CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 1197

Chapter 223, Laws of 2005

(partial veto)

59th Legislature
2005 Regular Session

INSURANCE

EFFECTIVE DATE: 7/24/05

Passed by the House March 3, 2005
Yeas 97 Nays 0

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate April 13, 2005
Yeas 45 Nays 0

BRAD OWEN

President of the Senate

Approved April 28, 2005, with the exception of sections 26-30, which are vetoed.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 1197** as passed by the House of Representatives and the Senate on the dates hereon set forth.

RICHARD NAFZIGER

Chief Clerk

FILED

April 28, 2005 - 3:49 p.m.

Secretary of State
State of Washington

SUBSTITUTE HOUSE BILL 1197

Passed Legislature - 2005 Regular Session

State of Washington 59th Legislature 2005 Regular Session

By House Committee on Financial Institutions & Insurance (originally sponsored by Representatives Roach and Kirby; by request of Insurance Commissioner)

READ FIRST TIME 02/07/05.

AN ACT Relating to insurance; amending RCW 48.02.180, 48.05.340, 48.11.100, 48.11.140, 48.14.010, 48.14.0201, 48.17.150, 48.18.100, 48.18.103, 48.18.430, 48.21.047, 48.23.010, 48.24.030, 48.29.010, 48.29.020, 48.29.120, 48.29.130, 48.29.170, 48.30.300, 48.30A.045, 48.30A.060, 48.30A.065, 48.31.100, 48.38.030, 48.44.240, 48.66.020, 48.66.045, 48.66.055, 48.66.130, 48.92.120, 48.98.015, 48.110.030, and 48.110.040; adding a new section to chapter 48.66 RCW; and repealing RCW 48.05.360, 48.29.030, 48.29.060, 48.29.070, 48.29.090, 48.29.100, 48.29.110, and 48.34.910.

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

Sec. 1. RCW 48.02.180 and 1981 c 339 s 1 are each amended to read as follows:

(1) ((~~In addition to such publications as are otherwise authorized under this code,~~)) I<u></u>he commissioner may ((~~from time to time~~)) <u>periodically</u> prepare and publish:

(a) ((~~Booklets containing the insurance code, or supplements thereto, and such related statutes as the commissioner deems suitable and useful for inclusion in an appendix of such booklet or~~

~~supplement.~~)) Title 48 RCW, Title 284 WAC, insurance bulletins and technical assistance advisories, and other laws, rules, or regulations relevant to the regulation of insurance;

(b) Manuals and other material ((~~relative~~)) relating to examinations for ((~~licensing as provided in chapter 48.17 RCW~~)) licensure; and

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

(2) The commissioner may ((~~furnish~~)) provide copies of the ((~~insurance code, supplements thereto, and related statutes~~)) publications referred to in subsection (1)(a) of this section free of charge to:

(a) Public offices and officers in this state ((~~concerned therewith, to~~));

(b) Public officials of other states and jurisdictions ((~~having supervision of~~)) that regulate insurance((~~, to~~));

(c) The library of congress((~~,~~)); and ((~~to~~))

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

(3) Except as provided in subsection (2) of this section, the commissioner shall sell ((~~copies of the insurance code, supplements thereto, examination manuals, and materials as~~)) the publications referred to in subsection (1) of this section((~~, at~~)). The commissioner may charge a reasonable price((~~, fixed by the commissioner, in amount~~)) that is not less than the cost of publication, handling, and distribution ((~~thereof~~)). The commissioner shall promptly deposit all funds received ((~~by him pursuant to~~)) under this subsection with the state treasurer to the credit of the ((~~general fund~~)) insurance commissioner's regulatory account. For appropriation purposes, ((~~such~~)) the funds received and deposited by the commissioner ((~~shall be treated as~~)) are a recovery of a previous expenditure.

