welfare benefit plan or a deferred compensation plan of a state or local government or tax exempt organization under section 457 of the internal revenue code;

(iv) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(v) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(vi) Formal prepaid funeral contracts.

(10) This section does not affect the application of chapter 21.20 RCW. [2009 c 18 § 2.]

Purpose—2009 c 18: "The purpose of this act is to permit and set standards for producers and insurers selling annuity products issued after July 26, 2009, that ensure consumers purchase annuities suitable to their financial and insurance needs and life circumstances." [2009 c 18 § 1.]

48.23.020 Standard provisions required—Life insurance. (1) No policy of life insurance other than industrial, group and pure endowments with or without return of premiums or of premiums and interest, shall be delivered or issued for delivery in this state unless it contains in substance all of the provisions required by RCW 48.23.030 to 48.23.130, inclusive. This provision shall not apply to annuity contracts.

(2) Any of such provisions or portions thereof not applicable to single premium or term policies shall to that extent not be incorporated therein. [1947 c 79 § .23.02; Rem. Supp. 1947 § 45.23.02.]

48.23.030 Grace period. There shall be a provision that the insured is entitled to a grace period of one month, but not less than thirty days, within which the payment of any premium after the first may be made, subject at the option of the insurer to an interest charge not in excess of six percent per annum for the number of days of grace elapsing before the payment of the premium, during which period of grace the policy shall continue in force, but in case the policy becomes a claim during the grace period before the overdue premium is paid, or the deferred premiums of the current policy year, if any, are paid, the amount of such premium or premiums with interest thereon may be deducted in any settlement under the policy. [1947 c 79 § .23.03; Rem. Supp. 1947 § 45.23.03.]

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48.23.040 Entire contract—Representations. In all such policies other than those containing a clause making the policy incontestable from date of issue, there shall be a provision that the policy and the application therefor, if a copy thereof has been endorsed upon or attached to the policy at issue and made a part thereof, shall constitute the entire contract between the parties, and that all statements made by the applicant or by the insured, shall, in the absence of fraud, be deemed representations and not warranties. [1947 c 79 § .23.04; Rem. Supp. 1947 § 45.23.04.]

48.23.050 Incontestability. There shall be a provision that the policy shall be incontestable after it has been in force during the lifetime of the insured for a period of two years from its date of issue, except for nonpayment of premiums and except, at the option of the insurer, as to provisions relative to benefits in event of total and permanent disability and as to provisions which grant additional insurance specifically against accidental death. [1947 c 79 § .23.05; Rem. Supp. 1947 § 45.23.05.]

48.23.060 Misstatement of age. There shall be a provision that if it is found that the age of the insured (or the age of any other individual considered in determining the premium) has been misstated, the amount payable under the policy shall be such as the premium would have purchased at the correct age or ages, according to the insurer's rate at date of issue. [1947 c 79 § .23.06; Rem. Supp. 1947 § 45.23.06.]

48.23.070 Participation in surplus. (1) In all policies which provide for participation in the insurer's surplus, there shall be a provision that the policy shall so participate annually in the insurer's divisible surplus as apportioned by the insurer, beginning not later than the end of the third policy year. Any policy containing provision for annual participation beginning at the end of the first policy year, may also provide that each dividend shall be paid subject to the payment of the premiums for the next ensuing year. The insured under any annual dividend policy shall have the right each year to have the current dividend arising from such participation either paid in cash, or applied in accordance with such other dividend option as may be specified in the policy and elected by the insured. The policy shall further provide which of the options shall be effective if the insured shall fail to notify the insurer in writing of his or her election within the period of grace allowed for the payment of premium.

(2) This section shall not apply to paid-up nonforfeiture benefits nor paid-up policies issued on default in payment of premiums. [2009 c 549 § 7107; 1947 c 79 § .23.07; Rem. Supp. 1947 § 45.23.07.]

48.23.075 Participation in surplus—Requirements for forms. (1) Life insurance and annuity policy forms of the following types shall be defined and designated as participating forms of insurance only if they contain a provision for participation in the insurer's surplus, and shall be defined and designated as nonparticipating forms if they do not contain a provision for participation in the insurer's surplus:

(a) Forms which provide that the premium or consideration at the time of issue and subsequent premiums or considerations will be established by the insurer based on current, or

then current, projected assumptions for such factors as interest, mortality, persistency, expense, or other factors, subject to a maximum guaranteed premium or premiums set forth in the policy; and

(b) Forms (except those for variable life insurance and variable annuity plans which are subject to chapter 48.18A RCW) which provide that their premiums or considerations are credited to an account to which interest is credited, and from which the cost of any life insurance or annuity benefits or other benefits or specified expenses are deducted.

(2) The commissioner may by regulation further clarify the definitions and requirements contained in subsection (1) of this section, and may classify any other types of forms as participating or nonparticipating, consistent therewith. [1982 c 181 § 19.]

Additional notes found at www.leg.wa.gov

48.23.080 Policy loan. (1) There shall be a provision that after three full years' premiums have been paid thereon, the insurer at any time, while the policy is in force, will advance, on proper assignment or pledge of the policy and on the sole security thereof, at a rate of interest provided in this chapter as now or hereafter amended, a sum to be determined as follows:

(a) If such policy is issued prior to the operative date of *RCW 48.23.350, the sum, including any interest paid in advance but not beyond the end of the current policy year, shall be equal to or at the option of the owner of the policy less than, the reserve at the end of the current policy year on the policy and on any dividend additions thereto, less a sum not more than two and one-half percent of the amount insured by the policy and of any dividend additions thereto. The policy may contain a provision by which the insurer reserves the right to defer the making of the loan, except when made to pay premiums, for a period not exceeding six months after the date of application therefor.

(b) If such policy is issued on or after such operative date, the sum, including any interest to the end of the current policy year shall not exceed the cash surrender value at the end of the current policy year, as required by *RCW 48.23.350.

(c)(i) The policy shall contain (A) a provision that policy loans shall bear interest at a specified rate not exceeding six percent per annum, or (B) a provision that policy loans shall bear interest at a variable of not less than four nor more than eight percent per annum.

(ii) The variable rate shall not be changed more frequently than once per year and no change may exceed one percent per annum except reductions. The insurer shall give at least thirty days' notice to the policy owner or the owner's designee of any changes in the interest rate.

(iii) The provisions of (c)(i) and (c)(ii) of this subsection shall apply only in policies in existence prior to August 1, 1981.

(2) Such policy shall further provide that the insurer may deduct from such loan value any existing indebtedness on the policy (unless such indebtedness has already been deducted in determining the cash surrender value) and any unpaid balance of the premium for the current policy year; and that if the loan is made or repaid on a date other than the anniversary of the policy, the insurer shall be entitled to interest for the

portion of the current policy year at the rate of interest specified in the policy.

(3) Such policy may further provide that if the interest on the loan is not paid when due, it shall be added to the existing indebtedness and shall bear interest at the same rate; and that if and when the total indebtedness on the policy, including interest due or accruing, equals or exceeds the amount of the loan value thereof which would otherwise exist at such time, the policy shall terminate in full settlement of such indebtedness and become void; except, that it shall be stipulated in the policy that no such termination shall be effective prior to the expiration of at least thirty days after notice of the pendency of the termination was mailed by the insurer to the insured and the assignee, if any, at their respective addresses last of record with the insurer.

(4) The insurer shall provide in any policy issued on or after the operative date of *RCW 48.23.350 that the making of any loan, other than a loan to pay premiums, may be deferred for not exceeding six months after the application for the loan has been received by it. [1981 c 247 § 3; 1977 ex.s. c 250 § 1; 1947 c 79 § .23.08; Rem. Supp. 1947 § 45.23.08.]

*Reviser's note: RCW 48.23.350 was repealed by 1982 1st ex.s. c 9 § 36; later enactment, see chapter 48.76 RCW.

Purpose—Effective date—1981 c 247: See notes following RCW 48.23.085.

Additional notes found at www.leg.wa.gov

48.23.085 Policy loan interest rates. (1) As used in this section, "published monthly average" means:

(a) The "Moody's Corporate Bond Yield Average - Monthly Average Corporates" as published by Moody's Investors Service, Incorporated or any successor thereto; or

(b) If the "Moody's Corporate Bond Yield Average - Monthly Average Corporates" is no longer published, a substantially similar average, established by rule issued by the commissioner.

(2) Policies issued on or after August 1, 1981, shall provide for policy loan interest rates by containing:

(a) A provision permitting a maximum interest rate of not more than eight percent per annum; or

(b) A provision permitting an adjustable maximum interest rate established from time to time by the life insurer as permitted by law.

(3) The rate of interest charged on a policy loan made under (2)(b) of this section shall not exceed the higher of the following:

(a) The published monthly average for the calendar month ending two months before the date on which the rate is determined; or

(b) The rate used to compute the cash surrender values under the policy during the applicable period plus one percent per annum.

(4) If the maximum rate of interest is determined pursuant to (2)(b) of this section, the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(5) The maximum rate for each policy shall be determined at regular intervals at least once every twelve months, but not more frequently than once in any three-month period. At the intervals specified in the policy:

(a) The rate being charged may be increased whenever such increase as determined under subsection (3) of this section would increase that rate by one-half of one percent or more per annum; and

(b) The rate being charged shall be reduced whenever such reduction as determined under subsection (3) of this section would decrease that rate by one-half of one percent or more per annum.

(6) The life insurer shall:

(a) Notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(b) Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in (c) of this subsection;

(c) Send to policyholders with loans reasonable advance notice of any increase in the rate; and

(d) Include in the notices required in this subsection the substance of the pertinent provisions of subsections (2) and (4) of this section.

(7) The substance of the pertinent provisions of subsections (2) and (4) of this section shall be set forth in the policies to which they apply.

(8) The loan value of the policy shall be determined in accordance with RCW 48.23.080, but no policy shall terminate in a policy year as the sole result of change in the interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(9) For purposes of this section:

(a) The rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy;

(b) The term "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due;

(c) The term "policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer; and

(d) The term "policy" includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(10) No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates. [1981 c 247 § 2.]

Purpose—1981 c 247: "The purpose of this act is to permit and set guidelines for life insurers to include in life insurance policies issued after the effective date of this act a provision for periodic adjustment of policy loan interest rates." [1981 c 247 § 1.]

Additional notes found at www.leg.wa.gov

48.23.090 Table of values and options. There shall be a table showing in figures the loan value, if any, and any options available under the policy each year upon default in premium payments, during at least the first twenty years of the policy, or for its life if maturity or expiry occurs in less

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than twenty years. [1947 c 79 § .23.09; Rem. Supp. 1947 § 45.23.09.]

48.23.100 Nonforfeiture options. There shall be a provision specifying the option to which the policyholder is automatically entitled in the absence of the election of other nonforfeiture options upon default in premium payment after nonforfeiture values become available. [1947 c 79 § .23.10; Rem. Supp. 1947 § 45.23.10.]

48.23.110 Table of installments. If the policy provides for payment of its proceeds in installments or as an annuity, a table showing the amount and period of such installments or annuity shall be included in the policy. Except, that if in the judgment of the commissioner it is not practical to include certain tables in the policy, the requirements of this section may be met as to such policy by the insurer filing such tables with the commissioner. [1947 c 79 § .23.11; Rem. Supp. 1947 § 45.23.11.]

48.23.120 Reinstatement. There shall be a provision that the policy may be reinstated at any time within three years after the date of default in the payment of any premium, unless the policy has been surrendered for its cash value, or the period of any extended insurance provided by the policy has expired, upon evidence of insurability satisfactory to the insurer and the payment of all overdue premiums, and payment (or, within the limits permitted by the then cash values of the policy, reinstatement) of any other indebtedness to the insurer upon the policy with interest as to premiums at a rate not exceeding six percent per annum compounded annually. [1981 c 247 § 4; 1947 c 79 § .23.12; Rem. Supp. 1947 § 45.23.12.]

Purpose—Effective date—1981 c 247: See notes following RCW 48.23.085.

48.23.130 Settlement on proof of death. There shall be a provision that when a policy becomes a claim by the death of the insured, settlement shall be made upon receipt of due proof of death and surrender of the policy. [1947 c 79 § .23.13; Rem. Supp. 1947 § 45.23.13.]

48.23.140 Standard provisions—Annuities, pure endowment contracts. No annuity or pure endowment contract, other than reversionary annuities, or survivorship annuities, or group annuities, shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions specified in RCW 48.23.150 to 48.23.210 inclusive. Any of such provisions not applicable to single premium annuities or single premium pure endowment contracts shall not, to that extent, be incorporated therein.

This section shall not apply to contracts for deferred annuities included in, or upon the lives of beneficiaries under, life insurance policies. [1947 c 79 § .23.14; Rem. Supp. 1947 § 45.23.14.]

48.23.150 Grace period—Annuities, pure endowments. In such contracts, there shall be a provision that there shall be a period of grace of one month, but not less than thirty days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the

option of the insurer, to an interest charge thereon at a rate to be specified in the contract but not exceeding six percent per annum for the number of days of grace elapsing before such payment, during which period of grace, the contract shall continue in full force; but in case a claim arises under the contract on account of death prior to expiration of the period of grace before the overdue payment to the insurer of the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement. [1947 c 79 § .23.15; Rem. Supp. 1947 § 45.23.15.]

48.23.160 Incontestability—Annuities, pure endowments. If any statements, other than those relating to age, sex, and identity, are required as a condition to issuing such an annuity or pure endowment contract, and subject to RCW 48.23.180, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of two years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer, such contract may also except any provisions relative to benefits in the event of total and permanent disability and any provisions which grant insurance specifically against death by accident. [1947 c 79 § .23.16; Rem. Supp. 1947 § 45.23.16.]

48.23.170 Entire contract—Annuities, pure endowments. In such contracts there shall be a provision that the contract shall constitute the entire contract between the parties, or, if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application therefor shall constitute the entire contract between the parties. [1947 c 79 § .23.17; Rem. Supp. 1947 § 45.23.17.]

48.23.180 Misstatement of age or sex—Annuities, pure endowments. In such contracts there shall be a provision that if the age or sex of the person or persons upon whose life or lives the contract is made, or if any of them has been misstated, the amount payable or benefit accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age or sex; and that if the insurer shall make or has made any underpayment or underpayments or any overpayment or overpayments on account of any such misstatement, the amount thereof, with interest at the rate to be specified in the contract but not exceeding six percent per annum, shall, in the case of underpayment, be paid the insured or, in the case of overpayment, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract. [1982 c 181 § 12; 1947 c 79 § .23.18; Rem. Supp. 1947 § 45.23.18.]

Additional notes found at www.leg.wa.gov

48.23.190 Dividends—Annuities, pure endowments. If such contract is participating, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract. [1947 c 79 § .23.19; Rem. Supp. 1947 § 45.23.19.]

48.23.200 Nonforfeiture benefits—Annuities, pure endowments. Such contracts issued after the operative date of RCW 48.23.360 and individual deferred annuities issued before the operative date of RCW 48.23.420 through *48.23.520 shall contain:

(1) A provision that in the event of default in any stipulated payment, the insurer will grant a paid-up nonforfeiture benefit on a plan stipulated in the contract, effective as of such date, of such value as is hereinafter specified.

(2) A statement of the mortality table and interest rate used in calculating the paid-up nonforfeiture benefit available under the contract.

(3) An explanation of the manner in which the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the contract or any indebtedness to the insurer on the contract. [1982 1st ex.s. c 9 § 34; 1979 c 157 § 3; 1947 c 79 § .23.20; Rem. Supp. 1947 § 45.23.20.]

*Reviser's note: RCW 48.23.520 was decodified pursuant to 2017 3rd s.p.s. c 25 § 13.

48.23.210 Reinstatement—Annuities, pure endowments. In such contracts there shall be a provision that the contract may be reinstated at any time within one year from the date of default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated, with interest thereon at a rate to be specified in the contract but not exceeding six percent per annum payable annually, and in cases where applicable, the insurer may also include a requirement of evidence of insurability satisfactory to the insurer. [1947 c 79 § .23.21; Rem. Supp. 1947 § 45.23.21.]

48.23.220 Standard provisions—Reversionary annuities. No contract for a reversionary annuity shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions specified in RCW 48.23.230 and 48.23.240. Any of such provisions not applicable to single premium annuities shall not, to that extent, be incorporated therein.

This section shall not apply to group annuities or to annuities included in life insurance policies. [1947 c 79 § .23.22; Rem. Supp. 1947 § 45.23.22.]

48.23.230 Sections applicable. Any such reversionary annuity contract shall contain the provisions specified in RCW 48.23.150 to 48.23.190, inclusive, except that under RCW 48.23.150 the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue or deferred payment in lieu of providing for a deduction of such payments from an amount payable upon a settlement under the contract. [1947 c 79 § .23.23; Rem. Supp. 1947 § 45.23.23.]

48.23.240 Reinstatement—Reversionary annuities. In such reversionary annuity contracts there shall be a provision that the contract may be reinstated at any time within three years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon condition that all overdue payments and any indebtedness to the insurer on

account of the contract be paid, or, within the limits permitted by the then cash values of the contract, reinstated, with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding six percent per annum compounded annually. [1947 c 79 § .23.24; Rem. Supp. 1947 § 45.23.24.]

48.23.250 Supplemental benefits. The commissioner may make reasonable rules and regulations concerning the conditions in provisions granting additional benefits in event of the insured's accidental death, or in event the insured becomes totally and permanently disabled, which are a part of or supplemental to life insurance contracts. [1947 c 79 § .23.25; Rem. Supp. 1947 § 45.23.25.]

48.23.260 Limitation of liability. (1) The insurer may in any life insurance policy or annuity or pure endowment contract limit its liability to a determinable amount not less than the full reserve of the policy and of dividend additions thereto in event only of death occurring:

(a) As a result of war, or any act of war, declared or undeclared, or of service in the military, naval or air forces or in civilian forces auxiliary thereto, or from any cause while a member of any such military, naval or air forces of any country at war, declared or undeclared.

(b) As a result of suicide of the insured, whether sane or insane, within two years from date of issue of the policy.

(c) As a result of aviation under conditions specified in the policy.

(2) An insurer may specify conditions pertaining to the items of subsection (1) of this section which in the commissioner's opinion are more favorable to the policyholder. [1947 c 79 § .23.26; Rem. Supp. 1947 § 45.23.26.]

48.23.270 Incontestability after reinstatement. The reinstatement of any policy of life insurance or contract of annuity hereafter delivered or issued for delivery in this state may be contestable on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement as the policy provides with respect to contestability after original issuance. [1947 c 79 § .23.27; Rem. Supp. 1947 § 45.23.27.]

48.23.290 Premium deposits. (1) A life insurer may, under such policy provisions or agreements as have been approved by the commissioner consistent with this section, contract for and accept premium deposits in addition to the regular premiums specified in the policy, for the purpose of paying future premiums, or to facilitate conversion of the policy, or to increase the benefits thereof.

(2) The unused accumulation from such deposits shall be held and accounted for as a premium deposit fund, and the policy or agreement shall provide for the manner of application of the premium deposit fund to the payment of premiums otherwise in default and for the disposition of the fund if it is not sufficient to pay the next premium.

(3) Such fund shall:

(a) Be available upon surrender of the policy, in addition to the cash surrender value; and

(b) be payable upon the insured's death or upon maturity of the policy; and

(c) be paid to the insured whenever the cash surrender value together with the premium deposit fund equals or exceeds the amount of insurance provided by the policy, unless the amount of the deposit does not exceed that which may be required to facilitate conversion of the policy to another plan in accordance with its terms.

(4) No part of the premium deposit fund shall be paid to the insured during the continuance of the policy except at such times and in such amounts as is specified in the policy or in the deposit agreement. [1947 c 79 § .23.29; Rem. Supp. 1947 § 45.23.29.]

48.23.300 Policy settlements—Interest. Any life insurer shall have the power to hold under agreement the proceeds of any policy issued by it, upon such terms and restrictions as to revocation by the policyholder and control by beneficiaries, and with such exemptions from the claims of creditors of beneficiaries other than the policyholder as set forth in the policy or as agreed to in writing by the insurer and the policyholder. Upon maturity of a policy in the event the policyholder has made no such agreement, the insurer shall have the power to hold the proceeds of the policy under an agreement with the beneficiaries. The insurer shall not be required to segregate funds so held but may hold them as part of its general assets.

An insurer shall pay interest on death benefits payable under the terms of a life insurance policy insuring the life of any person who was a resident of this state at the time of death. Such interest shall accrue commencing on the date of death at the rate then paid by the insurer on other withdrawable policy proceeds left with the company, but not less than eight percent. Benefits payable that have not been tendered to the beneficiary within ninety days of the receipt of proof of death shall accrue interest, commencing on the ninety-first day, at the aforementioned rate plus three percent. This section applies to death of insureds that occur on or after September 1, 1985. [1985 c 264 § 23; 1983 1st ex.s. c 32 § 21; 1947 c 79 § .23.30; Rem. Supp. 1947 § 45.23.30.]

48.23.310 Deduction of indebtedness. In determining the amount due under any life insurance policy heretofore or hereafter issued, deduction may be made of

(1) any unpaid premiums or installments thereof for the current policy year due under the terms of the policy, and of

(2) the amount of principal and accrued interest of any policy loan or other indebtedness against the policy then remaining unpaid, such principal increased by unpaid interest and compounded as provided in this chapter. [1947 c 79 § .23.31; Rem. Supp. 1947 § 45.23.31.]

48.23.320 Miscellaneous proceeds. Upon the death of the insured and except as is otherwise expressly provided by the policy or premium deposit agreement, a life insurer may pay to the surviving spouse, children, beneficiary, or other person other than the insured's estate, appearing to the insurer to be equitably entitled thereto, sums held by it and comprising:

(1) Premiums paid in advance, and which premiums did not fall due prior to such death, or funds held on deposit for the payment of future premiums.

(2) Dividends theretofore declared on the policy and held by the insurer under the insured's option.

(3) Dividends becoming payable on or after the death of the insured. [1947 c 79 § .23.32; Rem. Supp. 1947 § 45.23.32.]

48.23.330 Trafficking in dividend rights. No life insurer nor any of its representatives, agents, or affiliates, shall buy, take by assignment other than in connection with policy loans, or otherwise deal or traffic in any rights to dividends existing under participating life insurance policies issued by the insurer. [1947 c 79 § .23.33; Rem. Supp. 1947 § 45.23.33.]

48.23.340 Prohibited policy plans. No life insurer shall hereafter issue for delivery or deliver in this state any life insurance policy:

(1) Issued under any plan for the segregation of policyholders into mathematical groups and providing benefits for a surviving policyholder of a group arising out of the death of another policyholder of such group, or under any other similar plan.

(2) Providing benefits or values for surviving or continuing policyholders contingent upon the lapse or termination of the policies of other policyholders, whether by death or otherwise. [1947 c 79 § .23.34; Rem. Supp. 1947 § 45.23.34.]

48.23.345 Juvenile life insurance—Speculative or fraudulent purposes. Life insurers shall develop and implement underwriting standards and procedures designed to detect and prevent the purchase of juvenile life insurance for speculative or fraudulent purposes. These standards and procedures shall be made available for review by the commissioner.

Life insurers shall maintain records of underwriting rejections of applications for life insurance on juvenile lives for a period of ten years. [2001 c 197 § 1.]

Additional notes found at www.leg.wa.gov

48.23.360 Calculation of nonforfeiture benefits under annuities. (1) Nonforfeiture benefits: Any paid-up nonforfeiture benefit available under any annuity or pure endowment contract pursuant to RCW 48.23.200, in the event of default in a consideration due on any contract anniversary shall be such that its present value as of such anniversary shall be not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits (excluding any total disability benefits attached to such contracts) which would have been provided for by the contract including any existing paid-up additions, if there had been no default, over the sum of (a) the then present value of the net consideration defined in subsection (2) of this section corresponding to considerations which would have fallen due on and after such anniversary, and (b) the amount of any indebtedness to the company on the contract, including interest due or accrued. In determining the benefits referred to in this section and in calculating the net consideration referred to in such subsection (2), in the case of annuity contracts under which an election may be made to have annuity payments commence at optional dates, the annuity payments shall be deemed to commence at the latest date permitted by the con-

tract for the commencement of such payments and the considerations shall be deemed to be payable until such date, which, however, shall not be later than the contract anniversary nearest the annuitant's seventieth birthday.

(2) Net considerations: The net considerations for any annuity or pure endowment contract referred to in subsection (1) of this section shall be calculated on an annual basis, shall be such that the present value thereof at date of issue of the annuity shall equal the then present value of the future benefits thereunder (excluding any total disability benefits attached to such contracts) and shall be not less than the following percentages of the respective considerations specified in the contracts for the respective contract years:

First year fifty percent
Second and subsequent years ninety percent

PROVIDED, That in the case of participating annuity contracts the percentages hereinbefore specified may be decreased by five.

(3) Basis of calculation: All net considerations and present values for such contracts referred to in this section shall be calculated on the basis of the 1937 Standard Annuity Mortality Table or, at the option of the insurer, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the commissioner, and the rate of interest, not exceeding three and one-half percent per annum, specified in the contract for calculating cash surrender values, if any, and paid-up nonforfeiture benefits; except that with respect to annuity and pure endowment contracts issued on or after the operative date of *RCW 48.12.150(3)(b)(ii) for such contracts, such rate of interest may be as high as four percent per annum: PROVIDED, That if such rate of interest exceeds three and one-half percent per annum, all net considerations and present values for such contracts referred to in this section shall be calculated on the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the commissioner.

(4) Calculations on default: Any cash surrender value and any paid-up nonforfeiture benefit, available under any such contract in the event of default in the payment of any consideration due at any time other than on the contract anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional considerations beyond the last preceding contract anniversary. All values herein referred to may be calculated upon the assumption that any death benefit is payable at the end of the contract year of death.

(5) Deferment of payment: If an insurer provides for the payment of a cash surrender value, it shall reserve the right to defer the payment of such value for a period of six months after demand therefor with surrender of the contract.

(6) Lump sum in lieu: Notwithstanding the requirements of this section, any deferred annuity contract may provide that if the annuity allowed under any paid-up nonforfeiture benefit would be less than one hundred twenty dollars annually, the insurer may at its option grant a cash surrender value in lieu of such paid-up nonforfeiture benefit of such amount as may be required by subsection (3) of this section.

(7) Operative date: If no election is made by an insurer for an operative date prior to July 1, 1948, such date shall be the operative date for this section. [1973 1st ex.s. c 162 § 6;

1951 c 190 § 1; 1947 c 79 § .23.36; Rem. Supp. 1947 § 45.23.36.]

*Reviser's note: RCW 48.12.150 was repealed by 1982 1st ex.s. c 9 § 36; later enactment, see chapter 48.74 RCW.

48.23.370 Duties of insurer issuing both participating and nonparticipating policies—Rules. (1) A life insurer issuing both participating and nonparticipating policies shall maintain records which segregate the participating from the nonparticipating business and clearly show the profits and losses upon each such category of business.

(2) For the purposes of such accounting the insurer shall make a reasonable allocation as between the respective such categories of the expenses of such general operations or functions as are jointly shared. Any allocation of expense as between the respective categories shall be made upon a reasonable basis, to the end that each category shall bear a just portion of joint expense involved in the administration of the business of such category.

(3) No policy hereafter delivered or issued for delivery in this state shall provide for, and no life insurer or representative shall hereafter knowingly offer or promise payment, credit or distribution of participating "dividends," "earnings," "profits," or "savings," by whatever name called, to participating policies out of such profits, earnings or savings on nonparticipating policies.

(4) The commissioner may promulgate rules for the purpose of assuring the equitable treatment of all policyholders so that one group of policyholders shall not support or be supported by another group of policyholders. [1982 c 181 § 13; 1965 ex.s. c 70 § 22.]

Additional notes found at www.leg.wa.gov

48.23.380 Return of policy and refund of premium—Grace period—Notice—Effect. (1) Every individual life insurance policy issued after September 1, 1977, shall have printed on its face or attached thereto a notice stating in substance that the policy owner shall be permitted to return the policy within ten days after it is received by the policy owner and to have the premium paid refunded if, after examination of the policy, the policy owner 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 policy owner pursuant to such notice, returns the policy 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 had been issued.

(2) This section shall not apply to individual life insurance policies issued in connection with a credit transaction or issued under a contractual policy change or conversion privilege provision contained in a policy.

(3) No later than January 1, 2010, or when the insurer has used all of its existing paper individual life insurance policy forms which were in its possession on July 1, 2009, whichever is earlier, the notice required by subsection (1) of this section shall use the term insurance producer in place of agent. [2008 c 217 § 26; 1983 1st ex.s. c 32 § 10; 1977 c 60 § 1.]

Additional notes found at www.leg.wa.gov

(2021 Ed.)

48.23.410 Short title. RCW 48.23.420 through *48.23.520 shall be known as the standard nonforfeiture law for individual deferred annuities. [1982 1st ex.s. c 9 § 21.]

*Reviser's note: RCW 48.23.520 was decodified pursuant to 2017 3rd sp.s. c 25 § 13.

48.23.420 Inapplicability of enumerated sections to certain policies. RCW 48.23.420 through *48.23.520 do not apply to any reinsurance; group annuity 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; premium deposit fund; variable annuity; investment annuity; immediate annuity; any deferred annuity contract after annuity payments have commenced; or reversionary annuity; nor to any contract which is delivered outside this state through an insurance producer or other representative of the company issuing the contract. [2008 c 217 § 27; 1982 1st ex.s. c 9 § 22.]

*Reviser's note: RCW 48.23.520 was decodified pursuant to 2017 3rd sp.s. c 25 § 13.

Additional notes found at www.leg.wa.gov

48.23.430 Paid-up annuity and cash surrender provisions required. In the case of contracts issued on or after the operative date of this section as defined in *RCW 48.23.520, no contract of annuity, except as stated in RCW 48.23.420, 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 contract holder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in RCW 48.23.450, 48.23.460, 48.23.470, 48.23.480, and 48.23.500;

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or before the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in RCW 48.23.450, 48.23.460, 48.23.480, and 48.23.500. The company may reserve the right to defer the payment of such cash surrender benefit for a period not to exceed six months after demand therefor with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits; and

(4) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of

the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract, or any prior withdrawals from or partial surrenders of the contract.

Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid before such period would be less than twenty dollars monthly, the company may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment is relieved of any further obligation under such contract. [2004 c 91 § 1; 1982 1st ex.s. c 9 § 23.]

*Reviser's note: RCW 48.23.520 was decodified pursuant to 2017 3rd sp.s. c 25 § 13.

Additional notes found at www.leg.wa.gov

48.23.440 Minimum nonforfeiture amounts. The minimum values as specified in RCW 48.23.450, 48.23.460, 48.23.470, 48.23.480, and 48.23.500 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

(1) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments is equal to an accumulation up to such time at rates of interest as indicated in subsection (2) of this section of the net considerations, as defined in this subsection, paid prior to such time, decreased by the sum of the following:

(a) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in subsection (2) of this section;

(b) An annual contract charge of fifty dollars, accumulated at rates of interest as indicated in subsection (2) of this section;

(c) Any premium tax paid by the insurer for the contract, accumulated at rates of interest as indicated in subsection (2) of this section; and

(d) The amount of any indebtedness to the company on the contract, including interest due and accrued.

The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent of the gross considerations credited to the contract during that contract year.

(2) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent per annum and the following, which shall be specified in the contract if the interest rate will be reset:

(a) The five-year constant maturity treasury rate reported by the federal reserve as of a date certain, or averaged over a period, rounded to the nearest one-twentieth of one percent, specified in the contract no longer than fifteen months prior to the contract issue date or redetermination date under (d) of this subsection;

(b) Reduced by one hundred twenty-five basis points;

(c) Where the resulting interest rate is not less than one percent; and

(d) The interest rate shall apply to an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year constant maturity treasury rate to be used at each redetermination date.

(3) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subsection (2)(b) of this section by up to an additional one hundred basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction may not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. If a demonstration is not acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

(4) The commissioner may adopt rules to implement subsection (3) of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other policies that the commissioner determines justify an adjustment.

(5) Before January 1, 2006, an insurer may issue an annuity policy under this section as in effect on December 31, 2003; or issue an annuity policy under this section as in effect on July 1, 2004. On or after January 1, 2006, an insurer must issue an annuity policy under this section as in effect on or after July 1, 2004. [2004 c 91 § 2; 1982 1st ex.s. c 9 § 24.]

Additional notes found at www.leg.wa.gov

48.23.450 Minimum present value of paid-up annuity benefit. Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract. [1982 1st ex.s. c 9 § 25.]

48.23.460 Minimum cash surrender benefits—Death benefit. For contracts which provide cash surrender benefits, such cash surrender benefits available before maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any

existing additional amounts credited by the company to the contract. In no event may any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit. [1982 1st ex.s. c 9 § 26.]

48.23.470 Contracts without cash surrender, death benefits—Minimum present value of paid-up annuity benefits. For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid before the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event may the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time. [1982 1st ex.s. c 9 § 27.]

48.23.480 Optional maturity dates. For the purpose of determining the benefits calculated under RCW 48.23.460 and 48.23.470, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election is permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later. [1982 1st ex.s. c 9 § 28.]

48.23.490 Statement required in contract without cash surrender or death benefits. Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided. [1982 1st ex.s. c 9 § 29.]

48.23.500 Calculation of benefits available other than on contract anniversary. Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs. [1982 1st ex.s. c 9 § 30.]

48.23.510 Additional benefits. For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance

benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of RCW 48.23.450, 48.23.460, 48.23.470, 48.23.480, and 48.23.500, additional benefits payable (1) in the event of total and permanent disability, (2) as reversionary annuity or deferred reversionary annuity benefits, or (3) as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, or cash surrender and death benefits that may be required by RCW 48.23.410 through *48.23.520. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, or cash surrender and death benefits. [1982 1st ex.s. c 9 § 31.]

*Reviser's note: RCW 48.23.520 was decodified pursuant to 2017 3rd sp.s. c 25 § 13.

48.23.525 Individual life insurance—Noninsurance benefits—Rules. (1) A life insurer may include the following noninsurance benefits as part of a policy of individual life insurance, with the prior approval of the commissioner:

- (a) Will preparation services;
- (b) Financial planning and estate planning services;
- (c) Probate and estate settlement services;
- (d) Products or services related to any policy of individual life insurance that are intended to incent behavioral changes that improve the health and reduce the risk of death of the insured; and
- (e) Such other services as the commissioner may identify by rule.

(2) For products and services referenced in subsection (1)(d) of this section, the commissioner may adopt rules that include minimum product or service standards to protect policyholder privacy rights; establish standards for ensuring that incentives, in the aggregate, are directed to sharing the benefit of improving risk experience; and implement consumer protection design and administration of such product or service.

(3) The commissioner may adopt rules to ensure disclosure of the noninsurance benefits permitted under this section, including but not limited to guidelines concerning the provision of the coverage.

(4) Those providing the services listed in subsection (1) of this section must be appropriately licensed.

(5) This section does not require the commissioner to approve any particular proposed noninsurance benefit. The commissioner may disapprove any proposed noninsurance benefit that the commissioner determines may tend to promote or facilitate the violation of any other section of this title.

(6) This section does not expand, limit, or otherwise affect the authority and ethical obligations of those who are authorized by the state supreme court to practice law in this

state. This section does not limit the prohibition against the unauthorized practice of law under chapter 2.48 RCW.

(7) This section does not affect the application of chapter 21.20 RCW. [2020 c 197 § 4; 2009 c 76 § 1.]

Effective date—2020 c 197: See note following RCW 48.30.140.

48.23.900 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 § 119.]

Chapter 48.23A RCW

LIFE INSURANCE POLICY ILLUSTRATIONS

Sections

- 48.23A.005 Purpose—Standards for life insurance policy illustrations.
- 48.23A.010 Scope of chapter—Exceptions.
- 48.23A.015 Definitions.
- 48.23A.020 Marketing with or without an illustration—Notice to commissioner—Conditions—Availability.
- 48.23A.030 Illustration used in sale—Label—Required basic information—Prohibitions—Use of interest rate.
- 48.23A.040 Basic illustration—Conforming requirements—Brief descriptions—Numeric summaries—Required statements.
- 48.23A.050 Supplemental illustration—Conditions for use—Reference to basic illustration.
- 48.23A.060 Illustration used or not used during sale—Signed copy of illustration or acknowledgment of no use—Computer screen—Retained copies.
- 48.23A.070 Policy designated for use of illustrations—Annual report—Required information—In-force illustrations—Notice of adverse changes.
- 48.23A.080 Illustration actuaries—Conditions for appointment—Duties—Certifications—Disclosures to commissioner.
- 48.23A.090 Violations—RCW 48.30.010(1).
- 48.23A.901 Effective date—Application—1997 c 313.

48.23A.005 Purpose—Standards for life insurance policy illustrations. The purpose of this chapter is to provide standards for life insurance policy illustrations that will protect consumers and foster consumer education by providing illustration formats, prescribing standards to be followed when illustrations are used, and specifying the disclosures that are required in connection with illustrations. The goals of these standards are to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable. Insurers will, as far as possible, eliminate the use of footnotes and caveates and define terms used in the illustration in language that would be understood by a typical person within the segment of the public to which the illustration is directed. [1997 c 313 § 1.]

48.23A.010 Scope of chapter—Exceptions. This chapter applies to all group and individual life insurance policies and certificates except:

- (1) Variable life insurance;
- (2) Individual and group annuity contracts;
- (3) Credit life insurance; or
- (4) Life insurance policies with no illustrated death benefits on any individual exceeding ten thousand dollars. [1997 c 313 § 2.]

48.23A.015 Definitions. The definitions in this section apply throughout this chapter unless the context requires otherwise.

(1) "Actuarial standards board" means the board established by the American academy of actuaries to develop and adopt standards of actuarial practice.

(2) "Contract premium" means the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

(3) "Currently payable scale" means a scale of nonguaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next ninety-five days.

(4) "Disciplined current scale" means a scale of nonguaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the actuarial standards board may be relied upon if the standards:

- (a) Are consistent with all provisions of this chapter;
- (b) Limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;
- (c) Do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and
- (d) Do not permit assumed expenses to be less than minimum assumed expenses.

(5) "Generic name" means a short title descriptive of the policy being illustrated, such as whole life, term life, or flexible premium adjustable life.

(6) "Guaranteed elements" means the premiums, benefits, values, credits, or charges under a policy of life insurance that are guaranteed and determined at issue.

(7) "Nonguaranteed elements" means the premiums, benefits, values, credits, or charges under a policy of life insurance that are not guaranteed or not determined at issue.

(8) "Illustrated scale" means a scale of nonguaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

- (a) The disciplined current scale; or
 - (b) The currently payable scale.
- (9) "Illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years and that is one of the three types defined below:

(a) "Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and nonguaranteed elements.

(b) "Supplemental illustration" means an illustration furnished in addition to a basic illustration that meets the applicable requirements of this chapter, and that may be presented in a format differing from the basic illustration, but may only depict a scale of nonguaranteed elements that is permitted in a basic illustration.

(c) "In-force illustration" means an illustration furnished at any time after the policy that it depicts has been in force for one year or more.

(10) "Illustration actuary" means an actuary meeting the requirements of RCW 48.23A.080 who certifies to illustrations based on the standard of practice adopted by the actuarial standards board.

(11) "Lapse-supported illustration" means an illustration of a policy form failing the test of self-supporting, as defined in this section, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five years and one hundred percent policy persistency thereafter.

(a) "Minimum assumed expenses" means the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms from the following:

(i) Fully allocated expenses;

(ii) Marginal expenses; and

(iii) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the national association of insurance commissioners.

(b) Marginal expenses may be used only if greater than a generally recognized expense table. If no generally recognized expense table is approved, fully allocated expenses must be used.

(12) "Nonterm group life" means a group policy or individual policies of life insurance issued to members of an employer group or other permitted group where:

(a) Every plan of coverage was selected by the employer or other group representative;

(b) Some portion of the premium is paid by the group or through payroll deduction; and

(c) Group underwriting or simplified underwriting is used.

(13) "Policy owner" means the owner named in the policy or the certificate holder in the case of a group policy.

(14) "Premium outlay" means the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

(15) "Self-supporting illustration" means an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteenth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies, or upon policy expiration if sooner, the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value will include cash surrender

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values and any other illustrated benefit amounts available at the policy owner's election. [1997 c 313 § 3.]

48.23A.020 Marketing with or without an illustration—Notice to commissioner—Conditions—Availability. (1) Each insurer marketing policies to which this chapter is applicable shall notify the commissioner whether a policy form is to be marketed with or without an illustration. For all policy forms being actively marketed on January 1, 1998, the insurer shall identify in writing those forms and whether or not an illustration will be used with them. For policy forms filed after January 1, 1998, the identification shall be made at the time of filing. Any previous identification may be changed by notice to the commissioner.

(2) If the insurer identifies a policy form as one to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited.

(3) If a policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared and delivered in accordance with this chapter is required, except that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration furnished an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

(4) Potential enrollees of nonterm group life subject to this chapter shall be furnished a quotation with the enrollment materials. The quotation shall show potential policy values for sample ages and policy years on a guaranteed and nonguaranteed basis appropriate to the group and the coverage. This quotation is not considered an illustration for purposes of this chapter, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the certificate to enrollees for nonterm group life who enroll for more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any nonterm group life enrollee who requests it. [1997 c 313 § 4.]

48.23A.030 Illustration used in sale—Label—Required basic information—Prohibitions—Use of interest rate. (1) An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of this chapter, be clearly labeled "life insurance illustration," and contain the following basic information:

(a) Name of insurer;

(b) Name and business address of producer or insurer's authorized representative, if any;

(c) Name, age, and sex of proposed insured, except where a composite illustration is permitted under this chapter;

(d) Underwriting or rating classification upon which the illustration is based;

(e) Generic name of policy, the company product name, if different, and form number;

- (f) Initial death benefit; and
- (g) Dividend option election or application of nonguaranteed elements, if applicable.

(2) When using an illustration in the sale of a life insurance policy, an insurer or its producers or other authorized representatives shall not:

- (a) Represent the policy as anything other than life insurance policy;
 - (b) Use or describe nonguaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;
 - (c) State or imply that the payment or amount of nonguaranteed elements is guaranteed;
 - (d) Use an illustration that does not comply with the requirements of this chapter;
 - (e) Use an illustration that at any policy duration depicts policy performance more favorable to the policy owner than that produced by the illustrated scale of the insurer whose policy is being illustrated;
 - (f) Provide an applicant with an incomplete illustration;
 - (g) Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;
 - (h) Use the term "vanish" or "vanishing premium," or a similar term that implies the policy becomes paid up, to describe a plan for using nonguaranteed elements to pay a portion of future premiums;
 - (i) Except for policies that can never develop nonforfeiture values, use an illustration that is "lapse-supported"; or
 - (j) Use an illustration that is not "self-supporting."
- (3) If an interest rate used to determine the illustrated nonguaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale. [1997 c 313 § 5.]

48.23A.040 Basic illustration—Conforming requirements—Brief descriptions—Numeric summaries—Required statements. (1) A basic illustration shall conform with the following requirements:

- (a) The illustration shall be labeled with the date on which it was prepared.
- (b) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration (for example, the fourth page of a seven-page illustration shall be labeled "page 4 of 7 pages").
- (c) The assumed dates of payment receipt and benefit payout within a policy year shall be clearly identified.
- (d) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the policy is assumed to have been in force.
- (e) The assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay.
- (f) Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed.
- (g) If the illustration shows any nonguaranteed elements, they cannot be based on a scale more favorable to the policy

owner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled nonguaranteed.

(h) The guaranteed elements, if any, shall be shown before corresponding nonguaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the nonguaranteed elements (for example, "see page one for guaranteed elements").

(i) The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.

(j) The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policy owner in a lump sum after deduction of surrender charges, policy loans, and policy loan interest, as applicable.

(k) Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form.

(l) Any illustration of nonguaranteed elements shall be accompanied by a statement indicating that:

- (i) The benefits and values are not guaranteed;
- (ii) The assumptions on which they are based are subject to change by the insurer; and
- (iii) Actual results may be more or less favorable.

(m) If the illustration shows that the premium payer may have the option to allow policy charges to be paid using nonguaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlay of lesser amounts or shorter durations than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up.

(n) If the applicant plans to use dividends or policy values, guaranteed or nonguaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, the illustration may reflect those plans and the impact on future policy benefits and values.

(2) A basic illustration shall include the following:

- (a) A brief description of the policy being illustrated, including a statement that it is a life insurance policy;
- (b) A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the internal revenue code;

(c) A brief description of any policy features, riders, or options, guaranteed or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy;

(d) Identification and a brief definition of column headings and key terms used in the illustration; and

(e) A statement containing in substance the following: "This illustration assumes that the currently illustrated, nonguaranteed elements will continue unchanged for all

years shown. This is not likely to occur, and actual results may be more or less favorable than those shown."

(3)(a) Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium, as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values shall be based on the contract premium. This summary shall be shown for at least policy years five, ten, and twenty and at age seventy, if applicable, on the three bases shown below. For multiple life policies the summary shall show policy years five, ten, twenty, and thirty.

- (i) Policy guarantees;
- (ii) Insurer's illustrated scale;
- (iii) Insurer's illustrated scale used but with the nonguaranteed elements reduced as follows:

(A) Dividends at fifty percent of the dividends contained in the illustrated scale used;

(B) Nonguaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and

(C) All nonguaranteed charges, including but not limited to, term insurance charges and mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.

(b) In addition, if coverage would cease prior to policy maturity or age one hundred, the year in which coverage ceases shall be identified for each of the three bases.

(4) Statements substantially similar to the following shall be included on the same page as the numeric summary and signed by the applicant, or the policy owner in the case of an illustration provided at time of delivery, as required in this chapter.

(a) A statement to be signed and dated by the applicant or policy owner reading as follows: "I have received a copy of this illustration and understand that any nonguaranteed elements illustrated are subject to change and could be either higher or lower. The insurance producer has told me they are not guaranteed."

(b) A statement to be signed and dated by the insurance producer or other authorized representative of the insurer reading as follows: "I certify that this illustration has been presented to the applicant and that I have explained that any nonguaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."

(5)(a) A basic illustration shall include the following for at least each policy year from one to ten and for every fifth policy year thereafter ending at age one hundred, policy maturity, or final expiration; and except for term insurance beyond the twentieth year, for any year in which the premium outlay and contract premium, if applicable, is to change:

- (i) The premium outlay and mode the applicant plans to pay and the contract premium, as applicable;
- (ii) The corresponding guaranteed death benefit, as provided in the policy; and
- (iii) The corresponding guaranteed value available upon surrender, as provided in the policy.

(b) For a policy that provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium.

(c) Nonguaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any nonguaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a nonguaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column. [2008 c 217 § 28; 1997 c 313 § 6.]

Additional notes found at www.leg.wa.gov

48.23A.050 Supplemental illustration—Conditions for use—Reference to basic illustration. (1) A supplemental illustration may be provided so long as:

(a) It is appended to, accompanied by, or preceded by a basic illustration that complies with this chapter;

(b) The nonguaranteed elements shown are not more favorable to the policy owner than the corresponding elements based on the scale used in the basic illustration;

(c) It contains the same statement required of a basic illustration that nonguaranteed elements are not guaranteed; and

(d) For a policy that has a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.

(2) The supplemental illustration shall include a notice referring to the basic illustration for guaranteed elements and other important information. [1997 c 313 § 7.]

48.23A.060 Illustration used or not used during sale—Signed copy of illustration or acknowledgment of no use—Computer screen—Retained copies. (1)(a) If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of that illustration, signed in accordance with this chapter, shall be submitted to the insurer at the time of policy application. A copy shall also be provided to the applicant.

(b) If the policy is issued other than as applied for, a revised basic illustration conforming to the policy as issued shall be sent with the policy. The revised illustration shall conform to the requirements of this chapter, be labeled "revised illustration," and be signed and dated by the applicant or policy owner and producer or other authorized representative of the insurer no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

(2)(a) If no illustration is used by an insurance producer or other authorized representative in the sale of a life insurance policy, or if the policy is applied for other than as illustrated, the producer or representative shall certify to that effect in writing on a form provided by the insurer. On the same form the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding that an illustration conforming to the policy as issued will be provided no

later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application.

(b) If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

(3)(a) Where a computer screen illustration is used that cannot be printed out during use, the producer shall certify in writing on a form provided by the insurer that a computer screen illustration was displayed. Such form shall require the producer to provide, as applicable, the generic name of the policy and any riders illustrated, the guaranteed and nonguaranteed interest rates illustrated, the number of policy years illustrated, the initial death benefit, the premium amount illustrated, and the assumed number of years of premiums. On the same form the applicant shall acknowledge that an illustration matching that which was displayed on the computer screen will be provided no later than the time of policy delivery. A copy of this signed form shall be provided to the applicant at the time it is signed.

(b) If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed by the policy owner no later than the time the policy is delivered. A copy shall be provided to the policy owner and retained by the insurer.

(c) If a computer screen illustration is used that can be printed during use, a copy of that illustration, signed in accordance with this chapter, shall be submitted to the insurer at the time of policy application. A copy shall also be provided to the applicant.

(d) If the basic illustration or revised illustration is sent to the applicant or policy owner by mail from the insurer, it shall include instructions for the applicant or policy owner to sign the duplicate copy of the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under this subsection is satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed, postage prepaid envelope with instructions for the return of the signed numeric summary page.

(4) A copy of the basic illustration and a revised basic illustration, if any, signed as applicable, along with any certification that either no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three years after the policy is no longer in force. A copy need not be retained if no policy is issued. [1997 c 313 § 8.]

48.23A.070 Policy designated for use of illustrations—Annual report—Required information—In-force illustrations—Notice of adverse changes. (1) In the case of a policy designated as one for which illustrations will be used, the insurer shall provide each policy owner with an annual report on the status of the policy that shall contain at least the following information:

(a) For universal life policies, the report shall include the following:

(i) The beginning and end date of the current report period;

(ii) The policy value at the end of the previous report period and at the end of the current report period;

(iii) The total amounts that have been credited or debited to the policy value during the current report period, identifying each type, such as interest, mortality, expense, and riders;

(iv) The current death benefit at the end of the current report period on each life covered by the policy;

(v) The net cash surrender value of the policy as of the end of the current report period;

(vi) The amount of outstanding loans, if any, as of the end of the current report period; and

(vii) For fixed premium policies: If, assuming guaranteed interest, mortality, and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report; or

(viii) For flexible premium policies: If, assuming guaranteed interest, mortality, and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

(b) For all other policies, where applicable:

(i) Current death benefit;

(ii) Annual contract premium;

(iii) Current cash surrender value;

(iv) Current dividend;

(v) Application of current dividend; and

(vi) Amount of outstanding loan.

(c) Insurers writing life insurance policies that do not build nonforfeiture values shall only be required to provide an annual report with respect to these policies for those years when a change has been made to nonguaranteed policy elements by the insurer.

(2) If the annual report does not include an in-force illustration, it shall contain the following notice displayed prominently: "IMPORTANT POLICY OWNER NOTICE: You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling (insurer's phone number), writing to (insurer's name) at (insurer's address) or contacting your insurance producer. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department." The insurer may vary the sequential order of the methods for obtaining an in-force illustration.

(3) Upon the request of the policy owner, the insurer shall furnish an in-force illustration of current and future benefits and values based on the insurer's present illustrated scale. This illustration shall comply with the requirements of RCW 48.23A.030 (1) and (2) and 48.23A.040 (1) and (5). No signature or other acknowledgment of receipt of this illustration shall be required.

(4) If an adverse change in nonguaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report shall contain a notice of

that fact and the nature of the change prominently displayed. [2008 c 217 § 29; 1997 c 313 § 9.]

Additional notes found at www.leg.wa.gov

48.23A.080 Illustration actuaries—Conditions for appointment—Duties—Certifications—Disclosures to commissioner. (1) The board of directors of each insurer shall appoint one or more illustration actuaries.

(2) The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the actuarial standard of practice for compliance with the national association of insurance commissioners model regulation on life insurance illustrations adopted by the actuarial standards board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of this chapter.

(3) The illustration actuary shall:

(a) Be a member in good standing of the American academy of actuaries;

(b) Be familiar with the standard of practice regarding life insurance policy illustrations;

(c) Not have been found by the commissioner, following appropriate notice and hearing to have:

(i) Violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as an illustration actuary;

(ii) Been found guilty of fraudulent or dishonest practices;

(iii) Demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as an illustration actuary; or

(iv) Resigned or been removed as an illustration actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards;

(d) Not fail to notify the commissioner of any action taken by a commissioner of another state similar to that under (c) of this subsection;

(e) Disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If nonguaranteed elements illustrated for new policies are not consistent with those illustrated for similar in-force policies, this must be disclosed in the annual certification. If nonguaranteed elements illustrated for both new and in-force policies are not consistent with the nonguaranteed elements actually being paid, charged, or credited to the same or similar forms, this must be disclosed in the annual certification; and

(f) Disclose in the annual certification the method used to allocate overhead expenses for all illustrations:

(i) Fully allocated expenses;

(ii) Marginal expenses; or

(iii) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the national association of insurance commissioners.

(4)(a) The illustration actuary shall file a certification with the board of directors and with the commissioner:

(i) Annually for all policy forms for which illustrations are used; and

(ii) Before a new policy form is illustrated.

(b) If an error in a previous certification is discovered, the illustration actuary shall notify the board of directors of the insurer and the commissioner promptly.

(5) If an illustration actuary is unable to certify the scale for any policy form illustration the insurer intends to use, the actuary shall notify the board of directors of the insurer and the commissioner promptly of his or her inability to certify.

(6) A responsible officer of the insurer, other than the illustration actuary, shall certify annually:

(a) That the illustration formats meet the requirements of this chapter and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

(b) That the company has provided its insurance producers with information about the expense allocation method used by the company in its illustrations and disclosed as required in subsection (3)(f) of this section.

(7) The annual certifications shall be provided to the commissioner each year by a date determined by the insurer.

(8) If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the commissioner of that fact promptly and disclose the reason for the change. [2008 c 217 § 30; 1997 c 313 § 10.]

Additional notes found at www.leg.wa.gov

48.23A.090 Violations—RCW 48.30.010(1). In addition to any other penalties provided by law, an insurer or producer that violates a requirement of this chapter is guilty of a violation of RCW 48.30.010(1). [1997 c 313 § 11.]

48.23A.901 Effective date—Application—1997 c 313. This act takes effect January 1, 1998, and applies to policies sold on or after January 1, 1998. [1997 c 313 § 13.]

Chapter 48.24 RCW GROUP LIFE AND ANNUITIES

Sections

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- 48.24.190 Conversion on termination of policy.
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- 48.24.270 Payment of proceeds—Interest, when delayed.
- 48.24.280 Group life insurance—Noninsurance benefits.
- 48.24.900 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

Charitable gift annuity business: Chapter 48.38 RCW.

Exemption of proceeds, group life: RCW 48.18.420.

Group insurance on irrigation district employees: RCW 87.03.160.

Payment to person designated in policy or by assignment discharges insurer: RCW 48.18.370.

Payroll deduction of public employees for insurance and medical benefits authorized: RCW 41.04.020.

Payroll deductions and employees' contribution for group insurance on employees of second-class cities or towns authorized: RCW 35.23.460.

Policy dividends are payable to real party in interest: RCW 48.18.340.

Policy forms, execution, filing, etc.: Chapter 48.18 RCW.

48.24.010 Group requirements. (1) No contract of life insurance shall hereafter be delivered or issued for delivery in this state insuring the lives of more than one individual unless to one of the groups as provided for in this chapter, and unless in compliance with the other provisions of this chapter.

(2) Subsection (1) of this section shall not apply to contracts of life insurance

(a) insuring only individuals related by marriage, by blood, or by legal adoption; or

(b) insuring only individuals having a common interest through ownership of a business enterprise, or of a substantial legal interest or equity therein, and who are actively engaged in the management thereof; or

(c) insuring the lives of employees and retirees under contracts executed with the state health care authority under the provisions of chapter 41.05 RCW. [1988 c 107 § 22; 1973 1st ex.s. c 147 § 11; 1947 c 79 § .24.01; Rem. Supp. 1947 § 45.24.01.]

Additional notes found at www.leg.wa.gov

48.24.020 Employee groups. The lives of a group of individuals may be insured under a policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustee is deemed the policyholder, insuring employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(1) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietors or partnerships if the business of the employer and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees.

(2) The premium for the policy shall be paid by the policyholder, either wholly from the employer's funds or funds contributed by him or her, or partly from such funds and partly from funds contributed by the insured employees, or from funds contributed entirely by the insured employees. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(3) The policy must cover at least two employees at date of issue.

(4) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees or by the employer or trustees. [2005 c 222 § 1; 1955 c 303 § 29; 1947 c 79 § .24.02; Rem. Supp. 1947 § 45.24.02.]

48.24.025 Payment of premium by employee when compensation suspended due to labor dispute. Any employee whose compensation includes group life insurance, the premiums for which are 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 premiums as they become due directly to the policyholder whenever the employee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute, for a period not exceeding six months and at the rate and coverages as the policy provides. During that period of time the policy may not be altered or changed. Nothing in this section shall be deemed to impair the right of the insurer to make normal decreases or increases of the premium rate upon expiration and renewal of the policy, in accordance with the provisions of the policy. Thereafter, if such insurance coverage is no longer available, then the employee shall be given the opportunity to purchase an individual policy at a rate consistent with rates filed by the insurer with the commissioner. When the employee's compensation is so suspended or terminated, the employee shall be notified immediately by the policyholder in writing, by mail addressed to the address last on record with the policyholder, that the employee may pay the premiums to the policyholder as they become due as provided in this section.

Payment of the premiums must be made when due or the insurance coverage may be terminated by the insurer.

The provisions of any insurance policy contrary to provisions of this section are void and unenforceable after May 29, 1975. [1975 1st ex.s. c 117 § 2.]

Additional notes found at www.leg.wa.gov

48.24.027 Offering group life insurance to state residents—Commissioner's findings. (1) Group life insurance offered to a resident of this state under a group life insurance policy may be issued to a group other than one described in RCW 48.24.020, 48.24.035, 48.24.040, 48.24.045, 48.24.050, 48.24.060, 48.24.070, 48.24.080, 48.24.090, or 48.24.095 subject to the requirements in this subsection. No such group life insurance policy may be delivered in this state unless the commissioner finds that:

(a) The issuance of the group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged.

(2) No such group life insurance coverage may be offered under this section in this state by an insurer under a policy issued in another state unless the commissioner or the insurance commissioner of another state having requirements substantially similar to those contained in subsection (1)(a) through (c) of this section has made a determination that the requirements have been met.

(3) The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both. [2010 c 13 § 1.]

48.24.030 Dependents of employees or members of certain groups. (1) Insurance under any group life insurance policy issued under RCW 48.24.020, 48.24.050, 48.24.060, 48.24.070, 48.24.090, or 48.24.027 may be extended to insure the spouse and dependent children, or any class or classes thereof, of each insured employee or member who so elects, in amounts in accordance with a plan that precludes individual selection by the employees or members or by the employer or labor union or trustee, and which insurance on the life of any one family member including a spouse shall not be in excess of the amount on the life of the insured employee or member.

Premiums for the insurance on the family members shall be paid by the policyholder, either from the employer's funds, funds contributed to him or her, employee's funds, trustee's funds, or labor union funds.

(2) A spouse insured under this section has the same conversion right as to the insurance on his or her life as is vested in the employee or member under this chapter. [2010 c 13 § 2; 2006 c 25 § 14. Prior: 2005 c 223 § 13; 2005 c 222 § 2; 1993 c 132 § 1; 1975 1st ex.s. c 266 § 11; 1965 ex.s. c 70 § 23; 1963 c 192 § 1; 1953 c 197 § 10; 1947 c 79 § .24.03; Rem. Supp. 1947 § 45.24.03.]

Additional notes found at www.leg.wa.gov

48.24.035 Credit union groups. The lives of a group of individuals may be insured under a policy issued to a credit union, which shall be deemed the policyholder, to insure eligible members of such credit union for the benefit of persons other than the credit union or its officials, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of a credit union, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer, or all of any class or classes thereof determined by conditions pertaining to their age or membership in the credit union or both.

(2) The premium for the policy shall be paid by the policyholder, either wholly from the credit union's funds, or partly from such funds and partly from funds contributed by the insured members specifically for their insurance. No policy may be issued for which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance.

(3) The policy must cover at least twenty-five members at the date of issue.

(4) The amount of insurance under the policy shall not exceed the amount of the total shares and deposits of the member.

(5) As used herein, "credit union" means a credit union organized and operating under the federal credit union act of 1934 or chapter 31.12 RCW. [1982 c 181 § 14; 1961 c 194 § 8.]

Additional notes found at www.leg.wa.gov

48.24.040 Debtor groups. The lives of a group of individuals may be insured under a policy issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditors, subject to the provisions of the insurance code relating to credit life insurance and credit accident and health insurance and to the following requirements:

(1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable in installments, or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness, except that nothing in this section shall preclude an insurer from excluding from the classes eligible for insurance classes of debtors determined by age. The policy may provide that the term "debtors" shall include the debtors of one or more subsidiary corporations, and the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract, or otherwise.

(2) The premium for the policy shall be paid by the policyholder, either from the creditor's funds, or from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least seventy-five percent of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(3) The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least one hundred persons yearly, or may reasonably be expected to receive at least one hundred new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent of the new entrants become insured.

(4) Payment by the debtor insured under any such group life insurance contract of the premium charged the creditor by the insurer for such insurance pertaining to the debtor, shall not be deemed to constitute a charge upon a loan in violation of any usury law. [1967 c 150 § 28; 1961 c 194 § 9; 1955 c 303 § 18; 1947 c 79 § .24.04; Rem. Supp. 1947 § 45.24.04.]

48.24.045 Certain associations as groups. The lives of a group of individuals may be insured under a policy issued to an association which has been in active existence for at least one year, which has a constitution and bylaws, and

which has been organized and is maintained in good faith for purposes other than that of obtaining insurance. Under this group life insurance policy, the association shall be deemed the policyholder. The policy may insure association employees, members, or their employees. Beneficiaries under the policy shall be persons other than the association or its officers or trustees. The term "employees" as used in this section may include retired employees. [1979 ex.s. c 44 § 1.]

48.24.050 Labor union groups. The lives of a group of individuals may be insured under a policy issued to a labor union, which shall be deemed the policyholder, to insure members of such union for the benefit of persons other than the union or any of its officials, representatives or agents, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the union, or both.

(2) The premium for the policy shall be paid by the policyholder, either wholly from the union's funds, or partly from such funds and partly from funds contributed by the insured members specifically for their insurance. No policy may be issued of which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance. A policy on which the premium is to be derived in part from funds contributed by the insured members specifically for their insurance may be placed in force only if at least seventy-five percent of the then eligible members, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(3) The policy must cover at least twenty-five members at date of issue.

(4) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the union. [1955 c 303 § 19; 1947 c 79 § .24.05; Rem. Supp. 1947 § 45.24.05.]

48.24.060 Public employee associations. The lives of a group of public employees may be insured under a policy issued to the departmental head or to a trustee, or issued to an association of public employees formed for purposes other than obtaining insurance and having, when the policy is placed in force, a membership in the classes eligible for insurance of not less than seventy-five percent of the number of employees eligible for membership in such classes, which department head or trustee or association shall be deemed the policyholder, to insure such employees for the benefit of persons other than the policyholder or any of its officials, subject to the following requirements:

(1) The persons eligible for insurance under the policy shall be all of the employees of the department or members of the association, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the association, or both.

(2) The premium for the policy shall be paid by the policyholder, in whole or in part either from salary deductions authorized by, or charges collected from, the insured employees or members specifically for the insurance, or from the association's own funds, or from both. Any such deductions from salary may be paid by the employer to the association or directly to the insurer. No policy may be placed in force unless and until at least seventy-five percent of the then eligible employees or association members, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, have elected to be covered and have authorized their employer to make any required deductions from salary.

(3) The rate of charges to the insured employees or members specifically for the insurance, and the dues of the association if they include the cost of insurance, shall be determined according to each attained age or in not less than four reasonably spaced attained age groups. In no event shall the rate of such dues or charges be level for all members regardless of attained age.

(4) The policy must cover at least twenty-five persons at date of issue.

(5) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees or members or by the association.

As used herein, "public employees" means employees of the United States government, or of any state, or of any political subdivision or instrumentality of any of them. [1989 c 10 § 9. Prior: 1973 1st ex.s. c 163 § 8; 1973 1st ex.s. c 152 § 5; 1963 c 195 § 21; 1955 c 303 § 20; 1953 c 197 § 11; 1947 c 79 § .24.06; Rem. Supp. 1947 § 45.24.06.]

Additional notes found at www.leg.wa.gov

48.24.070 Trustee groups. The lives of a group of individuals may be insured under a policy issued to the trustees of a fund established by two or more employers or by two or more employer members of an employers' association, or by one or more labor unions, or by one or more employers and one or more labor unions, or by one or more employers and one or more labor unions whose members are in the same or related occupations or trades, which trustees shall be deemed the policyholder, to insure employees or members for the benefit of persons other than the employers or the unions, subject to the following requirements:

(1) If the policy is issued to two or more employer members of an employers' association, such policy may be issued only if (a) the association has been in existence for at least five years and was formed for purposes other than obtaining insurance and (b) the participating employers, meaning such employer members whose employees are to be insured, constitute at date of issue at least fifty percent of the total employers eligible to participate, unless the number of persons covered at date of issue exceeds six hundred, in which event such participating employers must constitute at least twenty-five percent of such total employers in either case omitting from consideration any employer whose employees are already covered for group life insurance.

(2) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the unions, or to both. The policy may provide that the term

"employees" shall include the individual proprietor or partners if an employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are connected with such trusteeship. The policy may provide that the term "employees" shall include retired employees.

(3) The premium for the policy shall be paid by the trustees wholly from funds contributed by the employer or employers of the insured persons, or by the union or unions, or partly or wholly from funds contributed by the insured persons, or any combination thereof. A policy on which all or part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance may be placed in force if the eligible persons elect to make the required contributions. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) The policy must cover at least twenty persons at date of issue.

(5) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers, or unions. [2007 c 80 § 9; 1973 1st ex.s. c 163 § 9; 1963 c 86 § 1; 1959 c 225 § 9; 1955 c 303 § 21; 1953 c 197 § 12; 1947 c 79 § .24.07; Rem. Supp. 1947 § 45.24.07.]

48.24.080 Insurance producer groups. The lives of a group of individuals may be insured under a policy issued to a principal, or if such principal is a life insurer, by or to such principal, covering when issued not less than twenty-five insurance producers of such principal, subject to the following requirements:

(1) The insurance producers eligible for insurance under the policy shall be those who are under contract to render personal services for such principal for a commission or other fixed or ascertainable compensation.

(2) The policy must insure either all of the insurance producers or all of any class or classes thereof, determined by conditions pertaining to the services to be rendered by such insurance producers, except that if a policy is intended to insure several such classes it may be issued to insure any such class of which seventy-five percent are covered and extended to other classes as seventy-five percent thereof express the desire to be covered.

(3) The premium on the policy shall be paid by the principal or by the principal and the insurance producers jointly. When the premium is paid by the principal and insurance producers jointly and the benefits of the policy are offered to all eligible insurance producers, the policy, when issued, must insure not less than seventy-five percent of such insurance producers.

(4) The amounts of insurance shall be based upon some plan which will preclude individual selection.

(5) The insurance shall be for the benefit of persons other than the principal.

(6) Such policy shall terminate if, subsequent to issue, the number of insurance producers insured falls below twenty-five lives or seventy-five percent of the number eligible and the contribution of the insurance producers, if the pre-

miums are on a renewable term insurance basis, exceed one dollar per month per one thousand dollars of insurance coverage plus any additional premium per one thousand dollars of insurance coverage charged to cover one or more hazardous occupations. [2008 c 217 § 32; 1949 c 190 § 33; Rem. Supp. 1949 § 45.24.08.]

Additional notes found at www.leg.wa.gov

48.24.090 Washington state patrol. The lives of a group of individuals may be insured under a policy issued to the commanding officer, which commanding officer shall be deemed the policyholder, to insure not less than twenty-five of the members of the Washington state patrol. Such policy shall be for the benefit of beneficiaries as designated by the individuals so insured, and the premium thereon may be paid by such members. Not less than seventy-five percent of all eligible members of such Washington state patrol, or of any unit thereof determined by conditions pertaining to their employment, may be so insured. [1947 c 79 § .24.09; Rem. Supp. 1947 § 45.24.09.]

48.24.095 Financial institutions. The lives of a group of individuals may be insured under a policy issued to a state or federally regulated financial institution, which financial institution shall be deemed the policyholder. The purpose of the policy shall be to insure the depositors or depositor members of the financial institution for the benefit of persons other than the financial institution or its officers. The issuance of the policy shall be subject to the following requirements:

(1) The persons eligible for insurance under the policy shall be the depositors or deposit members of such financial institution, except any as to whom evidence of individual insurability is not satisfactory to the insurer, or any class or classes thereof determined by conditions of age.

(2) The policy must cover at least one hundred persons at the date of issue.

(3) The amount of insurance under the policy shall not exceed the amount of the deposit account of the insured person or five thousand dollars whichever is less.

(4) Financial institutions referred to herein must be authorized to do business in the state of Washington and have their depositors' or members' deposit accounts insured against loss to the amount of at least fifteen thousand dollars by a corporate agency of the federal government. [1967 ex.s. c 95 § 15.]

48.24.100 Standard provisions. No policy of group life insurance shall be delivered or issued for delivery in this state unless it contains in substance the standard provisions as required by RCW 48.24.110 to 48.24.200, inclusive, or provisions which in the opinion of the commissioner are more favorable to the individuals insured, or at least as favorable to such individuals and more favorable to the policyholder; except that:

(1) Provisions set forth in RCW 48.24.160 to 48.24.200, inclusive, shall not apply to policies issued to a creditor to insure its debtors.

(2) If the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the commis-

sioner is or are equitable to the insured persons and to the policyholder, but such nonforfeiture benefits are not required to be the same as those required for individual life insurance policies. [1947 c 79 § .24.10; Rem. Supp. 1947 § 45.24.10.]

48.24.110 Grace period. There shall be a provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period. [1947 c 79 § .24.11; Rem. Supp. 1947 § 45.24.11.]

48.24.120 Incontestability. There shall be a provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by an individual insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such individual's lifetime nor unless it is contained in a written instrument signed by him [or her]. [2009 c 549 § 7108; 1947 c 79 § 24.12; Rem. Supp. 1947 § 45.24.12.]

48.24.130 The contract—Representations. There shall be a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued and become a part of the contract; that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or to his or her beneficiary. [2009 c 549 § 7109; 1947 c 79 § .24.13; Rem. Supp. 1947 § 45.24.13.]

48.24.140 Insurability. There shall be a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his or her coverage. [2009 c 549 § 7110; 1947 c 79 § .24.14; Rem. Supp. 1947 § 45.24.14.]

48.24.150 Misstatement of age or sex. There shall be a provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age or sex of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used. [1983 1st ex.s. c 32 § 22; 1947 c 79 § .24.15; Rem. Supp. 1947 § 45.24.15.]

48.24.160 Beneficiary—Funeral, last illness expenses. There shall be a provision that any sum becoming due by reason of the death of the individual insured shall be

payable to the beneficiary designated by such individual, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of such sum, living at the death of the individual insured and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding ten percent of such amount or one thousand dollars, whichever is greater, to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the individual insured. [1981 c 333 § 1; 1979 ex.s. c 199 § 9; 1955 c 303 § 23; 1947 c 79 § .24.16; Rem. Supp. 1947 § 45.24.16.]

48.24.170 Certificates. There shall be a provision that the insurer will issue to the policyholder for delivery to each individual insured a certificate setting forth a statement as to the insurance protection to which he or she is entitled, to whom the insurance benefits are payable, described by name, relationship, or reference to the insurance records of the policyholder or insurer, and the rights and conditions set forth in RCW 48.24.180, 48.24.190 and 48.24.200, following. [2009 c 549 § 7111; 1961 c 194 § 10; 1947 c 79 § .24.17; Rem. Supp. 1947 § 45.24.17.]

48.24.180 Conversion on termination of eligibility. There shall be a provision that if the insurance, or any portion of it, on an individual covered under the policy, other than a child insured pursuant to RCW 48.24.030, ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such individual shall be entitled to have issued to him or her by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one days after such termination, and provided further that,

(1) the individual policy shall, at the option of such individual, be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for;

(2) the individual policy shall be in an amount not in any event in excess of the amount of life insurance which ceases because of such termination nor less than one thousand dollars unless a smaller amount of coverage was provided for such individual under the group policy: PROVIDED, That any amount of insurance which matures on the date of such termination or has matured prior thereto under the group policy as an endowment payable to the individual insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

(3) the premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such individual then belongs, and to his or her age attained on the effective date of the individual policy. [2009 c 549 § 7112; 1955 c 303 § 24; 1947 c 79 § .24.18; Rem. Supp. 1947 § 45.24.18.]

48.24.190 Conversion on termination of policy.

There shall be a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured individuals, every individual insured thereunder at the date of such termination, other than a child insured pursuant to RCW 48.24.030, whose insurance terminates and who has been so insured for at least five years prior to such termination date shall be entitled to have issued to him or her by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by RCW 48.24.180, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of (a) [(1)] the amount of the individual's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he or she is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one days of such termination and (b) [(2)] two thousand dollars. [2009 c 549 § 7113; 1953 c 197 § 13; 1947 c 79 § .24.19; Rem. Supp. 1947 § 45.24.19.]

48.24.200 Death pending conversion. There shall be a provision that if a person insured under the group policy dies during the period within which he or she would have been entitled to have an individual policy issued to him or her in accordance with RCW 48.24.180 and 48.24.190, and before such an individual policy shall have become effective, the amount of life insurance which he or she would have been entitled to have issued to him or her under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made. [2009 c 549 § 7114; 1947 c 79 § .24.20; Rem. Supp. 1947 § 45.24.20.]

48.24.210 Limitation of liability. (1) The insurer may in any group life insurance contract provide that it is not liable, or is liable only in a reduced amount, for losses resulting:

(a) From war or any act of war, declared or undeclared, or of service in the military, naval or air forces or in civilian forces auxiliary thereto, or from any cause while a member of any such military, naval or air forces, of any country at war, declared or undeclared.

(b) From aviation under conditions specified in the policy.

(2) The insurer may in any such contract provide that any amount of insurance in excess of one thousand dollars on an individual life may be reduced to one thousand dollars or to any greater amount upon attainment of any age not less than age sixty-five or upon the anniversary of the policy nearest attainment of such age. [1947 c 79 § .24.21; Rem. Supp. 1947 § 45.24.21.]

48.24.240 Readjustment of premium. Any group life insurance contract may provide for a readjustment of the premium rate based on experience under that contract, at the end of the first or of any subsequent year of insurance, and which readjustment may be made retroactive for such policy year only. [1947 c 79 § .24.24; Rem. Supp. 1947 § 45.24.24.]

(2021 Ed.)

48.24.260 Application of dividends or rate reductions. Any policy dividends hereafter declared, or reduction in rate of premiums hereafter made or continued for the first or any subsequent year of insurance, under any policy of group life insurance heretofore or hereafter issued to any policyholder may be applied to reduce the policyholder's part of the cost of such insurance, except that if the aggregate dividends or refunds or credits under such group policy and any other group policy or contract issued to the policyholder exceed the aggregate contributions of the policyholder toward the cost of the coverages, such excess shall be applied by the policyholder for the sole benefit of insured individuals. [1947 c 79 § .24.26; Rem. Supp. 1947 § 45.24.26.]

48.24.270 Payment of proceeds—Interest, when delayed. (1) An insurer shall pay the proceeds of any benefits under a policy of group life insurance insuring the life of any person who was a resident of this state at the time of death. The proceeds must be paid not more than thirty days after the insurer has received satisfactory proof of death of the insured. If the proceeds are not paid within the thirty-day period, the insurer shall also pay interest on the proceeds from the date of death of the insured to the date when the proceeds are paid.

(2) The interest required under subsection (1) of this section accrues commencing on the date of death at the rate then paid by the insurer on other withdrawable policy proceeds left with the company or eight percent, whichever is greater.

(3) Benefits payable that have not been tendered to the beneficiary within ninety days of the receipt of proof of death accrue interest, commencing on the ninety-first day, at the rate under subsection (2) of this section plus three percent. [2008 c 310 § 1.]

48.24.280 Group life insurance—Noninsurance benefits. (1) A life insurer may include the following noninsurance benefits as part of a policy or certificate of group life insurance, with the prior approval of the commissioner:

(a) Will preparation services;

(b) Financial planning and estate planning services;

(c) Probate and estate settlement services;

(d) Grief counseling;

(e) Funeral planning and funeral services, but it must be disclosed that this noninsurance benefit does not constitute an insurance funded prearrangement contract, pursuant to RCW 18.39.255; and

(f) Such other services as the commissioner may identify by rule.

(2) The commissioner may adopt rules to regulate the disclosure of noninsurance benefits permitted under this section, including but not limited to guidelines regarding the coverage provided under the policy or certificate of insurance.

(3) Those providing the services listed in subsection (1) of this section must be appropriately licensed.

(4) This section does not require the commissioner to approve any particular proposed noninsurance benefit. The commissioner may disapprove any proposed noninsurance benefit that the commissioner determines may tend to promote or facilitate the violation of any other section of this title.

(5) This section does not expand, limit, or otherwise affect the authority and ethical obligations of those who are authorized by the state supreme court to practice law in this state. This section does not limit the prohibition against the unauthorized practice of law under chapter 2.48 RCW.

(6) This section does not affect the application of chapter 21.20 RCW. [2017 c 32 § 1; 2016 c 143 § 1; 2009 c 76 § 2.]

48.24.900 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 § 120.]

Chapter 48.25 RCW

INDUSTRIAL LIFE INSURANCE

Sections

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48.25.900	Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

Exemption of proceeds, life insurance: RCW 48.18.410.

Insurable interest, personal insurance, nonprofit organizations: RCW 48.18.030.

Minor may contract for life or disability insurance: RCW 48.18.020.

Payment to person designated in policy or by assignment discharges insurer: RCW 48.18.370.

Policy forms, execution, filing, etc.: Chapter 48.18 RCW.

48.25.010 Scope of chapter. The provisions of this chapter apply only to industrial life insurance contracts. [1947 c 79 § .25.01; Rem. Supp. 1947 § 45.25.01.]

48.25.020 Industrial life insurance defined. "Industrial" life insurance is any life insurance provided by an individual insurance contract issued in face amount of less than one thousand dollars, under which premiums are payable monthly or oftener, and bearing the words "industrial policy" printed upon the policy as a part of the descriptive matter. [1947 c 79 § .25.02; Rem. Supp. 1947 § 45.25.02.]

48.25.030 Compliance enjoined. No policy of industrial life insurance shall be delivered or be issued for delivery in this state after January 1, 1948, except in compliance with the provisions of this chapter and with other applicable provisions of this code. [1947 c 79 § .25.03; Rem. Supp. 1947 § 45.25.03.]

48.25.040 Standard provisions. No such policy shall be so issued or delivered unless it contains in substance the provisions as required by this chapter, or provisions which in the opinion of the commissioner are more favorable to the policyholder. [1947 c 79 § .25.04; Rem. Supp. 1947 § 45.25.04.]

48.25.050 Grace period. There shall be a provision that the insured is entitled to a grace period of four weeks within which the payment of any premium after the first may be made, except that in policies the premiums for which are payable monthly, the period of grace shall be one month but not less than thirty days; and that during the period of grace the policy shall continue in full force, but if during the grace period the policy becomes a claim, then any overdue and unpaid premiums may be deducted from any settlement under the policy. [1947 c 79 § .25.05; Rem. Supp. 1947 § 45.25.05.]

48.25.060 Entire contract. There shall be a provision that the policy shall constitute the entire contract between the parties, or, if a copy of the application is endorsed upon or attached to the policy when issued, a provision that the policy and the application therefor shall constitute the entire contract. If the application is so made a part of the contract, the policy shall also provide that all statements made by the applicant in such application shall, in the absence of fraud, be deemed to be representations and not warranties. [1947 c 79 § .25.06; Rem. Supp. 1947 § 45.25.06.]

48.25.070 Incontestability. There shall be a provision that the policy shall be incontestable after it has been in force during the lifetime of the insured for a period of two years from its date of issue except for nonpayment of premiums, and except, at the option of the insurer, as to supplemental provisions providing benefits for total and permanent disability or specifically for accidental death. [1947 c 79 § .25.07; Rem. Supp. 1947 § 45.25.07.]

48.25.080 Misstatement of age. There shall be a provision that if it is found that the age of the individual insured, or the age of any other individual considered in determining the premium, has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages. [1947 c 79 § .25.08; Rem. Supp. 1947 § 45.25.08.]

48.25.090 Dividends. If a participating policy, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy, and that dividends arising from such apportionment shall be credited annually beginning not later than the fifth contract year. This provision shall not prohibit the payment of additional dividends on default of payment of premiums or termination of the policy. [1947 c 79 § .25.09; Rem. Supp. 1947 § 45.25.09.]

48.25.100 Nonforfeiture benefits. There shall be a provision for nonforfeiture benefits as required by chapter 48.76 RCW. [1983 c 3 § 152; 1947 c 79 § .25.10; Rem. Supp. 1947 § 45.25.10.]

48.25.110 Cash surrender value. There shall be a provision for a cash surrender value as required by chapter 48.76 RCW. [1983 c 3 § 153; 1947 c 79 § .25.11; Rem. Supp. 1947 § 45.25.11.]

48.25.120 Reinstatement. There shall be a provision that the policy may be reinstated at any time within two years from the due date of the premium in default unless the cash surrender value has been paid, or the extension period expired, upon the production of evidence of insurability satisfactory to the insurer and the payment of all overdue premiums and payment or reinstatement of any unpaid loans or advances made by the insurer against the policy with interest at a rate not exceeding six percent per annum and payable annually. [1947 c 79 § .25.12; Rem. Supp. 1947 § 45.25.12.]

48.25.130 Settlement. There shall be a provision that when the policy becomes a claim by the death of the insured, settlement shall be made upon receipt of due proof of death or after a specified period not exceeding two months after receipt of such proof. [1947 c 79 § .25.13; Rem. Supp. 1947 § 45.25.13.]

48.25.140 Authority to alter policy. There shall be a provision that no insurance producer shall have the power or authority to waive, change, or alter any of the terms or conditions of any policy; except that, at the option of the insurer, the terms or conditions may be changed by an endorsement signed by a duly authorized officer of the insurer. [2017 3rd sp.s. c 25 § 17; 2008 c 217 § 33; 1947 c 79 § .25.14; Rem. Supp. 1947 § 45.25.14.]

Additional notes found at www.leg.wa.gov

48.25.150 Beneficiary. (1) Each such policy shall have a space on the front or back page of the policy for the name of the beneficiary designated with a reservation of the right to designate or change the beneficiary after the issuance of the policy.

(2) The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until endorsed on the policy by the insurer, and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. [1947 c 79 § .25.15; Rem. Supp. 1947 § 45.25.15.]

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48.25.160 Facility of payment clause. Such a policy may also provide that if the beneficiary designated in the policy does not surrender the policy with due proof of death within the period stated in the policy, which shall not be less than thirty days after the death of the insured, or if the beneficiary is the estate of the insured or is a minor, or dies before the insured or is not legally competent to give a valid release, then the insurer may make payment thereunder to the executor or administrator of the insured, or to any of the insured's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named beneficiary, or by reason of having incurred expense for the maintenance, medical attention or burial of the insured. Such policy may also include a similar provision applicable to any other payment due under the policy. [1947 c 79 § .25.16; Rem. Supp. 1947 § 45.25.16.]

48.25.170 Payment of premiums direct. In the case of weekly premium policies, there may be a provision that upon proper notice to the insurer while premiums on the policy are not in default beyond the grace period, of the intention to pay future premiums directly to the insurer at its home office or any office designated by the insurer for the purpose, the insurer will, at the end of each period of a year from the due date of the first premium so paid, for which period such premiums are so paid continuously without default beyond the grace period, refund a stated percentage of the premiums in an amount which fairly represents the savings in collection expense. [1947 c 79 § .25.17; Rem. Supp. 1947 § 45.25.17.]

48.25.180 Conversion—Weekly premium policies. There shall be a provision in the case of weekly premium policies granting, upon proper written request and upon presentation of evidence of the insurability of the insured satisfactory to the insurer, the privilege of converting his or her weekly premium industrial insurance to any form of life insurance with less frequent premium payments regularly issued by the insurer, in accordance with terms and conditions agreed upon with the insurer. The privilege of making such conversion need be granted only if the insurer's weekly premium industrial policies on the life insured, in force as premium paying insurance and on which conversion is requested, grant benefits in event of death, exclusive of additional accidental death benefits and exclusive of any dividend additions, in an amount not less than the minimum amount of such insurance with less frequent premium payments issued by the insurer at the age of the insured on the plan of industrial or ordinary insurance desired. [2009 c 549 § 7115; 1947 c 79 § .25.18; Rem. Supp. 1947 § 45.25.18.]

48.25.190 Conversion—Monthly premium policies. There shall be a provision, in the case of monthly premium industrial policies, granting, upon proper written request and upon presentation of evidence of the insurability of the insured satisfactory to the insurer, the privilege of converting his or her monthly premium industrial insurance to any form of ordinary life insurance regularly issued by the insurer, in accordance with terms and conditions agreed upon with the insurer. The privilege of making such conversions need be granted only if the insurer's monthly premium industrial pol-

icies on the life insured, in force as premium paying insurance and on which conversion is requested, grant benefits in event of death, exclusive of additional accidental death benefits and exclusive of any dividend additions, in an amount not less than the minimum amount of ordinary insurance issued by the insurer at the age of the insured on the plan of ordinary insurance desired. [2009 c 549 § 7116; 1947 c 79 § .25.19; Rem. Supp. 1947 § 45.25.19.]

48.25.200 Title on policy. There shall be a title on the face of each such policy briefly describing its form. [1947 c 79 § .25.20; Rem. Supp. 1947 § 45.25.20.]

48.25.210 Application to term and specified insurance. Any of the provisions required by this chapter or any portion thereof which are not applicable to single premium or term policies or to policies issued or granted pursuant to non-forfeiture provisions, shall to that extent not be incorporated therein. [1947 c 79 § .25.21; Rem. Supp. 1947 § 45.25.21.]

48.25.220 Prohibited provisions. No such policy shall contain:

(1) A provision by which the insurer may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same insurer.

(2) A provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical or surgical treatment or attention, except a provision which gives the insurer the right to declare the policy void if the insured has, within two years prior to the issuance of the policy, received institutional, hospital, medical or surgical treatment or attention and if the insured or claimant under the policy fails to show that the condition occasioning such treatment or attention was not of a serious nature or was not material to the risk.

(3) A provision giving the insurer the right to declare the policy void because the insured had been rejected for insurance, unless such right be conditioned upon a showing by the insurer, that knowledge of such rejection would have led to a refusal by the insurer to make such contract. [1947 c 79 § .25.22; Rem. Supp. 1947 § 45.25.22.]

48.25.230 Limitation of liability. The insurer may in any such policy limit its liability for the same causes and to the same extent as is provided in RCW 48.23.260 for other life insurance contracts. [1947 c 79 § .25.23; Rem. Supp. 1947 § 45.25.23.]

48.25.900 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 § 121.]

Chapter 48.25A RCW

LIFE INSURANCE—PROFIT-SHARING, CHARTER, FOUNDERS, AND COUPON POLICIES

Sections

- 48.25A.010 Definitions.
- 48.25A.020 Certain policies not to be issued or delivered after September 1, 1967.
- 48.25A.030 Coupon policies—Approval by commissioner.
- 48.25A.040 Coupon policies—Requirements.
- 48.25A.050 Revocation of certificates of authority and licenses for violation of chapter.

48.25A.010 Definitions. As used in this chapter:

(1) "Profit-sharing policy" means:

(a) A life insurance policy which by its terms expressly provides that the policyholder will participate in the distribution of earnings or surplus other than earnings or surplus attributable, by reasonable and nondiscriminatory standards, to the participating policies of the company and allocated to the policyholder on reasonable and nondiscriminatory standards; or

(b) A life insurance policy the provisions of which, through sales material or oral presentations, are interpreted by the company to prospective policyholders as entitling the policyholder to the benefits described in subsection (a) of this section.

(2) "Charter policy" or "founders policy" means:

(a) A life insurance policy which by its terms expressly provides that the policyholder will receive some preferential or discriminatory advantage or benefit not available to persons who purchase insurance from the company at future dates or under other circumstances; or

(b) A life insurance policy the provisions of which, through sales material or oral presentations, are interpreted by the company to prospective policyholders as entitling the policyholder to the benefits described in subsection (a) of this section.

(3) "Coupon policy" means a life insurance policy which provides a series of pure endowments maturing periodically in amounts not exceeding the gross annual policy premiums. The term "pure endowment" or "endowment" is used in its accepted actuarial sense, meaning a benefit becoming payable at a specific future date if the insured person is then living. [1967 ex.s. c 95 § 5.]

48.25A.020 Certain policies not to be issued or delivered after September 1, 1967. No profit-sharing, charter, or founders policy shall be issued or delivered in this state after September 1, 1967. [1967 ex.s. c 95 § 6.]

48.25A.030 Coupon policies—Approval by commissioner. No coupon policy shall be issued or delivered in this state until the form of the same has been filed with and approved by the commissioner. [1967 ex.s. c 95 § 7.]

48.25A.040 Coupon policies—Requirements. Coupon policies issued or delivered in this state shall be subject to the following provisions:

(1) No detachable coupons or certificates or passbooks may be used. No other device may be used which tends to emphasize the periodic endowment benefits or which tends to create the impression that the endowments represent interest earnings or anything other than benefits which have been purchased by part of the policyholder's premium payments.

(2) Each endowment benefit must have a fixed maturity date and payment of the endowment benefit shall not be contingent upon the payment of any premium becoming due on or after such maturity date.

(3) The endowment benefits must be expressed in dollar amounts rather than as percentages of other quantities or in other ways, both in the policy itself and in the sale thereof.

(4) A separate premium for the periodic endowment benefits must be shown in the policy adjacent to the rest of the policy premium information and must be given the same emphasis in the policy and in the sale thereof as that given the rest of the policy premium information. This premium shall be calculated with mortality, interest and expense factors which are consistent with those for the basic policy premium. [1967 ex.s. c 95 § 8.]

48.25A.050 Revocation of certificates of authority and licenses for violation of chapter. The commissioner may revoke all certificates of authority and licenses granted to any insurance company, its officers or agents violating any provision of this chapter. [1967 ex.s. c 95 § 9.]

Chapter 48.26 RCW

MARINE AND TRANSPORTATION INSURANCE (RESERVED)

Chapter 48.27 RCW

PROPERTY INSURANCE

Sections

48.27.010	Over-insurance prohibited.
48.27.020	Replacement insurance.
48.27.030	Policy does not cover flood damage—Notice to policyholder.

