Chapter 48.44 RCW
HEALTH CARE SERVICES

Sections

Insurance producers appointed by health care service contractors, additional regulations applicable: RCW 48.17.065.

RCW 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).

Application—2010 c 292: See note following RCW 48.43.005.

Severability—1983 c 286: See note following RCW 48.44.309.

Severability—1983 c 154: See note following RCW 48.44.299.

RCW 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.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 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.]

RCW 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 contractor 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.]

Severability—2003 c 250: See note following RCW 48.01.080.

RCW 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.]

Severability—2003 c 250: See note following RCW 48.01.080.

RCW 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.

Effective date—2001 c 196: See note following RCW 48.20.025.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

RCW 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).

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

Severability—1983 c 286: See note following RCW 48.44.309.

RCW 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.]

Legality of purchasing pools—Federal opinion requested—2006 c 100: See note following RCW 48.20.028.

RCW 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.

Legality of purchasing pools—Federal opinion requested—2006 c 100: See note following RCW 48.20.028.

Application—2004 c 244: See note following RCW 48.21.045.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

Short title—Part headings and captions not law—Severability—Effective dates—1997 c 231: See notes following RCW 48.43.005.

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 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.

Application—2010 c 292: See note following RCW 48.43.005.

Application—2004 c 244: See note following RCW 48.21.045.

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

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

RCW 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.]

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 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.]

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

RCW 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.]

RCW 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.]

RCW 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, securities, 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.]

RCW 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.]

RCW 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.]

RCW 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.]

RCW 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.]

RCW 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.]

RCW 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.]

RCW 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.]

Severability—2003 c 250: See note following RCW 48.01.080.

RCW 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.]

RCW 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.]

RCW 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 dissimilating 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 dissimilation 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.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 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.]

RCW 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.]

RCW 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.]

RCW 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.]

RCW 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.]

RCW 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.]

Severability—Effective date—1986 c 296: See notes following RCW 48.14.020.

RCW 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.]

RCW 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.]

RCW 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.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 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.]

RCW 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.]

RCW 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.]

RCW 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.

RCW 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.

RCW 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.]

RCW 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.]

Effective date—2007 c 259 §§ 18-22: See note following RCW 41.05.095.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 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.]

Severability—1983 c 154: See note following RCW 48.44.299.

RCW 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.]

Severability—1983 c 154: See note following RCW 48.44.299.

RCW 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.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 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.

Effective date—Severability—1987 c 458: See notes following RCW 48.21.160.

Severability—1975 1st ex.s. c 266: See note following RCW 48.01.010.

Legislative declaration—1974 ex.s. c 119: See RCW 48.21.160.

Chemical dependency benefits, rules: RCW 48.21.197.

RCW 48.44.241 Chemical dependency benefits—RCW 48.21.160 through 48.21.190, 48.44.240 inapplicable, when. See RCW 48.21.190.

RCW 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.]

Effective date—Severability—1987 c 458: See notes following RCW 48.21.160.

RCW 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.]

Severability—1975 1st ex.s. c 117: See note following RCW 48.21.075.

RCW 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.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 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.]

RCW 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.]

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

RCW 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.]

Severability—1983 c 154: "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." [1983 c 154 § 6.]

RCW 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.]

Severability—1983 c 154: See note following RCW 48.44.299.

RCW 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.

RCW 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 anticompetitive 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.]

Severability—1983 c 286: "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." [1983 c 286 § 5.]

RCW 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.]

Severability—1983 c 286: See note following RCW 48.44.309.

RCW 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, noninsulin 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.

(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.

Application—2004 c 244: See note following RCW 48.21.045.

Effective date—1997 c 276: See note following RCW 41.05.185.

RCW 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.

Effective date—Severability—1989 1st ex.s. c 9: See RCW 43.70.910 and 43.70.920.

Effective date—1984 c 22: See note following RCW 48.21.220.

Effective date—1983 c 249: See note following RCW 70.126.001.

Home health care, hospice care, rules: Chapter 70.126 RCW.

RCW 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.]

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

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

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

RCW 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, other than the cost-sharing prohibition provided in RCW 48.43.076, that are applicable to other benefits. 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. [2023 c 366 § 5; 1994 sp.s. c 9 § 734; 1989 c 338 § 3.]

***Reviser's note:** The reference to "nursing care quality assurance commission" was changed to "board of nursing" by 2023 c 123.

Intent—2023 c 366: See note following RCW 48.43.076.

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

RCW 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 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 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.]

RCW 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.]

Effective date—1985 c 54: See note following RCW 48.20.397.

RCW 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.]

Effective date—1985 c 54: See note following RCW 48.20.397.

RCW 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.]

Effective date—2007 c 8: See note following RCW 48.20.580.

Effective date—2006 c 74: See note following RCW 48.21.241.

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

RCW 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.]

Savings—Severability—1993 c 272: See notes following RCW 43.20B.347.

RCW 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.

RCW 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.]

RCW 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.

Application—1984 c 190 §§ 2, 5, and 8: See note following RCW 48.21.250.

RCW 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.]

Application—2010 c 110: See note following RCW 48.21.260.

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

RCW 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.

RCW 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.]

RCW 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.]

RCW 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.]

Effective date, application—Severability—1986 c 140: See notes following RCW 48.01.180.

RCW 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.]

RCW 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.]

RCW 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 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 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.]

RCW 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.

RCW 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.

RCW 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.]

Effective date—1991 c 87: See note following RCW 18.64.350.

RCW 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.]

RCW 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).]

Short title—1995 c 1 (Initiative Measure No. 607): See RCW 18.30.900.

RCW 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.]

RCW 48.44.535 Material acquisitions or dispositions. No acquisitions or dispositions of assets need be reported pursuant 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.]

RCW 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.]

RCW 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.]

RCW 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.]

RCW 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.]

RCW 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.]