Sec. 2. RCW 48.05.340 and 1995 c 83 s 14 are each amended to read as follows:

(1) Subject to RCW 48.05.350 ((~~and 48.05.360~~)) to qualify for authority to transact any one kind of insurance as defined in chapter 48.11 RCW or combination of kinds of insurance as ((~~shown below~~)) set

forth in this subsection, a foreign or alien insurer, whether stock or mutual, or a domestic insurer ((~~hereafter~~)) formed ((~~shall~~)) after the effective date of this section must possess unimpaired paid-in capital stock, if a stock insurer, or unimpaired surplus if a mutual insurer, and additional funds in surplus, as follows, and ((~~shall~~)) must thereafter maintain unimpaired a combined total of: (a) The paid-in capital stock if a stock insurer or surplus if a mutual insurer, plus (b) ((~~such~~)) additional funds in surplus equal to the total of the following initial requirements:

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

Title (((~~in accordance with the provisions of chapter 48.29 RCW~~)))	2,000,000	2,000,000

(2) Capital and surplus requirements are based upon all the kinds of insurance transacted by the insurer wherever it ((~~may~~)) operate<u>s</u> or propose<u>s</u> to operate, whether or not only a portion of ((~~such~~)) <u>the</u> kinds are to be transacted in this state.

(3) Until December 31, 1996, a foreign or alien insurer holding a certificate of authority to transact insurance in this state immediately prior to June 9, 1994, may continue to be authorized to transact the same kinds of insurance as long as it is otherwise qualified for ((~~such~~)) <u>that</u> authority. A domestic insurer<u>, except a title insurer,</u> holding a certificate of authority to transact insurance in this state immediately prior to June 9, 1994, may continue to be authorized to transact the same kinds of insurance as long as it is otherwise qualified for such an authority and thereafter maintains unimpaired the amount of paid-in capital stock, if a stock insurer, or basic surplus, if a mutual or reciprocal insurer, and special or additional surplus as required of it under laws in force immediately prior to June 9, 1994.

Sec. 3. RCW 48.11.100 and 1947 c 79 s .11.10 are each amended to read as follows:

"Title insurance" is insurance of owners of property or others having an interest ((~~therein~~)) <u>in real property</u>, against loss by encumbrance, or defective titles, or adverse claim to title, and <u>associated</u> services ((~~connected therewith~~)).

Sec. 4. RCW 48.11.140 and 1993 c 462 s 53 are each amended to read as follows:

(1) ((~~No~~)) <u>An</u> insurer ((~~shall~~)) <u>may not</u> retain any risk on any one subject of insurance, whether located or to be performed in this state or elsewhere, in an amount exceeding ten percent of its surplus to policyholders.

(2) For the purposes of this section, a "subject of insurance" as

to insurance against fire includes all properties insured by the same insurer ((~~which~~)) that are reasonably subject to loss or damage from the same fire.

(3) Reinsurance in an alien reinsurer not qualified under RCW ((~~48.05.300~~)) 48.12.166 may not be deducted in determining risk retained for the purposes of this section.

(4) In the case of surety insurance, the net retention shall be computed after deduction of reinsurances, the amount assumed by any co-surety, the value of any security deposited, pledged, or held subject to the consent of the surety and for the protection of the surety.

(5) This section does not apply to life insurance, disability insurance, title insurance, or insurance of marine risks or marine protection and indemnity risks.

Sec. 5. RCW 48.14.010 and 1994 c 131 s 2 are each amended to read as follows:

(1) The commissioner shall collect in advance the following fees:

(a)	**For filing charter documents:**	
	(i) Original charter documents, bylaws or record of organization of insurers, or certified copies thereof, required to be filed	$250.00
	(ii) Amended charter documents, or certified copy thereof, other than amendments of bylaws	$ 10.00
	(iii) No additional charge or fee shall be required for filing any of such documents in the office of the secretary of state.	
(b)	**Certificate of authority:**	
	(i) Issuance	$ 25.00
	(ii) Renewal	$ 25.00
(c)	**Annual statement of insurer, filing**	$ 20.00
(d)	**Organization or financing of domestic insurers and affiliated corporations:**	

(i) Application for solicitation permit, filing $100.00

(ii) Issuance of solicitation permit . . . $ 25.00

(e) Agents' licenses:

(i) Agent's qualification licenses every two years . . . . . $ 50.00

(ii) Filing of appointment of each such agent, every two years . . . . . $ 20.00

(iii) Limited license issued pursuant to RCW 48.17.190, every two years . . . . . $ 20.00

(f) Reinsurance intermediary licenses:

(i) Reinsurance intermediary-broker, each year . . . . . $ 50.00

(ii) Reinsurance intermediary-manager, each year $100.00

(g) Brokers' licenses:

(i) Broker's license, every two years $100.00

(ii) Surplus line broker, every two years $200.00

(h) Solicitors' license, every two years . . . . $ 20.00

(i) Adjusters' licenses:

(i) Independent adjuster, every two years . . . . . $ 50.00

(ii) Public adjuster, every two years . . . . . $ 50.00

(j) Resident general agent's license, every two years . . . . . $ 50.00

(k) Managing general agent appointment, every two years $200.00

(l) Examination for license, each examination:

		All examinations, except examinations administered by an independent testing service, the fees for which are to be approved by the commissioner and collected directly by and retained by such independent testing service . . .	$ 20.00
(m)	**Miscellaneous services:**		
	(i)	Filing other documents	$ 5.00
	(ii)	Commissioner's certificate under seal	$ 5.00
	(iii)	Copy of documents filed in the commissioner's office, reasonable charge therefor as determined by the commissioner.	

(2) All fees so collected shall be remitted by the commissioner to the state treasurer not later than the first business day following, and shall be placed to the credit of the general fund((~~: PROVIDED, That~~)).

(a) Fees for examinations administered by an independent testing service ((~~which~~)) that are approved by the commissioner ((~~pursuant to~~)) under subsection (1)(l) of this section shall be collected directly by ((~~such~~)) the independent testing service and retained by it.

(b) Fees for copies of documents filed in the commissioner's office shall be remitted by the commissioner to the state treasurer not later than the first business day following, and shall be placed to the credit of the insurance commissioner's regulatory account.

Sec. 6. RCW 48.14.0201 and 2004 c 260 s 24 are each amended to read as follows:

(1) As used in this section, "taxpayer" means a health maintenance organization as defined in RCW 48.46.020, a health care service contractor as defined in RCW 48.44.010, or a self-funded multiple employer welfare arrangement as defined in RCW 48.125.010.

(2) Each taxpayer shall pay a tax on or before the first day of March of each year to the state treasurer through the insurance commissioner's office. The tax shall be equal to the total amount of all premiums and prepayments for health care services received by the

taxpayer during the preceding calendar year multiplied by the rate of two percent.

(3) Taxpayers shall prepay their tax obligations under this section. The minimum amount of the prepayments shall be percentages of the taxpayer's tax obligation for the preceding calendar year recomputed using the rate in effect for the current year. For the prepayment of taxes due during the first calendar year, the minimum amount of the prepayments shall be percentages of the taxpayer's tax obligation that would have been due had the tax been in effect during the previous calendar year. The tax prepayments shall be paid to the state treasurer through the commissioner's office by the due dates and in the following amounts:

(a) On or before June 15, forty-five percent;

(b) On or before September 15, twenty-five percent;

(c) On or before December 15, twenty-five percent.

(4) For good cause demonstrated in writing, the commissioner may approve an amount smaller than the preceding calendar year's tax obligation as recomputed for calculating the health maintenance organization's, health care service contractor's, self-funded multiple employer welfare arrangement's, or certified health plan's prepayment obligations for the current tax year.

(5) Moneys collected under this section shall be deposited in the general fund through March 31, 1996, and in the health services account under RCW 43.72.900 after March 31, 1996.

(6) The taxes imposed in this section do not apply to:

(a) Amounts received by any taxpayer from the United States or any instrumentality thereof as prepayments for health care services provided under Title XVIII (medicare) of the federal social security act.

(b) Amounts received by any health care service contractor, as defined in RCW 48.44.010, as prepayments for health care services included within the definition of practice of dentistry under RCW 18.32.020.

(c) Participant contributions to self-funded multiple employer welfare arrangements that are not taxable in this state.

(7) Beginning January 1, 2000, the state does hereby preempt the field of imposing excise or privilege taxes upon taxpayers and no county, city, town, or other municipal subdivision shall have the right

to impose any such taxes upon such taxpayers. This subsection shall be limited to premiums and payments for health benefit plans offered by health care service contractors under chapter 48.44 RCW, health maintenance organizations under chapter 48.46 RCW, and self-funded multiple employer welfare arrangements as defined in RCW 48.125.010. The preemption authorized by this subsection shall not impair the ability of a county, city, town, or other municipal subdivision to impose excise or privilege taxes upon the health care services directly delivered by the employees of a health maintenance organization under chapter 48.46 RCW.