Binders: RCW 48.18.230.

Insurable interest, property insurance, nonprofit organizations: RCW 48.18.040.

Policy forms, execution, filing, etc.: Chapter 48.18 RCW.

Rates: Chapter 48.19 RCW.

Standard form of fire policy: RCW 48.18.120.

48.27.010 Over-insurance prohibited. (1) Over-insurance shall be deemed to exist if property or an insurable interest therein is insured by one or more insurance contracts against the same hazard in any amount in excess of the fair value of the property or of such interest, as determined as of the effective date of the insurance or of any renewal thereof, or in those instances when insured value is for improvements and land.

(2) For the purposes of this section only the term "fair value" means the cost of replacement less such depreciation as is properly applicable to the subject insured.

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(3) No person shall knowingly require, request, issue, place, procure, or accept any insurance contract which would result in over-insurance of the property or interest therein proposed to be insured, except as is provided in RCW 48.27.020.

(4) No person shall compel an insured or applicant for insurance to procure property insurance in an amount in excess of the amount which could reasonably be expected to be paid under the policy (or combination of policies) in the event of a loss, whether such insurance is required in connection with a loan or otherwise.

(5) Each violation of this section shall subject the violator to the penalties provided by this code. [1984 c 6 § 1; 1947 c 79 § .27.01; Rem. Supp. 1947 § 45.27.01.]

48.27.020 Replacement insurance. By any contract of insurance of property or of any insurable interest therein, the insurer may in connection with a special provision or endorsement made a part of the policy insure the cost of repair or replacement of such property, if damaged or destroyed by a hazard insured against, and without deduction of depreciation, subject to such reasonable rules and regulations as may be made by the commissioner. [1951 c 194 § 1; 1947 c 79 § .27.02; formerly Rem. Supp. 1947 § 45.27.02.]

48.27.030 Policy does not cover flood damage—Notice to policyholder. (1) Every insurer issuing a homeowner, condominium unit owner, residential tenant, and residential fire insurance policy that does not cover damage caused by flood must notify the policyholder that the policy does not cover damage caused by flood. The notice must also inform the policyholder how to contact the national flood insurance program ("NFIP") or one of the NFIP's agents. This notice must be provided:

- (a) At the time the policy is issued; and
- (b) At the time the policy is renewed.

(2) The following language, when combined with current information about how to contact the NFIP or its agent, satisfies the notice requirements of this section:

"This policy does not cover damage to your property caused by flooding. The federal government offers flood insurance through the National Flood Insurance Program to residents of communities that participate in its program. You can learn more about the National Flood Insurance Program at www.floodsmart.gov or by calling (888) 379-9531."

(3) Nothing in this section invalidates a flood exclusion, or any other exclusion, in an insurance policy subject to this section. [2009 c 14 § 1.]

Chapter 48.28 RCW SURETY INSURANCE

Sections

48.28.010	Requirements deemed met by surety insurer.
48.28.020	Fiduciary bonds—Premium as lawful expense.
48.28.030	Judicial bonds—Premium as part of recoverable costs.
48.28.040	Official bonds—Payment of premiums.
48.28.050	Release from liability.

Binders: RCW 48.18.230.

Official bonds in general: Chapter 42.08 RCW.

Policy forms, execution, filing, etc.: Chapter 48.18 RCW.

48.28.010 Requirements deemed met by surety insurer. Whenever by law or by rule of any court, public official, or public body, any surety bond, recognizance, obligation, stipulation or undertaking is required or is permitted to be given, any such bond, recognizance, obligation, stipulation, or undertaking which is otherwise proper and the conditions of which are guaranteed by an authorized surety insurer, or by an unauthorized surety insurer as a surplus line pursuant to chapter 48.15 RCW of this code, shall be approved and accepted and shall be deemed to fulfill all requirements as to number of sureties, residence or status of sureties, and other similar requirements, and no justification by such surety shall be necessary. [1947 c 79 § .28.01; Rem. Supp. 1947 § 45.28.01.]

48.28.020 Fiduciary bonds—Premium as lawful expense. Any fiduciary required by law to give bonds, may include as part of his or her lawful expense to be allowed by the court or official by whom he or she was appointed, the reasonable amount paid as premium for such bonds to the authorized surety insurer or to the surplus line surety insurer which issued or guaranteed such bonds. [2009 c 549 § 7117; 1955 c 30 § 1. Prior: 1947 c 79 § .28.02; Rem. Supp. 1947 § 45.28.02.]

48.28.030 Judicial bonds—Premium as part of recoverable costs. In any proceeding the party entitled to recover costs may include therein such reasonable sum as was paid to such surety insurer as premium for any bond or undertaking required therein, and as may be allowed by the court having jurisdiction of such proceeding. [1955 c 30 § 2. Prior: 1947 c 79 § .28.03; Rem. Supp. 1947 § 45.28.03.]

Rules of court: Cf. *RAP 14.3, 18.22.*

48.28.040 Official bonds—Payment of premiums. The premium for bonds given by such surety insurers for appointive or elective public officers and for such of their deputies or employees as are required to give bond shall be paid by the state, political subdivision, or public body so served. [1955 c 30 § 3. Prior: 1947 c 79 § .28.04; Rem. Supp. 1947 § 45.28.04.]

48.28.050 Release from liability. A surety insurer may be released from its liability on the same terms and conditions as are provided by law for the release of individuals as sureties. [1947 c 79 § .28.05; Rem. Supp. 1947 § 45.28.05.]

Chapter 48.29 RCW TITLE INSURERS

Sections

48.29.005	Administration of chapter—Rules.
48.29.010	Scope of chapter—Definitions.
48.29.015	Requirement to maintain records—Report to commissioner.
48.29.017	Statistical reporting agent—Duties—Required reports—Costs—Rules—Information and data exchange.
48.29.018	Information filed under RCW 48.29.017—Confidentiality.
48.29.020	Certificate of authority—Qualifications.
48.29.040	May do business in two or more counties—Restrictions.
48.29.120	Reserve requirements.
48.29.130	Investments.
48.29.140	Premium rates—Required filings—Transition date set by rule.

48.29.143	Premium rates—Actuarially sound estimates.
48.29.147	Required filings—Information subject to review—Commissioner's powers—Timing.
48.29.148	Form and rate filings by rating organization.
48.29.149	Form and rate filings by rating organization—Deviation.
48.29.150	Taxation of title insurers.
48.29.155	Agent license—Financial responsibility—Definitions.
48.29.160	Agents—County tract indexes required.
48.29.170	Agents—Separate licenses for individuals not required.
48.29.180	Disclosure of energy conservation payment obligations—Informational note—Liability.
48.29.190	Conducting business as escrow agent—Requirements—Violation, penalties.
48.29.193	Escrow services—Schedule of fees filed with commissioner.
48.29.195	Escrow services—Schedule of fees made available to public.
48.29.200	Prohibited practices.
48.29.210	Business inducements—Prohibited practices.
48.29.213	Return on ownership interest—Certain payments authorized.
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48.29.405	Rating organizations—License required.
48.29.410	Rating organizations—License applications.
48.29.415	Rating organizations—License issuance—Term.
48.29.420	Rating organizations—License suspension and revocation.
48.29.425	Rating organizations—Commissioner notification.
48.29.430	Rating organizations—Subscribers.
48.29.435	Rating organizations—Review by commissioner.
48.29.440	Rating organizations—Cooperative activities and practices.
48.29.445	Rating organizations—Actuarial, technical, and other services.
48.29.450	Rating organizations—Records—Commissioner cost recovery rules.
48.29.455	Rating organizations—Members and subscribers—Appeal to commissioner.
48.29.460	Rating organizations—Members and subscribers—Discrimination.
48.29.465	Rating organizations—Membership or subscription not required.
48.29.470	Rating organizations—Aggregate information and experience data—Exchange.
48.29.500	Advisory organizations—Filings with commissioner.
48.29.510	Advisory organizations—Acts and practices inconsistent with chapter.
48.29.901	Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

48.29.005 Administration of chapter—Rules. The commissioner may adopt rules to implement and administer this chapter, including but not limited to:

- (1) Establishing the information to be included in the report required under RCW 48.29.015;
- (2) Establishing the information required for the filing of rates for title insurance under RCW 48.29.147;
- (3) Establishing standards which title insurance rate filings must satisfy under RCW 48.29.147;
- (4) Establishing a date, which date shall not be earlier than January 1, 2010, by which all title insurers selling policies in this state must file their rates with the commissioner under RCW 48.29.143 and 48.29.147 rather than under RCW 48.29.140 and refile any rates that were in effect prior to the date established by the commissioner;
- (5) Defining what things of value a title insurance insurer or title insurance agent is permitted to give to any person in a position to refer or influence the referral of title insurance business under RCW 48.29.210(2). In adopting rules under this subsection, the commissioner shall work with representatives of the title insurance and real estate industries and consumer groups in developing the rules;
- (6) Establishing the fee for a license as a rating organization under RCW 48.29.410;
- (7) Establishing license requirements that an applicant for a license as a rating organization and a licensee must comply with; and

(8) Requiring a rating organization to periodically update the title insurance rates, manuals of rules and rates, rating plans, rate schedules, minimum rates, class rates, or rating rules, filed by the rating organization on behalf of its members or subscribers. [2017 c 103 § 23; 2008 c 110 § 9.]

48.29.010 Scope of chapter—Definitions. (1) This chapter relates only to title insurers for real property.

(2) This code does not apply to persons engaged in the business of preparing and issuing abstracts of title to property and certifying to their correctness so long as the persons do not guarantee or insure the titles.

(3) For purposes of this chapter, unless the context clearly requires otherwise:

(a) "Abstract of title" means a written representation, provided under contract, whether written or oral, intended to be relied upon by the person who has contracted for the receipt of this representation, listing all recorded conveyances, instruments, or documents that, under the laws of the state of Washington, impart constructive notice with respect to the chain of title to the real property described. An abstract of title is not a title policy as defined in this subsection.

(b)(i) "Advisory organization" means a group, association, or other organization of insurers that assists insurers or rating organizations in rate making by the collection and furnishing of loss or expense statistics, or by the submission of recommendations, but that does not make filings under this chapter.

(ii) The term "advisory organization" does not include subscribers' committees provided for in RCW 48.29.430 or the statistical reporting agent provided for in RCW 48.29.017.

(c) "Associates of producers" means any person who has one or more of the following relationships with a producer of title insurance business:

(i) A spouse, parent, or child of a producer;

(ii) A corporation or business entity that controls, is controlled by, or is under common control with a producer;

(iii) An employer, employee, independent contractor, officer, director, partner, franchiser, or franchisee of a producer; or

(iv) Anyone who has an agreement, arrangement, or understanding with a producer, the purpose or substantial effect of which is to enable the person in a position to influence the selection of a title insurer or title insurance agent to benefit financially from the selection of the title insurer or title insurance agent.

(d) "Financial interest" means any interest, legal or beneficial, that entitles the holder directly or indirectly to any of the net profits or net worth of the entity in which the interest is held.

(e) "Member" means an insurer that participates in or is entitled to participate in the management of a rating organization or an advisory organization.

(f) "Preliminary report," "commitment," or "binder" means reports furnished in connection with an application for title insurance and are offers to issue a title policy subject to the stated exceptions in the reports, the conditions and stipulations of the report and the issued policy, and other matters as may be incorporated by reference. The reports are not abstracts of title, nor are any of the rights, duties, or responsibilities

applicable to the preparation and issuance of an abstract of title applicable to the issuance of any report. The report is not a representation as to the condition of the title to real property, but is a statement of terms and conditions upon which the issuer is willing to issue its title policy, if the offer is accepted.

(g) "Producers of title insurance business" means real estate agents and brokers, lawyers, mortgagees, mortgage loan brokers, financial institutions, escrow agents, persons who lend money for the purchase of real estate or interests therein, building contractors, real estate developers and subdividers, and any other person who is or may be in a position to influence the selection of a title insurer or title insurance agent whether or not the consent or approval of any other person is sought or obtained with respect to the selection of the title insurer or title insurance agent.

(h)(i) "Rating organization" means an entity, the object or purpose of which is the adoption or making of title insurance forms, including forms of policy, application, rider, and endorsement, and title insurance rates, manuals of rules and rates, rating plans, rate schedules, minimum rates, class rates, and rating rules.

(ii) The term "rating organization" does not include two or more insurers operating under the authority granted in RCW 48.29.440.

(i) "Subscriber" means an insurer that employs the services of a rating organization for the purpose of making form or rate filings, whether or not the title insurer is a member of such rating organization.

(j) "Title policy" means any written instrument, contract, or guarantee by means of which title insurance liability is assumed. [2017 c 103 § 2; 2008 c 110 § 1; 2005 c 223 § 14; 1997 c 14 § 1; 1947 c 79 § .29.01; Rem. Supp. 1947 § 45.29.01.]

48.29.015 Requirement to maintain records—Report to commissioner. (1) A title insurance agent shall maintain records of its title orders sufficient to indicate the source of the title orders.

(2) Every title insurance agent shall file with the commissioner annually by March 15th of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for filing, a report, on a form prescribed by the commissioner, setting forth:

(a) The names and addresses of those persons, if any, who have had a financial interest in the title insurance agent during the calendar year, who are known or reasonably believed by the title insurance agent to be producers of title business or associates of producers; and

(b) The percent of title orders originating from each person who owns, or had owned during the preceding calendar year, a financial interest in the title insurance agent.

(3) Each title insurance agent shall keep current the information required by that portion of the report required by subsection (2)(a) of this section by reporting all changes or additions within fifteen days after the end of the month in which it learns of each change or addition.

(4) Each title insurance agent shall file that portion of the report required by subsection (2)(a) of this section with its application for a license. [2017 3rd sp.s. c 25 § 18; 2008 c 110 § 2.]

48.29.017 Statistical reporting agent—Duties—Required reports—Costs—Rules—Information and data exchange. (1) The commissioner must designate one statistical reporting agent to assist him or her in gathering information on title insurance policy issuance, business income, and expenses and making compilations thereof. The costs and expenses of the statistical reporting agent must be borne by all the authorized title insurance companies and title insurance agents licensed to conduct the business of title insurance in this state. The commissioner may adopt rules setting forth how the costs and expenses of the statistical reporting agent are to be paid and apportioned among the authorized title insurers and licensed title insurance agents.

(2) Upon designation of a statistical reporting agent by the commissioner under subsection (1) of this section all authorized title insurance companies and licensed title insurance agents must annually, by May 31st, file a report with the statistical reporting agent of their policy issuance, business income, expenses, and loss experience in this state. The report must be filed with the statistical reporting agent in a manner and form prescribed by the commissioner by rule, which must be consistent with the manner and form adopted by the national association of insurance commissioners.

(3) The statistical reporting agent must review the information filed with it for completeness, accuracy, and quality within one hundred twenty days of its receipt. All title insurance companies and title insurance agents must cooperate with the statistical reporting agent to verify the completeness, accuracy, and quality of the data that they submitted.

(4) Within thirty days after completing its review of the information for quality and accuracy, the statistical reporting agent must file the information for each title insurance company and title insurance agent, individually and in the aggregate, with the commissioner with a copy of the aggregate data from such statistical reporting agent provided to each title insurer and title insurance agent.

(5) The commissioner may adopt rules to implement and administer this section.

(6) The statistical reporting agent may exchange aggregate information and experience data with title insurance companies and rating organizations in this state in accordance with RCW 48.29.470. [2017 c 103 § 22; 2013 c 65 § 1.]

48.29.018 Information filed under RCW 48.29.017—Confidentiality. (1) Information filed with the commissioner under RCW 48.29.017 must be kept confidential and is not subject to public disclosure under chapter 42.56 RCW, unless the commissioner finds, after notice and hearing with the affected parties, it is in the public interest to disclose the information.

(2) The commissioner may share the information in subsection (1) of this section with 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, provided that the recipient agrees to maintain the confidentiality and privileged status of the information.

(3) This section does not prohibit the commissioner from sharing or publishing the information in an aggregate form. [2013 c 65 § 2.]

48.29.020 Certificate of authority—Qualifications.

A title insurer is not entitled to have a certificate of authority unless:

- (1) It is a stock corporation;
- (2) It owns or leases and maintains a complete set of tract indexes of the county in this state in which its principal office is located; and
- (3) It has and maintains the capital and surplus requirements set forth in RCW 48.05.340. [2005 c 223 § 15; 1990 c 76 § 1; 1955 c 86 § 12; 1947 c 79 § .29.02; Rem. Supp. 1947 § 45.29.02.]

Additional notes found at www.leg.wa.gov

48.29.040 May do business in two or more counties—Restrictions. (1) Subject to the deposit requirements of *RCW 48.29.030, a title insurer having its principal offices in one county may be authorized to transact business in only such additional counties as to which it owns or leases and maintains, or has a duly authorized agent that owns or leases and maintains, a complete set of tract indexes.

(2) A title insurer not authorized to transact business in a certain county may purchase a title policy on property located therein from another title insurer which is so authorized in that county. The first title insurer may thereafter issue its own policy of title insurance to the owner of such property. The first title insurer may combine the insurance on the title of such property in a single policy which also insures the title of one or more other pieces of property. The first title insurer must pay the full premium based on filed rates for the policy, and must charge the precise same amount to its own customer for the insurance as to the title of such property. A title insurer using the authority granted by this subsection in a transaction must so notify its customer. [1990 c 76 § 2; 1957 c 193 § 17; 1947 c 79 § .29.04; Rem. Supp. 1947 § 45.29.04.]

*Reviser's note: RCW 48.29.030 was repealed by 2005 c 223 § 35.

48.29.120 Reserve requirements. In determining the financial condition of a title insurer doing business under this title, the general provisions of chapter 48.12 RCW requiring the establishment of reserves sufficient to cover all known and unknown liabilities including allocated and unallocated loss adjustment expense apply, except that a title insurer shall establish and maintain:

(1) A known claim reserve in an amount estimated to be sufficient to cover all unpaid losses, claims, and allocated loss adjustment expenses arising under title insurance policies, guaranteed certificates of title, guaranteed searches, and guaranteed abstracts of title, and all unpaid losses, claims, and allocated loss adjustment expenses for which the title insurer may be liable, and for which the insurer has received notice by or on behalf of the insured, holder of a guarantee or escrow, or security depositor;

(2)(a) A statutory or unearned premium reserve consisting of:

(i) The amount of the special reserve fund that was required prior to July 24, 2005, which balance must be released in accordance with (b) of this subsection; and

(ii) Additions to the reserve after July 24, 2005, must be made out of total charges for title insurance policies and guarantees written, as set forth in the title insurer's most recent

annual statement on file with the commissioner, equal to the sum of the following:

(A) For each title insurance policy on a single risk written or assumed after July 24, 2005, fifteen cents per one thousand dollars of net retained liability for policies under five hundred thousand dollars; and

(B) For each title insurance policy on a single risk written or assumed after July 24, 2005, ten cents per one thousand dollars of net retained liability for policies of five hundred thousand or greater.

(b) The aggregate of the amounts set aside in this reserve in any calendar year pursuant to (a) of this subsection must be released from the reserve and restored to net profits over a period of twenty years under the following formula:

(i) Thirty-five percent of the aggregate sum on July 1st of the year next succeeding the year of addition;

(ii) Fifteen percent of the aggregate sum on July 1st of each of the succeeding two years;

(iii) Ten percent of the aggregate sum on July 1st of the next succeeding year;

(iv) Three percent of the aggregate sum on July 1st of each of the next three succeeding years;

(v) Two percent of the aggregate sum on July 1st of each of the next three succeeding years; and

(vi) One percent of the aggregate sum on July 1st of each of the next succeeding ten years.

(c) The insurer shall calculate an adjusted statutory unearned premium reserve as of July 24, 2005. The adjusted reserve is calculated as if (a)(ii) and (b) of this subsection had been in effect for all years beginning twenty years prior to July 24, 2005. For purposes of this calculation, the balance of the reserve as of that date is deemed to be zero. If the adjusted reserve so calculated exceeds the aggregate amount set aside for statutory or unearned premiums in the insurer's annual statement on file with the commissioner on July 24, 2005, the insurer shall, out of total charges for policies of title insurance, increase its statutory or unearned premium reserve by an amount equal to one-sixth of that excess in each of the succeeding six years, commencing with the calendar year that includes July 24, 2005, until the entire excess has been added.

(d) The aggregate of the amounts set aside in this reserve in any calendar year as adjustments to the insurer's statutory or unearned premium reserve under (c) of this subsection shall be released from the reserve and restored to net profits, or equity if the additions required by (c) of this subsection reduced equity directly, over a period not exceeding ten years under to the [under the] following table:

Year of Addition	Release
Year 1 ¹	Equally over 10 years
Year 2	Equally over 9 years
Year 3	Equally over 8 years
Year 4	Equally over 7 years
Year 5	Equally over 6 years
Year 6	Equally over 5 years

¹(The calendar year following July 24, 2005).

(3) A supplemental reserve shall be established consisting of any other reserves necessary, when taken in combination with the reserves required by subsections (1) and (2) of

this section, to cover the company's liabilities with respect to all losses, claims, and loss adjustment expenses.

(4) The supplemental reserve required under subsection (3) of this section shall be phased in as follows: Twenty-five percent of the otherwise applicable supplemental reserve is required until December 31, 2006; fifty percent of the otherwise applicable supplemental reserve is required until December 31, 2007; and seventy-five percent of the otherwise applicable supplemental reserve is required until December 31, 2008. [2005 c 223 § 16; 1947 c 79 § .29.12; Rem. Supp. 1947 § 45.29.12.]

48.29.130 Investments. A domestic title insurer shall invest its funds as follows:

(1) Funds in an amount not less than its reserve required by RCW 48.29.120 must be kept invested in investments eligible for domestic life insurers.

(2) Other funds may be invested in:

(a) The insurer's plant and equipment, up to a maximum of fifty percent of capital plus surplus.

(b) Stocks and bonds of abstract companies when approved by the commissioner.

(c) Investments eligible for the investment of funds of any domestic insurer. [2005 c 223 § 17; 1967 c 150 § 30; 1947 c 79 § .29.13; Rem. Supp. 1947 § 45.29.13.]

48.29.140 Premium rates—Required filings—Transition date set by rule. (1) Premium rates for the insuring or guaranteeing of titles shall not be excessive, inadequate, or unfairly discriminatory.

(2) Each title insurer shall forthwith file with the commissioner a schedule showing the premium rates to be charged by it. Every addition to or modification of such schedule or of any rate therein contained shall likewise be filed with the commissioner, and no such addition or modification shall be effective until expiration of fifteen days after date of such filing.

(3) The commissioner may order the modification of any premium rate or schedule of premium rates found by him or her after a hearing to be excessive, or inadequate, or unfairly discriminatory. No such order shall require retroactive modification.

(4) The commissioner shall by rule set a date, which shall not be earlier than January 1, 2010, by which title insurers must file every manual of rules and rates, rating plan, rate schedule, minimum rate, class rate, and rating rule, and every modification of any of these filings, under RCW 48.29.143 and 48.29.147, rather than under this section. [2008 c 110 § 8; 1947 c 79 § .29.14; Rem. Supp. 1947 § 45.29.14.]

48.29.143 Premium rates—Actuarially sound estimates. (1) Premium rates for the insuring or guaranteeing of titles shall not be excessive, inadequate, or unfairly discriminatory.

(2) A rate is not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer. Such costs include claims, claim settlement expenses, operational and administrative expenses, and the cost of capital. [2008 c 110 § 4.]

48.29.147 Required filings—Information subject to review—Commissioner's powers—Timing. (1)(a) Every title insurer shall, before using, file with the commissioner every form, manual of title insurance rules and rates, rating plan, rate schedule, minimum rate, class rate, and rating rule, and every modification of any of the filings under this subsection which it proposes.

(b) A rating organization's filing on behalf of its members or subscribers satisfies a title insurer's duty in (a) of this subsection if the title insurer is a member or subscriber of the rating organization.

(2) Every filing shall be accompanied by sufficient information to permit the commissioner to determine whether the filing meets the requirements of RCW 48.29.143 and this section for rate filings, and RCW 48.18.100 and 48.18.110 for form filings.

(3) Data used to justify title insurance rates may not include escrow income or expenses. The title insurance company or rating organization shall include a detailed explanation showing how expenses are allocated between the title operations and escrow operations of the insurer or title insurance agent.

(4) Every such filing shall state its proposed effective date.

(5) The commissioner shall review a filing as soon as reasonably possible after it is received, to determine whether it meets the requirements of RCW 48.29.143.

(6) The filing's proposed effective date shall be no earlier than thirty days after the date on which the filing is received by the commissioner. By giving notice to the insurer or rating organization within this thirty days, the commissioner may extend this waiting period for an additional period not to exceed an additional fifteen days. The commissioner may, upon application and for cause shown, waive part or all of the waiting period with respect to a filing the commissioner has not disapproved. If the commissioner does not disapprove the filing during the waiting period, the filing takes effect on its proposed effective date, except as to filings made by a rating organization on behalf of its members or subscribers pursuant to this section.

(7) If within the waiting period or any extension thereof as provided in subsection (6) of this section, the commissioner finds that a filing does not meet the requirements of RCW 48.29.143 or the requirements of subsections (2) through (4) of this section, the commissioner shall disapprove the filing and shall give notice to the insurer or rating organization that the filing has been disapproved. This notice must specify the respect in which the commissioner finds the filing fails to meet the requirements and must state that the filing does not become effective as proposed.

(8)(a) Except as to filings made by a rating organization on behalf of its members or subscribers pursuant to this section, if a filing is not disapproved by the commissioner within the waiting period or any extension thereof, the filing becomes effective as proposed.

(b) Before the commissioner approves a filing by a rating organization, the commissioner shall review all materials contained in the filing, including, as applicable, materials submitted by the rating organization, materials provided by the statistical reporting agent pursuant to RCW 48.29.017, as well as materials concerning any public hearings, market

investigations, studies, or other information collected during the review, and determine that the filing complies with the requirements of this chapter.

(c) Filings made by a rating organization on behalf of its members or subscribers pursuant to this section may not become effective, notwithstanding expiration of a waiting period, unless the commissioner approves the filings in accordance with (b) of this subsection.

(9) A filing made under this section is exempt from RCW 48.02.120(3). However, the filing and all supporting information accompanying it is open to public inspection only after the filing becomes effective.

(10) A title insurer or title insurance agent shall not make or issue a title insurance contract or policy, or use or collect any premium on or after a date set by the commissioner by rule, which date shall not be any earlier than January 1, 2010, except in accordance with rates and rules filed with the commissioner as required by this section or as provided under RCW 48.29.148.

(11) If at any time subsequent to the applicable review period provided for in subsection (6) of this section, the commissioner has reason to believe that a title insurer's or rating organization's rates do not meet the requirements of RCW 48.29.143 or are otherwise contrary to law, or if any person having an interest in the rates makes a written complaint to the commissioner setting forth specific and reasonable grounds for the complaint and requests a hearing, or if any insurer or rating organization upon notice of the commissioner's disapproval of a filing made under this section requests a hearing, the commissioner shall hold a hearing within thirty days and shall, in advance of it, give written notice of the hearing to all parties in interest. The commissioner may, by issuing an order, confirm, modify, change, or rescind any previous action, if it is warranted by the facts shown at the hearing. The order shall not affect any contract or policy made or issued prior to a reasonable period of time, to be specified in the order, after the order is issued.

(12) In any hearing regarding rates filed under this chapter the burden is on the title insurer or rating organization to prove by a preponderance of the evidence that the rates comply with RCW 48.29.143. [2017 c 103 § 21; 2008 c 110 § 5.]

48.29.148 Form and rate filings by rating organization. If so authorized by an insurer that is a member or subscriber of a rating organization, the commissioner shall accept, in lieu of filings by the insurer, form and rate filings on its behalf made by a rating organization then licensed as provided in this chapter. Rate filings accepted by the commissioner become effective only as provided in RCW 48.29.147. Form filings accepted by the commissioner become effective only as provided in chapter 48.18 RCW. [2017 c 103 § 3.]

48.29.149 Form and rate filings by rating organization—Deviation. Every member or subscriber to a rating organization shall adhere to the filings made on its behalf by such rating organization. Deviations from the rating organization's filings are permitted only when filed with the commissioner in accordance with this title. A copy of the deviation filing must be sent simultaneously to such rating organization. [2017 c 103 § 14.]

48.29.150 Taxation of title insurers. Title insurers and their property shall be taxed by this state in accordance with the general laws relating to taxation, and not otherwise. [1947 c 79 § .29.15; Rem. Supp. 1947 § 45.29.15.]

48.29.155 Agent license—Financial responsibility—Definitions. (1) At the time of filing an application for a title insurance agent license, or any renewal or reinstatement of a title insurance agent license, the applicant shall provide satisfactory evidence to the commissioner of having obtained the following as evidence of financial responsibility:

(a) A fidelity bond or fidelity insurance providing coverage in the aggregate amount of two hundred thousand dollars with a deductible no greater than ten thousand dollars covering the applicant and each corporate officer, partner, escrow officer, and employee of the applicant conducting the business of an escrow agent as defined in RCW 18.44.011 and exempt from licensing under *RCW 18.44.021(6), or a guarantee from a licensed title insurance company as authorized by subsection (5) of this section; and

(b) A surety bond in the amount of ten thousand dollars executed by the applicant as obligor and by a surety company authorized, or eligible under chapter 48.15 RCW, to do a surety business in this state as surety, or some other security approved by the commissioner, unless the fidelity bond or fidelity insurance obtained by the licensee to satisfy the requirement in (a) of this subsection does not have a deductible. The bond shall run to the state of Washington as obligee, and shall run to the benefit of the state and any person or persons who suffer loss by reason of the applicant's or its employee's violation of this chapter. The bond shall be conditioned that the obligor as licensee will faithfully conform to and abide by this chapter and all rules adopted under this chapter, and shall reimburse all persons who suffer loss by reason of a violation of this chapter or rules adopted under this chapter. The bond shall be continuous and may be canceled by the surety upon the surety giving written notice to the commissioner of its intent to cancel the bond. The cancellation shall be effective thirty days after the notice is received by the commissioner. Whether or not the bond is renewed, continued, reinstated, reissued, or otherwise extended, replaced, or modified, including increases or decreases in the penal sum, it shall be considered one continuous obligation, and the surety upon the bond shall not be liable in an aggregate amount exceeding the penal sum set forth on the face of the bond. In no event shall the penal sum, or any portion thereof, at two or more points in time be added together in determining the surety's liability. The bond is not liable for any penalties imposed on the licensee, including but not limited to any increased damages or attorneys' fees, or both, awarded under RCW 19.86.090.

(2) For the purposes of this section, a "fidelity bond" means a primary commercial blanket bond or its equivalent satisfactory to the commissioner and written by an insurer authorized, or eligible under chapter 48.15 RCW, to transact this line of business in the state of Washington. The bond shall provide fidelity coverage for any fraudulent or dishonest acts committed by any one or more of the employees, officers, or owners as defined in the bond, acting alone or in collusion with others. The bond shall be for the sole benefit of the title insurance agent and under no circumstances whatso-

ever shall the bonding company be liable under the bond to any other party. The bond shall name the title insurance agent as obligee and shall protect the obligee against the loss of money or other real or personal property belonging to the obligee, or in which the obligee has a pecuniary interest, or for which the obligee is legally liable or held by the obligee in any capacity, whether the obligee is legally liable therefor or not. The bond may be canceled by the insurer upon delivery of thirty days' written notice to the commissioner and to the title insurance agent.

(3) For the purposes of this section, "fidelity insurance" means employee dishonesty insurance or its equivalent satisfactory to the commissioner and written by an insurer authorized, or eligible under chapter 48.15 RCW, to transact this line of business in the state of Washington. The insurance shall provide coverage for any fraudulent or dishonest acts committed by any one or more of the employees, officers, or owners as defined in the policy of insurance, acting alone or in collusion with others. The insurance shall be for the sole benefit of the title insurance agent and under no circumstances whatsoever shall the insurance company be liable under the insurance to any other party. The insurance shall name the title insurance agent as the named insured and shall protect the named insured against the loss of money or other real or personal property belonging to the named insured, or in which the named insured has a pecuniary interest, or for which the named insured is legally liable or held by the named insured in any capacity, whether the named insured is legally liable therefor or not. The insurance coverage may be canceled by the insurer upon delivery of thirty days' written notice to the commissioner and to the title insurance agent.

(4) The fidelity bond or fidelity insurance, and the surety bond or other form of security approved by the commissioner, shall be kept in full force and effect as a condition precedent to the title insurance agent's authority to transact business in this state, and the title insurance agent shall supply the commissioner with satisfactory evidence thereof upon request.

(5) A title insurance company authorized to do business in Washington under RCW 48.05.030 may provide a guarantee in a form satisfactory to the commissioner accepting financial responsibility, up to the aggregate amount of two hundred thousand dollars, for any fraudulent or dishonest acts committed by any one or more of the employees, officers, or owners of a title insurance agent that is appointed as the title insurance company's agent. A title insurance company providing a guarantee as permitted under this subsection may only do so on behalf of its properly appointed title insurance agents. If the title insurance agent is an agent for two or more title insurance companies, any liability under the guarantee shall be borne by the title insurance company for those escrows for which a title insurance commitment or policy was issued on behalf of that title insurance company. If no commitment or policy was issued regarding the escrow for which moneys were lost, including but not limited to collection escrows, each title insurance company, for which the agent was appointed at the time of the fraudulent or dishonest act, shares in the liability. The liability will be shared proportionally, as follows: The premium the agent remitted to the title insurance company in the year prior to the fraudulent or dishonest act will be compared to the total premium the agent

remitted to all title insurance companies, for whom the title insurance agent was appointed, during the same period.

(6) All title insurance agents licensed on or before July 24, 2005, shall comply with this section within thirty days following July 24, 2005. [2005 c 115 § 1; 2003 c 202 § 1.]

*Reviser's note: RCW 18.44.021 was amended by 2015 c 229 § 1, changing subsection (6) to subsection (1)(f).

48.29.160 Agents—County tract indexes required.

To be licensed as [an] agent of a title insurer, the applicant must own or lease and maintain a complete set of tract indexes of the county or counties in which such agent will do business. [1981 c 223 § 1.]

48.29.170 Agents—Separate licenses for individuals not required. Title insurance agents are exempt from the provisions of *RCW 48.17.180(1) that require that each individual empowered to exercise the authority of a licensed firm or corporation must be separately licensed. [2005 c 223 § 18; 1981 c 223 § 2.]

*Reviser's note: RCW 48.17.180 was amended by 2007 c 117 § 15, deleting subsection (1), effective July 1, 2009.

48.29.180 Disclosure of energy conservation payment obligations—Informational note—Liability. The existence of notices of payment obligations in RCW 80.28.065 may be disclosed as an informational note to a preliminary commitment for policy of title insurance. Neither the inclusion nor the exclusion of any such informational note shall create any liability against such title insurer under any preliminary commitment for title insurance, policy or otherwise. [1993 c 245 § 4.]

Findings—Intent—1993 c 245: See note following RCW 80.28.065.

48.29.190 Conducting business as escrow agent—Requirements—Violation, penalties. (1) Every title insurance company and title insurance agent conducting the business of an escrow agent as defined in RCW 18.44.011 and exempt from licensing under *RCW 18.44.021(6) shall:

(a) Keep adequate records, as determined by rule by the insurance commissioner, of all transactions handled by the title insurance company or title insurance agent, including itemization of all receipts and disbursements of each transaction. These records shall be maintained in this state, unless otherwise approved by the insurance commissioner, for a period of six years from completion of the transaction. These records shall be open to inspection by the insurance commissioner or his or her authorized representatives;

(b) Keep separate escrow fund account or accounts in a recognized Washington state depository or depositories authorized to receive funds, in which shall be kept separate and apart and segregated from the title insurance company or title insurance agent's own funds, all funds or moneys of clients which are being held by the title insurance company or title insurance agent pending the closing of a transaction and such funds shall be deposited not later than the first banking day following receipt thereof; and

(c) Not make disbursements on any escrow account without first receiving deposits directly relating to the account in amounts at least equal to the disbursements. A title insurance company or title insurance agent shall not make

disbursements until the next business day after the business day on which the funds are deposited unless the deposit is made in cash, by interbank electronic transfer, or in a form that permits conversion of the deposit to cash on the same day the deposit is made. The deposits shall be in one of the following forms:

(i) Cash;

(ii) Interbank electronic transfers such that the funds are unconditionally received by the title insurance company or the title insurance agent or the title insurance company or title insurance agent's depository;

(iii) Checks, negotiable orders of withdrawal, money orders, cashier's checks, and certified checks that are payable in Washington state and drawn on financial institutions located in Washington state;

(iv) Checks, negotiable orders of withdrawal, money orders, and any other item that has been finally paid as described in RCW 62A.4-213 before any disbursement; or

(v) Any depository check, including any cashier's check, certified check, or teller's check, which is governed by the provisions of the federal expedited funds availability act, 12 U.S.C. Sec. 4001 et seq.

(2) For purposes of this section, "item" means any instrument for the payment of money even though it is not negotiable, but does not include money.

(3) Violation of this section shall subject a title insurance company or title insurance agent to penalties as prescribed in Title 9A RCW and remedies as provided in chapter 19.86 RCW and shall constitute grounds for suspension or revocation of the certificate of authority of a title insurance company or the license of a title insurance agent. In addition, a violation of this section may subject a title insurance company or a title insurance agent to penalties as prescribed in this title. [1999 c 30 § 34.]

*Reviser's note: RCW 18.44.021 was amended by 2015 c 229 § 1, changing subsection (6) to subsection (1)(f).

48.29.193 Escrow services—Schedule of fees filed with commissioner. (1) Each title insurer and title insurance agent shall immediately file with the commissioner a schedule of its fees for providing escrow services.

(2) The schedule shall:

(a) Be dated to show the date the fees for providing escrow services are to become effective, which date shall be no earlier than fifteen days after the schedule has been filed with the commissioner; and

(b) Set forth the total fees for providing escrow services by clearly stating the amounts to be charged for the escrow services, the manner in which the fees for the escrow services are to be determined, and any charges that will be charged to the consumer that are not included in the total escrow fee. [2008 c 110 § 6.]

48.29.195 Escrow services—Schedule of fees made available to public. (1) Each title insurer and title insurance agent shall make available to the public schedules of its currently effective title insurance premiums and fees for providing escrow services.

(2) The schedules shall:

(a) Be dated to show the date the title insurance premiums or fees for providing escrow services became effective;

(b) Be made available to the public during normal business hours in each office of the title insurer and its appointed title insurance agents in this state;

(c) Be made available on the title insurer's and title insurance agent's web site, if the title insurer or title insurance agent has a web site;

(d) Set forth the total title insurance premium charged for the title insurance policy issued by the title insurer either by stating the premium for each title insurance policy in given amounts of coverage, or by stating the charge per unit amount of coverage, or by a combination of the two; and

(e) Set forth the total fees for providing escrow services by clearly stating the amounts to be charged for the escrow services, the manner in which the fees for the escrow services are to be determined, and any charges that will be charged to the consumer that are not included in the total escrow fee.

(3) Each title insurer and title insurance agent shall keep a complete file of its schedules of title insurance premiums and fees for providing escrow services and all changes and amendments to those schedules until at least one year after they have ceased to be in effect. [2008 c 110 § 7.]

48.29.200 Prohibited practices. It is a violation of this chapter for any title insurance company and title insurance agent in the conduct of the business of an escrow agent as defined in RCW 18.44.011 and exempt from licensing under *RCW 18.44.021(6) to:

(1) Directly or indirectly employ any scheme, device, or artifice to defraud or mislead borrowers or lenders or to defraud any person;

(2) Directly or indirectly engage in any unfair or deceptive act or practice toward any person;

(3) Directly or indirectly obtain property by fraud or misrepresentation;

(4) Knowingly make, publish, or disseminate any false, deceptive, or misleading information in the conduct of the business of escrow, or relative to the business of escrow or relative to any person engaged therein;

(5) Knowingly receive or take possession for personal use of any property of any escrow business, other than in payment authorized by this chapter, and with intent to defraud, omit to make, or cause or direct to be made, a full and true entry thereof in the books and accounts of the title insurance company or title insurance agent;

(6) Make or concur in making any false entry, or omit or concur in omitting to make any material entry, in its books or accounts;

(7) Knowingly make or publish, or concur in making or publishing any written report, exhibit, or statement of its affairs or pecuniary condition containing any material statement which is false, or omit or concur in omitting any statement required by law to be contained therein;

(8) Willfully fail to make any proper entry in the books of the escrow business as required by law;

(9) Fail to disclose in a timely manner to the other officers, directors, controlling persons, or employees the receipt of service of a notice of an application for an injunction or other legal process affecting the property or business of a title insurance company or title insurance agent conducting an escrow business, including an order to cease and desist or other order of the insurance commissioner; or

(10) Fail to make any report or statement lawfully required by the insurance commissioner or other public official. [1999 c 30 § 35.]

*Reviser's note: RCW 18.44.021 was amended by 2015 c 229 § 1, changing subsection (6) to subsection (1)(f).

48.29.210 Business inducements—Prohibited practices. (1) A title insurer, title insurance agent, or employee, agent, or other representative of a title insurer or title insurance agent shall not, directly or indirectly, give any fee, kick-back, or other thing of value to any person as an inducement, payment, or reward for placing business, referring business, or causing title insurance business to be given to either the title insurer, or title insurance agent, or both.

(2) A title insurer, title insurance agent, or employee, agent, or other representative of a title insurer or title insurance agent shall not, directly or indirectly, give anything of value to any person in a position to refer or influence the referral of title insurance business to either the title insurance company or title insurance agent, or both, except as permitted under rules adopted by the commissioner. [2008 c 110 § 3.]

48.29.213 Return on ownership interest—Certain payments authorized. (1) RCW 48.29.210, 18.85.053, 18.44.305, or 19.146.103 does not make unlawful the payment by a title insurer or title insurance agent and the receipt by a producer of title insurance business of a return on ownership interest in the title insurer or title insurance agent.

(2) A return on ownership interest may include:

(a) Bona fide dividends, and capital or equity distributions, related to ownership interest or franchise relationship, between entities in an affiliated relationship; and

(b) Bona fide business loans, advances, and capital or equity contributions between entities in an affiliate relationship (in any direction), so long as they are for ordinary business purposes and are not fees for the referral of settlement service business or unearned fees.

(3) A return on ownership interest does not include:

(a) Any payment which has a basis of calculation of no apparent business motive other than distinguishing among recipients of payments on the basis of the amount of their actual, estimated, or anticipated referrals;

(b) Any payment which varies according to the relative amount of referrals by the different recipients of similar payments; or

(c) A payment based on an ownership, partnership, or joint venture share which has been adjusted on the basis of previous relative referrals by recipients of similar payments. [2008 c 110 § 13.]

48.29.400 Rating organizations—Intent. It is the legislature's intent to establish a system by which title insurers may adopt a rating organization's form and rate filings pursuant to this chapter in order to benefit consumers and entities purchasing, selling, or financing real property. It is further the legislature's intent that the system so established under state oversight comply with state and federal law so that title insurers and rating organizations acting in accordance with this chapter may lawfully cooperate in the preparation of title insurance forms and manuals, and the recommendation of

rates, subject to approval by the commissioner. [2017 c 103 § 1.]

48.29.405 Rating organizations—License required. A rating organization may not do business in this state or make filings with the commissioner unless then licensed by the commissioner as a rating organization. [2017 c 103 § 4.]

48.29.410 Rating organizations—License applications. Any person, whether domiciled within or outside this state, except as provided in this section, may make application to the commissioner for a license as a rating organization for title insurance. The application must include:

- (1) A copy of the applicant's constitution, articles of agreement or association, certificate of incorporation, or trust agreement, and of its bylaws, rules, and regulations governing the conduct of its business;
- (2) A list of its members and a list of its subscribers;
- (3) The name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served; and
- (4) A statement of its qualifications as a rating organization. [2017 c 103 § 5.]

48.29.415 Rating organizations—License issuance—Term. (1) If the commissioner finds that the applicant for a license as a rating organization is competent, trustworthy, and otherwise qualified to act, and that its constitution, articles of agreement or association, certificate of incorporation, or trust agreement, and its bylaws, rules, and regulations governing the conduct of its business conform to the requirements of law, the commissioner shall, upon payment of a license fee of the amount established by the commissioner pursuant to RCW 48.29.005, issue a license authorizing the applicant to act as a rating organization for title insurance.

(2) The commissioner shall grant or deny in whole or in part every such application within sixty days of the date of its filing.

(3) A license issued pursuant to this section remains in effect for three years unless sooner suspended or revoked by the commissioner. [2017 c 103 § 6.]

48.29.420 Rating organizations—License suspension and revocation. (1) The commissioner may, after a hearing, suspend or revoke the license issued to a rating organization for any of the following causes:

(a) The commissioner finds that the licensee no longer meets the qualifications for the license.

(b) The rating organization fails to comply with an order of the commissioner within the time limited by the order, or any extension thereof which the commissioner may grant.

(2) The commissioner shall not so suspend or revoke a license for failure to comply with an order until the time prescribed by this code for an appeal from such order to the superior court has expired or if such appeal has been taken, until such order has been affirmed.

(3) The commissioner may determine when a suspension or revocation of license is effective. A suspension of license remains in effect for the period fixed by the commissioner, unless the commissioner modifies or rescinds the suspension, or until the order, failure to comply with which constituted

grounds for the suspension, is modified, rescinded, or reversed. [2017 c 103 § 7.]

48.29.425 Rating organizations—Commissioner notification. Every rating organization shall notify the commissioner promptly of every change in:

(1) Its constitution, its articles of agreement or association, its certificate of incorporation, or trust agreement, and its bylaws, rules, and regulations governing the conduct of its business;

(2) Its list of members and subscribers; and

(3) The name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting such rating organization may be served. [2017 c 103 § 8.]

48.29.430 Rating organizations—Subscribers. (1) Subject to rules and regulations approved by the commissioner as reasonable, each rating organization shall permit any title insurance company, not a member, to subscribe to its rating services.

(2) Notice of proposed changes to the rules and regulations must be given to each subscriber.

(3) A title insurer shall not concurrently be a subscriber to the services of more than one rating organization.

(4) The subscribers of any rating organization may, from time to time, individually or through committees representing various subscribers, consult with the rating organization with respect to matters within this chapter that affect such subscribers. [2017 c 103 § 9.]

48.29.435 Rating organizations—Review by commissioner. (1) The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the commissioner at a hearing held upon notice to the rating organization and to the subscriber or insurer.

(2) If the commissioner finds that a rule or regulation is unreasonable in its application to subscribers, the commissioner shall order that the rule or regulation is not applicable to subscribers that are not members of the rating organization.

(3) If a rating organization fails to grant or reject an insurer's application for subscribership within thirty days after it was made, the insurer may request a review by the commissioner as if the application had been rejected. If the commissioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, the commissioner shall order the rating organization to admit the insurer as a subscriber. If the commissioner finds that the action of the rating organization was justified, the commissioner shall make an order affirming its action. [2017 c 103 § 10.]

48.29.440 Rating organizations—Cooperative activities and practices. (1) Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this chapter is hereby authorized and the filings resulting from such cooper-

ation are subject to all the provisions of this title that are applicable to filings generally.

(2) The commissioner shall review such cooperative activities and practices and if, after a hearing, the commissioner finds that any such activity or practice is inconsistent with the provisions of this code, the commissioner may issue a written order specifying in what respect such activity or practice is so inconsistent, and requiring the discontinuance of such activity or practice. [2017 c 103 § 11.]

48.29.445 Rating organizations—Actuarial, technical, and other services. Any rating organization may subscribe for or purchase actuarial, technical, or other services, and such services must be available to all subscribers without discrimination. [2017 c 103 § 12.]

48.29.450 Rating organizations—Records—Commissioner cost recovery rules. (1) Each rating organization shall keep an accurate and complete record of all work performed by it, and of all its receipts and disbursements. Such rating organization and its records shall be examined by the commissioner at such times and in such manner as is provided in chapter 48.03 RCW.

(2) The commissioner may adopt rules to enable the commissioner to recover the costs of the commissioner's examination of a rating organization from the rating organization or the rating organization's members and subscribers. [2017 c 103 § 13.]

48.29.455 Rating organizations—Members and subscribers—Appeal to commissioner. (1) Any member or subscriber to a rating organization may appeal to the commissioner from the rating organization's action or decision in approving or rejecting any proposed change in or addition to the rating organization's filings. The commissioner shall, after a hearing on the appeal:

(a) Issue an order approving the rating organization's action or decision or directing it to give further consideration to such proposal; or

(b) If the appeal is from the rating organization's action or decision in rejecting a proposed addition to its filings, the commissioner may, upon finding that the action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filings, on behalf of its subscribers, in a manner consistent with the commissioner's findings, within a reasonable time after the issuance of such order.

(2) If such appeal is based upon the rating organization's failure to make a filing on behalf of such subscriber which is based on a system of expense provisions that differs from the system of expense provisions included in a filing made by the rating organization, the commissioner shall, if the appeal is granted, order the rating organization to make the requested filing for use by the appellant.

(3) In deciding the appeal the commissioner shall apply the standards set forth in RCW 48.29.143 and 48.29.147 for rate filings, and the standards set forth in RCW 48.18.100 and 48.18.110 for form filings. [2017 c 103 § 15.]

48.29.460 Rating organizations—Members and subscribers—Discrimination. (1) Every rating organization

operating in this state shall furnish its services without discrimination as between its members and subscribers.

(2) This chapter is not intended to and does not govern or affect the membership relation as such between a rating organization and insurers that are its members. [2017 c 103 § 16.]

48.29.465 Rating organizations—Membership or subscription not required. This chapter does not require any insurer to be a member of or subscriber to, or in any other respect affiliated with, any rating organization. [2017 c 103 § 17.]

48.29.470 Rating organizations—Aggregate information and experience data—Exchange. Every rating organization may exchange aggregate information and experience data with insurers, rating organizations in this state, and the statistical reporting agent designated in accordance with RCW 48.29.017, and may consult with insurers and rating organizations in this state with respect to form and rate making and the application of rating systems, except to the extent that an agreement between a rating organization and its member or subscriber prohibits the rating organization from disclosing any information or experience data of such member or subscriber to other insurers, members, subscribers, rating organizations, or the statistical reporting agent. [2017 c 103 § 18.]

48.29.500 Advisory organizations—Filings with commissioner. Every advisory organization before serving as such to any rating organization or insurer doing business in this state must provide the following to the commissioner:

(1) A copy of its constitution, its articles of agreement or association, or its certificate of incorporation and of its bylaws, rules, and regulations governing its activities;

(2) A list of its members;

(3) The name and address of a resident of this state upon whom notices or orders of the commissioner or process issued at his or her direction may be served; and

(4) An agreement that the commissioner may examine such advisory organization in accordance with the provisions of RCW 48.03.010. [2017 c 103 § 19.]

48.29.510 Advisory organizations—Acts and practices inconsistent with chapter. If, after a hearing, the commissioner finds that the furnishing of information or assistance by an advisory organization involves any act or practice that is inconsistent with the provisions of this code, the commissioner may issue a written order specifying in what respect such act or practice is so inconsistent, and requiring the discontinuance of such act or practice. [2017 c 103 § 20.]

48.29.901 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 § 122.]

Chapter 48.30 RCW

UNFAIR PRACTICES AND FRAUDS

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48.30.900	Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

Discrimination prohibited: RCW 48.18.480.

48.30.010 Unfair practices in general—Remedies and penalties. (1) No person engaged in the business of insurance shall engage in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of such business as such methods, acts, or practices are defined pursuant to subsection (2) of this section.

(2) In addition to such unfair methods and unfair or deceptive acts or practices as are expressly defined and prohibited by this code, the commissioner may from time to time by regulation promulgated pursuant to chapter 34.05 RCW, define other methods of competition and other acts and practices in the conduct of such business reasonably found by the

commissioner to be unfair or deceptive after a review of all comments received during the notice and comment rule-making period.

(3)(a) In defining other methods of competition and other acts and practices in the conduct of such business to be unfair or deceptive, and after reviewing all comments and documents received during the notice and comment rule-making period, the commissioner shall identify his or her reasons for defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive and shall include a statement outlining these reasons as part of the adopted rule.

(b) The commissioner shall include a detailed description of facts upon which he or she relied and of facts upon which he or she failed to rely, in defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive, in the concise explanatory statement prepared under RCW 34.05.325(6).

(c) Upon appeal the superior court shall review the findings of fact upon which the regulation is based de novo on the record.

(4) No such regulation shall be made effective prior to the expiration of thirty days after the date of the order by which it is promulgated.

(5) If the commissioner has cause to believe that any person is violating any such regulation, the commissioner may order such person to cease and desist therefrom. The commissioner shall deliver such order to such person direct or mail it to the person by registered mail with return receipt requested. If the person violates the order after expiration of ten days after the cease and desist order has been received by him or her, he or she may be fined by the commissioner a sum not to exceed two hundred and fifty dollars for each violation committed thereafter.

(6) If any such regulation is violated, the commissioner may take such other or additional action as is permitted under the insurance code for violation of a regulation.

(7) An insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any first party claimant. "First party claimant" has the same meaning as in RCW 48.30.015. [2007 c 498 § 2 (Referendum Measure No. 67, approved November 6, 2007); 1997 c 409 § 107; 1985 c 264 § 13; 1973 1st ex.s. c 152 § 6; 1965 ex.s. c 70 § 24; 1947 c 79 § .30.01; Rem. Supp. 1947 § 45.30.01.]

Additional notes found at www.leg.wa.gov

48.30.015 Unreasonable denial of a claim for coverage or payment of benefits. (1) Any first party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action in the superior court of this state to recover the actual damages sustained, together with the costs of the action, including reasonable attorneys' fees and litigation costs, as set forth in subsection (3) of this section.

(2) The superior court may, after finding that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated a rule in subsection (5) of this section, increase the total award of damages to an amount not to exceed three times the actual damages.

(3) The superior court shall, after a finding of unreasonable denial of a claim for coverage or payment of benefits, or after a finding of a violation of a rule in subsection (5) of this section, award reasonable attorneys' fees and actual and statutory litigation costs, including expert witness fees, to the first party claimant of an insurance contract who is the prevailing party in such an action.

(4) "First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

(5) A violation of any of the following is a violation for the purposes of subsections (2) and (3) of this section:

(a) WAC 284-30-330, captioned "specific unfair claims settlement practices defined";

(b) WAC 284-30-350, captioned "misrepresentation of policy provisions";

(c) WAC 284-30-360, captioned "failure to acknowledge pertinent communications";

(d) WAC 284-30-370, captioned "standards for prompt investigation of claims";

(e) WAC 284-30-380, captioned "standards for prompt, fair and equitable settlements applicable to all insurers"; or

(f) An unfair claims settlement practice rule adopted under RCW 48.30.010 by the insurance commissioner intending to implement this section. The rule must be codified in chapter 284-30 of the Washington Administrative Code.

(6) This section does not limit a court's existing ability to make any other determination regarding an action for an unfair or deceptive practice of an insurer or provide for any other remedy that is available at law.

(7) This section does not apply to a health plan offered by a health carrier. "Health plan" has the same meaning as in RCW 48.43.005. "Health carrier" has the same meaning as in RCW 48.43.005.

(8)(a) Twenty days prior to filing an action based on this section, a first party claimant must provide written notice of the basis for the cause of action to the insurer and office of the insurance commissioner. Notice may be provided by regular mail, registered mail, or certified mail with return receipt requested. Proof of notice by mail may be made in the same manner as prescribed by court rule or statute for proof of service by mail. The insurer and insurance commissioner are deemed to have received notice three business days after the notice is mailed.

(b) If the insurer fails to resolve the basis for the action within the twenty-day period after the written notice by the first party claimant, the first party claimant may bring the action without any further notice.

(c) The first party claimant may bring an action after the required period of time in (a) of this subsection has elapsed.

(d) If a written notice of claim is served under (a) of this subsection within the time prescribed for the filing of an action under this section, the statute of limitations for the action is tolled during the twenty-day period of time in (a) of this subsection. [2007 c 498 § 3 (Referendum Measure No. 67, approved November 6, 2007).]

Additional notes found at www.leg.wa.gov

48.30.020 Anticomcompact law. (1) No person shall either within or outside of this state enter into any contract, understanding or combination with any other person to do jointly or severally any act or engage in any practice for the purpose of

(a) controlling the rates to be charged for insuring any risk or any class of risks in this state; or

(b) unfairly discriminating against any person in this state by reason of his or her plan or method of transacting insurance, or by reason of his or her affiliation or nonaffiliation with any insurance organization; or

(c) establishing or perpetuating any condition in this state detrimental to free competition in the business of insurance or injurious to the insuring public.

(2) This section shall not apply relative to ocean marine and foreign trade insurances.

(3) This section shall not be deemed to prohibit the doing of things permitted to be done in accordance with the provisions of chapter 48.19 RCW of this code.

(4) Whenever the commissioner has knowledge of any violation of this section he or she shall forthwith order the offending person to discontinue such practice immediately or show cause to the satisfaction of the commissioner why such order should not be complied with. If the offender is an insurer or a licensee under this code and fails to comply with such order within thirty days after receipt thereof, the commissioner may forthwith revoke the offender's certificate of authority or licenses. [2009 c 549 § 7118; 1947 c 79 § .30.02; Rem. Supp. 1947 § 45.30.02.]

48.30.030 False financial statements. No person shall knowingly file with any public official nor knowingly make, publish, or disseminate any financial statement of an insurer which does not accurately state the insurer's financial condition. [1947 c 79 § .30.03; Rem. Supp. 1947 § 45.30.03.]

48.30.040 False information and advertising. No person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance or relative to any person engaged therein. [1947 c 79 § .30.04; Rem. Supp. 1947 § 45.30.04.]

48.30.050 Advertising must show name and domicile. Every advertisement of, by, or on behalf of an insurer shall set forth the name in full of the insurer and the location of its home office or principal office, if any, in the United States (if an alien insurer). [1947 c 79 § .30.05; Rem. Supp. 1947 § 45.30.05.]

48.30.060 Insurer name—Deceptive use prohibited. No person who is not an insurer shall assume or use any name which deceptively infers or suggests that it is an insurer. [1947 c 79 § .30.06; Rem. Supp. 1947 § 45.30.06.]

48.30.070 Advertising of financial condition. (1) Every advertisement by or on behalf of any insurer purporting to show its financial condition may be in a condensed form but shall in substance correspond with the insurer's last verified statement filed with the commissioner.

(2) No insurer or person in its behalf shall advertise assets except those actually owned and possessed by the insurer in its own exclusive right, available for the payment of losses and claims, and held for the protection of its policyholders and creditors. [1947 c 79 § .30.07; Rem. Supp. 1947 § 45.30.07.]

48.30.075 Using existence of insurance guaranty associations in advertising, etc., to sell insurance. No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement which uses the existence of the Washington Insurance Guaranty Association or the Washington Life and Disability Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Washington Insurance Guaranty Association Act or the Washington Life and Disability Insurance Guaranty Association Act. [1975-'76 2nd ex.s. c 109 § 9.]

48.30.080 Defamation of insurer. No person shall make, publish, or disseminate, or aid, abet or encourage the making, publishing, or dissemination of any information or statement which is false or maliciously critical and which is designed to injure in its reputation or business any authorized insurer or any domestic corporation or reciprocal being formed pursuant to this code for the purpose of becoming an insurer. [1947 c 79 § .30.08; Rem. Supp. 1947 § 45.30.08.]

48.30.090 Misrepresentation of policies. No person shall make, issue or circulate, or cause to be made, issued or circulated any misrepresentation of the terms of any policy or the benefits or advantages promised thereby, or the dividends or share of surplus to be received thereon, or use any name or title of any policy or class of policies misrepresenting the nature thereof. [1947 c 79 § .30.09; Rem. Supp. 1947 § 45.30.09.]

48.30.100 Dividends not to be guaranteed. No insurer, insurance producer, title insurance agent, or other person shall guarantee or agree to the payment of future dividends or future refunds of unused premiums or savings in any specific or approximate amounts or percentages on account of any insurance contract. [2008 c 217 § 34; 1947 c 79 § .30.10; Rem. Supp. 1947 § 45.30.10.]

Additional notes found at www.leg.wa.gov

48.30.110 Contributions to candidates for insurance commissioner. (1) No insurer or fraternal benefit society doing business in this state shall directly or indirectly pay or use, or offer, consent, or agree to pay or use any money or thing of value for or in aid of any candidate for the office of insurance commissioner; nor for reimbursement or indemnification of any person for money or property so used.

(2) Any individual who violates any provision of this section, or who participates in, aids, abets, advises, or consents to any such violation, or who solicits or knowingly

receives any money or thing of value in violation of this section, shall be guilty of a gross misdemeanor and shall be liable to the insurer or society for the amount so contributed or received. [1982 c 181 § 18; 1947 c 79 § .30.11; Rem. Supp. 1947 § 45.30.11.]

Additional notes found at www.leg.wa.gov

48.30.120 Misconduct of officers, employees. No director, officer, agent, attorney-in-fact, or employee of an insurer shall:

(1) Knowingly receive or possess himself or herself of any of its property, otherwise than in payment for a just demand, and with intent to defraud, omit to make or to cause or direct to be made, a full and true entry thereof in its books and accounts; nor

(2) Make or concur in making any false entry, or concur in omitting to make any material entry, in its books or accounts; nor

(3) Knowingly concur in making or publishing any written report, exhibit or statement of its affairs or pecuniary condition containing any material statement which is false, or omit or concur in omitting any statement required by law to be contained therein; nor

(4) Having the custody or control of its books, willfully fail to make any proper entry in the books of the insurer as required by law, or to exhibit or allow the same to be inspected and extracts to be taken therefrom by any person entitled by law to inspect the same, or take extracts therefrom; nor

(5) If a notice of an application for an injunction or other legal process affecting or involving the property or business of the insurer is served upon him or her, fail to disclose the fact of such service and the time and place of such application to the other directors, officers, and managers thereof; nor

(6) Fail to make any report or statement lawfully required by a public officer. [2010 c 8 § 11004; 2009 c 549 § 7119; 1947 c 79 § .30.12; Rem. Supp. 1947 § 45.30.12.]

48.30.130 Presumption of knowledge of director. A director of an insurer is deemed to have such knowledge of its affairs as to enable him or her to determine whether any act, proceeding, or omission of its directors is a violation of any provision of this chapter. If present at a meeting of directors at which any act, proceeding, or omission of its directors which is a violation of any such provision occurs, he or she must be deemed to have concurred therein unless at the time he or she causes or in writing requires his or her dissent therefrom to be entered on the minutes of the directors.

If absent from such meeting, he or she must be deemed to have concurred in any such violation if the facts constituting such violation appear on the records or minutes of the proceedings of the board of directors, and he or she remains a director of the insurer for six months thereafter without causing or in writing requiring his or her dissent from such violation to be entered upon such record or minutes. [2009 c 549 § 7120; 1947 c 79 § .30.13; Rem. Supp. 1947 § 45.30.13.]

48.30.133 Gifts, etc., for the referral of insurance business—Restrictions. (1) An insurance producer may give to an individual, prizes, goods, wares, gift cards, gift certificates, or merchandise not exceeding one hundred dollars

in value per person in any consecutive twelve-month period for the referral of insurance business to the insurance producer, if the giving of the prizes, goods, wares, gift cards, gift certificates, or merchandise is not conditioned upon the person who is referred applying for or obtaining insurance through the insurance producer.

(2) The payment for the referral must not be in cash, currency, bills, coins, check, or by money order.

(3) The provisions of RCW 48.30.140 and 48.30.150 do not apply to prizes, goods, wares, gift cards, gift certificates, or merchandise given to a person in compliance with subsections (1) and (2) of this section.

(4) Notwithstanding subsections (1) and (2) of this section, an insurance producer may pay to an unlicensed individual who is neither an insured nor a prospective insured a referral fee conditioned on the submission of an application if made in compliance with the provisions of RCW 48.17.490(4). [2015 c 272 § 3.]

48.30.135 Sponsoring events or making contributions—Definitions. (Effective until January 1, 2022.) (1) An insurance producer may sponsor events for, or make contributions to a bona fide charitable or nonprofit organization, if the sponsorship or contribution is not conditioned upon the organization applying for or obtaining insurance through the insurance producer.

(2) For purposes of this section, a bona fide charitable or nonprofit organization is:

(a) Any nonprofit corporation duly existing under the provisions of chapter 24.03 RCW for charitable, benevolent, eleemosynary, educational, civic, patriotic, political, social, fraternal, cultural, athletic, scientific, agricultural, or horticultural purposes;

(b) Any professional, commercial, industrial, or trade association;

(c) Any organization duly existing under the provisions of chapter 24.12, 24.20, or 24.28 RCW;

(d) Any agricultural fair authorized under the provisions of chapter 15.76 or 36.37 RCW; or

(e) Any nonprofit organization, whether incorporated or otherwise, when determined by the commissioner to be organized and operated for one or more of the purposes described in (a) through (d) of this subsection.

(3) RCW 48.30.140 and 48.30.150 do not apply to sponsorships or charitable contributions that are provided or given in compliance with subsection (1) of this section. [2015 c 272 § 4.]

48.30.135 Sponsoring events or making contributions—Definitions. (Effective January 1, 2022.) (1) An insurance producer may sponsor events for, or make contributions to a bona fide charitable or nonprofit organization, if the sponsorship or contribution is not conditioned upon the organization applying for or obtaining insurance through the insurance producer.

(2) For purposes of this section, a bona fide charitable or nonprofit organization is:

(a) Any nonprofit corporation duly existing under the provisions of chapter 24.03A RCW for charitable, benevolent, eleemosynary, educational, civic, patriotic, political,

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social, fraternal, cultural, athletic, scientific, agricultural, or horticultural purposes;

(b) Any professional, commercial, industrial, or trade association;

(c) Any organization duly existing under the provisions of chapter 24.12, 24.20, or 24.28 RCW;

(d) Any agricultural fair authorized under the provisions of chapter 15.76 or 36.37 RCW; or

(e) Any nonprofit organization, whether incorporated or otherwise, when determined by the commissioner to be organized and operated for one or more of the purposes described in (a) through (d) of this subsection.

(3) RCW 48.30.140 and 48.30.150 do not apply to sponsorships or charitable contributions that are provided or given in compliance with subsection (1) of this section. [2021 c 176 § 5228; 2015 c 272 § 4.]

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

48.30.140 Rebating—Other inducements. (1) Except to the extent provided for in an applicable filing with the commissioner then in effect, no insurer, insurance producer, or title insurance agent shall, as an inducement to insurance, or after insurance has been effected, directly or indirectly, offer, promise, allow, give, set off, or pay to the insured or to any employee of the insured, any rebate, discount, abatement, or reduction of premium or any part thereof named in any insurance contract, or any commission thereon, or earnings, profits, dividends, or other benefit, or any other valuable consideration or inducement whatsoever which is not expressly provided for in the policy.

(2) Subsection (1) of this section shall not apply as to commissions paid to a licensed insurance producer, or title insurance agent for insurance placed on that person's own property or risks.

(3) This section shall not apply to the allowance by any marine insurer, or marine insurance producer, to any insured, in connection with marine insurance, of such discount as is sanctioned by custom among marine insurers as being additional to the insurance producer's commission.

(4) This section shall not apply to advertising or promotional programs conducted by insurers or insurance producers whereby prizes, goods, wares, gift cards, gift certificates, or merchandise, not exceeding one hundred dollars in value per person in the aggregate in any twelve-month period, are given to all insureds or prospective insureds under similar qualifying circumstances. This subsection does not apply to title insurers or title insurance agents.

(5) This section does not apply to an offset or reimbursement of all or part of a fee paid to an insurance producer as provided in RCW 48.17.270.

(6)(a) Subsection (1) of this section shall not be construed to prohibit a health carrier or disability insurer from including as part of a group or individual health benefit plan or contract containing health benefits, a wellness program which meets the requirements for an exception from the prohibition against discrimination based on a health factor under the health insurance portability and accountability act (P.L. 104-191; 110 Stat. 1936) and regulations adopted pursuant to that act.

(b) For purposes of this subsection: (i) "Health carrier" and "health benefit plan" have the same meaning as provided

in RCW 48.43.005; and (ii) "wellness program" has the same meaning as provided in 45 C.F.R. 146.121(f).

(7) Subsection (1) of this section does not apply to a payment by an insurer to offset documented expenses incurred by a group policyholder in changing coverages from one insurer to another. Insurers shall describe any such payment in the group insurance policy or in an applicable filing with the commissioner. If an implementation credit is given to a group, the implementation credit is part of the premium for the purposes of RCW 48.14.020 and 48.14.0201. This exception to subsection (1) of this section does not apply to "medicare supplemental insurance" or "medicare supplemental insurance policies" as defined in chapter 48.66 RCW.

(8) Subsection (7) of this section does not apply to small groups as defined in RCW 48.43.005.

(9) Subsection (1) of this section does not apply to products or services related to any policy of life insurance that are intended to incent behavioral changes that improve the health and reduce the risk of death of the insured. [2020 c 197 § 1; 2019 c 253 § 1; 2015 c 272 § 1; 2009 c 329 § 1; 2008 c 217 § 35; 1994 c 203 § 3; 1990 1st ex.s. c 3 § 8; 1985 c 264 § 14; 1975-'76 2nd ex.s. c 119 § 3; 1947 c 79 § .30.14; Rem. Supp. 1947 § 45.30.14.]

Effective date—2020 c 197: "This act takes effect July 1, 2020." [2020 c 197 § 5.]

Effective date—2019 c 253: "This act takes effect July 1, 2020." [2019 c 253 § 3.]

Additional notes found at www.leg.wa.gov

48.30.150 Illegal inducements. (1) No insurer, insurance producer, title insurance agent, or other person shall, as an inducement to insurance, or in connection with any insurance transaction, provide in any policy for, or offer, or sell, buy, or offer or promise to buy or give, or promise, or allow to, or on behalf of, the insured or prospective insured in any manner whatsoever:

(a) Any shares of stock or other securities issued or at any time to be issued on any interest therein or rights thereto; or

(b) Any special advisory board contract, or other contract, agreement, or understanding of any kind, offering, providing for, or promising any profits or special returns or special dividends; or

(c) Any prizes, goods, wares, gift cards, gift certificates, or merchandise of an aggregate value in excess of one hundred dollars per person in the aggregate in any consecutive twelve-month period. This subsection (1)(c) does not apply to title insurers or title insurance agents.

(2) Subsection (1) of this section shall not be deemed to prohibit the sale or purchase of securities as a condition to or in connection with surety insurance insuring the performance of an obligation as part of a plan of financing found by the commissioner to be designed and operated in good faith primarily for the purpose of such financing, nor shall it be deemed to prohibit the sale of redeemable securities of a registered investment company in the same transaction in which life insurance is sold.

(3)(a) Subsection (1) of this section shall not be deemed to prohibit a health carrier or disability insurer from including as part of a group or individual health benefit plan or contract providing health benefits, a wellness program which meets

the requirements for an exception from the prohibition against discrimination based on a health factor under the health insurance portability and accountability act (P.L. 104-191; 110 Stat. 1936) and regulations adopted pursuant to that act.

(b) For purposes of this subsection: (i) "Health carrier" and "health benefit plan" have the same meaning as provided in RCW 48.43.005; and (ii) "wellness program" has the same meaning as provided in 45 C.F.R. 146.121(f).

(4) Subsection (1) of this section does not prohibit an insurer from issuing any payment to offset documented expenses incurred by a group policyholder in changing coverages from one insurer to another as provided in RCW 48.30.140. If an implementation credit is given to a group, the implementation credit is part of the premium for the purposes of RCW 48.14.020 and 48.14.0201. This exception to subsection (1) of this section does not apply to "medicare supplemental insurance" or "medicare supplemental insurance policies" as defined in chapter 48.66 RCW.

(5) Subsection (4) of this section does not apply to small groups as defined in RCW 48.43.005.

(6) Subsection (1) of this section does not apply to products or services related to any policy of life insurance that are intended to incent behavioral changes that improve the health and reduce the risk of death of the insured. [2020 c 197 § 2; 2019 c 253 § 2; 2015 c 272 § 2; 2009 c 329 § 2; 2008 c 217 § 36; 1990 1st ex.s. c 3 § 9; 1975-'76 2nd ex.s. c 119 § 4; 1957 c 193 § 18; 1947 c 79 § .30.15; Rem. Supp. 1947 § 45.30.15.]

Effective date—2020 c 197: See note following RCW 48.30.140.

Effective date—2019 c 253: See note following RCW 48.30.140.

Additional notes found at www.leg.wa.gov

48.30.155 Life or disability insurers—Insurance as inducement to purchase of goods, etc. No life or disability insurer shall directly or indirectly participate in any plan to offer or effect any kind or kinds of insurance in this state as an inducement to the purchase by the public of any goods, securities, commodities, services or subscriptions to publications. This section shall not apply to group or blanket insurance issued pursuant to this code. This section does not apply to products or services related to any policy of life insurance that are intended to incent behavioral changes that improve the health and reduce the risk of death of the insured. [2020 c 197 § 3; 1957 c 193 § 19.]

Effective date—2020 c 197: See note following RCW 48.30.140.

48.30.157 Charges for extra services. Notwithstanding the provisions of RCW 48.30.140, 48.30.150, and 48.30.155, the commissioner may permit an insurance producer to enter into reasonable arrangements with insureds and prospective insureds to charge a reduced fee in situations where services that are charged for are provided beyond the scope of services customarily provided in connection with the solicitation and procurement of insurance, so that an overall charge to an insured or prospective insured is reasonable taking into account receipt of commissions and fees and their relation, proportionally, to the value of the total work performed. [2008 c 217 § 37; 1988 c 248 § 17; 1983 c 3 § 154; 1979 ex.s. c 199 § 10.]

Additional notes found at www.leg.wa.gov

48.30.170 Rebate—Acceptance prohibited. (1) No insured person shall receive or accept, directly or indirectly, any rebate of premium or part thereof, or any favor, advantage, share in dividends, or other benefits, or any valuable consideration or inducement not specified or provided for in the policy, or any commission on any insurance policy to which he or she is not lawfully entitled as a licensed insurance producer or title insurance agent. The retention by the nominal policyholder in any group life insurance contract of any part of any dividend or reduction of premium thereon contrary to the provisions of RCW 48.24.260, shall be deemed the acceptance and receipt of a rebate and shall be punishable as provided by this code.

(2) The amount of insurance whereon the insured has so received or accepted any such rebate or any such commission, other than as to life or disability insurances, shall be reduced in the proportion that the amount or value of the rebate or commission bears to the premium for such insurance. In addition to such reduction of insurance, if any, any such insured shall be liable to a fine of not more than two hundred dollars.

(3) This section shall not apply to an offset or reimbursement of all or part of a fee paid to an insurance producer as provided in RCW 48.17.270. [2008 c 217 § 38; 1994 c 203 § 4; 1947 c 79 § .30.17; Rem. Supp. 1947 § 45.30.17.]

Additional notes found at www.leg.wa.gov

48.30.180 "Twisting" prohibited. No person shall by misrepresentations or by misleading comparisons, induce or tend to induce any insured to lapse, terminate, forfeit, surrender, retain, or convert any insurance policy. [1947 c 79 § .30.18; Rem. Supp. 1947 § 45.30.18.]

48.30.190 Illegal dealing in premiums. (1) No person shall wilfully collect any sum as premium for insurance, which insurance is not then provided or is not in due course to be provided by an insurance policy issued by an insurer as authorized by this code.

(2) No person shall wilfully collect as premium for insurance any sum in excess of the amount actually expended or in due course is to be expended for insurance applicable to the subject on account of which the premium was collected.

(3) No person shall wilfully or knowingly fail to return to the person entitled thereto within a reasonable length of time any sum collected as premium for insurance in excess of the amount actually expended for insurance applicable to the subject on account of which the premium was collected.

(4) Each violation of this section which does not amount to a felony shall constitute a misdemeanor. [1947 c 79 § .30.19; Rem. Supp. 1947 § 45.30.19.]

48.30.200 Hypothecation of premium notes. It shall be unlawful for any insurer or its representative, or any insurance producer, to hypothecate, sell, or dispose of any promissory note, received in payment for any premium or part thereof on any contract of life insurance or of disability insurance applied for, prior to delivery of the policy to the applicant. [2008 c 217 § 39; 1947 c 79 § .30.20; Rem. Supp. 1947 § 45.30.20.]

Additional notes found at www.leg.wa.gov

(2021 Ed.)

48.30.210 Misrepresentation in application for insurance. A person who knowingly makes a false or misleading statement or impersonation, or who willfully fails to reveal a material fact, in or relative to an application for insurance to an insurer, is guilty of a gross misdemeanor, and the license of any such person may be revoked. [1995 c 285 § 18; 1990 1st ex.s. c 3 § 10; 1947 c 79 § .30.21; Rem. Supp. 1947 § 45.30.21.]

Additional notes found at www.leg.wa.gov

48.30.220 Destruction, injury, secretion, etc., of property. Any person, who, with intent to defraud or prejudice the insurer thereof, burns or in any manner injures, destroys, secretes, abandons, or disposes of any property which is insured at the time against loss or damage by fire, theft, embezzlement, or any other casualty, whether the same be the property of or in the possession of such person or any other person, under circumstances not making the offense arson in the first degree, is guilty of a class C felony. [1995 c 285 § 19; 1965 ex.s. c 70 § 25; 1947 c 79 § .30.22; Rem. Supp. 1947 § 45.30.22.]

Additional notes found at www.leg.wa.gov

48.30.230 False claims or proof—Penalty. (1) It is unlawful for any person, knowing it to be such, to:

(a) Present, or cause to be presented, a false or fraudulent claim, or any proof in support of such a claim, for the payment of a loss under a contract of insurance; or

(b) Prepare, make, or subscribe any false or fraudulent account, certificate, affidavit, or proof of loss, or other document or writing, with intent that it be presented or used in support of such a claim.

(2)(a) Except as provided in (b) of this subsection, a violation of this section is a gross misdemeanor.

(b) If the claim is in excess of one thousand five hundred dollars, the violation is a class C felony punishable according to chapter 9A.20 RCW. [2003 c 53 § 270; 1990 1st ex.s. c 3 § 11; 1947 c 79 § .30.23; Rem. Supp. 1947 § 45.30.23.]

Intent—Effective date—2003 c 53: See notes following RCW 2.48.180.

48.30.240 Rate wars prohibited. (1) Any insurer which precipitates, or aids in precipitating or conducting a rate war and by so doing writes or issues a policy of insurance at a less rate than permitted under its schedules filed with the commissioner, or below the rate deemed by him or her to be proper and adequate to cover the class of risk insured, shall have its certificate of authority to do business in this state suspended until such time as the commissioner is satisfied that it is charging a proper rate of premium.

(2) Any insurer which has precipitated, or aided in precipitating or conducting a rate war for the purpose of punishing or eliminating competitors or stifling competition, or demoralizing the business, or for any other purpose, and has ordered the cancellation or rewriting of policies at a rate lower than that provided by its rating schedules where such rate war is not in operation, and has paid or attempted to pay to the insured any return premiums, on any risk so to be rewritten, on which its appointed insurance producer has received or is entitled to receive a regular commission, such insurer shall not be allowed to charge back to such appointed

insurance producer any portion of a commission on the ground that the same has not been earned. [2008 c 217 § 40; 1947 c 79 § .30.24; Rem. Supp. 1947 § 45.30.24.]

Additional notes found at www.leg.wa.gov

48.30.250 Interlocking ownership, management. (1)

Any insurer may retain, invest in or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition or common management is inconsistent with any other provision of this title, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create a monopoly therein.

(2) Any person otherwise qualified may be a director of two or more insurers which are competitors, unless the effect thereof is to substantially lessen competition between insurers generally or tends to create a monopoly.

(3) If the commissioner finds, after a hearing thereon, that there is violation of this section he or she shall order all such persons and insurers to cease and desist from such violation within such time, or extension thereof, as may be specified in such order. [2009 c 549 § 7121; 1949 c 190 § 34; Rem. Supp. 1949 § 45.30.25.]

48.30.260 Right of debtor or borrower to select insurance producer, surplus line broker, or insurer. (1)

Every debtor or borrower, when property insurance of any kind is required in connection with the debt or loan, shall have reasonable opportunity and choice in the selection of the insurance producer, surplus line broker, and insurer through whom such insurance is to be placed; but only if the insurance is properly provided for the protection of the creditor or lender, whether by policy or binder, not later than at commencement of risk as to such property as respects such creditor or lender, and in the case of renewal of insurance, only if the renewal policy, or a proper binder therefor containing a brief description of the coverage bound and the identity of the insurer in which the coverage is bound, is delivered to the creditor or lender not later than thirty days prior to the renewal date.

(2) Every person who lends money or extends credit and who solicits insurance on real and personal property must explain to the borrower in prominently displayed writing that the insurance related to such loan or credit extension may be purchased from an insurer, surplus line broker, or insurance producer of the borrower's choice, subject only to the lender's right to reject a given insurer, surplus line broker, or insurance producer as provided in subsection (3)(b) of this section.

(3) No person who lends money or extends credit may:

(a) Solicit insurance for the protection of property, after a person indicates interest in securing a loan or credit extension, until such person has received a commitment from the lender as to a loan or credit extension;

(b) Unreasonably reject a contract of insurance furnished by the borrower for the protection of the property securing the credit or lien. A rejection shall not be deemed unreasonable if it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall

not discriminate against any particular type of insurer, nor shall such standards call for rejection of an insurance contract because the contract contains coverage in addition to that required in the credit transaction;

(c) Require that any borrower, mortgagor, purchaser, insurer, surplus line broker, or insurance producer pay a separate charge, in connection with the handling of any contract of insurance required as security for a loan, or pay a separate charge to substitute the insurance policy of one insurer for that of another. This subsection does not include the interest which may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document;

(d) Use or disclose, without the prior written consent of the borrower, mortgagor, or purchaser taken at a time other than the making of the loan or extension of credit, information relative to a contract of insurance which is required by the credit transaction, for the purpose of replacing such insurance;

(e) Require any procedures or conditions of duly licensed insurance producers, surplus line brokers, or insurers not customarily required of those insurance producers, surplus line brokers, or insurers affiliated or in any way connected with the person who lends money or extends credit; or

(f) Require property insurance in an amount in excess of the amount which could reasonably be expected to be paid under the policy, or combination of policies, in the event of a loss.

(4) Nothing contained in this section shall prevent a person who lends money or extends credit from placing insurance on real or personal property in the event the mortgagor, borrower, or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

(5) Nothing contained in this section shall apply to credit life or credit disability insurance. [2009 c 162 § 25; 2008 c 217 § 41; 1990 1st ex.s. c 3 § 13; 1988 c 248 § 18; 1984 c 6 § 2; 1977 c 61 § 1; 1957 c 193 § 20.]

Additional notes found at www.leg.wa.gov

48.30.270 Public building or construction contracts—Surety bonds or insurance—Violations concerning—Exemption. (1) No officer or employee of this state, or of any public agency, public authority or public corporation except a public corporation or public authority created pursuant to agreement or compact with another state, and no person acting or purporting to act on behalf of such officer or employee, or public agency or public authority or public corporation, shall, with respect to any public building or construction contract which is about to be, or which has been competitively bid, require the bidder to make application to, or to furnish financial data to, or to obtain or procure, any of the surety bonds or contracts of insurance specified in connection with such contract, or specified by any law, general, special or local, from a particular insurer, surplus line broker, or insurance producer.

(2) No such officer or employee or any person, acting or purporting to act on behalf of such officer or employee shall negotiate, make application for, obtain or procure any of such surety bonds or contracts of insurance, except contracts of insurance for builder's risk or owner's protective liability,

which can be obtained or procured by the bidder, contractor or subcontractor.

(3) This section shall not be construed to prevent the exercise by such officer or employee on behalf of the state or such public agency, public authority, or public corporation of its right to approve the form, sufficiency or manner or execution of the surety bonds or contracts of insurance furnished by the insurer selected by the bidder to underwrite such bonds, or contracts of insurance.

(4) Any provisions in any invitation for bids, or in any of the contract documents, in conflict with this section are declared to be contrary to the public policy of this state.

(5) A violation of this section shall be subject to the penalties provided by RCW 48.01.080.

(6) This section shall not apply to public construction projects, when the actual or estimated aggregate value of the project, exclusive of insurance and surety costs, exceeds two hundred million dollars. For purposes of applying the two hundred million dollar threshold set forth in this subsection, the term "public construction project" means a project that has a public owner and has phases, segments, or component parts relating to a common geographic site or public transportation system, but does not include the aggregation of unrelated construction projects.

(7) The exclusions specified in subsection (6) of this section do not apply to surety bonds. [2009 c 162 § 26; 2008 c 217 § 42; 2005 c 352 § 1; (2003 c 323 § 2 repealed by 2005 c 352 § 2); 2003 c 323 § 1. Prior: 2000 2nd sp.s. c 4 § 33; 2000 c 143 § 2; 1983 2nd ex.s. c 1 § 6; 1967 ex.s. c 12 § 3.]

Additional notes found at www.leg.wa.gov

48.30.300 Unfair discrimination, generally. Notwithstanding any provision contained in Title 48 RCW to the contrary:

(1) A person or entity engaged in the business of insurance in this state may not refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex, marital status, or sexual orientation as defined in RCW 49.60.040, or the presence of any disability of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage may not be restricted, modified, excluded, increased, or reduced on the basis of the sex, marital status, or sexual orientation, or be restricted, modified, excluded, or reduced on the basis of the presence of any disability of the insured or prospective insured.

(2) Except as provided in RCW 48.43.0128, 48.44.220, or 48.46.370, this subsection does not prohibit fair discrimination on the basis of sex, or marital status, or the presence of any disability when bona fide statistical differences in risk or exposure have been substantiated. [2020 c 274 § 32; 2020 c 228 § 8; 2006 c 4 § 18; 2005 c 223 § 19; 1993 c 492 § 287; 1975-'76 2nd ex.s. c 119 § 7.]

Reviser's note: This section was amended by 2020 c 228 § 8 and by 2020 c 274 § 32, 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).

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

Additional notes found at www.leg.wa.gov

(2021 Ed.)

48.30.310 Commercial motor vehicle employment driving record not to be considered, when. When an individual applies for a policy of casualty insurance providing either automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage, or automobile physical damage coverage on an individually owned passenger vehicle or a renewal of such policy, an insurer shall not consider the applicant's commercial motor vehicle employment driving record in determining whether the policy will be issued or renewed or in determining the rates for the policy. An insurer shall not cancel such policy or discriminate in regard to other terms or conditions of the policy based upon the applicant's commercial motor vehicle employment driving record.

"Employment driving record" means that record maintained by the director pertaining to motor vehicle accidents or convictions for violation of motor vehicle laws while the applicant is driving a commercial motor vehicle as an employee of another. [1977 ex.s. c 356 § 3.]

48.30.320 Notice of reason for cancellation, restrictions based on disability. Every authorized insurer, upon canceling, denying, or refusing to renew any individual life, individual disability, homeowner, dwelling fire, or private passenger automobile insurance policy, shall, upon written request, directly notify in writing the applicant or insured, as the case may be, of the reasons for the action by the insurer. Any benefits, terms, rates, or conditions of such an insurance contract which are restricted, excluded, modified, increased, or reduced because of the presence of a disability shall, upon written request, be set forth in writing and supplied to the insured. 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. [2020 c 274 § 33; 1979 c 133 § 1.]

48.30.330 Immunity from libel or slander. With respect to contracts of insurance as defined in RCW 48.30.320, 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 insurer, its authorized representative, its agents, its employees, furnishing to the insurer 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. [1979 c 133 § 2.]

48.30.340 Auto glass repair—Restrictions on insurer-owned facilities. (1) A person in this state has the right to choose any glass repair facility for the repair of a loss relating to motor vehicle glass.

(2) An insurer or its third-party administrator that owns in whole or in part an automobile glass repair facility that is processing a claim limited only to auto glass shall:

(a) Verbally inform the person making the claim of loss, of the right provided under subsection (1) of this section, at the time information regarding the automobile glass repair or replacement facilities is provided; and

(b) Verbally inform the person making the claim of loss that the third-party administrator is an entity separate from the insurer that has a financial arrangement to process automobile glass claims on the insurer's behalf.

(3) An insurer or its third-party administrator that owns an interest in an automobile glass repair or replacement facility shall post the following notice in each of its repair facilities:

"THIS AUTOMOBILE GLASS REPAIR OR REPLACEMENT FACILITY IS OWNED IN WHOLE OR IN PART BY (NAME OF INSURER OR INSURER'S THIRD-PARTY ADMINISTRATOR). YOU ARE HEREBY NOTIFIED THAT YOU ARE ENTITLED UNDER WASHINGTON LAW TO SEEK REPAIRS AT ANY AUTOMOBILE GLASS REPAIR OR REPLACEMENT FACILITY OF YOUR CHOICE."

The notice must be posted, in not less than eighteen point font, prominently in a location in which it is likely to be seen and read by a customer. If the automobile glass repair or replacement facility is mobile, the notice must be given to the person making the claim verbally by the insurer or its third-party administrator prior to commencement of the repair or replacement.

(4) A person making a claim of loss whose motor vehicle is repaired at an automotive glass repair or replacement facility subject to the notice requirements of this section may file a complaint with the office of the insurance commissioner.

(5) This section does not create a private right or cause of action to or on behalf of any person. [2007 c 74 § 1.]

48.30.350 Initiating arbitration of claims under the balance billing protection act with such frequency as to indicate a health carrier's general business practice. (1) It is an unfair or deceptive practice for a health carrier to initiate, with such frequency as to indicate a general business practice, arbitration under RCW 48.49.040 with respect to claims submitted by out-of-network providers for services included in RCW 48.49.020 that request payment of a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area.

(2) As used in this section, "health carrier" has the same meaning as in RCW 48.43.005. [2019 c 427 § 16.]

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

48.30.900 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 § 123.]

Chapter 48.30A RCW INSURANCE FRAUD

Sections

48.30A.005	Findings—Intent.
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48.30A.050	Insurance antifraud plan—Specific procedures.
48.30A.055	Insurance antifraud plan—Review—Disapproval—Notice—Audit to ensure compliance.
48.30A.060	Insurance antifraud plan—Actions taken by insurer—Report—Not public records.
48.30A.065	Insurance antifraud plan or summary report—Failure to file or exercise good faith—Penalty—Failure to follow plan—Civil penalty.
48.30A.070	Duty to investigate, enforce, and prosecute violations.
48.30A.900	Effective date—1995 c 285.

48.30A.005 Findings—Intent. The legislature finds that the business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. The payment of kickbacks, bribes, or rebates for referrals to service providers, as has been occurring with increasing regularity in this state, results in inflated or fraudulent insurance claims, results in greater insurance costs for all citizens, and is contrary to the public interest. In particular, the process whereby "cappers" buy and sell insurance claims without the controls of professional licensing and discipline creates a fertile ground for illegal activity and has, in this state, resulted in frauds committed against injured claimants, insurance companies, and the public. Operations that engage in this practice have some or all of the following characteristics: Cappers, acting under an agreement or understanding that they will receive a pecuniary benefit, refer claimants with real or imaginary claims, injuries, or property damage to service providers. This sets off a chain of events that corrupts both the provision of services and casualty or property insurance for all citizens. This chain of events includes false claims for services through the use of false estimates of repair; false prescriptions of care or rehabilitative therapy; services that either do not occur or are provided by persons unqualified to provide the services; submission of false claims; submission of and demands for fraudulent costs, lost wages, pain and suffering, and the like; and other devices meant to result in false claims under casualty or property insurance policies or contracts, whether insured or self-insured, and either directly or through subrogation.