(8) The taxes imposed by this section apply to a self-funded multiple employer welfare arrangement only in the event that they are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the commissioner shall initially request an advisory opinion from the United States department of labor or obtain a declaratory ruling from a federal court on the legality of imposing state premium taxes on these arrangements. If there has not been a final determination by the United States department of labor or a federal court that the taxes are not preempted by federal law, the taxes provided for in this section become effective on March 1, 2005, or thirty days following the issuance of a certificate of authority, whichever is later. During the time period between March 1, 2005, or thirty days following the issuance of a certificate of authority, whichever is later, and the final determination by the United States department of labor or a federal court, any taxes shall be deposited in an interest bearing escrow account maintained by the [self-funded] multiple employer welfare arrangement. Upon a final determination that the taxes are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq., all funds in the interest bearing escrow account shall be transferred to the state treasurer.

(9) The effect of transferring contracts for health care services from one taxpayer to another taxpayer is to transfer the tax prepayment obligation with respect to the contracts.

(10) On or before June 1st of each year, the commissioner shall notify each taxpayer required to make prepayments in that year of the amount of each prepayment and shall provide remittance forms to be used

by the taxpayer. However, a taxpayer's responsibility to make prepayments is not affected by failure of the commissioner to send, or the taxpayer to receive, the notice or forms.

Sec. 7. RCW 48.17.150 and 1994 c 131 s 4 are each amended to read as follows:

(1) To qualify for an agent's or broker's license, an applicant must otherwise comply with this code ((~~therefor~~)) and must:

(a) Be at least eighteen years of age ((~~or over~~)), if an individual;

(b) Be a bona fide resident of and actually reside in this state, or if a corporation, be other than an insurer and maintain a lawfully established place of business in this state, except as provided in RCW 48.17.330;

(c) Be empowered to be an agent or broker((~~, as the case may be,~~)) under its members' agreement, if a firm, or by its articles of incorporation, if a corporation;

(d) Complete ((~~such~~)) the minimum educational requirements for the issuance of an agent's license for the kinds of insurance specified in RCW 48.17.210 as may be required by regulation issued by the commissioner;

(e) Successfully pass any examination as required under RCW 48.17.110;

(f) Be a trustworthy person;

(g)(i) If for an agent's license, be appointed as its agent by one or more authorized insurers, subject to issuance of the license; ((~~and~~))

(ii) The commissioner may by regulation establish requirements, including notification formats, in addition to or in lieu of the requirements of (g)(i) of this subsection to allow an agent to act as a representative of and place insurance with an insurer without first notifying the commissioner of the appointment for a period of time up to but not exceeding thirty days from the date the first insurance application is executed by the agent; and

(h) If for broker's license, have had at least two years experience either as an agent, solicitor, adjuster, general agent, broker, or as an employee of insurers or representatives of insurers, and special

education or training of sufficient duration and extent reasonably to satisfy the commissioner that ((~~he~~)) the applicant possesses the competence necessary to fulfill the responsibilities of broker.

(2) The commissioner shall by regulation establish minimum continuing education requirements for the renewal or reissuance of a license to an agent or a broker((~~: PROVIDED, That~~)).

(a) The commissioner shall require that continuing education courses will be made available on a statewide basis in order to ensure that persons residing in all geographical areas of this state will have a reasonable opportunity to attend such courses.

(b) The continuing education requirements ((~~shall~~)) must be appropriate to the license for the kinds of insurance specified in RCW 48.17.210((~~: PROVIDED FURTHER, That~~)).

(c) The continuing education requirements may be waived by the commissioner for good cause shown.

(3) If the commissioner finds that the applicant is ((~~so~~)) qualified and that the license fee has been paid, the license shall be issued. Otherwise, the commissioner shall refuse to issue the license.

Sec. 8. RCW 48.18.100 and 1997 c 428 s 3 are each amended to read as follows:

(1) No insurance policy form ((~~other than surety bond forms, forms exempt under RCW 48.18.103,~~)) or application form where written application is required and is to be attached to the policy, or printed life or disability rider or endorsement form ((~~shall~~)) may be issued, delivered, or used unless it has been filed with and approved by the commissioner. This section ((~~shall~~)) does not apply to:

(a) Surety bond forms;

(b) Forms filed under RCW 48.18.103;

(c) Forms exempted from filing requirements by the commissioner under RCW 48.18.103;

(d) Manuscript policies, riders, or endorsements of unique character designed for and used with relation to insurance upon a particular subject; or

(e) Contracts of insurance procured under the provisions of chapter 48.15 RCW.

(2) Every such filing containing a certification, in a form approved by the commissioner, by either the chief executive officer of

the insurer or by an actuary who is a member of the American academy of actuaries, attesting that the filing complies with Title 48 RCW and Title 284 of the Washington Administrative Code, may be used by ((~~such~~)) the insurer immediately after filing with the commissioner. The commissioner may order an insurer to cease using a certified form upon the grounds set forth in RCW 48.18.110. This subsection ((~~shall~~)) does not apply to certain types of policy forms designated by the commissioner by rule.

(3) Except as provided in RCW 48.18.103, every filing that does not contain a certification pursuant to subsection (2) of this section ((~~shall~~)) must be made not less than thirty days in advance of ((~~any such~~)) issuance, delivery, or use. At the expiration of ((~~such~~)) the thirty days, the filed form ((~~so filed~~)) shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the commissioner. The commissioner may extend by not more than an additional fifteen days the period within which he or she may ((~~so~~)) affirmatively approve or disapprove any ((~~such~~)) form, by giving notice of ((~~such~~)) the extension before expiration of the initial thirty-day period. At the expiration of ((~~any such~~)) the period ((~~as so~~)) that has been extended, and in the absence of ((~~such~~)) prior affirmative approval or disapproval, ((~~any such~~)) the form shall be deemed approved. The commissioner may withdraw any ((~~such~~)) approval at any time for cause. By approval of any ((~~such~~)) form for immediate use, the commissioner may waive any unexpired portion of ((~~such~~)) the initial thirty-day waiting period.

(4) The commissioner's order disapproving any ((~~such~~)) form or withdrawing a previous approval ((~~shall~~)) must state the grounds ((~~therefor~~)) for disapproval.

(5) No ((~~such~~)) form ((~~shall~~)) may knowingly be ((~~so~~)) issued or delivered as to which the commissioner's approval does not then exist.

(6) The commissioner may, by ((~~order~~)) rule, exempt from the requirements of this section ((~~for so long as he or she deems proper,~~)) any class or type of insurance ((~~document or form or type thereof as specified in such order, to which in his or her opinion this section may not practicably be applied, or the~~)) policy forms if filing and approval ((~~of which are, in his or her opinion,~~)) is not desirable or necessary for the protection of the public.

(7) Every member or subscriber to a rating organization ((~~shall~~)) must adhere to the form filings made on its behalf by the organization. Deviations from ((~~such~~)) the organization are permitted only when filed with the commissioner in accordance with this chapter.

Sec. 9. RCW 48.18.103 and 2003 c 248 s 4 are each amended to read as follows:

(1) It is the intent of the legislature to assist the purchasers of commercial property casualty insurance by allowing policies to be issued more expeditiously and provide a more competitive market for forms.

(2) Commercial property casualty policies may be issued prior to filing the forms.

(3) All commercial property casualty forms ((~~shall~~)) must be filed with the commissioner within thirty days after an insurer issues any policy using them. This subsection does not apply to:

(a) Types or classes of forms that the commissioner exempts from filing by rule; and

(b) Manuscript policies, riders, or endorsements of unique character designed for and used with relation to insurance upon a particular subject.

((~~(3)~~)) (4) If, within thirty days after a commercial property casualty form has been filed, the commissioner finds that the form does not meet the requirements of this chapter, the commissioner shall disapprove the form and give notice to the insurer or rating organization that made the filing, specifying how the form fails to meet the requirements and stating when, within a reasonable period thereafter, the form shall be deemed no longer effective. The commissioner may extend the time for review ((~~another~~)) an additional fifteen days by giving notice to the insurer prior to the expiration of the original thirty-day period.

((~~(4)~~)) (5) Upon a final determination of a disapproval of a policy form under subsection ((~~(3)~~)) (4) of this section, the insurer ((~~shall~~)) must amend any previously issued disapproved form by endorsement to comply with the commissioner's disapproval.