The legislature finds that combatting these practices requires laws carefully fashioned to identify practices that

mimic customary business practices. The legislature does not intend this law to be used against medical and other business referral practices that are otherwise legal, customary, and unrelated to the furtherance of some or all of the corrupt practices identified in this chapter. [1995 c 285 § 1.]

48.30A.010 Definitions. The definitions set forth in this section apply throughout this chapter unless the context clearly indicates otherwise.

(1) "Casualty or property insurance" includes both the insurance under which a claim is filed and insurance that receives a claim through subrogation, and means insurance as defined in RCW 48.11.040 and 48.11.070 and includes self-insurance arrangements.

(2) "Claimant" means a person who has or is believed by an actor to have an insurance claim.

(3) "Group-buying arrangement" means an arrangement made by a membership organization having one hundred or more members in which the organization asks for or receives valuable consideration in exchange for referring its members to a service provider; the consideration asked for or received will be or is used to benefit the entire organization, not just one or more individuals in positions of power or influence in the organization; and reasonable efforts are made to disclose to affected members of the organization the nature of the referral relationship, including the nature, extent, amount, and use of the consideration.

(4) "Health care services" means a service provided to a claimant for treatment of physical or mental illness or injury arising in whole or substantial part from trauma.

(5) "Insurance claim" means a claim for payment, benefits, or damages under a contract, plan, or policy of casualty or property insurance.

(6) "Legal provider" means an active member in good standing of the Washington state bar association, and any other person authorized by the Washington state supreme court to engage in full or limited practice of law.

(7) "Service provider" means a person who directly or indirectly provides, advertises, or otherwise claims to provide services.

(8) "Services" means health care services, motor vehicle body or other motor vehicle repair, and preparing, processing, presenting, or negotiating an insurance claim.

(9) "Trauma" means a physical injury or wound caused by external force or violence. [1995 c 285 § 2.]

48.30A.015 Unlawful acts—Penalties. (1) It is unlawful for a person:

(a) Knowing that the payment is for the referral of a claimant to a service provider, either to accept payment from a service provider or, being a service provider, to pay another; or

(b) To provide or claim or represent to have provided services to a claimant, knowing the claimant was referred in violation of (a) of this subsection.

(2) It is unlawful for a service provider to engage in a regular practice of waiving, rebating, giving, paying, or offering to waive, rebate, give, or pay all or any part of a claimant's casualty or property insurance deductible.

(3) A violation of this section constitutes trafficking in insurance claims.

(4)(a) Trafficking in insurance claims is a gross misdemeanor for a single violation.

(b) Each subsequent violation, whether alleged in the same or in subsequent prosecutions, is a class C felony. [2003 c 53 § 271; 1995 c 285 § 3.]

Intent—Effective date—2003 c 53: See notes following RCW 2.48.180.

48.30A.020 Defenses to proceedings under this chapter. In a proceeding under this chapter, it is a defense if proven by the defendant by a preponderance of the evidence that, at the time of the offense:

(1) The conduct alleged was authorized by the rules of professional conduct or the admission to practice rules for lawyers as adopted by the state supreme court, Washington business and professions licensing statutes, or rules adopted by the secretary of health or the director of licensing;

(2) The payment was an incidental nonmonetary gift or gratuity, or was purely social in nature;

(3) The conduct alleged was an exercise of a group-buying arrangement;

(4) The conduct alleged was a legal provider paying a service provider's bills from the proceeds of an insurance claim that included the bills;

(5) The conduct alleged was a legal provider paying for services of an expert witness, including reports, consultation, and testimony; or

(6) The conduct alleged was a service provider's purchase of advertising from an unrelated business that provides referrals from advertising for groups of ten or more service providers that are not related to the advertising business and not related to each other. [1995 c 285 § 4.]

48.30A.030 Injunction available—Remedies—Costs—Attorneys' fees—Degree of proof—Time limit.

Independent of authority granted to the attorney general, the prosecuting attorney may petition the superior court for an injunction against a person who has violated this chapter. Remedies in an injunctive action brought by a prosecuting attorney are limited to an order enjoining, restraining, or preventing the doing of any act or practice that constitutes a violation of this chapter and imposing a civil penalty of up to five thousand dollars for each violation. The prevailing party in the action may, in the discretion of the court, recover its reasonable investigative costs and the costs of the action including a reasonable attorney's fee. The degree of proof required in an action brought under this section is a preponderance of the evidence. An action under this section must be brought within three years after the violation of this chapter occurred. [1995 c 285 § 6.]

48.30A.035 Detrimental judgment—Written notification to appropriate regulatory or disciplinary body or agency. Whenever a service provider or a person licensed by the state in a business or profession is convicted, enjoined, or found liable for damages or a civil penalty or other equitable relief under RCW 48.30A.030, the attorney general or the prosecuting attorney shall provide written notification of the judgment to the appropriate regulatory or disciplinary body or agency. [1995 c 285 § 7.]

48.30A.040 Violation—Cause for discipline—Unprofessional conduct—Regulatory penalty. A violation of this chapter is cause for discipline and constitutes unprofessional conduct that could result in any regulatory penalty provided by law, including refusal, revocation, or suspension of a business or professional license, or right or admission to practice. Conduct that constitutes a violation of this chapter is unprofessional conduct in violation of RCW 18.130.180. [1995 c 285 § 8.]

48.30A.045 Insurance antifraud plan—File plan and changes with commissioner—Exemptions. (1) Each insurer licensed to write direct insurance in this state, except those exempted in subsection (2) of this section, shall institute and maintain an insurance antifraud plan. An insurer licensed after July 1, 1995, shall file its antifraud plan within six months of licensure. An insurer shall file any change to the antifraud plan with the insurance commissioner within thirty days after the plan has been modified.

(2) This section does not apply to:

- (a) Health carriers, as defined in RCW 48.43.005;
- (b) Life insurers;
- (c) Title insurers;

(d) Property or casualty insurers with annual gross written medical malpractice insurance premiums in this state that exceed fifty percent of their total annual gross written premiums in this state;

(e) Credit-related insurance written in connection with a credit transaction in which the creditor is named as a beneficiary or loss payee under the policy, except vendor single-interest or collateral protection coverage as defined in RCW 48.22.110(4); or

(f) Insurers with gross written premiums of less than one thousand dollars in Washington during the reporting year. [2005 c 223 § 20; 1997 c 92 § 1; 1995 c 285 § 9.]

48.30A.050 Insurance antifraud plan—Specific procedures. An insurer's antifraud plan must establish specific procedures to:

(1) Prevent insurance fraud, including internal fraud involving employees or company representatives, fraud resulting from misrepresentation on applications for insurance coverage, and claims fraud;

(2) Review claims in order to detect evidence of possible insurance fraud and to investigate claims where fraud is suspected;

(3) Report fraud to appropriate law enforcement agencies and cooperate with those agencies in their prosecution of fraud cases;

(4) Undertake civil actions against persons who have engaged in fraudulent activities;

(5) Train company employees and agents in the detection and prevention of fraud. [1995 c 285 § 10.]

48.30A.055 Insurance antifraud plan—Review—Disapproval—Notice—Audit to ensure compliance. If after review of an insurer's antifraud plan, the commissioner finds that the plan does not comply with RCW 48.30A.050, the commissioner may disapprove the antifraud plan. Notice of disapproval must include a statement of the specific reasons for disapproval. The insurer shall refile a plan disapproved by the commissioner within sixty days of the date of the notice of disapproval. The commissioner may audit insurers to ensure compliance with antifraud plans. [1995 c 285 § 11.]

proved by the commissioner within sixty days of the date of the notice of disapproval. The commissioner may audit insurers to ensure compliance with antifraud plans. [1995 c 285 § 11.]

48.30A.060 Insurance antifraud plan—Actions taken by insurer—Report—Not public records. By March 31st of each year, each insurer shall provide to the insurance commissioner a summary report on actions taken under its antifraud plan to prevent and combat insurance fraud. The report must also include, but not be limited to, measures taken to protect and ensure the integrity of electronic data processing-generated data and manually compiled data, statistical data on the amount of resources committed to combatting fraud, and the amount of fraud identified and recovered during the reporting period. The antifraud plans and summary of the insurer's antifraud activities are not public records and are exempt from chapter 42.56 RCW, are proprietary, are not subject to public examination, and are not discoverable or admissible in civil litigation. [2005 c 274 § 312; 2005 c 223 § 21; 1995 c 285 § 12.]

Reviser's note: This section was amended by 2005 c 223 § 21 and by 2005 c 274 § 312, 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).

48.30A.065 Insurance antifraud plan or summary report—Failure to file or exercise good faith—Penalty—Failure to follow plan—Civil penalty. An insurer that fails to file a timely antifraud plan or summary report or that fails to make a good faith attempt to file an antifraud plan that complies with RCW 48.30A.050 or a summary report that complies with RCW 48.30A.060, is subject to the penalty provisions of RCW 48.01.080, but no penalty may be imposed for the first filing made by an insurer under this chapter. An insurer that fails to follow the antifraud plan is subject to a civil penalty not to exceed ten thousand dollars for each violation, at the discretion of the commissioner after consideration of all relevant factors, including the willfulness of the violation. [2005 c 223 § 22; 1995 c 285 § 13.]

48.30A.070 Duty to investigate, enforce, and prosecute violations. It is the duty of all peace officers, law enforcement officers, and law enforcement agencies within this state to investigate, enforce, and prosecute all violations of this chapter. [1995 c 285 § 14.]

48.30A.900 Effective date—1995 c 285. 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 shall take effect July 1, 1995. [1995 c 285 § 39.]

Chapter 48.31 RCW

MERGERS, REHABILITATION, LIQUIDATION, SUPERVISION

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48.31.010 Merger or consolidation. (1) Subject to the provisions of RCW 48.08.080, relating to the mutualization of stock insurers, RCW 48.09.350, relating to the conversion or reinsurance of mutual insurers, and RCW 48.10.330, relating to the consolidation or conversion of reciprocal insurers, a domestic insurer may merge or consolidate with another insurer, subject to the following conditions:

(a) The plan of merger or consolidation must be submitted to and be approved by the commissioner in advance of the merger or consolidation.

(b) The commissioner shall not approve any such plan unless, after a hearing, pursuant to such notice as the commissioner may require, he or she finds that it is fair, equitable, consistent with law, and that no reasonable objection exists. If the commissioner fails to approve the plan, he or she shall state his or her reasons for such failure in his or her order made on such hearing. The insurers involved in the merger shall bear the expense of the mailing of the notice of hearing and of the order on hearing.

(c) No director, officer, member, or subscriber of any such insurer, except as is expressly provided by the plan of merger or consolidation, shall receive any fee, commission, other compensation or valuable consideration whatsoever, for in any manner aiding, promoting or assisting in the merger or consolidation.

(d) Any merger or consolidation as to an incorporated domestic insurer shall in other respects be governed by the general laws of this state relating to business corporations. Except, that as to domestic mutual insurers, approval by two-thirds of its members who vote thereon pursuant to such notice and procedure as was approved by the commissioner shall constitute approval of the merger or consolidation as respects the insurer's members.

(2) Reinsurance of all or substantially all of the insurance in force of a domestic insurer by another insurer shall be deemed a consolidation for the purposes of this section. [2009 c 549 § 7122; 1973 1st ex.s. c 107 § 3; 1961 c 194 § 11; 1947 c 79 § .31.01; Rem. Supp. 1947 § 45.31.01.]

Additional notes found at www.leg.wa.gov

48.31.020 Definitions—Insurer, exceeded its powers, consent. (1) For the purposes of this chapter, other than as to RCW 48.31.010, and in addition to persons included under RCW 48.99.010, the term "insurer" shall be deemed to include an insurer authorized under chapter 48.05 RCW, an insurer or institution holding a certificate of exemption under RCW 48.38.010, a health care service contractor registered under chapter 48.44 RCW, and a health maintenance organization registered under chapter 48.46 RCW, as well as all persons engaged as, or purporting to be engaged as insurers, institutions issuing charitable gift annuities, health care service contractors, or health maintenance organizations in this state, and to persons in process of organization to become insurers, institutions issuing charitable gift annuities, health care service contractors, or health maintenance organizations.

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

(a) "Exceeded its powers" means the following conditions:

(i) The insurer has refused to permit examination of its books, papers, accounts, records, or affairs by the commissioner, his or her deputies, employees, or duly commissioned examiners as required by this title or any rules adopted by the commissioner;

(ii) A domestic insurer has unlawfully removed from this state books, papers, accounts, or records necessary for an examination of the insurer;

(iii) The insurer has failed to promptly comply with the filing of any applicable financial reports as required by this title or any rules adopted by the commissioner;

(iv) The insurer has neglected or refused to observe a lawful order of the commissioner to comply, within the time prescribed by law, with any prohibited deficiency in its applicable capital, capital stock, or surplus;

(v) The insurer is continuing to transact insurance or write business after its license has been revoked or suspended by the commissioner;

(vi) The insurer, by contract or otherwise, has unlawfully or has in violation of an order of the commissioner or with respect to a transaction to which the insurer has without first having obtained written approval of the commissioner if approval is required by law:

(A) Totally reinsured its entire outstanding business; or

(B) Merged or consolidated substantially its entire property or business with another insurer; or

(vii) The insurer engaged in any transaction in which it is not authorized to engage under this title or any rules adopted by the commissioner.

(b) "Consent" means agreement to administrative supervision by the insurer. [2005 c 432 § 1; 1998 c 284 § 8; 1989 c 151 § 1; 1947 c 79 § .31.02; Rem. Supp. 1947 § 45.31.02.]

48.31.021 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 § 20.]

Additional notes found at www.leg.wa.gov

48.31.025 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 as defined in RCW 48.99.010(12), 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 otherwise not subject to 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 publicly if the court finds that there is a public interest in the disclosure of the information and 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 disclosure would impair any vital governmental function, 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 § 1.]

48.31.030 Rehabilitation—Grounds. The commissioner may apply for an order directing him or her to rehabilitate a domestic insurer upon one or more of the following grounds: That the insurer

(1) Is insolvent; or

(2) Has refused to submit its books, records, accounts, or affairs to the reasonable examination of the commissioner; or

(3) Has failed to comply with the commissioner's order, made pursuant to law, to make good an impairment of capital (if a stock insurer) or an impairment of assets (if a mutual or reciprocal insurer) within the time prescribed by law; or

(4) Has transferred or attempted to transfer substantially its entire property or business, or has entered into any transaction the effect of which is to merge substantially its entire property or business in that of any other insurer without first having obtained the written approval of the commissioner; or

(5) Is found, after examination, to be in such condition that its further transaction of business will be hazardous to its policyholders, or to its creditors, or to its members, subscribers, or stockholders, or to the public; or

(6) Has willfully violated its charter or any law of this state; or

(7) Has an officer, director, or manager who has refused to be examined under oath, concerning its affairs, for which purpose the commissioner is authorized to conduct and to enforce by all appropriate and available means any such examination under oath in any other state or territory of the United States, in which any such officer, director, or manager may then presently be, to the full extent permitted by the laws of any such other state or territory, this special authorization considered; or

(8) Has been the subject of an application for the appointment of a receiver, trustee, custodian, or sequestrator of the insurer or of its property, or if a receiver, trustee, custodian, or sequestrator is appointed by a federal court or if such appointment is imminent; or

(9) Has consented to such an order through a majority of its directors, stockholders, members, or subscribers; or

(10) Has failed to pay a final judgment rendered against it in any state upon any insurance contract issued or assumed by it, within thirty days after the judgment became final or within thirty days after time for taking an appeal has expired, or within thirty days after dismissal of an appeal before final determination, whichever date is the later; or

(11) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that, if established, would endanger assets in an amount threatening the solvency of the insurer; or

(12) The insurer has failed to remove a person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the commissioner to be dishonest or untrustworthy in a way affecting the insurer's business; or

(13) Control of the insurer, whether by stock ownership or ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy; or

(14) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the commissioner, has failed to give an adequate explanation immediately; or

(15) The board of directors or the holders of a majority of the shares entitled to vote, request, or consent to rehabilitation under this chapter. [1993 c 462 § 75; 1949 c 190 § 28; 1947 c 79 § .31.03; Rem. Supp. 1949 § 45.31.03.]

Additional notes found at www.leg.wa.gov

48.31.040 Rehabilitation—Order—Termination. (1)

An order to rehabilitate a domestic insurer shall direct the commissioner forthwith to take possession of the property of the insurer and to conduct the business thereof, and to take such steps toward removal of the causes and conditions which have made rehabilitation necessary as the court may direct.

(2) If at any time the commissioner deems that further efforts to rehabilitate the insurer would be useless, he or she may apply to the court for an order of liquidation.

(3) The commissioner, or any interested person upon due notice to the commissioner, at any time may apply for an

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order terminating the rehabilitation proceeding and permitting the insurer to resume possession of its property and the conduct of its business, but no such order shall be granted except when, after a full hearing, the court has determined that the purposes of the proceedings have been fully accomplished.

(4) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this state, shall appoint the commissioner and his or her successors in office as the rehabilitator, and shall direct the rehabilitator to immediately take possession of the assets of the insurer, and to administer them under the general supervision of the court. The filing or recording of the order with the recorder of deeds of the county in this state in which the principal business of the company is conducted, or the county in this state in which the company's principal office or place of business is located, imparts the same notice as a deed or other evidence of title duly filed or recorded with that recorder of deeds would have imparted. The order to rehabilitate the insurer by operation of law vests title to all assets of the insurer in the rehabilitator.

(5) An order issued under this section requires accountings to the court by the rehabilitator. Accountings must be done at such intervals as the court specifies in its order, but no less frequently than semiannually.

(6) Entry of an order of rehabilitation does not constitute an anticipatory breach of contracts of the insurer nor may it be grounds for retroactive revocation or retroactive cancellation of contracts of the insurer, unless the revocation or cancellation is done by the rehabilitator. [1993 c 462 § 76; 1947 c 79 § .31.04; Rem. Supp. 1947 § 45.31.04.]

Additional notes found at www.leg.wa.gov

48.31.045 Rehabilitation order against insurer—Insurer is party to action or proceeding—Stay the action—Statute of limitations or defense of laches. (1)

A court in this state before which an action or proceeding in which the insurer is a party, or is obligated to defend a party, is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for ninety days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as he or she deems necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(2) A statute of limitations or defense of laches does not run with respect to an action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. An action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the order of rehabilitation is entered or the petition is denied. The rehabilitator may institute an action or proceeding pursuant to an order of rehabilitation, within the later of two years following entry of the order or two years of the date the rehabilitator discovers, or in the exercise of reasonable care should have discovered, the injury from which the action or proceeding arose and its

cause. However, actions against former directors, officers, and employees brought pursuant to an order of rehabilitation for the benefit or the protection of subscribers, policy beneficiaries, or the general public is subject to the limitations period of RCW 4.16.160.

(3) A guaranty association or foreign guaranty association covering life or health insurance or annuities has standing to appear in a court proceeding concerning the rehabilitation of a life or health insurer if the association is or may become liable to act as a result of the rehabilitation. [2007 c 80 § 10; 1993 c 462 § 77.]

Additional notes found at www.leg.wa.gov

48.31.050 Liquidation—Grounds. The commissioner may apply for an order directing him or her to liquidate the business of a domestic insurer or of the United States branch of an alien insurer having trusteed assets in this state, regardless of whether or not there has been a prior order directing him or her to rehabilitate such insurer, upon any of the grounds specified in RCW 48.31.030 or upon any one or more of the following grounds: That the insurer

(1) Has ceased transacting business for a period of one year; or

(2) Is an insolvent insurer and has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute any action or proceeding to liquidate its business or affairs, or to dissolve its corporate charter, or to procure the appointment of a receiver, trustee, custodian, or sequestrator under any law except this code; or

(3) Has not organized or completed its organization and obtained a certificate of authority as an insurer prior to the expiration or revocation of its solicitation permit. [2009 c 549 § 7123; 1947 c 79 § .31.05; Rem. Supp. 1947 § 45.31.05.]

48.31.060 Liquidation—Order. (1) An order to liquidate the business of a domestic insurer shall direct the commissioner forthwith to take possession of the property of the insurer, to liquidate its business, to deal with the insurer's property and business in his or her own name as commissioner or in the name of the insurer as the court may direct, to give notice to all creditors who may have claims against the insurer to present such claims.

(2) The commissioner may apply under this chapter for an order dissolving the corporate existence of a domestic insurer:

(a) Upon his or her application for an order of liquidation of such insurer, or at any time after such order has been granted; or

(b) Upon the grounds specified in item (3) of RCW 48.31.050, regardless of whether an order of liquidation is sought or has been obtained. [2009 c 549 § 7124; 1947 c 79 § .31.06; Rem. Supp. 1947 § 45.31.06.]

48.31.070 Liquidation—Alien insurers. An order to liquidate the business of the United States branch of an alien insurer having trusteed assets in this state shall be in the same terms as those prescribed for domestic insurers, except that only the assets of the business of such United States branch shall be included therein. [1947 c 79 § .31.07; Rem. Supp. 1947 § 45.31.07.]

48.31.080 Conservation of assets—Foreign insurers.

The commissioner may apply for an order directing him or her to conserve the assets within this state of a foreign insurer upon any one or more of the following grounds:

(1) Upon any of the grounds specified in items (1) to (9) inclusive of RCW 48.31.030 and in item (2) of RCW 48.31.050.

(2) That its property has been sequestered in its domiciliary sovereignty or in any other sovereignty. [2009 c 549 § 7125; 1947 c 79 § .31.08; Rem. Supp. 1947 § 45.31.08.]

48.31.090 Conservation of assets—Alien insurers.

The commissioner may apply for an order directing him or her to conserve the assets within this state of an alien insurer upon any one or more of the following grounds:

(1) Upon any of the grounds specified in items (1) to (9) inclusive of RCW 48.31.030 and in item (2) of RCW 48.31.050; or

(2) That the insurer has failed to comply, within the time designated by the commissioner, with an order of the commissioner pursuant to law to make good an impairment of its trusteed funds; or

(3) That the property of the insurer has been sequestered in its domiciliary sovereignty or elsewhere. [2009 c 549 § 7126; 1947 c 79 § .31.09; Rem. Supp. 1947 § 45.31.09.]

48.31.100 Foreign or alien insurers—Conservation, ancillary proceedings.

(1) An order to conserve the assets of a foreign or alien insurer must direct the commissioner immediately to take possession of the property of the insurer within this state and to conserve it, subject to the further direction of the court.

(2) Whenever a domiciliary receiver is appointed for a foreign or alien insurer in its domiciliary state that is also a reciprocal state, as defined in RCW 48.99.010, the court shall on application of the commissioner appoint the commissioner as the ancillary receiver in this state, subject to the provisions of the uniform insurers liquidation act. [2005 c 223 § 23; 1947 c 79 § .31.10; Rem. Supp. 1947 § 45.31.10.]

48.31.105 Conduct of proceedings—Requirement to cooperate—Definitions—Violations—Penalties.

(1) An officer, manager, director, trustee, owner, employee, or agent of an insurer or other person with authority over or in charge of a segment of the insurer's affairs shall cooperate with the commissioner in a proceeding under this chapter or an investigation preliminary to the proceeding. The term "person" as used in this section includes a person who exercises control directly or indirectly over activities of the insurer through a holding company or other affiliate of the insurer. "To cooperate" as used in this section includes the following:

(a) To reply promptly in writing to an inquiry from the commissioner requesting such a reply; and

(b) To make available to the commissioner books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his or her possession, custody, or control.

(2) A person may not obstruct or interfere with the commissioner in the conduct of a delinquency proceeding or an investigation preliminary or incidental thereto.

(3) This section does not abridge existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders.

(4) A person included within subsection (1) of this section who fails to cooperate with the commissioner, or a person who obstructs or interferes with the commissioner in the conduct of a delinquency proceeding or an investigation preliminary or incidental thereto, or who violates an order the commissioner issued validly under this chapter may:

(a) Be guilty of a gross misdemeanor and sentenced to pay a fine not exceeding ten thousand dollars or to undergo imprisonment for a term of not more than three hundred sixty-four days, or both; or

(b) After a hearing, be subject to the imposition by the commissioner of a civil penalty not to exceed ten thousand dollars and be subject further to the revocation or suspension of insurance licenses issued by the commissioner. [2011 c 96 § 38; 2003 c 53 § 272; 1993 c 462 § 58.]

Findings—Intent—2011 c 96: See note following RCW 9A.20.021.

Intent—Effective date—2003 c 53: See notes following RCW 2.48.180.

Additional notes found at www.leg.wa.gov

48.31.111 Commencement of delinquency proceeding by commissioner—Jurisdiction of courts. (1) A delinquency proceeding may not be commenced under this chapter by anyone other than the commissioner of this state, and no court has jurisdiction to entertain a proceeding commenced by another person.

(2) No court of this state has jurisdiction to entertain a complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of an insurer, or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to the proceedings, other than in accordance with this chapter.

(3) In addition to other grounds for jurisdiction provided by the law of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served under the rules of civil procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

(a) If the person served is an insurance producer, title insurance agent, surplus line broker, or other person who has written policies of insurance for or has acted in any manner on behalf of an insurer against which a delinquency proceeding has been instituted, in an action resulting from or incident to such a relationship with the insurer;

(b) If the person served is a reinsurer who has entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or is an insurance producer of or for the reinsurer, in an action on or incident to the reinsurance contract;

(c) If the person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in an action resulting from or incident to such a relationship with the insurer;

(d) If the person served is or was at the time of the institution of the delinquency proceeding against the insurer hold-

ing assets in which the receiver claims an interest on behalf of the insurer, in an action concerning the assets; or

(e) If the person served is obligated to the insurer in any way, in an action on or incident to the obligation.

(4) If the court on motion of a party finds that an action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state. [2009 c 162 § 27; 2008 c 217 § 43; 2003 c 248 § 11; 1993 c 462 § 59.]

Additional notes found at www.leg.wa.gov

48.31.115 Immunity from suit and liability—Persons entitled to protection. (1) The persons entitled to protection under this section are:

(a) The commissioner and any other receiver or administrative supervisor responsible for conducting a delinquency proceeding under this chapter, including present and former commissioners, administrative supervisors, and receivers; and

(b) The commissioner's employees, meaning all present and former special deputies and assistant special deputies and special receivers and special administrative supervisors appointed by the commissioner and all persons whom the commissioner, special deputies, or assistant special deputies have employed to assist in a delinquency proceeding under this chapter. Attorneys, accountants, auditors, and other professional persons or firms who are retained as independent contractors, and their employees, are not considered employees of the commissioner for purposes of this section.

(2) The commissioner and the commissioner's employees are immune from suit and liability, both personally and in their official capacities, for a claim for damage to or loss of property or personal injury or other civil liability caused by or resulting from an alleged act or omission of the commissioner or an employee arising out of or by reason of his or her duties or employment. However, nothing in this subsection may be construed to hold the commissioner or an employee immune from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of the commissioner or an employee.

(3) If a legal action is commenced against the commissioner or an employee, whether against him or her personally or in his or her official capacity, alleging property damage, property loss, personal injury, or other civil liability caused by or resulting from an alleged act or omission of the commissioner or an employee arising out of or by reason of his or her duties or employment, the commissioner and any employee shall be indemnified from the assets of the insurer for all expenses, attorneys' fees, judgments, settlements, decrees, or amounts due and owing or paid in satisfaction of or incurred in the defense of the legal action unless it is determined upon a final adjudication on the merits that the alleged act or omission of the commissioner or employee giving rise to the claim did not arise out of or by reason of his or her duties or employment, or was caused by intentional or willful and wanton misconduct.

(a) Attorneys' fees and related expenses incurred in defending a legal action for which immunity or indemnity is available under this section shall be paid from the assets of the insurer, as they are incurred, in advance of the final disposition of such action upon receipt of an undertaking by or on

behalf of the commissioner or employee to repay the attorneys' fees and expenses if it is ultimately determined upon a final adjudication on the merits and that the commissioner or employee is not entitled to immunity or indemnity under this section.

(b) Any indemnification under this section is an administrative expense of the insurer.

(c) In the event of an actual or threatened litigation against the commissioner or an employee for which immunity or indemnity may be available under this section, a reasonable amount of funds that in the judgment of the commissioner may be needed to provide immunity or indemnity shall be segregated and reserved from the assets of the insurer as security for the payment of indemnity until all applicable statutes of limitation have run or all actual or threatened actions against the commissioner or an employee have been completely and finally resolved, and all obligations of the insurer and the commissioner under this section have been satisfied.

(d) In lieu of segregation and reserving of funds, the commissioner may obtain a surety bond or make other arrangements that will enable the commissioner to secure fully the payment of all obligations under this section.

(4) If a legal action against an employee for which indemnity may be available under this section is settled before final adjudication on the merits, the insurer shall pay the settlement amount on behalf of the employee, or indemnify the employee for the settlement amount, unless the commissioner determines:

(a) That the claim did not arise out of or by reason of the employee's duties or employment; or

(b) That the claim was caused by the intentional or willful and wanton misconduct of the employee.

(5) In a legal action in which the commissioner is a defendant, that portion of a settlement relating to the alleged act or omission of the commissioner is subject to the approval of the court before which the delinquency proceeding is pending. The court may not approve that portion of the settlement if it determines:

(a) That the claim did not arise out of or by reason of the commissioner's duties or employment; or

(b) That the claim was caused by the intentional or willful and wanton misconduct of the commissioner.

(6) Nothing in this section removes or limits an immunity, indemnity, benefit of law, right, or defense otherwise available to the commissioner, an employee, or any other person, not an employee under subsection (1)(b) of this section, who is employed by or in the office of the commissioner or otherwise employed by the state. [2017 3rd sp.s. c 25 § 19; 2005 c 432 § 2; 1993 c 462 § 60.]

Additional notes found at www.leg.wa.gov

48.31.121 Court order for a formal delinquency proceeding—Commissioner may petition—Insurer may petition for hearing and review. (1) The commissioner may petition the court alleging, with respect to a domestic insurer:

(a) That there exists a ground that would justify a court order for a formal delinquency proceeding against an insurer under this chapter;

(b) That the interests of policyholders, creditors, or the public will be endangered by delay; and

(c) The contents of an order deemed necessary by the commissioner.

(2) Upon a filing under subsection (1) of this section, the court may issue forthwith, ex parte and without a hearing, the requested order that shall: Direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for transaction of its business; and until further order of the court enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the commissioner.

(3) The court shall specify in the order what the order's duration shall be, which shall be such time as the court deems necessary for the commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold hearings it deems desirable after such notice as it deems appropriate, and may extend, shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this chapter after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this chapter vacates the seizure order.

(4) Entry of a seizure order under this section does not constitute an anticipatory breach of a contract of the insurer.

(5) An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of an order under this section for a hearing and review of the order. The court shall hold the hearing and review not more than fifteen days after the request. A hearing under this subsection may be held privately in chambers, and it must be so held if the insurer proceeded against so requests.

(6) If, at any time after the issuance of an order under this section, it appears to the court that a person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given does not stay the effect of an order previously issued by the court. [1993 c 462 § 61.]

Additional notes found at www.leg.wa.gov

48.31.125 Order of liquidation—Termination of coverage. (1) All policies, including bonds and other noncancelable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation continue in force only until the earliest of:

(a) The end of a period of thirty days from the date of entry of the liquidation order;

(b) The expiration of the policy coverage;

(c) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

(d) The liquidator has effected a transfer of the policy obligation; or

(e) The date proposed by the liquidator and approved by the court to cancel coverage.

(2) An order of liquidation terminates coverages at the time specified in subsection (1) of this section for purposes of any other statute.

(3) Policies of life or health insurance or annuities shall continue in force for the period and under the terms provided by an applicable guaranty association or foreign guaranty association.

(4) Policies of life or health insurance or annuities or a period or coverage of the policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (1) and (2) of this section. [1993 c 462 § 62.]

Additional notes found at www.leg.wa.gov

48.31.131 Appointment of liquidator—Actions at law or equity—Statute of limitations or defense of laches. (1) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, an action at law or equity or in arbitration may not be brought against the insurer or liquidator, whether in this state or elsewhere, nor may such an existing action be maintained or further presented after issuance of the order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company when the injunctions are included in an order to liquidate an insurer issued under laws in other states corresponding to this subsection. Whenever, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, the liquidator may intervene in the action. The liquidator may defend an action in which he or she intervenes under this section at the expense of the estate of the insurer.

(2) The liquidator may institute an action or proceeding pursuant to an order of rehabilitation, within the later of two years following entry of the order or two years of the date the liquidator discovers, or in the exercise of reasonable care should have discovered, the injury from which the action or proceeding arose and its cause. However, actions against former directors, officers, and employees brought pursuant to an order of rehabilitation for the benefit or the protection of subscribers, policy beneficiaries, or the general public is subject to the limitations period of RCW 4.16.160.

(3) A statute of limitation or defense of laches does not run with respect to an action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. An action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the petition is denied.

(4) A guaranty association or foreign guaranty association has standing to appear in a court proceeding concerning the liquidation of an insurer if the association is or may become liable to act as a result of the liquidation. [2007 c 80 § 11; 1993 c 462 § 63.]

Additional notes found at www.leg.wa.gov

48.31.135 Recovery from reinsurers—Not reduced by delinquency proceedings—Direct payment to insured. The amount recoverable by the commissioner from reinsurers may not be reduced as a result of the delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement except as provided in RCW 48.31.290. Payment made directly to an insured or other creditor does not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct cov-

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erage of a named insured and the payment was made in discharge of that obligation. [1993 c 462 § 64.]

Additional notes found at www.leg.wa.gov

48.31.141 Responsibility for payment of a premium—Earned or unearned premium—Violations—Penalties—Rights of party aggrieved. (1)(a) An insurance producer, title insurance agent, surplus line broker, premium finance company, or any other person, other than the policy owner or the insured, responsible for the payment of a premium is obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency, whether earned or unearned, as shown on the records of the insurer. The liquidator also has the right to recover from the person a part of an unearned premium that represents commission of the person. Credits or setoffs or both may not be allowed to an insurance producer, title insurance agent, surplus line broker, or premium finance company for amounts advanced to the insurer by the insurance producer, title insurance agent, surplus line broker, or premium finance company on behalf of, but in the absence of a payment by, the policy owner or the insured.

(b) Notwithstanding (a) of this subsection, the insurance producer, title insurance agent, surplus line broker, premium finance company, or other person is not liable for uncollected unearned premium of the insurer. A presumption exists that the premium as shown on the books of the insurer is collected, and the burden is upon the insurance producer, title insurance agent, surplus line broker, premium finance company, or other person to demonstrate by a preponderance of the evidence that the unearned premium was not actually collected. For purposes of this subsection, "unearned premium" means that portion of an insurance premium covering the unexpired term of the policy or the unexpired period of the policy period.

(c) An insured is obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the records of the insurer.

(2) Upon a violation of this section, the commissioner may pursue either one or both of the following courses of action:

(a) Suspend or revoke or refuse to renew the licenses of the offending party or parties;

(b) Impose a penalty of not more than one thousand dollars for each violation.

(3) Before the commissioner may take an action as set forth in subsection (2) of this section, he or she shall give written notice to the person accused of violating the law, stating specifically the nature of the alleged violation, and fixing a time and place, at least ten days thereafter, when a hearing on the matter shall be held. After the hearing, or upon failure of the accused to appear at the hearing, the commissioner, if he or she finds a violation, shall impose those penalties under subsection (2) of this section that he or she deems advisable.

(4) When the commissioner takes action in any or all of the ways set out in subsection (2) of this section, the party aggrieved has the rights granted under the Administrative Procedure Act, chapter 34.05 RCW. [2009 c 162 § 28; 2008 c 217 § 44; 1993 c 462 § 65.]

Additional notes found at www.leg.wa.gov

48.31.145 Liquidator denies claim—Written notice—Objections of claimant—Court hearing. (1) When the liquidator denies a claim in whole or in part, the liquidator shall give written notice of the determination to the claimant or the claimant's attorney by first-class mail at the address shown in the proof of claim. Within sixty days from the mailing of the notice, the claimant may file his or her objections with the liquidator. If no such a filing is made, the claimant may not further object to the determination.

(2) Whenever the claimant files objections with the liquidator and the liquidator does not alter his or her denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first-class mail to the claimant or the claimant's attorney and to other persons directly affected, not less than ten nor more than thirty days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with his or her recommendation. [1993 c 462 § 66.]

Additional notes found at www.leg.wa.gov

48.31.151 Creditor's claim against insurer is secured by other person—Subrogated rights—Agreements concerning distributions. Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person, fails to prove and file that claim, the other person may do so in the creditor's name, and is subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he or she discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person is not entitled to a distribution until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. The creditor shall hold any excess received by him or her in trust for the other person. The term "other person" as used in this section does not apply to a guaranty association or foreign guaranty association. [1993 c 462 § 67.]

Additional notes found at www.leg.wa.gov

48.31.155 Unclaimed funds—Liquidator's application for discharge—Deposits with the department of revenue. Unclaimed funds subject to distribution remaining in the liquidator's hands when he or she is ready to apply to the court for discharge, including the amount distributable to a person who is unknown or cannot be found, shall be deposited with the state department of revenue as unclaimed funds, and shall be paid without interest to the person entitled to them or his or her legal representative upon proof satisfactory to the state department of revenue of his or her right to them. An amount on deposit not claimed within six years from the discharge of the liquidator is deemed to have been abandoned and shall be escheated without formal escheat proceedings and be deposited with the state treasurer. [2007 c 80 § 12; 1993 c 462 § 68.]

Additional notes found at www.leg.wa.gov

48.31.161 After termination of liquidation proceeding—Good cause to reopen proceedings. After the liquidation proceeding has been terminated and the liquidator dis-

charged, the commissioner or other interested party may at any time petition the court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order. [1993 c 462 § 69.]

Additional notes found at www.leg.wa.gov

48.31.165 Domiciliary receiver not appointed—Court order to liquidate—Notice—Domiciliary receiver appointed in other state. (1) If no domiciliary receiver has been appointed, the commissioner may apply to the court for an order directing him or her to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state, on any of the grounds stated in: RCW 48.31.030, except subsection (10) of that section; 48.31.050(2); or 48.31.080.

(2) When an order is sought under subsection (1) of this section, the court shall cause the insurer to be given thirty days' notice and time to respond, or a lesser period reasonable under the circumstances.

(3) If it appears to the court that the best interests of creditors, policyholders, and the public require, the court may issue an order to liquidate in whatever terms it deems appropriate. The filing or recording of the order with the recorder of deeds of the county in which the principal business of the company in this state is located or the county in which its principal office or place of business in this state is located, imparts the same notice as a deed or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(4) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under RCW 48.99.030. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under RCW 48.99.030.

(5) On the same grounds as are specified in subsection (1) of this section, the commissioner may petition an appropriate federal court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part thereof that the commissioner deems desirable for the protection of policyholders, creditors, and the public in this state.

(6) The court may order the commissioner, when he or she has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of this state against the insurer under those rules on the liquidation of insurers under this chapter that are otherwise compatible with this section. [1993 c 462 § 70.]

Additional notes found at www.leg.wa.gov

48.31.171 Domiciliary liquidator—Reciprocal state—Nonreciprocal state—Commissioner's duties. (1) Except as to special deposits and security on secured claims under RCW 48.99.030(2), the domiciliary liquidator of an insurer domiciled in a reciprocal state is vested by operation of law with the title to all of the assets, property, contracts, and rights of action, agents' balances, and all the books, accounts, and other records of the insurer located in this state.

The date of vesting is the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting is the date of entry of the order directing possession to be taken. The domiciliary liquidator has the immediate right to recover balances due from agents and to obtain possession of the books, accounts, and other records of the insurer located in this state. The domiciliary liquidator also has the right to recover all other assets of the insurer located in this state, subject to RCW 48.99.030.

(2) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this state is vested by operation of law with the title to all of the property, contracts, and rights of action, and all the books, accounts, and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The commissioner of this state may petition for a conservation or liquidation order under RCW 48.31.100 or 48.99.030, or for an ancillary receivership under RCW 48.99.030, or after approval by the court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(3) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings. [1993 c 462 § 71.]

Additional notes found at www.leg.wa.gov

48.31.175 Foreign or alien insurer—Property located in this state—Commissioner's discretion. The commissioner in his or her sole discretion may institute proceedings under RCW 48.31.121 at the request of the commissioner or other appropriate insurance official of the domiciliary state of a foreign or alien insurer having property located in this state. [1993 c 462 § 72.]

Additional notes found at www.leg.wa.gov

48.31.181 Liquidation proceedings—One or more reciprocal states—Distributions—Special deposit claims—Secured claims. (1) In a liquidation proceeding in this state involving one or more reciprocal states, the order of distribution of the domiciliary state controls as to claims of residents of this and reciprocal states. Claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where the assets are located.

(2) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in a deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the 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.

(3) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or another 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. [1993 c 462 § 73.]

Additional notes found at www.leg.wa.gov

48.31.184 Ancillary receiver in another state or foreign country—Failure to transfer assets. If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state assets within his or her control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, then the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under RCW 48.31.280(8). [2003 c 248 § 12; 1993 c 462 § 74.]

Additional notes found at www.leg.wa.gov

48.31.185 Receiver's proposal to disperse assets upon liquidation—Application for approval—Contents of proposal—Notice of application. (1) Within one hundred twenty days of a final determination of insolvency of an insurer and order of liquidation by a court of competent jurisdiction of this state, the receiver shall make application to the court for approval of a proposal to disperse assets out of that insurer's marshalled assets from time to time as assets become available to the Washington insurance guaranty association and the Washington life and disability insurance guaranty association and to any entity or person performing a similar function in another state. For purposes of this section, "associations" means the Washington insurance guaranty association and the Washington life and disability insurance guaranty association and any entity or person performing a similar function in other states.

(2) Such a proposal must at least include provisions for:

- (a) Reserving amounts for the payment of claims falling within the priorities established in RCW 48.31.280;
- (b) Disbursement of the assets marshalled to date and subsequent disbursements of assets as they become available;
- (c) Equitable allocation of disbursements to each of the associations entitled thereto;

(d) The securing by the receiver from each of the associations entitled to disbursements pursuant to this section an agreement to return to the receiver assets previously disbursed that are required to pay claims of secured creditors and claims falling within the priorities established in RCW 48.31.280. A bond is not required of any association; and

(e) A full report by the association to the receiver accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on those assets, and any other matters as the court may direct.

(3) The receiver's proposal must provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the receiver, and must further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of the claim payments made or to be made by the

associations then disbursements must be in the amount of available assets.

(4) The receiver's proposal shall, with respect to an insolvent insurer writing life insurance, disability insurance, or annuities, provide for disbursements of assets to the Washington life and disability insurance guaranty association or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the provisions of the Washington life and disability insurance guaranty association act.

(5) Notice of an application must be given to the associations in and to the commissioners of insurance of each of the states. Notice is effected when deposited in the United States certified mails, first class postage prepaid, at least thirty days prior to submission of the application to the court. [2003 c 248 § 13; 1975-'76 2nd ex.s. c 109 § 10.]

48.31.190 Commencement of proceeding—Venue—Effect of appellate review. (1) Proceedings under this chapter involving a domestic insurer shall be commenced in the superior court for the county in which is located the insurer's home office or, at the election of the commissioner, in the superior court for Thurston county. Proceedings under this chapter involving other insurers shall be commenced in the superior court for Thurston county.

(2) The commissioner shall commence any such proceeding, the attorney general representing him or her, by an application to the court or to any judge thereof, for an order directing the insurer to show cause why the commissioner should not have the relief prayed for.

(3) Upon a showing of an emergency or threat of imminent loss to policyholders of the insurer the court may issue an ex parte order authorizing the commissioner immediately to take over the premises and assets of the insurer, the commissioner then to preserve the status quo, pending a hearing on the order to show cause, which shall be heard as soon as the court calendar permits in preference to other civil cases.

(4) In response to any order to show cause issued under this chapter the insurer shall have the burden of going forward with and producing evidence to show why the relief prayed for by the commissioner is not required.

(5) On the return of such order to show cause, and after a full hearing, the court shall either deny the relief sought in the application or grant the relief sought in the application together with such other relief as the nature of the case and the interest of policyholders, creditors, stockholders, members, subscribers, or the public may require.

(6) No appellate review of a superior court order, entered after a hearing, granting the commissioner's petition to rehabilitate an insurer or to carry out an insolvency proceeding under this chapter, shall stay the action of the commissioner in the discharge of his responsibilities under this chapter, pending a decision by the appellate court in the matter.

(7) In any proceeding under this chapter the commissioner and his or her deputies shall be responsible on their official bonds for the faithful performance of their duties. If the court deems it desirable for the protection of the assets, it may at any time require an additional bond from the commissioner or his or her deputies. [2009 c 549 § 7127; 1993 c 462 § 82; 1988 c 202 § 46; 1969 ex.s. c 241 § 13; 1967 c 150 § 31; 1947 c 79 § .31.19; Rem. Supp. 1947 § 45.31.19.]

Additional notes found at www.leg.wa.gov

48.31.200 Injunctions. (1) Upon application by the commissioner for such an order to show cause or at any time thereafter, the court may without notice issue an injunction restraining the insurer, its officers, directors, stockholders, members, subscribers, agents, and all other persons from the transaction of its business or the waste or disposition of its property until the further order of the court.

(2) The court may at any time during a proceeding under this chapter issue such other injunctions or orders as may be deemed necessary to prevent interference with the commissioner or the proceeding, or waste of the assets of the insurer, or the commencement or prosecution of any actions, or the obtaining of preferences, judgments, attachments or other liens, or the making of any levy against the insurer or against its assets or any part thereof. [1947 c 79 § .31.20; Rem. Supp. 1947 § 45.31.20.]

48.31.210 Change of venue. At any time after the commencement of a proceeding under this chapter the commissioner may apply to the court for an order changing the venue of, and removing the proceeding to Thurston county, or to any other county of this state in which he or she deems that such proceeding may be most economically and efficiently conducted. [2009 c 549 § 7128; 1947 c 79 § .31.21; Rem. Supp. 1947 § 45.31.21.]

48.31.220 Deposit of moneys collected. The moneys collected by the commissioner in a proceeding under this chapter, shall be, from time to time, deposited in one or more state or national banks, savings banks, or trust companies, and in the case of the insolvency or voluntary or involuntary liquidation of any such depository which is an institution organized and supervised under the laws of this state, such deposits shall be entitled to priority of payment on an equality with any other priority given by the banking law of this state. The commissioner may in his or her discretion deposit such moneys or any part thereof in a national bank or trust company as a trust fund. [2009 c 549 § 7129; 1947 c 79 § .31.22; Rem. Supp. 1947 § 45.31.22.]

48.31.230 Exemption from filing fees. The commissioner shall not be required to pay any fee to any public officer in this state for filing, recording, issuing a transcript or certificate, or authenticating any paper or instrument pertaining to the exercise by the commissioner of any of the powers or duties conferred upon him or her under this chapter, whether or not such paper or instrument be executed by the commissioner or his or her deputies, employees, or attorneys of record and whether or not it is connected with the commencement of an action or proceeding by or against the commissioner, or with the subsequent conduct of such action or proceeding. [2009 c 549 § 7130; 1947 c 79 § .31.23; Rem. Supp. 1947 § 45.31.23.]

48.31.240 Borrowing on pledge of assets. For the purpose of facilitating the rehabilitation, liquidation, conservation or dissolution of an insurer pursuant to this chapter the commissioner may, subject to the approval of the court, borrow money and execute, acknowledge and deliver notes or

other evidences of indebtedness therefor and secure the repayment of the same by the mortgage, pledge, assignment, transfer in trust, or hypothecation of any or all of the property whether real, personal or mixed of such insurer, and the commissioner, subject to the approval of the court, shall have power to take any and all other action necessary and proper to consummate any such loans and to provide for the repayment thereof. The commissioner shall be under no obligation personally or in his or her official capacity as commissioner to repay any loan made pursuant to this section. [2009 c 549 § 7131; 1947 c 79 § .31.24; Rem. Supp. 1947 § 45.31.24.]

48.31.260 Liquidation—Date rights, liabilities fixed.

The rights and liabilities of the insurer and of its creditors, policyholders, stockholders, members, subscribers, and all other persons interested in its estate shall, unless otherwise directed by the court, be fixed as of the date on which the order directing the liquidation of the insurer is filed in the office of the clerk of the court which made the order, subject to the provisions of RCW 48.31.300 with respect to the rights of claimants holding contingent claims and RCW 48.31.280 with respect to the priority and order of distributions of claims. [2001 c 40 § 2; 1947 c 79 § .31.26; Rem. Supp. 1947 § 45.31.26.]

Additional notes found at www.leg.wa.gov

48.31.270 Voidable transfers. (1) Any transfer of, or lien upon, the property of an insurer which is made or created within four months prior to the granting of an order to show cause under this chapter with the intent of giving to any creditor or of enabling him or her to obtain a greater percentage of his or her debt than any other creditor of the same class and which is accepted by such creditor having reasonable cause to believe that such a preference will occur, shall be voidable.

(2) Every director, officer, employee, stockholder, member, subscriber, and any other person acting on behalf of such insurer who shall be concerned in any such act or deed and every person receiving thereby any property of such insurer or the benefit thereof shall be personally liable therefor and shall be bound to account to the commissioner.

(3) The commissioner as liquidator, rehabilitator or conservator in any proceeding under this chapter, may avoid any transfer of, or lien upon the property of an insurer which any creditor, stockholder, subscriber or member of such insurer might have avoided and may recover the property so transferred unless such person was a bona fide holder for value prior to the date of the granting of an order to show cause under this chapter. Such property or its value may be recovered from anyone who has received it except a bona fide holder for value as above specified. [2009 c 549 § 7132; 1947 c 79 § .31.27; Rem. Supp. 1947 § 45.31.27.]

48.31.280 Priority and order of distribution of claims. The priority of distribution of claims from the insurer's estate is as follows: Every claim in a class must be paid in full or adequate funds retained for payment before the members of the next class receive any payment; no subclasses may be established within a class; and no claim by a shareholder, policyholder, or other creditor may circumvent the priority classes through the use of equitable remedies. The order of distribution of claims is:

(1) Class 1. The costs and expenses of administration during rehabilitation and liquidation, including but not limited to the following:

(a) The actual and necessary costs of preserving or recovering the assets of the insurer;

(b) Compensation for all authorized services rendered in the rehabilitation and liquidation;

(c) Necessary filing fees;

(d) The fees and mileage payable to witnesses;

(e) Authorized reasonable attorneys' fees and other professional services rendered in the rehabilitation and liquidation;

(f) The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses.

(2) Class 2. Loss claims. For purposes of this section, loss claims are all claims under policies, including claims of the federal or a state or local government, for losses incurred, including third-party claims, and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, are loss claims. That portion of any loss indemnification that is provided for by other benefits or advantages recovered by the claimant, is not included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to an employee may be treated as a gratuity. Loss claims also include claims under nonassessable policies for unearned premium or other premium refunds.

(3) Class 3. Claims of the federal government, other than claims which are included as loss claims under subsection (2) of this section.

(4) Class 4. Reasonable compensation to employees for services performed to the extent that they do not exceed two months of monetary compensation and represent payment for services performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation; except, where there are no claims and no potential claims of the federal government in the estate, in which case claims in this class shall have priority over claims in class 2 and below. Principal officers and directors are not entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. This priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.

(5) Class 5. Claims of general creditors including claims of ceding and assuming companies in their capacity as such.

(6) Class 6. Claims of any state or local government, except those under subsection (2) of this section. Claims, including those of any governmental body for a penalty or forfeiture, are allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims are postponed to the class of claims under subsection (9) of this section.

(7) Class 7. Claims filed late or any other claims other than claims under subsections (8) and (9) of this section.

(8) Class 8. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies are limited in accordance with law.

(9) Class 9. The claims of shareholders or other owners in their capacity as shareholders. [2001 c 40 § 1; 1993 c 462 § 83; 1975-'76 2nd ex.s. c 109 § 1; 1947 c 79 § .31.28; Rem. Supp. 1947 § 45.31.28.]

Additional notes found at www.leg.wa.gov

48.31.290 Offsets. (1) In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this chapter, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection (2) of this section.

(2) No offset shall be allowed in favor of any such person where (a) the obligation of the insurer to such person would not at the date of the entry of any liquidation order, or otherwise, as provided in RCW 48.31.260, entitle him or her to share as a claimant in the assets of the insurer, or (b) the obligation of the insurer to such person was purchased by or transferred to such person with a view of its being used as an offset, or (c) the obligation of such person is to pay an assessment levied against the members of a mutual insurer, or against the subscribers of a reciprocal insurer, or is to pay a balance upon a subscription to the capital stock of a stock insurer. [2009 c 549 § 7133; 1947 c 79 § .31.29; Rem. Supp. 1947 § 45.31.29.]

48.31.300 Allowance of contingent and other claims.

(1) No contingent claim shall share in a distribution of the assets of an insurer which has been adjudicated to be insolvent by an order made pursuant to RCW 48.31.310, except that such claims shall be considered, if properly presented, and may be allowed to share where:

(a) Such claim becomes absolute against the insurer on or before the last day fixed for filing of proofs of claim against the assets of such insurer, or

(b) There is a surplus and the liquidation is thereafter conducted upon the basis that such insurer is solvent.

(2) Where an insurer has been so adjudicated to be insolvent any person who has a cause of action against an insured of such insurer under a liability insurance policy issued by such insurer, shall have the right to file a claim in the liquidation proceeding, regardless of the fact that such claim may be contingent, and such claim may be allowed

(a) If it may be reasonably inferred from the proof presented upon such claim that such person would be able to obtain a judgment upon such cause of action against such insured; and

(b) If such person shall furnish suitable proof, unless the court for good cause shown shall otherwise direct, that no further valid claims against such insurer arising out of his or her cause of action other than those already presented can be made; and

(c) If the total liability of such insurer to all claimants arising out of the same act of its insured shall be no greater than its maximum liability would be were it not in liquidation.

No judgment against such an insured taken after the date of the entry of the liquidation order shall be considered in the liquidation proceedings as evidence of liability, or of the amount of damages, and no judgment against an insured taken by default, inquest or by collusion prior to the entry of the liquidation order shall be considered as conclusive evidence in the liquidation proceeding either of the liability of such insured to such person upon such cause of action or of the amount of damages to which such person is therein entitled.

(3) No claim of any secured claimant shall be allowed at a sum greater than the difference between the value of the claim without security and the value of the security itself as of the date of the entry of the order of liquidation or such other date set by the court for fixation of rights and liabilities as provided in RCW 48.31.260 unless the claimant shall surrender his or her security to the commissioner in which event the claim shall be allowed in the full amount for which it is valued.

(4) Whether or not the third party files a claim, the insured may file a claim on his or her own behalf in the liquidation.

(5) No claim may be presented under this section if it is or may be covered by a guaranty association or foreign guaranty association. [1993 c 462 § 84; 1947 c 79 § .31.30; Rem. Supp. 1947 § 45.31.30.]

Additional notes found at www.leg.wa.gov

48.31.310 Time to file claims. (1) If upon the granting of an order of liquidation under this chapter or at any time thereafter during the liquidation proceeding, the insurer shall not be clearly solvent, the court shall after such notice and hearing as it deems proper, make an order declaring the insurer to be insolvent. Thereupon, regardless of any prior notice which may have been given to creditors, the commissioner shall notify all persons who may have claims against such insurer and who have not filed proper proofs thereof, to present the same to him or her, at a place specified in such notice, within four months from the date of the entry of such order, or if the commissioner shall certify that it is necessary, within such longer time as the court shall prescribe. The last day for the filing of proofs of claim shall be specified in the notice. Such notice shall be given in a manner determined by the court.

(2) Proofs of claim may be filed subsequent to the date specified, but no such claim shall share in the distribution of the assets until all allowed claims, proofs of which have been filed before said date, have been paid in full with interest. [2009 c 549 § 7134; 1947 c 79 § .31.31; Rem. Supp. 1947 § 45.31.31.]

48.31.320 Report for assessment. Within three years from the date an order of rehabilitation or liquidation of a domestic mutual insurer or a domestic reciprocal insurer was filed in the office of the clerk of the court by which such order was made, the commissioner may make a report to the court setting forth

- (1) the reasonable value of the assets of the insurer;
- (2) the insurer's probable liabilities; and

(3) the probable necessary assessment, if any, to pay all claims and expenses in full, including expenses of administration. [1947 c 79 § .31.32; Rem. Supp. 1947 § 45.31.32.]

48.31.330 Levy of assessment. (1) Upon the basis of the report provided for in RCW 48.31.320, including any amendments thereof, the court, ex parte, may levy one or more assessments against all members of such insurer who, as shown by the records of the insurer, were members (if a mutual insurer) or subscribers (if a reciprocal insurer) at any time within one year prior to the date of issuance of the order to show cause under RCW 48.31.190.

(2) Such assessment or assessments shall cover the excess of the probable liabilities over the reasonable value of the assets, together with the estimated cost of collection and percentage of uncollectibility thereof. The total of all assessments against any member or subscriber with respect to any policy, whether levied pursuant to this chapter or pursuant to any other provisions of this code, shall be for no greater amount than that specified in the policy or policies of the member or subscriber and as limited under this code; except that if the court finds that the policy was issued at a rate of premium below the minimum rate lawfully permitted for the risk insured, the court may determine the upper limit of such assessment upon the basis of such minimum rate.

(3) No assessment shall be levied against any member or subscriber with respect to any nonassessable policy issued in accordance with this code. [1947 c 79 § .31.33; Rem. Supp. 1947 § 45.31.33.]

48.31.340 Order for payment of assessment. After levy of assessment as provided in RCW 48.31.330, upon the filing of a further detailed report by the commissioner, the court shall issue an order directing each member (if a mutual insurer) or each subscriber (if a reciprocal insurer) if he or she shall not pay the amount assessed against him or her to the commissioner on or before a day to be specified in the order, to show cause why he or she should not be held liable to pay such assessment together with costs as set forth in RCW 48.31.360 and why the commissioner should not have judgment therefor. [2009 c 549 § 7135; 1947 c 79 § .31.34; Rem. Supp. 1947 § 45.31.34.]

48.31.350 Publication, transmittal of assessment order. The commissioner shall cause a notice of such assessment order setting forth a brief summary of the contents of such order to be:

(1) Published in such manner as shall be directed by the court; and

(2) Enclosed in a sealed envelope, addressed and mailed postage prepaid to each member or subscriber liable thereunder at his or her last known address as it appears on the records of the insurer, at least twenty days before the return day of the order to show cause provided for in RCW 48.31.340. [2009 c 549 § 7136; 1947 c 79 § .31.35; Rem. Supp. 1947 § 45.31.35.]

48.31.360 Judgment upon the assessment. (1) On the return day of the order to show cause provided for in RCW 48.31.340 if the member or subscriber does not appear and serve verified objections upon the commissioner, the court

shall make an order adjudging that such member or subscriber is liable for the amount of the assessment against him or her together with ten dollars costs, and that the commissioner may have judgment against the member or subscriber therefor.

(2) If on such return day the member or subscriber shall appear and serve verified objections upon the commissioner there shall be a full hearing before the court or a referee to hear and determine, who, after such hearing, shall make an order either negating the liability of the member or subscriber to pay the assessment or affirming his or her liability to pay the whole or some part thereof together with twenty-five dollars costs and the necessary disbursements incurred at such hearing, and directing that the commissioner in the latter case may have judgment therefor.

(3) A judgment upon any such order shall have the same force and effect, and may be entered and docketed, and may be appealed from as if it were a judgment in an original action brought in the court in which the proceeding is pending. [2009 c 549 § 7137; 1947 c 79 § .31.36; Rem. Supp. 1947 § 45.31.36.]

48.31.400 Administrative supervision—Conditions—Notice and hearing. (1) An insurer may be subject to administrative supervision by the commissioner if upon examination or at any other time the commissioner makes a finding that:

(a) The insurer's condition renders the continuance of its business financially hazardous to the public or to its insureds consistent with this title or any rules adopted by the commissioner;

(b) The insurer has or appears to have exceeded its powers granted under its certificate of authority and this title or any rules adopted by the commissioner;

(c) The insurer has failed to comply with the applicable provisions of Title 48 RCW or rules adopted by the commissioner such that its condition has or will render the continuance of its business financially hazardous to the public or to its insureds;

(d) The business of the insurer is being conducted fraudulently; or

(e) The insurer gives its consent.

(2) If the commissioner determines that the conditions set forth in subsection (1) of this section exist, the commissioner shall:

(a) Notify the insurer of his or her determination;

(b) Furnish to the insurer a written list of the requirements to abate this determination; and

(c) Notify the insurer that it is under the supervision of the commissioner and that the commissioner is applying and effectuating the provisions of this chapter. Action by the commissioner shall be subject to review pursuant to chapters 48.04 and 34.05 RCW.

(3) If placed under administrative supervision, the insurer has sixty days, or another period of time as designated by the commissioner, to comply with the requirements of the commissioner subject to the provisions of this chapter.

(4) If it is determined after notice and hearing that the conditions giving rise to the administrative supervision still exist at the end of the supervision period under subsection (3) of this section, the commissioner may extend the period.

(5) If it is determined that none of the conditions giving rise to the administrative supervision exist, or that the insurer has remedied the conditions that gave rise to the supervision, the commissioner shall release the insurer from supervision. [2005 c 432 § 3.]

48.31.405 Administrative supervision—Confidentiality. (1) Except as set forth in this section, proceedings, hearings, notices, correspondence, reports, records, and other information in the possession of the commissioner relating to the supervision of any insurer under this chapter are confidential and are 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, except as provided by this section. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(2) The employees of the commissioner have access to these proceedings, hearings, notices, correspondence, reports, records, or information as permitted by the commissioner. Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner is 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) The commissioner may share the notices, correspondence, reports, records, or information with other state, federal, and international regulatory agencies, with the national association of insurance commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, if the commissioner determines that the disclosure is necessary or proper for the enforcement of the laws of this or another state of the United States, and provided that the recipient agrees to maintain the confidentiality of the documents, material, or other information. No waiver of any applicable privilege or claim of confidentiality may occur as a result of the sharing of documents, materials, or other information under this subsection.

(4) The commissioner may open the proceedings or hearings or make public the notices, correspondence, reports, records, or other information if the commissioner deems that it is in the best interest of the public or in the best interest of the insurer or its insureds, creditors, or the general public. However, the determination of whether to disclose any confidential information at the public proceedings or hearings is subject to applicable law.

(5) This section does not apply to hearings, notices, correspondence, reports, records, or other information obtained upon the appointment of a receiver for the insurer by a court of competent jurisdiction. [2006 c 209 § 5; 2005 c 432 § 4.]

48.31.410 Administrative supervision—Standards and procedures—Limitations on insurer. During the period of administrative supervision, the commissioner or the commissioner's designated appointee shall serve as the administrative supervisor. The commissioner shall establish standards and procedures that maintain reasonable and customary claims practices and otherwise provide for the orderly continuation of the insurer's operations and business. Consid-

ering these standards and procedures, the commissioner may provide that the insurer may not do any of the following things during the period of supervision, without the prior approval of the commissioner or the appointed administrative supervisor:

- (1) Dispose of, convey, or encumber any of its assets or its business in force;
- (2) Withdraw any of its bank accounts;
- (3) Lend any of its funds;
- (4) Invest any of its funds;
- (5) Transfer any of its property;
- (6) Incur any debt, obligation, or liability;
- (7) Merge or consolidate with another company;
- (8) Approve new premiums or renew any policies;
- (9) Enter into any new reinsurance contract or treaty;
- (10) Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate, or contract, except for nonpayment of premiums due;
- (11) Release, pay, or refund premium deposits; accrued cash or loan values; unearned premiums; or other reserves on any insurance policy, certificate, or contract;
- (12) Make any material change in management; or
- (13) Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends, or other payments deemed preferential. [2005 c 432 § 5.]

48.31.415 Administrative supervision—Insurer may contest. During the period of administrative supervision the insurer may contest an action taken, proposed to be taken, or failed to be taken by the administrative supervisor specifying the manner wherein the action being complained of would not result in improving the condition of the insurer. Denial of the insurer's request upon reconsideration entitles the insurer to request a proceeding under chapters 48.04 and 34.05 RCW. [2005 c 432 § 6.]

48.31.420 Administrative supervision—No limitation on judicial proceedings. RCW 48.31.020, 48.31.115, 48.31.400 through 48.31.415, 48.31.425, and 48.31.435 do not preclude the commissioner from initiating judicial proceedings to place an insurer in rehabilitation or liquidation proceedings or other delinquency proceedings, however designated under the laws of this state, regardless of whether the commissioner has previously initiated administrative supervision proceedings under this chapter against the insurer. [2005 c 432 § 7.]

48.31.425 Administrative supervision—Commissioner contacts. The commissioner may meet with the administrative supervisor appointed under this chapter and with the attorney or other representative of the administrative supervisor, without the presence of any other person, at the time of any proceeding or during the pendency of any proceeding held under authority of this chapter to carry out the commissioner's duties under this chapter or for the supervisor to carry out his or her duties under this chapter. [2005 c 432 § 8.]

48.31.430 Administrative supervision—Chapters 48.04 and 34.05 RCW. An action or the failure to act by the

commissioner is subject to chapters 48.04 and 34.05 RCW. [2005 c 432 § 9.]

48.31.435 Administrative supervision—Rules. The commissioner may adopt rules to implement and administer RCW 48.31.020, 48.31.115, and 48.31.400 through 48.31.425. [2005 c 432 § 10.]

Chapter 48.31B RCW INSURER HOLDING COMPANY ACT

Sections

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48.31B.901	Severability—1993 c 462.
48.31B.902	Implementation—1993 c 462.

48.31B.005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Affiliate" means an affiliate of, or person affiliated with, a specific person, and includes 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 insurance commissioner, the commissioner's deputies, or the office of the insurance commissioner, as appropriate.

(3) "Control," including the terms "controlling," "controlled by," and "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 con-

tract 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. Control is presumed to exist if 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. This presumption may be rebutted by a showing made in a manner similar to that provided by RCW 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 such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(4) "Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in RCW 48.05.440 or 48.43.310 or would cause the insurer to be in hazardous financial condition as defined in WAC 284-16-310.

(5) "Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner under RCW 48.31B.036 to have sufficient contacts with the internationally active insurance group.

(6) "Insurance holding company system" means a system that consists of two or more affiliated persons, one or more of which is an insurer.

(7) "Insurer" includes an insurer authorized under chapter 48.05 RCW, a fraternal mutual insurer or society holding a license under RCW 48.36A.290, a health care service contractor registered under chapter 48.44 RCW, a health maintenance organization registered under chapter 48.46 RCW, and a self-funded multiple employer welfare arrangement under chapter 48.125 RCW, as well as all persons engaged as, or purporting to be engaged as insurers, fraternal benefit societies, health care service contractors, health maintenance organizations, or self-funded multiple employer welfare arrangements in this state, and to persons in process of organization to become insurers, fraternal benefit societies, health care service contractors, health maintenance organizations, or self-funded multiple employer welfare arrangements, except it does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(8) "Internationally active insurance group" means an insurance holding company system that:

(a) Includes an insurer registered under RCW 48.31B.025; and

(b) Meets the following criteria:

(i) Premiums written in at least three countries;

(ii) The percentage of gross premiums written outside the United States is at least ten percent of the insurance holding company system's total gross written premiums; and

(iii) Based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars or the total gross written premiums of the insurance holding company system are at least ten billion dollars.

(9) "Person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert, but does not include a joint venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property.

(10) "Securityholder" means a securityholder of a specified person who owns any security of that person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

(11) "Subsidiary" means a subsidiary of a specified person who is an affiliate controlled by that person directly or indirectly through one or more intermediaries.

(12) "Voting security" includes any security convertible into or evidencing a right to acquire a voting security. [2020 c 243 § 1; 2015 c 122 § 1; 1993 c 462 § 2.]

Effective dates—2015 c 122: "Except for section 14 of this act, which takes effect July 1, 2017, this act takes effect January 1, 2016." [2015 c 122 § 23.]

48.31B.010 Domestic insurer may acquire subsidiaries—Authorized investments—Insurer ceases to control subsidiary—Disposal of investment. (1) A domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. The subsidiaries may conduct any kind of business or businesses and their authority to do so is not limited by reason of the fact that they are subsidiaries of a domestic insurer.

(2) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under this title, a domestic insurer may also:

(a) Invest in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of ten percent of the insurer's assets or fifty percent of the insurer's surplus as regards policyholders, provided that, after such investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries, health maintenance organizations, and health care service contractors are excluded, and there is included:

(i) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities;

(ii) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities; and

(iii) All contributions to the capital and surplus of a subsidiary subsequent to its acquisition or formation;

(b) Invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer provided that each subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in (a) of this subsection or chapter 48.13 RCW applicable to the insurer. For the purpose of this subsection, the total investment of the insurer includes:

(i) Any direct investment by the insurer in an asset;

(ii) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which is calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary; and

(iii) With the approval of the commissioner, any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries, provided that after the investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(3) Investments in common stock, preferred stock, debt obligations, or other securities made according to subsection (2) of this section are not subject to any of the otherwise applicable restrictions or prohibitions contained in this title applicable to such investments of insurers.

(4) Whether any investment made according to subsection (2) of this section meets the applicable requirements of that subsection is to be determined before the investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, net including dividends.

(5) If an insurer ceases to control a subsidiary, it shall dispose of any investment in that subsidiary within three years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after the investment was made, the investment met the requirements for investment under any other section of this title, and the insurer has notified the commissioner thereof. [2015 c 122 § 2; 1993 c 462 § 3.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.015 Control of insurer—Acquisition, merger, or exchange—Preacquisition notification—Divestment of controlling interest—Jurisdiction of courts. (1)(a) No person other than the issuer may make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities of, seek to acquire, or acquire, in the open market or otherwise, voting security of a domestic insurer if, after the consummation thereof, the person would, directly or indirectly, or by conversion or by exercise of a right to acquire, be in control of the insurer and no person may enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time the offer,

request, or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the insurer, a statement containing the information required by this section and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner as prescribed in this chapter.

(b) For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, must file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least thirty days prior to the cessation of control. The commissioner determines whether the person or persons seeking to divest or acquire a controlling interest in an insurer must file and obtain approval of the transaction. The information remains confidential until the conclusion of the transaction unless the commissioner, in his or her discretion, determines that the confidential treatment interferes with the enforcement of this section. If the statement referred to in (a) of this subsection is otherwise filed, this subsection does not apply.

(c) With respect to a transaction subject to this section, the acquiring person must also file a preacquisition notification with the commissioner, which must contain the information set forth in RCW 48.31B.020(3)(a). A failure to file the notification may be subject to penalties specified in RCW 48.31B.020(5)(c).

(d) For purposes of this section a domestic insurer includes a person controlling a domestic insurer unless the person, as determined by the commissioner, is either directly or through its affiliates primarily engaged in business other than the business of insurance. For the purposes of this section, "person" does not include any securities broker holding, in usual and customary broker's function, less than twenty percent of the voting securities of an insurance company or of any person who controls an insurance company.

(2) The statement to be filed with the commissioner under this section must be made under oath or affirmation and must contain the following:

(a) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (1) of this section is to be effected, and referred to in this section as the acquiring party and:

(i) If that person is an individual, his or her principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years; and

(ii) If that person is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as the person and any predecessors have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to those positions. The list must include for each such individual the information required by (a)(i) of this subsection;

(b) The source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose, including any

pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing consideration. However, when a source of consideration is a loan made in the lender's ordinary course of business, the identity of the lender must remain confidential, if the person filing the statement so requests;

(c) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years of each acquiring party, or for such lesser period as the acquiring party and any predecessors have been in existence, and similar unaudited information as of a date not earlier than ninety days prior to the filing of the statement;

(d) Any plans or proposals that each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

(e) The number of shares of any security referred to in subsection (1) of this section which each acquiring party proposes to acquire, the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection (1) of this section, and a statement as to the method by which the fairness of the proposal was arrived at;

(f) The amount of each class of any security referred to in subsection (1) of this section that is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) A full description of any contracts, arrangements, or understandings with respect to any security referred to in subsection (1) of this section in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description must identify the persons with whom the contracts, arrangements, or understandings have been entered into;

(h) A description of the purchase of any security referred to in subsection (1) of this section during the twelve calendar months preceding the filing of the statement, by an acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid;

(i) A description of any recommendations to purchase any security referred to in subsection (1) of this section made during the twelve calendar months preceding the filing of the statement, by an acquiring party, or by anyone based upon interviews or at the suggestion of the acquiring party;

(j) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (1) of this section, and, if distributed, of additional soliciting material relating to them;

(k) The term of an agreement, contract, or understanding made with or proposed to be made with any broker-dealer as to solicitation or securities referred to in subsection (1) of this section for tender, and the amount of fees, commissions, or other compensation to be paid to broker-dealers with regard thereto;

(l) An agreement by the person required to file the statement referred to in subsection (1) of this section that it will

provide the annual report, specified in RCW 48.31B.025(12), for so long as control exists;

(m) An acknowledgment by the person required to file the statement referred to in subsection (1) of this section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer;

(n) Such additional information as the commissioner may prescribe by rule as necessary or appropriate for the protection of policyholders of the insurer or in the public interest;

(o) If the person required to file the statement referred to in subsection (1) of this section is a partnership, limited partnership, syndicate, or other group, the commissioner may require that the information called for by (a) through (n) of this subsection must be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls a partner or member. If any partner, member, or person is a corporation or the person required to file the statement referred to in subsection (1) of this section is a corporation, the commissioner may require that the information called for by (a) through (n) of this subsection must be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of the corporation;

(p) If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer under this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, must be filed with the commissioner and sent to the insurer within two business days after the person learns of the change.

(3) If any offer, request, invitation, agreement, or acquisition referred to in subsection (1) of this section is proposed to be made by means of a registration statement under the securities act of 1933 or in circumstances requiring the disclosure of similar information under the securities exchange act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (1) of this section may utilize the documents in furnishing the information called for by that statement.

(4)(a) The commissioner shall approve a merger or other acquisition of control referred to in subsection (1) of this section unless, after a public hearing thereon, he or she finds that:

(i) After the change of control, the domestic insurer referred to in subsection (1) of this section would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(ii) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein. In applying the competitive standard in this subsection (4)(a)(ii):

(A) The informational requirements of RCW 48.31B.020(3)(a) and the standards of RCW 48.31B.020(4)(b) apply;

(B) The merger or other acquisition may not be disapproved if the commissioner finds that any of the situations meeting the criteria provided by RCW 48.31B.020(4)(c) exist; and

(C) The commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;

(iii) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(iv) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets, consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(v) The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(vi) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(b) The public hearing referred to in (a) of this subsection must be held within thirty days after the statement required by subsection (1) of this section is filed, and at least twenty days' notice must be given by the commissioner to the person filing the statement. Not less than seven days' notice of the public hearing must be given by the person filing the statement to the insurer and to such other persons as may be designated by the commissioner. The commissioner must make a determination within the sixty-day period preceding the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, any person to whom notice of the hearing was sent, and any other person whose interest may be affected has the right to present evidence, examine, and cross-examine witnesses, and offer oral and written arguments and in connection therewith are entitled to conduct discovery proceedings in the same manner as is presently allowed in the superior court of this state. All discovery proceedings must be concluded not later than three days prior to the commencement of the public hearing.

(c) If the proposed acquisition of control will require the approval of more than one commissioner, the public hearing referred to in (b) of this subsection may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (1) of this section. Such person shall file the statement referred to in subsection (1) of this section with the national association of insurance commissioners within five days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt out within ten days of the receipt of the statement referred to in subsection (1) of this section. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner may attend such hearing, in person, or by telecommunication.

(d) In connection with a change of control of a domestic insurer, any determination by the commissioner that the per-

son acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and rules of this state shall be made not later than sixty days after the date of notification of the change in control submitted pursuant to subsection (1)(a) of this section.

(e) The commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

(5) This section does not apply to:

(a) Any transaction that is subject to RCW 48.31.010, dealing with the merger or consolidation of two or more insurers;

(b) An offer, request, invitation, agreement, or acquisition which the commissioner by order exempts as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or as otherwise not comprehended within the purposes of this section.

(6) The following are violations of this section:

(a) The failure to file a statement, amendment, or other material required to be filed under subsection (1) or (2) of this section; or

(b) The effectuation or an attempt to effectuate an acquisition of control of, divestiture of, or merger with, a domestic insurer unless the commissioner has given approval thereto.

(7) The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files a statement with the commissioner under this section, and over all actions involving that person arising out of violations of this section, and each such person is deemed to have performed acts equivalent to and constituting an appointment by that person of the commissioner to be the person's true and lawful attorney upon whom may be served all lawful process in an action, suit, or proceeding arising out of violations of this section. Copies of all lawful process must be served on the commissioner and transmitted by registered or certified mail by the commissioner to such person at the person's last known address. [2015 c 122 § 3; 1993 c 462 § 4.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.020 Acquisition of insurer—Change in control—Definitions—Exemptions—Competition—Preacquisition notification—Violations—Penalties. (1) The following definitions apply for the purposes of this section only:

(a) "Acquisition" means any agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance, and mergers.

(b) An "involved insurer" includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

(2)(a) Except as exempted in (b) of this subsection, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state.

(b) This section does not apply to the following:

(i) A purchase of securities solely for investment purposes so long as the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under RCW 48.31B.005(3), it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of this state;

(ii) The acquisition of a person by another person when neither person is directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the commissioner in accordance with subsection (3)(a) of this section thirty days prior to the proposed effective date of the acquisition. However, the preacquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by this subsection (2)(b);

(iii) The acquisition of already affiliated persons;

(iv) An acquisition if, as an immediate result of the acquisition:

(A) In no market would the combined market share of the involved insurers exceed five percent of the total market;

(B) There would be no increase in any market share; or

(C) In no market would the:

(I) Combined market share of the involved insurers exceed twelve percent of the total market; and

(II) Market share increase by more than two percent of the total market.

For the purpose of this subsection (2)(b)(iv), a market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;

(v) An acquisition for which a preacquisition notification would be required under this section due solely to the resulting effect on the ocean marine insurance line of business;

(vi) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition, there is a lack of feasible alternative to improving such condition, and the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary commissioner to the commissioner of this state.

(3) An acquisition covered by subsection (2) of this section may be subject to an order under subsection (5) of this section unless the acquiring person files a preacquisition notification and the waiting period has expired. The acquired person may file a preacquisition notification. The commissioner must give confidential treatment to information submitted under this subsection (3) in the same manner as provided in RCW 48.31B.038.

(a) The preacquisition notification must be in such form and contain such information as prescribed by the national association of insurance commissioners relating to those markets that, under subsection (2)(b)(iv) of this section, cause the acquisition not to be exempted from this section. The commissioner may require such additional material and information as he or she deems necessary to determine whether the

proposed acquisition, if consummated, would violate the competitive standard of subsection (4) of this section. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of the person indicating his or her ability to render an informed opinion.

(b) The waiting period required begins on the date of the receipt by the commissioner of a preacquisition notification and ends on the earlier of the thirtieth day after the date of the receipt or the termination of the waiting period by the commissioner. Prior to the end of the waiting period, the commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period ends on the earlier of the thirtieth day after receipt of the additional information by the commissioner or the termination of the waiting period by the commissioner.

(4)(a) The commissioner may enter an order under subsection (5)(a) of this section with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in a line of insurance in this state or tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with subsection (3) of this section.

(b) In determining whether a proposed acquisition would violate the competitive standard of (a) of this subsection, the commissioner shall consider the following:

(i) An acquisition covered under subsection (2) of this section involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standards:

(A) If the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more; or

(B) If the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

A highly concentrated market is one in which the share of the four largest insurers is seventy-five percent or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table is prima facie evidence of violation of the competitive standard in (a) of this subsection. For the purpose of this subsection (4)(b)(i), the insurer with the largest share of the market is Insurer A.

(ii) There is a significant trend toward increased concentration when the aggregate market share of a grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven percent or more of the market over a period of time extending from a base year five to ten years before the acquisition up to the time of the acquisition. An acquisition or merger covered under subsection (2) of this section involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in (a) of this subsection if:

(A) There is a significant trend toward increased concentration in the market;

(B) One of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market share; and

(C) Another involved insurer's market is two percent or more.

(iii) For the purposes of this subsection (4)(b):

(A) "Insurer" includes any company or group of companies under common management, ownership, or control;

(B) "Market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, adopted by the National Association of Insurance Commissioners and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be this state;

(C) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(iv) Even though an acquisition is not prima facie violative of the competitive standard under (b)(i) and (ii) of this subsection, the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under (b)(i) and (ii) of this subsection, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subsection include, but are not limited to, the following: Market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(c) An order may not be entered under subsection (5)(a) of this section if:

(i) The acquisition will yield substantial economies of scale or economies in resource use that cannot be feasibly achieved in any other way, and the public benefits that would arise from the economies exceed the public benefits that would arise from not lessening competition; or

(ii) The acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits that would arise from not lessening competition.

(5)(a)(i) If an acquisition violates the standards of this section, the commissioner may enter an order:

(A) Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation; or

(B) Denying the application of an acquired or acquiring insurer for a license to do business in this state.

(ii) Such an order may not be entered unless:

(A) There is a hearing;

(B) Notice of the hearing is issued prior to the end of the waiting period and not less than fifteen days prior to the hearing; and

(C) The hearing is concluded and the order is issued no later than sixty days after the filing of the preacquisition notification with the commissioner.

(iii) Every order must be accompanied by a written decision of the commissioner setting forth findings of fact and conclusions of law.

(iv) An order pursuant to this subsection (5)(a) does not apply if the acquisition is not consummated.

(b) Any person who violates a cease and desist order of the commissioner under (a) of this subsection and while the order is in effect, may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or more of the following:

(i) A monetary fine of not more than ten thousand dollars for every day of violation; or

(ii) Suspension or revocation of the person's license; or

(iii) Both (b)(i) and (ii) of this subsection.

(c) Any insurer or other person who fails to make a filing required by this section, and who also fails to demonstrate a good faith effort to comply with the filing requirement, is subject to a civil penalty of not more than fifty thousand dollars.

(6) RCW 48.31B.045 (2) and (3) and 48.31B.055 do not apply to acquisitions covered under subsection (2) of this section. [2015 c 122 § 4; 1993 c 462 § 5.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.025 Registration with commissioner—Information required—Rule making—Disclaimer of affiliation—Annual enterprise risk report—Failure to file. (1) Every insurer that is authorized to do business in this state and is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in:

(a) This section;

(b) RCW 48.31B.030 (1)(a), (2), and (3); and

(c) Either RCW 48.31B.030(1)(b) or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen days after the end of the month in which it learns of each change or addition.

Any insurer which is subject to registration under this section shall register within fifteen days after it becomes subject to registration, and annually thereafter by May 1st of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any insurer authorized to do business in the state that

is a member of a holding company system, and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in subsection (3) of this section, or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

(2) Every insurer subject to registration shall file the registration statement on a form and in a format prescribed by the national association of insurance commissioners, containing the following current information:

(a) The capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

(b) The identity and relationship of every member of the insurance holding company system;

(c) The following agreements in force, and transactions currently outstanding or that have occurred during the last calendar year between the insurer and its affiliates:

(i) Loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(ii) Purchases, sales, or exchange of assets;

(iii) Transactions not in the ordinary course of business;

(iv) Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(v) All management agreements, service contracts, and cost-sharing arrangements;

(vi) Reinsurance agreements;

(vii) Dividends and other distributions to shareholders; and

(viii) Consolidated tax allocation agreements;

(d) Any pledge of the insurer's stock, including stock of subsidiary or controlling affiliate, for a loan made to a member of the insurance holding company system;

(e) If requested by the commissioner, the insurer must include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the United States securities and exchange commission pursuant to the securities act of 1933, as amended, or the securities exchange act of 1934, as amended. An insurer required to file financial statements pursuant to this subsection (2)(e) may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the United States securities and exchange commission;

(f) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in registration forms adopted or approved by the commissioner;

(g) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

(h) Any other information required by the commissioner by rule.

(3) All registration statements must contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(4) No information need be disclosed on the registration statement filed under subsection (2) of this section if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent or less of an insurer's admitted assets as of December 31st next preceding are not deemed material for purposes of this section.

(5) Subject to RCW 48.31B.030(2), each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen business days after their declaration.

(6) Any person within an insurance holding company system subject to registration is required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with this chapter.

(7) The commissioner shall terminate the registration of an insurer that demonstrates that it no longer is a member of an insurance holding company system.

(8) The commissioner may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement.

(9) The commissioner may allow an insurer authorized to do business in this state and which is part of an insurance holding company system to register on behalf of an affiliated insurer which is required to register under subsection (1) of this section and to file all information and material required to be filed under this section.

(10) This section does not apply to an insurer, information, or transaction if and to the extent that the commissioner by rule or order exempts the insurer, information, or transaction from this section.

(11) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer, or any insurer or any member of an insurance holding company system may file the disclaimer. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation is deemed to have been granted unless the commissioner, within thirty days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party is relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved.

(12) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report must, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report must be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the financial

analysis handbook adopted by the national association of insurance commissioners.

(13) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for filing is a violation of this section. [2015 c 122 § 5; 2000 c 214 § 1; 1993 c 462 § 6.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.030 Insurer subject to registration—Standards for transactions within a holding company system—Extraordinary dividends or distributions—Insurer's surplus—Officers and directors. (1)(a) Transactions within an insurance holding company system to which an insurer subject to registration is a party are subject to the following standards:

(i) The terms must be fair and reasonable;

(ii) Agreements for cost-sharing services and management must include such provisions as required by rule issued by the commissioner;

(iii) Charges or fees for services performed must be fair and reasonable;

(iv) Expenses incurred and payment received must be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(v) The books, accounts, and records of each party to all such transactions must be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(vi) The insurer's surplus regarding policyholders following any dividends or distributions to shareholders or affiliates must be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(b) The following transactions involving a domestic insurer and a person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to the materiality standards contained in this subsection (1)(b), may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty days before, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The notice for amendments or modifications must include the reasons for the change and the financial impact on the domestic insurer. Informal notice must be reported, within thirty days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any:

(i) Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments if the transactions are equal to or exceed:

(A) With respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders;

(B) With respect to life insurers, three percent of the insurer's admitted assets; each as of December 31st next preceding;

(ii) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, an affiliate of the insurer making the loans or extensions of credit if the transactions are equal to or exceed:

(A) With respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders;

(B) With respect to life insurers, three percent of the insurer's admitted assets; each as of December 31st next preceding;

(iii) Reinsurance agreements or modifications thereto, including:

(A) All reinsurance pooling agreements;

(B) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five percent of the insurer's surplus as regards policyholders, as of December 31st next preceding, including those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(iv) All management agreements, service contracts, tax allocation agreements, guarantees, and all cost-sharing arrangements;

(v) Guarantees when made by a domestic insurer. However, a guarantee which is quantifiable as to amount is not subject to the notice requirements of this subsection (1)(b)(v) unless it exceeds the lesser of one-half of one percent of the insurer's admitted assets or ten percent of surplus as regards policyholders as of December 31st next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this subsection (1)(b)(v);

(vi) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired according to RCW 48.31B.010 or authorized according to chapter 48.13 RCW, or in nonsubsidiary insurance affiliates that are subject to this chapter, are exempt from this requirement; and

(vii) Any material transactions, specified by rule, which the commissioner determines may adversely affect the interests of the insurer's policyholders.

This subsection does not authorize or permit any transaction which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(c) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur

otherwise. If the commissioner determines that the separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise his or her authority under RCW 48.31B.045.

(d) The commissioner, in reviewing transactions under (b) of this subsection, must consider whether the transactions comply with the standards set forth in (a) of this subsection and whether they may adversely affect the interests of policyholders.

(e) The commissioner must be notified within thirty days of an investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent of the corporation's voting securities.

(2)(a) A domestic insurer shall not pay an extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty days after the commissioner declares that he or she has received notice of the declaration thereof and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period.

(b) For purposes of this section, an extraordinary dividend or distribution is any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve months exceeds the lesser of:

(i) Ten percent of the insurer's surplus as regards policyholders or net worth as of December next preceding; or

(ii) The net gain from operations of the insurer, if the insurer is a life insurance company, or the net income if the company is not a life insurance company, not including realized capital gains for the twelve-month period ending December next preceding, but does not include pro rata distributions of any class of the insurer's own securities.

(c) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carry forward provision must be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

(d) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the commissioner's approval. The declaration confers no rights upon shareholders until: (i) The commissioner has approved the payment of the dividend or distribution; or (ii) the commissioner has not disapproved the payment within the thirty-day period referred to in (a) of this subsection.

(3) For purposes of this chapter, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, must be considered:

(a) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(b) The extent to which the insurer's business is diversified among several lines of insurance;

(c) The number and size of risks insured in each line of business;

(d) The extent of the geographical dispersion of the insurer's insured risks;

(e) The nature and extent of the insurer's reinsurance program;

(f) The quality, diversification, and liquidity of the insurer's investment portfolio;

(g) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

(h) The surplus as regards policyholders maintained by other comparable insurers;

(i) The adequacy of the insurer's reserves; and

(j) The quality and liquidity of investments in affiliates.

The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.

(4)(a) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer are not thereby relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer must be managed so as to assure its separate operating identity consistent with this title.

(b) This section does not preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property, or services with one or more other persons under arrangements meeting the standards of subsection (1)(a) of this section.

(c) At least one-third of a domestic insurer's directors and at least one-third of the members of each committee of the insurer's board of directors must be persons who are not: (i) Officers or employees of the insurer or of any entity that controls, is controlled by, or is under common control with the insurer; or (ii) beneficial owners of a controlling interest in the voting securities of the insurer or of any such entity. A quorum for transacting business at a meeting of the insurer's board of directors or any committee of the board of directors must include at least one such person.

(d) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer, and recommending to the board of directors the selection and compensation of the principal officers.

(e) The provisions of (c) and (d) of this subsection do not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual holding company, or publicly held corporation, has a board of directors and committees thereof that meet the requirements of (c) and (d) of this subsection with respect to such controlling entity.

(f) An insurer may make application to the commissioner for a waiver from the requirements of this subsection, if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the federal crop insurance cor-

poration and federal flood program, is less than three hundred million dollars. An insurer may also make application to the commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity. [2015 c 122 § 6; 1993 c 462 § 7.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.035 Examination of insurers—Commissioner may order production of information—Failure to comply—Costs of examination.