((~~(5)~~)) (6) For purposes of this section, "commercial property casualty" means insurance pertaining to a business, profession,

occupation, nonprofit organization, or public entity for the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, or 48.11.070.

((~~(6)~~)) (7) Except as provided in subsection ((~~(4)~~)) (5) of this section, the disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice of disapproval.

((~~(7)~~)) (8) Every member or subscriber to a rating organization must adhere to the form filings made on its behalf by the organization. An insurer may deviate from forms filed on its behalf by an organization only if the insurer files the forms with the commissioner in accordance with this chapter.

(9) In the event a hearing is held on the actions of the commissioner under subsection ((~~(3)~~)) (4) of this section, the burden of proof shall be on the commissioner.

Sec. 10. RCW 48.18.430 and 1949 c 190 s 25 are each amended to read as follows:

(1) The benefits, rights, privileges, and options ((~~which~~)) under any annuity contract ((~~heretofore or hereafter issued are due or prospectively~~)) that are due the annuitant who paid the consideration for the annuity contract((~~, shall not be~~)) are not subject to execution ((~~nor shall~~)) and the annuitant may not be compelled to exercise ((~~any such~~)) those rights, powers, or options, ((~~nor shall~~)) and creditors ((~~be~~)) are not allowed to interfere with or terminate the contract, except:

(a) As to amounts paid for or as premium on ((~~any such~~)) an annuity with intent to defraud creditors, with interest thereon, and of which the creditor has given the insurer written notice at its home office prior to ((~~the~~)) making ((~~of~~)) the payments to the annuitant out of which the creditor seeks to recover. ((~~Any such~~)) The notice ((~~shall~~)) must specify the amount claimed or ((~~such~~)) the facts ((~~as~~)) that will enable the insurer to ((~~ascertain such~~)) determine the amount, and ((~~shall~~)) must set forth ((~~such~~)) the facts ((~~as~~)) that will enable the insurer to ((~~ascertain~~)) determine the insurance or annuity contract, the person insured or annuitant and the payments sought to be avoided on the ((~~ground~~)) basis of fraud.

(b) The total exemption of benefits presently due and payable to ((~~any~~)) an annuitant periodically or at stated times under all annuity contracts ((~~under which he is an annuitant, shall~~)) may not at any time exceed two thousand five hundred ((~~and fifty~~)) dollars per month for the length of time represented by ((~~such~~)) the installments, and ((~~that such~~)) a periodic payment in excess of two thousand five hundred ((~~and fifty~~)) dollars per month ((~~shall be~~)) is subject to garnishee execution to the same extent as are wages and salaries.

(c) If the total benefits presently due and payable to ((~~any~~)) an annuitant under all annuity contracts ((~~under which he is an annuitant, shall~~)) at any time exceeds payment at the rate of two thousand five hundred ((~~and fifty~~)) dollars per month, then the court may order ((~~such~~)) the annuitant to pay to a judgment creditor or apply on the judgment, in installments, ((~~such~~)) the portion of ((~~such~~)) the excess benefits ((~~as to~~)) that the court ((~~may appear~~)) determines to be just and proper, after due regard for the reasonable requirements of the judgment debtor and ((~~his family, if dependent upon him~~)) the judgment debtor's dependent family, as well as any payments required to be made by the annuitant to other creditors under prior court orders.

(2) The benefits, rights, privileges, or options accruing under ((~~such~~)) an annuity contract to a beneficiary or assignee ((~~shall not be~~)) are not transferable ((~~nor~~)) or subject to commutation, and if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained ((~~herein~~)) in this section for the annuitant((~~, shall apply with respect to such~~)) apply to the beneficiary or assignee.

(3) An annuity contract within the meaning of this section ((~~shall be~~)) is any obligation to pay certain sums at stated times, during life or lives, or for a specified term or terms, issued for a valuable consideration, regardless of whether or not ((~~such~~)) the sums are payable to one or more persons, jointly or otherwise, but does not include payments under life insurance contracts at stated times during life or lives, or for a specified term or terms.

Sec. 11. RCW 48.21.047 and 1995 c 265 s 22 are each amended to read as follows:

(1) ((~~No insurer shall~~)) An insurer may not offer any health

benefit plan to any small employer without complying with ((~~the provisions of~~)) RCW 48.21.045((~~(5)~~)) (3).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care ((~~shall not be considered~~)) are not small employers and ((~~such plans shall not be subject to the provisions of RCW 48.21.045(5)~~)) the plans are not subject to RCW 48.21.045(3).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 12. RCW 48.23.010 and 1979 c 130 s 2 are each amended to read as follows:

((~~The provisions of this chapter apply~~)) This chapter applies to contracts of life insurance and annuities other than group life insurance, group annuities, and, except for RCW 48.23.260, 48.23.270, and 48.23.340, ((~~and 48.23.350,~~)) other than industrial life insurance((~~: PROVIDED, That the provisions of~~)). However, Title 48 RCW ((~~shall~~)) does not apply to charitable gift annuities issued by a board of a state university, regional university, or a state college, nor to the issuance thereof.

Sec. 13. RCW 48.24.030 and 1993 c 132 s 1 are each amended to read as follows:

(1) Insurance under any group life insurance policy issued ((~~pursuant to~~)) under RCW 48.24.020, ((~~or~~)) 48.24.050, ((~~or~~)) 48.24.060, ((~~or~~)) 48.24.070, or 48.24.090 may, if seventy-five percent of the then insured employees or labor union members or public employee association members or members of the Washington state patrol elect, be extended to insure the spouse and dependent children, or any class or classes thereof, of each ((~~such~~)) insured employee or member who so elects, in amounts in accordance with a plan ((~~which~~)) that precludes individual selection by the employees or members or by the employer or labor union or trustee((~~, and which insurance on the life of any one family member including a spouse shall not be in excess of fifty percent of the insurance on the life of the insured employee or member~~)).

Premiums for the insurance on ((~~such~~)) the family members shall be

paid by the policyholder, either from the employer's funds or funds contributed by him, trustee's funds, or labor union funds, and/or from funds contributed by the insured employees or members, or from both.

(2) ((~~Such~~)) A spouse insured ((~~pursuant to~~)) under this section ((~~shall have~~)) has the same conversion right as to the insurance on his or her life as is vested in the employee or member under this chapter.

Sec. 14. RCW 48.29.010 and 1997 c 14 s 1 are each amended to read as follows:

(1) This chapter relates only to title insurers for real property.

(2) ((~~None of the provisions of~~)) This code ((~~shall be deemed to~~)) does not apply to persons engaged in the business of preparing and issuing abstracts of title to property and certifying to ((~~the~~)) their correctness ((~~thereof~~)) so long as ((~~such~~)) the persons do not guarantee or insure ((~~such~~)) the titles.

(3) For purposes of this chapter, unless the context clearly requires otherwise:

(a) "Title policy" means any written instrument, contract, or guarantee by means of which title insurance liability is assumed.

(b) "Abstract of title" means a written representation, provided ((~~pursuant to~~)) under contract, whether written or oral, intended to be relied upon by the person who has contracted for the receipt of ((~~such~~)) this representation, listing all recorded conveyances, instruments, or documents ((~~which~~)) that, under the laws of the state of Washington, impart constructive notice with respect to the chain of title to the real property described. An abstract of title is not a title policy as defined in this subsection.

(c) "Preliminary report," "commitment," or "binder" means reports furnished in connection with an application for title insurance and are offers to issue a title policy subject to the stated exceptions ((~~set forth~~)) in the reports, the conditions and stipulations of the report and the issued policy, and ((~~such~~)) other matters as may be incorporated by reference. The reports are not abstracts of title, nor are any of the rights, duties, or responsibilities applicable to the preparation and issuance of an abstract of title applicable to the issuance of any report. ((~~Any such~~)) The report ((~~shall not be construed as, nor constitute,~~)) is not a representation as to the

condition of the title to real property, but ((~~shall constitute~~)) is a statement of terms and conditions upon which the issuer is willing to issue its title policy, if ((~~such~~)) the offer is accepted.

Sec. 15. RCW 48.29.020 and 1990 c 76 s 1 are each amended to read as follows:

A title insurer ((~~shall not be~~)) is not entitled to have a certificate of authority unless ((~~it otherwise qualifies therefor, nor unless~~)):

(1) It is a stock corporation((~~.~~));

(2) It owns or leases and maintains a complete set of tract indexes of the county in this state in which its principal office ((~~within this state~~)) is located((~~.~~)); and

(3) ((~~It deposits and keeps on deposit with the commissioner a guaranty fund in amount as set forth in RCW 48.29.030 and comprised of cash or public obligations as specified in RCW 48.13.040.~~)) It has and maintains the capital and surplus requirements set forth in RCW 48.05.340.