(1) Subject to the limitation contained in this section and in addition to the powers that the commissioner has under chapter 48.03 RCW relating to the examination of insurers, the commissioner has the power to examine any insurer registered under RCW 48.31B.025 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(2)(a) The commissioner may order any insurer registered under RCW 48.31B.025 to produce such records, books, papers, or other information in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this title.

(b) To determine compliance with this title, the commissioner may order any insurer registered under RCW 48.31B.025 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the commissioner, the insurer shall provide the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the commissioner that the detailed explanation is without merit, the commissioner may require, after notice and hearing, the insurer to pay a fine of ten thousand dollars for each day's delay, or may suspend or revoke the insurer's license. The commissioner shall transfer the fine collected under this section to the state treasurer for deposit into the general fund.

(3) The commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as are reasonably necessary to assist in the conduct of the examination under subsection (1) of this section. Any persons so retained are under the direction and control of the commissioner and shall act in a purely advisory capacity.

(4) Notwithstanding the provisions under RCW 48.03.060, each registered insurer producing for examination records, books, and papers under subsection (1) of this section is liable for and must pay the expense of the examination.

(5) In the event the insurer fails to comply with an order, the commissioner has the power to examine the affiliates to obtain the information. The commissioner also has the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey

a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court. Every person is required to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. Every person is entitled to the same fees and mileage, if claimed, as a witness as provided in RCW 48.03.070. The fees, mileage, and other actual expenses, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, must be itemized and charged against, and be paid by, the company being examined. [2015 c 122 § 7; 1993 c 462 § 8.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.036 Internationally active insurance groups—Group-wide supervision—Commissioner's authority and duties—Costs. (1) The commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group under this section. However, the commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

- (a) Does not have substantial insurance operations in the United States;
- (b) Has substantial insurance operations in the United States, but not in this state; or
- (c) Has substantial insurance operations in the United States and this state, but the commissioner has determined under the factors set forth in subsections (2) and (6) of this section that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a group-wide supervisor under this section.

(2) In cooperation with other state, federal, and international regulatory agencies, the commissioner must identify a single group-wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The commissioner shall consider the following factors when making a determination or acknowledgment under this subsection:

- (a) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets, or liabilities;
- (b) The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;
- (c) The location of the executive offices or largest operational offices of the internationally active insurance group;

(d) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:

- (i) Substantially similar to the system of regulation provided under the laws of this state; or
- (ii) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(e) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

However, a commissioner identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor must be made after consideration of the factors listed in (a) through (e) of this subsection, and must be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

(3) When another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, in the event of a material change in the internationally active insurance group that results in:

(a) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets, or liabilities; or

(b) This state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group, the commissioner shall make a determination or acknowledgment as to the appropriate group-wide supervisor for the internationally active insurance group under subsection (2) of this section.

(4) Under RCW 48.31B.035 the commissioner is authorized to collect from any insurer registered under RCW 48.31B.025 all information necessary to determine whether the commissioner may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered under RCW 48.31B.025 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group has no less than thirty days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the Washington State Register and on the commissioner's web site the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

(5) If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner is authorized to engage in any of the following group-wide supervision activities:

(a) Assess the enterprise risks within the internationally active insurance group to ensure that:

(i) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(ii) Reasonable and effective mitigation measures are in place;

(b) Request from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

(i) Governance, risk assessment, and management;

(ii) Capital adequacy; and

(iii) Material intercompany transactions;

(c) Coordinate and, through the authority of the regulatory officials of the jurisdiction where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of the internationally active insurance group that are engaged in the business of insurance;

(d) Communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of RCW 48.31B.038, through supervisory colleges as set forth in RCW 48.31B.037 or otherwise;

(e) Enter into agreements with or obtain documents from any insurer registered under RCW 48.31B.025, any member of the internationally active insurance group, and any other state, federal, and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. The agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(f) Other group-wide supervision activities, consistent with the authorities and purposes of this subsection (5), as considered necessary by the commissioner.

(6) If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the national association of insurance commissioners is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor. However:

(a) The commissioner's cooperation must be in compliance with the laws of this state; and

(b) The regulatory official acknowledged as the group-wide supervisor must also recognize and cooperate with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where the recognition and cooperation is not reasonably

reciprocal, the commissioner is authorized to refuse recognition and cooperation.

(7) The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under RCW 48.31B.025, any affiliate of the insurer, and other state, federal, and international regulatory agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

(8) The commissioner may adopt rules necessary for the implementation and administration of this section.

(9) A registered insurer subject to this section is liable for and must pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries, and other professionals and all reasonable travel expenses. [2020 c 243 § 3.]

48.31B.037 Commissioner may participate in a supervisory college—Purposes—Costs. (1) With respect to any insurer registered under RCW 48.31B.025, and in accordance with subsection (3) of this section, the commissioner has the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this title. The powers of the commissioner with respect to supervisory colleges include, but are not limited to, the following:

(a) Initiating the establishment of a supervisory college;

(b) Clarifying the membership and participation of other supervisors in the supervisory college;

(c) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(d) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(e) Establishing a crisis management plan.

(2) Each registered insurer subject to this section is liable for and must pay the reasonable expenses of the commissioner's participation in a supervisory college in accordance with subsection (3) of this section, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the commissioner may establish a regular assessment to the insurer for the payment of these expenses.

(3) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management, and governance processes, and as part of the examination of individual insurers in accordance with RCW 48.31B.035, the commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal, and international regulatory agencies. The commissioner may enter into agreements in accordance with RCW 48.31B.038(3) providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. This section does not delegate to the supervisory college the authority of the com-

missioner to regulate or supervise the insurer or its affiliates within its jurisdiction. [2015 c 122 § 8.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.038 Confidentiality of certain documents, materials, or other information—Permitted uses. (1)

Documents, materials, or other information in the possession or control of the commissioner that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to RCW 48.31B.035 and all information reported or provided to the commissioner under RCW 48.31B.015(2) (l) and (m), 48.31B.025, 48.31B.030, and 48.31B.036 are confidential by law and privileged, are 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 to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby, notice and opportunity to be heard, determines that the interest of policyholders, shareholders, or the public is served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

(2) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner or with whom such documents, materials, or other information are shared pursuant to this chapter is permitted or may be 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 duties, the commissioner:

(a) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (1) of this section, with other state, federal, and international regulatory agencies, with the national association of insurance commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, including members of any supervisory college described in RCW 48.31B.037, provided the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information, and has verified in writing the legal authority to maintain confidentiality;

(b) Notwithstanding (a) of this subsection, may only share confidential and privileged documents, material, or information reported pursuant to RCW 48.31B.025(12) with commissioners of states having statutes or rules substantially similar to subsection (1) of this section and who have agreed in writing not to disclose such information;

(c) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information from the national association of insurance commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other

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foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or 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, or information; and

(d) Shall enter into written agreements with the national association of insurance commissioners governing sharing and use of information provided pursuant to this chapter consistent with this subsection that shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the national association of insurance commissioners and its affiliates and subsidiaries pursuant to this chapter, including procedures and protocols for sharing by the national association of insurance commissioners with other state, federal, or international regulators;

(ii) Specify that ownership of information shared with the national association of insurance commissioners and its affiliates and subsidiaries pursuant to this chapter remains with the commissioner and the national association of insurance commissioners' use of the information is subject to the direction of the commissioner;

(iii) Require prompt notice to be given to an insurer whose confidential information in the possession of the national association of insurance commissioners pursuant to this chapter is subject to a request or subpoena to the national association of insurance commissioners for disclosure or production; and

(iv) Require the national association of insurance commissioners and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the national association of insurance commissioners and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the national association of insurance commissioners and its affiliates and subsidiaries pursuant to this chapter.

(4) The sharing of information by the commissioner pursuant to 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) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (3) of this section.

(6) Documents, materials, or other information in the possession or control of the national association of insurance commissioners pursuant to this chapter are confidential by law and privileged, are 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. [2020 c 243 § 2; 2015 c 122 § 9.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.040 Rule making. The commissioner may, in accordance with the administrative procedure act, chapter 34.05 RCW, adopt rules interpreting and implementing this chapter. [2015 c 122 § 10; 1993 c 462 § 9.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.045 Violations of chapter—Commissioner may seek superior court order. (1) Whenever it appears to the commissioner that an insurer or a director, officer, employee, or agent of the insurer has committed or is about to commit a violation of this chapter or any rule or order of the commissioner under this chapter, the commissioner may apply to the superior court for Thurston county or to the court for the county in which the principal office of the insurer is located for an order enjoining the insurer or the director, officer, employee, or agent from violating or continuing to violate this chapter or any such rule or order, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

(2) No security that is the subject of an agreement or arrangement regarding acquisition, or that is acquired or to be acquired, in contravention of this chapter or of a rule or order of the commissioner under this chapter may be voted at a shareholders' meeting, or may be counted for quorum purposes. Any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding, but no action taken at any such meeting may be invalidated by the voting of the securities, unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the commissioner has reason to believe that a security of the insurer has been or is about to be acquired in contravention of this chapter or of a rule or order of the commissioner under this chapter, the insurer or the commissioner may apply to the superior court for Thurston county or to the court for the county in which the insurer has its principal place of business to enjoin an offer, request, invitation, agreement, or acquisition made in contravention of RCW 48.31B.015 or a rule or order of the commissioner under that section to enjoin the voting of a security so acquired, to void a vote of the security already cast at a meeting of shareholders, and for such other relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

(3) If a person has acquired or is proposing to acquire voting securities in violation of this chapter or a rule or order of the commissioner under this chapter, the superior court for Thurston county or the court for the county in which the insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner seize or sequester voting securities of the insurer owned directly or indirectly by the person, and issue such order with respect to the securities as may be appropriate to carry out this chapter.

Notwithstanding any other provisions of law, for the purposes of this chapter, the situs of the ownership of the securities of domestic insurers is in this state. [1993 c 462 § 10.]

48.31B.050 Violations of chapter—Fines—Civil forfeitures—Orders—Referral to prosecuting attorney—Imprisonment—Orders of supervision. (1) The commissioner shall require, after notice and hearing, an insurer failing, without just cause, to file a registration statement as required in this chapter, to pay a fine of not more than ten thousand dollars per day. The maximum fine under this section is one million dollars. The commissioner may reduce the

fine if the insurer demonstrates to the commissioner that the imposition of the fine would constitute a financial hardship to the insurer. The commissioner shall pay a fine collected under this section to the state treasurer for the account of the general fund.

(2) Every director or officer of an insurance holding company system who knowingly violates this chapter, or participates in, or assents to, or who knowingly permits an officer or agent of the insurer to engage in transactions or make investments that have not been properly reported or submitted under RCW 48.31B.025(1) or 48.31B.030(1)(b) or (2), or that violate this chapter, shall pay, in their individual capacity, a fine of not more than ten thousand dollars per violation, after notice and hearing before the commissioner. In determining the amount of the fine, the commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

(3) Whenever it appears to the commissioner that an insurer subject to this chapter or a director, officer, employee, or agent of the insurer has engaged in a transaction or entered into a contract that is subject to RCW 48.31B.030 and that would not have been approved had approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the commissioner may also order the insurer to void any such contracts and restore the status quo if that action is in the best interest of the policyholders, creditors, or the public.

(4) Whenever it appears to the commissioner that an insurer or a director, officer, employee, or agent of the insurer has committed a willful violation of this chapter, the commissioner may refer the matter to the prosecuting attorney of Thurston county or the county in which the principal office of the insurer is located. An insurer that willfully violates this chapter may be fined not more than one million dollars. Any individual who willfully violates this chapter may be fined in his or her individual capacity not more than ten thousand dollars, or be imprisoned for not more than three years, or both.

(5) An officer, director, or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made a false statement or false report or false filing with the intent to deceive the commissioner in the performance of his or her duties under this chapter, upon conviction thereof, shall be imprisoned for not more than three years or fined not more than ten thousand dollars or both. The officer, director, or employee upon whom the fine is imposed shall pay the fine in his or her individual capacity.

(6) Whenever it appears to the commissioner that any person has committed a violation of RCW 48.31B.015 and which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with RCW 48.31.400. [2015 c 122 § 11; 1993 c 462 § 11.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.055 Violations of chapter—Impairment of financial condition—Commissioner may take possession.

Whenever it appears to the commissioner that a person has committed a violation of this chapter that so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders, or the public, the commissioner may proceed as provided in RCW 48.31.030 and 48.31.040 to take possession of the property of the domestic insurer and to conduct the business of the insurer. [1993 c 462 § 12.]

48.31B.060 Order for liquidation or rehabilitation—Recovery of distributions or payments—Personal liability—Maximum amount recoverable. (1) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order may recover on behalf of the insurer: (a) From a parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions, other than distributions of shares of the same class of stock, paid by the insurer on its capital stock; or (b) a payment in the form of a bonus, termination settlement, or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer, or employee, where the distribution or payment under (a) or (b) of this subsection is made at any time during the one year before the petition for liquidation, conservation, or rehabilitation, as the case may be, subject to the limitations of subsections (2), (3), and (4) of this section.

(2) No such distribution is recoverable if it is shown that when paid, the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) A person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate when the distributions were paid is liable up to the amount of distributions or payments under subsection (1) of this section the person received. A person who controlled the insurer at the time the distributions were declared is liable up to the amount of distributions he or she would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(4) The maximum amount recoverable under this section is the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(5) To the extent that a person liable under subsection (3) of this section is insolvent or otherwise fails to pay claims due from it under those provisions, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, is jointly and severally liable for a resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it. [1993 c 462 § 13.]

48.31B.065 Violations of chapter—Contrary to interests of policyholders or the public—Suspension, revocation, or nonrenewal of license. Whenever it appears to the commissioner that a person has committed a violation of this chapter that makes the continued operation of an insurer con-

trary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke, or refuse to renew the insurer's license or authority to do business in this state for such period as he or she finds is required for the protection of policyholders or the public. Such a determination must be accompanied by specific findings of fact and conclusions of law. [1993 c 462 § 14.]

48.31B.070 Person aggrieved by actions of commissioner. (1) A person aggrieved by an act, determination, rule, order, or any other action of the commissioner under this chapter may proceed in accordance with the administrative procedure act, chapter 34.05 RCW.

(2) A person aggrieved by a failure of the commissioner to act or make a determination required by this chapter may petition the commissioner under the procedure described in the administrative procedure act, chapter 34.05 RCW. [2015 c 122 § 12; 1993 c 462 § 15.]

Effective dates—2015 c 122: See note following RCW 48.31B.005.

48.31B.900 Short title. This chapter may be known and cited as the Insurer Holding Company Act. [1993 c 462 § 1.]

48.31B.901 Severability—1993 c 462. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected. [1993 c 462 § 112.]

48.31B.902 Implementation—1993 c 462. The insurance commissioner may take such steps as are necessary to ensure that this act is implemented on July 25, 1993. [1993 c 462 § 106.]

Chapter 48.32 RCW WASHINGTON INSURANCE GUARANTY ASSOCIATION ACT

Sections

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48.32.900	Short title.
48.32.901	Effective date—2005 c 100.
48.32.910	Construction—1971 ex.s. c 265.
48.32.920	Section headings not part of law.

48.32.010 Purpose. The purpose of this chapter is to provide a mechanism for the payment of covered claims to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders under certain policies of insur-

ance covered by the scope of this chapter because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers. [2005 c 100 § 1; 1971 ex.s. c 265 § 1.]

48.32.020 Scope. This chapter applies to all kinds of direct insurance, except life, title, surety, disability, credit, mortgage guaranty, workers' compensation, and ocean marine. Workers' compensation as used in this section does not include longshore and harbor workers' compensation act insurance. [2005 c 100 § 2; 1987 c 185 § 29; 1975-'76 2nd ex.s. c 109 § 2; 1971 ex.s. c 265 § 2.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

48.32.030 Definitions. As used in this chapter:

(1) "Account" means one of the three accounts created in RCW 48.32.040.

(2) "Association" means the Washington insurance guaranty association created in RCW 48.32.040.

(3) "Commissioner" means the insurance commissioner of this state.

(4) "Covered claim" means:

(a) Except for longshore and harbor workers' compensation act insurance, an unpaid claim, including one for unearned premiums, that arises out of and is within the coverage of an insurance policy to which this chapter applies issued by an insurer, if such insurer becomes an insolvent insurer after the first day of April, 1971 and (i) the claimant or insured is a resident of this state at the time of the insured event; or (ii) the property from which the claim arises is permanently located in this state. "Covered claim" does not include any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise. However, a claim for any such amount asserted against a person insured under a policy issued by an insurer which has become an insolvent insurer, which, if it were not a claim by or for the benefit of a reinsurer, insurer, insurance pool, or underwriting association, would be a "covered claim" may be filed directly with the receiver of the insolvent insurer, but in no event may any such claim be asserted in any legal action against the insured of such insolvent insurer. In addition, "covered claim" does not include any claim filed with the association subsequent to the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer; and

(b) For longshore and harbor workers' compensation act insurance, an unpaid claim, excluding one for unearned premiums, for benefits due an injured worker under the longshore and harbor workers' compensation act that is within the coverage of an insurance policy to which this chapter applies issued by an insurer, if that insurer becomes an insolvent insurer after April 20, 2005, and (i) the worksite from which the injury occurred is within this state or on the navigable waters within or immediately offshore of this state, or (ii) the worksite from which the injury occurred is outside this state, the injured worker is a permanent resident of this state, the injured worker is temporarily working at the worksite from which the injury occurred, and the injured worker is not covered under a policy of longshore and harbor workers' com-

ensation insurance issued in another state. "Covered claim" does not include any amount due any insurer, reinsurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise.

(5) "Insolvent insurer" means:

(a) An insurer (i) authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred and (ii) determined to be insolvent and ordered liquidated by a court of competent jurisdiction, and which adjudication was subsequent to the first day of April, 1971; and

(b) In the case of an insurer writing longshore and harbor workers' compensation act insurance, an insurer (i) authorized to write this class of insurance at the time the policy was written and (ii) determined to be insolvent and ordered liquidated by a court of competent jurisdiction subsequent to April 20, 2005.

(6) "Longshore and harbor workers' compensation act" means the longshore and harbor workers' compensation act as defined in U.S.C. Title 33, Chapter 18, 901 et seq. and its extensions commonly known as the defense base act, outer continental shelf lands act, nonappropriated funds instrumentalities act, District of Columbia workers' compensation act, and the war hazards act.

(7) "Member insurer" means any person who (a) writes any kind of insurance to which this chapter applies under RCW 48.32.020, including the exchange of reciprocal or interinsurance contracts, and (b) holds a certificate of authority to transact insurance in this state.

(8) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this chapter applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(9) "Person" means any individual, corporation, partnership, association, or voluntary organization. [2005 c 100 § 3; 1975-'76 2nd ex.s. c 109 § 3; 1971 ex.s. c 265 § 3.]

48.32.040 Creation of the association—Required accounts. There is hereby created a nonprofit unincorporated legal entity to be known as the Washington insurance guaranty association. All insurers defined as member insurers in RCW 48.32.030 shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation established and approved under RCW 48.32.070 and shall exercise its powers through a board of directors established under RCW 48.32.050. For purposes of administration and assessment, the association shall be divided into three separate accounts: (1) The automobile insurance account; (2) the account for longshore and harbor workers' compensation act insurance; and (3) the account for all other insurance to which this chapter applies. [2005 c 100 § 4; 1975-'76 2nd ex.s. c 109 § 4; 1971 ex.s. c 265 § 4.]

48.32.050 Board of directors. (1) The board of directors of the association shall consist of not less than five nor more than nine persons serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commis-

sioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

(2) In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented. In the event of the insolvency of a member insurer who writes longshore and harbor workers' compensation act insurance, at least one member of the board must represent the interests of this class of insurer, and this member shall be added to the board at the next annual meeting following the insolvency.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors. [2005 c 100 § 5; 1975-'76 2nd ex.s. c 109 § 5; 1971 ex.s. c 265 § 5.]

48.32.060 Powers and duties of the association. (1) The association shall:

(a)(i) For other than covered claims involving the longshore and harbor workers' compensation act, be obligated to the extent of the covered claims existing prior to the order of liquidation and arising within thirty days after the order of liquidation, or before the policy expiration date if less than thirty days after the order of liquidation, or before the insured replaces the policy or on request effects cancellation, if he or she does so within thirty days of the order of liquidation, but such an obligation includes only that amount of each covered claim which is in excess of one hundred dollars and is less than three hundred thousand dollars. In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the face amount of the policy from which the claim arises.

(ii) For covered claims involving longshore and harbor workers' compensation act insurance, be obligated to the extent of covered claims for insolvencies occurring after April 20, 2005. This obligation is for the statutory obligations established under the longshore and harbor workers' compensation act. However, the insured employer shall reimburse the association for any deductibles that are owed as part of the insured's obligations.

(b) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent.

(c)(i) Allocate claims paid and expenses incurred among the three accounts enumerated in RCW 48.32.040 separately, and assess member insurers separately for each account amounts necessary to pay the obligations of the association under (a) of this subsection subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examinations under RCW 48.32.110, and other expenses authorized by this chapter. Except as provided for in this subsection for member insurers who write longshore and harbor workers' compensation act insurance, the assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assess-

ment not later than thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than two percent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available may be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association shall pay claims in any order which it may deem reasonable, including the payment of claims in the order such claims are received from claimants or in groups or categories of claims, or otherwise. The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer serving as a servicing facility may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by such member insurer if they are chargeable to the account for which the assessment is made.

(ii) For member insurers who write longshore and harbor workers' compensation act insurance, (c)(i) of this subsection applies except as modified by the following:

(A) Beginning July 1, 2005, and prior to an insolvency, each member insurer who writes longshore and harbor workers' compensation act insurance in this state, whether on a primary or excess coverage basis, shall be assessed at a rate to be determined by the association, but not more than an annual rate of three percent of the net direct written premium for the calendar year preceding the assessment on this kind of insurance. Insurer assessments prior to an insolvency shall continue until a fund is established that equals four percent of the aggregate net direct premium for the calendar year preceding the assessment on all insurers authorized to write this kind of insurance;

(B) Subsequent to an insolvency, each member insurer who writes longshore and harbor workers' compensation act insurance in this state, whether on a primary or excess coverage basis, shall be assessed at a rate to be determined by the association, but not more than an annual rate of three percent of the net direct written premium for the calendar year preceding the assessment on this kind of insurance. Insurer assessments subsequent to an insolvency shall continue until a fund is established that the association deems sufficient to meet all claim and loan obligations of the fund, provided that the net fund balance may not at any time exceed four percent of the aggregate net direct premium for the calendar year preceding the assessment on all insurers authorized to write this kind of insurance; and

(C) If any insurer fails to provide its net direct written premium data in an accurate and timely manner upon request by the association, the association may, at its discretion, substitute that insurer's direct written premiums for workers' compensation reported or reportable in its statutory annual statement page fourteen data for the state of Washington.

(d) Investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims.

(e) Notify such persons as the commissioner directs under RCW 48.32.080(2)(a).

(f) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer.

(g) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this chapter.

(2) The association may:

(a) Appear in, defend, and appeal any action on a claim brought against the association.

(b) Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

(c) Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation. If such a loan is related to the account for longshore and harbor workers' compensation act insurance, the association may seek such a loan from the Washington longshore and harbor workers' compensation act insurance assigned risk plan under RCW 48.22.070 or from other interested parties.

(d) Sue or be sued.

(e) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this chapter.

(f) Perform such other acts as are necessary or proper to effectuate the purpose of this chapter.

(g) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.

(3) The association shall not access any funds from the automobile insurance account or the account for all other insurance to which this chapter applies to cover the cost of claims or administration arising under the account for longshore and harbor workers' compensation act insurance. [2005 c 100 § 6; 1975-'76 2nd ex.s. c 109 § 6; 1971 ex.s. c 265 § 6.]

48.32.070 Plan of operation. (1)(a) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the commissioner.

(b) If the association fails to submit a suitable plan of operation within ninety days following May 21, 1971 or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this

chapter. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall:

(a) Establish the procedures whereby all the powers and duties of the association under RCW 48.32.060 will be performed.

(b) Establish procedures for handling assets of the association.

(c) Establish the amount and method of reimbursing members of the board of directors under RCW 48.32.050.

(d) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of such claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

(e) Establish regular places and times for meetings of the board of directors.

(f) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

(g) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty days after the action or decision.

(h) Establish the procedures whereby selections for the board of directors will be submitted to the commissioner.

(i) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under RCW 48.32.060 subsections (1)(c) and (2)(c), are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter. [1971 ex.s. c 265 § 7.]

48.32.080 Duties and powers of the commissioner.

(1) The commissioner shall:

(a) Notify the association promptly whenever he or she or any of his or her examiners has, or comes into, possession of any data or information relative to any insurer under his or her jurisdiction for any purpose indicating that such insurer is in or is approaching a condition of impaired assets, imminent insolvency, or insolvency.

(b) Furnish to the association copies of all preliminary and final audits, investigations, memorandums, opinions, and reports relative to any insurer under his or her jurisdiction for any purpose, promptly upon the preparation of any thereof.

(c) Notify the association of the existence of an insolvent insurer not later than three days after he receives notice of the determination of the insolvency. The association shall be entitled to a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member insurer at the same time such complaint is filed with a court of competent jurisdiction.

(d) Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

(2) The commissioner may:

(a) Require that the association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this chapter. Such notification shall be by mail at their last known address, where available, but if sufficient information for notification by mail is not available, notice by publication or in a newspaper of general circulation shall be sufficient.

(b) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due. Such fine shall not exceed five percent of the unpaid assessment per month, except that no fine shall be less than one hundred dollars per month.

(c) Revoke the designation of any servicing facility if he or she finds claims are being handled unsatisfactorily.

(3) Whenever the commissioner or any of his or her examiners comes into possession of or obtains any data or information indicating that any insurer under his or her jurisdiction for any purpose is in or is approaching a condition of impaired assets, imminent insolvency, or insolvency, he or she shall within fifteen days of having such data or information commence investigation and/or take formal action relative to any such insurer, and in addition within said time shall notify the association of such condition. Upon failure of the commissioner so to act, the association is hereby authorized and directed to act and commence appropriate investigation or proceedings or may at its option refer the matter to the attorney general for appropriate action relative to which the attorney general shall keep the association advised through-out any such action or proceedings.

(4) Any final action or order of the commissioner under this chapter shall be subject to judicial review in a court of competent jurisdiction. [2009 c 549 § 7138; 1975-'76 2nd ex.s. c 109 § 7; 1971 ex.s. c 265 § 8.]

48.32.090 Effect of paid claims. (1) Any person recovering under this chapter shall be deemed to have assigned his or her rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this chapter shall cooperate with the association to the same extent as such person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out.

(2) The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of covered

claims by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this chapter against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

(3) The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the right of the association against the assets of the insolvent insurer. [2009 c 549 § 7139; 1971 ex.s. c 265 § 9.]

48.32.100 Nonduplication of recovery. (1) Any person having a claim against his or her insurer under any provision in his or her insurance policy which is also a covered claim shall be required to exhaust first any right under that policy. Any amount payable on a covered claim under this chapter shall be reduced by the amount of a recovery under the claimant's insurance policy.

(2) Any person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, from the association of the location of the property, and if it is a workers' compensation claim or a longshore and harbor workers' compensation act claim, from the association of the permanent residence of the claimant. Any recovery under this chapter shall be reduced by the amount of the recovery from any other insurance guaranty association or its equivalent. [2005 c 100 § 7; 1987 c 185 § 30; 1971 ex.s. c 265 § 10.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

48.32.110 Prevention of insolvencies. To aid in the detection and prevention of insurer insolvencies:

(1) It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public.

(2) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within thirty days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the commissioner designates. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (3) of this section. The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

(3) It shall be the duty of the commissioner to report to the board of directors when he or she has reasonable cause to believe that any member insurer examined or being examined at the request of the board of directors may be insolvent or in a financial condition hazardous to the policyholders or the public.

(4) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents.

(5) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(6) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the association, and submit such report to the commissioner. [2009 c 549 § 7140; 1971 ex.s. c 265 § 11.]

48.32.120 Examination of the association. The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit, not later than March 30th of each year, a financial report for the preceding calendar year in a form approved by the commissioner. [1971 ex.s. c 265 § 12.]

48.32.130 Tax exemption. The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property. [1971 ex.s. c 265 § 13.]

48.32.145 Credit against premium tax for assessments paid pursuant to RCW 48.32.060(1)(c). Every member insurer that prior to April 1, 1993, or after July 27, 1997, shall have paid one or more assessments levied pursuant to RCW 48.32.060(1)(c) shall be entitled to take a credit against any premium tax falling due under RCW 48.14.020. The amount of the credit shall be one-fifth of the aggregate amount of such aggregate assessments paid during such calendar year for each of the five consecutive calendar years beginning with the calendar year following the calendar year in which such assessments are paid. Whenever the allowable credit is or becomes less than one thousand dollars, the entire amount of the credit may be offset against the premium tax at the next time the premium tax is paid. [1997 c 300 § 1; 1993 sp.s. c 25 § 901; 1977 ex.s. c 183 § 1; 1975-'76 2nd ex.s. c 109 § 11.]

Additional notes found at www.leg.wa.gov

48.32.150 Immunity. There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association or its agents or employees, the board of directors, or the commissioner or his or her representatives for any action taken by them in the performance of their powers and duties under this chapter. [2009 c 549 § 7141; 1971 ex.s. c 265 § 15.]

[Title 48 RCW—page 254]

48.32.160 Stay of proceedings—Setting aside judgment. All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall be stayed for one hundred eighty days and such additional time thereafter as may be fixed by the court from the date the insolvency is determined to permit proper defense by the association of all pending causes of action. Any judgment under any decision, verdict, or finding based on default of the insolvent insurer or on its failure to defend an insured which is unsatisfied at the date the insolvency is determined shall be set aside on the motion of the association and the association shall be permitted to defend such claim on the merits. [1975-'76 2nd ex.s. c 109 § 8; 1971 ex.s. c 265 § 16.]

48.32.170 Termination, distribution of fund. (1) The commissioner shall by order terminate the operation of the Washington insurers insolvency pool as to any kind of insurance afforded by property or casualty insurance policies with respect to which he or she has found, after hearing, that there is in effect a statutory or voluntary plan which:

(a) Is a permanent plan which is adequately funded or for which adequate funding is provided; and

(b) Extends, or will extend to state policyholders and residents protection and benefits with respect to insolvent insurers not substantially less favorable and effective to such policyholders and residents than the protection and benefits provided with respect to such kind of insurance under this chapter.

(2) The commissioner shall by the same such order authorize discontinuance of future payments by insurers to the Washington insurers insolvency pool with respect to the same kinds of insurance: PROVIDED, That assessments and payments shall continue, as necessary, to liquidate covered claims of insurers adjudged insolvent prior to said order and the related expenses not covered by such other plan.

(3) In the event the operation of any account of the Washington insurers insolvency pool shall be so terminated as to all kinds of insurance otherwise within its scope, the pool as soon as possible thereafter shall distribute the balance of the moneys and assets remaining in said account (after discharge of the functions of the pool with respect to prior insurer insolvencies not covered by such other plan, together with related expenses) to the insurers which are then writing in this state policies of the kinds of insurance covered by such account, and which had made payments into such account, pro rata upon the basis of the aggregate of such payments made by the respective insurers to such account during the period of five years next preceding the date of such order. Upon completion of such distribution with respect to all of the accounts specified in RCW 48.32.060, this chapter shall be deemed to have expired. [2009 c 549 § 7142; 1971 ex.s. c 265 § 17.]

48.32.900 Short title. This chapter shall be known and may be cited as the Washington Insurance Guaranty Association Act. [1971 ex.s. c 265 § 18.]

48.32.901 Effective date—2005 c 100. 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 [April 20, 2005]. [2005 c 100 § 8.]

48.32.910 Construction—1971 ex.s. c 265. This chapter shall be liberally construed to effect the purpose under RCW 48.32.010 which shall constitute an aid and guide to interpretation. [1971 ex.s. c 265 § 19.]

48.32.920 Section headings not part of law. Section headings as used in this chapter do not constitute any part of the law. [1971 ex.s. c 265 § 22.]

Chapter 48.32A RCW

WASHINGTON LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION ACT

Sections

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48.32A.005 Short title. This chapter may be known and cited as the Washington life and disability insurance guaranty association act. [2001 c 50 § 1.]

48.32A.015 Purpose. (1) The purpose of this chapter is to protect, subject to certain limitations, the persons specified in RCW 48.32A.025(1) against failure in the performance of contractual obligations, under life and disability insurance policies and annuity contracts specified in RCW 48.32A.025(2), because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(2) To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited by this chapter, and members of the association are subject to assessment to provide funds to carry out the purpose of this chapter. [2001 c 50 § 2.]

48.32A.025 Coverage and limitations. (1) This chapter provides coverage for the policies and contracts specified in subsection (2) of this section as follows:

(a) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under (b) of this subsection;

(b) To persons who are owners of or certificate holders under the policies or contracts, other than unallocated annuity

contracts and structured settlement annuities, and in each case who:

(i) Are residents; or

(ii) Are not residents, but only under all of the following conditions:

(A) The insurer that issued the policies or contracts is domiciled in this state;

(B) The states in which the persons reside have associations similar to the association created by this chapter; and

(C) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law;

(c) For unallocated annuity contracts specified in subsection (2) of this section, (a) and (b) of this subsection do not apply, and this chapter, except as provided in (e) and (f) of this subsection, does provide coverage to:

(i) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(ii) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents;

(d) For structured settlement annuities specified in subsection (2) of this section, (a) and (b) of this subsection do not apply, and this chapter, except as provided in (e) and (f) of this subsection, does provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(i) Is a resident, regardless of where the contract owner resides; or

(ii) Is not a resident, but only under both of the following conditions:

(A)(I) The contract owner of the structured settlement annuity is a resident; or

(II) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state; and the state in which the contract owner resides has an association similar to the association created by this chapter; and

(B) Neither the payee, nor beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

(e) This chapter does not provide coverage to:

(i) A person who is a payee, or beneficiary, of a contract owner resident of this state, if the payee, or beneficiary, is afforded any coverage by the association of another state; or

(ii) A person covered under (c) of this subsection, if any coverage is provided by the association of another state to the person; and

(f) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of this subsection (1)(f) in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this chapter shall be con-

strued in conjunction with other state laws to result in coverage by only one association.

(2)(a) This chapter provides coverage to the persons specified in subsection (1) of this section for direct, nongroup life, disability, or annuity policies or contracts and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts. However, any annuity contracts that are unallocated annuity contracts are subject to the specific provisions in this chapter for unallocated annuity contracts.

(b) This chapter does not provide coverage for:

(i) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

(B) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, disability, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under:

(A) A multiple employer welfare arrangement as defined in 29 U.S.C. Sec. 1144;

(B) A minimum premium group insurance plan;

(C) A stop-loss group insurance plan; or

(D) An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

(A) Dividends or experience rating credits;

(B) Voting rights; or

(C) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension benefit guaranty corporation, regardless of whether the federal pension benefit guaranty corporation has yet become liable to make any payments with respect to the benefit plan;

(viii) A portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery;

(ix) A portion of a policy or contract to the extent that the assessments required by RCW 48.32A.085 with respect to the policy or contract are preempted by federal or state law;

(x) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(A) Claims based on marketing materials;

(B) Claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(C) Misrepresentations of or regarding policy benefits;

(D) Extra-contractual claims; or

(E) A claim for penalties or consequential or incidental damages;

(xi) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer; or

(xii) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subsection (2)(b)(xii), the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture.

(3) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b)(i) With respect to one life, regardless of the number of policies or contracts:

(A) Five hundred thousand dollars in life insurance death benefits, but not more than five hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(B) In disability insurance benefits:

(I) Five hundred thousand dollars for coverages not defined as disability income insurance or basic hospital, medical, and surgical insurance or major medical insurance including any net cash surrender and net cash withdrawal values;

(II) Five hundred thousand dollars for disability income insurance;

(III) Five hundred thousand dollars for basic hospital medical and surgical insurance or major medical insurance; or

(C) Five hundred thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, except as provided in (ii), (iii), and (v) of this subsection (3)(b);

(ii) With respect to each individual participating in a governmental retirement benefit plan established under section 401, 403(b), or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, one hundred thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(iii) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, five hundred thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(iv) However, in no event shall the association be obligated to cover more than: (A) An aggregate of five hundred thousand dollars in benefits with respect to any one life under (i), (ii), and (iii) of this subsection (3)(b) except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under (i)(B) of this subsection (3)(b), in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual; or (B) with respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner;

(v) With respect to either: (A) One contract owner provided coverage under subsection (1)(d)(ii) of this section; or (B) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in (ii) of this subsection (3)(b), five million dollars in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than

five million dollars in benefits with respect to all these unallocated contracts; or

(vi) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(4) In performing its obligations to provide coverage under RCW 48.32A.075, the association is not required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract. [2001 c 50 § 3.]

48.32A.035 Construction. This chapter shall be construed to effect the purpose under RCW 48.32A.015. [2001 c 50 § 4.]

48.32A.045 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Account" means either of the two accounts created under RCW 48.32A.055.

(2) "Association" means the Washington life and disability insurance guaranty association created under RCW 48.32A.055.

(3) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(4) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

(5) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(6) "Commissioner" means the insurance commissioner of this state.

(7) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under RCW 48.32A.025.

(8) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under RCW 48.32A.025.

(9) "Extra-contractual claims" includes, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.

(10) "Impaired insurer" means a member insurer which, after July 22, 2001, is not an insolvent insurer, and is placed

under an order of rehabilitation or conservation by a court of competent jurisdiction.

(11) "Insolvent insurer" means a member insurer which, after July 22, 2001, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(12) "Member insurer" means an insurer licensed, or that holds a certificate of authority, to transact in this state any kind of insurance for which coverage is provided under RCW 48.32A.025, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

- (a) A health care service contractor, whether profit or nonprofit;
 - (b) A health maintenance organization;
 - (c) A fraternal benefit society;
 - (d) A mandatory state pooling plan;
 - (e) A mutual assessment company or other person that operates on an assessment basis;
 - (f) An insurance exchange;
 - (g) An organization that has a certificate or license limited to the issuance of charitable gift annuities under RCW 48.38.010; or
 - (h) An entity similar to (a) through (g) of this subsection.
- (13) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or any successor thereto.

(14) "Owner" of a policy or contract and "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. "Owner," "contract owner," and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

(15) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(16) "Plan sponsor" means:

- (a) The employer in the case of a benefit plan established or maintained by a single employer;
- (b) The employee organization in the case of a benefit plan established or maintained by an employee organization; or
- (c) In the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(17) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under RCW 48.32A.025(2), except that assessable premium shall not be reduced on account of RCW 48.32A.025(2)(b)(iii) relating to interest limitations

and RCW 48.32A.025(3)(b) relating to limitations with respect to one individual, one participant, and one contract owner. "Premiums" does not include:

(a) Premiums in excess of five million dollars on an unallocated annuity contract not issued under a governmental retirement benefit plan, or its trustee, established under section 401, 403(b), or 457 of the United States Internal Revenue Code; or

(b) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(18)(a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

- (i) The state in which the primary executive and administrative headquarters of the entity is located;
- (ii) The state in which the principal office of the chief executive officer of the entity is located;
- (iii) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;
- (iv) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;
- (v) The state from which the management of the overall operations of the entity is directed; and
- (vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors in (a)(i) through (v) of this subsection.

However, in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state is the principal place of business of the plan sponsor.

(b) The principal place of business of a plan sponsor of a benefit plan described in subsection (16)(c) of this section is the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, is the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(19) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

(20) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A

person may be a resident of only one state, which in the case of a person other than a natural person is its principal place of business. Citizens of the United States that are either (a) residents of foreign countries, or (b) residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this chapter, are residents of the state of domicile of the insurer that issued the policies or contracts.

(21) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(22) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

(23) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, disability, or annuity policy or contract.

(24) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate. [2001 c 50 § 5.]

48.32A.055 Creation of the association. (1) There is created a nonprofit unincorporated legal entity to be known as the Washington life and disability insurance guaranty association which is composed of the commissioner ex officio and each member insurer. All member insurers must be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under RCW 48.32A.095 and shall exercise its powers through a board of directors established under RCW 48.32A.065. For purposes of administration and assessment, the association shall maintain two accounts:

(a) The life insurance and annuity account which includes the following subaccounts:

(i) Life insurance account;

(ii) Annuity account which includes annuity contracts owned by a governmental retirement plan, or its trustee, established under section 401, 403(b), or 457 of the United States Internal Revenue Code, but otherwise excludes unallocated annuities; and

(iii) Unallocated annuity account, which excludes contracts owned by a governmental retirement benefit plan, or its trustee, established under section 401, 403(b), or 457 of the United States Internal Revenue Code; and

(b) The disability insurance account.

(2) The association is under the immediate supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association. [2001 c 50 § 6.]

48.32A.065 Board of directors. (1) The board of directors of the association consists of the commissioner ex officio and not less than five nor more than nine member insurers serving terms as established in the plan of operation. The

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insurer members of the board are selected by member insurers subject to the approval of the commissioner.

Vacancies on the board are filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

(2) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board are not otherwise compensated by the association for their services. [2001 c 50 § 7.]

48.32A.075 Powers and duties of the association. (1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(a) Guaranty, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; or

(b) Provide such moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate (a) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under (a) of this subsection.

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)(A) Guaranty, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer; or

(B) Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

(b) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to life and disability insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(A) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to the policies and contracts;

(B) With respect to nongroup policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds or annuitants, for nongroup policies and contracts, or group policy owners with respect to group policies and contracts, thirty days notice of the termination of the benefits provided;

(iii) With respect to nongroup life and disability insurance policies and annuities covered by the association, make diligent efforts to make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make diligent efforts to make available substitute coverage on an individual basis in accordance with the provisions of (b)(iv) of this subsection, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class;

(iv)(A) The substitute coverage under (b)(iii) of this subsection, must be offered through a solvent, admitted insurer. In the alternative, the association in its discretion, and subject to any conditions imposed by the association and approved by the commissioner, may reissue the terminated coverage;

(B) Substituted coverage must be offered without requiring evidence of insurability, and may not provide for any waiting period or exclusion that would not have applied under the terminated policy;

(C) The association may reinsure any reissued policy;

(v) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium must be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance commissioner and the receivership court;

(vi) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued policy cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured, or the association; or

(vii) When proceeding under this subsection (2)(b) with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with RCW 48.32A.025(2)(b)(iii).

(3) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy or coverage under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(5) The protection provided by this chapter does not apply when any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6) In carrying out its duties under subsection (2) of this section, the association may:

(a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, are in the public interest; and

(b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, under RCW 48.31.171, shall be promptly paid to the association. The association is entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association and not retained under this subsection. Any amount so paid to the association less the amount not retained by it shall be treated as a distribution of estate assets under RCW 48.31.185 or similar provision of the state of domicile of the impaired or insolvent insurer.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (2) of this section, the commissioner has the powers and duties of the association under this chapter with respect to the insolvent insurer.

(9) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

(10) The association has standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or other-

wise. Standing extends to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association also has the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(11)(a) A person receiving benefits under this chapter is deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the person.

(b) The subrogation rights of the association under this subsection have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(c) In addition to (a) and (b) of this subsection, the association has all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contracts, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the United States Internal Revenue Code.

(d) If (a) through (c) of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in this subsection, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(12) In addition to the rights and powers elsewhere in this chapter, the association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under RCW 48.32A.085 and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the association not in default are legal investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;

(e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(f) Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life or disability insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;

(g) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(h) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; and

(i) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

(13) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(14)(a) At any time within one year after the coverage date, which is the date on which the association becomes responsible for the obligations of a member insurer, the association may elect to succeed to the rights and obligations of the member insurer, that accrue on or after the coverage date and that relate to contracts covered, in whole or in part, by the association, under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement. The election is effective when notice is provided to the receiver, rehabilitator, or liquidator and to the affected reinsurers. If the association makes an election, the following provisions apply with respect to the agreements selected by the association:

(i) The association is responsible for all unpaid premiums due under the agreements, for periods both before and after the coverage date, and is responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to contracts covered, in whole or in part, by the association. The association may charge contracts covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association;

(ii) The association is entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the association, in whole or in part. However, upon receipt of any such amounts, the association is obliged to pay to the beneficiary under the policy or contract on account of which the amounts were paid a portion of the amount equal to the excess of: The amount received by the association, over the benefits paid by the association on account of the policy or contract, less the retention of the impaired or insolvent member insurer applicable to the loss or event;

(iii) Within thirty days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by either the member insurer, or its receiver, rehabilitator, or liquidator, or the indemnity reinsurer during the period between the coverage date and the date of the association's election. Either the association or indemnity reinsurer shall pay the net balance due the other within five days of the completion of this calculation. If the receiver, rehabilitator, or liquidator has received any amounts due the association pursuant to (a)(ii) of this subsection, the receiver, rehabilitator, or liquidator shall remit the same to the association as promptly as practicable; and

(iv) If the association, within sixty days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association, in whole or in part, the reinsurer is not entitled to terminate the reinsurance agreements, insofar as the agreements relate to contracts covered by the association, in whole or in part, and is not entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the association;

(b) In the event the association transfers its obligations to another insurer, and if the association and the other insurer agree, the other insurer succeeds to the rights and obligations of the association under (a) of this subsection effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to in (a) of this subsection. However:

(i) The indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;

(ii) The obligations described in (a)(ii) of this subsection no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer; and

(iii) This subsection (14)(b) does not apply if the association has previously expressly determined in writing that it will not exercise the election referred to in (a) of this subsection;

(c) The provisions of this subsection supersede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator, or rehabilitator of the insolvent member insurer. The receiver, rehabilitator, or liquidator remains entitled to any amounts payable by the reinsurer under the reinsurance agreement

with respect to losses or events that occur in periods prior to the coverage date, subject to applicable setoff provisions; and

(d) Except as set forth under this subsection, this subsection does not alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. This subsection does not abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. This subsection does not give a policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

(15) The board of directors of the association has discretion and may exercise reasonable business judgment to determine the means by which the association provides the benefits of this chapter in an economical and efficient manner.

(16) When the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(17) Venue in a suit against the association arising under this chapter is in the county in which liquidation or rehabilitation proceedings have been filed in the case of a domestic insurer. In other cases, venue is in King county or Thurston county. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

(18) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under subsection (1) or (2) of this section, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for: (i) A fixed interest rate; (ii) payment of dividends with minimum guarantees; or (iii) a different method for calculating interest or changes in value;

(b) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms. [2001 c 50 § 8.]

48.32A.085 Assessments. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments are due not less than thirty days after prior written notice to the member insurers and accrue interest at twelve percent per annum on and after the due date.

(2) There are two classes of assessments, as follows:

(a) Class A assessments are authorized and called for the purpose of meeting administrative and legal costs and other

expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer; and

(b) Class B assessments are authorized and called to the extent necessary to carry out the powers and duties of the association under RCW 48.32A.075 with regard to an impaired or an insolvent insurer.

(3)(a) The amount of a class A assessment is determined by the board and may be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. The total of all nonpro rata assessments may not exceed one hundred fifty dollars per member insurer in any one calendar year. The amount of a class B assessment may be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard determined by the board to be fair and reasonable under the circumstances.

(b) Class B assessments against member insurers for each account and subaccount must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the insurer became impaired, bears to premiums received on business in this state for those calendar years by all assessed member insurers.

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (2) of this section and computation of assessments under this subsection must be made with a reasonable degree of accuracy, recognizing that exact determinations are not always possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a)(i) Subject to the provisions of (a)(ii) of this subsection, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account may not in one calendar year exceed two percent of that member insurer's average annual premiums received in

this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(ii) If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation in (a)(i) of this subsection must be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated under this section.

(iii) If the maximum assessment, together with the other assets of the association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon thereafter as permitted by this chapter.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment is insufficient to cover anticipated claims.

(c) If the maximum assessment for a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the association, then under subsection (3)(b) of this section, the board shall access the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in (a) of this subsection.

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses claims.

(7) Any member insurer may when determining its premium rates and policy owner dividends, as to any kind of insurance within the scope of this chapter, consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(8) The association shall issue to each insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment paid. All outstanding certificates must be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

(9)(a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment is available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment must be accompanied by a statement in writing that

the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess must be returned to the member company. Interest on a refund due a protesting member must be paid at the rate actually earned by the association.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request. [2001 c 50 § 9.]

48.32A.095 Plan of operation. (1)(a) The association shall submit to the commissioner a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments are effective upon the commissioner's written approval or unless it has not been disapproved within thirty days.

(b) If the association fails to submit a suitable plan of operation within one hundred twenty days following July 22, 2001, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules as necessary or advisable to effectuate the provisions of this chapter. The rules continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation must, in addition to requirements enumerated elsewhere in this chapter:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under RCW 48.32A.065;

(c) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(e) Establish the procedures whereby selections for the board of directors are made and submitted to the commissioner;

(f) Establish any additional procedures for assessments under RCW 48.32A.085; and

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under RCW 48.32A.075(12)(c) and 48.32A.085, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association, or organization must be reimbursed for any payments made on behalf of the association and must be paid for its performance of any function of the association. A delegation under this subsection takes effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter. [2001 c 50 § 10.]

48.32A.105 Duties and powers of the commissioner.

(1) In addition to the duties and powers enumerated elsewhere in this chapter, the commissioner shall:

(a) Upon request of the board of directors, provide the association with a statement of the premiums in this and other appropriate states for each member insurer;

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer constitutes notice to its shareholders, if any; the failure of the insurer to promptly comply with such a demand does not excuse the association from the performance of its powers and duties under this chapter; and

(c) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(2) In addition to the duties and powers enumerated elsewhere in this chapter, the commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent of the unpaid assessment per month, but no forfeiture may be less than one hundred dollars per month.

(3) A final action by the board of directors of the association may be appealed to the commissioner by a member insurer if the appeal is taken within sixty days of the member insurer's receipt of notice of the final action being appealed. A final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

(4) The liquidator, rehabilitator, or conservator of an impaired insurer may notify all interested persons of the effect of this chapter. [2001 c 50 § 11.]

48.32A.115 Prevention of insolvencies. The commissioner shall aid in the detection and prevention of insurer insolvencies or impairments.

(1) It is the duty of the commissioner to:

(a) Notify the commissioners of all the other states, territories of the United States, and the District of Columbia within thirty days following the action taken or the date the action occurs, when the commissioner takes any of the following actions against a member insurer:

(i) Revocation of license;

(ii) Suspension of license; or

(iii) Makes a formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners or creditors;

(b) Report to the board of directors when the commissioner has taken any of the actions set forth in (a) of this subsection or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board of directors must contain all significant details of the action taken or the report received from another commissioner;

(c) Report to the board of directors when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer; and

(d) Furnish to the board of directors the national association of insurance commissioners insurance regulatory information system ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information must be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

(2) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the commissioner regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(3) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. The reports and recommendations are not public documents.

(4) The board of directors may, upon majority vote, notify the commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

(5) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies. [2001 c 50 § 12.]

48.32A.125 Credits for assessments paid—Tax offsets. (1) A member insurer may offset against its premium tax liability to this state an assessment described in RCW 48.32A.085(8) to the extent of twenty percent of the amount

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of the assessment for each of the five calendar years following the year in which the assessment was paid. In the event a member insurer ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(2) Any sums that are acquired by refund, under RCW 48.32A.085(6), from the association by member insurers, and that have been offset against premium taxes as provided in subsection (1) of this section, must be paid by the insurers to the commissioner and then deposited with the state treasurer for credit to the general fund of the state of Washington. The association shall notify the commissioner that refunds have been made. [2001 c 50 § 13.]

48.32A.135 Miscellaneous provisions. (1) This chapter does not reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records must be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under RCW 48.32A.075. The records of the association with respect to an impaired or insolvent insurer may not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. This subsection does not limit the duty of the association to render a report of its activities under RCW 48.32A.145.

(3) For the purpose of carrying out its obligations under this chapter, the association is a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee under RCW 48.32A.075(11). Assets of the impaired or insolvent insurer attributable to covered policies must be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) As a creditor of the impaired or insolvent insurer as established in subsection (3) of this section, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association is entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(5)(a) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and the policy

owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration must be given to the welfare of the policy owners of the continuing or successor insurer.

(b) A distribution to stockholders, if any, of an impaired or insolvent insurer shall not be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under RCW 48.32A.075 with respect to the insurer have been fully recovered by the association.

(6)(a) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order has a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of (b) through (d) of this subsection.

(b) A distribution is not recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the insurer at the time the distributions were paid is liable up to the amount of distributions received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared, is liable up to the amount of distributions which would have been received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(e) If any person liable under (c) of this subsection is insolvent, all its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate. [2001 c 50 § 14.]

48.32A.145 Examination of the association—Annual report. The association is subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than one hundred eighty days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report. [2001 c 50 § 15.]

48.32A.155 Tax exemptions. The association is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property. [2001 c 50 § 16.]

48.32A.165 Immunity. There is no liability on the part of and no cause of action of any nature may arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or

the commissioner or the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this chapter. Immunity extends to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees. [2001 c 50 § 17.]

48.32A.175 Stay of proceedings—Reopening default judgments. All proceedings in which the insolvent insurer is a party in any court in this state are stayed sixty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default the association may apply to have such a judgment set aside by the same court that made such a judgment and must be permitted to defend against the suit on the merits. [2001 c 50 § 18.]

48.32A.185 Prohibited advertisement of insurance guaranty association act in insurance sales—Notice to policy owners. (1) No person, including an insurer, agent, or affiliate of an insurer may make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Washington life and disability insurance guaranty association act. However, this section does not apply to the Washington life and disability insurance guaranty association or any other entity which does not sell or solicit insurance.

(2) Within one hundred eighty days after July 22, 2001, the association shall prepare a summary document describing the general purposes and current limitations of this chapter and complying with subsection (3) of this section. This document must be submitted to the commissioner for approval. The document must also be available upon request by a policy owner. The distribution, delivery, contents, or interpretation of this document does not guarantee that either the policy or the contract or the owner of the policy or contract is covered in the event of the impairment or insolvency of a member insurer. The description document must be revised by the association as amendments to this chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, or insured any greater rights than those stated in this chapter.

(3) The document prepared under subsection (2) of this section must contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer must:

(a) State the name and address of the life and disability insurance guaranty association and insurance department;

(b) Prominently warn the policy or contract owner that the life and disability insurance guaranty association may not cover the policy or, if coverage is available, it is subject to

substantial limitations and exclusions and conditioned on continued residence in this state;

(c) State the types of policies for which guaranty funds provide coverage;

(d) State that the insurer and its agents are prohibited by law from using the existence of the life and disability insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(e) State that the policy or contract owner should not rely on coverage under the life and disability insurance guaranty association when selecting an insurer;

(f) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter; and

(g) Provide other information as directed by the commissioner including but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under chapter 42.56 RCW.

(4) A member insurer must retain evidence of compliance with subsection (2) of this section for as long as the policy or contract for which the notice is given remains in effect. [2005 c 274 § 313; 2001 c 50 § 19.]

48.32A.901 Prospective application—Savings—2001 c 50. (1) This chapter does not apply to any impaired insurer that was under an order of rehabilitation or conservation, or to any insolvent insurer that was placed under an order of liquidation, prior to July 22, 2001.

(2) Any section repealed in this act pertaining to the powers and obligations of the association, reinsurance and guaranty of policies, assessments, and premium tax offsets shall apply to impaired insurers placed under an order of rehabilitation or conservation, and to insolvent insurers placed under an order of liquidation, prior to July 22, 2001. [2001 c 50 § 20.]

Chapter 48.34 RCW

CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND HEALTH INSURANCE

Sections

48.34.010	Declaration of purpose—Liberal construction.
48.34.020	Chapter part of insurance code—What insurance subject to chapter.
48.34.030	Definitions.
48.34.040	Authorized forms.
48.34.050	Life—Limitation on amount under individual policy.
48.34.060	Life—Limitation on amount repayable under group policy.
48.34.070	Accident and health—Limitation on amount.
48.34.080	Commencement, termination date of term.
48.34.090	Policy or certificate—Contents—Delivery, copy of application or notice in lieu—Substitute insurer, premium, etc., on rejection.
48.34.100	Filing policies, notices, riders, etc.—Approval by commissioner—Preexisting policies—Forms.
48.34.110	Refunds—Credits—Charges to debtor.
48.34.120	Debtor's right to furnish and obtain own insurance.

48.34.010 Declaration of purpose—Liberal construction. The purpose of this chapter is to promote the public welfare by regulating credit life insurance and credit accident and health insurance. Nothing in this chapter is intended to prohibit or discourage reasonable competition. The provi-

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sions of this chapter shall be liberally construed. [1961 c 219 § 1.]

48.34.020 Chapter part of insurance code—What insurance subject to chapter. (1) This chapter is a part of the insurance code.

(2) All life insurance and all accident and health insurance in connection with loans or other credit transactions shall be subject to the provisions of this chapter, except such insurance under an individual policy in connection with a loan or other credit transaction of more than ten years duration. Insurance shall not be subject to the provisions of this chapter where its issuance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor. [1969 ex.s. c 241 § 14; 1961 c 219 § 2.]

48.34.030 Definitions. For the purpose of this chapter: (1) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction;

(2) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

(3) "Creditor" means the lender of money or vendor or lessor of goods, services, properties, rights, or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of any such lender, vendor, or lessor, and an affiliate, associate, or subsidiary of any of them or a director, officer, or employee of any of them or any other person in any way associated with any of them;

(4) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, properties, rights, or privileges for which payment is arranged through a credit transaction;

(5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with the loan or other credit transaction. [1961 c 219 § 3.]

48.34.040 Authorized forms. Credit life insurance and credit accident and health insurance shall be issued only in the following forms:

(1) Individual policies of life insurance issued to debtors on the term plan;

(2) Individual policies of accident and health insurance issued to debtors on a term plan, or disability benefit provisions in individual policies of credit life insurance;

(3) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

(4) Group policies of accident and health insurance issued to creditors on a term plan insuring debtors, or disability benefit provisions in group credit life insurance policies to provide such coverage. [1961 c 219 § 4.]

48.34.050 Life—Limitation on amount under individual policy. The initial amount of credit life insurance under an individual policy shall not exceed the total amount repayable under the contract of indebtedness. Where an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled

or actual amount of unpaid indebtedness, whichever is greater. [1961 c 219 § 5.]

48.34.060 Life—Limitation on amount repayable under group policy. The initial amount of credit life insurance under a group policy shall at no time exceed the amount owed by the debtor which is repayable in installments to the creditor. [1987 c 130 § 1; 1983 1st ex.s. c 32 § 23; 1977 c 61 § 2; 1967 ex.s. c 82 § 1; 1961 c 219 § 6.]

48.34.070 Accident and health—Limitation on amount. The total amount of periodic indemnity payable by credit accident and health insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness; and the amount of such periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments. [1961 c 219 § 7.]

48.34.080 Commencement, termination date of term. The term of any credit life insurance or credit accident and health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor: PROVIDED, That, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than thirty days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than fifteen days beyond the scheduled maturity date of indebtedness, except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in RCW 48.34.110. [1961 c 219 § 8.]

48.34.090 Policy or certificate—Contents—Delivery, copy of application or notice in lieu—Substitute insurer, premium, etc., on rejection. (1) All credit life insurance and credit accident and health insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(2) Each individual policy or group certificate of credit life insurance, and/or credit accident and health insurance shall, in addition to other requirements of law, set forth the name and home office address of the insurer, the name or names of the debtor or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor, the premium or amount of payment, if any, by the debtor separately for credit life insurance and credit accident and health insurance, a description of the coverage including the amount and term thereof, and any exceptions, limitations and restric-

tions, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance exceeds the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate. With respect to any policy issued after September 8, 1975, credit life insurance shall not be subject to any exceptions or reductions other than for fraud, or for suicide occurring within two years of the effective date of the insurance.

(3) The individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as provided in subsections (4) and (5).

(4) If such individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer; the name or names of the debtor; the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and health insurance; the amount, term and a brief description of the coverage provided, shall be delivered to the debtor at the time such indebtedness is incurred. The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument, or agreement, or the application for any such loan, sale or credit, unless the information required by this subsection is prominently set forth therein under a descriptive heading which shall be underlined and printed in capital letters. Upon acceptance of the insurance by the insurer and within thirty days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in RCW 48.34.080.

(5) If the named insurer does not accept the risk, then the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and if the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund shall be made. [1975 1st ex.s. c 266 § 13; 1961 c 219 § 9.]

Additional notes found at www.leg.wa.gov

48.34.100 Filing policies, notices, riders, etc.—Approval by commissioner—Preexisting policies—Forms. (1) All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the commissioner.

(2) No such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, or riders shall be used in this state until approved by the commissioner pursuant to RCW 48.18.100 and 48.18.110. In addition to any grounds for disapproval provided therein, the form shall be disapproved both as to credit life and credit accident and health insurance if the benefits

provided therein are not reasonable in relation to the premium charged.

(3) If a group policy of credit life insurance or credit accident and health insurance has been delivered in this state before midnight, June 7, 1961, on the first anniversary date following such time the terms of the policy as they apply to persons newly insured thereafter shall be rewritten to conform with the provisions of this chapter.

(4) If a group policy has been or is delivered in another state before or after August 11, 1969, the forms to be filed by the insurer with the commissioner are the group certificates and notices of proposed insurance delivered or issued for delivery in this state. He or she shall approve them if:

(a) They provide the information that would be required if the group policy was delivered in this state; and

(b) The applicable premium rates or charges do not exceed those established by his or her rules or regulations. [2010 c 8 § 11005; 2009 c 549 § 7143; 1969 ex.s. c 241 § 15; 1961 c 219 § 10.]

48.34.110 Refunds—Credits—Charges to debtor.

(1) Each individual policy, or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto. The formula to be used in computing such refund shall be filed with and approved by the commissioner.

(2) If a creditor requires a debtor to make any payment for credit life insurance or credit accident and health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

(3) The amount charged to a debtor for any credit life or credit accident and health insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined. [1961 c 219 § 11.]

48.34.120 Debtor's right to furnish and obtain own insurance. When the credit life insurance or credit accident and health insurance is required in connection with any credit transaction, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or her or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state. [2009 c 549 § 7144; 1961 c 219 § 12.]

Chapter 48.35 RCW ALIEN INSURERS

Sections

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48.35.030	Deposit required—Duration.
48.35.040	Trusts created before May 17, 1991.
48.35.050	Alien insurer—State authorization required.
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48.35.090	Trust agreement—Vesting of trustee assets.
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48.35.160	United States manager—Mexican or Canadian insurers.
48.35.170	Domestication of alien insurer—Commissioner's approval.
48.35.180	Domestication agreement—Necessary authorization.
48.35.190	Domestication agreement—Commissioner's approval of corporate proceedings.
48.35.200	Domestication—When effective—Deposits—Transfer of assets.

48.35.010 Application—Definition. This chapter applies to all alien insurers using this state as a state of entry to transact insurance in the United States.

For the purposes of this chapter, "alien insurer" has the definition supplied in RCW 48.05.010. [1991 c 268 § 1.]

48.35.020 Deposit required—Amount. (1) An alien insurer may use this state as a state of entry to transact insurance in the United States by maintaining in this state a deposit of assets in a solvent trust company or other solvent financial institution having trust powers domiciled in this state and so designated by the commissioner. The commissioner's designated depositories are authorized to receive and hold a deposit of assets. A deposit so held is at the expense of the insurer. A solvent financial institution domiciled in this state, the deposits of which are insured by the federal deposit insurance corporation and which is a member of the federal reserve system, may be designated as the commissioner's depository to receive and hold a deposit of assets.

(2) The deposit, together with other trust deposits of the insurer held in the United States for the same purpose, must be in an amount not less than the higher of deposits required of an alien insurer under RCW 48.05.090 or five hundred thousand dollars and consist of eligible assets as set forth in RCW 48.16.030.

(3) The deposit may be referred to as "trusteed assets." [1991 c 268 § 2.]

48.35.030 Deposit required—Duration. The deposit required by this chapter must be for the benefit, security, and protection of the policyholders or creditors, or both, of the insurer in the United States. It shall be maintained as long as there is outstanding any liability of the insurer arising out of its insurance transactions in the United States. [1991 c 268 § 4.]

48.35.040 Trusts created before May 17, 1991. All trusts of trustee assets created before May 17, 1991, must be continued under the instruments creating those trusts. If the commissioner determines that the instruments are inconsistent with the provisions of this chapter, the insurer shall correct those inconsistencies within six months of the commissioner's determination. [1991 c 268 § 3.]

48.35.050 Alien insurer—State authorization required. An alien insurer proposing to use this state as a state of entry to transact insurance in the United States, must be authorized to transact insurance in this state and may make

and execute any trust agreement required by this chapter. [1991 c 268 § 6.]

48.35.060 Trusteed assets—Creation—Commissioner's approval of trust agreement. (1) The alien insurer shall create the trustee assets required by this chapter under a written trust agreement between the insurer and the trustee, consistent with the provisions of this chapter, and in such form and manner as the commissioner may designate or approve.

(2) The agreement is effective when filed with and approved in writing by the commissioner. The commissioner shall not approve any trust agreement not found to be in compliance with state or federal law or the terms of which do not in fact provide reasonably adequate protection for the insurer's policyholders or creditors, or both, in the United States. [1991 c 268 § 5.]

48.35.070 Trust agreement—Amendment. A trust agreement may be amended. However, the amendment is not effective until filed with the commissioner and the commissioner finds and states in writing that the amendment is in compliance with this chapter. [1991 c 268 § 7.]

48.35.080 Trust agreement—Withdrawal of commissioner's approval. The commissioner may withdraw his or her approval of a trust agreement, or of an amendment to the agreement, if the commissioner determines that the requisites for the approval no longer exist. The determination shall be made after notice and a hearing as provided in chapter 48.04 RCW. [1991 c 268 § 8.]

48.35.090 Trust agreement—Vesting of trustee assets. The trust agreement must provide that title to the trustee assets vests and remains vested in the trustees and their successors for the purposes of the trust deposit. [1991 c 268 § 9.]

48.35.100 Trustee assets—Trustee's records. The trustee shall keep the trustee assets separate from other assets and shall maintain a record sufficient to identify the trustee assets at all times. [1991 c 268 § 10.]

48.35.110 Trustee assets—Trustee's statements—Commissioner's approval. (1) The trustee of trustee assets shall file statements with the commissioner, in a form required by the commissioner, certifying the character and amount of the assets.

(2) If the trustee fails to file a requested statement after a reasonable time has expired, the commissioner may suspend or revoke the certificate of authority of the insurer required under RCW 48.05.030. [1991 c 268 § 11.]

48.35.120 Trustee assets—Examination—Commissioner's approval of assignment or transfer. (1) The commissioner may examine trustee assets of any insurer at any time in accordance with the same conditions and procedures governing the examination of insurers provided in chapter 48.03 RCW.

(2) The depositing insurer shall not assign or transfer, voluntarily, involuntarily, or by operation of law, all or a part

of its interest in the trustee assets without the prior written approval of the commissioner, and a transfer or assignment occurring without approval is void. The assignee or transferee of the trustee assets shall irrevocably and automatically assume all of the obligations and liabilities of the assignor or transferor. [1991 c 268 § 12.]

48.35.130 Trustee assets—Commissioner's approval of withdrawals. (1) The trust agreement must provide that the commissioner shall authorize and approve in writing all withdrawals of trustee assets in advance except as follows:

(a) Any or all income, earnings, dividends, or interest accumulations of the trustee assets may be paid over to the United States manager of the insurer upon request of the insurer or the manager;

(b) Withdrawals coincident with substitutions of securities or assets that are at least equal in value to those being withdrawn, if the substituted securities or assets would be eligible for investment by domestic insurers, and the insurer's United States manager requests the withdrawal in writing under a general or specific written authority previously given or delegated by the insurer's board of directors, or other similar governing body, and a copy of such authority has been filed with the trustee;

(c) For the purpose of making deposits required by another state in which the insurer is, or becomes, an authorized insurer and for the protection of the insurer's policyholders or creditors, or both, in the state or United States, if the withdrawal does not reduce the insurer's deposit in this state to an amount less than the minimum deposit required. The trustee shall transfer any assets withdrawn and in the amount required to be deposited in the other state, directly to the depository required to receive the deposit as certified in writing by the public official having supervision of insurance in that state; and

(d) For the purpose of transferring the trustee assets to an official liquidator, conservator, or rehabilitator under an order of a court of competent jurisdiction.

(2) The commissioner shall authorize a withdrawal of only those assets that are in excess of the amount of assets required to be held in trust, or as may otherwise be consistent with the provisions of this chapter.

(3) If at any time the insurer becomes insolvent or if its assets held in the United States are less than required as determined by the commissioner, the commissioner shall order in writing the trustee to suspend the withdrawal of assets until a further order of the commissioner releasing the assets. [1991 c 268 § 13.]

48.35.140 Trustee assets—Substitution of trustee. A new trustee may be substituted for the original trustee of trustee assets in the event of a vacancy or for other proper cause. Any such substitution is subject to the commissioner's approval. [1991 c 268 § 14.]

48.35.150 Trustee assets—Compensation and expenses of trustees. The insurer shall provide for the compensation and expenses of the trustees of assets of an alien insurer under this chapter in an amount, or on a basis, as agreed upon by the insurer and the trustees in the trust agree-

ment, subject to the prior approval of the commissioner. [1991 c 268 § 15.]

48.35.160 United States manager—Mexican or Canadian insurers. The provisions of this chapter applicable to a United States manager shall, in the case of insurers domiciled in Mexico or Canada, be deemed to refer to the president, vice president, secretary, or treasurer of the Mexican or Canadian insurer. [1991 c 268 § 16.]

48.35.170 Domestication of alien insurer—Commissioner's approval. (1) Upon compliance with this chapter, an alien insurer authorized to do business in this state may, with the prior written approval of the commissioner, domesticate its United States branch by entering into an agreement in writing with a domestic insurer providing for the acquisition by the domestic insurer of all of the assets and the assumption of all of the liabilities of the United States branch.

(2) The acquisition of assets and assumption of liabilities of the United States branch by the domestic insurer is effected by filing with the commissioner an instrument or instruments of transfer and assumption in form satisfactory to the commissioner and executed by the alien insurer and the domestic insurer. [1991 c 268 § 17.]

48.35.180 Domestication agreement—Necessary authorization. (1) The domestication agreement shall be authorized, adopted, approved, signed, and acknowledged by the alien insurer in accordance with the laws of the country under which it is organized.

(2) In the case of a domestic insurer, the domestication agreement shall be approved, adopted, and authorized by its board of directors and executed by its president or a vice president and attested by its secretary or assistant secretary under its corporate seal. [1991 c 268 § 18.]

48.35.190 Domestication agreement—Commissioner's approval of corporate proceedings. An executed counterpart of the domestication agreement, together with certified copies of the corporate proceedings of the domestic insurer and the alien insurer, approving, adopting, and authorizing the execution of the domestication agreement, shall be submitted to the commissioner for approval. The commissioner shall thereupon consider the agreement, and, if the commissioner finds that the same is in accordance with the provisions hereof and that the interests of the policyholders of the United States branch of the alien insurer and of the domestic insurer are not materially adversely affected, the commissioner shall approve the domestication agreement and authorize the consummation thereof. [1991 c 268 § 19.]

48.35.200 Domestication—When effective—Deposits—Transfer of assets. (1) Upon the filing with the commissioner of a certified copy of the instrument of transfer and assumption pursuant to which a domestic company succeeds to the business and assets of the United States branch of an alien insurer and assumes all its liabilities, the domestication of the United States branch is deemed effective; and all the rights, franchises, and interests of the United States branch in and to every species of property and things, in actions thereunder belonging, are deemed as transferred to and vested in

the domestic insurer, and simultaneously the domestic insurer is deemed to have assumed all of the liabilities of the United States branch. The domestic insurer is considered as having the age as the oldest of the two parties to the domestication agreement for purposes of laws relating to age of company.

(2) All deposits of the United States branch held by the commissioner, or by state officers, or other state regulatory agencies pursuant to requirements of state laws, are deemed to be held as security for the satisfaction by the domestic insurer of all liabilities to policyholders within the United States assumed from the United States branch; and the deposits are deemed to be assets of the domestic insurer and are reported as such in the annual financial statements and other reports that the domestic insurer may be required to file. Upon the ultimate release by a state officer or agency of a deposit, the securities and cash constituting the released deposit is delivered and paid over to the domestic insurer as the lawful successor in interest to the United States branch.

(3) Contemporaneously with the consummation of the domestication of the United States branch, the commissioner shall direct the trustee, if any, of the United States branch's trusteed assets, as set forth in RCW 48.35.020, to transfer and deliver to the domestic insurer all assets, if any, held by such trustee. [1991 c 268 § 20.]

Chapter 48.36A RCW

FRATERNAL BENEFIT SOCIETIES

Sections

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- 48.36A.020 Lodge system—Lodges for children.
- 48.36A.030 Representative form of government.
- 48.36A.040 Definitions.
- 48.36A.050 Beneficial operations—Laws and rules.
- 48.36A.060 Membership classes, rights, grievances.
- 48.36A.070 Location of office and meetings—Official publications, annual statement.
- 48.36A.080 Immunity of officers—Indemnification of person responsible—Insurance for liability.
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- 48.36A.110 Amendment of society's laws.
- 48.36A.120 Not-for-profit institutions authorized—Funeral homes prohibited.
- 48.36A.130 Reinsurance.
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- 48.36A.210 Authorized investments.
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- 48.36A.286 Rehabilitation, liquidation, or conservation of society—Same as insurance companies—Priority of distribution of claims.
- 48.36A.290 License required—Obtaining.
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- 48.36A.350 Service of process upon commissioner.
- 48.36A.360 Penalties.
- 48.36A.370 Exemptions.
- 48.36A.380 World War I societies.
- 48.36A.390 Fraternal mutual insurers.
- 48.36A.400 Fraternal mutual life insurers.
- 48.36A.410 Review of commissioner's decisions and findings.
- 48.36A.901 Effective date—1987 c 366.

48.36A.010 Fraternal benefit society defined. Any incorporated society, order, or supreme lodge, without capital stock, including one exempted under the provisions of RCW 48.36A.370(1)(b) whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this chapter, is hereby declared to be a fraternal benefit society. [1987 c 366 § 1.]

48.36A.020 Lodge system—Lodges for children. (1) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated, or admitted in accordance with its laws, rules, and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(2) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of the children, nor shall they have a voice or vote in the management of the society. [1987 c 366 § 2.]

48.36A.030 Representative form of government. A society has a representative form of government when:

(1) It has a supreme governing body constituted in one of the following ways:

(a) The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every four years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws; or

(b) The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four years. Vacancies on the board

between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society;

(2) The officers of the society are elected either by the supreme governing body or by the board of directors;

(3) Only benefit members are eligible for election to the supreme governing body and the board of directors; and

(4) Each voting member shall have one vote. No vote may be cast by proxy. [1987 c 366 § 3.]

48.36A.040 Definitions. As used in this chapter, the following terms have the meanings indicated unless the context clearly requires otherwise:

(1) "Benefit contract" means the agreement for provision of benefits authorized by RCW 48.36A.160, as that agreement is described in RCW 48.36A.190(1).

(2) "Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

(3) "Certificate" means the document issued as written evidence of the benefit contract.

(4) "Premiums" means premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.

(5) "Laws" means the society's articles of incorporation, constitution, and bylaws, however designated.

(6) "Rules" means all rules, regulations, or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

(7) "Society" means fraternal benefit society, unless otherwise indicated.

(8) "Lodge" means subordinate member units of the society, known as camps, courts, councils, branches, or by any other designation. [1987 c 366 § 4.]

48.36A.050 Beneficial operations—Laws and rules.

(1) A society shall operate for the benefit of members and their beneficiaries by:

(a) Providing benefits as specified in RCW 48.36A.160; and

(b) Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purposes for the benefit of its members, which may also be extended to others.

These purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(2) Every society may adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It may change, alter, add to, or amend such laws and rules and has such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society. [1987 c 366 § 5.]

48.36A.060 Membership classes, rights, grievances.

(1) A society shall specify in its laws or rules:

(a) Eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen and not greater than age twenty-one;

(b) The process for admission to membership for each membership class; and

(c) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(2) A society may also admit social members who have no voice or vote in the management of the insurance affairs of the society.

(3) Membership rights in the society are personal to the member and are not assignable.

(4) A society may provide in its laws or rules for grievance or complaint procedures for members. [1987 c 366 § 6.]

48.36A.070 Location of office and meetings—Official publications, annual statement. (1) The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province, or territory where the society has at least one subordinate lodge, or in such other location as determined by the supreme governing body, and all business transacted at the meetings is as valid in all respects as if the meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(2) (a) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Required reports, notices, and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(b) Not later than June 1st of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, the synopsis may be published in the society's official publication. [1987 c 366 § 7.]

48.36A.080 Immunity of officers—Indemnification of person responsible—Insurance for liability. (1) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(2) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, the person in connection with or arising out of any action, suit, or proceeding, whether civil, criminal, administrative, or investigative, or threat thereof, in which the person may be involved by reason of the fact that the person is or was a director, officer, employee, or agent of the society or of any firm, corporation, or organization which the person served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed (a) in rela-

tion to any matter in such action, suit, or proceeding as to which the person shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee, or agent of the society; or (b) in relation to any matter in the action, suit, or proceeding, or threat thereof, which has been made the subject of a compromise settlement; unless in either case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that their conduct was unlawful. The determination whether the conduct of the person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in (a) or (b) of this subsection may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to the action, suit, or proceeding or by a court of competent jurisdiction. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to the person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which the person may be entitled as a matter of law and shall inure to the benefit of the person's heirs, executors, and administrators.

(3) A society may purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against the person and incurred by the person in any capacity or arising out of the person's status as such, whether or not the society would have the power to indemnify the person against the liability under this section. [1987 c 366 § 8.]

48.36A.090 Nonwaiver provisions. The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member. [1987 c 366 § 9.]

48.36A.100 Formation of domestic society—Procedures and requirements. A domestic society organized on or after January 1, 1988, shall be formed as follows, but not until it has and continues to maintain unimpaired surplus in the minimum amount of total capital and surplus required by RCW 48.05.340:

(1) Seven or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign, and acknowledge before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:

(a) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(b) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. The purposes shall not include more liberal powers than are granted by this chapter;

(c) The names and residences of the incorporators and the names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all the officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.

(2) The articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society, and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the commissioner, who may require further information as the commissioner deems necessary. The bond with sureties approved by the commissioner shall be in an amount, not less than three hundred thousand dollars nor more than one million five hundred thousand dollars as required by the commissioner. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the commissioner shall so certify, retain, and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(3) No preliminary certificate of authority granted under the provisions of this section shall be valid after one year from its date or after a further period, not exceeding one year, as may be authorized by the commissioner upon cause shown, unless the five hundred applicants required by subsection (4) of this section have been secured and the organization has been completed under this chapter. The articles of incorporation and all other proceedings thereunder shall become null and void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business under this chapter.

(4) Upon receipt of a preliminary certificate of authority from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each applicant a receipt for the amount collected. No society shall incur any liability other than for the return of the advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

(a) Actual bona fide applications for benefits have been secured on not less than five hundred applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

(b) At least ten subordinate lodges have been established into which the five hundred applicants have been admitted;

(c) There has been submitted to the commissioner, under oath of the president or secretary, or corresponding officer of the society, a list of the applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted, and premiums therefor; and

(d) It has been shown to the commissioner, by sworn statement of the treasurer, or corresponding officer of the society, that at least five hundred applicants have each paid in cash at least one regular monthly premium and the total amount of collected premiums equals at least one hundred fifty thousand dollars. The advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one year, the premiums shall be returned to the applicants.

(5) The commissioner may make such examination and require such further information as the commissioner deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of this chapter, the commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of the certificate. The commissioner shall cause a record of the certificate of authority to be made. A certified copy of the record may be given in evidence with like effect as the original certificate of authority.

(6) Any incorporated society authorized to transact business in this state at the time this chapter becomes effective shall not be required to reincorporate.

(7) The commissioner may, by rule, require domestic fraternal societies to have and maintain a larger amount of surplus than the minimum amount of capital and surplus prescribed under RCW 48.05.340, based upon the type, volume, and nature of insurance business transacted, consistent with the principles of risk-based capital modified to recognize the special characteristics of fraternal benefit societies. [1996 c 236 § 1; 1987 c 366 § 10.]

48.36A.110 Amendment of society's laws. (1) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. The referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission, a majority of the members voting shall have signified their consent to the amendment by one of the specified methods.

(2) No amendment to the laws of any domestic society shall take effect unless approved by the commissioner. The commissioner shall approve the amendment if the commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects, and purposes of the society. Unless the commissioner disapproves any amendment within sixty days after the filing of same, the amendment shall be considered

approved. The approval or disapproval by the commissioner shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case the commissioner disapproves the amendment, the reasons for the disapproval shall be stated in the written notice.

(3) Within ninety days from the approval by the commissioner, all amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that the amendments or synopsis thereof, have been furnished to the addressee.

(4) Every foreign or alien society authorized to do business in this state shall file with the commissioner a certified copy of all amendments of, or additions to, its laws within ninety days after their enactment.

(5) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of their legal adoption. [1987 c 366 § 11.]

48.36A.120 Not-for-profit institutions authorized—Funeral homes prohibited. (1) A society may create, maintain, and operate, or establish organizations to operate, not-for-profit institutions to further the purposes permitted by RCW 48.36A.050(1)(b). The institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement.

(2) No society shall own or operate funeral homes or undertaking establishments. [1987 c 366 § 12.]

48.36A.130 Reinsurance. (1) A domestic society may, by a reinsurance agreement, transfer any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the commissioner, but no domestic society may reinsure substantially all of its insurance in force without the written permission of the commissioner. It may take credit for the reserves on the transferred risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a transferring society for reinsurance made, transferred, renewed, or otherwise becoming effective after January 1, 1988, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the transferring society under the contract or contracts reinsured without diminution because of the insolvency of the transferring society.

(2) Notwithstanding the limitation in subsection (1) of this section, a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner under RCW 48.36A.140. [1987 c 366 § 13.]

48.36A.140 Consolidation and merger. (1) A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the commissioner:

(a) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(b) A sworn statement by the president and secretary or corresponding officers of each society showing their financial condition on a date fixed by the commissioner but not earlier than December 31st next preceding the date of the contract;

(c) A certificate of the officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and

(d) Evidence that at least sixty days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(2) If the commissioner finds that the contract is in conformity with the provisions of this section, that the financial statements are correct, and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to that effect. Upon approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event, the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval is filed with the commissioner of this state or, if the laws of the state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the commissioner of insurance of the state or territory and a certificate of such approval is filed with the commissioner of this state.

(3) Upon the consolidation or merger becoming effective, all the rights, franchises, and interests of the consolidated or merged societies in and to every species of property, real, personal, or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after the consolidation or merger.

(4) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that the notice or document has been duly addressed and mailed, shall be prima facie evidence that the notice or document has been furnished to the addressees. [1987 c 366 § 14.]

48.36A.150 Conversion to mutual life insurance company. Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of the insurance laws of this state for mutual life insurance companies. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion.

The affirmative vote of two-thirds of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan, or if the society is organized under the direct election method pursuant to RCW 48.36A.030(1)(b), the plan of conversion shall be submitted by mail to the benefit members or the plan may be published in the official publication authorized by RCW 48.36A.070(2)(a). The affirmative vote of two-thirds of the benefit members voting thereon shall be necessary for the approval of the plan. No conversion shall take effect unless and until approved by the commissioner who may give approval if the commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society. [1987 c 366 § 15.]

48.36A.160 Contractual benefits. (1) A society may provide the following contractual benefits in any form:

- (a) Death benefits;
- (b) Endowment benefits;
- (c) Annuity benefits;
- (d) Temporary or permanent disability benefits;
- (e) Hospital, medical, or nursing benefits;
- (f) Monument or tombstone benefits to the memory of deceased members; and
- (g) Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

(2) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (1) of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person. [1987 c 366 § 16.]

48.36A.170 Designation of beneficiary—Funeral benefits. (1) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(2) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the portion paid shall not exceed the sum of one thousand dollars.

(3) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of the benefit, except to the extent that funeral benefits may be paid under this section, shall be payable to the personal representative of the deceased insured, provided that if the owner of the certificate is other than the insured, the proceeds shall be payable to the owner. [1987 c 366 § 17.]

48.36A.180 Protection of benefits. No money or other benefit, charity, relief, or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment, or other process, or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society. [1987 c 366 § 18.]

48.36A.190 Benefit certificates—Impaired reserves. (1) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(2) Except as provided in RCW 48.36A.220, any changes, additions, or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though the changes, additions, or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition, or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(3) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(4) Except as provided in RCW 48.36A.220, a society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of the deficiency as ascertained by its board, and that if the payment is not made, either (a) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or (b) in lieu of or in combination with (a) of this subsection, the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(5) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(6) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with the commissioner in the manner provided for like policies issued by life insurers in this state. Every life, accident, health, or disability insurance certificate and every annuity certificate

issued on or after one year from January 1, 1988, shall be approved by the commissioner and shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life insurers in this state, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificates shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(7) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government, and control of such certificates and all rights, obligations, and liabilities incident thereto and connected therewith. Ownership rights prior to the transfer shall be specified in the certificate.

(8) A society may specify the terms and conditions on which benefit contracts may be assigned. [1987 c 366 § 19.]

48.36A.200 Paid-up nonforfeiture benefits and cash surrender values. (1) For certificates issued prior to one year after January 1, 1988, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall comply with the provisions of law applicable immediately prior to January 1, 1988.

(2) For certificates issued on or after one year from January 1, 1988, for which reserves are computed on the commissioner's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial table or the commissioner's 1958 standard ordinary mortality table, or the commissioner's 1980 standard mortality table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

(3) For annuity certificates issued on or after one year from January 1, 1988, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing annuities. [1987 c 366 § 20.]

48.36A.210 Authorized investments. A society shall invest its funds only in investments that are authorized by the

laws of this state for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country, or province in which it is incorporated, shall be deemed to have met the requirements of this section for the investment of funds. [1987 c 366 § 21.]

48.36A.220 Assets—Investment and disbursement.

(1) All assets shall be held, invested, and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(2) A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society.

(3) A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to all the provisions of law regulating life insurers establishing such accounts and issuing such contracts, as provided in chapter 48.18A RCW. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis to which RCW 48.36A.190 (2) and (4) shall not apply. [1987 c 366 § 22.]

48.36A.230 Chapter exclusive. Societies shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state unless they are expressly designated therein, or unless it is specifically made applicable by this chapter. [1987 c 366 § 23.]

48.36A.240 Funds tax exempt, exception. Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal, and school tax, other than taxes on real estate and office equipment. [1987 c 366 § 24.]

48.36A.250 Valuation standards—Reserves. (1) Standards of valuation for certificates issued prior to one year after January 1, 1988, shall be those provided by the laws applicable immediately prior to January 1, 1988.

(2) The minimum standards of valuation for certificates issued on or after one year from January 1, 1988, shall be based on the following tables:

(a) For certificates of life insurance: The commissioner's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial mortality table, the commissioner's 1958 standard ordinary mortality table, the commissioner's 1980 standard ordinary mortality table, or any more recent table made applicable to life insurers;

(b) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits, and for noncancellable accident and health benefits: Such tables as are authorized for use by life insurers in this state.

All of the above shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(3) The commissioner may, in the commissioner's discretion, accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The commissioner may, in the commissioner's discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

(4) Any society, with the consent of the commissioner of insurance of the state of domicile of the society and under the conditions, if any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required by this section, but the contractual rights of any benefit member shall not be affected thereby. [1987 c 366 § 25.]

48.36A.260 Annual financial statement. (1) Every domestic society shall annually, on or before the first day of March, unless for cause shown such time has been extended by the commissioner, file with the commissioner a true statement of its financial condition, transactions, and affairs for the preceding calendar year and pay a fee of ten dollars for filing. The statement shall be in general form and context as approved by the national association of insurance commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner.

(2) All domestic, foreign, and alien societies transacting business 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 convention blank in electronic form.

(3) As part of the required annual statement, each society shall, on or before the first day of March, file with the commissioner a valuation of its certificates in force on December 31st last preceding, provided the commissioner may, in the commissioner's discretion for cause shown, extend the time for filing the valuation for not more than two calendar months. The valuation shall be done in accordance with the standards specified in RCW 48.36A.250. The valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(4) A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit one hundred dollars for each day during which the neglect continues, and, upon notice by the commissioner, its authority to do business in this state shall cease while the default continues. [2007 c 80 § 4; 1987 c 366 § 26.]

48.36A.263 Filing of financial statements. Every fraternal benefit society holding a certificate of authority shall file its financial statements as required by this code 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. [1999 c 33 § 2.]

48.36A.270 Licenses and renewals—Fees—Existing societies. A license under this chapter continues in force until suspended, revoked, or not renewed. A license is subject to renewal annually on the first day of July upon payment of the fee for the license. If not so renewed, the certificate expires as of the thirtieth day of June of the same year. Licenses existing on June 9, 1994, continue in force until July 1, 1995, unless revoked or suspended. For each license or renewal the society shall pay the commissioner the fee established pursuant to RCW 48.14.010, subject to the retaliatory provision of RCW 48.14.040. A certified copy or duplicate of the license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter. [1994 c 131 § 1; 1987 c 366 § 27.]

48.36A.272 Notice of intent to suspend, revoke, or refuse to renew a license. The commissioner shall give a society notice of his or her intention to suspend, revoke, or refuse to renew its license not less than ten days before the effective date of the order of suspension, revocation or refusal, except that advance notice of intention is not required where the order results from a domestic society's failure to make good a deficiency of assets as required by the commissioner. [1996 c 236 § 4.]

48.36A.274 Duration of suspension. The commissioner shall not suspend a society's license for a period in excess of one year, and shall state in his or her order of suspension the period during which the order is effective. [1996 c 236 § 5.]

48.36A.276 Reauthorization of license. A society whose license has been suspended, revoked, or refused may not subsequently be authorized unless the grounds for the suspension, revocation, or refusal no longer exist and the society is otherwise fully qualified. [1996 c 236 § 6.]

48.36A.278 Notice to agents of loss of authority. Upon the suspension, revocation, or refusal of a society's license, the commissioner shall give notice to the society and shall suspend, revoke, or refuse the authority of its agents to represent it in this state and give notice to the agents. [1996 c 236 § 7.]

48.36A.280 Examinations. (1) The commissioner, or any person the commissioner may appoint, may examine any domestic, foreign, or alien society transacting or applying for admission to transact business in this state in the same manner as authorized by chapter 48.03 RCW. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(2) The expense of each examination and of each valuation, including the compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued. The payments shall be made upon receipt of statements furnished by the commissioner. [1987 c 366 § 28.]

48.36A.282 Transactions hazardous to certificate holders or creditors—Standards for consideration. The following standards may be considered by the commissioner to determine whether the continued operation of any society transacting an insurance business in this state might be deemed to be hazardous to the certificate holders or creditors. The commissioner may consider:

(1) Adverse findings reported in either a financial condition or market conduct examination report, or both, of a state insurance department that could lead to impairment of surplus;

(2) The national association of insurance commissioners insurance regulatory information system and its related reports;

(3) The ratios of commission expense, general insurance expense, policy benefits, and reserve increases as to annual premium and net investment income that could lead to an impairment of surplus;

(4) The society's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to assure the society's ability to meet its outstanding obligations as they mature;

(5) The ability of an assuming reinsurer to perform and whether the society's reinsurance program provides sufficient protection for the society's remaining surplus after taking into account the society's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

(6) The society's operating loss in the last twelve-month period or any shorter period of time, including but not limited to net capital gain or loss, change in nonadmitted assets, and cash refunds paid to members, is greater than fifty percent of the society's remaining surplus as regards certificate holders in excess of the minimum required;

(7) Whether any affiliate, subsidiary, or reinsurer is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligation;

(8) Contingent liabilities, pledges, or guaranties which either individually or collectively involve a total amount that in the opinion of the commissioner may affect the solvency of the society;

(9) The age and collectibility of receivables;

(10) Whether the management of a society, including officers, trustees, directors, or any other person who directly or indirectly controls the operation of the society, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the society in such a position;

(11) Whether management of a society has failed to respond to inquiries relative to the condition of the society or has furnished misleading information concerning an inquiry;

(12) Whether management of a society either has filed any false or misleading sworn financial statement, or has released a false or misleading financial statement to lending institutions or to the general public, or has made a false or

misleading entry, or has omitted an entry of material amount in the books of the society;

(13) Whether the society has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner; and

(14) Whether the society has experienced or will experience in the foreseeable future, either cash flow problems or liquidity problems, or both. [1996 c 236 § 8.]

48.36A.284 Determination of financial condition—Hazardous to certificate holders—Commissioner's order—Hearing. (1) For the purpose of making a determination of a society's financial condition, the commissioner may:

(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired, or otherwise subject to a delinquency proceeding;

(b) Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates;

(c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

(d) Increase the society's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the society will be called upon to meet the obligation undertaken within the next twelve-month period.

(2) If the commissioner determines that the continued operation of the society authorized to transact business in this state may be hazardous to the certificate holders, then the commissioner may, in conjunction with or in lieu of a notice required or permitted by RCW 48.36A.272, issue an order requiring the society to:

(a) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(b) Reduce, suspend, or limit the volume of business being accepted or renewed;

(c) Reduce general insurance and commission expenses by specified methods;

(d) Increase the society's surplus;

(e) Suspend or limit the declaration and payment of refunds by a society to its members;

(f) File reports in a form acceptable to the commissioner concerning the market value of a society's assets;

(g) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;

(h) Document the adequacy of premium rates in relation to the risks insured; or

(i) File, in addition to regular annual statements, interim financial reports on the form adopted by the national association of insurance commissioners or on a format promulgated by the commissioner.

(3) Any society subject to an order under subsection (2) of this section may make a written demand for a hearing, subject to the requirements of RCW 48.04.010, by specifying in what respects it is aggrieved and the grounds to be relied upon as basis for the relief to be demanded at the hearing. [1996 c 236 § 9.]

48.36A.286 Rehabilitation, liquidation, or conservation of society—Same as insurance companies—Priority of distribution of claims. (1) Any rehabilitation, liquidation, or conservation of a domestic fraternal benefit society is the same as the rehabilitation, liquidation, or conservation of an insurance company and shall 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 domestic fraternal benefit society upon any one or more of the following grounds: That the domestic fraternal benefit society:

- (a) Is insolvent; or
 - (b) Has ceased transacting insurance business for a period of one year; or
 - (c) Is insolvent and has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute any action or proceeding to liquidate its business or affairs, or to dissolve its corporate charter, or to procure the appointment of a receiver, trustee, custodian, or sequestrator under any law except this code; or
 - (d) Any of the matters set forth in RCW 48.36A.310.
- (2) The priority of the distribution of claims from a domestic fraternal benefit society's estate shall be as set forth in RCW 48.31.280. [1996 c 236 § 10.]

48.36A.290 License required—Obtaining. (1) No foreign or alien society shall transact business in this state without a license issued by the commissioner. Any society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies and must have and continue to maintain unimpaired surplus in the minimum amount of total capital and surplus required by RCW 48.05.340. A society may be licensed to transact business in this state upon filing with the commissioner:

- (a) A duly certified copy of its articles of incorporation;
- (b) A copy of its bylaws, certified by its secretary or corresponding officer;
- (c) A power of attorney to the commissioner as prescribed in RCW 48.36A.410;
- (d) A statement of its business under oath by its president and secretary, or corresponding officers, in a form prescribed by the commissioner, verified by an examination made by the supervising insurance official of its home state or other state, territory, province, or country, satisfactory to the commissioner;
- (e) Certification from the proper official of its home state, territory, province, or country that the society is legally incorporated and licensed to transact business;
- (f) Copies of its certificate forms; and
- (g) Such other information as the commissioner may deem necessary; and upon a showing that its assets are invested in accordance with the provisions of this chapter.

(2) After June 30, 1997, a foreign or alien society which does not have unimpaired surplus in the minimum amount of total capital and surplus required by RCW 48.05.340 may not issue any new policies or certificates until the society has unimpaired surplus in the minimum amount of total capital and surplus required by RCW 48.05.340; however, a foreign

or alien society may continue to issue new policies or certificates to members of the society who have an existing policy or certificate in force with the society on June 30, 1997. Once such a foreign or alien society obtains unimpaired surplus in the minimum amount of total capital and surplus required by RCW 48.05.340, the society must continue to maintain unimpaired surplus in the minimum amount of total capital and surplus required by RCW 48.05.340.

(3) After June 30, 1997, a foreign or alien society which had unimpaired surplus in the minimum amount of total capital and surplus required by RCW 48.05.340 on December 31, 1996, must continue to maintain unimpaired surplus in the minimum amount of total capital and surplus required by RCW 48.05.340.

(4) The commissioner may, by rule, require foreign or alien fraternal societies to have and maintain a larger amount of surplus than the minimum amount of capital and surplus prescribed under RCW 48.05.340, based upon the type, volume, and nature of insurance business transacted, consistent with the principles of risk-based capital modified to recognize the special characteristics of fraternal benefit societies. [1996 c 236 § 2; 1987 c 366 § 29.]

48.36A.310 Deficiencies, noncompliance by societies—Actions against license. (1) The commissioner may refuse, suspend, or revoke a fraternal benefit society's license, if the society:

- (a) Has exceeded its powers;
- (b) Has failed to comply with any of the provisions of this chapter;
- (c) Is not fulfilling its contracts in good faith;
- (d) Is conducting its business fraudulently;
- (e) Has a membership of less than four hundred after an existence of one year or more;
- (f) Is found by the commissioner to be in such a condition that its further transaction of insurance in this state would be hazardous to certificate holders and the people in this state;
- (g) Refuses to remove or discharge a trustee, director, or officer who has been convicted of any crime involving fraud, dishonesty, or like moral turpitude;
- (h) Refuses to be examined, or if its trustees, directors, officers, employees, or representatives refuse to submit to examination or to produce its accounts, records, and files for examination by the commissioner when required, or refuse to perform any legal obligation relative to the examination;
- (i) Fails to pay any final judgment rendered against it in this state upon any certificate, or undertaking issued by it, within thirty days after the judgment became final or within thirty days after time for taking an appeal has expired, or within thirty days after dismissal of an appeal before final determination, whichever date is the later;
- (j) Is found by the commissioner, after investigation or upon receipt of reliable information, to be managed by persons, whether by its trustees, directors, officers, or by any other means, who are incompetent or untrustworthy or so lacking in fraternal benefit society managerial experience as to make a proposed operation hazardous to its members; or that there is good reason to believe it is affiliated directly or indirectly through ownership, control, or business relations, with any person or persons whose business operations are or

have been found to be in violation of any law or rule, to the detriment of the members of the society or of the public, by bad faith or by manipulation of the assets, or of accounts, or of reinsurance of the society; or

(k) Does business through insurance producers or other representatives in this state or in any other state who are not properly licensed under applicable laws and rules.

(2) Nothing in this section shall prevent a society from continuing, in good faith, all contracts made in this state during the time the society was legally authorized to transact business herein. [2008 c 217 § 45; 1996 c 236 § 3; 1987 c 366 § 31.]

Additional notes found at www.leg.wa.gov

48.36A.320 Requirements for injunction. No application or petition for injunction against any domestic, foreign, or alien society, or lodge thereof, shall be maintained in any court of this state unless made by the attorney general upon request of the commissioner. [1987 c 366 § 32.]

48.36A.330 Insurance producers. (1) Insurance producers of societies shall be licensed in accordance with the applicable provisions of chapter 48.17 RCW regulating the licensing, revocation, suspension, or termination of licenses of resident and nonresident insurance producers.

(2) The following individuals shall not be deemed an insurance producer of a fraternal benefit society within the provisions of subsection (1) of this section:

(a) Any regular salaried officer or employee of a licensed society who devotes substantially all of their services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained; or

(b) Any insurance producer or representative of a society who devotes, or intends to devote, less than fifty percent of their time to the solicitation and procurement of insurance contracts for such society: PROVIDED, That any person who in the preceding calendar year has solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of fifty thousand dollars shall be conclusively presumed to be devoting, or intending to devote, fifty percent of the person's time to the solicitation or procurement of insurance contracts for such society. [2008 c 217 § 46; 1987 c 366 § 33.]

Additional notes found at www.leg.wa.gov

48.36A.340 Unfair trade practices. (1) Except as provided in subsection (2) of this section, every society authorized to do business in this state shall be subject to the provisions of chapter 48.30 RCW relating to unfair trade practices.

(2) Nothing in chapter 48.30 RCW shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society. [1987 c 366 § 34.]

48.36A.350 Service of process upon commissioner. (1) Every society authorized to do business in this state must (2021 Ed.)

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 society.

(2) With the appointment the society must designate the person to whom the commissioner must forward legal process so served upon him or her.

(3) The appointment of the commissioner as attorney is irrevocable, binds any successor in interest or to the assets or liabilities of the society, and remains in effect as long as there is in force in this state any contract made by the society or liabilities or duties arising therefrom.

(4) The service of process must be accomplished and processed in the manner prescribed under RCW 48.02.200. [2011 c 47 § 11; 1987 c 366 § 35.]

48.36A.360 Penalties. (1) Any person who wilfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society, shall upon conviction be fined not less than one hundred dollars nor more than five hundred dollars or imprisonment in the county jail not less than thirty days nor more than three hundred sixty-four days, or both.

(2) Any person who wilfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this chapter, or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of false swearing and shall be subject to the penalties under RCW 9A.72.040.

(3) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state shall be guilty of a misdemeanor and upon conviction be fined not less than fifty dollars nor more than two hundred dollars.

(4) Any person guilty of a wilful violation of, or neglect or refusal to comply with, the provisions of this chapter for which a penalty is not otherwise prescribed, shall upon conviction, be subject to a fine not exceeding two hundred dollars. [2011 c 96 § 39; 1987 c 366 § 36.]

Findings—Intent—2011 c 96: See note following RCW 9A.20.021.

48.36A.370 Exemptions. (1) Nothing contained in this chapter shall be so construed as to affect or apply to:

(a) Grand or subordinate lodges of Masons, Odd Fellows, Improved Order of Red Men, Fraternal Order of Eagles, Loyal Order of Moose, or Knights of Pythias, exclusive of the insurance department of the Supreme Lodge of Knights of Pythias, the Grand Aerie Fraternal Order of Eagles, and the Junior Order of United American Mechanics, exclusive of the beneficiary degree of insurance branch of the National Council Junior Order [of] United American Mechanics, or similar societies which do not issue insurance certificates;

(b) Orders, societies, or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and

the ladies' societies or ladies' auxiliaries to such orders, societies, or associations;

(c) Any association of local lodges of a society now doing business in this state which provides death benefits not exceeding three hundred dollars to any one person, or disability benefit not exceeding three hundred dollars in any one year to any one person, or both; or any contracts of reinsurance business on such plan in this state;

(d) Domestic societies which limit their membership to the employees of a particular city or town, designated firm, business house, or corporation;

(e) Domestic lodges, orders, or associations of a purely religious, charitable, and benevolent description, which do not provide for a death benefit of more than one hundred dollars, or for disability benefits of more than one hundred fifty dollars to any one person in any one year: PROVIDED, That any such domestic order or society which has more than five hundred members and provides for death or disability benefits, and any such domestic lodge, order, or society which issues to any person a certificate providing for the payment of benefits, shall not be exempt by the provisions of this section, but shall comply with all the requirements of this chapter.

The commissioner may require from any society such information as will enable the commissioner to determine whether the society is exempt from the provisions of this chapter.

(2) No society, which is exempt by the provisions of this section from the requirements of this chapter shall give or allow or promise to give or allow to any person any compensation for procuring new members.

(3) Any fraternal benefit society, heretofore organized and incorporated and operating as set forth in RCW 48.36A.010, 48.36A.020, and 48.36A.030, providing for benefits in case of death or disability resulting solely from accidents, but which does not obligate itself to pay other death or sick benefits, may be licensed under the provisions of this chapter, and shall have all the privileges and shall be subject to all the provisions and regulations of this chapter, except that the provisions of this chapter requiring medical examinations, valuations of benefit certificates, and that the certificate shall specify the amount of benefits, shall not apply to such society.

(4) The commissioner may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether the society or association is exempt from the provisions of this chapter.

(5) Societies, exempted under the provisions of this section, shall also be exempt from all other provisions of the insurance laws of this state. [1987 c 366 § 37.]

48.36A.380 World War I societies. Any corporation, society, order, or voluntary association operating as set forth in RCW 48.36A.010, 48.36A.020, and 48.36A.030, organized during the war in which the United States entered on April 6, 1917, with the purposes of assisting the government of the United States in maintaining and increasing the production of commodities essential for the prosecution of that war, and of developing loyalty to the United States, or whose membership is limited to veterans of that war, may be licensed under the provisions of this chapter and shall have

all the privileges and shall be subject to all the provisions and regulations of this chapter, except that the provisions of this chapter requiring death benefits of at least one thousand dollars, medical examinations, and valuations of benefit certificates, shall not apply to such society, but the society may provide benefits in case of death or disability resulting solely from accidents in an amount not exceeding one thousand dollars and may also provide for death or funeral benefits, or both, not exceeding one hundred dollars each, and for sick or disability benefits not exceeding five hundred dollars to any one person, in any one year. Any corporation, society, order, or voluntary association organized under the provisions of this section shall file with the insurance commissioner a copy of all its rates and policy forms. Rates and policy forms must be approved by the insurance commissioner before becoming effective. All rates and forms approved by the commissioner shall be observed by the society until amended rates or forms shall have been filed with and approved by the insurance commissioner. [1987 c 366 § 38.]

48.36A.390 Fraternal mutual insurers. (1) A domestic mutual property insurer which is affiliated with and is comprised exclusively of members of a specified fraternal society that conducts its business and secures its membership on the lodge system, having ritualistic work and ceremonies, is herein designated as a fraternal mutual insurer.

(2) Only fraternal mutual property insurers which were authorized insurers immediately prior to October 1, 1947, may hereafter be so authorized.

(3) A fraternal mutual insurer shall be subject to the applicable provisions of this title governing domestic mutual insurers except only as to the provisions relative to taxes, fees, and licenses. The bylaws of such insurer shall be as adopted or amended by majority vote of its members present at a duly held meeting of its members, and a copy thereof shall be filed with the commissioner. Such an insurer shall pay for its annual license and filing its annual statement, the sum of ten dollars. Such an insurer shall pay the expense of examinations of it by the commissioner. The payment shall be made upon receipt of statements furnished by the commissioner.

(4) A fraternal mutual insurer may insure corporations, associations, and firms owned by and affiliated with such society and operated for the benefit of its members, and may insure corporations and firms a majority of whose shareholders or members are members of such society.

(5) A fraternal mutual insurer shall participate in and accept its equitable share of insurance to be issued to applicants under any assigned risk plan operating pursuant to RCW 48.22.020, and may participate in and accept its equitable share of insurance to be issued to applicants under any similar plan lawfully existing in any state in which the insurer is authorized to transact insurance, notwithstanding that the applicants are not otherwise qualified for insurance under subsection (4) of this section. Applicants who are not qualified by membership or otherwise for acceptance by the insurer, shall be so assigned to the insurer except to make up the deficiency, if any, between the number of qualified applicants available for assignment and the maximum quota of applicants to be assigned to the insurer within the current period.

(6) A fraternal mutual insurer doing business on the assessment premium plan:

(a) Shall be exempt also from the provisions of this chapter governing financial qualifications;

(b) Shall not be authorized to transact any kind of insurance other than property insurance, nor have authority to accept reinsurance.

(7) A fraternal mutual insurer doing business on the cash premium plan:

(a) May be authorized to transact additional kinds of insurance, other than life or title insurance, subject to the same requirements as to surplus funds and reserves as apply to domestic mutual insurers on the cash premium plan;

(b) May accept reinsurance only of such kinds of insurance as it is authorized to transact direct and only from insurers likewise affiliated with and composed solely of the members of the same designated fraternal society. [1987 c 366 § 39.]

48.36A.400 Fraternal mutual life insurers. (1) A mutual life insurer which is affiliated with and insures exclusively members of a specified fraternal society, which society conducts its business and secures its membership on the lodge system, having ritualistic work and ceremonies, is herein designated as a fraternal mutual life insurer.

(2) Such an insurer shall be subject to the applicable provisions of this title governing mutual life insurers except only as to the provisions relative to annual meeting, taxes, fees, and licenses. Such an insurer shall pay for its annual license and filing its annual statement, the sum of ten dollars. Such an insurer shall pay the expense of examinations of it by the commissioner, upon statement furnished by the commissioner. [1987 c 366 § 40.]

48.36A.410 Review of commissioner's decisions and findings. All decisions and findings of the commissioner made under the provisions of this chapter shall be subject to review as provided in chapter 34.05 RCW. [1987 c 366 § 41.]

48.36A.901 Effective date—1987 c 366. This act shall take effect January 1, 1988. [1987 c 366 § 45.]

Chapter 48.37 RCW

MARKET CONDUCT OVERSIGHT

Sections

48.37.005	Short title.
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48.37.130	Coordination with other state insurance regulators through the NAIC.

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48.37.140 Additional duties of the commissioner.

48.37.005 Short title. This chapter may be known and cited as the market conduct oversight law. [2007 c 82 § 2.]

48.37.010 Purpose—Intent. (1) The purpose of this chapter is to establish a framework for the commissioner's market conduct actions, including:

(a) Processes and systems for identifying, assessing, and prioritizing market conduct problems that have a substantial adverse impact on consumers, policyholders, and claimants;

(b) Market conduct actions by the commissioner to substantiate such market conduct problems and a means to remedy significant market conduct problems; and

(c) Procedures to communicate and coordinate market conduct actions among state insurance regulators to foster the most efficient and effective use of resources.

(2) It is the intent of the legislature that the market analysis or market conduct process utilize available technology in the least intrusive and most cost-efficient manner to develop a baseline understanding of the marketplace and to identify insurers or practices that deviate significantly from the norm or that pose a potential risk to the insurance consumer. It is also the intent of the legislature that this process include discretion for the commissioner to use market conduct examinations when the continuum of available market conduct actions have not sufficiently addressed issues concerning insurer activities in Washington, or when the continuum of available market conduct actions are not reasonably expected to address issues concerning insurer activities in Washington.

(3) It is further the intent of the legislature that the commissioner work with the national association of insurance commissioners toward development of an accreditation process for market conduct oversight and an effective process for domestic deference that creates protections for Washington consumers and efficient and effective regulation of the industry. [2007 c 82 § 3.]

48.37.020 Application. This chapter applies to all entities regulated by this title, and to all persons or entities acting as or holding themselves out as insurers in this state, unless otherwise exempted from the provisions of this title. [2007 c 82 § 4.]

48.37.030 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Best practices organization" means insurance marketplace standards association or a similar generally recognized organization whose purpose and central mission is the promotion of high ethical standards in the insurance marketplace.

(2) "Commissioner" means the insurance commissioner of this state.

(3) "Complaint" means a written or documented oral communication primarily expressing a grievance, meaning an expression of dissatisfaction.

(4) "Insurer" means every person engaged in the business of making contracts of insurance and includes every such entity regardless of name which is regulated by this title. For purposes of this chapter, health care service contractors

defined in chapter 48.44 RCW, health maintenance organizations defined in chapter 48.46 RCW, fraternal benefit societies defined in chapter 48.36A RCW, and self-funded multiple employer welfare arrangements defined in chapter 48.125 RCW are defined as insurers.

(5) "Market analysis" means a process whereby market conduct oversight personnel collect and analyze information from filed schedules, surveys, required reports, and other sources in order to develop a baseline understanding of the marketplace and to identify patterns or practices of insurers that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

(6) "Market conduct action" means any of the full range of activities that the commissioner may initiate to assess and address the market conduct practices of insurers admitted to do business in this state, and entities operating illegally in this state, beginning with market analysis and extending to examinations. The commissioner's activities to resolve an individual consumer complaint or other report of a specific instance of misconduct are not market conduct actions for purposes of this chapter.

(7) "Market conduct oversight personnel" means those individuals employed or contracted by the commissioner to collect, analyze, review, or act on information on the insurance marketplace that identifies patterns or practices of insurers.

(8) "National association of insurance commissioners" (NAIC) has the same meaning as in RCW 48.02.140.

(9) "NAIC market regulation handbook" means the outline of the elements and objectives of market analysis developed and adopted by the NAIC, and the process by which states can establish and implement market analysis programs, and the set of guidelines developed and adopted by the NAIC that document established practices to be used by market conduct oversight personnel in developing and executing an examination, or a successor product.

(10) "NAIC market conduct uniform examination procedures" means the set of guidelines developed and adopted by the NAIC designed to be used by market conduct oversight personnel in conducting an examination, or a successor product.

(11) "NAIC standard data request" means the set of field names and descriptions developed and adopted by the NAIC for use by market conduct oversight personnel in market analysis, market conduct examination, or other market conduct actions, or a successor product.

(12) "Qualified contract examiner" means a person under contract to the commissioner, who is qualified by education, experience, and, where applicable, professional designations, to perform market conduct actions.

(13)(a) "Market conduct examination" means the examination of the insurance operations of an insurer licensed to do business in this state and entities operating illegally in this state, in order to evaluate compliance with the applicable laws and regulations of this state. A market conduct examination may be either a comprehensive examination or a targeted examination. A market conduct examination is separate and distinct from a financial examination of any insurer performed pursuant to chapter 48.03, 48.44, or 48.46 RCW, but may be conducted at the same time.

(b) "Comprehensive market conduct examination" means a review of one or more lines of business of an insurer. The term includes a review of rating, tier classification, underwriting, policyholder service, claims, marketing and sales, producer licensing, complaint handling practices, or compliance procedures and policies.

(c) "Targeted examination" means a focused examination conducted for cause, based on the results of market analysis indicating the need to review either a specific line or lines of business, or specific business practices, including but not limited to: (i) Underwriting and rating; (ii) marketing and sales; (iii) complaint handling; (iv) operations and management; (v) advertising; (vi) licensing; (vii) policyholder services; (viii) nonforfeitures; (ix) claims handling; and (x) policy forms and filings. A targeted examination may be conducted by desk examination or by an on-site examination.

(d) "Desk examination" means an examination that is conducted by an examiner at a location other than the insurer's premises. A desk examination is usually performed at the commissioner's offices with the insurer providing requested documents by hard copy, microfiche, discs, or other electronic media, for review.

(e) "On-site examination" means an examination conducted at the insurer's home office or the location where the records under review are stored.

(14) "Third-party model or product" means a model or product provided by an entity separate from and not under direct or indirect corporate control of the insurer using the model or product.

(15) "Insurance compliance self-evaluative audit" means a voluntary, internal evaluation, review, assessment, audit, or investigation for the purpose of identifying or preventing noncompliance with, or promoting compliance with laws, regulations, orders, or industry or professional standards, which is conducted by or on behalf of a company licensed or regulated under the insurance laws of this state, or which involves an activity regulated under this title.

(16) "Insurance compliance self-evaluative audit document" means documents prepared as a result of or in connection with an insurance compliance self-evaluative audit. An insurance compliance self-evaluative audit document may include:

(a) A written response to the findings of an insurance compliance self-evaluative audit;

(b) Any supporting information that is collected or developed for the primary purpose and in the course of an insurance compliance self-evaluative audit, including but not limited to field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer-generated or electronically recorded information, phone records, maps, charts, graphs, and surveys;

(c) Any of the following:

(i) An insurance compliance self-evaluative audit report prepared by an auditor, who may be an employee of the company or an independent contractor, which may include the scope of the audit, the information gained in the audit, conclusions, and recommendations, with exhibits and appendices;

(ii) Memoranda and documents analyzing portions or all of the insurance compliance self-evaluative audit report and discussing potential implementation issues;

(iii) An implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance; or

(iv) Analytic data generated in the course of conducting the insurance compliance self-evaluative audit. [2007 c 82 § 5.]

48.37.040 Market analysis procedures—Commissioner's duties—Rules. (1)(a) The commissioner shall collect and report market data information to the NAIC's market information systems, including the complaint database system, the examination tracking system, the regulatory retrieval system, other successor systems, or to additional systems as the commissioner determines is necessary for market analysis.

(b) Market data and information that is collected and maintained by the commissioner shall be compiled and submitted in a manner that meets the requirements of the NAIC and its systems.

(2)(a) Each entity subject to the provisions of this chapter shall file a market conduct annual statement or successor product, in the general form and context, in the time frame required by, and according to instructions provided by the NAIC, for each line of business written in the state of Washington. If a particular line of business does not have an approved market conduct annual statement form, the company is not required to file a report for that line of business until such time as [the] NAIC adopts an annual statement form for that line of business.

(b) The commissioner may, for good cause, grant an extension of time for filing a market conduct annual statement, if written application for extension is received at least five business days before the filing due date. Any insurer that fails to file its market conduct annual statement when due or by the end of any extension of time for filing, which the commissioner in his or her sole discretion may have granted, is subject to the penalty and enforcement provisions applicable to the insurer as found in the Washington insurance code.

(3)(a) The commissioner shall gather information from data currently available to the commissioner, surveys, required reports, information collected by the NAIC, other sources in both the public or private sectors, and information from within and outside the insurance industry. The commissioner may request insurers to submit data and information that is necessary to conduct market analysis and shall adopt rules that provide for access to records and compliance with the request, that do not cause undue burden or cost to the consumer or insurer.

(b) The information shall be analyzed in order to develop a baseline understanding of the marketplace and to identify for further review insurers or practices that deviate significantly from the norm or that may pose a potential risk to the insurance consumer. The commissioner shall use the NAIC market regulation handbook as one resource in performing this analysis.

(c) The commissioner shall adopt by rule a process for verification by an insurer of Washington state-specific complaint information concerning that insurer before using the

complaint information for market conduct surveillance purposes or transmitting it to NAIC databases after July 1, 2007.

(4)(a) If the commissioner determines, as a result of market analysis, that further inquiry into a particular insurer or practice is needed, the following continuum of market actions may be considered before conducting a market conduct examination. The commissioner shall not be required to follow the exact sequence of market conduct actions in the continuum or to use all actions in the continuum. As part of the chosen continuum action, the commissioner must discuss with the insurer the data used to choose the option and provide the insurer with an opportunity for data verification at that time. These actions may include, but are not limited to:

(i) Correspondence with the insurer;

(ii) Insurer interviews;

(iii) Information gathering;

(iv) Policy and procedure reviews;

(v) Interrogatories;

(vi) Review of insurer self-evaluation and compliance programs. This may include consideration of the insurer's membership in a best practices organization, if the commissioner is satisfied that the organization's qualification process is likely to provide reasonable assurance of compliance with pertinent insurance laws;

(vii) Desk examinations; and

(viii) Investigations.

(b) Except in extraordinary circumstances, the commissioner shall select the least intrusive and most cost-effective market conduct action that the commissioner determines will provide the necessary protections for consumers.

(5) The commissioner shall take those steps reasonably necessary to eliminate duplicative inquiries. The commissioner shall not request insurers to submit data or information provided as part of an insurer's annual financial statement, the annual market conduct statement of the NAIC, or other required schedules, surveys, or reports that are regularly submitted to the commissioner, or with data requests made by other states if that information is available to the commissioner, unless the information is state specific. The commissioner shall coordinate market conduct actions and findings with other state insurance regulators.

(6) For purposes of conducting an examination or other market conduct action on an insurer, the commissioner may examine or conduct a market conduct action on any managing general agent or other person, insofar as that examination or market conduct action is, in the sole discretion of the commissioner, necessary or material to the examination or market conduct action of the insurer. [2007 c 82 § 6.]

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

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

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

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

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

(5) At the beginning of the next legislative session after the adoption of the rules adopted under the authority of this section, the commissioner shall report to the appropriate policy committees of the legislature what rules were adopted; what statutory policies these rules were intended to implement; and such other matters as are indicated for the legislature's understanding of the role played by the NAIC in regulation of the insurance industry of Washington. [2007 c 82 § 7.]

48.37.060 Market conduct examinations—Procedures—Final orders—Fees. (1) When the commissioner determines that other market conduct actions identified in RCW 48.37.040(4)(a) have not sufficiently addressed issues raised concerning company activities in Washington state, the commissioner has the discretion to conduct market conduct examinations in accordance with the NAIC market conduct uniform examination procedures and the NAIC market regulation handbook.

(2)(a) In lieu of an examination of an insurer licensed in this state, the commissioner shall accept an examination report of another state, unless the commissioner determines that the other state does not have laws substantially similar to those of this state, or does not have a market oversight system that is comparable to the market conduct oversight system set forth in this law.

(b) The commissioner's determination under (a) of this subsection is discretionary with the commissioner and is not subject to appeal.

(c) If the insurer to be examined is part of an insurance holding company system, the commissioner may also seek to simultaneously examine any affiliates of the insurer under common control and management which are licensed to write the same lines of business in this state.

(3) Before commencement of a market conduct examination, market conduct oversight personnel shall prepare a work plan consisting of the following:

- (a) The name and address of the insurer being examined;
- (b) The name and contact information of the examiner-in-charge;
- (c) The name of all market conduct oversight personnel initially assigned to the market conduct examination;
- (d) The justification for the examination;
- (e) The scope of the examination;
- (f) The date the examination is scheduled to begin;
- (g) Notice of any noninsurance department personnel who will assist in the examination;

(h) A time estimate for the examination;

(i) A budget for the examination if the cost of the examination is billed to the insurer; and

(j) An identification of factors that will be included in the billing if the cost of the examination is billed to the insurer.

(4)(a) Within ten days of the receipt of the information contained in subsection (3) of this section, insurers may request the commissioner's discretionary review of any alleged conflict of interest, pursuant to RCW 48.37.090(2), of market conduct oversight personnel and noninsurance department personnel assigned to a market conduct examination. The request for review shall specifically describe the alleged conflict of interest in the proposed assignment of any person to the examination.

(b) Within five business days of receiving a request for discretionary review of any alleged conflict of interest in the proposed assignment of any person to a market conduct examination, the commissioner or designee shall notify the insurer of any action regarding the assignment of personnel to a market conduct examination based on the insurer's allegation of conflict of interest.

(5) Market conduct examinations shall, to the extent feasible, use desk examinations and data requests before an on-site examination.

(6) Market conduct examinations shall be conducted in accordance with the provisions set forth in the NAIC market regulation handbook and the NAIC market conduct uniform examinations procedures, subject to the precedence of the provisions of chapter 82, Laws of 2007.

(7) The commissioner shall use the NAIC standard data request.

(8) Announcement of the examination shall be sent to the insurer and posted on the NAIC's examination tracking system as soon as possible but in no case later than sixty days before the estimated commencement of the examination, except where the examination is conducted in response to extraordinary circumstances as described in RCW 48.37.050(2)(a). The announcement sent to the insurer shall contain the examination work plan and a request for the insurer to name its examination coordinator.

(9) If an examination is expanded significantly beyond the original reasons provided to the insurer in the notice of the examination required by subsection (3) of this section, the commissioner shall provide written notice to the insurer, explaining the expansion and reasons for the expansion. The commissioner shall provide a revised work plan if the expansion results in significant changes to the items presented in the original work plan required by subsection (3) of this section.

(10) The commissioner shall conduct a preexamination conference with the insurer examination coordinator and key personnel to clarify expectations at least thirty days before commencement of the examination, unless otherwise agreed by the insurer and the commissioner.

(11) Before the conclusion of the field work for market conduct examination, the examiner-in-charge shall review examination findings to date with insurer personnel and schedule an exit conference with the insurer, in accordance with procedures in the NAIC market regulation handbook.

(12)(a) No later than sixty days after completion of each market conduct examination, the commissioner shall make a

full written report of each market conduct examination containing only facts ascertained from the accounts, records, and documents examined and from the sworn testimony of individuals, and such conclusions and recommendations as may reasonably be warranted from such facts.

(b) The report shall be certified by the commissioner or by the examiner-in-charge of the examination, and shall be filed in the commissioner's office subject to (c) of this subsection.

(c) The commissioner shall furnish a copy of the market conduct examination report to the person examined not less than ten days and, unless the time is extended by the commissioner, not more than thirty days prior to the filing of the report for public inspection in the commissioner's office. If the person so requests in writing within such period, the commissioner shall hold a hearing to consider objections of such person to the report as proposed, and shall not so file the report until after such hearing and until after any modifications in the report deemed necessary by the commissioner have been made.

(d) Within thirty days of the end of the period described in (c) of this subsection, unless extended by order of the commissioner, the commissioner shall consider the report, together with any written submissions or rebuttals and any relevant portions of the examiner's work papers and enter an order:

(i) Adopting the market conduct examination report as filed or with modification or corrections. If the market conduct examination report reveals that the company is operating in violation of any law, rule, or order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure that violation;

(ii) Rejecting the market conduct examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information, and refile under this subsection; or

(iii) Calling for an investigatory hearing with no less than twenty days' notice to the company for purposes of obtaining additional documentation, data, information, and testimony.

(e) All orders entered under (d) of this subsection must be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the market conduct examination report, relevant examiner work papers, and any written submissions or rebuttals. The order is considered a final administrative decision and may be appealed under the administrative procedure act, chapter 34.05 RCW, and must be served upon the company by certified mail or certifiable electronic means, together with a copy of the adopted examination report. A copy of the adopted examination report must be sent by certified mail or certifiable electronic means to each director at the director's residential address or to a personal email account.

(f)(i) Upon the adoption of the market conduct examination report under (d) of this subsection, the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of five days except that the order may be disclosed to the person examined. Thereafter, the commissioner may open the report for

public inspection so long as no court of competent jurisdiction has stayed its publication.

(ii) If the commissioner determines that regulatory action is appropriate as a result of any market conduct examination, he or she may initiate any proceedings or actions as provided by law.

(iii) Nothing contained in this subsection requires the commissioner to disclose any information or records that would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

(g) The insurer's response shall be included in the commissioner's order adopting the final report as an exhibit to the order. The insurer is not obligated to submit a response.

(13) The commissioner may withhold from public inspection any examination or investigation report for so long as he or she deems it advisable.

(14)(a) Market conduct examinations within this state of any insurer domiciled or having its home offices in this state, other than a title insurer, made by the commissioner or the commissioner's examiners and employees shall, except as to fees, mileage, and expense incurred as to witnesses, be at the expense of the state.

(b) Every other examination, whatsoever, or any part of the market conduct examination of any person domiciled or having its home offices in this state requiring travel and services outside this state, shall be made by the commissioner or by examiners designated by the commissioner and shall be at the expense of the person examined; but a domestic insurer shall not be liable for the compensation of examiners employed by the commissioner for such services outside this state.

(c) When making a market conduct examination under this chapter, the commissioner may contract, in accordance with applicable state contracting procedures, for qualified attorneys, appraisers, independent certified public accountants, contract actuaries, and other similar individuals who are independently practicing their professions, even though those persons may from time to time be similarly employed or retained by persons subject to examination under this chapter, as examiners as the commissioner deems necessary for the efficient conduct of a particular examination. The compensation and per diem allowances paid to such contract persons shall be reasonable in the market and time incurred, shall not exceed one hundred twenty-five percent of the compensation and per diem allowances for examiners set forth in the guidelines adopted by the national association of insurance commissioners, unless the commissioner demonstrates that one hundred twenty-five percent is inadequate under the circumstances of the examination, and subject to the provisions of (a) of this subsection.

(d)(i) The person examined and liable shall reimburse the state upon presentation of an itemized statement thereof, for the actual travel expenses of the commissioner's examiners, their reasonable living expenses 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 examining insurers domiciled outside the state of Washington 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 and the expense schedule established by the office of financial management, whichever is higher. A domestic title insurer shall pay the examination expense and costs to the commissioner as itemized and billed by the commissioner.

(ii) The commissioner or the commissioner's examiners shall not receive or accept any additional emolument on account of any examination.

(iii) Market conduct examination fees subject to being reimbursed by an insurer shall be itemized and bills shall be provided to the insurer on a monthly basis for review prior to submission for payment, or as otherwise provided by state law.

(e) Nothing contained in this chapter limits the commissioner's authority to terminate or suspend any examination 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 examination are prima facie evidence in any legal or regulatory action.

(f) The commissioner shall maintain active management and oversight of market conduct examination costs, including costs associated with the commissioner's own examiners, and with retaining qualified contract examiners necessary to perform an examination. Any agreement with a contract examiner shall:

(i) Clearly identify the types of functions to be subject to outsourcing;

(ii) Provide specific timelines for completion of the outsourced review;

(iii) Require disclosure to the insurer of contract examiners' recommendations;

(iv) Establish and use a dispute resolution or arbitration mechanism to resolve conflicts with insurers regarding examination fees; and

(v) Require disclosure of the terms of the contracts with the outside consultants that will be used, specifically the fees and/or hourly rates that can be charged.

(g) The commissioner, or the commissioner's designee, shall review and affirmatively endorse detailed billings from the qualified contract examiner before the detailed billings are sent to the insurer. [2015 3rd sp.s. c 1 § 323; 2011 1st sp.s. c 43 § 460; 2008 c 100 § 2; 2007 c 82 § 8.]

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

48.37.070 Access to records and information—Commissioner's authority—Depositions, subpoena, and oaths.

(1) Except as otherwise provided by law, market conduct oversight personnel shall have free, convenient, and full access to all books, records, employees, officers, and directors, as practicable, of the insurer during regular business hours.

(2) An insurer using a third-party model or product for any of the activities under examination shall cause, upon the request of market conduct oversight personnel, the details of such models or products to be made available to such personnel.

(3) Each officer, director, employee, and agent of an insurer shall facilitate and aid in a market conduct action or examination.

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner, any employee of the office of the insurance commissioner, or any agent retained by the office of the insurance commissioner to assist in the market conduct examination under this chapter.

(5)(a) The commissioner may take depositions, subpoena witnesses or documentary evidence, administer oaths, and examine under oath any individual relative to the affairs of any person being examined, or relative to the subject of any hearing or investigation: PROVIDED, That the provisions of RCW 34.05.446 shall apply in lieu of the provisions of this section as to subpoenas relative to hearings in rule-making and adjudicative proceedings.

(b) The subpoena shall be effective if served within the state of Washington and shall be served in the same manner as if issued from a court of record.

(c) Witness fees and mileage, if claimed, shall be allowed the same as for testimony in a court of record. Witness fees, mileage, and the actual expenses necessarily incurred in securing attendance of witnesses and their testimony shall be itemized, and shall be paid by the person as to whom the examination is being made, or by the person if other than the commissioner, at whose request the hearing is held.

(d) Enforcement of subpoenas shall be in accordance with RCW 34.05.588.

(6) In order to assist in the performance of the commissioner's duties, the commissioner may:

(a) Share documents, materials, market conduct examination reports, preliminary market conduct examination reports, and other matters related to such reports, or other information, including the confidential and privileged documents, materials, or information subject to subsection (1) of this section, with other state, federal, and international regulatory agencies and law enforcement authorities, and the NAIC and its affiliates and subsidiaries, provided that the recipient agrees to and asserts that it has the legal authority to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(b) Receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or 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, or information; and

(c) Enter into agreements governing the sharing and use of information consistent with this subsection. [2007 c 82 § 9.]

48.37.080 Confidentiality. (1) All data and documents, including but not limited to working papers, third-party models or products, complaint logs, and copies thereof, created, produced, or obtained by or disclosed to the commissioner, the commissioner's authorized representative, or an examiner appointed by the commissioner in the course of any market conduct actions or examinations made under this chapter, or

in the course of market analysis by the commissioner of the market conditions of an insurer, or obtained by the NAIC as a result of any of the provisions of this chapter, to the extent the documents are in the possession of the commissioner or the NAIC, shall be confidential by law and privileged, shall not be subject to the provisions of chapter 42.56 RCW, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(2) If the commissioner elects to issue a report of an examination, a preliminary or draft market conduct examination report is confidential and not subject to disclosure by the commissioner nor is it subject to subpoena or discovery. This subsection does not limit the commissioner's authority to use a preliminary or draft market conduct examination report and related information in furtherance of any legal or regulatory action, or to release it in accordance with the provisions of RCW 48.02.065.

(3) An insurance compliance self-evaluative audit document in the possession of the commissioner is confidential by law and privileged, and shall not be:

- (a) Made public by the commissioner;
- (b) Subject to the provisions of chapter 42.56 RCW;
- (c) Subject to subpoena; and
- (d) Subject to discovery and admissible in evidence in any private civil action.

(4) Neither the disclosure of any self-evaluative audit document to the commissioner or to the commissioner's designee nor the citation to this document in connection with an agency action shall constitute a waiver of any privilege that may otherwise apply. [2007 c 82 § 10.]

48.37.090 Market conduct oversight personnel. (1) Market conduct oversight personnel shall be qualified by education, experience, and, where applicable, professional designations. The commissioner may supplement the in-house market conduct oversight staff with qualified outside professional assistance if the commissioner determines that the assistance is necessary.

(2) Market conduct oversight personnel have a conflict of interest, either directly or indirectly, if they are affiliated with the management of, and have, within five years of any market conduct action, been employed by, or own a pecuniary interest in the insurer, subject to any examination under this chapter. This section shall not be construed to automatically preclude an individual from being:

- (a) A policyholder or claimant under an insurance policy;
- (b) A grantor of a mortgage or similar instrument on the individual's residence from a regulated entity, if done under customary terms and in the ordinary course of business;
- (c) An investment owner in shares of regulated diversified investment companies; or
- (d) A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed. [2007 c 82 § 11.]

48.37.100 Immunity for the commissioner, market conduct oversight personnel, authorized representatives, and examiners. (1) No cause of action shall arise, nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives, market conduct over-

sight personnel, or an examiner appointed by the commissioner for any statements made, or conduct performed in good faith while carrying out the provisions of this chapter.

(2) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative, market conduct oversight personnel, or examiner, under an examination made under this chapter, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(3) A person identified in subsection (1) of this section is 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.

(4) If a claim is made or threatened as described in subsection (1) of this section, the commissioner shall provide or pay for the defense of himself or herself, the examiner or representative, and shall pay a judgment or settlement, until it is determined that the person did not act in good faith or did act with fraudulent intent or the intent to deceive.

(5) The immunity, indemnification, and other protections under this section are in addition to those now or hereafter existing under other law.

(6) This section does not abrogate or modify in any way any common law or statutory privilege or immunity, now or hereafter existing under this section or other law, enjoyed by any person identified in subsection (1) of this section. [2007 c 82 § 12.]

48.37.110 Fines and penalties. (1) Fines and penalties, applicable to the insurer as found in the Washington insurance code, levied as a result of a market conduct action or examination shall be consistent, reasonable, and justified.

(2) The commissioner shall take into consideration actions taken by insurers to maintain membership in, and comply with the standards of, best practices organizations, and the extent to which insurers maintain regulatory compliance programs to self-assess, self-report, and remediate problems detected, and may include those considerations in determining the appropriate fines or penalties levied in accordance with subsection (1) of this section.

(3) Commissioner enforcement actions shall not be based solely on violations identified in the insurer self-evaluative audit document, unless the commissioner confirms both that the violations occurred and that the insurer has not taken reasonable action based on the self-evaluative audit document to resolve and remediate the identified violations. [2007 c 82 § 13.]

48.37.120 Dispute resolution—Rules. (1) At any point in the market analysis, the insurer may request a review and resolution of issues by identifying the issues either orally or in writing to the market conduct oversight manager, or deputy insurance commissioner responsible for market conduct

oversight. At each level, a response to the insurer shall be provided within five business days.

(2) At any point in the market conduct examination, the insurer may request a review and resolution of issues either orally or in writing to the market conduct oversight manager, or deputy insurance commissioner responsible for market conduct oversight. At each level, a response to the insurer shall be provided within five business days. This authorization for dispute resolution shall be secondary to the specific procedures set forth in RCW 48.37.060.

(3) After the deputy insurance commissioner responsible for market conduct oversight has responded to an insurer's issues, the insurer may request mediation of the issues. The insurance commissioner shall adopt by rule a process to govern mediation of insurer market conduct oversight issues. That rule shall:

(a) Provide for the selection by the commissioner of a panel of preapproved mediators;

(b) Require that insurers, upon notice of the start of a market analysis process or the start of a market conduct examination, identify from the preapproved list a mediator and an alternative mediator;

(c) Require the party requesting mediation to pay the costs of the mediator; and

(d) Provide for other rule provisions as are reasonably necessary for the efficient operation of a mediation process.

(4) At any point in the dispute resolution process contained in this section, the insurer may commence an adjudicative proceeding under chapters 48.04 and 34.05 RCW. [2007 c 82 § 14.]

48.37.130 Coordination with other state insurance regulators through the NAIC. (1) The commissioner shall share information and coordinate the commissioner's market analysis, market conduct actions, and examination efforts with other state insurance regulators. Such matters will be coordinated in accordance with guidelines adopted by the NAIC.

(2)(a) If a market conduct examination or action performed by another state insurance regulator results in a finding that an insurer should modify a specific practice or procedure, the commissioner shall, in lieu of conducting a market conduct action or examination, accept verification that the insurer made a similar modification in this state, unless the commissioner determines that the other state does not have laws substantially similar to those of this state, or does not have a market conduct oversight system that is comparable to the market conduct oversight system set forth in this chapter.

(b) The commissioner's determination under (a) of this subsection is discretionary with the commissioner and is not subject to appeal. [2007 c 82 § 15.]

48.37.140 Additional duties of the commissioner. (1) The commissioner shall designate a specific person or persons within the commissioner's office whose responsibilities shall include the receipt of information from employees of insurers and licensed entities concerning violations of laws or rules by their employers, as defined in this chapter. These persons shall be provided with proper training on the handling of such information. The information shall be confidential and not open to public inspection.

(2) At least once per year, or more frequently if deemed necessary, the commissioner shall make available in an appropriate manner to insurers and other entities subject to the scope of this title, information on new laws and regulations, enforcement actions, and other information the commissioner deems pertinent to ensure compliance with market conduct requirements. [2007 c 82 § 16.]

Chapter 48.38 RCW

CHARITABLE GIFT ANNUITY BUSINESS

Sections

48.38.010	Certificate of exemption—Qualification for—Application, contents—Minimum unrestricted net assets—"Qualified actuary" defined.
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48.38.010 Certificate of exemption—Qualification for—Application, contents—Minimum unrestricted net assets—"Qualified actuary" defined. The commissioner may grant a certificate of exemption to any insurer or educational, religious, charitable, or scientific institution conducting a charitable gift annuity business:

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

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

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

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

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

(6) Which has and maintains minimum unrestricted net assets of five hundred thousand dollars. "Unrestricted net assets" means the excess of total assets over total liabilities that are neither permanently restricted nor temporarily restricted by donor-imposed stipulations;

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

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

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

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

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

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

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

(10) Which:

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

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

(c) On or before March 1st of each year, pays an annual filing fee of twenty-five dollars plus five dollars for each charitable gift annuity contract written for residents of this state during its fiscal year ending on or before December 31st of the previous calendar year. [2012 c 211 § 5; 2010 c 27 § 2; 1998 c 284 § 1; 1979 c 130 § 6.]

Additional notes found at www.leg.wa.gov

48.38.012 Minimum unrestricted net assets required.

After June 30, 1998, an insurer or institution which does not have the minimum unrestricted net assets required by RCW 48.38.010(6) may not issue any new charitable gift annuities until the insurer or institution has and maintains the minimum unrestricted net assets required by RCW 48.38.010(6). [1998 c 284 § 7.]

48.38.020 Separate reserve fund—Treatment of assets—Minimum amounts—Purchase of single premium life annuity. (1) Upon granting to such insurer or institution under RCW 48.38.010 a certificate of exemption to conduct a charitable gift annuity business, the insurance commissioner shall require it to establish and maintain a separate reserve fund adequate to meet the future payments under its charitable gift annuity contracts.

(2) The assets of the separate reserve fund:

(a) Shall be held legally and physically segregated from the other assets of the certificate of exemption holder;

(b) Shall be invested in the same manner that persons of reasonable prudence, discretion, and intelligence exercise in the management of a like enterprise, not in regard to speculating but in regard to the permanent disposition of their funds, considering the probable income as well as the probable safety of their capital. Investments shall be of sufficient value, liquidity, and diversity to assure the insurer or institution's ability to meet its outstanding obligations; and

(c) Shall not be liable for any debts of the insurer or institution holding a certificate of exemption under this chapter, other than those incurred pursuant to the issuance of charitable gift annuities.

(3) The amount of the separate reserve fund shall be:

(a) For contracts issued prior to July 1, 1998, not less than an amount computed in accordance with the standard of valuation based on the 1971 individual annuity mortality table with six percent interest for single premium immediate annuity contracts and four percent interest for all other individual annuity contracts;

(b) For contracts issued on or after July 1, 1998, in an amount not less than the aggregate reserves calculated according to the standards set forth in RCW 48.74.030 for other annuities with no cash settlement options;

(c) Plus a surplus of ten percent of the combined amounts under (a) and (b) of this subsection.

(4) The general assets of the insurer or institution holding a certificate of exemption under this chapter shall be liable for the payment of annuities to the extent that the separate reserve fund is inadequate.

(5) If an institution holding a certificate of exemption under RCW 48.38.010 has purchased a single premium life annuity that pays the entire amount stipulated in the gift annuity agreement or agreements from an insurer (a) holding a certificate of authority under chapter 48.05 RCW, (b) licensed in the state in which the institution has its principle office, and (c) licensed in the state in which the single premium life annuity is issued, then in determining the minimum reserve fund that must be maintained under this section, a deduction shall be allowed from the minimum reserve fund in an amount not exceeding the reserve fund amount required for the annuity or annuities for which the single premium life annuity is purchased, subject to the following conditions:

(i) The institution has filed with the commissioner a copy of the single premium life annuity purchased and specifying which charitable gift annuity or annuities are being insured; and

(ii) The institution has entered into a written agreement with the annuitant and the insurer issuing the single premium life annuity providing that if for any reason the institution is unable to continue making the annuity payments required by its annuity agreements, the annuitants shall receive payments directly from the insurer and the insurer shall be credited with all of these direct payments in the accounts between the insurer and the institution. [2012 c 211 § 6; 2002 c 295 § 1; 1998 c 284 § 2; 1979 c 130 § 7.]

Additional notes found at www.leg.wa.gov

48.38.030 Charitable annuity contract or policy form—Contents. Each charitable annuity contract or policy form must include the following information:

- (1) The value of the property to be transferred;
- (2) The amount of the annuity to be paid to the transferor or the transferor's nominee;
- (3) The manner in which and the intervals at which payment is to be made;
- (4) The age of the person during whose life payment is to be made; and
- (5) The reasonable value as of the date of the agreement of the benefits created. This value may not exceed by more than fifteen percent the net single premium for the benefits, determined according to the standard of valuation set forth in RCW 48.38.020(3). [2005 c 223 § 24; 1979 c 130 § 8.]

Additional notes found at www.leg.wa.gov

48.38.040 Certificate holder exempt from certain title provisions—Chapter 48.31 RCW applies. (1) An insurer or institution holding a certificate of exemption under this chapter shall be exempt from all other provisions of this title except as specifically enumerated in this chapter by reference.

(2) An insurer or institution holding a certificate of exemption under this chapter is subject to chapter 48.31 RCW. [1998 c 284 § 3; 1979 c 130 § 9.]

Additional notes found at www.leg.wa.gov

48.38.042 Certificate holder—Variable annuity business prohibited. An insurer or institution holding a certificate of exemption to issue charitable gift annuities under this chapter shall not transact or be authorized to transact a variable annuity business as described in chapter 48.18A RCW. [1998 c 284 § 5.]

48.38.050 Grounds for denial, revocation, or suspension of certificate of exemption—Fine may be levied. (1) The insurance commissioner may refuse to grant, or may revoke or suspend, a certificate of exemption if the insurance commissioner finds that the insurer or institution does not meet the requirements of this chapter or if the insurance commissioner finds that the insurer or institution has violated RCW 48.01.030, any provisions of chapter 48.30 RCW, or this chapter, and any applicable provisions of Title 284 WAC, or is found by the insurance commissioner to be in such condition that its further issuance of charitable gift annuities would be hazardous to annuity contract holders and the people of this state.

(2) After hearing or with the consent of the insurer or institution and in addition to or in lieu of the suspension, revocation, or refusal to renew any certificate of exemption, the commissioner may levy a fine upon the insurer or institution in an amount not more than ten thousand dollars. The order levying such a 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 such a fine when due the commissioner may revoke the certificate of exemption of the insurer or institution if not already revoked, and the fine shall be recovered in a civil action brought in 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. [2012 c 211 § 7; 1998 c 284 § 4; 1979 c 130 § 10.]

Additional notes found at www.leg.wa.gov

48.38.060 Hearings and appeals provisions inapplicable. For purposes of this chapter, the provisions of chapter 48.04 RCW are applicable. [1979 c 130 § 11.]

Additional notes found at www.leg.wa.gov

48.38.070 Enforcement powers and duties. For the purposes of this chapter, the insurance commissioner has the same powers and duties of enforcement as are provided in RCW 48.02.080. [1979 c 130 § 12.]

Additional notes found at www.leg.wa.gov

48.38.075 Rules. The commissioner may adopt rules to implement and administer this chapter. [1998 c 284 § 6.]

Chapter 48.39 RCW

CONTRACTS BETWEEN INSURANCE CARRIERS, HEALTH CARE PROVIDERS, AND THIRD-PARTY PAYORS

Sections

48.39.003	Findings.
48.39.005	Definitions.
48.39.010	Notice of material amendments to contract—Failure to comply.
48.39.020	Payor may require provider to extend payor's medicaid rates—Limitations.
48.39.030	Ambulatory surgical facilities—Payor survey requirements.

48.39.003 Findings. The legislature finds that Washington state is a provider friendly state within which to practice medicine. As part of health care reform, Washington state endeavors to establish and operate a state-based health benefits exchange wherein insurance products will be offered for sale and add potentially three hundred thousand patients to commercial insurance, and to expand access to medicaid for potentially three hundred thousand new enrollees. Such a successful and new insurance market in Washington state will require the willing participation of all categories of health care providers. The legislature further finds that principles of fair contracting apply to all contracts between health care providers and health insurance carriers offering insurance within Washington state and that fair dealings and transparency in expectations should be present in interactions between all third-party payors and health care providers. [2013 c 293 § 1.]

48.39.005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Health care provider" or "provider" has the same meaning as in RCW 48.43.005 and, for the purposes of this chapter, includes facilities licensed under chapter 70.41 RCW.

(2) "Material amendment" means an amendment to a contract between a payor and health care provider that would result in requiring a health care provider to participate in a health plan, product, or line of business with a lower fee

schedule in order to continue to participate in a health plan, product, or line of business with a higher fee schedule. A material amendment does not include any of the following:

(a) A decrease in payment or compensation resulting from a change in a fee schedule published by the payor upon which the payment or compensation is based and the date of applicability is clearly identified in the contract, compensation addendum, or fee schedule notice;

(b) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract; or

(c) Changes unrelated to compensation so long as reasonable notice of not less than sixty days is provided.

(3) "Payor" or "third-party payor" means carriers licensed under chapters 48.20, 48.21, 48.44, and 48.46 RCW, and managed health care systems as defined in RCW 74.09.522. [2013 c 293 § 2.]

Reviser's note: The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

48.39.010 Notice of material amendments to contract—Failure to comply. (1) A third-party payor shall provide no less than sixty days' notice to the health care provider of any proposed material amendments to a health care provider's contract with the third-party payor.

(2) Any material amendment to a contract must be clearly defined in a notice to the provider from the third-party payor as being a material change to the contract before the provider's notice period begins. The notice must also inform the providers that they may choose to reject the terms of the proposed material amendment through written or electronic means at any time during the notice period and that such rejection may not affect the terms of the health care provider's existing contract with the third-party payor.

(3) A health care provider's rejection of the material amendment does not affect the terms of the health care provider's existing contract with the third-party payor.

(4) A failure to comply with the terms of subsections (1), (2), and (3) of this section shall void the effectiveness of the material amendment. [2013 c 293 § 3.]

48.39.020 Payor may require provider to extend payor's medicaid rates—Limitations. A payor may require a health care provider to extend the payor's medicaid rates, or some percentage above the payor's medicaid rates, that govern a health benefit program administered by a public purchaser to a commercial plan or line of business offered by a payor that is not administered by a public purchaser only if the health care provider has expressly agreed in writing to the extension. For the purposes of this section, "administered by a public purchaser" does not include commercial coverage offered through the Washington health benefit exchange. Nothing in this section prohibits a payor from utilizing medicaid rates, or some percentage above medicaid rates, as a base when negotiating payment rates with a health care provider. [2013 c 293 § 4.]

48.39.030 Ambulatory surgical facilities—Payor survey requirements. If a payor that contracts with an ambulatory surgical facility licensed under chapter 70.230 RCW (2021 Ed.)

requires successful completion of a survey as part of the contract, the ambulatory surgical facility is deemed to have met survey requirements if it has successfully completed a survey performed pursuant to medicare certification or by an accrediting organization that has been determined by the secretary of the department of health to have substantially equivalent survey standards to those of the centers for medicare and medicaid services. The payor may not impose additional survey requirements on the ambulatory surgical facility. [2016 c 146 § 5.]

Chapter 48.41 RCW

HEALTH INSURANCE COVERAGE ACCESS ACT

Sections

48.41.010	Short title.
48.41.020	Intent.
48.41.030	Definitions.
48.41.037	Washington state health insurance pool account.
48.41.040	Health insurance pool—Creation, membership, organization, operation, rules.
48.41.050	Operation plan—Contents.
48.41.060	Board powers and duties.
48.41.070	Examination and report.
48.41.080	Pool administrator—Selection, term, duties, pay.
48.41.090	Financial participation in pool—Computation, deficit assessments.
48.41.100	Eligibility for coverage.
48.41.110	Policy coverage—Eligible expenses, cost containment, limits—Explanatory brochure.
48.41.120	Comprehensive pool policy—Deductibles—Coinsurance—Carryover.
48.41.130	Policy forms—Approval required.
48.41.140	Coverage for children, dependents.
48.41.150	Medical supplement policy.
48.41.160	Pool policy requirements—Continued coverage—Rate changes—Continuation—Statement of intent to discontinue pool coverage.
48.41.170	Required rule making.
48.41.190	Civil and criminal immunity.
48.41.200	Rates—Standard risk and maximum.
48.41.210	Last payor of benefits.
48.41.220	Mental health services—Definition—Coverage required, when.
48.41.240	Review of populations needing coverage through pool—Analysis and recommendations—Report.
48.41.250	Administration of risk management functions—Contract with commissioner authorized—Recommendations—Report to legislature.
48.41.900	Federal supremacy.
48.41.920	Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

Group stop loss insurance exemption: RCW 48.21.015.

48.41.010 Short title. This chapter shall be known and may be cited as the "Washington state health insurance coverage access act". [1987 c 431 § 1.]

48.41.020 Intent. It is the purpose and intent of the legislature to provide access to health insurance coverage to all residents of Washington who are denied health insurance. It is the intent of the Washington state health insurance coverage access act to provide a mechanism to ensure the availability of comprehensive health insurance to persons unable to obtain such insurance coverage on either an individual or group basis directly under any health plan. [2000 c 79 § 5; 1987 c 431 § 2.]

Additional notes found at www.leg.wa.gov

48.41.030 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Accounting year" means a twelve-month period determined by the board for purposes of recordkeeping and accounting. The first accounting year may be more or less than twelve months and, from time to time in subsequent years, the board may order an accounting year of other than twelve months as may be required for orderly management and accounting of the pool.

(2) "Administrator" means the entity chosen by the board to administer the pool under RCW 48.41.080.

(3) "Board" means the board of directors of the pool.

(4) "Commissioner" means the insurance commissioner.

(5) "Covered person" means any individual resident of this state who is eligible to receive benefits from any member, or other health plan.

(6) "Health care facility" has the same meaning as in RCW 70.38.025.

(7) "Health care provider" means any physician, facility, or health care professional, who is licensed in Washington state and entitled to reimbursement for health care services.

(8) "Health care services" means services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(9) "Health carrier" or "carrier" has the same meaning as in RCW 48.43.005.

(10) "Health coverage" means any group or individual disability insurance policy, health care service contract, and health maintenance agreement, except those contracts entered into for the provision of health care services pursuant to Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 et seq. The term does not include short-term care, long-term care, dental, vision, accident, fixed indemnity, disability income contracts, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of the worker's compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(11) "Health plan" means any arrangement by which persons, including dependents or spouses, covered or making application to be covered under this pool, have access to hospital and medical benefits or reimbursement including any group or individual disability insurance policy; health care service contract; health maintenance agreement; uninsured arrangements of group or group-type contracts including employer self-insured, cost-plus, or other benefit methodologies not involving insurance or not governed by Title 48 RCW; coverage under group-type contracts which are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by medicare or other governmental benefits. This term includes coverage through "health coverage" as defined under this section, and specifically excludes those types of programs excluded under the definition of "health coverage" in subsection (10) of this section.

(12) "Medical assistance" means coverage under Title XIX of the federal Social Security Act (42 U.S.C., Sec. 1396 et seq.) and chapter 74.09 RCW.

(13) "Medicare" means coverage under Title XVIII of the Social Security Act, (42 U.S.C. Sec. 1395 et seq., as amended).

(14) "Member" means any commercial insurer which provides disability insurance or stop loss insurance, any health care service contractor, any health maintenance organization licensed under Title 48 RCW, and any self-funded multiple employer welfare arrangement as defined in RCW 48.125.010. "Member" also means the Washington state health care authority as issuer of the state uniform medical plan. "Member" shall also mean, as soon as authorized by federal law, employers and other entities, including a self-funding entity and employee welfare benefit plans that provide health plan benefits in this state on or after May 18, 1987. "Member" does not include any insurer, health care service contractor, or health maintenance organization whose products are exclusively dental products or those products excluded from the definition of "health coverage" set forth in subsection (10) of this section.

(15) "Network provider" means a health care provider who has contracted in writing with the pool administrator or a health carrier contracting with the pool administrator to offer pool coverage to accept payment from and to look solely to the pool or health carrier according to the terms of the pool health plans.

(16) "Plan of operation" means the pool, including articles, bylaws, and operating rules, adopted by the board pursuant to RCW 48.41.050.

(17) "Point of service plan" means a benefit plan offered by the pool under which a covered person may elect to receive covered services from network providers, or nonnetwork providers at a reduced rate of benefits.

(18) "Pool" means the Washington state health insurance pool as created in RCW 48.41.040. [2004 c 260 § 25; 2001 c 196 § 2; 2000 c 79 § 6; 1997 c 337 § 6; 1997 c 231 § 210; 1989 c 121 § 1; 1987 c 431 § 3.]

Additional notes found at www.leg.wa.gov

48.41.037 Washington state health insurance pool account. The Washington state health insurance pool account is created in the custody of the state treasurer. All receipts from moneys specifically appropriated to the account must be deposited in the account. Expenditures from this account shall be used to cover deficits incurred by the Washington state health insurance pool under this chapter in excess of the threshold established in this section. To the extent funds are available in the account, funds shall be expended from the account to offset that portion of the deficit that would otherwise have to be recovered by imposing an assessment on members in excess of a threshold of seventy cents per insured person per month. The commissioner shall authorize expenditures from the account, to the extent that funds are available in the account, upon certification by the pool board that assessments will exceed the threshold level established in this section. The account is subject to the allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

Whether the assessment has reached the threshold of seventy cents per insured person per month shall be determined by dividing the total aggregate amount of assessment by the proportion of total assessed members. Thus, stop loss

members shall be counted as one-tenth of a whole member in the denominator given that is the amount they are assessed proportionately relative to a fully insured medical member. [2007 c 259 § 29; 2000 c 79 § 36.]

Additional notes found at www.leg.wa.gov

48.41.040 Health insurance pool—Creation, membership, organization, operation, rules. (1) There is created a nonprofit entity to be known as the Washington state health insurance pool. All members in this state on or after May 18, 1987, shall be members of the pool. When authorized by federal law, all self-insured employers shall also be members of the pool.

(2) Pursuant to chapter 34.05 RCW the commissioner shall, within ninety days after May 18, 1987, give notice to all members of the time and place for the initial organizational meetings of the pool. A board of directors shall be established, which shall be comprised of ten members. The governor shall select one member of the board from each list of three nominees submitted by statewide organizations representing each of the following: (a) Health care providers; (b) health insurance agents; (c) small employers; and (d) large employers. The governor shall select two members of the board from a list of nominees submitted by statewide organizations representing health care consumers. In making these selections, the governor may request additional names from the statewide organizations representing each of the persons to be selected if the governor chooses not to select a member from the list submitted. The remaining four members of the board shall be selected by election from among the members of the pool. The elected members shall, to the extent possible, include at least one representative of health care service contractors, one representative of health maintenance organizations, and one representative of commercial insurers which provides disability insurance. The members of the board shall elect a chair from the voting members of the board. The insurance commissioner shall be a nonvoting, ex officio member. When self-insured organizations other than the Washington state health care authority become eligible for participation in the pool, the membership of the board shall be increased to eleven and at least one member of the board shall represent the self-insurers.

(3) The original members of the board of directors shall be appointed for intervals of one to three years. Thereafter, all board members shall serve a term of three years. Board members shall receive no compensation, but shall be reimbursed for all travel expenses as provided in RCW 43.03.050 and 43.03.060.

(4) The board shall submit to the commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The commissioner shall, after notice and hearing pursuant to chapter 34.05 RCW, approve the plan of operation if it is determined to assure the fair, reasonable, and equitable administration of the pool and provides for the sharing of pool losses on an equitable, proportionate basis among the members of the pool. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. If the board fails to submit a plan of operation within one hundred eighty

days after the appointment of the board or any time thereafter fails to submit acceptable amendments to the plan, the commissioner shall, within ninety days after notice and hearing pursuant to chapters 34.05 and 48.04 RCW, adopt such rules as are necessary or advisable to effectuate this chapter. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. [2000 c 80 § 1; 2000 c 79 § 7; 1989 c 121 § 2; 1987 c 431 § 4.]

Additional notes found at www.leg.wa.gov

48.41.050 Operation plan—Contents. The plan of operation submitted by the board to the commissioner shall:

- (1) Establish procedures for the handling and accounting of assets and moneys of the pool;
- (2) Establish regular times and places for meetings of the board of directors;
- (3) Establish procedures for records to be kept of all financial transactions and for an annual fiscal reporting to the commissioner;
- (4) Contain additional provisions necessary and proper for the execution of the powers and duties of the pool;
- (5) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;
- (6) Establish the amount of assessment pursuant to RCW 48.41.060, which shall occur after March 1st of each calendar year, and which shall be due and payable within thirty days of the receipt of the assessment notice;
- (7) Select an administrator in accordance with RCW 48.41.080;
- (8) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and to maintain public awareness of the plan; and
- (9) Establish procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the board. [1987 c 431 § 5.]

48.41.060 Board powers and duties. (1) The board shall have the general powers and authority granted under the laws of this state to insurance companies, health care service contractors, and health maintenance organizations, licensed or registered to offer or provide the kinds of health coverage defined under this title. In addition thereto, the board shall:

- (a) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices consistent with Washington state individual plan rating requirements under RCW 48.44.022 and 48.46.064;
- (b)(i) Assess members of the pool in accordance with the provisions of this chapter, and make advance interim assess-

ments as may be reasonable and necessary for the organizational or interim operating expenses. Any interim assessments will be credited as offsets against any regular assessments due following the close of the year.

(ii) Self-funded multiple employer welfare arrangements are subject to assessment under this subsection only in the event that assessments are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the commissioner shall initially request an advisory opinion from the United States department of labor or obtain a declaratory ruling from a federal court on the legality of imposing assessments on these arrangements before imposing the assessment. Once the legality of the assessments has been determined, the multiple employer welfare arrangement certified by the insurance commissioner must begin payment of these assessments.

(iii) If there has not been a final determination of the legality of these assessments, then beginning on the earlier of (A) the date the fourth multiple employer welfare arrangement has been certified by the insurance commissioner, or (B) April 1, 2006, the arrangement shall deposit the assessments imposed by this subsection into an interest bearing escrow account maintained by the arrangement. Upon a final determination that the assessments are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq., all funds in the interest bearing escrow account shall be transferred to the board;

(c) Issue policies of health coverage in accordance with the requirements of this chapter;

(d) Establish procedures for the administration of the premium discount provided under RCW 48.41.200(3)(a)(iii);

(e) Contract with the Washington state health care authority for the administration of the premium discounts provided under RCW 48.41.200(3)(a) (i) and (ii);

(f) Set a reasonable fee to be paid to an insurance producer licensed in Washington state for submitting an acceptable application for enrollment in the pool; and

(g) Provide certification to the commissioner when assessments will exceed the threshold level established in RCW 48.41.037.

(2) In addition thereto, the board may:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter including the authority, with the approval of the commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(c) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the pool, policy, and other contract design, and any other function within the authority of the pool; and

(d) Conduct periodic audits to assure the general accuracy of the financial data submitted to the pool, and the board shall cause the pool to have an annual audit of its operations by an independent certified public accountant.

(3) Nothing in this section shall be construed to require or authorize the adoption of rules under chapter 34.05 RCW. [2013 c 279 § 2; 2011 c 314 § 13; 2009 c 555 § 2; 2008 c 217 § 47; 2005 c 7 § 2; 2004 c 260 § 26; 2000 c 79 § 9; 1997 c 337 § 5; 1997 c 231 § 211; 1989 c 121 § 3; 1987 c 431 § 6.]

Effective date—2013 c 279 §§ 2 and 3: "Sections 2 and 3 of this act take effect January 1, 2014." [2013 c 279 § 6.]

Finding—Intent—2013 c 279: "The federal patient protection and affordable care act of 2010, P.L. 111-148, as amended, prohibits the imposition of any preexisting condition coverage exceptions in the individual market for insurance coverage beginning January 1, 2014. The affordable care act also extends opportunities for individuals to enroll in comprehensive coverage in a health benefit exchange beginning January 1, 2014. The legislature finds that some individuals may still be barred from enrolling in the new comprehensive coverage options and it is the intent of the legislature to continue some limited access to the Washington state health insurance pool for a transitional period, and to provide for modification to the pool to reflect changes in federal law and insurance availability." [2013 c 279 § 1.]

Report on implementation of 1987 c 431: "The board shall report to the commissioner and the appropriate committees of the legislature by April 1, 1990, on the implementation of this act. The report shall include information regarding enrollment, coverage utilization, cost, and any problems with the program and suggest remedies." [1987 c 431 § 26.]

Additional notes found at www.leg.wa.gov

48.41.070 Examination and report. The pool shall be subject to examination by the commissioner as provided under chapter 48.03 RCW. The board of directors shall submit to the commissioner, not later than one hundred twenty days after the end of each accounting year, a financial report for the year in a form approved by the commissioner. [1998 c 245 § 98; 1989 c 121 § 4; 1987 c 431 § 7.]

48.41.080 Pool administrator—Selection, term, duties, pay. The board shall select an administrator through a competitive bidding process to administer the pool.

(1) The board shall evaluate bids based upon criteria established by the board, which shall include:

(a) The administrator's proven ability to handle health coverage;

(b) The efficiency of the administrator's claim-paying procedures;

(c) An estimate of the total charges for administering the plan; and

(d) The administrator's ability to administer the pool in a cost-effective manner.

(2) The administrator shall serve for a period of three years subject to removal for cause. At least six months prior to the expiration of each three-year period of service by the administrator, the board shall invite all interested parties, including the current administrator, to submit bids to serve as the administrator for the succeeding three-year period. Selection of the administrator for this succeeding period shall be made at least three months prior to the end of the current three-year period, unless at the time required for submission of bids pursuant to this subsection to the pool will be discontinued before the end of the succeeding thirty-six month period.

(3) The administrator shall perform such duties as may be assigned by the board including:

(a) Administering eligibility and administrative claim payment functions relating to the pool;

(b) Establishing a premium billing procedure for collection of premiums from covered persons. Billings shall be

made on a periodic basis as determined by the board, which shall not be more frequent than a monthly billing;

(c) Performing all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(i) Making available information relating to the proper manner of submitting a claim for benefits to the pool, and distributing forms upon which submission shall be made;

(ii) Taking steps necessary to offer and administer managed care benefit plans; and

(iii) Evaluating the eligibility of each claim for payment by the pool;

(d) Submission of regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board;

(e) Following the close of each accounting year, determination of net paid and earned premiums, the expense of administration, and the paid and incurred losses for the year and reporting this information to the board and the commissioner on a form as prescribed by the commissioner.

(4) The administrator shall be paid as provided in the contract between the board and the administrator for its expenses incurred in the performance of its services. [2011 c 314 § 14; 2000 c 79 § 10; 1997 c 231 § 212; 1989 c 121 § 5; 1987 c 431 § 8.]

Additional notes found at www.leg.wa.gov

48.41.090 Financial participation in pool—Computation, deficit assessments. (1) Following the close of each accounting year, the pool administrator shall determine the total net cost of pool operation which shall include:

(a) Net premium (premiums less administrative expense allowances), the pool expenses of administration, and incurred losses for the year, taking into account investment income and other appropriate gains and losses; and

(b) The amount of pool contributions specified in the state omnibus appropriations act for deposit into the health benefit exchange account under RCW 43.71.060, to assist with the transition of enrollees from the pool into the health benefit exchange created by chapter 43.71 RCW.

(2)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the commissioner; and shall be determined by multiplying the total cost of pool operation by a fraction. The numerator of the fraction equals that member's total number of resident insured persons, including spouse and dependents, covered under all health plans in the state by that member during the preceding calendar year. The denominator of the fraction equals the total number of resident insured persons, including spouses and dependents, covered under all health plans in the state by all pool members during the preceding calendar year.

(b) For purposes of calculating the numerator and the denominator under (a) of this subsection:

(i) All health plans in the state by the state health care authority include only the uniform medical plan;

(ii) Each ten resident insured persons, including spouse and dependents, under a stop loss plan or the uniform medical plan shall count as one resident insured person;

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(iii) Health plans serving medical care services program clients under RCW 74.09.035 are exempted from the calculation; and

(iv) Health plans established to serve elderly clients or medicaid clients with disabilities under chapter 74.09 RCW when the plan has been implemented on a demonstration or pilot project basis are exempted from the calculation until July 1, 2009.

(c) Except as provided in RCW 48.41.037, any deficit incurred by the pool, including pool contributions for deposit into the health benefit exchange account, shall be recouped by assessments among members apportioned under this subsection pursuant to the formula set forth by the board among members. The monthly per member assessment may not exceed the 2013 assessment level. If the maximum assessment is insufficient to cover a pool deficit the assessment shall be used first to pay all incurred losses and pool administrative expenses, with the remainder being available for deposit in the health benefit exchange account.

(3) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. If an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (2) of this section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency.

(4) Subject to the limitation imposed in subsection (2)(c) of this section, the pool administrator shall transfer the assessments for pool contributions for the operation of the health benefit exchange to the treasurer for deposit into the health benefit exchange account with the quarterly assessments for 2014 as specified in the state omnibus appropriations act. If assessments exceed actual losses and administrative expenses of the pool and pool contributions for deposit into the health benefit exchange account, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims. [2013 2nd sp.s. c 6 § 7; (2018 c 219 § 4 expired December 31, 2019); 2005 c 405 § 2; 2000 c 79 § 11; 1989 c 121 § 6; 1987 c 431 § 9.]

Expiration date—2018 c 219 §§ 3 and 4: See note following RCW 48.41.200.

Findings—Intent—2018 c 219: See note following RCW 41.05.820.

Additional notes found at www.leg.wa.gov

48.41.100 Eligibility for coverage. (1)(a) The following persons who are residents of this state are eligible for pool coverage:

(i) Any resident of the state not eligible for medicare coverage or medicaid coverage, and residing in a county where an individual health plan other than a catastrophic health plan as defined in RCW 48.43.005 is not offered to the resident during defined open enrollment or special enrollment periods at the time of application to the pool, whether through the health benefit exchange operated pursuant to chapter 43.71 RCW or in the private insurance market;

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(ii) Any resident of the state not eligible for medicare coverage, enrolled in the pool prior to December 31, 2013, shall remain eligible for pool coverage except as provided in subsections (2) and (3) of this section;

(iii) Any person becoming eligible for medicare before August 1, 2009, who provides evidence of (A) a rejection for medical reasons, (B) a requirement of restrictive riders, (C) an up-rated premium, (D) a preexisting conditions limitation, or (E) lack of access to or for a comprehensive medicare supplemental insurance policy under chapter 48.66 RCW, the effect of any of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one member within six months of the date of application; and

(iv) Any person becoming eligible for medicare on or after August 1, 2009, who does not have access to a reasonable choice of comprehensive medicare part C plans, as defined in (b) of this subsection, and who provides evidence of (A) a rejection for medical reasons, (B) a requirement of restrictive riders, (C) an up-rated premium, (D) a preexisting conditions limitation, or (E) lack of access to or for a comprehensive medicare supplemental insurance policy under chapter 48.66 RCW, the effect of any of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one member within six months of the date of application.

(b) For purposes of (a)(i) of this subsection, by December 1, 2013, the board shall develop and implement a process to determine an applicant's eligibility based on the criteria specified in (a)(i) of this subsection.

(c) For purposes of (a)(iv) of this subsection (1), a person does not have access to a reasonable choice of plans unless the person has a choice of health maintenance organization or preferred provider organization medicare part C plans offered by at least three different carriers that have had provider networks in the person's county of residence for at least five years. The plan options must include coverage at least as comprehensive as a plan F medicare supplement plan combined with medicare parts A and B. The plan options must also provide access to adequate and stable provider networks that make up-to-date provider directories easily accessible on the carrier website, and will provide them in hard copy, if requested. In addition, if no health maintenance organization or preferred provider organization plan includes the health care provider with whom the person has an established care relationship and from whom he or she has received treatment within the past twelve months, the person does not have reasonable access.

(2) The following persons are not eligible for coverage by the pool:

(a) Any person having terminated coverage in the pool unless (i) twelve months have lapsed since termination, or (ii) that person can show continuous other coverage which has been involuntarily terminated for any reason other than non-payment of premiums. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

(b) Inmates of public institutions and those persons who become eligible for medical assistance after June 30, 2008, as defined in RCW 74.09.010. However, these exclusions do

not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b)).

(3) When a carrier or insurer regulated under chapter 48.15 RCW begins to offer an individual health benefit plan in a county where no carrier had been offering an individual health benefit plan:

(a) If the health benefit plan offered is other than a catastrophic health plan as defined in RCW 48.43.005, any person enrolled in a pool plan pursuant to subsection (1)(a)(i) of this section in that county shall no longer be eligible for coverage under that plan pursuant to subsection (1)(a)(i) of this section; and

(b) The pool administrator shall provide written notice to any person who is no longer eligible for coverage under a pool plan under this subsection (3) within thirty days of the administrator's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage options, either in or outside of the pool, available to the person; and (iii) describe the enrollment process for the available options outside of the pool. [2021 c 60 § 1; 2017 c 110 § 2; 2013 c 279 § 3. Prior: 2011 c 315 § 5; 2011 c 314 § 15; 2009 c 555 § 3; 2007 c 259 § 30; 2001 c 196 § 3; 2000 c 79 § 12; 1995 c 34 § 5; 1989 c 121 § 7; 1987 c 431 § 10.]

Findings—Intent—2017 c 110: "(1) The legislature finds that:

(a) The Washington state health insurance pool currently provides subsidized health coverage to almost one thousand five hundred people in medicare supplemental plans and nonmedicare health plans;

(b) Enrollees in Washington state health insurance pool plans tend to have higher health care costs than enrollees in other types of health plans;

(c) Having a separate insurance pool for high-risk individuals benefits all purchasers of health insurance products by keeping premium costs down;

(d) The costs of subsidizing Washington state health insurance pool enrollees are borne disproportionately by purchasers of small group and individual market plans;

(e) The Washington state health insurance pool is scheduled to close its nonmedicare enrollment after December 31, 2017; and

(f) Uncertainty due to changes to the health care marketplace on the federal and state levels increases the necessity of keeping the Washington state health insurance pool open, at least in the short term.

(2) The legislature therefore intends to:

(a) Extend the expiration date for nonmedicare coverage in the Washington state health insurance pool; and

(b) Study:

(i) The necessity of continuing Washington state health insurance pool coverage in the short and long terms;

(ii) The role of the Washington state health insurance pool in light of the evolving health care landscape; and

(iii) The creation of a funding mechanism that equitably and broadly apportions Washington state health insurance pool costs across Washington's health care marketplace." [2017 c 110 § 1.]

Effective date—2013 c 279 §§ 2 and 3: See note following RCW 48.41.060.

Finding—Intent—2013 c 279: See note following RCW 48.41.060.

Effective date—2011 c 315 §§ 5 and 6: "Sections 5 and 6 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately [May 11, 2011]." [2011 c 315 § 7.]

Intent—2011 c 315: See note following RCW 48.43.005.

Additional notes found at www.leg.wa.gov

48.41.110 Policy coverage—Eligible expenses, cost containment, limits—Explanatory brochure. (1) The pool shall offer one or more care management plans of coverage.

Such plans may, but are not required to, include point of service features that permit participants to receive in-network benefits or out-of-network benefits subject to differential cost shares. The pool may incorporate managed care features into existing plans.

(2) The administrator shall prepare a brochure outlining the benefits and exclusions of pool policies in plain language. After approval by the board, such brochure shall be made reasonably available to participants or potential participants.

(3) The health insurance policies issued by the pool shall pay only reasonable amounts for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of covered illnesses, injuries, and conditions. Eligible expenses are the reasonable amounts for the health care services and items for which benefits are extended under a pool policy.

(4) The pool shall offer at least two policies, one of which will be a comprehensive policy that must comply with RCW 48.41.120 and must at a minimum include the following services or related items:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, including no less than a total of one hundred eighty inpatient days in a calendar year, and no less than thirty days inpatient care for alcohol, drug, or chemical dependency or abuse per calendar year;

(b) Professional services including surgery for the treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered or licensed practical nurses, or other health care providers;

(c) No less than twenty outpatient professional visits for the diagnosis or treatment of alcohol, drug, or chemical dependency or abuse rendered during a calendar year by a state-certified chemical dependency program approved under *chapter 70.96A RCW, or by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners;

(d) Drugs and contraceptive devices requiring a prescription;

(e) Services of a skilled nursing facility, excluding custodial and convalescent care, for not less than one hundred days in a calendar year as prescribed by a physician;

(f) Services of a home health agency;

(g) Chemotherapy, radioisotope, radiation, and nuclear medicine therapy;

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

(k) Durable medical equipment which has no personal use in the absence of the condition for which prescribed;

(l) Diagnostic x-rays and laboratory tests;

(m) Oral surgery including at least the following: Fractures of facial bones; excisions of mandibular joints, lesions of the mouth, lip, or tongue, tumors, or cysts excluding treatment for temporomandibular joints; incision of accessory sinuses, mouth salivary glands or ducts; dislocations of the jaw; plastic reconstruction or repair of traumatic injuries

occurring while covered under the pool; and excision of impacted wisdom teeth;

(n) Maternity care services;

(o) Services of a physical therapist and services of a speech therapist;

(p) Hospice services;

(q) Professional ambulance service to the nearest health care facility qualified to treat the illness or injury;

(r) Mental health services pursuant to RCW 48.41.220; and

(s) Other medical equipment, services, or supplies required by physician's orders and medically necessary and consistent with the diagnosis, treatment, and condition.

(5) The board shall design and employ cost containment measures and requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

(6) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the board for nonnetwork providers under point of service plans. No limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

(7)(a) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a six-month benefit waiting period for preexisting conditions for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services or benefits for outpatient prescription drugs. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be as provided in subsection (8) of this section.

(b) The pool shall not impose any preexisting condition waiting period for any person under the age of nineteen.

(8)(a) Except as provided in (b) of this subsection, the pool shall credit any preexisting condition waiting period in its plans for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new pool plan. For the person previously enrolled in a group health benefit plan, the pool must credit the aggregate of all periods of preceding coverage not separated by more than sixty-three days toward the waiting period of the new health plan. For the person previously enrolled in an individual health benefit plan other than a catastrophic health plan, the pool must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan.

(b) The pool shall waive any preexisting condition waiting period for a person who is an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).

(9) If an application is made for the pool policy as a result of rejection by a carrier, then the date of application to the carrier, rather than to the pool, should govern for purposes of determining preexisting condition credit.

(10) The pool shall contract with organizations that provide care management that has been demonstrated to be effective and shall encourage enrollees who are eligible for care management services to participate. The pool may encourage the use of shared decision making and certified decision aids for preference-sensitive care areas. [2012 c 211 § 25; 2011 c 315 § 6. Prior: 2007 c 259 § 26; 2007 c 8 § 5; 2001 c 196 § 4; 2000 c 80 § 2; 2000 c 79 § 13; 1997 c 231 § 213; 1987 c 431 § 11.]

***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.

Effective date—2011 c 315 §§ 5 and 6: See note following RCW 48.41.100.

Intent—2011 c 315: See note following RCW 48.43.005.

Additional notes found at www.leg.wa.gov

48.41.120 Comprehensive pool policy—Deductibles—Coinsurance—Carryover. (1) Subject to the limitation provided in subsection (3) of this section, the comprehensive pool policy offered under RCW 48.41.110(4) shall impose a deductible as provided in this subsection. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall initially be offered. The board may authorize deductibles in other amounts. The deductible shall be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

(2) Subject to the limitations provided in subsection (3) of this section, a mandatory coinsurance requirement shall be imposed at a rate not to exceed twenty percent of eligible expenses in excess of the mandatory deductible and which supports the efficient delivery of high quality health care services for the medical conditions of pool enrollees.

(3) The maximum aggregate out-of-pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance under the comprehensive pool policy offered under RCW 48.41.110(4) shall not exceed in a calendar year:

(a) One thousand five hundred dollars per individual, or three thousand dollars per family, per calendar year for the five hundred dollar deductible policy;

(b) Two thousand five hundred dollars per individual, or five thousand dollars per family per calendar year for the one thousand dollar deductible policy; or

(c) An amount authorized by the board for any other deductible policy.

(4) Except for those enrolled in a high deductible health plan qualified under federal law for use with a health savings account, eligible expenses incurred by a covered person in the last three months of a calendar year, and applied toward a deductible, shall also be applied toward the deductible amount in the next calendar year.

(5) The board may modify cost-sharing as an incentive for enrollees to participate in care management services and other cost-effective programs and policies. [2007 c 259 § 31; 2000 c 79 § 14; 1989 c 121 § 8; 1987 c 431 § 12.]

Additional notes found at www.leg.wa.gov

48.41.130 Policy forms—Approval required. All policy forms issued by the pool shall conform in substance to prototype forms developed by the pool, and shall in all other respects conform to the requirements of this chapter, and shall be filed with and approved by the commissioner before they are issued. [2000 c 79 § 15; 1997 c 231 § 215; 1987 c 431 § 13.]

Additional notes found at www.leg.wa.gov

48.41.140 Coverage for children, dependents. (1) Coverage shall provide that health insurance benefits are applicable to children of the person in whose name the policy is issued including adopted and newly born natural children. Coverage shall also include necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the policy may require that notification of the birth or adoption of a child and payment of the required premium must be furnished to the pool within thirty-one days after the date of birth or adoption in order to have the coverage continued beyond the thirty-one day period. For purposes of this subsection, a child is deemed to be adopted, and benefits are payable, when the child is physically placed for purposes of adoption under the laws of this state with the person in whose name the policy is issued; and, when the person in whose name the policy is issued assumes financial responsibility for the medical expenses of the child. For purposes of this subsection, "newly born" means, and benefits are payable, from the moment of birth.

(2) A pool policy shall provide that coverage of a dependent person shall terminate when the person becomes twenty-six years of age: PROVIDED, That coverage of such person shall not terminate at age twenty-six while he or she is and continues to be both (a) incapable of self-sustaining employment by reason of developmental or physical disability and (b) chiefly dependent upon the person in whose name the policy is issued for support and maintenance, provided proof of such incapacity and dependency is furnished to the pool by the policyholder within thirty-one days of the dependent's attainment of age twenty-six and subsequently as may be required by the pool but not more frequently than annually after the two-year period following the dependent's attainment of age twenty-six. [2020 c 274 § 34; 2011 c 314 § 16; 2000 c 79 § 16; 1987 c 431 § 14.]

Additional notes found at www.leg.wa.gov

48.41.150 Medical supplement policy. (1) The board shall offer a medical supplement policy for persons receiving medicare parts A and B. The supplement policy shall provide benefits of one hundred percent of the deductible and copayment required under medicare and eighty percent of the charges for covered services under this chapter that are not paid by medicare. The coverage shall include a limitation of one thousand dollars per person on total annual out-of-pocket expenses for the covered services.

(2) If federal law is adopted that addresses this subject, the board shall offer a policy that is consistent with that federal law. [1989 c 121 § 9; 1987 c 431 § 15.]

48.41.160 Pool policy requirements—Continued coverage—Rate changes—Continuation—Statement of intent to discontinue pool coverage. (1) On or before December 31, 2007, the pool shall cancel all existing pool policies and replace them with policies that are identical to the existing policies except for the inclusion of a provision providing for a guarantee of the continuity of coverage consistent with this section. As a means to minimize the number of policy changes for enrollees, replacement policies provided under this subsection also may include the plan modifications authorized in RCW 48.41.100, 48.41.110, and 48.41.120.

(2) A pool policy shall contain a guarantee of the individual's right to continued coverage, subject to the provisions of subsections (4), (5), (7), and (8) of this section.

(3) The guarantee of continuity of coverage required by this section shall not prevent the pool from canceling or non-renewing a policy for:

- (a) Nonpayment of premium;
- (b) Violation of published policies of the pool;
- (c) Failure of a covered person who becomes eligible for medicare benefits by reason of age to apply for a pool medical supplement plan, or a medicare supplement plan or other similar plan offered by a carrier pursuant to federal laws and regulations;
- (d) Failure of a covered person to pay any deductible or copayment amount owed to the pool and not the provider of health care services;
- (e) Covered persons committing fraudulent acts as to the pool;
- (f) Covered persons materially breaching the pool policy; or
- (g) Changes adopted to federal or state laws when such changes no longer permit the continued offering of such coverage.

(4)(a) The guarantee of continuity of coverage provided by this section requires that if the pool replaces a plan, it must make the replacement plan available to all individuals in the plan being replaced. The replacement plan must include all of the services covered under the replaced plan, and must not significantly limit access to the kind of services covered under the replacement plan through unreasonable cost-sharing requirements or otherwise. The pool may also allow individuals who are covered by a plan that is being replaced an unrestricted right to transfer to a fully comparable plan.

(b) The guarantee of continuity of coverage provided by this section requires that if the pool discontinues offering a plan: (i) The pool must provide notice to each individual of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the pool must offer to each individual provided coverage under the discontinued plan the option to enroll in any other plan currently offered by the pool for which the individual is otherwise eligible; and (iii) in exercising the option to discontinue a plan and in offering the option of coverage under (b)(ii) of this subsection, the pool must act uniformly without regard to any health status-related factor

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of enrolled individuals or individuals who may become eligible for this coverage.

(c) The pool cannot replace or discontinue a plan under this subsection (4) until it has completed an evaluation of the impact of replacing the plan upon:

- (i) The cost and quality of care to pool enrollees;
- (ii) Pool financing and enrollment;
- (iii) The board's ability to offer comprehensive and other plans to its enrollees;
- (iv) Other items identified by the board.

In its evaluation, the board must request input from the constituents represented by the board members.

(d) The guarantee of continuity of coverage provided by this section does not apply if the pool has zero enrollment in a plan.

(5) The pool may not change the rates for pool policies except on a class basis, with a clear disclosure in the policy of the pool's right to do so.

(6) A pool policy offered under this chapter shall provide that, upon the death of the individual in whose name the policy is issued, every other individual then covered under the policy may elect, within a period specified in the policy, to continue coverage under the same or a different policy.

(7) All pool policies issued on or after January 1, 2014, must reflect the new eligibility requirements of RCW 48.41.100.

(8) Pool policies issued prior to January 1, 2014, shall be modified effective January 1, 2018, consistent with subsection (3)(g) of this section. [2021 c 60 § 2; 2017 c 110 § 3; 2013 c 279 § 4; 2007 c 259 § 27; 1987 c 431 § 16.]

Findings—Intent—2017 c 110: See note following RCW 48.41.100.

Finding—Intent—2013 c 279: See note following RCW 48.41.060.

Additional notes found at www.leg.wa.gov

48.41.170 Required rule making. The commissioner shall adopt rules pursuant to chapter 34.05 RCW that:

- (1) Provide for disclosure by the member of the availability of insurance coverage from the pool; and
- (2) Implement this chapter. [1987 c 431 § 17.]

48.41.190 Civil and criminal immunity. The pool, members of the pool, board directors of the pool, officers of the pool, employees of the pool, the commissioner, the commissioner's representatives, and the commissioner's employees shall not be civilly or criminally liable and shall not have any penalty or cause of action of any nature arise against them for any action taken or not taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter. Nothing in this section prohibits legal actions against the pool to enforce the pool's statutory or contractual duties or obligations. [2007 c 259 § 33; 1989 c 121 § 10; 1987 c 431 § 19.]

Additional notes found at www.leg.wa.gov

48.41.200 Rates—Standard risk and maximum. (1) The pool shall determine the standard risk rate by calculating the average individual standard rate charged for coverage comparable to pool coverage by the five largest members, measured in terms of individual market enrollment, offering such coverages in the state. In the event five members do not

offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage in the individual market.

(2) Subject to subsection (3) of this section, maximum rates for pool coverage shall be as follows:

(a) Maximum rates for a pool indemnity health plan shall be one hundred fifty percent of the rate calculated under subsection (1) of this section;

(b) Maximum rates for a pool care management plan shall be one hundred twenty-five percent of the rate calculated under subsection (1) of this section; and

(c) Maximum rates for a person eligible for pool coverage pursuant to RCW 48.41.100(1)(a) who was enrolled at any time during the sixty-three day period immediately prior to the date of application for pool coverage in a group health benefit plan or an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005, where such coverage was continuous for at least eighteen months, shall be:

(i) For a pool indemnity health plan, one hundred twenty-five percent of the rate calculated under subsection (1) of this section; and

(ii) For a pool care management plan, one hundred ten percent of the rate calculated under subsection (1) of this section.

(3)(a) Subject to (b) and (c) of this subsection:

(i) The rate for any person whose current gross family income is less than two hundred fifty-one percent of the federal poverty level shall be reduced by thirty percent from what it would otherwise be;

(ii) The rate for any person whose current gross family income is more than two hundred fifty but less than three hundred one percent of the federal poverty level shall be reduced by fifteen percent from what it would otherwise be;

(iii) The rate for any person who has been enrolled in the pool for more than thirty-six months shall be reduced by five percent from what it would otherwise be.

(b) In no event shall the rate for any person be less than one hundred ten percent of the rate calculated under subsection (1) of this section.

(c) Rate reductions under (a)(i) and (ii) of this subsection shall be available only to the extent that funds are specifically appropriated for this purpose in the omnibus appropriations act. [2007 c 259 § 28; (2018 c 219 § 3 expired December 31, 2019); 2000 c 79 § 17; 1997 c 231 § 214; 1987 c 431 § 20.]

Expiration date—2018 c 219 §§ 3 and 4: "Sections 3 and 4 of this act expire December 31, 2019." [2018 c 219 § 5.]

Findings—Intent—2018 c 219: See note following RCW 41.05.820.

Additional notes found at www.leg.wa.gov

48.41.210 Last payor of benefits. It is the express intent of this chapter that the pool be the last payor of benefits whenever any other benefit is available.

(1) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or health benefit plans, including but not limited to self-insured plans and by all hospital and medical expense benefits paid or payable under any worker's compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault,

and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The administrator or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this subsection. [1987 c 431 § 21.]

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

(a) For each health insurance policy issued or renewed by the pool 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 insurer's medical director or designee determines the treatment to be medically necessary; and

(b) For each health insurance policy issued or renewed by the pool on or after 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 health and substance use 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) Each health insurance policy issued by the pool 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 policy. 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 policy 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 policy 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 policy.

(3) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable 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 § 4; 2007 c 8 § 6.]

Additional notes found at www.leg.wa.gov

48.41.240 Review of populations needing coverage through pool—Analysis and recommendations—Report.

(1) The board shall review populations that may need ongoing access to coverage through the pool, with specific attention to those persons who may be excluded from or may receive inadequate coverage beginning January 1, 2014, such as persons with end-stage renal disease or HIV/AIDS, or persons not eligible for coverage in the exchange.

(2) If the review under subsection (1) of this section indicates a continued need for coverage through the pool after December 31, 2013, the board shall submit recommendations regarding any modifications to pool eligibility requirements for new and ongoing enrollment after December 31, 2013. The recommendations must address any needed modifications to the standard health questionnaire or other eligibility screening tool that could be used in a manner consistent with federal law to determine eligibility for enrollment in the pool.

(3) The board shall complete an analysis of current pool assessment requirements in relation to assessments that will fund the reinsurance program and recommend changes to pool assessments or any credits against assessments that may be considered for the reinsurance program. The analysis shall recommend whether the categories of members paying assessments should be adjusted to make the assessment fair and equitable among all payers.

(4) The board shall report its recommendations to the governor and the legislature by December 1, 2012.

(5) The board shall revisit the study of eligibility completed in 2012 with another review of the populations that may need ongoing access to coverage through the pool, to be submitted to the governor and legislature by November 1, 2015. The eligibility study shall include the nonmedicare populations scheduled to lose coverage and medicare populations, and consider whether the enrollees have access to comprehensive coverage alternatives that include appropriate pharmacy coverage. The study shall include recommendations to address any barriers in eligibility that remain in accessing other coverage such as medicare supplemental coverage or comprehensive pharmacy coverage, as well as suggestions for financing changes and recommendations on a future expiration of the pool. [2013 c 279 § 5; 2012 c 87 § 17.]

Finding—Intent—2013 c 279: See note following RCW 48.41.060.

Spiritual care services—2012 c 87: See RCW 43.71.901.

48.41.250 Administration of risk management functions—Contract with commissioner authorized—Recommendations—Report to legislature. (1) The pool is authorized to contract with the commissioner to administer risk

management functions if necessary, consistent with RCW 48.43.720, and consistent with P.L. 111-148 of 2010, as amended. Prior to entering into a contract, the pool may conduct preoperational and planning activities related to these programs, including defining and implementing an appropriate legal structure or structures to administer and coordinate the reinsurance or risk adjustment programs.

(2) The reasonable costs incurred by the pool for preoperational and planning activities related to the reinsurance program may be reimbursed from federal funds or from the additional contributions authorized under RCW 48.43.720 to pay the administrative costs of the reinsurance program.

(3) If the pool contracts to administer and coordinate the reinsurance or risk adjustment program, the board must submit recommendations to the legislature with suggestions for additional consumer representatives or other representative members to the board.

(4) The pool shall report on these activities to the appropriate committees of the senate and house of representatives by December 15, 2012, and December 15, 2013. [2012 c 87 § 18.]

Effective date—2012 c 87 §§ 4, 16, 18, and 19-23: See note following RCW 43.71.030.

Spiritual care services—2012 c 87: See RCW 43.71.901.

48.41.900 Federal supremacy. If any part of this chapter is found to be in conflict with federal requirements which are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this chapter is hereby declared to be inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and such finding or determination shall not affect the operation of the remainder of this chapter in its application to the agencies concerned. The rules under this chapter shall meet federal requirements which are a necessary condition to the receipt of federal funds by the state. [1987 c 431 § 22.]

48.41.920 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 § 124.]

Chapter 48.42 RCW

PERSONAL COVERAGE, GENERAL AUTHORITY

Sections

48.42.010	Personal coverage, authority of commissioner—Definition.
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48.42.030	Examination by commissioner—When required, scope of.

- 48.42.040 Application of this title to otherwise unregulated entities.
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 48.42.090 Prenatal testing—Limitation on changes to coverage.
 48.42.100 Women's health care services—Duties of health care carriers.

48.42.010 Personal coverage, authority of commissioner—Definition. (1) Notwithstanding any other provision of law, and except as provided in this chapter, any person or other entity which provides coverage in this state for life insurance, annuities, loss of time, medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, the providing of services, or otherwise, shall be subject to the authority of the state insurance commissioner, unless the person or other entity shows that while providing the services it is subject to the jurisdiction and regulation of another agency of this state, any subdivisions thereof, or the federal government.

(2) "Another agency of this state, any subdivision thereof, or the federal government" does not include the Washington health benefit exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended. [2012 c 87 § 10; 1985 c 264 § 15; 1983 c 36 § 1.]

Spiritual care services—2012 c 87: See RCW 43.71.901.

48.42.020 Showing regulation by other agency, how done—Definition. (1) A person or entity may show that it is subject to the jurisdiction and regulation of another agency of this state, any subdivision thereof, or the federal government, by providing to the insurance commissioner the appropriate certificate, license, or other document issued by the other governmental agency which permits or qualifies it to provide the coverage as defined in RCW 48.42.010.

(2) "Another agency of this state, any subdivision thereof, or the federal government" does not include the Washington health benefit exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended. [2012 c 87 § 11; 1983 c 36 § 2.]

Spiritual care services—2012 c 87: See RCW 43.71.901.

48.42.030 Examination by commissioner—When required, scope of. Any person or entity which is unable to show under RCW 48.42.020 that it is subject to the jurisdiction and regulation of another agency of this state, any subdivision thereof, or the federal government, shall submit to an examination by the insurance commissioner to determine the organization and solvency of the person or the entity, and to determine whether or not such person or entity complies with the applicable provisions of this title. [1983 c 36 § 3.]

48.42.040 Application of this title to otherwise unregulated entities. Any person or entity unable to show that it is subject to the jurisdiction and regulation of another agency of this state, any subdivision thereof, or the federal government, shall be subject to all appropriate provisions of this title regarding the conduct of its business including, but not limited to, RCW 48.43.300 through 48.43.370. [1998 c 241 § 16; 1983 c 36 § 4.]

48.42.050 Notice to purchasers by uninsured production agency—Notice to production agency by administrator of coverage. Any production agency or administrator which advertises, sells, transacts, or administers the coverage in this state described in RCW 48.42.010 and which is required to submit to an examination by the insurance commissioner under RCW 48.42.030, shall, if the coverage is not fully insured or otherwise fully covered by an admitted life or disability insurer or health care service contractor or health maintenance organization agreement, advise every purchaser, prospective purchaser, and covered person of the lack of insurance or other coverage.

Any administrator which advertises or administers the coverage in this state described in RCW 48.42.010 and which is subject to an examination by the insurance commissioner under RCW 48.42.030 shall advise any production agency of the elements of the coverage, including the amount of "stop-loss" insurance in effect. [1983 c 36 § 5.]

48.42.090 Prenatal testing—Limitation on changes to coverage. The carrier or provider of any group disability contract, health care services contract or health maintenance agreement shall not cancel, reduce, limit or otherwise alter or change the coverage provided solely on the basis of the result of any prenatal test. [1988 c 276 § 9.]

48.42.100 Women's health care services—Duties of health care carriers. (Effective until July 1, 2022.) (1) For purposes of this section, health care carriers includes disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, health maintenance organizations regulated under chapter 48.46 RCW, plans operating under the health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated under chapter 48.43 RCW.

(2) For purposes of this section and consistent with their lawful scopes of practice, types of health care practitioners that provide women's health care services shall include, but need not be limited by a health care carrier to, the following: Any generally recognized medical specialty of practitioners licensed under chapter 18.57 or 18.71 RCW who provides women's health care services; practitioners licensed under chapters 18.57A and 18.71A RCW when providing women's health care services; midwives licensed under chapter 18.50 RCW; and advanced registered nurse practitioner specialists in women's health and midwifery under chapter 18.79 RCW.

(3) For purposes of this section, women's health care services shall include, but need not be limited by a health care carrier to, the following: Maternity care; reproductive health services; gynecological care; general examination; and preventive care as medically appropriate and medically appropriate follow-up visits for the services listed in this subsection.

(4) Health care carriers shall ensure that enrolled female patients have direct access to timely and appropriate covered women's health care services from the type of health care practitioner of their choice in accordance with subsection (5) of this section.

(5)(a) Health care carrier policies, plans, and programs written, amended, or renewed after July 23, 1995, shall pro-

vide women patients with direct access to the type of health care practitioner of their choice for appropriate covered women's health care services without the necessity of prior referral from another type of health care practitioner.

(b) Health care carriers may comply with this section by including all the types of health care practitioners listed in this section for women's health care services for women patients.

(c) Nothing in this section shall prevent health care carriers from restricting women patients to seeing only health care practitioners who have signed participating provider agreements with the health care carrier. [2000 c 7 § 1; 1995 c 389 § 1.]

48.42.100 Women's health care services—Duties of health care carriers. (Effective July 1, 2022.) (1) For purposes of this section, health care carriers includes disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, health maintenance organizations regulated under chapter 48.46 RCW, plans operating under the health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated under chapter 48.43 RCW.

(2) For purposes of this section and consistent with their lawful scopes of practice, types of health care practitioners that provide women's health care services shall include, but need not be limited by a health care carrier to, the following: Any generally recognized medical specialty of practitioners licensed under chapter 18.57 or 18.71 RCW who provides women's health care services; practitioners licensed under chapter 18.71A RCW when providing women's health care services; midwives licensed under chapter 18.50 RCW; and advanced registered nurse practitioner specialists in women's health and midwifery under chapter 18.79 RCW.

(3) For purposes of this section, women's health care services shall include, but need not be limited by a health care carrier to, the following: Maternity care; reproductive health services; gynecological care; general examination; and preventive care as medically appropriate and medically appropriate follow-up visits for the services listed in this subsection.

(4) Health care carriers shall ensure that enrolled female patients have direct access to timely and appropriate covered women's health care services from the type of health care practitioner of their choice in accordance with subsection (5) of this section.

(5)(a) Health care carrier policies, plans, and programs written, amended, or renewed after July 23, 1995, shall provide women patients with direct access to the type of health care practitioner of their choice for appropriate covered women's health care services without the necessity of prior referral from another type of health care practitioner.

(b) Health care carriers may comply with this section by including all the types of health care practitioners listed in this section for women's health care services for women patients.

(c) Nothing in this section shall prevent health care carriers from restricting women patients to seeing only health care practitioners who have signed participating provider

agreements with the health care carrier. [2020 c 80 § 35; 2000 c 7 § 1; 1995 c 389 § 1.]

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

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CONSTRUCTION

- 48.43.902 Effective date—1996 c 312.
- 48.43.904 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

48.43.001 Intent. It is the intent of the legislature to ensure that all enrollees in managed care settings have access to adequate information regarding health care services covered by health carriers' health plans, and provided by health care providers and health care facilities. It is only through such disclosure that Washington state citizens can be fully informed as to the extent of health insurance coverage, availability of health care service options, and necessary treatment. With such information, citizens are able to make knowledgeable decisions regarding their health care. [1996 c 312 § 1.]

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

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or facility or by a nonparticipating provider or facility.

(4) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

(5) "Balance bill" means a bill sent to an enrollee by an out-of-network provider or facility for health care services

provided to the enrollee after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing.

(6) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

(7) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(e).

(8) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

(9) "Board" means the governing board of the Washington health benefit exchange established in chapter 43.71 RCW.

(10)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

(i) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars, both amounts to be adjusted annually by the insurance commissioner; and

(ii) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least six thousand dollars, both amounts to be adjusted annually by the insurance commissioner.

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

(11) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(12) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(13) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

(14) "Dependent" means, at a minimum, the enrollee's legal spouse and dependent children who qualify for coverage under the enrollee's health benefit plan.

(15) "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(16) "Emergency services" means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

(17) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

(18) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(19) "Essential health benefit categories" means:

- (a) Ambulatory patient services;
- (b) Emergency services;
- (c) Hospitalization;
- (d) Maternity and newborn care;
- (e) Mental health and substance use disorder services, including behavioral health treatment;
- (f) Prescription drugs;
- (g) Rehabilitative and habilitative services and devices;
- (h) Laboratory services;
- (i) Preventive and wellness services and chronic disease management; and
- (j) Pediatric services, including oral and vision care.

(20) "Exchange" means the Washington health benefit exchange established under chapter 43.71 RCW.

(21) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

(22) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

(23) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L. 111-152 (2010) is not subject to subtitles A or C of the act as amended.

(24) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

(25) "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.

(26) "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.

(27) "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.

(28) "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, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

(29) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 or 48.83 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Coverage supplemental to the coverage provided under chapter 55, Title 10, United States Code;

(d) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(e) Disability income;

(f) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(g) Workers' compensation coverage;

(h) Accident only coverage;

(i) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

(j) Employer-sponsored self-funded health plans;

(k) Dental only and vision only coverage;

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner;

(m) Civilian health and medical program for the veterans affairs administration (CHAMPVA); and

(n) Stand-alone prescription drug coverage that exclusively supplements medicare part D coverage provided through an employer group waiver plan under federal social security act regulation 42 C.F.R. Sec. 423.458(c).

(30) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(31) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations.

(32) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

(33) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(34) "Out-of-network" or "nonparticipating" means a provider or facility that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

(35) "Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

(36) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(37) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(38)(a) "Protected individual" means:

(i) An adult covered as a dependent on the enrollee's health benefit plan, including an individual enrolled on the health benefit plan of the individual's registered domestic partner; or

(ii) A minor who may obtain health care without the consent of a parent or legal guardian, pursuant to state or federal law.

(b) "Protected individual" does not include an individual deemed not competent to provide informed consent for care under **RCW 11.88.010(1)(e).

(39) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

(40) "Sensitive health care services" means health services related to reproductive health, sexually transmitted diseases, substance use disorder, gender dysphoria, gender affirming care, domestic violence, and mental health.

(41) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole

proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

(42) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(43) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

(44) "Surgical or ancillary services" means surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

(45) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

(46) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs. [2020 c 196 § 1. Prior: 2019 c 427 § 2; 2019 c 56 § 2; 2019 c 33 § 1; 2016 c 65 § 2; prior: 2012 c 211 § 17; 2012 c 87 § 1; prior: 2011 c 315 § 2; 2011 c 314 § 3; prior: 2010 c 292 § 1; prior: 2008 c 145 § 20; 2008 c 144 § 1; prior: 2007 c 296 § 1; 2007 c 259 § 32; 2006 c 25 § 16; 2004 c 244 § 2; prior: 2001 c 196 § 5; 2001 c 147 § 1; 2000 c 79 § 18; prior: 1997 c 231 § 202; 1997 c 55 § 1; 1995 c 265 § 4.]

Reviser's note: *(1) Chapter 70.96A RCW was repealed and/or recodified in its entirety pursuant to 2016 sp.s. c 29 §§ 301, 601, and 701.

** (2) RCW 11.88.010 was repealed by 2020 c 312 § 904, effective January 1, 2022.

Effective date—2020 c 196: "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 27, 2020]." [2020 c 196 § 2.]

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

Findings—Declarations—Effective date—2019 c 56: See notes following RCW 48.43.5051.

Effective date—2019 c 33: "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 [April 17, 2019]." [2019 c 33 § 17.]

Spiritual care services—2012 c 87: See RCW 43.71.901.

Intent—2011 c 315: "The federal patient protection and affordable care act (P.L. 111-148) prohibits insurance carriers from applying preexisting condition limitations for persons under age nineteen, beginning on or after September 23, 2010. The guidance from the United States department of health and human services provides some direction for the implementation of the new policy requirement, and the office of the insurance commissioner further clarified open enrollment requirements to help prevent disruption in the individual health insurance marketplace. It is the intent of this act to:

(1) Maintain access to individual plan options for persons under age nineteen; and

(2) Provide clarity for the establishment of open enrollment and special open enrollment periods that balance access to guaranteed issue coverage with efforts that protect market stability." [2011 c 315 § 1.]

Additional notes found at www.leg.wa.gov

48.43.007 Availability of price and quality information—Transparency tools for members—Requirements.

(1) Each carrier offering or renewing a health benefit plan on or after January 1, 2016, must offer member transparency tools with certain price and quality information to enable the member to make treatment decisions based on cost, quality, and patient experience. The transparency tools must aim for best practices and, at a minimum:

(a) Must display cost data for common treatments within the following categories:

- (i) Inpatient treatments;
- (ii) Outpatient treatments;
- (iii) Diagnostic tests; and
- (iv) Office visits;

(b) Recognizing integrated health care delivery systems focus on total cost of care, carrier's operating integrated care delivery systems may meet the requirement of (a) of this subsection by providing meaningful consumer data based on the total cost of care. This subsection applies only to the portion of enrollment a carrier offers pursuant to chapter 48.46 RCW and as part of an integrated delivery system, and does not exempt from (a) of this subsection coverage offered pursuant to chapter 48.21, 48.44, or 48.46 RCW if not part of an integrated delivery system;

(c) Are encouraged to display the cost for prescription medications on their member web site or through a link to a third party that manages the prescription benefits;

(d) Must include a patient review option or method for members to provide a rating or feedback on their experience with the medical provider that allows other members to see the patient review, the feedback must be monitored for appropriateness and validity, and the site may include independently compiled quality of care ratings of providers and facilities;

(e) Must allow members to access the estimated cost of the treatment, or the total cost of care, as set forth in (a) and (b) of this subsection on a portable electronic device;

(f) Must display options based on the selected search criteria for members to compare;

(g) Must display the estimated cost of the treatment, or total cost of the care episode, and the estimated out-of-pocket costs of the treatment for the member and display the application of personalized benefits such as deductibles and cost-sharing;

(h) Must display quality information on providers when available; and

(i) Are encouraged to display alternatives that are more cost-effective when there are alternatives available, such as the use of an ambulatory surgical center when one is available or medical versus surgical alternatives as appropriate.

(2) In addition to the required features on cost and quality information, the member transparency tools must include information to allow a provider and hospital search of in-network providers and hospitals with provider information including specialists, distance from patient, the provider's contact information, the provider's education, board certification and other credentials, where to find information on malpractice history and disciplinary actions, affiliated hospitals and other providers in a clinic, and directions to provider offices and hospitals.

(3) Each carrier offering or renewing a health benefit plan on or after January 1, 2016, must provide enrollees with the performance information required by section 2717 of the patient protection and affordable care act, P.L. 111-148 (2010), as amended by the health care and education reconciliation act, P.L. 111-152 (2010), and any federal regulations or guidance issued under that section of the affordable care act.

(4) Each carrier offering or renewing a health benefit plan on or after January 1, 2016, must, within thirty days from the offer or renewal date, attest to the office of the insurance commissioner that the member transparency tools meet the requirements in this section and access to the tools is available on the home page within the health plan's secured member web site. [2014 c 224 § 3.]

Intent—2014 c 224: "Consumers face a challenge finding reliable, consumer friendly information on health care pricing and quality. Greater transparency of health care prices and quality leads to engaged, activated consumers. Research indicates that engaged and educated consumers help control costs and improve quality with lower costs per patient, lower hospital readmission rates, and the use of higher quality providers. Washington is a leader in efforts to develop and publish provider quality information.

Although data is available today, research indicates the existing information is not user-friendly, consumers do not know which measures are most relevant, and quality ratings are inconsistent or nonstandardized. It is the intent of the legislature to ensure consumer tools are available to educate and engage patients in managing their care and understanding the costs and quality." [2014 c 224 § 1.]

48.43.008 Enrollment in employer-sponsored health plan—Person eligible for medical assistance. When the health care authority determines that it is cost-effective to enroll a person eligible for medical assistance under chapter 74.09 RCW in an employer-sponsored health plan, a carrier shall permit the enrollment of the person in the health plan for which he or she is otherwise eligible without regard to any open enrollment period restrictions. [2011 1st sp.s. c 15 § 77; 2007 c 259 § 24.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Additional notes found at www.leg.wa.gov

48.43.009 Health care sharing ministries. Health care sharing ministries are not health carriers as defined in RCW 48.43.005 or insurers as defined in RCW 48.01.050. For purposes of this section, "health care sharing ministry" has the same meaning as in 26 U.S.C. Sec. 5000A. [2011 c 314 § 18.]

48.43.012 Health plans—Preexisting conditions—Rules. (1) No carrier may reject an individual for an individual or group health benefit plan based upon preexisting conditions of the individual.

(2) No carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions including, but not limited to, preexisting condition exclusions or waiting periods.

(3) No carrier may avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. A new or changed rate classification will be deemed an attempt to avoid the provisions of this section if the new or changed classification

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would substantially discourage applications for coverage from individuals who are higher than average health risks. These provisions apply only to individuals who are Washington residents.

(4) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 § 2; 2011 c 315 § 3; 2001 c 196 § 6; 2000 c 79 § 19.]

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

Intent—2011 c 315: See note following RCW 48.43.005.

Additional notes found at www.leg.wa.gov

48.43.01211 Health plans—Eligibility—Health status-related factors—Rules. (1) A health carrier or health plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- (a) Health status;
- (b) Medical condition, including both physical and mental illnesses;
- (c) Claims experience;
- (d) Receipt of health care;
- (e) Medical history;
- (f) Genetic information;
- (g) Evidence of insurability, including conditions arising out of acts of domestic violence;
- (h) Disability; or
- (i) Any other health status-related factor determined appropriate by the commissioner.

(2) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 § 3.]

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

48.43.0122 Individual health benefit plans—Open enrollment and special enrollment periods—Rules—Enforcement. (1) The commissioner shall adopt rules establishing and implementing requirements for the open enrollment periods and special enrollment periods that carriers must follow for individual health benefit plans.

(2) The commissioner shall monitor the sale of individual health benefit plans and if a carrier refuses to sell guaranteed issue policies to persons in compliance with rules adopted by the commissioner pursuant to subsection (1) of this section, the commissioner may levy fines or suspend or revoke a certificate of authority as provided in chapter 48.05 RCW. [2019 c 33 § 11; 2011 c 315 § 4.]

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

Intent—2011 c 315: See note following RCW 48.43.005.

48.43.0123 Health plans—Rescission of coverage—Rules. (1) A health plan or health carrier offering group or individual coverage may not rescind such coverage with respect to an enrollee once the enrollee is covered under the

plan or coverage involved, except that this section does not apply to a covered person who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. The plan or coverage may not be canceled except as permitted under RCW 48.43.035 or 48.43.038.

(2) The commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 § 8.]

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

48.43.0124 Health plans—Cost sharing for essential health benefits—Rules. (1) For plan years beginning in 2020, the cost sharing incurred under a health plan for the essential health benefits may not exceed the following amounts:

(a) For self-only coverage:

(i) The amount required under federal law for the calendar year; or

(ii) If there are no cost-sharing requirements under federal law, eight thousand two hundred dollars increased by the premium adjustment percentage for the calendar year.

(b) For coverage other than self-only coverage:

(i) The amount required under federal law for the calendar year; or

(ii) If there are no cost-sharing requirements under federal law, sixteen thousand four hundred dollars increased by the premium adjustment percentage for the calendar year.

(2) Regardless of whether an enrollee is covered by a self-only plan or a plan that is other than self-only, the enrollee's cost sharing for the essential health benefits may not exceed the self-only annual limitation on cost sharing.

(3) For purposes of this section, "the premium adjustment percentage for the calendar year" means the percentage, if any, by which the average per capita premium for health insurance in Washington for the preceding year, as estimated by the commissioner no later than April 1st of such preceding year, exceeds such average per capita premium for 2020 as determined by the commissioner.

(4) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 § 10.]

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

48.43.0125 Essential health benefits—Annual or lifetime dollar limits. A health carrier may not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted as reference-based limitations under rules adopted by the commissioner. [2019 c 33 § 12.]

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

48.43.0126 Summary of benefits and explanation of coverage—Standards and requirements—Notice of modification—Fines—Standards for definitions of health insurance terms—Rules. (1) The commissioner shall develop standards for use by a health carrier offering individual or group coverage, in compiling and providing to applicants and enrollees a summary of benefits and coverage

explanation that accurately describes the benefits and coverage under the applicable plan. In developing the standards, the commissioner must use the standards developed under 42 U.S.C. Sec. 300gg-15 in use on April 17, 2019.

(2) The standards must provide for the following:

(a) The standards must ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed four pages in length and does not include print smaller than twelve-point font.

(b) The standards must ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

(c) The standards must ensure that the summary of benefits and coverage includes:

(i) Uniform definitions of standard insurance and medical terms, consistent with the standard definitions developed under this section, so that consumers may compare health insurance coverage and understand the terms of coverage, or exceptions to such coverage;

(ii) A description of the coverage, including cost sharing for:

(A) The essential health benefits; and

(B) Other benefits identified by the commissioner;

(iii) The exceptions, reductions, and limitations on coverage;

(iv) The cost-sharing provisions, including deductible, coinsurance, and copayment obligations;

(v) The renewability and continuation of coverage provisions;

(vi) A coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing. The scenarios must be based on recognized clinical practice guidelines;

(vii) A statement of whether the plan:

(A) Provides minimum essential coverage under 26 U.S.C. Sec. 5000A(f); and

(B) Ensures that the plan share of the total allowed costs of benefits provided under the plan is no less than sixty percent of the costs;

(viii) A statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

(ix) A contact number for the consumer to call with additional questions and a web site where a copy of the actual individual coverage policy or group certificate of coverage may be reviewed and obtained.

(3) The commissioner shall periodically review and update the standards developed under this section.

(4) A health carrier must provide a summary of benefits and coverage explanation to:

(a) An applicant at the time of application;

(b) An enrollee prior to the time of enrollment or reenrollment, as applicable; and

(c) A policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

(5) A health carrier may provide the summary of benefits and coverage either in paper or electronically.

(6) If a health carrier makes any material modification in any of the terms of the plan that is not reflected in the most recently provided summary of benefits and coverage, the carrier shall provide notice of the modification to enrollees no later than sixty days prior to the date on which the modification will become effective.

(7) A health carrier that fails to provide the information required under this section is subject to a fine of no more than one thousand dollars for each failure. A failure with respect to each enrollee constitutes a separate offense for purposes of this subsection.

(8) The commissioner shall, by rule, provide for the development of standards for the definitions of terms used in health insurance coverage, including the following:

(a) Insurance-related terms, including premium; deductible; coinsurance; copayment; out-of-pocket limit; preferred provider; nonpreferred provider; out-of-network copayments; usual, customary, and reasonable fees; excluded services; grievance; appeals; and any other terms the commissioner determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage; and

(b) Medical terms, including hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and any other terms the commissioner determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits or exceptions to those benefits.

(9) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 § 13.]

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

48.43.0127 Group health plans—Waiting period—

Rules. (1) A group health plan and a health carrier offering group health coverage may not apply any waiting period that exceeds ninety days.

(2) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 § 14.]

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

48.43.0128 Nongrandfathered health plans and plans issued or renewed on or after January 1, 2022—Prohibited discrimination—Rules. (1) A health carrier offering a nongrandfathered health plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution may not:

(a) In its benefit design or implementation of its benefit design, discriminate against individuals because of their age,

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expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; and

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

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

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

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

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

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

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

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

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

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

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

(8) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement subsections (1) and (2) of this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2021 c 280 § 3; 2020 c 228 § 9; 2019 c 33 § 15.]

Short title—2021 c 280: See note following RCW 49.60.178.

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

48.43.016 Utilization management standards and criteria—Health carrier requirements—Definitions. (1) A health carrier or its contracted entity that imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan shall inform an enrollee which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers.

(2)(a) A health carrier or its contracted entity may not require utilization management or review of any kind including, but not limited to, prior, concurrent, or postservice authorization for an initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care for each of the following: Chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapies. Visits for which utilization management or review is prohibited under this section are subject to quantitative treatment limits of the health plan. Notwithstanding RCW 48.43.515(5) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section.

(b) For visits for which utilization management or review is prohibited under this section, a health carrier or its contracted entity may not:

- (i) Deny or limit coverage on the basis of medical necessity or appropriateness; or
- (ii) Retroactively deny care or refuse payment for the visits.

(3) A health carrier shall post on its web site and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the carrier uses for medical necessity decisions.

(4) A health care provider with whom a health carrier consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service.

(5) A health carrier may not require a provider to provide a discount from usual and customary rates for health care services not covered under a health plan, policy, or other agreement, to which the provider is a party.

(6) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(7) For purposes of this section:

(a) "New episode of care" means treatment for a new condition or diagnosis for which the enrollee has not been

treated by a provider of the same licensed profession within the previous ninety days and is not currently undergoing any active treatment.

(b) "Contracting provider" does not include providers employed within an integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW. [2020 c 193 § 2; 2019 c 308 § 22; 2018 c 193 § 1; 2015 c 251 § 2.]

Intent—2020 c 193: "The legislature intends to facilitate patient access to appropriate therapies for newly diagnosed health conditions while recognizing the necessity for health carriers to employ reasonable utilization management techniques." [2020 c 193 § 1.]

Findings—2019 c 308: See note following RCW 18.06.010.

Effective date—2015 c 251: See note following RCW 41.05.074.

48.43.0161 Prior authorization practices—Carrier annual reporting requirements—Commissioner's standardized report. (1) Except as provided in subsection (2) of this section, by October 1, 2020, and annually thereafter, for individual and group health plans issued by a carrier that has written at least one percent of the total accident and health insurance premiums written by all companies authorized to offer accident and health insurance in Washington in the most recently available year, the carrier shall report to the commissioner the following aggregated and deidentified data related to the carrier's prior authorization practices and experience for the prior plan year:

(a) Lists of the ten inpatient medical or surgical codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(b) Lists of the ten outpatient medical or surgical codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(c) Lists of the ten inpatient mental health and substance use disorder service codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total

number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; [and]

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(d) Lists of the ten outpatient mental health and substance use disorder service codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; [and]

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved;

(e) Lists of the ten durable medical equipment codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; [and]

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(f) Lists of the ten diabetes supplies and equipment codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; [and]

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(g) The average determination response time in hours for prior authorization requests to the carrier with respect to each

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code reported under (a) through (f) of this subsection for each of the following categories of prior authorization:

(i) Expedited decisions;

(ii) Standard decisions; and

(iii) Extenuating circumstances decisions.

(2) For the October 1, 2020, reporting deadline, a carrier is not required to report data pursuant to subsection (1)(a)(iii), (b)(iii), (c)(iii), (d)(iii), (e)(iii), or (f)(iii) of this section until April 1, 2021, if the commissioner determines that doing so constitutes a hardship.

(3) By January 1, 2021, and annually thereafter, the commissioner shall aggregate and deidentify the data collected under subsection (1) of this section into a standard report and may not identify the name of the carrier that submitted the data. The initial report due on January 1, 2021, may omit data for which a hardship determination is made by the commissioner under subsection (2) of this section. Such data must be included in the report due on January 1, 2022. The commissioner must make the report available to interested parties.

(4) The commissioner may request additional information from carriers reporting data under this section.

(5) The commissioner may adopt rules to implement this section. In adopting rules, the commissioner must consult stakeholders including carriers, health care practitioners, health care facilities, and patients.

(6) For the purpose of this section, "prior authorization" means a mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow before a service is delivered, to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan, including any term used by a carrier or its designated or contracted representative to describe this process. [2020 c 316 § 1.]

48.43.021 Personally identifiable health information—Restrictions on release. Except as otherwise required by statute or rule, a carrier and the Washington state health insurance pool, and persons acting at the direction of or on behalf of a carrier or the pool, who are in receipt of an enrollee's or applicant's personally identifiable health information included in the standard health questionnaire shall not disclose the identifiable health information unless such disclosure is explicitly authorized in writing by the person who is the subject of the information. [2000 c 79 § 22.]

Additional notes found at www.leg.wa.gov

48.43.022 Enrollee identification card—Social security number restriction. After December 31, 2005, a health carrier that issues a card identifying a person as an enrollee, and requires the person to present the card to providers for purposes of claims processing, may not display on the card an identification number that includes more than a four-digit portion of the person's complete social security number. [2004 c 115 § 1.]

48.43.023 Pharmacy identification cards—Rules. (1) A health carrier that provides coverage for prescription drugs provided on an outpatient basis and issues a card or other technology for claims processing, or an administrator of a health benefit plan including, but not limited to, third-party

administrators for self-insured plans, pharmacy benefits managers, and state administered plans, shall issue to its enrollees a pharmacy identification card or other technology containing all information required for proper prescription drug claims adjudication.

(2) Upon renewal of the health benefit plan, information on the pharmacy identification card or other technology shall be made current by the health carrier or other entity that issues the card.

(3) Nothing in this section shall be construed to require any health carrier or administrator of a health benefit plan to issue a pharmacy identification card or other technology separate from another identification card issued to an enrollee under the health benefit plan if the identification card contains all of the information required under subsection (1) of this section.

(4) This section applies to health benefit plans that are delivered, issued for delivery, or renewed on or after July 1, 2003. For the purposes of this section, renewal of a health benefit policy, contract, or plan occurs on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

(5) The insurance commissioner may adopt rules to implement chapter 106, Laws of 2001, taking into consideration any relevant standards developed by the national council for prescription drug programs and the requirements of the federal health insurance portability and accountability act of 1996. [2001 c 106 § 2.]

Intent—2001 c 106: "It is the intent of the legislature to improve care to patients by minimizing confusion, eliminating unnecessary paperwork, decreasing administrative burdens, and streamlining dispensing of prescription products paid for by third-party payors." [2001 c 106 § 1.]

48.43.028 Eligibility to purchase certain health benefit plans—Small employers and small groups. To the extent required of the federal health insurance portability and accountability act of 1996, the eligibility of an employer or group to purchase a health benefit plan set forth in RCW 48.21.045(1)(b), 48.44.023(1)(b), and 48.46.066(1)(b) must be extended to all small employers and small groups as defined in RCW 48.43.005. [2001 c 196 § 10.]

Additional notes found at www.leg.wa.gov

48.43.035 Group health benefit plans—Guaranteed issue and continuity of coverage—Exceptions. For group health benefit plans, the following shall apply:

(1) All health carriers shall accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a health carrier the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

(2) Except as provided in subsection (5) of this section, all health plans shall contain or incorporate by endorsement a

guarantee of the continuity of coverage of the plan. For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium. The carrier may consider the group's anniversary date as the renewal date for purposes of complying with the provisions of this section.

(3) The guarantee of continuity of coverage required in health plans shall not prevent a carrier from canceling or non-renewing a health plan for:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the insurance commissioner;

(c) Covered persons entitled to become eligible for medicare benefits by reason of age who fail to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations;

(d) Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;

(e) Covered persons committing fraudulent acts as to the carrier;

(f) Covered persons who materially breach the health plan; or

(g) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.

(4) The provisions of this section do not apply in the following cases:

(a) A carrier has zero enrollment on a product;

(b) A carrier replaces a product and the replacement product is provided to all covered persons within that class or line of business, includes all of the services covered under the replaced product, and does not significantly limit access to the kind of services covered under the replaced product. The health plan may also allow unrestricted conversion to a fully comparable product;

(c) No sooner than January 1, 2005, a carrier discontinues offering a particular type of health benefit plan offered for groups of up to two hundred if: (i) The carrier provides notice to each group of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each group provided coverage of this type the option to enroll, with regard to small employer groups, in any other small employer group plan, or with regard to groups of up to two hundred, in any other applicable group plan, currently being offered by the carrier in the applicable group market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for this coverage;

(d) A carrier discontinues offering all health coverage in the small group market or for groups of up to two hundred, or both markets, in the state and discontinues coverage under all existing group health benefit plans in the applicable market involved if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all such coverage in the state and its intent to discontinue coverage under all such existing health benefit plans at least one hundred eighty days

prior to the date of the discontinuation of coverage under all such existing health benefit plans; and (ii) the carrier provides notice to each covered group of the intent to discontinue the existing health benefit plan at least one hundred eighty days prior to the date of discontinuation. In the case of discontinuation under this subsection, the carrier may not issue any group health coverage in this state in the applicable group market involved for a five-year period beginning on the date of the discontinuation of the last health benefit plan not so renewed. This subsection (4) does not require a carrier to provide notice to the commissioner of its intent to discontinue offering a health benefit plan to new applicants when the carrier does not discontinue coverage of existing enrollees under that health benefit plan; or

(e) A carrier is withdrawing from a service area or from a segment of its service area because the carrier has demonstrated to the insurance commissioner that the carrier's clinical, financial, or administrative capacity to serve enrollees would be exceeded.

(5) The provisions of this section do not apply to health plans deemed by the insurance commissioner to be unique or limited or have a short-term purpose, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner. [2010 c 292 § 2; 2004 c 244 § 4; 2000 c 79 § 24; 1995 c 265 § 7.]

Additional notes found at www.leg.wa.gov

48.43.038 Individual health plans—Guarantee of continuity of coverage—Exceptions. (1) Except as provided in subsection (4) of this section, all individual health plans shall contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium.

(2) The guarantee of continuity of coverage required in individual health plans shall not prevent a carrier from canceling or nonrenewing a health plan for:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the commissioner;

(c) Covered persons entitled to become eligible for medicare benefits by reason of age who fail to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations;

(d) Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;

(e) Covered persons committing fraudulent acts as to the carrier;

(f) Covered persons who materially breach the health plan; or

(g) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.

(3) This section does not apply in the following cases:

(a) A carrier has zero enrollment on a product;

(b) A carrier is withdrawing from a service area or from a segment of its service area because the carrier has demon-

strated to the commissioner that the carrier's clinical, financial, or administrative capacity to serve enrollees would be exceeded;

(c) No sooner than the first day of the month following the expiration of a one hundred eighty-day period beginning on March 23, 2000, a carrier discontinues offering a particular type of health benefit plan offered in the individual market if: (i) The carrier provides notice to each covered individual provided coverage of this type of such discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each individual provided coverage of this type the option, without being subject to the standard health questionnaire, to enroll in any other individual health benefit plan currently being offered by the carrier; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage; or

(d) A carrier discontinues offering all individual health coverage in the state and discontinues coverage under all existing individual health benefit plans if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all individual health coverage in the state and its intent to discontinue coverage under all existing health benefit plans at least one hundred eighty days prior to the date of the discontinuation of coverage under all existing health benefit plans; and (ii) the carrier provides notice to each covered individual of the intent to discontinue his or her existing health benefit plan at least one hundred eighty days prior to the date of such discontinuation. In the case of discontinuation under this subsection, the carrier may not issue any individual health coverage in this state for a five-year period beginning on the date of the discontinuation of the last health plan not so renewed. Nothing in this subsection (3) shall be construed to require a carrier to provide notice to the commissioner of its intent to discontinue offering a health benefit plan to new applicants where the carrier does not discontinue coverage of existing enrollees under that health benefit plan.

(4) The provisions of this section do not apply to health plans deemed by the commissioner to be unique or limited or have a short-term purpose, after a written request for such classification by the carrier and subsequent written approval by the commissioner. [2000 c 79 § 25.]

Additional notes found at www.leg.wa.gov

48.43.039 Grace period—Notification or information—Information concerning delinquencies or nonpayment of premiums—Defined. (1) For an enrollee who is in the second or third month of the grace period, an issuer of a qualified health plan shall:

(a) Upon request by a health care provider or health care facility, provide information regarding the enrollee's eligibility status in real time;

(b) Notify a health care provider or health care facility that an enrollee is in the grace period within three business days after submittal of a claim or status request for services provided; and

(c) If the health care provider or health care facility is providing care to an enrollee in the grace period, the provider or facility shall, wherever possible, encourage the enrollee to

pay delinquent premiums to the issuer and provide information regarding the impact of nonpayment of premiums on access to services.

(2) The information or notification required under subsection (1) of this section must, at a minimum:

(a) Indicate "grace period" or use the appropriate national coding standard as the reason for pending the claim if a claim is pending due to the enrollee's grace period status; and

(b) Except for notifications provided electronically, indicate that enrollee is in the second or third month of the grace period.

(3) No earlier than January 1, 2016, and once the exchange has terminated premium aggregation functionality for qualified health plans offered in the individual exchange and issuers are accepting all payments from enrollees directly, an issuer of a qualified health plan shall:

(a) For an enrollee in the grace period, include a statement in a delinquency notice that concisely explains the impact of nonpayment of premiums on access to coverage and health care services and encourages the enrollee to contact the issuer regarding coverage options that may be available;

(b) For an enrollee who has exhausted the grace period, include a statement in a termination notice for nonpayment of premium informing the enrollee that other coverage options such as medicaid may be available and to contact the issuer or the exchange for additional information; and

(c) For a delinquency notice described in this subsection, include concise information on how a subsidized enrollee may report to the exchange a change in income or circumstances, including any deadline for doing so, and an explanation that it may result in a change in premium or cost-sharing amount or program eligibility.

(4) Upon the transfer of premium collection to the qualified health plan, each qualified health plan must provide detailed reports to the exchange to support the legislative reporting requirements.

(5) For purposes of this section, "grace period" means nonpayment of premiums by an enrollee receiving advance payments of the premium tax credit, as defined in section 1412 of the patient protection and affordable care act, P.L. 111-148, as amended by the health care and education reconciliation act, P.L. 111-152, and implementing regulations issued by the federal department of health and human services. [2018 c 44 § 9; 2015 3rd sp.s. c 33 § 4; 2014 c 84 § 3; 2014 c 84 § 2.]

Contingent effective date—2014 c 84 § 3: "Section 3 of this act takes effect January 1st following the issuance of a report under section 2(3) of this act indicating that coverage was terminated due to nonpayment of premium for ten thousand or more enrollees who were in the grace period in that calendar year. In no case may section 3 of this act take effect before January 1, 2015. The health benefit exchange must provide notice of the effective date of section 3 of this act to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the health benefit exchange." [2014 c 84 § 4.] The health benefit exchange issued a report meeting the contingency requirements of this section on December 1, 2014; therefore, the effective date of section 3, chapter 84, Laws of 2014 is January 1, 2015.

48.43.041 Individual health benefit plans—Mandatory benefits. (1) All individual health benefit plans, other than catastrophic health plans, offered or renewed on or after

October 1, 2000, shall include benefits described in this section. Nothing in this section shall be construed to require a carrier to offer an individual health benefit plan.

(a) Maternity services that include, with no enrollee cost-sharing requirements beyond those generally applicable cost-sharing requirements: Diagnosis of pregnancy; prenatal care; delivery; care for complications of pregnancy; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; appropriate medications; anesthesia; and services required under RCW 48.43.115; and

(b) Prescription drug benefits with at least a two thousand dollar benefit payable by the carrier annually.

(2) If a carrier offers a health benefit plan that is not a catastrophic health plan to groups, and it chooses to offer a health benefit plan to individuals, it must offer at least one health benefit plan to individuals that is not a catastrophic health plan. [2000 c 79 § 26.]

*Reviser's note: Section 26 of this act takes effect October 1, 2000.

Additional notes found at www.leg.wa.gov

48.43.043 Colorectal cancer examinations and laboratory tests—Required benefits or coverage. (1) Health plans issued or renewed on or after July 1, 2008, must provide benefits or coverage for colorectal cancer examinations and laboratory tests consistent with the guidelines or recommendations of the United States preventive services task force or the federal centers for disease control and prevention. Benefits or coverage must be provided:

(a) For any of the colorectal screening examinations and tests in the selected guidelines or recommendations, at a frequency identified in such guidelines or recommendations, as deemed appropriate by the patient's physician after consultation with the patient; and

(b) To a covered individual who is:

(i) At least fifty years old; or

(ii) Less than fifty years old and at high risk or very high risk for colorectal cancer according to such guidelines or recommendations.

(2) To encourage colorectal cancer screenings, patients and health care providers must not be required to meet burdensome criteria or overcome significant obstacles to secure such coverage. An individual may not be required to pay an additional deductible or coinsurance for testing that is greater than an annual deductible or coinsurance established for similar benefits. If the health plan does not cover a similar benefit, a deductible or coinsurance may not be set at a level that materially diminishes the value of the colorectal cancer benefit required.

(3)(a) A health carrier is not required under this section to provide for a referral to a nonparticipating health care provider, unless the carrier does not have an appropriate health care provider that is available and accessible to administer the screening exam and that is a participating health care provider with respect to such treatment.

(b) If a health carrier refers an individual to a nonparticipating health care provider pursuant to this section, screening exam services or resulting treatment, if any, must be provided at no additional cost to the individual beyond what the individual would otherwise pay for services provided by a participating health care provider. [2007 c 23 § 1.]

48.43.045 Health plan requirements—Annual reports—Exemptions. (1) Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:

(a) Permit every category of health care provider to provide health services or care included in the basic essential health benefits benchmark plan established by the commissioner consistent with RCW 48.43.715, to the extent that:

(i) The provision of such health services or care is within the health care providers' permitted scope of practice;

(ii) The providers agree to abide by standards related to:

(A) Provision, utilization review, and cost containment of health services;

(B) Management and administrative procedures; and

(C) Provision of cost-effective and clinically efficacious health services; and

(iii) The plan covers such services or care in the essential health benefits benchmark plan. The reference to the essential health benefits does not create a mandate to cover a service that is otherwise not a covered benefit.

(b) Annually report the names and addresses of all officers, directors, or trustees of the health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals, unless substantially similar information is filed with the commissioner or the national association of insurance commissioners. This requirement does not apply to a foreign or alien insurer regulated under chapter 48.20 or 48.21 RCW that files a supplemental compensation exhibit in its annual statement as required by law.

(2) The requirements of subsection (1)(a) of this section do not apply to a licensed health care profession regulated under Title 18 RCW when the licensing statute for the profession states that such requirements do not apply. [2015 c 237 § 2; 2007 c 253 § 12; 2007 c 98 § 18; 2006 c 25 § 7; 1997 c 231 § 205; 1995 c 265 § 8.]

Additional notes found at www.leg.wa.gov

48.43.047 Health plans—Minimum coverage for preventative services—No cost-sharing requirements. (1) A health plan issued on or after June 7, 2018, must, at a minimum, provide coverage for the same preventative services required to be covered under 42 U.S.C. Sec. 300gg-13 (2016) and any federal rules or guidance in effect on December 31, 2016, implementing 42 U.S.C. Sec. 300gg-13.

(2) The health plan may not impose cost-sharing requirements for the preventative services required to be covered under subsection (1) of this section.

(3) The insurance commissioner shall enforce this section consistent with federal rules, guidance, and case law in effect on December 31, 2016, applicable to 42 U.S.C. 300gg-13 (2016). [2018 c 14 § 1.]

48.43.049 Health carrier data—Information from annual statement—Format prescribed by commissioner—Public availability. (1) Each health carrier offering a health benefit plan shall submit to the commissioner on or before April 1st of each year as part of the additional data statement or as a supplemental data statement the following information:

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(a) The following information for the preceding year that is derived from the carrier's annual statement, including the exhibit of premiums, enrollments, and utilization for its Washington business, and the additional data to the annual statement. The information must be shown for five categories, total, individual contracts, small group contracts, and large group contracts (excluding government contracts), and government contracts:

(i) The total number of members;

(ii) The total amount of revenue;

(iii) The total amount of hospital and medical payments;

(iv) The medical loss ratio, that is computed by dividing the total amount of hospital and medical payments by the total amount of revenues;

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

(vi) The percentage change in the average premium per member per month, measured from the previous year; and

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual statement:

(i) The total amount of claim adjustment expenses;

(ii) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses and the assessment against the carrier for the Washington state health insurance pool;

(iii) The total amount of the reserves maintained for unpaid claims;

(iv) The total net underwriting gain or loss;

(v) The carrier's net income after taxes;

(vi) Dividends to stockholders;

(vii) The net change in capital and surplus from the prior year; and

(viii) The total amount of the capital and surplus.

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

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

(4) For the purposes of licensed disability insurers, the commissioner shall work collaboratively with insurers to develop an additional or supplemental data statement that utilizes to the maximum extent possible information from the annual statement forms that are currently filed by these entities. [2006 c 104 § 2.]

Intent—2006 c 104: "Health carriers are currently required to file statutory annual statements with the office of the insurance commissioner or the national association of insurance commissioners. These annual statements are extensive and contain a significant amount of financial information. These annual statements are public documents; however, such financial information can be complex and difficult to read and understand.

It is the intent of this act to provide a method of reporting certain financial data in a user-friendly format. It is also the intent of this act, to the extent possible, to utilize existing information from the annual statements when developing the additional or supplemental data statement required by this act, and to the extent possible, avoid imposing additional reporting requirements that have the unintended consequences of unduly increasing administrative costs for carriers required to file such information." [2006 c 104 § 1.]

48.43.055 Procedures for review and adjudication of health care provider complaints—Requirements. (1)

[Title 48 RCW—page 319]

Except as provided by subsection (2) of this section, each health carrier as defined under RCW 48.43.005 shall file with the commissioner its procedures for review and adjudication of complaints initiated by health care providers. Procedures filed under this section shall provide a fair review for consideration of complaints. Every health carrier shall provide reasonable means allowing any health care provider aggrieved by actions of the health carrier to be heard after submitting a written request for review. If the health carrier fails to grant or reject a request within thirty days after it is made, the complaining health care provider may proceed as if the complaint had been rejected. A complaint that has been rejected by the health carrier may be submitted to nonbinding mediation. Mediation shall be conducted under chapter 7.07 RCW, or any other rules of mediation agreed to by the parties. This section is solely for resolution of provider complaints. Complaints by, or on behalf of, a covered person are subject to the grievance processes in RCW 48.43.530.

(2) For purposes of out-of-network payment disputes between a health carrier and health care provider covered under the provisions of chapter 48.49 RCW, the arbitration provisions of chapter 48.49 RCW apply. [2019 c 427 § 28; 2005 c 172 § 19; 2002 c 300 § 6; 1995 c 265 § 20.]

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

Additional notes found at www.leg.wa.gov

48.43.059 Payments made by a second-party payment process—Definition. (1) For the purposes of this section, "second-party payment process" means a process in which: (a) An individual has an account under his or her name maintained with a financial institution and is either managed by the financial institution or an entity that, with the express agreement with the individual, has established the account on behalf of the individual with a financial institution; (b) the account is funded with funds from the individual or his or her family members or in a manner otherwise consistent with federal law including, but not limited to, federal guidance implementing the federal patient protection and affordable care act; and (c) the account is under the control of the covered person, such that the covered person may authorize payments from the account.

(2) All issuers must accept any payments made by a second-party payment process; however, no issuer need accept payment by a second-party payment process if the second-party payer is controlled by or receives funding from any entity where such entity may be reimbursed by an issuer for providing health care services or if the account under the control of the covered person is funded by any such entity, except those third-party entities from whom federal law requires such issuer to accept payment.

(3) Payments made under subsection (2) of this section may be made with any legal tender denominated in United States dollars. [2015 c 284 § 2.]

Recognition—Intent—2015 c 284: "(1) The legislature recognizes that under regulations implementing the federal patient protection and affordable care act, issuers offering individual market qualified health plans are required to accept third-party premium and cost-sharing payments from the Ryan White HIV/AIDS program under Title XXVI of the public health service act, Indian tribes, tribal organizations or urban Indian organizations, and state and federal government programs. However, federal regulators have stated that they have serious concerns about payments made on a third-party

basis by hospitals, health care providers, and other commercial entities using their own funds because of the potential that such payments could cause distortions in the insurance market.

(2) The legislature intends to clarify that an entity that makes premium payments from accounts that are owned and controlled by the covered person do not constitute a third party for the purposes of acceptance of premium payments by an issuer. The legislature does not intend to impact third-party payment programs required under federal law, including, but not limited to, federal guidance implementing the federal patient protection and affordable care act." [2015 c 284 § 1.]

48.43.065 Right of individuals to receive services—Right of providers, carriers, and facilities to refuse to participate in or pay for services for reason of conscience or religion—Requirements. (1) The legislature recognizes that every individual possesses a fundamental right to exercise their religious beliefs and conscience. The legislature further recognizes that in developing public policy, conflicting religious and moral beliefs must be respected. Therefore, while recognizing the right of conscientious objection to participating in specific health services, the state shall also recognize the right of individuals enrolled with plans containing the basic health plan services to receive the full range of services covered under the plan.

(2)(a) No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objection.

(b) The provisions of this section are not intended to result in an enrollee being denied timely access to any service included in the basic health plan services. Each health carrier shall:

(i) Provide written notice to enrollees, upon enrollment with the plan, listing services that the carrier refuses to cover for reason of conscience or religion;

(ii) Provide written information describing how an enrollee may directly access services in an expeditious manner; and

(iii) Ensure that enrollees refused services under this section have prompt access to the information developed pursuant to (b)(ii) of this subsection.

(c) The insurance commissioner shall establish by rule a mechanism or mechanisms to recognize the right to exercise conscience while ensuring enrollees timely access to services and to assure prompt payment to service providers.

(3)(a) No individual or organization with a religious or moral tenet opposed to a specific service may be required to purchase coverage for that service or services if they object to doing so for reason of conscience or religion.

(b) The provisions of this section shall not result in an enrollee being denied coverage of, and timely access to, any service or services excluded from their benefits package as a result of their employer's or another individual's exercise of the conscience clause in (a) of this subsection.

(c) The insurance commissioner shall define by rule the process through which health carriers may offer the basic health plan services to individuals and organizations identified in (a) and (b) of this subsection in accordance with the provisions of subsection (2)(c) of this section.

(4) Nothing in this section requires a health carrier, health care facility, or health care provider to provide any health care services without appropriate payment of premium or fee. [1995 c 265 § 25.]

Additional notes found at www.leg.wa.gov

48.43.071 Health care information—Requirement to provide free copy to covered person appealing denial of social security benefits—Exceptions. Upon request of a covered person or a covered person's personal representative, an issuer shall provide the covered person or representative with one copy of the covered person's health care information free of charge if the covered person is appealing the denial of federal supplemental security income or social security disability benefits. The issuer may provide the health care information in either paper or electronic format. An issuer is not required to provide a covered person or a covered person's personal representative with a free copy of health care information that has previously been provided free of charge pursuant to a request within the preceding two years. For purposes of this section, "health care information" has the same meaning as in RCW 70.02.010. [2018 c 87 § 4.]

48.43.072 Required reproductive health care coverage—Restrictions on copayments, deductibles, and other form of cost sharing. (1) A health plan or student health plan, including student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration or to be guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, shall provide coverage for:

(a) All contraceptive drugs, devices, and other products, approved by the federal food and drug administration, including over-the-counter contraceptive drugs, devices, and products, approved by the federal food and drug administration. This includes condoms, regardless of the gender or sexual orientation of the covered person, and regardless of whether they are to be used for contraception or exclusively for the prevention of sexually transmitted infections;

(b) Voluntary sterilization procedures;

(c) The consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices, and other products or services in (a) and (b) of this subsection;

(d) The following preventive services:

(i) Screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault; and

(ii) Well-person preventive visits;

(e) Medically necessary services and prescription medications for the treatment of physical, mental, sexual, and reproductive health care needs that arise from a sexual assault; and

(f) The following reproductive health-related over-the-counter drugs and products approved by the federal food and drug administration: Prenatal vitamins for pregnant persons; and breast pumps for covered persons expecting the birth or adoption of a child.

(2) The coverage required by subsection (1) of this section:

(a) May not require copayments, deductibles, or other forms of cost sharing:

(i) Except for:

(A) The medically necessary services and prescription medications required by subsection (1)(e) of this section; and

(B) The drugs and products in subsection (1)(f) of this section; or

(ii) Unless the health plan is offered as a qualifying health plan for a health savings account. For such a qualifying health plan, the carrier must establish the plan's cost sharing for the coverage required by subsection (1) of this section at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws and regulations; and

(b) May not require a prescription to trigger coverage of over-the-counter contraceptive drugs, devices, and products, approved by the federal food and drug administration, except those reproductive health-related drugs and products as set forth in subsection (1)(f) of this section.

(3) A health carrier may not deny the coverage required in subsection (1) of this section because an enrollee changed the enrollee's contraceptive method within a twelve-month period.

(4) Except as otherwise authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage required under this section, such as medical management techniques that limit enrollee choice in accessing the full range of contraceptive drugs, devices, or other products, approved by the federal food and drug administration.

(5) Benefits provided under this section must be extended to all enrollees, enrolled spouses, and enrolled dependents.

(6) This section may not be construed to allow for denial of care on the basis of race, color, national origin, sex, sexual orientation, gender expression or identity, marital status, age, citizenship, immigration status, or disability.

(7) A health plan or student health plan, including student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration or to be guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, issued or renewed on or after January 1, 2021, may not issue automatic initial denials of coverage for reproductive health care services that are ordinarily or exclusively available to individuals of one gender, based on the fact that the individual's gender assigned at birth, gender identity, or gender otherwise recorded in one or more government-issued documents, is different from the one to which such health services are ordinarily or exclusively available.

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

(a) "Gender expression" means a person's gender-related appearance and behavior, whether or not stereotypically associated with the person's gender assigned at birth.

(b) "Gender identity" means a person's internal sense of the person's own gender, regardless of the person's gender assigned at birth.

(c) "Reproductive health care services" means any medical services or treatments, including pharmaceutical and preventive care service or treatments, directly involved in the reproductive system and its processes, functions, and organs involved in reproduction, in all stages of life. Reproductive health care services does not include infertility treatment.

(d) "Reproductive system" includes, but is not limited to: Genitals, gonads, the uterus, ovaries, fallopian tubes, and breasts.

(e) "Well-person preventive visits" means the preventive annual visits recommended by the federal health resources and services administration women's preventive services guidelines, with the understanding that those visits must be covered for women, and when medically appropriate, for transgender, nonbinary, and intersex individuals.

(9) This section may not be construed to authorize discrimination on the basis of gender identity or expression, or perceived gender identity or expression, in the provision of nonreproductive health care services.

(10) The commissioner, under RCW 48.30.300, and the human rights commission, under chapter 49.60 RCW[,] shall share enforcement authority over complaints of discrimination under this section as set forth in RCW 49.60.178.

(11) The commissioner may adopt rules to implement this section. [2019 c 399 § 3; 2018 c 119 § 2.]

Recommendations—Preexposure and postexposure prophylaxis financial support awareness—2019 c 399: "The department of health shall develop recommendations for increasing awareness about financial support that is available for preexposure and postexposure prophylaxis. The department of health shall consult with the state board of health, the health care authority, and the health benefit exchange in developing its recommendation related to outreach and education to affected populations. By December 1, 2019, the department of health shall provide its recommendations to the appropriate committees of the legislature." [2019 c 399 § 7.]

Effective dates—2019 c 399 §§ 2 and 3: See note following RCW 74.09.875.

Findings—Short title—2019 c 399: See notes following RCW 74.09.875.

Findings—Declarations—2018 c 119: "The legislature finds and declares that:

(1) Washington has a long history of protecting gender equity and women's reproductive health;

(2) Access to the full range of health benefits and preventive services, as guaranteed under the laws of this state, provides all Washingtonians with the opportunity to lead healthier and more productive lives;

(3) Reproductive health care is the care necessary to support the reproductive system, the capability to reproduce, and the freedom and services necessary to decide if, when, and how often to do so, which can include contraception, cancer and disease screenings, abortion, preconception, maternity, prenatal, and postpartum care. This care is an essential part of primary care for women and teens, and often reproductive health issues are the primary reason they seek routine medical care;

(4) Neither a woman's income level nor her type of insurance should prevent her from having access to a full range of reproductive health care, including contraception and abortion services;

(5) Restrictions and barriers to health coverage for reproductive health care have a disproportionate impact on low-income women, women of color, immigrant women, and young women, and these women are often already disadvantaged in their access to the resources, information, and services necessary to prevent an unintended pregnancy or to carry a healthy pregnancy to term;

(6) This state has a history of supporting and expanding timely access to comprehensive contraceptive access to prevent unintended pregnancy;

(7) Existing state and federal law should be enhanced to ensure greater contraceptive coverage and timely access for all individuals covered by health plans in Washington to all methods of contraception approved by the federal food and drug administration;

(8) Nearly half of pregnancies in both the United States and Washington are unintended. Unintended pregnancy is associated with negative outcomes, such as delayed prenatal care, maternal depression, increased risk of physical violence during pregnancy, low birth weight, decreased mental and physical health during childhood, and lower education attainment for the child;

(9) Access to contraception has been directly connected to the economic success of women and the ability of women to participate in society equally;

(10) Cost-sharing requirements and other barriers can dramatically reduce the use of preventive health care measures, particularly for women in lower income households, and eliminating cost sharing and other barriers for contraceptives leads to sizable increases in the use of preventive health care measures;

(11) It is vital that the full range of contraceptives are available to women because contraindications may restrict the use of certain types of contraceptives and because women need access to the contraceptive method most effective for their health;

(12) Medical management techniques such as denials, step therapy, or prior authorization in public and private health care coverage can impede access to the most effective contraceptive methods;

(13) Many insurance companies do not typically cover male methods of contraception, or they require high cost sharing despite the critical role men play in the prevention of unintended pregnancy; and

(14) Restrictions on abortion coverage interfere with a woman's personal, private pregnancy decision making, with his or her health and well-being, and with his or her constitutionally protected right to safe and legal medical abortion care." [2018 c 119 § 1.]

48.43.073 Required abortion coverage—Limitations.

(1) Except as provided in subsection (5) of this section, if a health plan issued or renewed on or after January 1, 2019, provides coverage for maternity care or services, the health plan must also provide a covered person with substantially equivalent coverage to permit the abortion of a pregnancy. Except as provided in subsection (5) of this section, if a student health plan, including student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration or to be guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, issued or renewed on or after January 1, 2022, provides coverage for maternity care or services, the health plan must also provide a covered person with substantially equivalent coverage to permit the abortion of a pregnancy.

(2)(a) Except as provided in (b) of this subsection, a health plan or student health plan subject to subsection (1) of this section may not limit in any way a person's access to services related to the abortion of a pregnancy.

(b)(i) Coverage for the abortion of a pregnancy may be subject to terms and conditions generally applicable to the health plan or student health plan's coverage of maternity care or services, including applicable cost sharing.

(ii) A health plan or student health plan is not required to cover abortions that would be unlawful under RCW 9.02.120.

(3) Nothing in this section may be interpreted to limit in any way an individual's constitutionally or statutorily protected right to voluntarily terminate a pregnancy.

(4) This section does not, pursuant to 42 U.S.C. Sec. 18054(a)(6), apply to a multistate plan that does not provide coverage for the abortion of a pregnancy.

(5) If the application of this section to a health plan or student health plan results in noncompliance with federal requirements that are a prescribed condition to the allocation of federal funds to the state, this section is inapplicable to the plan to the minimum extent necessary for the state to be in compliance. The inapplicability of this section to a specific health plan or student health plan under this subsection does

not affect the operation of this section in other circumstances. [2021 c 53 § 1; 2018 c 119 § 3.]

Findings—Declarations—2018 c 119: See note following RCW 48.43.072.

48.43.074 Qualified health plans—Single invoice billing—Certification of compliance required in the segregation plan for premium amounts attributable to coverage of abortion services. (1) The legislature intends to codify the state's current practice of requiring health carriers to bill enrollees with a single invoice and to segregate into a separate account the premium attributable to abortion services for which federal funding is prohibited. Washington has achieved full compliance with section 1303 of the federal patient protection and affordable care act by requiring health carriers to submit a single invoice to enrollees and to segregate into a separate account the premium amounts attributable to coverage of abortion services for which federal funding is prohibited. Further, section 1303 states that the act does not preempt or otherwise have any effect on state laws regarding the prohibition of, or requirement of, coverage, funding, or procedural requirements on abortions.

(2) In accordance with RCW 48.43.073 related to requirements for coverage and funding of abortion services, an issuer offering a qualified health plan must:

(a) Bill enrollees and collect payment through a single invoice that includes all benefits and services covered by the qualified health plan; and

(b) Include in the segregation plan required under applicable federal and state law a certification that the issuer's billing and payment processes meet the requirements of this section. [2019 c 399 § 5.]

Effective date—2019 c 399 § 5: "Section 5 of 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 13, 2019]." [2019 c 399 § 10.]

Findings—Short title—2019 c 399: See notes following RCW 74.09.875.

Recommendations—Preexposure and postexposure prophylaxis financial support awareness—2019 c 399: See note following RCW 48.43.072.

48.43.078 Digital breast tomosynthesis—Intent to ensure women with access—Commissioner's and health care authority's duty to clarify mandates. (1) Digital breast tomosynthesis, also called three-dimensional mammography, is the latest advancement in breast imaging. Studies indicate that digital breast tomosynthesis can result in a forty-one percent increase in invasive cancer detection, a fifteen percent decrease in the recall rate from screening mammography, and a twenty-nine percent increase in the detection of all breast cancers. In addition, the American college of radiology has indicated that tomosynthesis is no longer investigational. Therefore, it is the intent of the legislature to ensure women have access to the most effective breast imaging and to clarify that the existing mandate for mammography must include tomosynthesis.

(2) The legislature directs the office of the insurance commissioner to clarify that the existing mandates for mammography in RCW 48.20.393, 48.21.225, 48.44.325, and 48.46.275 include coverage for tomosynthesis under the same terms and conditions currently allowed for mammogra-

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phy. The application of a deductible and cost sharing is prohibited, consistent with 42 U.S.C. Sec. 300-gg-13.

(3) The legislature also directs the health care authority to clarify that the existing mandate for mammography in RCW 41.05.180 includes coverage for tomosynthesis under the same terms and conditions currently allowed for mammography. The application of a deductible and cost sharing is prohibited, consistent with 42 U.S.C. Sec. 300-gg-13. [2018 c 115 § 1.]

48.43.081 Anatomic pathology services—Payment for services—Definitions. (1) A clinical laboratory or physician, located in this state, or in another state, providing anatomic pathology services for patients in this state, shall present or cause to be presented a claim, bill, or demand for payment for these services only to the following:

(a) The patient;

(b) The responsible insurer or other third-party payer;

(c) The hospital, public health clinic, or nonprofit health clinic ordering such services;

(d) A direct patient-provider primary care practice regulated by chapter 48.150 RCW, provided the practice:

(i) Is in compliance with all applicable provisions of law to regulate that practice;

(ii) Has furnished a written confirmation to the physician or laboratory providing the anatomic pathology service that the patient is not covered for anatomic pathology services under any health insurance plan or program;

(iii) Furnishes the patient with an itemized bill that does not, directly or indirectly, mark up or increase the actual amount billed by the physician or clinical laboratory that performed the service; and

(iv) Discloses to the patient, through printed material or through a web site, that all anatomic pathology services are billed at exactly the amount charged for the service by the physician or laboratory that provided the service, and the identity of the provider;

(e) The referring laboratory, excluding a laboratory of a physician's office or group practice that does not perform the professional component of the anatomic pathology service for which such claim, bill, or demand is presented; or

(f) Governmental agencies or their specified public or private agent, agency, or organization on behalf of the recipient of the services.

(2) Except for a physician at a referring laboratory that has been billed pursuant to subsection (1)(d) or (6) of this section, no licensed practitioner in the state may, directly or indirectly, charge, bill, or otherwise solicit payment for anatomic pathology services unless such services were rendered personally by the licensed practitioner or under the licensed practitioner's direct supervision in accordance with section 353 of the public health service act (42 U.S.C. Sec. 263a).

(3) No patient, insurer, third-party payer, hospital, public health clinic, or nonprofit health clinic may be required to reimburse any licensed practitioner for charges or claims submitted in violation of this section.

(4) Nothing in this section may be construed to mandate the assignment of benefits for anatomic pathology services as defined in this section.

(5) For purposes of this section, "anatomic pathology services" means:

(a) Histopathology or surgical pathology, meaning the gross and microscopic examination performed by a physician or under the supervision of a physician, including histologic processing;

(b) Cytopathology, meaning the microscopic examination of cells from the following: (i) Fluids, (ii) aspirates, (iii) washings, (iv) brushings, or (v) smears, including the pap test examination performed by a physician or under the supervision of a physician;

(c) Hematology, meaning the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician, or under the supervision of a physician, and peripheral blood smears when the attending or treating physician, or technologist requests that a blood smear be reviewed by a pathologist;

(d) Subcellular pathology or molecular pathology, meaning the assessment of a patient specimen for the detection, localization, measurement, or analysis of one or more protein or nucleic acid targets; and

(e) Blood-banking services performed by pathologists.

(6) The provisions of this section do not prohibit billing of a referring laboratory for anatomic pathology services in instances where a sample or samples must be sent to another physician or laboratory for consultation or histologic processing, except that for purposes of this subsection the term "referring laboratory" does not include a laboratory of a physician's office or group practice that does not perform the professional component of the anatomic pathology service involved.

(7) The uniform disciplinary act, chapter 18.130 RCW, governs the discipline of any practitioner who violates the provisions of this section. [2012 c 100 § 1; 2011 c 128 § 1.]

Retroactive application—2012 c 100: "Section 1 of this act applies retroactively to July 22, 2011, so that no entity is liable for having presented or caused to be presented a claim, bill, or demand for payment to a direct patient-provider primary care practice in accordance with section 1(1)(d) of this act." [2012 c 100 § 2.]

48.43.083 Chiropractor services—Participating provider agreement—Health carrier reimbursement. (1) A health carrier must reimburse a chiropractor who has signed a participating provider agreement for services determined by the carrier to be medically necessary if:

(a) The service is:

(i) Covered chiropractic health care, as defined in RCW 48.43.515, by the health plan under which the enrollee received the services; and

(ii) Provided by the chiropractor, or the chiropractor's employee specified in RCW 18.25.190 (2) or (3) who works in the same location as the chiropractor and to whom the chiropractor, pursuant to rules adopted by the Washington state chiropractic quality assurance commission, has delegated the service. The employee must meet the health carrier's reasonable qualifications for all such providers in the relevant class, including but not limited to standards for education and background checks, as applicable; and

(b) The chiropractor complies with the terms and conditions of the participating provider agreement. Violations of the participating provider agreement by an employee of the chiropractor to whom he or she has delegated a service may

be deemed by the carrier to have been committed by the chiropractor.

(2) If a health carrier offers a participating provider agreement to a chiropractor within a single practice organized as a sole proprietorship, partnership, or corporation, the carrier must offer the same participating provider agreement to any other chiropractor within that practice providing services at the same location. The agreement may allow either party to terminate it without cause. [2007 c 502 § 1.]

Additional notes found at www.leg.wa.gov

48.43.085 Health carrier may not prohibit its enrollees from contracting for services outside the health care plan. Notwithstanding any other provision of law, no health carrier subject to the jurisdiction of the state of Washington may prohibit directly or indirectly its enrollees from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the enrollees choose. Nothing in this section shall be construed to bind a carrier for any services delivered outside the health plan. The provisions of this section shall be disclosed pursuant to *RCW 48.43.095(2). The insurance commissioner is prohibited from adopting rules regarding this section. [1996 c 312 § 3.]

*Reviser's note: RCW 48.43.095 was repealed by 2000 c 5 § 29, effective July 1, 2001.

48.43.087 Contracting for services at enrollee's expense—Mental health care practitioner—Conditions—Exception. (1) For purposes of this section:

(a) "Health carrier" includes disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, plans operating under the health care authority under chapter 41.05 RCW, the basic health plan operating under chapter 70.47 RCW, the state health insurance pool operating under chapter 48.41 RCW, insuring entities regulated under this chapter, and health maintenance organizations regulated under chapter 48.46 RCW.

(b) "Intermediary" means a person duly authorized to negotiate and execute provider contracts with health carriers on behalf of mental health care practitioners.

(c) Consistent with their lawful scopes of practice, "mental health care practitioners" includes only the following: Any generally recognized medical specialty of practitioners licensed under chapter 18.57 or 18.71 RCW who provide mental health services, advanced practice psychiatric nurses as authorized by the nursing care quality assurance commission under chapter 18.79 RCW, psychologists licensed under chapter 18.83 RCW, and mental health counselors, marriage and family therapists, and social workers licensed under chapter 18.225 RCW.

(d) "Mental health services" means outpatient services.

(2) Consistent with federal and state law and rule, no contract between a mental health care practitioner and an intermediary or between a mental health care practitioner and a health carrier that is written, amended, or renewed after June 6, 1996, may contain a provision prohibiting a practitioner and an enrollee from agreeing to contract for services solely at the expense of the enrollee as follows:

(a) On the exhaustion of the enrollee's mental health care coverage;

(b) During an appeal or an adverse certification process;

(c) When an enrollee's condition is excluded from coverage; or

(d) For any other clinically appropriate reason at any time.

(3) If a mental health care practitioner provides services to an enrollee during an appeal or adverse certification process, the practitioner must provide to the enrollee written notification that the enrollee is responsible for payment of these services, unless the health carrier elects to pay for services provided.

(4) This section does not apply to a mental health care practitioner who is employed full time on the staff of a health carrier. [2001 c 251 § 33; 1996 c 304 § 1.]

Additional notes found at www.leg.wa.gov

48.43.091 Health carrier coverage of outpatient mental health services—Requirements. Every health carrier that provides coverage for any outpatient mental health service shall comply with the following requirements:

(1) In performing a utilization review of mental health services for a specific enrollee, the utilization review is limited to accessing only the specific health care information contained in the enrollee's record.

(2) In performing an audit of a provider that has furnished mental health services to a carrier's enrollees, the audit is limited to accessing only the records of enrollees covered by the specific health carrier for which the audit is being performed, except as otherwise permitted by RCW 70.02.050 and *71.05.630. [1999 c 87 § 1.]

*Reviser's note: RCW 71.05.630 was repealed by 2013 c 200 § 34, effective July 1, 2014.

48.43.093 Health carrier coverage of emergency medical services—Requirements—Conditions. (1) When conducting a review of the necessity and appropriateness of emergency services or making a benefit determination for emergency services:

(a) A health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. In addition, a health carrier shall not require prior authorization of emergency services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from an out-of-network hospital emergency department, a health carrier shall cover emergency services necessary to screen and stabilize a covered person. In addition, a health carrier shall not require prior authorization of the services provided prior to the point of stabilization.

(b) If an authorized representative of a health carrier authorizes coverage of emergency services, the health carrier shall not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health condition made by the provider of emergency services.

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(c) Coverage of emergency services may be subject to applicable in-network copayments, coinsurance, and deductibles, as provided in chapter 48.49 RCW.

(2) If a health carrier requires preauthorization for postevaluation or poststabilization services, the health carrier shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review. In order for postevaluation or poststabilization services to be covered by the health carrier, the provider or facility must make a documented good faith effort to contact the covered person's health carrier within thirty minutes of stabilization, if the covered person needs to be stabilized. The health carrier's authorized representative is required to respond to a telephone request for preauthorization from a provider or facility within thirty minutes. Failure of the health carrier to respond within thirty minutes constitutes authorization for the provision of immediately required medically necessary postevaluation and poststabilization services, unless the health carrier documents that it made a good faith effort but was unable to reach the provider or facility within thirty minutes after receiving the request.

(3) A health carrier shall immediately arrange for an alternative plan of treatment for the covered person if an out-of-network emergency provider and health carrier cannot reach an agreement on which services are necessary beyond those immediately necessary to stabilize the covered person consistent with state and federal laws.

(4) Nothing in this section is to be construed as prohibiting the health carrier from requiring notification within the time frame specified in the contract for inpatient admission or as soon thereafter as medically possible but no less than twenty-four hours. Nothing in this section is to be construed as preventing the health carrier from reserving the right to require transfer of a hospitalized covered person upon stabilization. Follow-up care that is a direct result of the emergency must be obtained in accordance with the health plan's usual terms and conditions of coverage. All other terms and conditions of coverage may be applied to emergency services. [2019 c 427 § 3; 1997 c 231 § 301.]

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

Additional notes found at www.leg.wa.gov

48.43.094 Pharmacist provided services—Health plan requirements. (Effective until July 1, 2022.) (1) For health plans issued or renewed on or after January 1, 2017:

(a) Benefits shall not be denied for any health care service performed by a pharmacist licensed under chapter 18.64 RCW if:

(i) The service performed was within the lawful scope of such person's license;

(ii) The plan would have provided benefits if the service had been performed by a physician licensed under chapter 18.71 or 18.57 RCW, an advanced registered nurse practitioner licensed under chapter 18.79 RCW, or a physician's assistant licensed under chapter 18.71A or 18.57A RCW; and

(iii) The pharmacist is included in the plan's network of participating providers; and

(b) The health plan must include an adequate number of pharmacists in its network of participating medical providers.

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(2) The participation of pharmacies in the plan network's drug benefit does not satisfy the requirement that plans include pharmacists in their networks of participating medical providers.

(3) For health benefit plans issued or renewed on or after January 1, 2016, but before January 1, 2017, health plans that delegate credentialing agreements to contracted health care facilities must accept credentialing for pharmacists employed or contracted by those facilities. Health plans must reimburse facilities for covered services provided by network pharmacists within the pharmacists' scope of practice per negotiations with the facility.

(4) This section does not supersede the requirements of RCW 48.43.045. [2015 c 237 § 1.]

Lead organization and advisory committee—2015 c 237: "(1) The insurance commissioner shall designate a lead organization to establish and facilitate an advisory committee to implement the provisions of section 1 of this act. The lead organization and advisory committee shall develop best practice recommendations on standards for credentialing, privileging, billing, and payment processes to ensure pharmacists are adequately included and appropriately utilized in participating provider networks of health plans. In developing these standards, the committee shall also discuss topics as they relate to implementation including current credentialing requirements for health care providers consistent with chapter 18.64 RCW, existing processes of similarly situated health care providers, pharmacist training, care coordination, and the role of pharmacist prescriptive authority agreements pursuant to WAC 246-863-100.

(2) The lead organization shall create an advisory committee including, but not limited to, representatives of the following stakeholders:

- (a) The insurance commissioner or designee;
- (b) The secretary of health or designee;
- (c) An organization representing pharmacists;
- (d) An organization representing physicians;
- (e) An organization representing hospitals;
- (f) A hospital conducting internal credentialing of pharmacists;
- (g) A clinic with pharmacists providing medical services;
- (h) A community pharmacy with pharmacists providing medical services;
- (i) The two largest health carriers in Washington based upon enrollment;
- (j) A health care system that coordinates care and coverage;
- (k) A school or college of pharmacy in Washington;
- (l) A representative from a pharmacy benefit manager or organization that represents pharmacy benefit managers; and
- (m) Other representatives appointed by the insurance commissioner.

(3) No later than December 1, 2015, the advisory committee shall present initial best practice recommendations to the insurance commissioner and the department of health. If necessary, the insurance commissioner or department of health may adopt rules to implement the standards developed by the lead organization and advisory committee. The advisory committee will remain intact to assist the insurance commissioner or department of health in rule making. The rules adopted by the insurance commissioner or the department of health must be consistent with the recommendations developed by the advisory committee.

(4) For purposes of this section, "lead organization" means a private sector organization or organizations designated by the insurance commissioner to lead development of processes, guidelines, and standards to streamline health care administration to be adopted by payors and providers of health care services operating in the state." [2015 c 237 § 3.]

48.43.094 Pharmacist provided services—Health plan requirements. (Effective July 1, 2022.) (1) For health plans issued or renewed on or after January 1, 2017:

(a) Benefits shall not be denied for any health care service performed by a pharmacist licensed under chapter 18.64 RCW if:

- (i) The service performed was within the lawful scope of such person's license;
- (ii) The plan would have provided benefits if the service had been performed by a physician licensed under chapter

18.71 or 18.57 RCW, an advanced registered nurse practitioner licensed under chapter 18.79 RCW, or a physician's assistant licensed under chapter 18.71A RCW; and

(iii) The pharmacist is included in the plan's network of participating providers; and

(b) The health plan must include an adequate number of pharmacists in its network of participating medical providers.

(2) The participation of pharmacies in the plan network's drug benefit does not satisfy the requirement that plans include pharmacists in their networks of participating medical providers.

(3) For health benefit plans issued or renewed on or after January 1, 2016, but before January 1, 2017, health plans that delegate credentialing agreements to contracted health care facilities must accept credentialing for pharmacists employed or contracted by those facilities. Health plans must reimburse facilities for covered services provided by network pharmacists within the pharmacists' scope of practice per negotiations with the facility.

(4) This section does not supersede the requirements of RCW 48.43.045. [2020 c 80 § 36; 2015 c 237 § 1.]

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Lead organization and advisory committee—2015 c 237: "(1) The insurance commissioner shall designate a lead organization to establish and facilitate an advisory committee to implement the provisions of section 1 of this act. The lead organization and advisory committee shall develop best practice recommendations on standards for credentialing, privileging, billing, and payment processes to ensure pharmacists are adequately included and appropriately utilized in participating provider networks of health plans. In developing these standards, the committee shall also discuss topics as they relate to implementation including current credentialing requirements for health care providers consistent with chapter 18.64 RCW, existing processes of similarly situated health care providers, pharmacist training, care coordination, and the role of pharmacist prescriptive authority agreements pursuant to WAC 246-863-100.

(2) The lead organization shall create an advisory committee including, but not limited to, representatives of the following stakeholders:

- (a) The insurance commissioner or designee;
- (b) The secretary of health or designee;
- (c) An organization representing pharmacists;
- (d) An organization representing physicians;
- (e) An organization representing hospitals;
- (f) A hospital conducting internal credentialing of pharmacists;
- (g) A clinic with pharmacists providing medical services;
- (h) A community pharmacy with pharmacists providing medical services;
- (i) The two largest health carriers in Washington based upon enrollment;
- (j) A health care system that coordinates care and coverage;
- (k) A school or college of pharmacy in Washington;
- (l) A representative from a pharmacy benefit manager or organization that represents pharmacy benefit managers; and
- (m) Other representatives appointed by the insurance commissioner.

(3) No later than December 1, 2015, the advisory committee shall present initial best practice recommendations to the insurance commissioner and the department of health. If necessary, the insurance commissioner or department of health may adopt rules to implement the standards developed by the lead organization and advisory committee. The advisory committee will remain intact to assist the insurance commissioner or department of health in rule making. The rules adopted by the insurance commissioner or the department of health must be consistent with the recommendations developed by the advisory committee.

(4) For purposes of this section, "lead organization" means a private sector organization or organizations designated by the insurance commissioner to lead development of processes, guidelines, and standards to streamline health care administration to be adopted by payors and providers of health care services operating in the state." [2015 c 237 § 3.]

48.43.096 Medication synchronization policy required for health plans covering prescription drugs—Requirements—Definitions. (1) A health benefit plan issued or renewed after December 31, 2015, that provides coverage for prescription drugs must implement a medication synchronization policy for the dispensing of prescription drugs to the plan's enrollees.

(a) If an enrollee requests medication synchronization for a new prescription, the health plan must permit filling the drug: (i) For less than a one-month supply of the drug if synchronization will require more than a fifteen-day supply of the drug; or (ii) for more than a one-month supply of the drug if synchronization will require a fifteen-day supply of the drug or less.

(b) The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug subject to coinsurance that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications.

(c) The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug with a copayment that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications by:

(i) Discounting the copayment rate by fifty percent;

(ii) Discounting the copayment rate based on fifteen-day increments; or

(iii) Any other method that meets the intent of this section and is approved by the office of the insurance commissioner.

(2) Upon request of an enrollee, the prescribing provider or pharmacist shall:

(a) Determine that filling or refilling the prescription is in the best interest of the enrollee, taking into account the appropriateness of synchronization for the drug being dispensed;

(b) Inform the enrollee that the prescription will be filled to less than the standard refill amount for the purpose of synchronizing his or her medications; and

(c) Deny synchronization on the grounds of threat to patient safety or suspected fraud or abuse.

(3) For purposes of this section, the following terms have the following meanings unless the context clearly requires otherwise:

(a) "Medication synchronization" means the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period.

(b) "Prescription" has the same meaning as in RCW 18.64.011. [2015 c 213 § 1.]

48.43.097 Filing of financial statements—Every health carrier. Every health carrier holding a registration from the commissioner shall file its financial statements as required by this code 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. [1999 c 33 § 3.]

48.43.105 Preparation of documents that compare health carriers—Immunity—Due diligence. (1) A public or private entity who exercises due diligence in preparing a

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document of any kind that compares health carriers of any kind is immune from civil liability from claims based on the document and the contents of the document.

(2)(a) There is absolute immunity to civil liability from claims based on such a comparison document and its contents if the information was provided by the carrier, was substantially accurately presented, and contained the effective date of the information that the carrier supplied, if any.

(b) Where due diligence efforts to obtain accurate information have been taken, there is immunity from claims based on such a comparison document and its contents if the publisher of the comparison document asked for such information from the carrier, was refused, and relied on any usually reliable source for the information including, but not limited to, carrier enrollees, customers, insurance producers, or providers. The carrier enrollees, customers, insurance producers, or providers are likewise immune from civil liability on claims based on information they provided if they believed the information to be accurate and had exercised due diligence in their efforts to confirm the accuracy of the information provided.

(3) The immunity from liability contained in this section applies only if the comparison document contains the following in a conspicuous place and in easy to read typeface:

This comparison is based on information believed to be reliable by its publisher, but the accuracy of the information cannot be guaranteed. Caution is suggested to all readers who are encouraged to confirm data of importance to the reader before any purchasing or other decisions are made.

(4) The insurance commissioner is prohibited from adopting rules regarding this section. [2008 c 217 § 48; 1996 c 312 § 5.]

Additional notes found at www.leg.wa.gov

48.43.115 Maternity services—Intent—Definitions—Patient preference—Clinical sovereignty of provider—Notice to policyholders—Application. (*Effective until July 1, 2022.*)

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

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

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

or 18.71A RCW, or an advanced registered nurse practitioner licensed under chapter 18.79 RCW.

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

(3)(a) Every health carrier that provides coverage for maternity services must permit the attending provider, in consultation with the mother, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice.

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

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

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

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

(f) Coverage for the newly born child must be no less than the coverage of the child's mother for no less than three weeks, even if there are separate hospital admissions.

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

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

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

(7) This section applies to coverage for maternity services under a contract issued or renewed by a health carrier after June 6, 1996, and applies to plans operating under the

health care authority under chapter 41.05 RCW beginning January 1, 1998. [2003 c 248 § 14; 1996 c 281 § 1.]

Additional notes found at www.leg.wa.gov

48.43.115 Maternity services—Intent—Definitions—Patient preference—Clinical sovereignty of provider—Notice to policyholders—Application. (Effective July 1, 2022.)

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

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

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

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

(3)(a) Every health carrier that provides coverage for maternity services must permit the attending provider, in consultation with the mother, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice.

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

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

(d) Covered eligible services may not be denied for follow-up care, including in-person care, as ordered by the attending provider in consultation with the mother. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section,

home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

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

(f) Coverage for the newly born child must be no less than the coverage of the child's mother for no less than three weeks, even if there are separate hospital admissions.

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

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

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

(7) This section applies to coverage for maternity services under a contract issued or renewed by a health carrier after June 6, 1996, and applies to plans operating under the health care authority under chapter 41.05 RCW beginning January 1, 1998. [2020 c 80 § 37; 2003 c 248 § 14; 1996 c 281 § 1.]

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Additional notes found at www.leg.wa.gov

48.43.125 Coverage at a long-term care facility following hospitalization—Definition. (1) A carrier that provides coverage for a person at a long-term care facility following the person's hospitalization shall, upon the request of the person or his or her legal representative as authorized in RCW 7.70.065, provide such coverage at the facility in which the person resided immediately prior to the hospitalization if:

(a) The person's primary care physician determines that the medical care needs of the person can be met at the requested facility;

(b) The requested facility has all applicable licenses and certifications, and is not under a stop placement order that prevents the person's readmission;

(c) The requested facility agrees to accept payment from the carrier for covered services at the rate paid to similar facilities that otherwise contract with the carrier to provide such services; and

(d) The requested facility, with regard to the following, agrees to abide by the standards, terms, and conditions required by the carrier of similar facilities with which the carrier otherwise contracts: (i) Utilization review, quality assurance, and peer review; and (ii) management and administrative procedures, including data and financial reporting that may be required by the carrier.

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(2) For purposes of this section, "long-term care facility" or "facility" means a nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.025, or assisted living facility licensed under chapter 18.20 RCW. [2012 c 10 § 43; 1999 c 312 § 2.]

Application—2012 c 10: See note following RCW 18.20.010.

Findings—1999 c 312: "The legislature finds that a long-term care facility is home for any individual who resides there, and the individual has the right to receive services in his or her own home and to be cared for by the organization with which he or she has a contractual agreement to provide housing and related services. The legislature further finds that restricting individuals from returning to the long-term care facility in which they were residing prior to hospitalization may detrimentally impact the health and well-being of frail individuals and their families." [1999 c 312 § 1.]

Additional notes found at www.leg.wa.gov

48.43.176 Eosinophilic gastrointestinal associated disorder—Elemental formula. (1) Each health benefit plan issued or renewed after December 31, 2015, must offer benefits or coverage for medically necessary elemental formula, regardless of delivery method, when a licensed physician or other health care provider with prescriptive authority:

(a) Diagnoses a patient with an eosinophilic gastrointestinal associated disorder; and

(b) Orders and supervises the use of the elemental formula.

(2) Nothing in this section prohibits a health benefit plan from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for medically necessary elemental formula. [2014 c 115 § 2.]

48.43.180 Denturist services. Notwithstanding any provision of any certified health plan 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 plan would have provided benefits if such service had been performed by a dentist licensed under chapter 18.32 RCW. [1995 c 1 § 23 (Initiative Measure No. 607, approved November 8, 1994).]

Additional notes found at www.leg.wa.gov

48.43.185 General anesthesia services for dental procedures. (1) Each group health benefit plan that provides coverage for hospital, medical, or ambulatory surgery center services must cover general anesthesia services and related facility charges in conjunction with any dental procedure performed in a hospital or ambulatory surgical center if such anesthesia services and related facility charges are medically necessary because the covered person:

(a) Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or

(b) Has a medical condition that the person's physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the person's physician.

(2) Each group health benefit plan or group dental plan that provides coverage for dental services must cover medically necessary general anesthesia services in conjunction with any covered dental procedure performed in a dental

office if the general anesthesia services are medically necessary because the covered person is under the age of seven or physically or developmentally disabled.

(3) This section does not prohibit a group health benefit plan or group dental plan from:

(a) Applying cost-sharing requirements, maximum annual benefit limitations, and prior authorization requirements to the services required under this section; or

(b) Covering only those services performed by a health care provider, or in a health care facility, that is part of its provider network; nor does it limit the health carrier in negotiating rates and contracts with specific providers.

(4) This section does not apply to medicare supplement policies, or supplemental contracts covering a specified disease or other limited benefits.

(5) For the purpose of this section, "general anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.

(6) This section applies to group health benefit plans and group dental plans issued or renewed on or after January 1, 2002. [2001 c 321 § 2.]

48.43.190 Payment of chiropractic services—Parity.

(1)(a) A health carrier may not pay a chiropractor less for a service or procedure identified under a particular physical medicine and rehabilitation code, evaluation and management code, or spinal manipulation code, as listed in a nationally recognized services and procedures code book such as the American medical association current procedural terminology code book, than it pays any other type of provider licensed under Title 18 RCW for a service or procedure under the same or substantially similar code, except as provided in (b) of this subsection. A carrier may not circumvent this requirement by creating a chiropractor-specific code not listed in the nationally recognized code book otherwise used by the carrier for provider payment.

(b) This section does not affect a health carrier's:

(i) Implementation of a health care quality improvement program to promote cost-effective and clinically efficacious health care services, including but not limited to pay-for-performance payment methodologies and other programs fairly applied to all health care providers licensed under Title 18 RCW that are designed to promote evidence-based and research-based practices;

(ii) Health care provider contracting to comply with the network adequacy standards;

(iii) Authority to pay in-network providers differently than out-of-network providers; and

(iv) Authority to pay a chiropractor less than another provider for procedures or services under the same or a substantially similar code based upon differences in the cost of maintaining a practice or carrying malpractice insurance, as recognized by a nationally accepted reimbursement methodology.

(c) This section does not, and may not be construed to:

(i) Require the payment of provider billings that do not meet the definition of a clean claim as set forth in rules adopted by the commissioner;

(ii) Require any health plan to include coverage of any condition; or

(iii) Expand the scope of practice for any health care provider.

(2) This section applies only to payments made on or after January 1, 2009. [2018 c 181 § 1; 2008 c 304 § 1.]

Rules—2018 c 181 § 1: "The office of the insurance commissioner may adopt any rules necessary to implement section 1 of this act." [2018 c 181 § 2.]

Effective date—2018 c 181 § 1: "Section 1 of this act takes effect January 1, 2019." [2018 c 181 § 3.]

48.43.195 Contraceptive drugs—Twelve-month refill coverage. (1) A health benefit plan issued or renewed on or after January 1, 2018, that includes coverage for contraceptive drugs must provide reimbursement for a twelve-month refill of contraceptive drugs obtained at one time by the enrollee, unless the enrollee requests a smaller supply or the prescribing provider instructs that the enrollee must receive a smaller supply. The health plan must allow enrollees to receive the contraceptive drugs on-site at the provider's office, if available. Any dispensing practices required by the plan must follow clinical guidelines for appropriate prescribing and dispensing to ensure the health of the patient while maximizing access to effective contraceptive drugs.

(2) Nothing in this section prohibits a health plan from limiting refills that may be obtained in the last quarter of the plan year if a twelve-month supply of the contraceptive drug has already been dispensed during the plan year.

(3) For purposes of this section, "contraceptive drugs" means all drugs approved by the United States food and drug administration that are used to prevent pregnancy, including, but not limited to, hormonal drugs administered orally, transdermally, and intravaginally. [2017 c 293 § 2.]

Finding—Intent—2017 c 293: "The legislature finds that a significant percentage of pregnancies are unintended and could be averted with broader access to health care and effective contraception. Research suggests that moving from twenty-eight day dispensing of contraceptive drugs to twelve-month dispensing improves adherence to maintenance of the drugs and effective use of the contraceptives. It is therefore the intent of the legislature to require private health insurers to require dispensing of contraceptive drugs with up to a twelve-month supply provided at one time." [2017 c 293 § 1.]

DISCLOSURE OF MATERIAL TRANSACTIONS

48.43.200 Disclosure of certain material transactions—Report—Information is confidential. (1) Every certified health plan 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 48.43.205 through 48.43.225 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 certified health plan to which it pertains unless the commissioner, after giving the certified health plan 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 § 7.]

48.43.205 Material acquisitions or dispositions. No acquisitions or dispositions of assets need be reported pursuant to RCW 48.43.200 if the acquisitions or dispositions are not material. For purposes of RCW 48.43.200 through 48.43.225, 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 certified health plan's total assets as reported in its most recent statutory statement filed with the commissioner. [1995 c 86 § 8.]

48.43.210 Asset acquisitions—Asset dispositions. (1) Asset acquisitions subject to RCW 48.43.200 through 48.43.225 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 certified health plan or the acquisition of materials for such purpose.

(2) Asset dispositions subject to RCW 48.43.200 through 48.43.225 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 § 9.]

48.43.215 Report of a material acquisition or disposition of assets—Information required. (1) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

- (a) Date of the transaction;
- (b) Manner of acquisition or disposition;
- (c) Description of the assets involved;
- (d) Nature and amount of the consideration given or received;
- (e) Purpose of or reason for the transaction;
- (f) Manner by which the amount of consideration was determined;
- (g) Gain or loss recognized or realized as a result of the transaction; and
- (h) Names of the persons from whom the assets were acquired or to whom they were disposed.

(2021 Ed.)

(2) Certified health plans are required to report material acquisitions and dispositions on a nonconsolidated basis unless the certified health plan is part of a consolidated group of insurers that utilizes a pooling arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the certified health plan's reserves and such certified health plan ceded substantially all of its direct and assumed business to the pool. A certified health plan has ceded substantially all of its direct and assumed business to a pool if the certified health plan has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the certified health plan's net worth. [1995 c 86 § 10.]

48.43.220 Material nonrenewals, cancellations, or revisions of ceded reinsurance agreements. (1) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements need be reported under RCW 48.43.200 if the nonrenewals, cancellations, or revisions are not material. For purposes of RCW 48.43.200 through 48.43.225, a material nonrenewal, cancellation, or revision is one that affects:

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

(b) More than ten percent of a certified health plan'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 the certified health plan'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 § 11.]

48.43.225 Report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements—Information required. (1) The following is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

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

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

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

(d) If applicable, the identity of the replacement reinsurers.

(2) Certified health plans are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the certified health plan is part of a consolidated group of insurers which utilizes a pooling arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the certified health plan's reserves and the certified health plan ceded substantially all of its direct and assumed business to the pool. A certified health plan has ceded substantially all

of its direct and assumed business to a pool if the certified health plan has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the certified health plan's net worth. [1995 c 86 § 12.]

MISCELLANEOUS

48.43.290 Coverage for prescribed durable medical equipment and mobility enhancing equipment—Sales and use taxes—Definitions. (1) Health plans issued or renewed on or after January 1, 2011, that include coverage for prescribed durable medical equipment and mobility enhancing equipment must include the sales tax or use tax calculation in plan payment, consistent with the application of sales tax in chapter 82.08 RCW or use tax in chapter 82.12 RCW.

(2) The payment for covered durable medical equipment and mobility enhancing equipment must:

(a) Reflect the negotiated provider agreement for the prescribed equipment; and

(b) Separately identify the sales tax or use tax calculation that is included in the payment if the provider submitting a claim or invoice for reimbursement submits to the health plan a claim or invoice with a separate line item for the geographically adjusted sales tax.

(3) The following definitions apply to this section unless the context clearly requires otherwise.

(a) "Durable medical equipment" means equipment, including repair and replacement parts for durable medical equipment that:

(i) Can withstand repeated use;

(ii) Is primarily and customarily used to serve a medical purpose;

(iii) Generally is not useful to a person in the absence of illness or injury; and

(iv) Is not worn in or on the body.

(b) "Mobility enhancing equipment" means equipment, including repair and replacement parts for mobility enhancing equipment that:

(i) Is primarily and customarily used to provide or increase the ability to move from one place to another and that is appropriate for use either in a home or a motor vehicle;

(ii) Is not generally used by persons with normal mobility; and

(iii) Does not include any motor vehicle or equipment on a motor vehicle normally provided by a motor vehicle manufacturer. [2010 c 44 § 1.]

RISK-BASED CAPITAL STANDARDS FOR HEALTH CARRIERS

48.43.300 Definitions. The definitions in this section apply throughout RCW 48.43.300 through 48.43.370 unless the context clearly requires otherwise.

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with RCW 48.43.305(4).

(2) "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(3) "Domestic carrier" means any carrier domiciled in this state, or any person or entity subject to chapter 48.42 RCW domiciled in this state.

(4) "Foreign or alien carrier" means any carrier that is licensed to do business in this state but is not domiciled in this state, or any person or entity subject to chapter 48.42 RCW not domiciled in this state.

(5) "NAIC" means the national association of insurance commissioners.

(6) "Negative trend" means, with respect to a carrier, a negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the RBC instructions.

(7) "RBC" means risk-based capital.

(8) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(9) "RBC level" means a carrier's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(a) "Company action level RBC" means, with respect to any carrier, the product of 2.0 and its authorized control level RBC;

(b) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(c) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(d) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(10) "RBC plan" means a comprehensive financial plan containing the elements specified in RCW 48.43.310(2). If the commissioner rejects the RBC plan, and it is revised by the carrier, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

(11) "RBC report" means the report required in RCW 48.43.305.

(12) "Total adjusted capital" means the sum of:

(a) Either a carrier's statutory capital and surplus or net worth, or both, as determined in accordance with statutory accounting applicable to the annual financial statements required to be filed with the commissioner; and

(b) Other items, if any, as the RBC instructions may provide. [1998 c 241 § 1.]

48.43.305 Report of RBC levels—Distribution of report—Formula for determination—Commissioner may make adjustments. (1) Every domestic carrier shall, on or prior to the filing date of March 1st, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, every domestic carrier shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and

(b) With the insurance commissioner in any state in which the carrier is authorized to do business, if the insurance

commissioner has notified the carrier of its request in writing, in which case the carrier shall file its RBC report not later than the later of:

(i) Fifteen days from the receipt of notice to file its RBC report with that state; or

(ii) The filing date.

(2) A carrier's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account (and may adjust for the covariance between):

(a) The risk with respect to the carrier's assets;

(b) The risk of adverse insurance experience with respect to the carrier's liabilities and obligations;

(c) The interest rate risk with respect to the carrier's business; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions; determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) An excess of capital over the amount produced by the risk-based capital requirements contained in RCW 48.43.300 through 48.43.370 and the formulas, schedules, and instructions referenced in RCW 48.43.300 through 48.43.370 is desirable in the business of insurance. Accordingly, carriers should seek to maintain capital above the RBC levels required by RCW 48.43.300 through 48.43.370. Additional capital is used and useful in the insurance business and helps to secure a carrier against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in RCW 48.43.300 through 48.43.370.

(4) If a domestic carrier files an RBC report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the carrier of the adjustment. The notice shall contain a statement of the reason for the adjustment. [1998 c 241 § 2.]

48.43.310 Company action level event—Required RBC plan—Commissioner's review—Notification—Challenge by carrier. (1) "Company action level event" means any of the following events:

(a) The filing of an RBC report by a carrier which indicates that:

(i) The carrier's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; or

(ii) The carrier has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3 and has a negative trend;

(b) The notification by the commissioner to the carrier of an adjusted RBC report that indicates an event in (a) of this subsection, provided the carrier does not challenge the adjusted RBC report under RCW 48.43.330; or

(c) If, under RCW 48.43.330, a carrier challenges an adjusted RBC report that indicates the event in (a) of this subsection, the notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge.

(2) In the event of a company action level event, the carrier shall prepare and submit to the commissioner an RBC plan that:

(a) Identifies the conditions that contribute to the company action level event;

(b) Contains proposals of corrective actions that the carrier intends to take and would be expected to result in the elimination of the company action level event;

(c) Provides projections of the carrier's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, surplus, capital and surplus, and net worth. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(d) Identifies the key assumptions impacting the carrier's projections and the sensitivity of the projections to the assumptions; and

(e) Identifies the quality of, and problems associated with, the carrier's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(3) The RBC plan shall be submitted:

(a) Within forty-five days of the company action level event; or

(b) If the carrier challenges an adjusted RBC report under RCW 48.43.330, within forty-five days after notification to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge.

(4) Within sixty days after the submission by a carrier of an RBC plan to the commissioner, the commissioner shall notify the carrier whether the RBC plan may be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the carrier shall set forth the reasons for the determination, and may set forth proposed revisions that will render the RBC plan satisfactory. Upon notification from the commissioner, the carrier shall prepare a revised RBC plan, that may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) Within forty-five days after the notification from the commissioner; or

(b) If the carrier challenges the notification from the commissioner under RCW 48.43.330, within forty-five days after a notification to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge.

(5) In the event of a notification by the commissioner to a carrier that the carrier's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, subject to the carrier's rights to a hearing under RCW 48.43.330, specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic carrier that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance com-

missioner in any state in which the carrier is authorized to do business if:

(a) Such state has an RBC provision substantially similar to RCW 48.43.335(1); and

(b) The insurance commissioner of that state has notified the carrier of its request for the filing in writing, in which case the carrier shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) Fifteen days after the receipt of notice to file a copy of its RBC plan or revised plan with the state; or

(ii) The date on which the RBC plan or revised RBC plan is filed under subsections (3) and (4) of this section. [2012 c 211 § 8; 1998 c 241 § 3.]

48.43.315 Regulatory action level event—Required RBC plan—Commissioner's review—Notification—Challenge by carrier. (1) "Regulatory action level event" means, with respect to any carrier, any of the following events:

(a) The filing of an RBC report by the carrier which indicates that the carrier's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) The notification by the commissioner to a carrier of an adjusted RBC report that indicates the event in (a) of this subsection, provided the carrier does not challenge the adjusted RBC report under RCW 48.43.330;

(c) If, under RCW 48.43.330, the carrier challenges an adjusted RBC report that indicates the event in (a) of this subsection, the notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge;

(d) The failure of the carrier to file an RBC report by the filing date, unless the carrier has provided an explanation for such failure that is satisfactory to the commissioner and has cured the failure within ten days after the filing date;

(e) The failure of the carrier to submit an RBC plan to the commissioner within the time period set forth in RCW 48.43.310(3);

(f) Notification by the commissioner to the carrier that:

(i) The RBC plan or revised RBC plan submitted by the carrier is, in the judgment of the commissioner, unsatisfactory; and

(ii) The notification constitutes a regulatory action level event with respect to the carrier, provided the carrier has not challenged the determination under RCW 48.43.330;

(g) If, under RCW 48.43.330, the carrier challenges a determination by the commissioner under (f) of this subsection, the notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the challenge;

(h) Notification by the commissioner to the carrier that the carrier has failed to adhere to its RBC plan or revised RBC plan, but only if such failure has a substantial adverse effect on the ability of the carrier to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the carrier has not challenged the determination under RCW 48.43.330; or

(i) If, under RCW 48.43.330, the carrier challenges a determination by the commissioner under (h) of this subsection,

the notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the challenge.

(2) In the event of a regulatory action level event the commissioner shall:

(a) Require the carrier to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform the examination or analysis the commissioner deems necessary of the assets, liabilities, and operations of the carrier including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying those corrective actions the commissioner determines are required.

(3) In determining corrective actions, the commissioner may take into account those factors deemed relevant with respect to the carrier based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the carrier, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within forty-five days after the occurrence of the regulatory action level event;

(b) If the carrier challenges an adjusted RBC report under RCW 48.43.330 and the challenge is not frivolous in the judgment of the commissioner within forty-five days after the notification to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge; or

(c) If the carrier challenges a revised RBC plan under RCW 48.43.330 and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge.

(4) The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the carrier's RBC plan or revised RBC plan, examine or analyze the assets, liabilities, and operations of the carrier and formulate the corrective order with respect to the carrier. The fees, costs, and expenses relating to consultants shall be borne by the affected carrier or other party as directed by the commissioner. [1998 c 241 § 4.]

48.43.320 Authorized control level event—Commissioner's options. (1) "Authorized control level event" means any of the following events:

(a) The filing of an RBC report by the carrier which indicates that the carrier's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) The notification by the commissioner to the carrier of an adjusted RBC report that indicates the event in (a) of this subsection, provided the carrier does not challenge the adjusted RBC report under RCW 48.43.330;

(c) If, under RCW 48.43.330, the carrier challenges an adjusted RBC report that indicates the event in (a) of this subsection, notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge;

(d) The failure of the carrier to respond, in a manner satisfactory to the commissioner, to a corrective order, provided

the carrier has not challenged the corrective order under RCW 48.43.330; or

(e) If the carrier has challenged a corrective order under RCW 48.43.330 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the carrier to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) In the event of an authorized control level event with respect to a carrier, the commissioner shall:

(a) Take those actions required under RCW 48.43.315 regarding a carrier with respect to which a regulatory action level event has occurred; or

(b) If the commissioner deems it to be in the best interests of either the policyholders or subscribers, or both, and creditors of the carrier and of the public, take those actions necessary to cause the carrier to be placed under regulatory control under chapter 48.31 RCW. In the event the commissioner takes such actions, the authorized control level event is sufficient grounds for the commissioner to take action under chapter 48.31 RCW, and the commissioner shall have the rights, powers, and duties with respect to the carrier as are set forth in chapter 48.31 RCW. In the event the commissioner takes actions under this subsection (2)(b) pursuant to an adjusted RBC report, the carrier is entitled to those protections afforded to carriers under the provisions of RCW 48.31.121 pertaining to summary proceedings. [1998 c 241 § 5.]

48.43.325 Mandatory control level event—Commissioner's duty—Regulatory control. (1) "Mandatory control level event" means any of the following events:

(a) The filing of an RBC report which indicates that the carrier's total adjusted capital is less than its mandatory control level RBC;

(b) Notification by the commissioner to the carrier of an adjusted RBC report that indicates the event in (a) of this subsection, provided the carrier does not challenge the adjusted RBC report under RCW 48.43.330; or

(c) If, under RCW 48.43.330, the carrier challenges an adjusted RBC report that indicates the event in (a) of this subsection, notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge.

(2) In the event of a mandatory control level event, with respect to a carrier, the commissioner shall take those actions necessary to place the carrier under regulatory control under chapter 48.31 RCW. In that event, the mandatory control level event is sufficient grounds for the commissioner to take action under chapter 48.31 RCW, and the commissioner shall have the rights, powers, and duties with respect to the carrier as are set forth in chapter 48.31 RCW. If the commissioner takes actions pursuant to an adjusted RBC report, the carrier is entitled to the protections of RCW 48.31.121 pertaining to summary proceedings. However, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period. [1998 c 241 § 6.]

48.43.330 Carrier's right to hearing—Request by carrier—Date set by commissioner. (1) Upon notification to a carrier by the commissioner of any of the following, the carrier shall have the right to a hearing, in accordance with chapters 48.04 and 34.05 RCW, at which the carrier may challenge any determination or action by the commissioner:

(a) Of an adjusted RBC report; or

(b)(i) That the carrier's RBC plan or revised RBC plan is unsatisfactory; and

(ii) The notification constitutes a regulatory action level event with respect to such carrier; or

(c) That the carrier has failed to adhere to its RBC plan or revised RBC plan and that such failure has a substantial adverse effect on the ability of the carrier to eliminate the company action level event with respect to the carrier in accordance with its RBC plan or revised RBC plan; or

(d) Of a corrective order with respect to the carrier.

(2) The carrier shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under this section. Upon receipt of the carrier's request for a hearing, the commissioner shall set a date for the hearing. The date shall be no less than ten nor more than thirty days after the date of the carrier's request. [1998 c 241 § 7.]

48.43.335 Confidentiality of RBC reports and plans—Use of certain comparisons prohibited—Certain information intended solely for use by commissioner. (1)

All RBC reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of a carrier and any corrective order issued by the commissioner, with respect to any domestic carrier or foreign carrier that are filed with the commissioner constitute information that might be damaging to the carrier if made available to its competitors, and therefore shall be kept confidential by the commissioner. This information shall 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.

(2) The comparison of a carrier's total adjusted capital to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action with respect to the carrier, and is not a means to rank carriers generally. Therefore, except as otherwise required under the provisions of RCW 48.43.300 through 48.43.370, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any carrier, or of any component derived in the calculation, by any carrier, insurance producer, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. However, if any materially false statement with respect to the comparison regarding a carrier's total adjusted capital to its RBC levels (or any of them) or an inappropriate comparison of any other amount to the carrier's

RBC levels is published in any written publication and the carrier is able to demonstrate to the commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the carrier may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(3) The RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of carriers and the need for possible corrective action with respect to carriers and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a carrier or any affiliate is authorized to write. [2008 c 217 § 49; 1998 c 241 § 8.]

Additional notes found at www.leg.wa.gov

48.43.340 Powers or duties of commissioner not limited—Rules. (1) The provisions of RCW 48.43.300 through 48.43.370 are supplemental to any other provisions of the laws and rules of this state, and shall not preclude or limit any other powers or duties of the commissioner under such laws and rules, including, but not limited to, chapter 48.31 RCW.

(2) The commissioner may adopt reasonable rules necessary for the implementation of RCW 48.43.300 through 48.43.370. [1998 c 241 § 9.]

48.43.345 Foreign or alien carriers—Required RBC report—Commissioner may require RBC plan—Mandatory control level event. (1) Any foreign or alien carrier shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended by the later of:

(a) The date an RBC report would be required to be filed by a domestic carrier under RCW 48.43.300 through 48.43.370; or

(b) Fifteen days after the request is received by the foreign or alien carrier. Any foreign or alien carrier shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(2) In the event of a company action level event, regulatory action level event, or authorized control level event with respect to any foreign or alien carrier as determined under the RBC statute applicable in the state of domicile of the carrier or, if no RBC statute is in force in that state, under the provisions of RCW 48.43.300 through 48.43.370, if the insurance commissioner of the state of domicile of the foreign or alien carrier fails to require the foreign or alien carrier to file an RBC plan in the manner specified under that state's RBC statute or, if no RBC statute is in force in that state, under RCW 48.43.310, the commissioner may require the foreign or alien carrier to file an RBC plan with the commissioner. In this event, the failure of the foreign or alien carrier to file an RBC plan with the commissioner is grounds to order the carrier to cease and desist from writing new insurance business in this state.

(3) In the event of a mandatory control level event with respect to any foreign or alien carrier, if no domiciliary

receiver has been appointed with respect to the foreign or alien carrier under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign or alien carrier, the commissioner may apply for an order under RCW 48.31.080 or 48.31.090 to conserve the assets within this state of foreign or alien carriers, and the occurrence of the mandatory control level event is considered adequate grounds for the application. [1998 c 241 § 10.]

48.43.350 No liability or cause of action against commissioner or department. There is no liability on the part of, and no cause of action shall arise against, the commissioner or insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under RCW 48.43.300 through 48.43.370. [1998 c 241 § 11.]

48.43.355 Notice by commissioner to carrier—When effective. All notices by the commissioner to a carrier that may result in regulatory action are effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission, are effective upon the carrier's receipt of such notice. [1998 c 241 § 12.]

48.43.360 Initial RBC reports—Calculation of initial RBC levels—Subsequent reports. For RBC reports to be filed by carriers commencing operations after June 11, 1998, those carriers shall calculate the initial RBC levels using financial projections, considering managed care arrangements, for its first full year in operation. Such projections, including the risk-based capital requirement, must be included as part of a comprehensive business plan that is submitted as part of the application for registration under RCW 48.44.040 and 48.46.030. The resulting RBC requirement shall be reported in the first RBC report submitted under RCW 48.43.305. For subsequent reports, the RBC results using actual financial data shall be included. [1998 c 241 § 13.]

48.43.366 Self-funded multiple employer welfare arrangements. A self-funded multiple employer welfare arrangement, as defined in RCW 48.125.010, is subject to the same RBC reporting requirements as a domestic carrier under RCW 48.43.300 through 48.43.370. [2004 c 260 § 19.]

Additional notes found at www.leg.wa.gov

48.43.370 RBC standards not applicable to certain carriers. RCW 48.43.300 through 48.43.370 shall not apply to a carrier which is subject to the provisions of RCW 48.05.430 through *48.05.490. [1998 c 241 § 15.]

*Reviser's note: RCW 48.05.490 was repealed by 2006 c 25 § 11.

PRESCRIPTION DRUG UTILIZATION MANAGEMENT

48.43.400 Prescription drug utilization management—Definitions. The definitions in this section apply throughout this section and RCW 48.43.410 and 48.43.420 unless the context clearly requires otherwise.

(1) "Clinical practice guidelines" means a systemically developed statement to assist decision making by health care

providers and patients about appropriate health care for specific clinical circumstances and conditions.

(2) "Clinical review criteria" means the written screening procedures, decision rules, medical protocols, and clinical practice guidelines used by a health carrier or prescription drug utilization management entity as an element in the evaluation of medical necessity and appropriateness of requested prescription drugs under a health plan.

(3) "Emergency fill" means a limited dispensed amount of medication that allows time for the processing of prescription drug utilization management.

(4) "Medically appropriate" means prescription drugs that under the applicable standard of care are appropriate: (a) To improve or preserve health, life, or function; (b) to slow the deterioration of health, life, or function; or (c) for the early screening, prevention, evaluation, diagnosis, or treatment of a disease, condition, illness, or injury.

(5) "Prescription drug utilization management" means a set of formal techniques used by a health carrier or prescription drug utilization management entity, that are designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of prescription drugs including, but not limited to, prior authorization and step therapy protocols.

(6) "Prescription drug utilization management entity" means an entity affiliated with, under contract with, or acting on behalf of a health carrier to perform prescription drug utilization management.

(7) "Prior authorization" means a mandatory process that a carrier or prescription drug utilization management entity requires a provider or facility to follow to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan.

(8) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition will be covered by a health carrier. [2019 c 171 § 1.]

Rules—2019 c 171: See note following RCW 48.43.420.

48.43.410 Prescription drug utilization management—Clinical review criteria—Requirement to be evidence-based and updated regularly. For health plans delivered, issued for delivery, or renewed on or after January 1, 2021, clinical review criteria used to establish a prescription drug utilization management protocol must be evidence-based and updated on a regular basis through review of new evidence, research, and newly developed treatments. [2019 c 171 § 2.]

Rules—2019 c 171: See note following RCW 48.43.420.

48.43.420 Prescription drug utilization management—Exception request process—Conditions, requirements, and time frames for approval or denial of requests—Emergency fill coverage—Notice of new policies and procedures. For health plans delivered, issued for delivery, or renewed on or after January 1, 2021:

(1) When coverage of a prescription drug for the treatment of any medical condition is subject to prescription drug utilization management, the patient and prescribing practitioner must have access to a clear, readily accessible, and

convenient process to request an exception through which the prescription drug utilization management can be overridden in favor of coverage of a prescription drug prescribed by a treating health care provider. A health carrier or prescription drug utilization management entity may use its existing medical exceptions process to satisfy this requirement. The process must be easily accessible on the health carrier and prescription drug utilization management entity's web site. Approval criteria must be clearly posted on the health carrier and prescription drug utilization management entity's web site. This information must be in plain language and understandable to providers and patients.

(2) Health carriers must disclose all rules and criteria related to the prescription drug utilization management process to all participating providers, including the specific information and documentation that must be submitted by a health care provider or patient to be considered a complete exception request.

(3) An exception request must be granted if the health carrier or prescription drug utilization management entity determines that the evidence submitted by the provider or patient is sufficient to establish that:

(a) The required prescription drug is contraindicated or will likely cause a clinically predictable adverse reaction by the patient;

(b) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(c) The patient has tried the required prescription drug or another prescription drug in the same pharmacologic class or a drug with the same mechanism of action while under his or her current or a previous health plan, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(d) The patient is currently experiencing a positive therapeutic outcome on a prescription drug recommended by the patient's provider for the medical condition under consideration while on his or her current or immediately preceding health plan, and changing to the required prescription drug may cause clinically predictable adverse reactions, or physical or mental harm to, the patient; or

(e) The required prescription drug is not in the best interest of the patient, based on documentation of medical appropriateness, because the patient's use of the prescription drug is expected to:

(i) Create a barrier to the patient's adherence to or compliance with the patient's plan of care;

(ii) Negatively impact a comorbid condition of the patient;

(iii) Cause a clinically predictable negative drug interaction; or

(iv) Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

(4) Upon the granting of an exception, the health carrier or prescription drug utilization management entity shall authorize coverage for the prescription drug prescribed by the patient's treating health care provider.

(5)(a) For nonurgent exception requests, the health carrier or prescription drug utilization management entity must:

(i) Within three business days notify the treating health care provider that additional information, as disclosed under subsection (2) of this section, is required in order to approve or deny the exception request, if the information provided is not sufficient to approve or deny the request; and

(ii) Within three business days of receipt of sufficient information from the treating health care provider as disclosed under subsection (2) of this section, approve a request if the information provided meets at least one of the conditions referenced in subsection (3) of this section or if deemed medically appropriate, or deny a request if the requested service does not meet at least one of the conditions referenced in subsection (3) of this section.

(b) For urgent exception requests, the health carrier or prescription drug utilization management entity must:

(i) Within one business day notify the treating health care provider that additional information, as disclosed under subsection (2) of this section, is required in order to approve or deny the exception request, if the information provided is not sufficient to approve or deny the request; and

(ii) Within one business day of receipt of sufficient information from the treating health care provider as disclosed under subsection (2) of this section, approve a request if the information provided meets at least one of the conditions referenced in subsection (3) of this section or if deemed medically appropriate, or deny a request if the requested service does not meet at least one of the conditions referenced in subsection (3) of this section.

(c) If a response by a health carrier or prescription drug utilization management entity is not received within the time frames established under this section, the exception request is deemed granted.

(d) For purposes of this subsection, exception requests are considered urgent when an enrollee is experiencing a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

(6) Health carriers must cover an emergency supply fill if a treating health care provider determines an emergency fill is necessary to keep the patient stable while the exception request is being processed. This exception shall not be used to solely justify any further exemption.

(7) When responding to a prescription drug utilization management exception request, a health carrier or prescription drug utilization management entity shall clearly state in their response if the exception request was approved or denied. The health carrier must use clinical review criteria as referenced in RCW 48.43.410 for the basis of any denial. Any denial must be based upon and include the specific clinical review criteria relied upon for the denial and include information regarding how to appeal denial of the exception request. If the exception request from a treating health care provider is denied for administrative reasons, or for not including all the necessary information, the health carrier or prescription drug utilization management entity must inform the provider what additional information is needed and the deadline for its submission.

(8) The health carrier or prescription drug utilization management entity must permit a stabilized patient to remain on a drug during an exception request process.

(9) A health carrier must provide sixty days' notice to providers and patients for any new policies or procedures applicable to prescription drug utilization management protocols. New health carrier policies or procedures may not be applied retroactively.

(10) This section does not prevent:

(a) A health carrier or prescription drug utilization management entity from requiring a patient to try an AB-rated generic equivalent or a biological product that is an interchangeable biological product prior to providing coverage for the equivalent branded prescription drug;

(b) A health carrier or prescription drug utilization management entity from denying an exception for a drug that has been removed from the market due to safety concerns from the federal food and drug administration; or

(c) A health care provider from prescribing a prescription drug that is determined to be medically appropriate. [2019 c 171 § 3.]

Rules—2019 c 171: "The insurance commissioner shall adopt rules necessary for the implementation of this act." [2019 c 171 § 4.]

48.43.430 Prescription medication—Maximum charge at point of sale—Requirements. (1) Beginning January 1, 2021, the maximum amount a health carrier or pharmacy benefit manager may require a person to pay at the point of sale for a covered prescription medication is the lesser of:

(a) The applicable cost sharing for the prescription medication; or

(b) The amount the person would pay for the prescription medication if the person purchased the prescription medication without using a health plan.

(2) A health carrier or pharmacy benefit manager may not require a pharmacist to dispense a brand name prescription medication when a less expensive therapeutically equivalent generic prescription medication is available.

(3) For purposes of this section, "pharmacy benefit manager" has the same meaning as in *RCW 19.340.010. [2020 c 116 § 1.]

***Reviser's note:** RCW 19.340.010 was repealed by 2020 c 240 § 19, effective January 1, 2022. For later enactment, see RCW 48.200.020.

HEALTH CARE PATIENT PROTECTION

48.43.500 Intent—Purpose—2000 c 5. It is the intent of the legislature that enrollees covered by health plans receive quality health care designed to maintain and improve their health. The purpose of chapter 5, Laws of 2000 is to ensure that health plan enrollees:

(1) Have improved access to information regarding their health plans;

(2) Have sufficient and timely access to appropriate health care services, and choice among health care providers;

(3) Are assured that health care decisions are made by appropriate medical personnel;

(4) Have access to a quick and impartial process for appealing plan decisions;

(5) Are protected from unnecessary invasions of health care privacy; and

(6) Are assured that personal health care information will be used only as necessary to obtain and pay for health care or to improve the quality of care. [2000 c 5 § 1.]

Additional notes found at www.leg.wa.gov

48.43.505 Enrollee's and protected individual's right to privacy and confidential services—Health carrier or insurer duties—Requests for confidential communications—Rules. (1) Health carriers and insurers shall adopt policies and procedures that conform administrative, business, and operational practices to protect an enrollee's and protected individual's right to privacy or right to confidential health care services granted under state or federal laws.

(2) A health carrier may not require protected individuals to obtain the policyholder, primary subscriber, or other covered person's authorization to receive health care services or to submit a claim if the protected individual has the right to consent to care.

(3) A health carrier must recognize the right of a protected individual or enrollee to exclusively exercise rights granted under this section regarding health information related to care that the enrollee or protected individual has received.

(4) A health carrier or insurer must direct all communication regarding a protected individual's receipt of sensitive health care services directly to the protected individual receiving care, or to a physical or email address or telephone number specified by the protected individual. A carrier or insurer may not disclose nonpublic personal health information concerning sensitive health care services provided to a protected individual to any person, including the policyholder, the primary subscriber, or any plan enrollees other than the protected individual receiving care, without the express written consent or verbal authorization on a recorded telephone line of the protected individual receiving care. Communications subject to this limitation include the following written, verbal, or electronic communications:

- (a) Bills and attempts to collect payment;
- (b) A notice of adverse benefits determinations;
- (c) An explanations of benefits notice;
- (d) A carrier's request for additional information regarding a claim;
- (e) A notice of a contested claim;
- (f) The name and address of a provider, a description of services provided, and other visit information; and
- (g) Any written, oral, or electronic communication from a carrier that contains protected health information.

(5) Protected individuals may request that health carrier communications regarding the receipt of sensitive health care services be sent to another individual, including the policyholder, primary subscriber, or a health care provider, for the purposes of appealing adverse benefits determinations.

(6) Health carriers shall:

(a) Limit disclosure of any information, including personal health information, about a protected individual who is the subject of the information and shall direct communications containing such information directly to the protected individual, or to a physical or email address or telephone number specified by the protected individual, if he or she requests such a limitation, regardless of whether the information pertains to sensitive services;

(b) Permit protected individuals to use the form described in RCW 48.43.5051(2) and must also allow enrollees and protected individuals to make the request by telephone, email, or the internet;

(c) Ensure that requests for nondisclosure remain in effect until the protected individual revokes or modifies the request in writing;

(d) Limit disclosure of information under this subsection consistent with the protected individual's request; and

(e) Ensure that requests for nondisclosure are implemented no later than three business days after receipt of a request.

(7) Health carriers may not require a protected individual to waive any right to limit disclosure under this section as a condition of eligibility for or coverage under a health benefit plan.

(8) For the protection of patient confidentiality, any communication from a health carrier relating to the provision of health care services, if the communications disclose protected health information, including medical information or provider name and address, relating to receipt of sensitive services, must be provided in the form and format requested by the individual patient receiving care.

(9) The commissioner may adopt rules to implement this section after considering relevant standards adopted by national managed care accreditation organizations and the national association of insurance commissioners, and after considering the effect of those standards on the ability of carriers to undertake enrollee care management and disease management programs. [2019 c 56 § 3; 2000 c 5 § 5.]

Findings—Declarations—Effective date—2019 c 56: See notes following RCW 48.43.5051.

Additional notes found at www.leg.wa.gov

48.43.5051 Requests for confidential communications—Monitoring and ensuring compliance—Standardized form for submission of requests—Rules. (1) The commissioner shall:

(a) Develop a process for the regular collection of information from carriers on requests for confidential communications pursuant to RCW 48.43.505 for the purposes of monitoring compliance, including monitoring:

(i) The effectiveness of the process described in RCW 48.43.505 in allowing protected individuals to redirect insurance communications, the extent to which protected individuals are using the process, and whether the process is working properly; and

(ii) The education and outreach activities conducted by carriers to inform enrollees about their right to confidential communications;

(b) Establish a process for ensuring compliance; and

(c) Develop rules necessary to implement chapter 56, Laws of 2019.

(2) The commissioner shall work with stakeholders to develop and make available to the public a standardized form that a protected individual may submit to a carrier to make a confidential communications request. At minimum, this form must:

(a) Inform a protected individual about the protected individual's right to confidential communications;

(b) Allow a protected individual to indicate where to redirect communications, including a specified physical or email address or specified telephone number; and

(c) Include a disclaimer that it may take up to three business days from the date of receipt for a carrier to process the form. [2019 c 56 § 4.]

Findings—Declarations—2019 c 56: "The legislature finds and declares:

(1) All people deserve the right to choose the health services that are right for them, and the right to confidential access to those health services.

(2) When people are assured of the ability to confidentially access health care services, they are more likely to seek health services, disclose health risk behaviors to a clinician, and return for follow-up care.

(3) When denied confidential access to needed care, people may delay or forgo care, leading to higher rates of unprotected sex, unintended pregnancy, untreated sexually transmitted infections, and mental health issues, or they may turn to public health safety net funds or free clinics to receive confidential care—important resources that should be reserved for people who do not have insurance coverage." [2019 c 56 § 1.]

Effective date—2019 c 56: "This act takes effect January 1, 2020." [2019 c 56 § 8.]

48.43.510 Carrier required to disclose health plan information—Marketing and advertising restrictions—

Rules. (1) A carrier that offers a health plan may not offer to sell a health plan to an enrollee or to any group representative, agent, employer, or enrollee representative without first offering to provide, and providing upon request, the following information before purchase or selection:

(a) A listing of covered benefits, including prescription drug benefits, if any, a copy of the current formulary, if any is used, definitions of terms such as generic versus brand name, and policies regarding coverage of drugs, such as how they become approved or taken off the formulary, and how consumers may be involved in decisions about benefits;

(b) A listing of exclusions, reductions, and limitations to covered benefits, and any definition of medical necessity or other coverage criteria upon which they may be based;

(c) A statement of the carrier's policies for protecting the confidentiality of health information;

(d) A statement of the cost of premiums and any enrollee cost-sharing requirements;

(e) A summary explanation of the carrier's review of adverse benefit determinations and grievance processes;

(f) A statement regarding the availability of a point-of-service option, if any, and how the option operates; and

(g) A convenient means of obtaining lists of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network. The offer to provide the information referenced in this subsection (1) must be clearly and prominently displayed on any information provided to any prospective enrollee or to any prospective group representative, agent, employer, or enrollee representative.

(2) Upon the request of any person, including a current enrollee, prospective enrollee, or the insurance commissioner, a carrier must provide written information regarding any health care plan it offers, that includes the following written information:

(a) Any documents, instruments, or other information referred to in the medical coverage agreement;

(b) A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary

care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral;

(c) Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services;

(d) A written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between a carrier and a provider or network;

(e) Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;

(f) An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan; however, the individual requesting an annual accounting may only receive information about that individual's own care, and may not receive information pertaining to protected individuals who have requested confidential communications pursuant to RCW 48.43.505;

(g) A copy of the carrier's review of adverse benefit determinations grievance process for claim or service denial and its grievance process for dissatisfaction with care; and

(h) Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.

(3) Each carrier shall provide to all enrollees and prospective enrollees a list of available disclosure items.

(4) Nothing in this section requires a carrier or a health care provider to divulge proprietary information to an enrollee, including the specific contractual terms and conditions between a carrier and a provider.

(5) No carrier may advertise or market any health plan to the public as a plan that covers services that help prevent illness or promote the health of enrollees unless it:

(a) Provides all clinical preventive health services provided by the basic health plan, authorized by chapter 70.47 RCW;

(b) Monitors and reports annually to enrollees on standardized measures of health care and satisfaction of all enrollees in the health plan. The state department of health shall recommend appropriate standardized measures for this purpose, after consideration of national standardized measurement systems adopted by national managed care accreditation organizations and state agencies that purchase managed health care services; and

(c) Makes available upon request to enrollees its integrated plan to identify and manage the most prevalent diseases within its enrolled population, including cancer, heart disease, and stroke.

(6) No carrier may preclude or discourage its providers from informing an enrollee of the care he or she requires, including various treatment options, and whether in the providers' view such care is consistent with the plan's health coverage criteria, or otherwise covered by the enrollee's medical coverage agreement with the carrier. No carrier may prohibit,

discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of an enrollee with a carrier. Nothing in this section shall be construed to authorize a provider to bind a carrier to pay for any service.

(7) No carrier may preclude or discourage enrollees or those paying for their coverage from discussing the comparative merits of different carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

(8) Each carrier must communicate enrollee information required in chapter 5, Laws of 2000 by means that ensure that a substantial portion of the enrollee population can make use of the information. Carriers may implement alternative, efficient methods of communication to ensure enrollees have access to information including, but not limited to, web site alerts, postcard mailings, and electronic communication in lieu of printed materials.

(9) The commissioner may adopt rules to implement this section. In developing rules to implement this section, the commissioner shall consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services, as well as opportunities to reduce administrative costs included in health plans. [2019 c 56 § 5; 2012 c 211 § 26; 2009 c 304 § 1; 2000 c 5 § 6.]

Findings—Declarations—Effective date—2019 c 56: See notes following RCW 48.43.5051.

Additional notes found at www.leg.wa.gov

48.43.515 Access to appropriate health services—Enrollee options—Rules. (1) Each enrollee in a health plan must have adequate choice among health care providers.

(2) Each carrier must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. Enrollees also must be permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the enrollee's request for the change.

(3) Each carrier must have a process whereby an enrollee with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time.

(4) Each carrier must provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted. If the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers.

(5) Each carrier shall provide enrollees with direct access to the participating chiropractor of the enrollee's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting enrollees to seeing only providers who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health services as stated in the plan's medical

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coverage agreement, with the exception of any provisions related to prior referral for services.

(6) Each carrier must provide, upon the request of an enrollee, access by the enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice.

(7) Each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the enrollees or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new enrollees to the terminated provider.

(8) Every carrier shall meet the standards set forth in this section and any rules adopted by the commissioner to implement this section. In developing rules to implement this section, the commissioner shall consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services. [2000 c 5 § 7.]

Additional notes found at www.leg.wa.gov

48.43.517 Enrollment of child participating in medical assistance program—Employer-sponsored health plan. When the health care authority has determined that it is cost-effective to enroll a child participating in a medical assistance program under chapter 74.09 RCW in an employer-sponsored health plan, the carrier shall permit the enrollment of the participant who is otherwise eligible for coverage in the health plan without regard to any open enrollment restrictions. The request for special enrollment shall be made by the authority or participant within sixty days of the authority's determination that the enrollment would be cost-effective. [2011 1st sp.s. c 15 § 78; 2007 c 5 § 7.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

48.43.520 Requirement to maintain a documented utilization review program description and written utilization review criteria—Rules. (1) Carriers that offer a health plan shall maintain a documented utilization review program description and written utilization review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Carriers shall make clinical protocols, medical management standards, and other review criteria available upon request to participating providers.

(2) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

(3) A carrier shall not be required to use medical evidence or standards in its utilization review of religious non-medical treatment or religious nonmedical nursing care. [2000 c 5 § 8.]

Additional notes found at www.leg.wa.gov

48.43.525 Prohibition against retrospective denial of health plan coverage—Rules. (1) A health carrier that offers a health plan shall not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered.

(2) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services. [2000 c 5 § 9.]

Additional notes found at www.leg.wa.gov

48.43.530 Requirement for carriers to have comprehensive grievance and appeal processes—Carrier's duties—Procedures—Appeals—Rules. (1) Each carrier and health plan must have fully operational, comprehensive grievance and appeal processes, and for plans that are not grandfathered, fully operational, comprehensive, and effective grievance and review of adverse benefit determination processes that comply with the requirements of this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner must consider applicable grievance and appeal or review of adverse benefit determination process standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services, and for health plans that are not grandfathered health plans as approved by the United States department of health and human services or the United States department of labor. In the case of coverage offered in connection with a group health plan, if either the carrier or the health plan complies with the requirements of this section and RCW 48.43.535, then the obligation to comply is satisfied for both the carrier and the plan with respect to the health insurance coverage.

(2) Each carrier and health plan must process as a grievance an enrollee's expression of dissatisfaction about customer service or the quality or availability of a health service. Each carrier must implement procedures for registering and responding to oral and written grievances in a timely and thorough manner.

(3) Each carrier and health plan must provide written notice to an enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility. Such notice must be sent directly to a protected individual receiving care when accessing sensitive health care services or when a protected individual has requested confidential communication pursuant to RCW 48.43.505(5).

(4) An enrollee's written or oral request that a carrier reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility must be processed as follows:

(a) When the request is made under a grandfathered health plan, the plan and the carrier must process it as an appeal;

(b) When the request is made under a health plan that is not grandfathered, the plan and the carrier must process it as a review of an adverse benefit determination; and

(c) Neither a carrier nor a health plan, whether grandfathered or not, may require that an enrollee file a complaint or grievance prior to seeking appeal of a decision or review of an adverse benefit determination under this subsection.

(5) To process an appeal, each plan that is not grandfathered and each carrier offering that plan must:

(a) Provide written notice to the enrollee when the appeal is received;

(b) Assist the enrollee with the appeal process;

(c) Make its decision regarding the appeal within thirty days of the date the appeal is received. An appeal must be expedited if the enrollee's provider or the carrier's medical director reasonably determines that following the appeal process response timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours of the date the appeal is received;

(d) Cooperate with a representative authorized in writing by the enrollee;

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the enrollee and, with the permission of the enrollee, to the enrollee's providers. The written notice must explain the carrier's and health plan's decision and the supporting coverage or clinical reasons and the enrollee's right to request independent review of the carrier's decision under RCW 48.43.535.

(6) Written notice required by subsection (3) of this section must explain:

(a) The carrier's and health plan's decision and the supporting coverage or clinical reasons; and

(b) The carrier's and grandfathered plan's appeal or for plans that are not grandfathered, adverse benefit determination review process, including information, as appropriate, about how to exercise the enrollee's rights to obtain a second opinion, and how to continue receiving services as provided in this section.

(7) When an enrollee requests that the carrier or health plan reconsider its decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving through the health plan and the carrier's or health plan's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier and health plan must continue to provide that health service until the appeal, or for health plans that are not grandfathered, the review of an adverse benefit determination, is resolved. If the resolution of the appeal, review of an adverse benefit determination, or any review sought by the enrollee under RCW 48.43.535 affirms the carrier's or health plan's decision, the enrollee may be responsible for the cost of this continued health service.

(8) Each carrier and health plan must provide a clear explanation of the grievance and appeal, or for plans that are not grandfathered, the process for review of an adverse benefit determination process upon request, upon enrollment to new enrollees, and annually to enrollees and subcontractors.

(9) Each carrier and health plan must ensure that each grievance, appeal, and for plans that are not grandfathered,

grievance and review of adverse benefit determinations, process is accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance, appeal or review of an adverse benefit determination.

(10)(a) Each plan that is not grandfathered and the carrier that offers it must: Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

(b) Each grandfathered plan and the carrier that offers it must: Track each review of an adverse benefit determination until final resolution; maintain and make accessible to the commissioner, for a period of six years, a log of all such determinations; and identify and evaluate trends in requests for and resolution of review of adverse benefit determinations.

(11) In complying with this section, plans that are not grandfathered and the carriers offering them must treat a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at that time, and any decision to deny coverage in an initial eligibility determination as an adverse benefit determination. [2019 c 56 § 6; 2012 c 211 § 20; 2011 c 314 § 4; 2000 c 5 § 10.]

Findings—Declarations—Effective date—2019 c 56: See notes following RCW 48.43.5051.

Additional notes found at www.leg.wa.gov

48.43.535 Independent review of health care disputes—System for using certified independent review organizations—Rules. (1) There is a need for a process for the fair consideration of disputes relating to decisions by carriers that offer a health plan to deny, modify, reduce, or terminate coverage of or payment for health care services for an enrollee. For purposes of this section, "carrier" also applies to a health plan if the health plan administers the appeal process directly or through a third party.

(2) An enrollee may seek review by a certified independent review organization of a carrier's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the enrollee, or after the carrier has exceeded the timelines for grievances provided in RCW 48.43.530, without good cause and without reaching a decision.

(3) The commissioner must establish and use a rotational registry system for the assignment of a certified independent review organization to each dispute. The system should be flexible enough to ensure that an independent review organization has the expertise necessary to review the particular medical condition or service at issue in the dispute, and that any approved independent review organization does not have a conflict of interest that will influence its independence.

(4) Carriers must provide to the appropriate certified independent review organization, not later than the third business day after the date the carrier receives a request for review, a copy of:

(a) Any medical records of the enrollee that are relevant to the review;

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization;

(c) Any documentation and written information submitted to the carrier in support of the appeal; and

(d) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

(5) Enrollees must be provided with at least five business days to submit to the independent review organization in writing additional information that the independent review organization must consider when conducting the external review. The independent review organization must forward any additional information submitted by an enrollee to the plan or carrier within one business day of receipt by the independent review organization.

(6) The medical reviewers from a certified independent review organization will make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for an enrollee. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

(7) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the enrollee or the enrollee's representative.

(a) An enrollee or carrier may request an expedited external review if the adverse benefit determination or internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function. The independent review organization must make its decision to uphold or reverse the adverse benefit determination or final internal adverse benefit determination and notify the enrollee and the carrier or health plan of the determination as expeditiously as possible but within not more than seventy-two hours after the receipt of the request for expedited external review. If the notice is not in writing, the independent review organization must provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.

(b) For claims involving experimental or investigational treatments, the independent review organization must ensure

that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

(8) Carriers must timely implement the certified independent review organization's determination, and must pay the certified independent review organization's charges.

(9) When an enrollee requests independent review of a dispute under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.

(10) Each certified independent review organization must maintain written records and make them available upon request to the commissioner.

(11) A certified independent review organization may notify the office of the insurance commissioner if, based upon its review of disputes under this section, it finds a pattern of substandard or egregious conduct by a carrier.

(12)(a) The commissioner shall adopt rules to implement this section after considering relevant standards adopted by national managed care accreditation organizations and the national association of insurance commissioners.

(b) This section is not intended to supplant any existing authority of the office of the insurance commissioner under this title to oversee and enforce carrier compliance with applicable statutes and rules. [2012 c 211 § 21; 2011 c 314 § 5; 2000 c 5 § 11.]

Additional notes found at www.leg.wa.gov

48.43.537 Health care disputes—Certifying independent review organizations—Application—Restrictions—Maximum fee schedule for conducting reviews—Rules.

(1) No later than January 1, 2017, the insurance commissioner shall adopt rules providing a procedure and criteria for certifying one or more organizations to perform independent review of health care disputes described in RCW 48.43.535.

(2) The rules must require that the organization ensure:

(a) The confidentiality of medical records transmitted to an independent review organization for use in independent reviews;

(b) That each health care provider, physician, or contract specialist making review determinations for an independent review organization is qualified. Physicians, other health care providers, and, if applicable, contract specialists must be appropriately licensed, certified, or registered as required in Washington state or in at least one state with standards substantially comparable to Washington state. Reviewers may be drawn from nationally recognized centers of excellence, academic institutions, and recognized leading practice sites. Expert medical reviewers should have substantial, recent clinical experience dealing with the same or similar health conditions. The organization must have demonstrated expertise and a history of reviewing health care in terms of medical necessity, appropriateness, and the application of other health plan coverage provisions;

(c) That any physician, health care provider, or contract specialist making a review determination in a specific review is free of any actual or potential conflict of interest or bias. Neither the expert reviewer, nor the independent review organization, nor any officer, director, or management employee of the independent review organization may have any material professional, familial, or financial affiliation with any of the following: The health carrier; professional associations of carriers and providers; the provider; the provider's medical or practice group; the health facility at which the service would be provided; the developer or manufacturer of a drug or device under review; or the enrollee;

(d) The fairness of the procedures used by the independent review organization in making the determinations;

(e) That each independent review organization make its determination:

(i) Not later than the earlier of:

(A) The fifteenth day after the date the independent review organization receives the information necessary to make the determination; or

(B) The twentieth day after the date the independent review organization receives the request that the determination be made. In exceptional circumstances, when the independent review organization has not obtained information necessary to make a determination, a determination may be made by the twenty-fifth day after the date the organization received the request for the determination; and

(ii) In requests for expedited review under RCW 48.43.535(7)(a), as expeditiously as possible but within not more than seventy-two hours after the date the independent review organization receives the request for expedited review;

(f) That timely notice is provided to enrollees of the results of the independent review, including the clinical basis for the determination;

(g) That the independent review organization has a quality assurance mechanism in place that ensures the timeliness and quality of review and communication of determinations to enrollees and carriers, and the qualifications, impartiality, and freedom from conflict of interest of the organization, its staff, and expert reviewers; and

(h) That the independent review organization meets any other reasonable requirements of the insurance commissioner directly related to the functions the organization is to perform under this section and RCW 48.43.535, and related to assessing fees to carriers in a manner consistent with the maximum fee schedule developed under this section.

(3) To be certified as an independent review organization under this chapter, an organization must submit to the insurance commissioner an application in the form required by the insurance commissioner. The application must include:

(a) For an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;

(b) The name of any holder of bonds or notes of the applicant that exceed one hundred thousand dollars;

(c) The name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control;

(d) The name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed

under (c) of this subsection and a description of any relationship the named individual has with:

- (i) A carrier;
- (ii) A utilization review agent;
- (iii) A nonprofit or for-profit health corporation;
- (iv) A health care provider;
- (v) A drug or device manufacturer; or
- (vi) A group representing any of the entities described by (d)(i) through (v) of this subsection;

(e) The percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under RCW 48.43.535;

(f) A description of the areas of expertise of the health care professionals and contract specialists making review determinations for the applicant; and

(g) The procedures to be used by the independent review organization in making review determinations regarding reviews conducted under RCW 48.43.535.

(4) If at any time there is a material change in the information included in the application under subsection (3) of this section, the independent review organization shall submit updated information to the insurance commissioner.

(5) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a carrier or a trade or professional association of health care providers or carriers.

(6) An independent review organization, and individuals acting on its behalf, are immune from suit in a civil action when performing functions under chapter 5, Laws of 2000. However, this immunity does not apply to an act or omission made in bad faith or that involves gross negligence.

(7) Independent review organizations must be free from interference by state government in its functioning except as provided in subsection (8) of this section.

(8) The rules adopted under this section shall include provisions for terminating the certification of an independent review organization for failure to comply with the requirements for certification. The insurance commissioner may review the operation and performance of an independent review organization in response to complaints or other concerns about compliance. The rules adopted under this section must include a reasonable maximum fee schedule that independent review organizations shall use to assess carriers for conducting reviews authorized under RCW 48.43.535.

(9) In adopting rules for this section, the insurance commissioner shall take into consideration rules adopted by the department of health that regulate independent review organizations and standards for independent review organizations adopted by national accreditation organizations. The insurance commissioner may accept national accreditation or certification by another state as evidence that an organization satisfies some or all of the requirements for certification by the insurance commissioner as an independent review organization.

(10) The rules adopted under this section must require independent review organizations to report decisions and associated information directly to the insurance commissioner. [2016 c 139 § 1; 2012 c 211 § 14; 2005 c 54 § 1; 2000 c 5 § 12. Formerly RCW 43.70.235.]

Savings clause—Automatic certification—2016 c 139: "(1) Independent review organizations remain subject to RCW 48.43.537, as it existed on

(2021 Ed.)

January 1, 2016, and the rules adopted by the department of health under that section through December 31, 2016. Beginning on January 1, 2017, the insurance commissioner is the sole certifying authority for independent review organizations under RCW 48.43.537.

(2) On January 1, 2017, the insurance commissioner shall automatically certify each independent review organization that was certified in good standing by the department of health on December 31, 2016." [2016 c 139 § 2.]

Intent—Purpose—2000 c 5: See RCW 48.43.500.

Additional notes found at www.leg.wa.gov

48.43.540 Requirement to designate a licensed medical director—Exemption. Any carrier that offers a health plan and any self-insured health plan subject to the jurisdiction of Washington state shall designate a medical director who is licensed under chapter 18.57 or 18.71 RCW. However, a naturopathic or complementary alternative health plan, which provides solely complementary alternative health care to individuals, groups, or health plans, may have a medical director licensed under chapter 18.36A RCW. A carrier that offers dental only coverage shall designate a dental director who is licensed under chapter 18.32 RCW, or licensed in a state that has been determined by the dental quality assurance commission to have substantially equivalent licensing standards to those of Washington. A health plan or self-insured health plan that offers only religious nonmedical treatment or religious nonmedical nursing care shall not be required to have a medical director. [2002 c 103 § 1; 2000 c 5 § 13.]

Additional notes found at www.leg.wa.gov

48.43.545 Standard of care—Liability—Causes of action—Defense—Exception. (1)(a) A health carrier shall adhere to the accepted standard of care for health care providers under chapter 7.70 RCW when arranging for the provision of medically necessary health care services to its enrollees. A health carrier shall be liable for any and all harm proximately caused by its failure to follow that standard of care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, an enrollee.

(b) A health carrier is also liable for damages under (a) of this subsection for harm to an enrollee proximately caused by health care treatment decisions that result from a failure to follow the accepted standard of care made by its:

- (i) Employees;
- (ii) Agents; or
- (iii) Ostensible agents who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control.

(2) The provisions of this section may not be waived, shifted, or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be delegated. Any effort to waive, modify, delegate, or shift liability for a breach of the duty established by this section, through a contract for indemnification or otherwise, is invalid.

(3) This section does not create any new cause of action, or eliminate any presently existing cause of action, with respect to health care providers and health care facilities that are included in and subject to the provisions of chapter 7.70 RCW.

(4) It is a defense to any action or liability asserted under this section against a health carrier that:

(a) The health care service in question is not a benefit provided under the plan or the service is subject to limitations under the plan that have been exhausted;

(b) Neither the health carrier, nor any employee, agent, or ostensible agent for whose conduct the health carrier is liable under subsection (1)(b) of this section, controlled, influenced, or participated in the health care decision; or

(c) The health carrier did not deny or unreasonably delay payment for treatment prescribed or recommended by a participating health care provider for the enrollee.

(5) This section does not create any liability on the part of an employer, an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employers, or a governmental agency that purchases coverage on behalf of individuals and families. The governmental entity established to offer and provide health insurance to public employees, public retirees, and their covered dependents under RCW 41.05.140 is subject to liability under this section.

(6) Nothing in any law of this state prohibiting a health carrier from practicing medicine or being licensed to practice medicine may be asserted as a defense by the health carrier in an action brought against it under this section.

(7)(a) A person may not maintain a cause of action under this section against a health carrier unless:

(i) The affected enrollee has suffered substantial harm. As used in this subsection, "substantial harm" means loss of life, loss or significant impairment of limb, bodily or cognitive function, significant disfigurement, or severe or chronic physical pain; and

(ii) The affected enrollee or the enrollee's representative has exercised the opportunity established in RCW 48.43.535 to seek independent review of the health care treatment decision.

(b) This subsection (7) does not prohibit an enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or other relief available under law, if its requirements place the enrollee's health in serious jeopardy.

(8) In an action against a health carrier, a finding that a health care provider is an employee, agent, or ostensible agent of such a health carrier shall not be based solely on proof that the person's name appears in a listing of approved physicians or health care providers made available to enrollees under a health plan.

(9) Any action under this section shall be commenced within three years of the completion of the independent review process.

(10) This section does not apply to workers' compensation insurance under Title 51 RCW. [2000 c 5 § 17.]

Additional notes found at www.leg.wa.gov

48.43.550 Delegation of duties—Carrier accountability. Each carrier is accountable for and must oversee any activities required by chapter 5, Laws of 2000 that it delegates to any subcontractor. No contract with a subcontractor executed by the health carrier or the subcontractor may relieve the health carrier of its obligations to any enrollee for

the provision of health care services or of its responsibility for compliance with statutes or rules. [2000 c 5 § 18.]

Additional notes found at www.leg.wa.gov

MISCELLANEOUS

48.43.600 Overpayment recovery—Carrier. (1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section, a carrier may not: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(2) A carrier may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within thirty months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(3) A carrier may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if: (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) the carrier is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

(4) If a contract between a carrier and a health care provider conflicts with this section, this section shall prevail. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a carrier any payment previously made to satisfy a claim.

(5) For purposes of this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(6) This section neither permits nor precludes a carrier from recovering from a subscriber, enrollee, or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee, or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy, or other benefit agreement.

(7) This section does not apply to claims for health care services provided through dental only health carriers, health care services provided under Title XVIII (medicare) of the social security act, or medicare supplemental plans regulated under chapter 48.66 RCW. [2005 c 278 § 1.]

Additional notes found at www.leg.wa.gov

48.43.605 Overpayment recovery—Health care provider. (1) Except in the case of fraud, or as provided in subsection (2) of this section, a health care provider may not: (a) Request additional payment from a carrier to satisfy a claim unless he or she does so in writing to the carrier within twenty-four months after the date that the claim was denied or payment intended to satisfy the claim was made; or (b) request that the additional payment be made any sooner than six months after receipt of the request. Any such request must specify why the provider believes the carrier owes the additional payment.

(2) A health care provider may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request additional payment from a carrier to satisfy a claim unless he or she does so in writing to the carrier within thirty months after the date the claim was denied or payment intended to satisfy the claim was made; or (b) request that the additional payment be made any sooner than six months after receipt of the request. Any such request must specify why the provider believes the carrier owes the additional payment, and include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim.

(3) If a contract between a carrier and a health care provider conflicts with this section, this section shall prevail. However, nothing in this section prohibits a carrier from choosing at any time to make additional payments to a provider to satisfy a claim.

(4) This section does not apply to claims for health care services provided through dental only health carriers, health care services provided under Title XVIII (medicare) of the social security act, or medicare supplemental plans regulated under chapter 48.66 RCW. [2005 c 278 § 2.]

Additional notes found at www.leg.wa.gov

48.43.650 Fixed payment insurance products—Commissioner's annual report. The commissioner shall collect information from insurers offering fixed payment insurance products, and report aggregated data for each calendar year, including the number of groups purchasing the products, the number of enrollees, and the number of consumer complaints filed. The reports shall be provided to the legislature annually to reflect the calendar year experience, and the initial report shall reflect calendar year 2008 and be due no later than June 1, 2009, and each June thereafter. [2007 c 296 § 6.]

48.43.670 Plan or contract renewal—Modification of wellness program. Upon the renewal date of an individual or group health benefit plan or contract containing health benefits, the modification of a wellness program, as defined in 45 C.F.R. 146.121(f), included in such a plan or contract shall not be considered a cancellation or nonrenewal of such plan or contract. [2009 c 329 § 3.]

48.43.680 Lifetime limit on transplants—Definition. (1) A health benefit plan that is issued or renewed on or after January 1, 2010, and that provides coverage for organ and tissue transplants, may not permit a separate lifetime limit on transplants of any less than three hundred fifty thousand dollars. The lifetime limit on transplants shall apply from one day prior to the date of the transplant or the date of hospital admission, for a patient who receives a transplant during the course of a longer hospital stay, through one hundred days after the transplant. Donor-related services may apply to the lifetime limit on transplants any time. The major medical lifetime limit shall apply to health care services provided before and after this time period. Benefits provided are subject to all other terms and conditions of the health benefit plan, including but not limited to any applicable coinsurances, deductibles, and copayments.

(2) "Organ and tissue transplant" means the same as defined under the applicable health benefit plan. [2009 c 487 § 1.]

48.43.690 Assessments under RCW 70.290.040 considered medical expenses. Assessments paid by carriers under RCW 70.290.040 may be considered medical expenses for purposes of rate setting and regulatory filings. [2010 c 174 § 15.]

Additional notes found at www.leg.wa.gov

48.43.700 Exchange—Plans that a carrier must offer—Review—Rules. (1) For plan or policy years beginning January 1, 2014, a carrier offering a health benefit plan that meets the definition of bronze level in section 1302 of P.L. 111-148 of 2010, as amended, in the individual market outside of the exchange must also offer plans that meet the definition of silver and gold level plans in section 1302 of P.L. 111-148 of 2010, as amended, in the individual market outside of the exchange.

(2) For plan or policy years beginning January 1, 2014, a carrier offering a health benefit plan that meets the definition of bronze level in section 1302 of P.L. 111-148 of 2010, as amended, in the small group market outside of the exchange must also offer plans that meet the definition of silver and gold level plans in section 1302 of P.L. 111-148 of 2010, as amended, in the small group market outside of the exchange.

(3) A health benefit plan meeting the definition of a catastrophic plan in *RCW 48.43.005(8)(c)(i) may only be sold through the exchange.

(4) By December 1, 2016, the exchange board, in consultation with the commissioner, must complete a review of the impact of this section on the health and viability of the markets inside and outside the exchange and submit the recommendations to the legislature on whether to maintain the market rules or let them expire.

(5) The commissioner shall evaluate plans offered at each actuarial value defined in section 1302 of P.L. 111-148 of 2010, as amended, and determine whether variation in prescription drug benefit cost-sharing, both inside and outside the exchange in both the individual and small group markets results in adverse selection. If so, the commissioner may adopt rules to assure substantial equivalence of prescription drug cost-sharing. [2014 c 31 § 1; 2012 c 87 § 6.]

*Reviser's note: RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (8) to subsection (10), effective January 1, 2020.

Spiritual care services—2012 c 87: See RCW 43.71.901.

48.43.705 Plans offered outside of exchange. All non-grandfathered individual and small group health plans, other than catastrophic health plans, offered outside of the

exchange must conform with the actuarial value tiers specified in section 1302 of P.L. 111-148 of 2010, as amended, as bronze, silver, gold, or platinum. [2014 c 31 § 2; 2012 c 87 § 7.]

Spiritual care services—2012 c 87: See RCW 43.71.901.

48.43.710 Certification as qualified health plan not an exemption. Certification by the Washington health benefit exchange of a plan as a qualified health plan, or of a carrier as a qualified issuer, does not exempt the plan or carrier from any of the requirements of this title or rules adopted by the commissioner pursuant to chapter 34.05 RCW to implement this title. [2012 c 87 § 12.]

Spiritual care services—2012 c 87: See RCW 43.71.901.

48.43.715 Individual and small group market—Selection of benchmark plan—Minimum requirements—Criteria—List of state-mandated health benefits. (1) The commissioner, in consultation with the board and the health care authority, shall, by rule, select the largest small group plan in the state by enrollment as the benchmark plan for the individual and small group market for purposes of establishing the essential health benefits in Washington state.

(2) If the essential health benefits benchmark plan for the individual and small group market does not include all of the ten essential health benefits categories, the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed.

(3) All individual and small group health plans must cover the ten essential health benefits categories, other than a health plan offered through the federal basic health program, a grandfathered health plan, or medicaid. Such a health plan may not be offered in the state unless the commissioner finds that it is substantially equal to the benchmark plan. When making this determination, the commissioner:

(a) Must ensure that the plan covers the ten essential health benefits categories;

(b) May consider whether the health plan has a benefit design that would create a risk of biased selection based on health status and whether the health plan contains meaningful scope and level of benefits in each of the ten essential health benefits categories;

(c) Notwithstanding (a) and (b) of this subsection, for benefit years beginning January 1, 2015, must establish by rule the review and approval requirements and procedures for pediatric oral services when offered in stand-alone dental plans in the nongrandfathered individual and small group markets outside of the exchange; and

(d) Must allow health carriers to also offer pediatric oral services within the health benefit plan in the nongrandfathered individual and small group markets outside of the exchange.

(4) Beginning December 15, 2012, and every year thereafter, the commissioner shall submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list and any

statutory changes needed if funds are not appropriated to defray the state costs for the listed mandate. The commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay the state portion of the identified costs. [2019 c 33 § 9; 2013 c 325 § 1; 2012 c 87 § 13.]

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

Spiritual care services—2012 c 87: See RCW 43.71.901.

48.43.720 Reinsurance and risk adjustment programs—Affordable care act—Rules. (1)(a) The commissioner, in consultation with the board, shall adopt rules establishing the reinsurance and risk adjustment programs required by P.L. 111-148 of 2010, as amended.

(b) The commissioner must include in deliberations related to reinsurance rule making an analysis of an invisible high risk pool option, in which the full premium and risk associated with certain high-risk or high-cost enrollees would be ceded to the transitional reinsurance program. The analysis must include a determination as to whether that option is authorized under the federal reinsurance program regulations, whether the option would provide sufficiently comprehensive coverage for current nonmedicare high risk pool enrollees, and how an invisible high risk pool option could be designed to ensure that carriers ceding risk provide effective care management to high-risk or high-cost enrollees.

(2) Consistent with federal law, the rules for the reinsurance program must, at a minimum, establish:

(a) A mechanism to collect reinsurance contribution funds;

(b) A reinsurance payment formula; and

(c) A mechanism to disburse reinsurance payments.

(3)(a) The commissioner may adjust the rules adopted under this section as needed to preserve a healthy market both inside and outside of the exchange.

(b) The rules adopted under this section must identify and may require submission of the data needed to support operation of the reinsurance and risk adjustment programs established under this section. The commissioner must identify by rule the sources of the data, and other requirements related to the collection, validation, correction, interpretation, transmission or exchange, and retention of the data.

(4) The commissioner shall contract with one or more nonprofit entities to administer the risk adjustment and reinsurance programs.

(5) Contribution amounts for the transitional reinsurance program under section 1341 of P.L. 111-148 of 2010, as amended, may be increased to include amounts sufficient to cover the costs of administration of the reinsurance program including reasonable costs incurred for preoperational and planning activities related to the reinsurance program. [2012 c 87 § 16.]

Effective date—2012 c 87 §§ 4, 16, 18, and 19-23: See note following RCW 43.71.030.

Spiritual care services—2012 c 87: See RCW 43.71.901.

48.43.725 Exclusion of mandated benefits from health plan—Carrier requirements—Notice—Fees—Commissioner's duties. (1) A health carrier that excludes, under state or federal law, any benefit required or mandated

by this title or rules adopted by the commissioner from any health plan or student health plan shall:

(a) Notify each enrollee in writing of the following:

(i) Which benefits the health plan or student health plan does not cover; and

(ii) Alternate ways in which the enrollees may access excluded benefits in a timely manner;

(b) Ensure that enrollees have prompt access to the information required under this subsection; and

(c) Clearly and legibly include the information specified in (a)(i) and (ii) of this subsection in any of its marketing materials that include a list of benefits covered under the plan. The information must also be listed in the benefit booklet and posted on the carrier's health plan or student health plan web site.

(2) For the purpose of mitigating inequity in the health insurance market, unless waived by the commissioner pursuant to (c) of this subsection, the commissioner must assess a fee on any health carrier offering a health plan or student health plan if the health plan or student health plan excludes, under state or federal law, any essential health benefit or coverage that is otherwise required or mandated by this title or rules adopted by the commissioner.

(a) The commissioner shall set the fee in an amount that is the actuarial equivalent of costs attributed to the provision and administration of the excluded benefit. As part of its rate filing, a health carrier subject to this subsection (2) must submit to the commissioner an estimate of the amount of the fee, including supporting documentation of its methods for estimating the fee. The carrier must include in its supporting documentation a certification by a member of the American academy of actuaries that the estimated fee is the actuarial equivalent of costs attributed to the provision and administration of the excluded benefit.

(b) Fees paid under this section must be deposited into the general fund.

(c) The commissioner may waive the fee assessed under this subsection (2) if he or she finds that the carrier excluding a mandated benefit for a health plan or student health plan provides health plan enrollees or student health plan enrollees alternative access to all excluded mandated benefits.

(3) Beginning July 1, 2021, the commissioner shall provide on its web site written notice of the carrier requirements in this section and information on alternate ways in which enrollees may access excluded benefits in a timely manner.

(4) Nothing in this section limits the authority of the commissioner to take enforcement action if a health carrier unlawfully fails to comply with the provisions of this title.

(5) The commissioner shall adopt any rules necessary to implement this section. [2020 c 283 § 1.]

48.43.730 Carrier must file provider contracts and compensation agreements with commissioner—Approval or disapproval—Confidentiality—Hearings—Rules—Definitions. (1) For the purposes of this section:

(a) "Carrier" means a:

(i) Health carrier as defined in RCW 48.43.005; and

(ii) Limited health care service contractor that offers limited health care service as defined in RCW 48.44.035.

(b) "Provider" means:

(i) A health care provider as defined in RCW 48.43.005;

(ii) A participating provider as defined in RCW 48.44.010;

(iii) A health care facility, as defined in RCW 48.43.005; and

(iv) Intermediaries that have agreed in writing with a carrier to provide access to providers under this subsection (1)(b) who render covered services to enrollees of a carrier.

(c) "Provider compensation agreement" means any written agreement that includes specific information about payment methodology, payment rates, and other terms that determine the remuneration a carrier will pay to a provider.

(d) "Provider contract" means a written contract between a carrier and a provider for any health care services rendered to an enrollee.

(2) A carrier must file all provider contracts and provider compensation agreements with the commissioner thirty calendar days before use. When a carrier and provider negotiate a provider contract or provider compensation agreement that deviates from a filed agreement, the carrier must also file that specific contract or agreement with the commissioner thirty calendar days before use.

(a) Any provider contract and related provider compensation agreements not affirmatively disapproved by the commissioner are deemed approved, except the commissioner may extend the approval date an additional fifteen calendar days upon giving notice before the expiration of the initial thirty-day period.

(b) Changes to previously filed and approved provider compensation agreements modifying the compensation amount or related terms that help determine the compensation amount must be filed and are deemed approved upon filing if no other changes are made to the previously approved provider contract or compensation agreement.

(3) The commissioner may not base a disapproval of a provider compensation agreement on the amount of compensation or other financial arrangements between the carrier and the provider, unless that compensation amount causes the underlying health benefit plan to otherwise be in violation of state or federal law. This subsection does not grant the commissioner the authority to regulate provider reimbursement amounts.

(4) The commissioner may withdraw approval of a provider contract or provider compensation agreement at any time for cause.

(5) Provider compensation agreements 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 compensation agreement from public inspection, and the carrier indicates that the compensation agreement is to be withheld from public inspection, the commissioner shall reject the filing and notify the carrier through the system for electronic rate and form filings to amend its filing to comply with the confidentiality filing instructions.

(6) In the event a provider contract or provider compensation agreement is disapproved or withdrawn from use by

the commissioner, the carrier has the right to demand and receive a hearing under chapters 48.04 and 34.05 RCW.

(7) Provider contracts filed pursuant to subsection (2) of this section shall identify the network or networks to which the contract applies.

(8) The commissioner may adopt rules to implement this section. [2019 c 427 § 30; 2013 c 277 § 1.]

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

48.43.731 Health care benefit management contracts—Carrier filing requirements—Notice to enrollees—Confidentiality of filings. (Effective January 1, 2022.) (1) A carrier must file with the commissioner in the form and manner prescribed by the commissioner every contract and contract amendment between the carrier and any health care benefit manager registered under RCW 48.200.030, within thirty days following the effective date of the contract or contract amendment.

(2) For health plans issued or renewed on or after January 1, 2022, carriers must notify health plan enrollees in writing of each health care benefit manager contracted with the carrier to provide any benefit management services in the administration of the health plan.

(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 carrier indicates that the contract is to be withheld from public inspection, the commissioner must reject the filing and notify the carrier through the system for electronic rate and form filings to amend its filing to comply with the confidentiality filing instructions.

(4) For purposes of this section, "health care benefit manager" has the same meaning as in RCW 48.200.020. [2020 c 240 § 6.]

Rule making—Effective date—2020 c 240: See RCW 48.200.900 and 48.200.901.

48.43.733 Rates and forms of group health benefit plans—Timing of filings—Exceptions—Rules. (1) All rates and forms of group health benefit plans other than small group plans, and all stand-alone dental and all stand-alone vision plans offered by a health carrier or limited health care service contractor as defined in RCW 48.44.035 and modification of a contract form or rate must be filed before the contract form is offered for sale to the public and before the rate schedule is used.

(2) Filings of negotiated health benefit plans, stand-alone dental, and stand-alone vision contract forms for groups other than small groups, and applicable rate schedules, that are placed into effect at time of negotiation or that have a retroactive effective date are not required to be filed in accordance with subsection (1) of this section, but must be filed within thirty working days after the earlier of:

(a) The date group contract negotiations are completed; or

(b) The date renewal premiums are implemented.

(3) For purposes of this section, a negotiated contract form is a health benefit plan, stand-alone dental plan, or stand-alone vision plan where benefits, and other terms and conditions, including the applicable rate schedules are negotiated and agreed to by the carrier or limited health care service contractor and the policy or contract holder. The negotiated policy form and associated rate schedule must otherwise comply with state and federal laws governing the content and schedule of rates for the negotiated plans.

(4) Stand-alone dental and stand-alone vision plans offered by a disability insurer to out-of-state groups specified by RCW 48.21.010(2) may be negotiated, but may not be offered in this state before the commissioner finds that the stand-alone dental or stand-alone vision plan otherwise meets the standards set forth in RCW 48.21.010(2) (a) and (b).

(5) The commissioner may, subject to a carrier's or limited health care service contractor's right to demand and receive a hearing under chapters 48.04 and 34.05 RCW, disapprove filings submitted under this section, as permitted under RCW 48.18.110, 48.44.020, and 48.46.060.

(6) The commissioner shall amend existing rules to standardize the rate and form filing process as well as regulatory review standards for the rates and forms of the plans submitted under this section. The commissioner may amend the rules previously adopted under RCW 48.43.733 and shall amend any additional rating requirements established by existing rule, that are not applied to health care service contractors and health maintenance organizations.

(7) The requirements of this section apply to all group health benefit plans other than small group plans, all stand-alone dental plans, and all stand-alone vision plans issued or renewed on or after March 31, 2016. [2016 c 156 § 2; 2015 c 19 § 3.]

Effective date—2016 c 156: "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, 2016]." [2016 c 156 § 3.]

Intent—2016 c 156: "It is the intent of the legislature to enhance competition among all health carriers and limited health care service contractors by having the office of the insurance commissioner establish regulatory uniformity for the rate and form filing process and the rate and form filing content and regulatory review standards for group health benefit plans other than small group health benefit plans, as well as all stand-alone dental plans and all stand-alone vision plans." [2016 c 156 § 1.]

Intent—2015 c 19: See note following RCW 48.18.100.

48.43.734 Health carrier rate filings—Review of surplus, capital, and profit levels. (1) For individual and small group rate filings with an effective date on or after January 1, 2021, submitted by a health carrier for either the individual or small group markets, the commissioner may review the carrier's surplus, capital, or profit levels as an element in determining the reasonableness of the proposed rate.

(2) In reviewing the surplus, capital, or profit levels, the commissioner must take into consideration the current capital facility needs for carriers, including those maintaining and operating hospital and clinical facilities.

(3) Except as provided in subsection (1) of this section, this section does not affect the rate review authority granted to the commissioner by chapter 48.19, 48.44, or 48.46 RCW.

(4) Nothing in this section affects the requirement that all approved individual and small group rates be actuarially sound according to chapter 48.19, 48.44, or 48.46 RCW.

(5) The commissioner may adopt rules to implement this section. [2020 c 247 § 1.]

48.43.735 Reimbursement of health care services provided through telemedicine or store and forward technology—Audio-only telemedicine. (1)(a) For health plans issued or renewed on or after January 1, 2017, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:

(i) The plan provides coverage of the health care service when provided in person by the provider;

(ii) The health care service is medically necessary;

(iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal patient protection and affordable care act in effect on January 1, 2015;

(iv) The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information; and

(v) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(b)(i) Except as provided in (b)(ii) of this subsection, for health plans issued or renewed on or after January 1, 2021, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine the same amount of compensation the carrier would pay the provider if the health care service was provided in person by the provider.

(ii) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of eleven or more providers may elect to negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services.

(iii) For purposes of this subsection (1)(b), the number of providers in a provider group refers to all providers within the group, regardless of a provider's location.

(2) For purposes of this section, reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health carrier and the health care provider.

(3) An originating site for a telemedicine health care service subject to subsection (1) of this section includes a:

(a) Hospital;

(b) Rural health clinic;

(c) Federally qualified health center;

(d) Physician's or other health care provider's office;

(e) Licensed or certified behavioral health agency;

(f) Skilled nursing facility;

(g) Home or any location determined by the individual receiving the service; or

(h) Renal dialysis center, except an independent renal dialysis center.

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(4) Except for subsection (3)(g) of this section, any originating site under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health carrier. A distant site, a hospital that is an originating site for audio-only telemedicine, or any other site not identified in subsection (3) of this section may not charge a facility fee.

(5) A health carrier may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

(6) A health carrier may subject coverage of a telemedicine or store and forward technology health service under subsection (1) of this section to all terms and conditions of the plan in which the covered person is enrolled including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

(7) This section does not require a health carrier to reimburse:

(a) An originating site for professional fees;

(b) A provider for a health care service that is not a covered benefit under the plan; or

(c) An originating site or health care provider when the site or provider is not a contracted provider under the plan.

(8)(a) If a provider intends to bill a patient or the patient's health plan for an audio-only telemedicine service, the provider must obtain patient consent for the billing in advance of the service being delivered.

(b) If the commissioner has cause to believe that a provider has engaged in a pattern of unresolved violations of this subsection (8), the commissioner may submit information to the appropriate disciplining authority, as defined in RCW 18.130.020, for action. Prior to submitting information to the appropriate disciplining authority, the commissioner may provide the provider with an opportunity to cure the alleged violations or explain why the actions in question did not violate this subsection (8).

(c) If the provider has engaged in a pattern of unresolved violations of this subsection (8), the appropriate disciplining authority may levy a fine or cost recovery upon the provider in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the disciplining authority. Upon completion of its review of any potential violation submitted by the commissioner or initiated directly by an enrollee, 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.

(9) For purposes of this section:

(a)(i) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(ii) For purposes of this section only, "audio-only telemedicine" does not include:

(A) The use of facsimile or email; or

(B) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results;

(b) "Disciplining authority" has the same meaning as in RCW 18.130.020;

(c) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;

(d) "Established relationship" means the covered person has had at least one in-person appointment within the past year with the provider providing audio-only telemedicine or with a provider employed at the same clinic as the provider providing audio-only telemedicine or the covered person was referred to the provider providing audio-only telemedicine by another provider who has had at least one in-person appointment with the covered person within the past year and has provided relevant medical information to the provider providing audio-only telemedicine;

(e) "Health care service" has the same meaning as in RCW 48.43.005;

(f) "Hospital" means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;

(g) "Originating site" means the physical location of a patient receiving health care services through telemedicine;

(h) "Provider" has the same meaning as in RCW 48.43.005;

(i) "Store and forward technology" means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email; and

(j) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" includes audio-only telemedicine, but does not include facsimile or email.

(9) [(10)] The commissioner may adopt any rules necessary to implement this section. [2021 c 157 § 2; 2020 c 92 § 1; 2017 c 219 § 1; 2016 c 68 § 3; 2015 c 23 § 3.]

Conflict with federal requirements—2021 c 157: See note following RCW 74.09.327.

Effective date—2020 c 92: "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 19, 2020]." [2020 c 92 § 5.]

Effective date—2017 c 219: "Sections 1 through 3 of this act take effect January 1, 2018." [2017 c 219 § 4.]

Effective date—2016 c 68: "Sections 3 through 5 of this act take effect January 1, 2018." [2016 c 68 § 7.]

Intent—2016 c 68: "The legislature recognizes telemedicine will play an increasingly important role in the health care system. Telemedicine is a meaningful and efficient way to treat patients and control costs while improving access to care. The expansion of the use of telemedicine should be thoughtfully and systematically considered in Washington state in order to maximize its application and expand access to care. Therefore, it is the intent of the legislature to broaden the reimbursement opportunities for health care services and establish a collaborative for the advancement of telemedicine to

provide guidance, research, and recommendations for the benefit of professionals providing care through telemedicine." [2016 c 68 § 1.]

Effective date—Adoption of sections—2015 c 23 §§ 2-4: See notes following RCW 41.05.700.

Intent—2015 c 23: See note following RCW 41.05.700.

48.43.740 Dental only plan—Emergency dental conditions—Definitions. (1) A health carrier offering a dental only plan may not deny coverage for treatment of emergency dental conditions that would otherwise be considered a covered service of an existing benefit contract on the basis that the services were provided on the same day the covered person was examined and diagnosed for the emergency dental condition.

(2) For purposes of this section:

(a) "Emergency dental condition" means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate dental attention to result in:

(i) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(b) "Health carrier," in addition to the definition in RCW 48.43.005, also includes health care service contractors, limited health care service contractors, and disability insurers offering dental only coverage. [2015 c 9 § 1.]

Effective date—2015 c 9: "This act takes effect January 1, 2017." [2015 c 9 § 3.]

48.43.743 Dental only plan—Annual data statement—Contents—Public use—Definition. (1) Each health carrier offering a dental only plan shall submit to the commissioner on or before April 1st of each year as part of the additional data statement or as a supplemental data statement the following information for the preceding year that is derived from the carrier's annual statement, including the exhibit of premiums, enrollments, and utilization for the company at an aggregate level and the additional data to the annual statement:

(a) The total number of dental members;

(b) The total amount of dental revenue;

(c) The total amount of dental payments;

(d) The dental loss ratio that is computed by dividing the total amount of dental payments by the total amount of dental revenues;

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

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

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

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

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

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

(6) Nothing in this section is intended to establish a minimum dental loss ratio. [2015 c 9 § 2.]

Effective date—2015 c 9: See note following RCW 48.43.740.

48.43.750 Health care provider credentialing applications—Use of electronic database by health carriers. (1)(a) A health carrier must use the database selected pursuant to RCW 48.165.035 to accept and manage credentialing applications from health care providers. A health carrier may not require a health care provider to submit credentialing information in any format other than through the database selected pursuant to RCW 48.165.035.

(b) Effective June 1, 2018, a health carrier shall make a determination approving or denying a credentialing application submitted to the carrier no later than ninety days after receiving a complete application from a health care provider.

(c) Effective June 1, 2020, a health carrier shall make a determination approving or denying a credentialing application submitted to the carrier no later than ninety days after receiving a complete application from a health care provider. All determinations made by a health carrier in approving or denying credentialing applications must average no more than sixty days.

(d) This section does not require health carriers to approve a credentialing application or to place providers into a network.

(2) This section does not apply to health care entities that utilize credentialing delegation arrangements in the credentialing of their health care providers with health carriers.

(3) For purposes of this section, "credentialing" means the collection, verification, and assessment of whether a health care provider meets relevant licensing, education, and training requirements.

(4) Nothing in this section creates an oversight or enforcement duty on behalf of the office of the insurance commissioner against a health carrier for failure to comply with the terms of this section. [2020 c 4 § 1; 2016 c 123 § 1.]

Effective date—2016 c 123: "This act takes effect June 1, 2018." [2016 c 123 § 3.]

48.43.755 Health care provider credentialing applications—Use of electronic database by providers. (1) When submitting a credentialing application to a health carrier, a health care provider shall submit the application to health carriers using the database selected pursuant to RCW 48.165.035.

(2) A health care provider shall update credentialing information as necessary to provide for the purposes of recre-credentialing.

(3) This section does not apply to providers practicing at entities that utilize credentialing delegation arrangements in

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the credentialing of their health care providers with health carriers.

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

(a) "Credentialing" has the same meaning as in RCW 48.43.750.

(b) "Health care provider" has the same meaning as in *RCW 48.43.005(23)(a).

(c) "Health carrier" has the same meaning as in RCW 48.43.005. [2016 c 123 § 2.]

***Reviser's note:** RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (23) to subsection (24), and effective January 1, 2020, changing subsection (23) to subsection (26).

Effective date—2016 c 123: See note following RCW 48.43.750.

48.43.757 Health care provider credentialing applications—Reimbursement requirements. (1) If a carrier approves a health care provider's credentialing application, upon completion of the credentialing process, the carrier must reimburse a health care provider under the following circumstances:

(a) When credentialing a new health care provider through a new provider contract, the carrier must reimburse the health care provider for covered services provided to the carrier's enrollee retroactively to the date of contract effectiveness if the credentialing process extends beyond the effective date of the new contract.

(b) When credentialing a provider to be added to an approved and in-use provider contract where a relationship existed between the carrier and the health care provider or the entity for whom the health care provider is employed or engaged at the time the health care provider submitted the completed credentialing application, the carrier must reimburse the health care provider for covered health care services provided to the carrier's enrollees during the credentialing process beginning when the health care provider submitted a completed credentialing application to the carrier.

(2) The health carrier must reimburse the health care provider at the contracted rate for the applicable health benefit plan that the health care provider would have been paid at the time the services were provided if the health care provider were fully credentialed by the carrier.

(3) Nothing in this section requires reimbursement of health care provider-rendered services that are not benefits or services covered by the health carrier's health benefit plan.

(4) Nothing in this section requires a health carrier to pay reimbursement for any covered medical services provided by a health care provider applicant if the health care provider's credentialing application is not approved or if the carrier and health care provider do not enter into a contractual relationship. [2020 c 4 § 2.]

48.43.760 Opioid use disorder—Coverage without prior authorization. For health plans issued or renewed on or after January 1, 2020, a health carrier shall provide coverage without prior authorization of at least one federal food and drug administration approved product for the treatment of opioid use disorder in the drug classes opioid agonists, opioid antagonists, and opioid partial agonists. [2019 c 314 § 37.]

Declaration—2019 c 314: See note following RCW 18.22.810.

48.43.761 Withdrawal management services—Substance use disorder treatment services—Prior authorization—Utilization review—Medical necessity review. (1) Except as provided in subsection (2) of this section, a health plan issued or renewed on or after January 1, 2021, may not require an enrollee to obtain prior authorization for withdrawal management services or inpatient or residential substance use disorder treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

(2)(a) A health plan issued or renewed on or after January 1, 2021, must:

(i) Provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.

(b) The health plan may not require an enrollee to obtain prior authorization for the services specified in (a) of this subsection as a condition for payment of services prior to the times specified in (a) of this subsection. Once the times specified in (a) of this subsection have passed, the health plan may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or lower level of care under subsection (6) of this section.

(c)(i) The behavioral health agency under (a) of this subsection must notify an enrollee's health plan as soon as practicable after admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time of notification does not reduce the requirements established in (a) of this subsection.

(ii) The behavioral health agency under (a) of this subsection must provide the health plan with its initial assessment and initial treatment plan for the enrollee within two business days of admission, excluding weekends and holidays, or within three days in the case of a behavioral health agency that provides withdrawal management services.

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the plan may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under RCW 41.05.528. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business day after [the] start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the health plan must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

(3) The behavioral health agency shall document to the health plan the patient's need for continuing care and justification for level of care placement following the current treatment period, based on the standard set of criteria established under RCW 41.05.528, with documentation recorded in the patient's medical record.

(4) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(5) If the behavioral health agency under subsection (2)(a) of this section is not in the enrollee's network:

(a) The health plan is not responsible for reimbursing the behavioral health agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health agency may not balance bill, as defined in RCW 48.43.005.

(6) When the treatment plan approved by the health plan involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the health plan shall work with the current agency to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility or level of care. The health plan shall pay the agency for the cost of care at the current facility until the seamless transfer to the different facility or lower level of care is complete. A seamless transfer to a lower level of care may include same day or next day appointments for outpatient care, and does not include payment for nontreatment services, such as housing services. If placement with an agency in the health plan's network is not available, the health plan shall pay the current agency until a seamless transfer arrangement is made.

(7) The requirements of this section do not apply to treatment provided in out-of-state facilities.

(8) For the purposes of this section "withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery. [2020 c 345 § 3.]

Findings—Intent—2020 c 345: See note following RCW 41.05.526.

48.43.762 Opioid overdose reversal medication bulk purchasing and distribution program. For health plans issued or renewed on or after January 1, 2023, health carriers must participate in the opioid overdose reversal medication bulk purchasing and distribution program established in RCW 70.14.170 once the program is operational. A health plan may not impose enrollee cost sharing related to opioid overdose reversal medication provided through the bulk purchasing and distribution program established in RCW 70.14.170. [2021 c 273 § 11.]

Rules—2021 c 273 §§ 7-12: See note following RCW 70.14.170.

Findings—Intent—2021 c 273: See note following RCW 70.14.180.

48.43.765 Health carrier network adequacy—Mental health and substance abuse treatment. (1) The commissioner shall amend his or her rules on electronic provider directories to require health carriers to include a notation when any mental health provider or substance abuse provider is closed to new patients.

(2) Beginning January 1, 2020, a health carrier shall prominently post the information listed in (a) through (e) of

this subsection on its web site in an easily understandable format and in a manner that any interested party may obtain the information:

(a) Whether the health carrier classifies mental health treatment and substance abuse treatment as primary care or specialty care and the number of business days within which an enrollee must have access to covered mental health treatment services and substance abuse treatment services under network access standards pertaining to primary care or specialty care, as applicable, adopted by the commissioner;

(b) Information on actions an enrollee may take if he or she is unable to access covered mental health treatment services or substance abuse treatment services within the requisite number of business days, including any tools or resources the carrier makes available to enrollees to assist them in finding available providers and information on how to file a complaint with the office of the insurance commissioner;

(c) Any instances where the commissioner has taken disciplinary action against the health carrier for failing to comply with network access standards for covered mental health treatment services or substance abuse treatment services;

(d) A link to the commissioner's report published under subsection (5) of this section; and

(e) Resources for persons who are experiencing a mental health crisis including, but not limited to, information on the national suicide prevention lifeline.

(3) The commissioner shall, by rule, specify a model format for the information required to be posted on a health carrier's web site under subsection (2) of this section.

(4) The commissioner may audit the information a health carrier provides under this section for accuracy.

(5) The commissioner shall annually publish on the commissioner's web site a report on the number of consumer complaints per licensed health carrier the commissioner received in the previous calendar year regarding consumers who were not able to access covered mental health treatment services or substance abuse treatment services within the time limits established by the commissioner for primary care or specialty care. [2019 c 11 § 1.]

Short title—2019 c 11: "This act may be known and cited as Brennen's law." [2019 c 11 § 2.]

48.43.770 Individual market health plan availability—Annual report. The commissioner shall submit an annual report to the appropriate committees of the legislature on the number of health plans available per county in the individual market. [2019 c 364 § 7.]

48.43.775 Qualified health plan participation—Reimbursement rate for other health plans. A carrier may not require a provider or facility participating in a qualified health plan under RCW 41.05.410 to, as a condition of participation in a qualified health plan under RCW 41.05.410, accept a reimbursement rate for other health plans offered by the carrier at the same rate as the provider or facility is reimbursed for a qualified health plan under RCW 41.05.410. [2019 c 364 § 8.]

48.43.780 Insulin drugs—Cap on enrollee's required payment amount—Cost-sharing requirements. (Expires January 1, 2023.) (1) Except as required in subsection (2) of (2021 Ed.)

this section, a health plan issued or renewed on or after January 1, 2021, that provides coverage for prescription insulin drugs for the treatment of diabetes must cap the total amount that an enrollee is required to pay for a covered insulin drug at an amount not to exceed one hundred dollars per thirty-day supply of the drug. Prescription insulin drugs must be covered without being subject to a deductible, and any cost sharing paid by an enrollee must be applied toward the enrollee's deductible obligation.

(2) If the federal internal revenue service removes insulin from the list of preventive care services which can be covered by a qualifying health plan for a health savings account before the deductible is satisfied, for a health plan that provides coverage for prescription insulin drugs for the treatment of diabetes and is offered as a qualifying health plan for a health savings account, the carrier must establish the plan's cost sharing for the coverage of prescription insulin for diabetes at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions from his or her health savings account under internal revenue service laws and regulations. The office of the insurance commissioner must provide written notice of the change in internal revenue service guidance to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the office.

(3) This section expires January 1, 2023. [2020 c 346 § 5; 2020 c 245 § 1.]

Reviser's note: This section was amended by 2020 c 245 § 1 and by 2020 c 346 § 5, 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.

48.43.785 COVID-19 personal protective equipment expenses—Health care provider reimbursement. (Contingent expiration date.) (1) For the duration of the federal public health emergency related to COVID-19, a health benefit plan shall reimburse a health care provider who bills for incurred personal protective equipment expenses as a separate expense, using the American medical association's current procedural terminology code 99072 or as subsequently amended, \$6.57 for each individual patient encounter.

(2) For purposes of this section, cost sharing is limited to the covered service according to the terms and conditions of the health benefit plan and does not apply to an expense for personal protective equipment.

(3) This section is not intended to apply to health care services that are not provided in person. [2021 c 94 § 2.]

Contingent expiration date—2021 c 94 § 2: "Section 2 of this act expires upon the termination of the federal public health emergency related to COVID-19 as proclaimed by the United States department of health and human services." [2021 c 94 § 5.]

Findings—2021 c 94: "(1) The legislature finds that:

(a) The delivery of health care services is essential and maintaining patient safety during the ongoing public health emergency is paramount;

(b) Pursuant to state and federal regulations, and in the interest of minimizing the risk of viral transmission, health care providers have incurred substantially increased costs during the public health emergency associated with the procurement of personal protective equipment;

(c) Costs associated with providing care are typically factored into contracts between a health carrier and a health care provider, but the dramatically increased personal protective equipment costs related to the pandemic,

in terms of procurement and increased "per unit" costs, were neither foreseeable nor contemplated in existing contracts; and

(d) Health care providers do not want to bill patients directly for costs associated with personal protective equipment, and in many cases are precluded from doing so pursuant to terms of contract between health care providers and health carriers, so many health care providers currently do not have a mechanism to recoup costs of personal protective equipment.

(2) Therefore, the legislature finds that to help ensure patient safety and continued access to personal protective equipment, it is necessary that health carriers reimburse health care providers for costs associated with personal protective equipment." [2021 c 94 § 1.]

Application—2021 c 94: "This act applies prospectively for the duration of the state of emergency related to COVID-19." [2021 c 94 § 3.]

Effective date—2021 c 94: "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 [April 16, 2021]." [2021 c 94 § 4.]

48.43.790 Behavioral services—Next-day appointments. Health plans issued or renewed on or after January 1, 2023, must make next-day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions to receive covered behavioral health services. The appointment may be with a licensed provider other than a licensed behavioral health professional, as long as that provider is acting within their scope of practice, and may be provided through telemedicine consistent with RCW 48.43.735. Need for urgent symptomatic care is associated with the presentation of behavioral health signs or symptoms that require immediate attention, but are not emergent. [2021 c 302 § 106.]

Findings—Intent—2021 c 302: See note following RCW 71.24.890.

48.43.795 Qualified health plans—Acceptance of premium and cost-sharing assistance. For qualified health plans offered on the exchange, a carrier shall:

(1) Accept payments for enrollee premiums or cost-sharing assistance under RCW 43.71.110 or as part of a sponsorship program under RCW 43.71.030(4). Nothing in this subsection expands or restricts the types of sponsorship programs authorized under state and federal law;

(2) Clearly communicate premium assistance amounts to enrollees as part of the invoicing and payment process; and

(3) Accept and process enrollment and payment data transferred by the exchange in a timely manner. [2021 c 246 § 4.]

CONSTRUCTION

48.43.902 Effective date—1996 c 312. This act shall take effect July 1, 1996. [1996 c 312 § 8.]

48.43.904 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 § 125.]

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48.44.010 Definitions. For the purposes of this chapter:

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

(2) "Census date" means the date upon which a health care services contractor offering coverage to a small employer must base rate calculations. For a small employer applying for a health benefit plan through a contractor other than its current contractor, the census date is the date that

final group composition is received by the contractor. For a small employer that is renewing its health benefit plan through its existing contractor, the census date is ninety days prior to the effective date of the renewal.

(3) "Commissioner" means the insurance commissioner.

(4) "Copayment" means an amount specified in a group or individual contract which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(5) "Deductible" means the amount an enrolled participant is responsible to pay before the health care service contractor begins to pay the costs associated with treatment.

(6) "Enrolled participant" means a person or group of persons who have entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health care service contractor to receive health care services.

(7) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.44.037(3) and are recorded as equity.

(8) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specific group. The group contract may include coverage for dependents.

(9) "Health care service contractor" means any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services. "Health care service contractor" does not include direct patient-provider primary care practices as defined in RCW 48.150.010.

(10) "Health care services" means and includes medical, surgical, dental, chiropractic, hospital, optometric, podiatric, pharmaceutical, ambulance, custodial, mental health, and other therapeutic services.

(11) "Individual contract" means a contract for health care services issued to and covering an individual. An individual contract may include dependents.

(12) "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.

(13) "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.

(14) "Participating provider" means a provider, who or which has contracted in writing with a health care service contractor to accept payment from and to look solely to such contractor according to the terms of the subscriber contract for any health care services rendered to a person who has previously paid, or on whose behalf prepayment has been made, to such contractor for such services.

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

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

(17) "Uncovered expenditures" means the costs to the health care service contractor for health care services that are the obligation of the health care service contractor for which

an enrolled participant would also be liable in the event of the health care service contractor'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 care service contractor, or for services that are guaranteed, insured or assumed by a person or organization other than the health care service contractor. [2010 c 292 § 3; 2007 c 267 § 2; 1990 c 120 § 1; 1986 c 223 § 1. Prior: 1983 c 286 § 3; 1983 c 154 § 3; 1980 c 102 § 10; 1965 c 87 § 1; 1961 c 197 § 1; 1947 c 268 § 1; Rem. Supp. 1947 § 6131-10.]

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

48.44.011 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 care service contractor to solicit applications for health care service contracts on its behalf.

(2) No person shall act as or hold himself or herself out to be an appointed insurance producer of a health care service contractor unless licensed as a disability insurance producer by this state and appointed by the health care service contractor 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 § 50; 1983 c 202 § 1; 1969 c 115 § 7.]

Additional notes found at www.leg.wa.gov

48.44.013 Filings with secretary of state—Copy for commissioner. Health care service contractors and limited health care service contractors 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 § 16.]

48.44.015 Registration by health care service contractors required—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 care service contractor, as defined in RCW 48.44.010 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 care service contrac-

tor domiciled in this state other than the memberships and bonds of a nonprofit corporation shall be subject to the provisions of chapter 48.06 RCW relating to obtaining solicitation permits the same as if health care service contractors 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 § 7; 1983 c 202 § 2; 1969 c 115 § 6.]

Additional notes found at www.leg.wa.gov

48.44.016 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 care services contract.

(3) Any person who knowingly violates RCW 48.44.015(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 48.44.015(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 § 8.]

Additional notes found at www.leg.wa.gov

48.44.017 Schedule of rates for individual contracts—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 care service contractor of health care services, as defined in RCW 48.43.005, provided to a contract holder or paid to or on behalf of a contract holder 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 care service contractor means the percentage of the total number of applicants for individual health benefit plans received by that health care

service contractor in the aggregate in the applicable year which are not accepted for enrollment by that health care service contractor 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 care service contractor must file supporting documentation of its method of determining the rates charged for its individual contracts. At a minimum, the health care service contractor must provide the following supporting documentation:

(a) A description of the health care service contractor's rate-making methodology;

(b) An actuarially determined estimate of incurred claims which includes the experience data, assumptions, and justifications of the health care service contractor'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 § 11; 2008 c 303 § 5; 2001 c 196 § 11; 2000 c 79 § 29.]

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

Effective date—2011 c 314 §§ 10-12: See note following RCW 48.20.025.

Additional notes found at www.leg.wa.gov

48.44.020 Contracts for services—Examination of contract forms by commissioner—Grounds for disapproval—Liability of participant. (1) Any health care service contractor may enter into contracts 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 such health care service contractor providing one or more health care services to such persons and such activity shall not be subject to the laws relating to insurance if the health care services are rendered by the health care service contractor or by a participating provider.

(2) The commissioner may on examination, subject to the right of the health care service contractor to demand and receive a hearing under chapters 48.04 and 34.05 RCW, disapprove any individual or group contract form for any of the following grounds:

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

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

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

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

(e) If it violates any provision of this chapter; or

(f) If it fails to conform to minimum provisions or standards required by regulation made by the commissioner pursuant to chapter 34.05 RCW; or

(g) If any contract 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.

(3) In addition to the grounds listed in subsection (2) of this section, the commissioner may disapprove any contract if the benefits provided therein are unreasonable in relation to the amount charged for the contract. 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 care service contractor has filed the documents required in RCW 48.44.017(2) and any rules adopted pursuant thereto, the filing shall be deemed approved.

(4)(a) Every contract between a health care service contractor and a participating provider of health care services shall be in writing and shall state that in the event the health care service contractor fails to pay for health care services as provided in the contract, the enrolled participant shall not be liable to the provider for sums owed by the health care service contractor. Every such contract shall provide that this requirement shall survive termination of the contract.

(b) No participating provider, insurance producer, trustee, or assignee may maintain any action against an enrolled participant to collect sums owed by the health care service contractor. [2008 c 303 § 2; 2008 c 217 § 51; 2000 c 79 § 28; 1990 c 120 § 5; 1986 c 223 § 2; 1985 c 283 § 1; 1983 c 286 § 4; 1973 1st ex.s. c 65 § 1; 1969 c 115 § 1; 1961 c 197 § 2; 1947 c 268 § 2; Rem. Supp. 1947 § 6131-11.]

Reviser's note: This section was amended by 2008 c 217 § 51 and by 2008 c 303 § 2, 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).

Additional notes found at www.leg.wa.gov

48.44.021 Calculation of premiums—Members of a purchasing pool—Adjusted community rating method—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 care service contractor 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 care service contractor 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 experience of health benefit plans offered to small employers under RCW 48.44.023.

(3) As used in this section and RCW 48.44.023, "health benefit plan," "small employer," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005. [2006 c 100 § 4.]

Additional notes found at www.leg.wa.gov

48.44.022 Calculation of premiums—Adjusted community rate—Definitions. (1) Except for health benefit plans covered under RCW 48.44.021, premium rates for health benefit plans for individuals shall be subject to the following provisions:

(a) The health care service contractor 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 care service contractor 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 purchasing coverage, except individuals purchasing coverage under RCW 48.44.021, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.44.023.

(3) As used in this section and RCW 48.44.023 "health benefit plan," "small employer," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005. [2006 c 100 § 3; 2004 c 244 § 6; 2000 c 79 § 30; 1997 c 231 § 208; 1995 c 265 § 15.]

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

Additional notes found at www.leg.wa.gov

48.44.023 Health plan benefits for small employers—Coverage—Exemption from statutory requirements—Premium rates—Requirements for providing coverage for small employers. (1)(a) A health care services contractor 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 contractor 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 contractor offering a health benefit plan under this subsection shall clearly disclose all 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 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.

(2) Nothing in this section shall prohibit a health care service contractor 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 contractor 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 contractor 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 48.44.010, 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 contractor 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 contractor 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 contractor 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 contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor 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 § 4; 2009 c 131 § 2; 2008 c 143 § 7; 2007 c 260 § 8; 2004 c 244 § 7; 1995 c 265 § 16; 1990 c 187 § 3.]

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

48.44.024 Requirements for plans offered to small employers—Definitions. (1) A health care service contractor may not offer any health benefit plan to any small employer without complying with RCW 48.44.023(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 the plans are not subject to RCW 48.44.023(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 § 15; 1995 c 265 § 23.]

Additional notes found at www.leg.wa.gov

48.44.026 Payment for certain health care services. Checks in payment for claims pursuant to any health care service contract for health care services provided by persons licensed or regulated under chapters 18.25, 18.29, 18.30, 18.32, 18.53, 18.57, 18.64, 18.71, 18.73, 18.74, 18.83, or 18.79 RCW, as it applies to registered nurses and advanced registered nurse practitioners, where the provider is not a participating provider under a contract with the health care service contractor, shall be made out to both the provider and the enrolled participant with the provider as the first named payee, jointly, to require endorsement by each: PROVIDED, That payment shall be made in the single name of the enrolled participant if the enrolled participant as part of his or her claim furnishes evidence of prepayment to the health care service provider: AND PROVIDED FURTHER, That nothing in this section shall preclude a health care service contractor from voluntarily issuing payment in the single name of the provider. [1999 c 130 § 1; 1994 sp.s. c 9 § 732; 1990 c 120 § 6; 1989 c 122 § 1; 1984 c 283 § 1; 1982 c 168 § 1.]

Additional notes found at www.leg.wa.gov

48.44.030 Underwriting of indemnity by insurance policy, bond, securities, or cash deposit. If any of the health care services which are promised in any such agreement are not to be performed by the health care service contractor, or by a participating provider, such activity shall not be subject to the laws relating to insurance, provided provision is made for reimbursement or indemnity of the persons who have previously paid, or on whose behalf prepayment has been made, for such services. Such reimbursement or indemnity shall either be underwritten by an insurance company authorized to write accident, health and disability insurance in the state or guaranteed by a surety company authorized to do business in this state, or guaranteed by a deposit of cash or securities eligible for investment by insurers pursuant to chapter 48.13 RCW, with the insurance commissioner, as hereinafter provided. If the reimbursement or indemnity is

underwritten by an insurance company, the contract or policy of insurance may designate the health care service contractor as the named insured, but shall be for the benefit of the persons who have previously paid, or on whose behalf prepayment has been made, for such health care services. If the reimbursement or indemnity is guaranteed by a surety company, the surety bond shall designate the state of Washington as the named obligee, but shall be for the benefit of the persons who have previously paid, or on whose behalf prepayment has been made, for such health care services, and shall be in such amount as the insurance commissioner shall direct, but in no event in a sum greater than the amount of one hundred fifty thousand dollars or the amount necessary to cover incurred but unpaid reimbursement or indemnity benefits as reported in the last annual statement filed with the insurance commissioner, and adjusted to reflect known or anticipated increases or decreases during the ensuing year, plus an amount of unearned prepayments applicable to reimbursement or indemnity benefits satisfactory to the insurance commissioner, whichever amount is greater. A copy of such insurance policy or surety bond, as the case may be, and any modification thereof, shall be filed with the insurance commissioner. If the reimbursement or indemnity is guaranteed by a deposit of cash or securities, such deposit shall be in such amount as the insurance commissioner shall direct, but in no event in a sum greater than the amount of one hundred fifty thousand dollars or the amount necessary to cover incurred but unpaid reimbursement or indemnity benefits as reported in the last annual statement filed with the insurance commissioner, and adjusted to reflect known or anticipated increases or decreases during the ensuing year, plus an amount of unearned prepayments applicable to reimbursement or indemnity benefits satisfactory to the insurance commissioner, whichever amount is greater. Such cash or security deposit shall be held in trust by the insurance commissioner and shall be for the benefit of the persons who have previously paid, or on whose behalf prepayment has been made, for such health care services. [1990 c 120 § 7; 1986 c 223 § 3; 1981 c 339 § 22; 1969 c 115 § 2; 1961 c 197 § 3; 1947 c 268 § 3; Rem. Supp. 1947 § 6131-12.]

48.44.033 Financial failure—Supervision of commissioner—Priority of distribution of assets. (1) Any rehabilitation, liquidation, or conservation of a health care service contractor shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall 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 care service contractor upon any one or more grounds set out in RCW 48.31.030, 48.31.050, and 48.31.080.

(2) For purpose of determining the priority of distribution of general assets, claims of enrolled participants and enrolled participants' beneficiaries shall 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 care plan, that

liability shall have the status of an enrolled participant claim for distribution of general assets.

(3) Any 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 shall have a priority of distribution of the general assets immediately following that of enrolled participants and enrolled participants' beneficiaries as described herein, and immediately preceding the priority of distribution described in chapter 48.31 RCW. [1990 c 120 § 2.]

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

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

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

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

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

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

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

(5) For all limited health care service contractors that have had a certificate of registration for less than three years, their uncovered expenditures shall be either insured or guaranteed by a foreign or domestic carrier admitted in the state of Washington or by another carrier acceptable to the commissioner. All such contractors shall also deposit with the commissioner one-half of one percent of their projected premium for the next year in cash, approved surety bond, securities, or other form acceptable to the commissioner.

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

rities, or other form acceptable to the commissioner. Compliance with subsection (5) of this section shall also constitute compliance with this requirement.

(7) Limited health service contractors need not comply with RCW 48.44.030 or 48.44.037. [1997 c 212 § 1; 1990 c 120 § 3.]

48.44.037 Minimum net worth—Requirement to maintain—Determination of amount. (1) Except as provided in subsection (2) of this section, every health care service contractor must have and maintain a minimum net worth equal to the greater of:

(a) Three million dollars; or

(b) Two percent of the 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 the annual premium on the premium in excess of one hundred fifty million dollars.

(2) A health care service contractor registered before July 27, 1997, that, on July 27, 1997, has a minimum net worth equal to or greater than that required by subsection (1) of this section must continue to have and maintain the minimum net worth required by subsection (1) of this section. A health care service contractor 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 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 care service contractor 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 which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of the claims.

Liabilities shall be computed in accordance with regulations adopted by the commissioner upon reasonable consideration of the ascertained experience and character of the health care service contractor.

(5) All income from reserves on deposit with the commissioner shall belong to the depositing health care service contractor and shall be paid to it as it becomes available.

(6) Any funded reserve required by this chapter shall be considered an asset of the health care service contractor in determining the organization's net worth.

(7) A health care service contractor that has made a securities deposit with the commissioner may, at its option, withdraw the securities deposit or any part thereof 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. [1997 c 212 § 2; 1990 c 120 § 4.]

48.44.039 Minimum net worth—Domestic or foreign health care service contractor. (1) For purposes of this section:

(a) "Domestic health care service contractor" means a health care service contractor formed under the laws of this state; and

(b) "Foreign health care service contractor" means a health care service contractor 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 care service contractor 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 care service contractor 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 care service contractor 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 care service contractor as being hazardous to its subscribers and the people in this state.

(4) If the deficiency is not cured the domestic health care service contractor shall not issue or deliver any individual or group contract after the expiration of the ninety-day period.

(5) If the minimum net worth of a foreign health care service contractor 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 care service contractor's registration as being hazardous to its subscribers or the people in this state. [1997 c 212 § 3.]

48.44.040 Registration with commissioner—Fee.

Every health care service contractor who or which enters into agreements which require prepayment for health care services shall register with the insurance commissioner on forms to be prescribed and provided by him or her. Such registrants shall state their name, address, type of organization, area of operation, type or types of health care services provided, and such other information as may reasonably be required by the insurance commissioner and shall file with such registration a copy of all contracts being offered and a schedule of all

rates charged. No registrant shall change any rates, modify any contract, or offer any new contract, until he or she has filed a copy of the changed rate schedule, modified contract, or new contract with the insurance commissioner. The insurance commissioner shall charge a fee of ten dollars for the filing of each original registration statement and may require each registrant to file a current reregistration statement annually thereafter. [2009 c 549 § 7145; 1947 c 268 § 4; Rem. Supp. 1947 § 6131-13.]

48.44.050 Rules and regulations. The insurance commissioner shall make reasonable regulations in aid of the administration of this chapter which may include, but shall not be limited to regulations concerning the maintenance of adequate insurance, bonds, or cash deposits, information required of registrants, and methods of expediting speedy and fair payments to claimants. [1947 c 268 § 5; Rem. Supp. 1947 § 6131-14.]

48.44.055 Plan for handling insolvency—Commissioner's review. Each health care service contractor shall have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract 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 care service contractor's insolvency for which premium payment has been made and until the enrolled participants are discharged from inpatient facilities;
 - (3) Use of insolvency reserves established under RCW 48.44.030;
 - (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 the benefits are continued. [1990 c 120 § 11.]

48.44.057 Insolvency—Commissioner's duties—Participants' options—Allocation of coverage. (1)(a) In the event of insolvency of a health services 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 services 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 services 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 120 § 8.]

48.44.060 Penalty. Except as otherwise provided in this chapter, any person who violates any of the provisions of this chapter is guilty of a gross misdemeanor. [2003 c 250 § 9; 1947 c 268 § 6; Rem. Supp. 1947 § 6131-15.]

Additional notes found at www.leg.wa.gov

48.44.080 Master lists of contractor's participating providers—Filing with commissioner—Notice of termination or participation. Every health care service contractor shall file with its annual statement with the insurance commissioner a master list of the participating providers with whom or with which such health care service contractor has executed contracts of participation, certifying that each such participating provider has executed such contract of participation. The health care service contractor shall on the first day of each month notify the insurance commissioner in writing in case of the termination of any such contract, and of any participating provider who has entered into a participating contract during the preceding month. [1990 c 120 § 10; 1986 c 223 § 4; 1965 c 87 § 3; 1961 c 197 § 5.]

48.44.090 Refusal to register corporate, etc., contractor if name confusing with existing contractor or insurance company. The insurance commissioner shall refuse to accept the registration of any corporation, cooperative group, or association seeking to act as a health care service contractor if, in his or her discretion, the insurance commissioner deems that the name of the corporation, cooperative group, or association would be confused with the name of an existing registered health care service contractor or authorized insurance company. [2009 c 549 § 7146; 1961 c 197 § 6.]

48.44.095 Annual financial statement—Filings—Contents—Fee—Penalty for failure to file. (1) Every domestic health care service contractor 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 care service contractor showing its financial condition as of the last day of the preceding calendar year. The statement shall be in such form as is furnished or prescribed by the commissioner. The commissioner may for good reason allow a reasonable extension of the time within which such annual statement shall be filed.

(2) In addition to the requirements of subsection (1) of this section, every health care service contractor 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 commissioner 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.

(3) Coincident with the filing of its annual statement and other schedules, each health care service contractor 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.

(4) Foreign health care service contractors that are domiciled in a state that has a law substantially similar to subsection (2) of this section are considered to be in compliance with this section.

(5) 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.

(6) The commissioner may suspend or revoke the certificate of registration of any health care service contractor 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. [2006 c 25 § 8; 1997 c 212 § 4; 1993 c 492 § 295; 1983 c 202 § 3; 1969 c 115 § 5.]

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

Additional notes found at www.leg.wa.gov

48.44.100 Filing inaccurate financial statement prohibited. No person shall knowingly file with any public official or knowingly make, publish, or disseminate any financial statement of a health care service contractor which does not accurately state the health care service contractor's financial condition. [1961 c 197 § 7.]

48.44.110 False representation, advertising. No person shall knowingly make, publish, or disseminate any false, deceptive, or misleading representation or advertising in the conduct of the business of a health care service contractor, or relative to the business of a health care service contractor or to any person engaged therein. [1961 c 197 § 8.]

48.44.120 Misrepresentations of contract terms, benefits, etc. No person shall knowingly make, issue, or circulate, or cause to be made, issued, or circulated, a misrepresentation of the terms of any contract, or the benefits or advantages promised thereby, or use the name or title of any contract or class of contract misrepresenting the nature thereof. [1961 c 197 § 9.]

48.44.130 Future dividends or refunds—When permissible. No health care service contractor nor any individual acting on behalf thereof shall 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. [1961 c 197 § 10.]

48.44.140 Misleading comparisons to terminate or retain contract. No health care service contractor nor any person representing a health care service contractor shall by misrepresentation or misleading comparisons induce or attempt to induce any member of any health care service contractor to terminate or retain a contract or membership. [1961 c 197 § 11.]

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

(2) Every health care service contractor 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 health care service contractor.

(3) The commissioner may elect to accept and rely on audit reports made by an independent certified public accountant for the health care service contractor 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) Whenever any health care service contractor applies for initial admission, the commissioner may make, or cause to be made, an examination of the applicant's business and affairs. Whenever such 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 health care service contractor, accept an examination report of the applicant by the regulatory official in its state of domicile. [2009 c 549 § 7147; 1986 c 296 § 8; 1983 c 63 § 1; 1969 c 115 § 12.]

Additional notes found at www.leg.wa.gov

48.44.150 Certificate of registration not an endorsement—Display in solicitation prohibited. The granting of a certificate of registration to a health care service contractor is permissive only, and shall not constitute an endorsement by the insurance commissioner of any person or thing related to the health care service contractor, and no person shall advertise or display a certificate of registration for use as an inducement in any solicitation. [1961 c 197 § 12.]

48.44.160 Revocation, suspension, refusal of registration—Hearing—Cease and desist orders, injunctive action—Grounds. The insurance commissioner may, subject to a hearing if one is demanded pursuant to chapters 48.04 and 34.05 RCW, revoke, suspend, or refuse to accept or renew registration from any health care service contractor, or he or she may issue a cease and desist order, or bring an

action in any court of competent jurisdiction to enjoin a health care service contractor from doing further business in this state, if such health care service contractor:

(1) Fails to comply with any provision of chapter 48.44 RCW or any proper order or regulation of the commissioner.

(2) Is found by the commissioner to be in such financial condition that its further transaction of business in this state would jeopardize the payment of claims and refunds to subscribers.

(3) Has refused to remove or discharge a director or officer who has been convicted of any crime involving fraud, dishonesty, or like moral turpitude, after written request by the commissioner for such removal, and expiration of a reasonable time therefor as specified in such request.

(4) Usually compels claimants under contracts either to accept less than the amount due them or to bring suit against it to secure full payment of the amount due.

(5) Is affiliated with and under the same general management, or interlocking directorate, or ownership as another health care contractor which operates in this state without having registered therefor, except as is permitted by this chapter.

(6) Refuses to be examined, or if its directors, officers, employees or representatives refuse to submit to examination or to produce its accounts, records, and files for examination by the commissioner when required, or refuse to perform any legal obligation relative to the examination.

(7) Fails to pay any final judgment rendered against it in this state upon any contract, bond, recognizance, or undertaking issued or guaranteed by it, within thirty days after the judgment became final or within thirty days after time for taking an appeal has expired, or within thirty days after dismissal of an appeal before final determination, whichever date is the later.

(8) Is found by the commissioner, after investigation or upon receipt of reliable information, to be managed by persons, whether by its directors, officers, or by any other means, who are incompetent or untrustworthy or so lacking in health care contracting or related managerial experience as to make the operation hazardous to the subscribing public; or that there is good reason to believe it is affiliated directly or indirectly through ownership, control, or other business relations, with any person or persons whose business operations are or have been marked, to the detriment of policyholders or stockholders, or investors or creditors or subscribers or of the public, by bad faith or by manipulation of assets, or of accounts, or of reinsurance. [2009 c 549 § 7148; 1988 c 248 § 19; 1973 1st ex.s. c 65 § 2; 1969 c 115 § 3; 1961 c 197 § 13.]

48.44.164 Notice of suspension, revocation, or refusal to be given contractor—Authority of insurance producers. Upon the suspension, revocation or refusal of a health care service contractor's registration, the commissioner shall give notice thereof to such contractor and shall likewise suspend, revoke, or refuse the authority of its appointed insurance producers to represent it in this state and give notice thereof to the appointed insurance producers. [2008 c 217 § 52; 1969 c 115 § 10.]

Additional notes found at www.leg.wa.gov

48.44.166 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 care service contractor 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 in 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 § 4; 1969 c 115 § 11.]

48.44.170 Hearings and appeals. For the purposes of this chapter, the insurance commissioner shall be subject to and may avail himself or herself of the provisions of chapter 48.04 RCW, which relate to hearings and appeals. [2009 c 549 § 7149; 1961 c 197 § 14.]

48.44.180 Enforcement. 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. [1961 c 197 § 15.]

48.44.200 Individual health care service plan contracts—Coverage of dependent child with developmental or physical disability. An individual health care service plan contract, delivered or issued for delivery in this state more than one hundred twenty days after August 11, 1969, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the contract 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, provided proof of such incapacity and dependency is furnished to the health care service plan corporation by the subscriber within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the corporation but not more frequently than annually after the two year period following the child's attainment of the limiting age. [2020 c 274 § 35; 1977 ex.s. c 80 § 33; 1969 ex.s. c 128 § 1.]

Purpose—Intent—Severability—1977 ex.s. c 80: See notes following RCW 4.16.190.

48.44.210 Group health care service plan contracts—Coverage of dependent child with developmental or physical disability. A group health care service plan contract, delivered or issued for delivery in this state more than one hundred twenty days after August 11, 1969, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the

contract 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 employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the health care service plan corporation by the employee or member within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the corporation, but not more frequently than annually after the two year period following the child's attainment of the limiting age. [2020 c 274 § 36; 1977 ex.s. c 80 § 34; 1969 ex.s. c 128 § 2.]

Purpose—Intent—Severability—1977 ex.s. c 80: See notes following RCW 4.16.190.

48.44.212 Coverage of dependent children to include newborn infants and congenital anomalies from moment of birth—Notification period. (1) Any health care service plan contract under this chapter delivered or issued for delivery in this state more than one hundred twenty days after February 16, 1974, which provides coverage for dependent children of the insured or covered group member, shall provide coverage for newborn infants of the insured or covered group member from and after the moment of birth. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

(2) If payment of an additional premium is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium must be furnished to the contractor. The notification period shall be no less than sixty days from the date of birth. This subsection applies to policies issued or renewed on or after January 1, 1984. [1984 c 4 § 1; 1983 c 202 § 5; 1974 ex.s. c 139 § 3.]

48.44.215 Option to cover child under age twenty-six. (1) Each individual health care service plan contract 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 care service plan contract 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 health care service plan that provides coverage for a subscriber's child must offer the option of covering any child under the age of twenty-six unless the 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 § 18; 2011 c 314 § 6; 2007 c 259 § 21.]

Additional notes found at www.leg.wa.gov

48.44.220 Discrimination prohibited. No health care service contractor shall deny coverage to any person solely on account of race, religion, national origin, or the presence of any disability. Nothing in this section shall be construed as

limiting a health care service contractor'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 care service contractor for purposes of determining coverage for any person.

No health care service contractor shall refuse to provide reimbursement or indemnity to any person for covered health care services for reasons that the health care services were provided by a holder of a license under chapter 18.22 RCW. [2020 c 274 § 37; 1983 c 154 § 4; 1979 c 127 § 1; 1969 c 115 § 4.]

Additional notes found at www.leg.wa.gov

48.44.225 Podiatric physicians and surgeons not excluded. A health care service contractor which provides foot care services shall not exclude any individual doctor who is licensed to perform podiatric health care services from being a participant for reason that the doctor is licensed under chapter 18.22 RCW. Rejections of requests by doctors to be participants must be in writing stating the cause for the rejection. [1983 c 154 § 5.]

Additional notes found at www.leg.wa.gov

48.44.230 Individual health service plan contract—Return within ten days of delivery—Refunds—Void from beginning—Notice required. Every subscriber of an individual health care service plan contract issued after September 1, 1973, may return the contract to the health care service contractor or the insurance producer through whom it was purchased within ten days of its delivery to the subscriber if, after examination of the contract, he or she is not satisfied with it for any reason, and the health care service contractor shall refund promptly any fee paid for such contract. Upon such return of the contract it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. Notice of the substance of this section shall be printed on the face of each such contract or be attached thereto. 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. [2008 c 217 § 53; 1983 1st ex.s. c 32 § 11; 1973 1st ex.s. c 65 § 4.]

Additional notes found at www.leg.wa.gov

48.44.240 Chemical dependency benefits—Provisions of group contracts delivered or renewed after January 1, 1988. Each group contract 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 that is an "approved substance use disorder treatment program" under *RCW 70.96A.020(2). [2018 c 201 § 8012; 2005 c 223 § 25; 1990 1st ex.s. c 3 § 12; 1987 c 458 § 16; 1975 1st ex.s. c 266 § 14; 1974 ex.s. c 119 § 4.]

*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

(2021 Ed.)

48.44.241 Chemical dependency benefits—RCW 48.21.160 through 48.21.190, 48.44.240 inapplicable, when. See RCW 48.21.190.

48.44.245 "Chemical dependency" defined. For the purposes of RCW 48.44.240, "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 § 17.]

Additional notes found at www.leg.wa.gov

48.44.250 Payment of premium by employee in event of suspension of compensation due to labor dispute. Any employee whose compensation includes a health care services contract providing health care services expenses, the premiums for which are 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 premiums as they become due directly to the contract holder whenever the employee's compensation is suspended or terminated directly or indirectly as the 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 care services contract provides. During that period of time such contract may not be altered or changed. Nothing in this section shall be deemed to impair the right of the health care service contractor to make normal decreases or increases of the premium rate upon expiration and renewal of the contract, in accordance with the provisions of the contract. Thereafter, if such health care services coverage is no longer available, then the employee shall be given the opportunity to purchase an individual health care services contract at a rate consistent with rates filed by the health care service contractor with the commissioner. When the employee's compensation is so suspended or terminated, the employee shall be notified immediately by the contract holder in writing, by mail addressed to the address last of record with the contract holder, that the employee may pay the premiums to the contract holder as they become due as provided in this section.

Payment of the premiums must be made when due or the coverage may be terminated by the health care service contractor.

The provisions of any health care services contract contrary to provisions of this section are void and unenforceable after May 29, 1975. [1982 c 149 § 1; 1975 1st ex.s. c 117 § 3.]

Additional notes found at www.leg.wa.gov

48.44.260 Notice of reason for cancellation, denial, or refusal to renew contract. Every authorized health care service contractor, upon canceling, denying, or refusing to renew any individual health care service contract, shall, upon

written request, directly notify in writing the applicant or subscriber, as the case may be, of the reasons for the action by the health care service contractor. Any benefits, terms, rates, or conditions of such a contract which are restricted, excluded, modified, increased, or reduced shall, upon written request, be set forth in writing and supplied to the subscriber. 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 § 290; 1979 c 133 § 3.]

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

Additional notes found at www.leg.wa.gov

48.44.270 Immunity from libel or slander. With respect to health care service contracts as defined in RCW 48.44.260, 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 care service contractor, its authorized representative, its agents, its employees, furnishing to the health care service contractor 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. [1979 c 133 § 4.]

48.44.290 Registered nurses or advanced registered nurses. Notwithstanding any provision of this chapter, for any health care service contract thereunder which is entered into or renewed after July 26, 1981, benefits shall not be denied under such contract for any health care service performed by a holder of a license for registered nursing practice or advanced registered nursing practice issued pursuant to chapter 18.79 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of chapter 18.71 RCW shall be asserted to deny benefits under this section.

The provisions of this section are intended to be remedial and procedural to the extent that they do not impair the obligation of any existing contract. [1994 sp.s. c 9 § 733; 1986 c 223 § 6; 1981 c 175 § 1.]

Additional notes found at www.leg.wa.gov

48.44.299 Legislative finding. The legislature finds and declares that there is a paramount concern that the right of the people to obtain access to health care in all its facets is being impaired by prepaid agreements which provide benefits, reimbursement, or indemnity by health care service contractors, whether for profit or for nonprofit, which do not provide parity of reimbursement among licensed health care providers performing the same health care services. It is further the intent of the legislature not to mandate the providing of any health care benefit, but rather to require parity of reimbursement for the same health care services performed by all

licensees who perform such services within the scope of their respective licenses thereby assuring the people of the state access to health care services of their choice. [1983 c 154 § 1.]

Additional notes found at www.leg.wa.gov

48.44.300 Podiatric medicine and surgery—Benefits not to be denied. Benefits shall not be denied under a contract for any health care service performed by a holder of a license issued under chapter 18.22 RCW if (1) the service performed was within the lawful scope of the person's license, and (2) the contract would have provided benefits if the service had been performed by a holder of a license issued under chapter 18.71 RCW. There shall not be imposed upon one class of doctors providing health care services as defined by this chapter any requirement that is not imposed upon all other doctors providing the same or similar health care services within the scope of their license.

The provisions of this section are intended to be procedural to the extent that they do not impair the obligation of any existing contract. [1986 c 223 § 7; 1983 c 154 § 2.]

Additional notes found at www.leg.wa.gov

48.44.305 When injury caused by intoxication or use of narcotics. A health care service contractor 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 § 4.]

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

48.44.309 Legislative finding. The legislature finds and declares that there is a paramount concern that the right of the people to obtain access to health care in all its facets is being impaired. The legislature further finds that there is a heavy reliance by the public upon prepaid health care service agreements and insurance, whether profit or nonprofit, as the only effective manner in which the large majority of the people can obtain access to quality health care. Further, the legislature finds that health care service agreements may be anti-competitive because of the exclusion of other licensed forms of health care and that because of the high costs of health care, there is a need for competition to reduce these costs. It is, therefore, declared to be in the public interest that these contracts as a form of insurance be regulated under the police power of the state to assure that all the people have the greatest access to health care services. [1983 c 286 § 1.]

Additional notes found at www.leg.wa.gov

48.44.310 Chiropractic care, coverage required, exceptions. (1) Each group contract for comprehensive health care service which is entered into, or renewed, on or after September 8, 1983, between a health care service contractor and the person or persons to receive such care shall offer coverage for chiropractic care on the same basis as any other care.

(2) A patient of a chiropractor shall not be denied benefits under a contract because the practitioner is not licensed under chapter 18.57 or 18.71 RCW.

(3) This section shall not apply to a group contract for comprehensive health care services entered into in accordance with a collective bargaining agreement between management and labor representatives. Benefits for chiropractic care shall be offered by the employer in good faith on the same basis as any other care as a subject for collective bargaining for group contracts for health care services. [1986 c 223 § 8; 1983 c 286 § 2.]

Additional notes found at www.leg.wa.gov

48.44.315 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 care service contractors, 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 care services contractor from restricting patients to seeing only health care providers who have signed participating provider agreements with the health care services contractor or an insuring entity under contract with the health care services contractor.

(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.

(2021 Ed.)

(6) The health care service contractor 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 § 9; 2020 c 245 § 5; 2004 c 244 § 12; 1997 c 276 § 4.]

Reviser's note: This section was amended by 2020 c 245 § 5 and by 2020 c 346 § 9, 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

48.44.320 Home health care, hospice care, optional coverage required—Standards, limitations, restrictions—Rules—Medicare supplemental contracts excluded. (1)

Every health care service contractor entering into or renewing a group health care service contract governed by this chapter shall offer optional coverage for home health care and hospice care for persons who are homebound and would otherwise require hospitalization. Such optional coverage need only be offered in conjunction with a policy that provides payment for hospitalization as a part of health care coverage. Persons seeking such services for palliative care in conjunction with treatment or management of serious or life-threatening illness need not be homebound in order to be eligible for coverage under this section.

(2) Home health care and hospice care coverage offered under subsection (1) of this section shall conform to the following standards, limitations, and restrictions in addition to those set forth in chapters 70.126 and 70.127 RCW:

(a) The coverage may include reasonable deductibles, coinsurance provisions, and internal maximums;

(b) The coverage should be structured to create incentives for the use of home health care and hospice care as an alternative to hospitalization;

(c) The coverage may contain provisions for utilization review and quality assurance;

(d) The coverage may require that home health agencies and hospices have written treatment plans approved by a physician licensed under chapter 18.57 or 18.71 RCW, and may require such treatment plans to be reviewed at designated intervals;

(e) The coverage shall provide benefits for, and restrict benefits to, services rendered by home health and hospice agencies licensed under chapter 70.127 RCW;

(f) Hospice care coverage shall provide benefits for terminally ill patients for an initial period of care of not less than six months and may provide benefits for an additional six months of care in cases where the patient is facing imminent death or is entering remission if certified in writing by the attending physician;

(g) Home health care coverage shall provide benefits for a minimum of one hundred thirty health care visits per calendar year. However, a visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment constitutes one visit;

(h) The coverage may be structured so that services or supplies included in the primary contract are not duplicated in the optional home health and hospice coverage.

(3) The insurance commissioner shall adopt any rules necessary to implement this section.

(4) The requirements of this section shall not apply to contracts or policies governed by chapter 48.66 RCW.

(5) An insurer, as a condition of reimbursement, may require compliance with home health and hospice certification regulations established by the United States department of health and human services. [2015 c 22 § 3; 1989 1st ex.s. c 9 § 222; 1988 c 245 § 33; 1984 c 22 § 3; 1983 c 249 § 3.]

Application—2015 c 22: See note following RCW 48.21.220.

Home health care, hospice care, rules: Chapter 70.126 RCW.

Additional notes found at www.leg.wa.gov

48.44.323 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 § 21; 2011 c 159 § 5.]

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

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

48.44.325 Mammograms—Insurance coverage. Each health care service contract 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.

This section shall not be construed to prevent the application of standard contract provisions applicable to other benefits such as deductible or copayment provisions. This section does not limit the authority of a contractor 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 § 734; 1989 c 338 § 3.]

Additional notes found at www.leg.wa.gov

48.44.327 Prostate cancer screening. (1) Each health care service contract 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 recommenda-

tion 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 contractor 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 § 4.]

48.44.330 Reconstructive breast surgery. (1) Each contract for health care entered into or renewed after July 24, 1983, between a health care services contractor and the person or persons to receive the care shall provide coverage for reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness, or injury.

(2) Each contract for health care entered into or renewed after January 1, 1986, between a health care services contractor and the person or persons to receive the care 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 § 7; 1983 c 113 § 3.]

Additional notes found at www.leg.wa.gov

48.44.335 Mastectomy, lumpectomy. No health care service contractor under this chapter may refuse to issue any contract or cancel or decline to renew the contract 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 § 3.]

Additional notes found at www.leg.wa.gov

48.44.341 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 care service contractor'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 service contract or a plan deemed by the commissioner to have a short-term limited purpose or duration, providing health benefit plans 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 comparable 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 § 5; 2007 c 8 § 3; 2006 c 74 § 2; 2005 c 6 § 4.]

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

Additional notes found at www.leg.wa.gov

48.44.342 Mental health treatment—Waiver of preauthorization for persons involuntarily committed. A health care service contractor providing hospital or medical services or benefits in this state shall waive a preauthorization from the contractor before an insured or an insured's covered dependents receive mental health treatment rendered by a state hospital as defined in RCW 72.23.010 if the insured or the insured's covered dependents are involuntarily committed to a state hospital as defined in RCW 72.23.010. [1993 c 272 § 4.]

Additional notes found at www.leg.wa.gov

(2021 Ed.)

48.44.344 Benefits for prenatal diagnosis of congenital disorders—Contracts entered into or renewed on or after January 1, 1990. On or after January 1, 1990, every group health care services contract entered into or renewed that covers hospital, medical, or surgical expenses on a group basis, 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 care service contractor in accord with standards set in rule by the board of health. Every group health care services contractor shall communicate the availability of such coverage to all group health care service contract holders and to all groups with whom they are negotiating. [1988 c 276 § 7.]

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

48.44.350 Financial interests of health care service contractors, restricted—Exceptions, regulations. (1) No person having any authority in the investment or disposition of the funds of a health care service contractor and no officer or director of a health care service contractor shall accept, except for the health care service contractor, 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 care service contractor, or be pecuniarily interested therein in any capacity; except, that such a person may procure a loan from the health care service contractor directly upon approval by two-thirds of its directors and upon the pledge of securities eligible for the investment of the health care service contractor'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 care service contractor, 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 care service contractor in the ordinary course of the health care service contractor's business and in the usual private professional or business capacity of the director or the corporation or firm. [1986 c 223 § 9; 1983 c 202 § 6.]

48.44.360 Continuation option to be offered. Every health care service contractor that issues group contracts providing group coverage for hospital or medical expense shall offer the contract holder an option to include a contract provision granting a person who becomes ineligible for coverage under the group contract, the right to continue the group benefits for a period of time and at a rate agreed upon. The contract provision shall provide that when such coverage terminates, the covered person may convert to a contract as provided in RCW 48.44.370. [1984 c 190 § 5.]

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

Additional notes found at www.leg.wa.gov

[Title 48 RCW—page 373]

48.44.370 Conversion contract to be offered—Exceptions, conditions. (1) Except as otherwise provided by this section, any group health care service contract that provides benefits for hospital or medical expenses must contain a provision granting a person covered by the group contract the right to obtain a conversion contract from the contractor upon termination of the person's eligibility for coverage under the group contract.

(2) A contractor need not offer a conversion contract to:

(a) A person whose coverage under the group contract 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 contract, a person must submit a written application and the first premium payment for the conversion contract 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 contract shall become effective, without lapse of coverage, immediately following termination of coverage under the group contract.

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

(5) The health care service contractor shall determine the premium for the conversion contract in accordance with the contractor's table of premium rates applicable to the age and class of risk of each person to be covered under the contract and the type and amount of benefits provided. [2010 c 110 § 2; 1984 c 190 § 6.]

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

Additional notes found at www.leg.wa.gov

48.44.380 Conversion contract—Restrictions and requirements—Rules. (1) A health care service contractor shall not require proof of insurability as a condition for issuance of the conversion contract.

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

(3) A health care service contractor must offer at least three contract benefit plans that comply with the following:

(a) A major medical plan with a five thousand dollar deductible per person;

(b) A comprehensive medical plan with a five hundred dollar deductible per person; and

(c) A basic medical plan with a one thousand dollar deductible per person.

(4) The insurance commissioner may revise the deductible amounts in subsection (3) of this section from time to time to reflect changing health care costs.

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

(6) The commissioner shall adopt rules to establish specific standards for conversion contract 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 § 5; 2011 c 314 § 7; 1984 c 190 § 7.]

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.

48.44.390 Modification of basis of agreement, endorsement required. 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 care service contractor. [1986 c 223 § 10.]

48.44.400 Continuance provisions for former family members. After July 1, 1986, or on the next renewal date of the agreement, whichever is later, every health care service agreement issued, amended, or renewed 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 care service agreement without a physical examination, statement of health, or other proof of insurability. [1986 c 223 § 11.]

48.44.420 Coverage for adopted children. (1) Any health care service contract under this chapter delivered or issued for delivery in this state, which provides coverage for dependent children, as defined in the contract of the subscriber, shall cover adoptive children placed with the subscriber 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 contract may require that notification of placement of a child for adoption and payment of the required premium must be furnished to the health care services contractor. The notification period shall be no less than sixty days from the date of placement. [1986 c 140 § 4.]

Additional notes found at www.leg.wa.gov

48.44.430 Cancellation of rider. Upon application by a subscriber, a rider shall be canceled if at least five years after its issuance, no health care services have been received by the subscriber 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 subscriber from that condition, such agreement not to be unreasonably withheld. The option of the subscriber 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 § 3.]

48.44.440 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 contract 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. [1988 c 173 § 3.]

48.44.450 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. Benefits shall be payable only where the services have been 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 covered services have been rendered by such licensee. Nothing in this section shall prohibit a health care service contractor from requiring that covered services be delivered by a provider who participates by contract with the health care service contractor unless no participating provider is available to deliver covered services. Nothing in this section shall prohibit a health care service contractor from negotiating rates with qualified providers.

(3) Benefits provided under this section shall be for medically necessary services as determined by the health care service contractor. Benefits shall be payable for services for the maintenance of a covered individual in cases where signifi-

cant deterioration in the patient's condition would result without the service. Benefits shall be payable 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 care service contractor, retain authority to design and employ utilization and cost controls. Therefore, benefits delivered under this section may be subject to contractual provisions regarding deductible amounts and/or copayments established by the employer purchasing coverage and the health care service contractor. 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 care service contractor. [1989 c 345 § 1.]

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

(a) Health care service contractors offering medical coverage only may limit benefits in such coverages to medical services related to treatment of temporomandibular joint disorders. Health care service contractors offering dental coverage only may limit benefits in such coverage to dental services related to treatment of temporomandibular joint disorders. No health care service contractor offering medical coverage only may define all temporomandibular joint disorders as purely dental in nature, and no health care service contractor offering dental coverage only may define all temporomandibular joint disorders as purely medical in nature.

(b) Health care contractors 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 contractor 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 § 3.]

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

48.44.465 Prescriptions—Preapproval of individual claims—Subsequent rejection prohibited—Written record required. Health care service contractors 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 § 4.]

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

48.44.470 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 care service contractor providing coverage of prescription drugs from nonresident pharmacies may only provide coverage from licensed nonresident pharmacies. The health care service contractors 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 care service contractor 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 § 314; 1991 c 87 § 9.]

Additional notes found at www.leg.wa.gov

48.44.495 Dental services that are not subject to contract or provider agreement. (1) Notwithstanding any other provisions of law, no contract of any health care service contractor subject to the jurisdiction of the state of Washington that covers any dental services, and no contract or participating provider agreement with a dentist may:

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

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

(2) For the purposes of this section, "covered services" means dental services that are reimbursable under the applicable subscriber agreement or would be reimbursable but for the application of contractual limitations such as benefit maximums, deductibles, coinsurance, waiting periods or frequency limitations. [2010 c 228 § 3.]

48.44.500 Denturist services. Notwithstanding any provision of any health care service contract 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 contract would have provided benefits if such service had been performed by a dentist licensed under chapter 18.32 RCW. [1995 c 1 § 24 (Initiative Measure No. 607, approved November 8, 1994).]

Additional notes found at www.leg.wa.gov

48.44.530 Disclosure of certain material transactions—Report—Information is confidential. (1) Every health care service contractor 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 48.44.535 through 48.44.555 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 care service contractor to which it pertains unless the commissioner, after giving the health care service contractor 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 § 13.]

48.44.535 Material acquisitions or dispositions. No acquisitions or dispositions of assets need be reported pursu-

ant to RCW 48.44.530 if the acquisitions or dispositions are not material. For purposes of RCW 48.44.530 through 48.44.555, 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 care service contractor's total assets as reported in its most recent statutory statement filed with the commissioner. [1995 c 86 § 14.]

48.44.540 Asset acquisitions—Asset dispositions. (1) Asset acquisitions subject to RCW 48.44.530 through 48.44.555 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 care service contractor or the acquisition of materials for such purpose.

(2) Asset dispositions subject to RCW 48.44.530 through 48.44.555 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 § 15.]

48.44.545 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 § 16.]

48.44.550 Material nonrenewals, cancellations, or revisions of ceded reinsurance agreements. (1) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements need be reported under RCW 48.44.530 if the nonrenewals, cancellations, or revisions are not material. For purposes of RCW 48.44.530 through 48.44.555, a material nonrenewal, cancellation, or revision is one that affects:

- (a) More than fifty percent of a health care service contractor's total reserve credit taken for business ceded, on an annualized basis, as indicated in the health care service contractor's most recent annual statement;
- (b) More than ten percent of a health care service contractor'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 care service contractor'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 § 17.]

48.44.555 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 § 18.]

48.44.900 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 § 126.]

Chapter 48.45 RCW RURAL HEALTH CARE

Sections

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48.45.010	Definitions.
48.45.020	Rural health care service arrangements.
48.45.030	Rule making.

48.45.005 Findings. The legislature finds that the residents of rural communities are having difficulties in locating and purchasing affordable health insurance. The legislature further finds that many rural communities have sufficient funds to pay for needed services, but those funds are being expended elsewhere causing insufficient funding of local health services. As part of the solution to this problem, rural communities need to be able to structure the financing of local health services to better serve local residents. The legislature further finds that as rural communities need well financed and organized health care, it is in the interest of residents of rural communities that existing unauthorized entities comply with appropriate fiscal solvency standards and consumer safeguards, and that those entities be given an opportunity to come into compliance with existing state laws. [1990 c 271 § 20.]

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

(1) "Rural community" means any grouping of consumers, seventy-five percent of whom reside in areas outside of a standard metropolitan statistical area as defined by the United States bureau of census.

(2) "Consumer" means any person enrolled and eligible to receive benefits in the rural health care arrangement.

(3) "Rural health care service arrangement" or "arrangement" means any arrangement which is established or maintained for the purpose of offering or providing through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits in the event of sickness, accident, or disability in a rural community, as defined in this section, that is subject to the jurisdiction of the insurance commissioner but is not now a currently authorized carrier. [1990 c 271 § 22.]

48.45.020 Rural health care service arrangements. Rural health care service arrangements existing on March 29, 1990, may continue in full operation only so long as they comply with all of the following:

(1) Within ten days following March 29, 1990, all rural health care service arrangements shall inform the insurance commissioner of their intent to apply for approval to operate as an entity authorized under chapter 48.44 RCW or intend to merge with an entity authorized under Title 48 RCW or merge with an entity defined in this section;

(2) The arrangement submits an application for approval as an entity authorized under chapter 48.44 RCW by May 1, 1990;

(3) The arrangement has one hundred thousand dollars on deposit with the insurance commissioner by July 1, 1990;

(4) The arrangement has one hundred fifty thousand dollars on deposit with the insurance commissioner by September 1, 1990; and

(5) The arrangement complies with all reasonable requirements of the insurance commissioner excluding the deposit requirement, except as outlined in this section.

If such rural health care service arrangements fail to comply with any of the above requirements, or if during the application process an entity engages in any activities which the insurance commissioner reasonably determines may cause imminent harm to consumers, the entity may be subject to appropriate legal action by the insurance commissioner pursuant to the authority provided in Title 48 RCW.

A rural health care service arrangement which comes into compliance with Title 48 RCW through the method outlined in this chapter shall be subject to all applicable requirements of Title 48 RCW except that the deposit requirements shall not be increased until May 1, 1991. [1990 c 271 § 23.]

48.45.030 Rule making. The insurance commissioner, pursuant to chapter 34.05 RCW, may promulgate rules to implement RCW 48.45.010 and 48.45.020. [1990 c 271 § 24.]

Chapter 48.46 RCW

HEALTH MAINTENANCE ORGANIZATIONS

Sections

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- 48.46.625 Report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements—Information required.
- 48.46.900 Liberal construction.
- 48.46.920 Short title.
- 48.46.930 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

Insurance producers appointed by health maintenance organizations, additional regulations applicable: RCW 48.17.065.

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

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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.

Effective date—2011 c 314 §§ 10-12: See note following RCW 48.20.025.

Additional notes found at www.leg.wa.gov

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

ing 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 popula-

tion. [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) 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 commissioner 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.]

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 maintenance 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 combina-

tion 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—New-born 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 organization 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

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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.]

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 medi-

cal 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.

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 supplemental 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 comparable 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

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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 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 maintenance 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

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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.

[Title 48 RCW—page 397]

(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), implementing 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 main-

tenance 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.]

(2021 Ed.)

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. [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, share-

holders, 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

48.47.005	Legislative findings—Purpose.
48.47.010	Definitions.
48.47.020	Submission of mandated health benefit proposal—Review—Benefit must be authorized by law.

(2021 Ed.)

48.47.030 Mandated health benefit proposal—Guidelines for assessing impact—Inclusion of ad hoc review panels—Health care authority.

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 authority 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.
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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.
48.49.030	Enrollee's obligation to pay for services—When satisfied—Determination of commercially reasonable payment amount through good faith negotiation between carrier and out-of-network provider or facility—Carrier's duties.

- 48.49.040 Dispute resolution process—Determination of commercially reasonable payment amount.
- 48.49.050 Commissioner's annual report on dispute resolution information regarding arbitration over commercially reasonable payment amounts.
- 48.49.060 Notice of consumer rights concerning balance billing protection—Development of standard template language by commissioner.
- 48.49.070 Hospital or ambulatory surgical facility—Requirement to provide certain information on web site or upon consumer request—Requirement to provide carriers with nonemployed provider lists.
- 48.49.080 Health care provider—Requirement to provide certain information on web site or upon consumer request—Requirement to submit network status information to carriers.
- 48.49.090 Carrier—Requirement to update web site and provider directory—Requirement to provide enrollee with certain information.
- 48.49.100 Pattern of unresolved violations—Enforcement action by department of health or appropriate disciplining authority.
- 48.49.110 Rule-making authority.
- 48.49.120 No application of chapter to health plans under chapter 74.09 RCW.
- 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.
- 48.49.140 Liberal construction of chapter to promote public interest.
- 48.49.150 Determining the adequacy of provider networks—Required considerations.
- 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 out-of-network facilities or by out-of-network 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 chapter 427, Laws of 2019;

(b) Remove consumers from balance billing disputes and require that out-of-network providers and carriers negotiate out-of-network payments in good faith under the terms of chapter 427, Laws of 2019; and

(c) Provide an environment that encourages self-funded groups to negotiate out-of-network payments in good faith with providers and facilities in return for balance billing protections. [2019 c 427 § 1.]

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.]

(2021 Ed.)

48.49.020 Balance billing—When prohibited—Carrier's duty to hold an enrollee harmless from balance billing under certain circumstances. (1) An out-of-network provider or facility may not balance bill an enrollee for the following health care services:

(a) Emergency services provided to an enrollee; or

(b) Nonemergency health care services provided to an enrollee at an in-network hospital licensed under chapter 70.41 RCW or an in-network ambulatory surgical facility licensed under chapter 70.230 RCW if the services:

(i) Involve surgical or ancillary services; and

(ii) Are provided by an out-of-network provider.

(2) Payment for services described in subsection (1) of this section is subject to the provisions of RCW 48.49.030 and 48.49.040.

(3)(a) Except to the extent provided in (b) of this subsection, the carrier must hold an enrollee harmless from balance billing when emergency services described in subsection (1)(a) of this section are provided by an out-of-network hospital in a state that borders Washington state.

(b)(i) Upon the effective date of federal legislation prohibiting balance billing when emergency services described in subsection (1)(a) of this section are provided by a hospital, the carrier no longer has a duty to hold enrollees harmless from balance billing under (a) of this subsection; or

(ii) Upon the effective date of an interstate compact with a state bordering Washington state or enactment of legislation by a state bordering Washington state prohibiting balance billing when emergency services described in subsection (1)(a) of this section are provided by a hospital located in that border state to a Washington state resident, the carrier no longer has a duty to hold enrollees harmless from balance billing under (a) of this subsection for services provided by a hospital in that border state. The commissioner shall engage with border states on appropriate means to prohibit balance billing by out-of-state hospitals of Washington state residents.

(4) This section applies to health care providers or facilities 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 and 48.49.040 as provided in RCW 48.49.130. [2019 c 427 § 6.]

48.49.030 Enrollee's obligation to pay for services—When satisfied—Determination of commercially reasonable payment amount through good faith negotiation between carrier and out-of-network provider or facility—Carrier's duties. (1) If an enrollee receives emergency or nonemergency health care services under the circumstances described in RCW 48.49.020:

(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 carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area. The carrier must provide an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing amount determined under this subsection.

(b) The carrier, out-of-network provider, or out-of-network facility, and an agent, trustee, or assignee of the carrier, out-of-network provider, or out-of-network facility must ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection.

(c) The out-of-network provider or out-of-network facility, and an agent, trustee, or assignee of the out-of-network provider or out-of-network facility 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 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 an out-of-network provider or facility's services in the same manner as cost-sharing for health care services provided by an in-network provider or facility 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 out-of-network provider or out-of-network facility an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection, the provider or facility 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) The allowed amount paid to an out-of-network provider for health care services described under RCW 48.49.020 shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. Within thirty calendar days of receipt of a claim from an out-of-network provider or facility, the carrier shall offer to pay the provider or facility a commercially reasonable amount. If the out-of-network provider or facility wants to dispute the carrier's payment, the provider or facility must notify the carrier no later than thirty calendar days after receipt of payment or payment notification from the carrier. If the out-of-network provider or facility disputes the carrier's initial offer, the carrier and provider or facility have thirty calendar days from the initial offer to negotiate in good faith. If the carrier and the out-of-network provider or facility do not agree to a commercially reasonable payment amount within thirty calendar days, and the carrier, out-of-network provider or out-of-network facility chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration, as provided in RCW 48.49.040.

(3) The carrier must make payments for health care services described in RCW 48.49.020 provided by out-of-network providers or facilities directly to the provider or facility, rather than the enrollee.

(4) 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 chapter 427, Laws of 2019.

(5) A health care provider, hospital, or ambulatory surgical facility may not require a patient at any time, for any procedure, service, or supply, to sign or execute by electronic

means, any document that would attempt to avoid, waive, or alter any provision of this section.

(6) This section shall only apply to health care providers or facilities 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 through 48.49.040 as provided in RCW 48.49.130. [2019 c 427 § 7.]

48.49.040 Dispute resolution process—Determination of commercially reasonable payment amount. (1)(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, out-of-network provider or out-of-network facility chooses to pursue further action to resolve the dispute, the carrier, out-of-network provider, or out-of-network facility shall initiate arbitration to determine a commercially reasonable payment amount. To initiate arbitration, the carrier, provider, or facility 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) Multiple claims may be addressed in a single arbitration proceeding if the claims at issue:

(i) Involve identical carrier and provider or facility parties;

(ii) Involve claims with the same or related current procedural terminology codes relevant to a particular procedure; and

(iii) Occur within a period of two months of one another.

(2) 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 should 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.

(3)(a) 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. The initiating party must include in its 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 with-

out 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. 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.

(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.

(4) 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 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.

(5) Within ten 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 (3) of this section or impede the commissioner's duty to prepare the annual report under RCW 48.49.050.

(6) 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.

(7) This section applies to health care providers or facilities 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 and this section as provided in RCW 48.49.130.

(8) 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. [2019 c 427 § 8.]

(2021 Ed.)

48.49.050 Commissioner's annual report on dispute resolution information regarding arbitration over commercially reasonable payment amounts. (Expires January 1, 2024.) (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 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 web site 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, 2024. [2019 c 427 § 9.]

48.49.060 Notice of consumer rights concerning balance billing protection—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 that:

(a) The prohibition against balance billing in this chapter is applicable to health plans issued by carriers in Washington state and self-funded group health plans that elect to participate in RCW 48.49.020 through 48.49.040 as provided in RCW 48.49.130;

(b) They cannot be balance billed for the health care services described in RCW 48.49.020 and will receive the protections provided by RCW 48.49.030; and

(c) They may be balance billed for health care services under circumstances other than those described in RCW 48.49.020 or if they are enrolled in a health plan to which chapter 427, Laws of 2019 does not apply, and steps they can take if they are balance billed.

(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. [2019 c 427 § 10.]

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

(i) The listing of the carrier health plan provider networks with which the hospital or ambulatory surgical facility

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 or ambulatory surgical facility does not maintain a web site, 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 or ambulatory surgical facility 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 surgical or ancillary 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 non-employed 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. [2019 c 427 § 11.]

48.49.080 Health care provider—Requirement to provide certain information on web site 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 web site, 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 web site, 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 web site and provider directory—Requirement to provide enrollee with certain information. (1) A carrier must update its web site 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; and

(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 or facility, 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 appli-

cable 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 surgical or ancillary services at specified 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. [2019 c 427 § 13.]

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, or ambulatory surgical facility, 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, or ambulatory surgical facility, 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, or ambulatory surgical facility, 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, or ambulatory surgical facility 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 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. [2019 c 427 § 14.]

48.49.110 Rule-making authority. The commissioner may adopt rules to implement and administer this chapter, including rules governing the dispute resolution process established in RCW 48.49.040. [2019 c 427 § 15.]

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. The provisions of this chapter apply to a self-funded group health plan governed by 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 through 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 through 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 through 48.49.040. [2019 c 427 § 23.]

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.]

48.49.150 Determining the adequacy of provider networks—Required considerations. When determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, the commissioner must consider whether the carrier's proposed provider network or in-force provider network includes a sufficient number of contracted providers of emergency and surgical or ancillary 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. [2019 c 427 § 25.]

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

(2021 Ed.)

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:

- The chief of the Washington state patrol and the director of fire protection;
- The prosecuting attorney of the county where the criminal activity occurred;
- State, county, and local law enforcement agencies;
- The state attorney general;
- The federal bureau of investigation, or any other federal law enforcement agency;
- The United States attorney's office; and
- 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 probable 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:

- Pertinent insurance policy information relating to a claim under investigation and any application for such a policy;
- Policy premium payment records which are available;
- History of previous claims in which the person was involved; and
- 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)(e).

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 commissioner'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.]

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

48.62.011	Legislative intent—Construction.
48.62.021	Definitions.
48.62.031	Authority to self-insure—Options—Risk manager.
48.62.034	Joint self-insurance program—Actions authorized.
48.62.037	Board of pilotage commissioners—Participation in joint self-insurance program—Liability insurance coverage.
48.62.061	Rule making by state risk manager—Standards.
48.62.071	Program approval required—State risk manager—Plan of management and operation.
48.62.081	Multistate program participants—Requirements.
48.62.091	Program approval or disapproval—Procedures—Annual report.
48.62.101	Access to information—Executive sessions—Public records act.
48.62.111	Investments—Designated treasurer—Deposit requirements—Bond.
48.62.121	General operating regulations—Employee remuneration—Governing control—School districts—Use of insurance producers and surplus line brokers—Health care services—Trusts.
48.62.123	Existing benefit program established as a trust—Risk manager—Limited extension of deadline for compliance.
48.62.125	Educational service districts—Rules—Superintendent of public instruction.
48.62.131	Preexisting programs—Notice to state auditor.
48.62.141	Insufficient assets—Program requirement.
48.62.151	Insurance premium taxes—Exemption.
48.62.161	Establishment of fee to cover costs—State risk manager.
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. (Effective until January 1, 2022.) 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, stu-

dents, 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 24.03.005(3) 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. [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.]

***Reviser's note:** RCW 24.03.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (3) to subsection (16), effective January 1, 2016.

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

48.62.021 Definitions. (Effective January 1, 2022.)

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

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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 discussion 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 gov-

ernment 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 pilot-

age 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.]

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Chapter 48.64 RCW

AFFORDABLE HOUSING ENTITIES—JOINT SELF-INSURANCE PROGRAMS

Sections

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48.64.070	Multistate programs—Conditions and requirements for participation.
48.64.080	Program approval or disapproval—Plan review—State risk manager's duties—Violations—Fines—Annual program reports.
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 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 pro-

gram 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 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. [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

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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 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 issuing 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 affir-

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mative 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;
- (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 affir-

viding 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 pay-

ment, 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 insol-

vency, 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 initial 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 subsection (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.]

(2021 Ed.)

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.]

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 disclo-

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sure 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.

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 successor, 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 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 nonfor-

feiture 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 subsection 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.]

(2021 Ed.)

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 commissioners 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 privi-

leged, 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.
48.76.070	Calculation of cash surrender value and paid-up nonforfeiture benefit.
48.76.080	Cash surrender value required for policies issued on or after January 1, 1986.
48.76.090	Chapter inapplicable to certain policies.
48.76.100	Operative date of chapter.
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 policy 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.

(2021 Ed.)

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 state-

ment 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 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 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 commissioner's 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 commissioner's 1961 standard industrial mortality table or the commissioner's 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 commissioner's standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted

for the commissioner's 1961 standard industrial mortality table or the commissioner's 1961 industrial extended term insurance table. If the commissioner approves by rule any commissioner's 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 calcu-

lated, 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 payor 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 pre-existing 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.]

(2021 Ed.)

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.

(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 misrepresentation 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 producers 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, pro-

ducer 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.

(2021 Ed.)

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 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 com-

missioner. [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 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.

(2021 Ed.)

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.

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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.]

(2021 Ed.)

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.
48.92.020	Definitions.
48.92.030	Requirements for chartering.
48.92.040	Required acts—Prohibited practices.
48.92.050	Insolvency guaranty fund, participation prohibited—Joint underwriting associations, participation required.
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.
48.92.140	Rules.

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;

(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 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.

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(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 established 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

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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

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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.

(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 nondomestic 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—Mini-

num 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-man-

ager 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.

(2021 Ed.)

(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 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 applicable 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 con-

trolling 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.
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

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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

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 pos-

session; 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.]

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

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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, dis-

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seminated, 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 pro-

vider, 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 con-

nection 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 resident 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 connection 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 pre-

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pared 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 settlement 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 provider 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, 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 apply-

ing 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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48.110.900	Date of application to service contracts.
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 main-

tenance 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 prod-

uct 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 arising 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 pur-

chase 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 guaran-

tee 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 ser-

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vice 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 discloses:

(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 obligated 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.

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(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 requirement 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.

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(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 provid-

ers 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 hear-

ing—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 contracts 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 distrib-

utors. 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 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. [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

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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

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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, 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

(2021 Ed.)

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.]

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 web site, 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 producer 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:

(2021 Ed.)

(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

48.125.003	Short title.
48.125.005	Purposes.
48.125.010	Definitions.
48.125.020	Certificate of authority required.
48.125.030	Certificate of authority—Requirements for issuance.
48.125.040	Certificate of authority—Continued compliance with certain conditions—Commissioner's discretion.
48.125.050	Certificate of authority—Application—Form—Documentation.
48.125.060	Surplus required—Amount—Enforcement.
48.125.070	Contribution rates.
48.125.080	Certificate of authority—Granting or denying application.
48.125.090	Reporting requirements.
48.125.100	Failure to comply with chapter—Sanctions.
48.125.110	Certificate of authority—Failure to obtain.
48.125.120	Policy must contain specific notice.
48.125.130	Additional compliance requirements.
48.125.140	Examination of operations—Commissioner's powers—Definition of affiliate.
48.125.150	Chapter not applicable.
48.125.160	Taxable amounts—Participant contributions.
48.125.200	Prostate cancer screening.
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;

(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

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(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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48.130.005 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 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.]

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 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 enacting 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.]

(2021 Ed.)

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 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:

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(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

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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 ser-

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vices 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 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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48.155.140	Temporary and permanent injunctive relief—When authorized.

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

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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).

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 web site 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 require-

ments 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 writ-

ten 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 web site. (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

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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 web site 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 web site 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 over-

all 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 web site 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 web site 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 web site 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.
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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

fees 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:

(2021 Ed.)

(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 ser-

vices 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 web site. 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 web site 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 web site where providers can obtain payors' preauthorization, benefits advisory, and preadmission requirements;

(c) Establish guidelines for payors to develop and maintain a web site 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

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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 precensure 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.]

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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 occu-

pant 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. 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. 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

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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. (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 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. 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. 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.

48.177.010 Insurance that covers commercial transportation services—Requirements—Terms of coverage.

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, non-profit 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.

(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.

vider'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.]

48.177.010 Insurance that covers commercial transportation services—Requirements—Terms of coverage.

(1)(a) Before being used to provide commercial transportation services, every personal vehicle must be covered by a primary automobile insurance policy that specifically covers commercial transportation services. However, the insurance coverage requirements of this section are alternatively satisfied by securing coverage pursuant to chapter 46.72 or 46.72A RCW that covers the personal vehicle being used to provide commercial transportation services and that is in effect twenty-four hours per day, seven days per week. Except as provided in subsection (2) of this section, a commercial transportation services provider must secure this policy for every personal vehicle used to provide commercial transportation services. For purposes of this section, a "primary automobile insurance policy" is not a private passenger automobile insurance policy.

(b) The primary automobile insurance policy required under this section must provide coverage, as specified in this subsection (1)(b), at all times the driver is logged in to a commercial transportation services provider's digital network or software application and at all times a passenger is in the vehicle as part of a prearranged ride.

(i) The primary automobile insurance policy required under this subsection must provide the following coverage during commercial transportation services applicable during the period before a driver accepts a requested ride through a digital network or software application:

(A) Liability coverage in an amount no less than fifty thousand dollars per person for bodily injury, one hundred thousand dollars per accident for bodily injury of all persons, and thirty thousand dollars for damage to property;

(B) Underinsured motorist coverage to the extent required under RCW 48.22.030; and

(C) Personal injury protection coverage to the extent required under RCW 48.22.085 and 48.22.095.

(ii) The primary automobile insurance policy required under this subsection must provide the following coverage, applicable during the period of a prearranged ride:

(A) Combined single limit liability coverage in the amount of one million dollars for death, personal injury, and property damage;

(B) Underinsured motorist coverage in the amount of one million dollars; and

(C) Personal injury protection coverage to the extent required under RCW 48.22.085 and 48.22.095.

(2)(a) As an alternative to the provisions of subsection (1) of this section, if the office of the insurance commissioner approves the offering of an insurance policy that recognizes that a person is acting as a driver for a commercial transportation services provider and using a personal vehicle to provide commercial transportation services, a driver may secure a primary automobile insurance policy covering a personal vehicle and providing the same coverage as required in sub-

section (1) of this section. The policy coverage may be in the form of a rider to, or endorsement of, the driver's private passenger automobile insurance policy only if approved as such by the office of the insurance commissioner.

(b) If the primary automobile insurance policy maintained by a driver to meet the obligation of this section does not provide coverage for any reason, including that the policy lapsed or did not exist, the commercial transportation services provider must provide the coverage required under this section beginning with the first dollar of a claim.

(c) The primary automobile insurance policy required under this subsection and subsection (1) of this section may be secured by any of the following:

(i) The commercial transportation services provider as provided under subsection (1) of this section;

(ii) The driver as provided under (a) of this subsection; or

(iii) A combination of both the commercial transportation services provider and the driver.

(3) The insurer or insurers providing coverage under subsections (1) and (2) of this section are the only insurers having the duty to defend any liability claim from an accident occurring while commercial transportation services are being provided.

(4) In addition to the requirements in subsections (1) and (2) of this section, before allowing a person to provide commercial transportation services as a driver, a commercial transportation services provider must provide written proof to the driver that the driver is covered by a primary automobile insurance policy that meets the requirements of this section. Alternatively, if a driver purchases a primary automobile insurance policy as allowed under subsection (2) of this section, the commercial transportation services provider must verify that the driver has done so.

(5) A primary automobile insurance policy required under subsection (1) or (2) of this section may be placed with an insurer licensed under this title to provide insurance in the state of Washington or as an eligible surplus line insurance policy as described in RCW 48.15.040.

(6) Insurers that write automobile insurance in Washington may exclude any and all coverage afforded under a private passenger automobile insurance policy issued to an owner or operator of a personal vehicle for any loss or injury that occurs while a driver for a commercial transportation services provider is logged in to a commercial transportation services provider's digital network or while a driver provides a prearranged ride. This right to exclude all coverage may apply to any coverage included in a private passenger automobile insurance policy including, but not limited to:

(a) Liability coverage for bodily injury and property damage;

(b) Personal injury protection coverage;

(c) Underinsured motorist coverage;

(d) Medical payments coverage;

(e) Comprehensive physical damage coverage; and

(f) Collision physical damage coverage.

(7) Nothing in this section shall be construed to require a private passenger automobile insurance policy to provide primary or excess coverage or a duty to defend for the period of time in which a driver is logged in to a commercial transportation services provider's digital network or software applica-

tion or while the driver is engaged in a prearranged ride or the driver otherwise uses a vehicle to transport passengers for compensation.

(8) Insurers that exclude coverage under subsection (6) of this section have no duty to defend or indemnify any claim expressly excluded under subsection (6) of this section. Nothing in this section shall be deemed to invalidate or limit an exclusion contained in a policy, including any policy in use or approved for use in Washington state before July 24, 2015, that excludes coverage for vehicles used to carry persons or property for a charge or available for hire by the public.

(9) An exclusion exercised by an insurer in subsection (6) of this section applies to any coverage selected or rejected by a named insured under RCW 48.22.030 and 48.22.085. The purchase of a rider or endorsement by a driver under subsection (2)(a) of this section does not require a separate coverage rejection under RCW 48.22.030 or 48.22.085.

(10) If more than one insurance policy provides valid and collectible coverage for a loss arising out of an occurrence involving a motor vehicle operated by a driver, the responsibility for the claim must be divided as follows:

(a) Except as provided otherwise under subsection (2)(c) of this section, if the driver has been matched with a passenger and is traveling to pick up the passenger, or the driver is providing services to a passenger, the commercial transportation services provider that matched the driver and passenger must provide insurance coverage; or

(b) If the driver is logged in to the digital network or software application of more than one commercial transportation services provider but has not been matched with a passenger, the liability must be divided equally among all of the applicable insurance policies that specifically provide coverage for commercial transportation services.

(11) In an accident or claims coverage investigation, a commercial transportation services provider or its insurer must cooperate with a private passenger automobile insurance policy insurer and other insurers that are involved in the claims coverage investigation to facilitate the exchange of information, including the provision of (a) dates and times at which an accident occurred that involved a participating driver and (b) within ten business days after receiving a request, a copy of the provider's electronic record showing the precise times that the participating driver logged on and off the provider's digital network or software application on the day the accident or other loss occurred. The commercial transportation services provider or its insurer must retain all data, communications, or documents related to insurance coverage or accident details for a period of not less than the applicable statutes of limitation, plus two years from the date of an accident to which those records pertain.

(12) This section does not modify or abrogate any otherwise applicable insurance requirement set forth in this title.

(13) After July 1, 2016, an insurance company regulated under this title may not deny an otherwise covered claim arising exclusively out of the personal use of the private passenger automobile solely on the basis that the insured, at other times, used the private passenger automobile covered by the policy to provide commercial transportation services.

(14) If an insurer for a commercial transportation services provider makes a payment for a claim covered under comprehensive coverage or collision coverage, the commer-

cial transportation services provider must cause its insurer to issue the payment directly to the business repairing the vehicle or jointly to the owner of the vehicle and the primary lienholder on the covered vehicle.

(15)(a) To be eligible for securing a primary automobile insurance policy under this section, a commercial transportation services provider must make the following disclosures to a prospective driver in the prospective driver's terms of service:

WHILE OPERATING ON THE DIGITAL NETWORK OR SOFTWARE APPLICATION OF THE COMMERCIAL TRANSPORTATION SERVICES PROVIDER, YOUR PRIVATE PASSENGER AUTOMOBILE INSURANCE POLICY MIGHT NOT AFFORD LIABILITY, UNDERINSURED MOTORIST, PERSONAL INJURY PROTECTION, COMPREHENSIVE, OR COLLISION COVERAGE, DEPENDING ON THE TERMS OF THE POLICY.

IF THE VEHICLE THAT YOU PLAN TO USE TO PROVIDE COMMERCIAL TRANSPORTATION SERVICES FOR OUR COMPANY HAS A LIEN AGAINST IT, YOU MUST NOTIFY THE LIENHOLDER THAT YOU WILL BE USING THE VEHICLE FOR COMMERCIAL TRANSPORTATION SERVICES THAT MAY VIOLATE THE TERMS OF YOUR CONTRACT WITH THE LIENHOLDER.

(b) The prospective driver must acknowledge the terms of service electronically or by signature. [2015 c 236 § 2.]

Chapter 48.180 RCW NONPROFIT CORPORATIONS—JOINT SELF-INSURANCE PROGRAMS

Sections

48.180.005	Intent—Liberal construction.
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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 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. (Effective until January 1, 2022.) 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 24.03.005.

(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. [2015 c 109 § 6.]

48.180.010 Definitions. (Effective January 1, 2022.) 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 cor-

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porations 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 sub-

mitted 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 web site—Requirements to post on web site.

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 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 web site—Requirements to post on web site.

(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 web site. If the insurer elects to post insurance policy forms and endorsements on its web site 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

48.190.005	Intent.
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48.190.020	Formation—Powers—Service of process.
48.190.030	Applicability of chapter.
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48.190.050	State risk manager—Approval of program creation—Required submissions.
48.190.060	State risk manager—Approval and denial of program creation—Violations of chapter—Reports.
48.190.070	Participation with entities from other states.
48.190.080	Designation of treasurer—Interest and earnings.
48.190.090	Receiving or soliciting anything of value—Inducement.
48.190.100	Tax exemptions.
48.190.110	Fees.
48.190.120	Civil immunity—Filings and publications.

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 noti-

fies 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 (2021 Ed.)

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.]

Chapter 48.195 RCW CORPORATE GOVERNANCE ANNUAL DISCLOSURE

Sections

48.195.005	Purpose—Application.
48.195.010	Definitions.
48.195.020	Annual disclosure—Lead state when insurer part of insurance group—Additional information may be required.
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

Sections

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48.200.040	Contract requirements—Written agreement describing rights and responsibilities—Filing of contracts—Confidentiality.
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48.200.210	Definitions applicable to RCW 48.200.220 through 48.200.290.
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48.200.260	Preliminary audit report—Dispute or denial of claim—Final audit report—Recoupment of disputed funds.
48.200.270	Application.
48.200.280	Predetermination of reimbursement costs—Appeals—Review by commissioner.
48.200.290	Enforcement—Disputes—Civil penalties.
48.200.900	Rule making—2020 c 240.
48.200.901	Effective date—2020 c 240.

48.200.010 Findings—Intent. (Effective January 1, 2022.) (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. (Effective January 1, 2022.)

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 or 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. (Effective January 1, 2022.)

(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 over-

sight 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. (Effective January 1, 2022.)

(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. (Effective January 1, 2022.)

(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. (Effective January 1, 2022.) 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.

(2021 Ed.)

(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. (Effective January 1, 2022.) 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. (Effective January 1, 2022.) 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. (*Effective January 1, 2022.*) 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. (*Effective January 1, 2022.*) 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. (*Effective January 1, 2022.*) (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. (*Effective January 1, 2022.*) 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. (*Effective January 1, 2022.*) (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. (Effective January 1, 2022.) (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 allocable 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.