Sec. 16. RCW 48.29.120 and 1947 c 79 s .29.12 are each amended to read as follows:

((~~(1) Each title insurer shall annually apportion to a special reserve fund an amount determined by applying the rate of twenty-five cents for each one thousand dollars of net increase of insurance it has in force as at the end of such year. Such apportionment shall be continued or resumed as needed to maintain the special reserve fund at an amount equal to not less than the guaranty fund deposit required of the insurer.~~

~~(2) The special reserve fund shall be held by the insurer as an additional guaranty fund, and shall be used only for the payment of losses after the insurer's liquid resources available for the payment of losses, other than such special reserve fund or the guaranty fund deposit, have been exhausted.~~

~~(3) For the purposes of computing the special reserve fund as provided in subsection (1) of this section, net increase of insurance in force resulting from reinsurance of the risks of another title insurer shall not be included to the extent that a like special reserve fund on such insurance is maintained by the ceding insurer.~~)) In

determining the financial condition of a title insurer doing business under this title, the general provisions of chapter 48.12 RCW requiring the establishment of reserves sufficient to cover all known and unknown liabilities including allocated and unallocated loss adjustment expense apply, except that a title insurer shall establish and maintain:

(1) A known claim reserve in an amount estimated to be sufficient to cover all unpaid losses, claims, and allocated loss adjustment expenses arising under title insurance policies, guaranteed certificates of title, guaranteed searches, and guaranteed abstracts of title, and all unpaid losses, claims, and allocated loss adjustment expenses for which the title insurer may be liable, and for which the insurer has received notice by or on behalf of the insured, holder of a guarantee or escrow, or security depositor;

(2)(a) A statutory or unearned premium reserve consisting of:

(i) The amount of the special reserve fund that was required prior to the effective date of this section, which balance must be released in accordance with (b) of this subsection; and

(ii) Additions to the reserve after the effective date of this section must be made out of total charges for title insurance policies and guarantees written, as set forth in the title insurer's most recent annual statement on file with the commissioner, equal to the sum of the following:

(A) For each title insurance policy on a single risk written or assumed after the effective date of this section, fifteen cents per one thousand dollars of net retained liability for policies under five hundred thousand dollars; and

(B) For each title insurance policy on a single risk written or assumed after the effective date of this section, ten cents per one thousand dollars of net retained liability for policies of five hundred thousand or greater.

(b) The aggregate of the amounts set aside in this reserve in any calendar year pursuant to (a) of this subsection must be released from the reserve and restored to net profits over a period of twenty years under the following formula:

(i) Thirty-five percent of the aggregate sum on July 1st of the year next succeeding the year of addition;

(ii) Fifteen percent of the aggregate sum on July 1st of each of the succeeding two years;

(iii) Ten percent of the aggregate sum on July 1st of the next succeeding year;

(iv) Three percent of the aggregate sum on July 1st of each of the next three succeeding years;

(v) Two percent of the aggregate sum on July 1st of each of the next three succeeding years; and

(vi) One percent of the aggregate sum on July 1st of each of the next succeeding ten years.

(c) The insurer shall calculate an adjusted statutory unearned premium reserve as of the effective date of this section. The adjusted reserve is calculated as if (a)(ii) and (b) of this subsection had been in effect for all years beginning twenty years prior to the effective date of this section. For purposes of this calculation, the balance of the reserve as of that date is deemed to be zero. If the adjusted reserve so calculated exceeds the aggregate amount set aside for statutory or unearned premiums in the insurer's annual statement on file with the commissioner on the effective date of this section, the insurer shall, out of total charges for policies of title insurance, increase its statutory or unearned premium reserve by an amount equal to one-sixth of that excess in each of the succeeding six years, commencing with the calendar year that includes the effective date of this section, until the entire excess has been added.

(d) The aggregate of the amounts set aside in this reserve in any calendar year as adjustments to the insurer's statutory or unearned premium reserve under (c) of this subsection shall be released from the reserve and restored to net profits, or equity if the additions required by (c) of this subsection reduced equity directly, over a period not exceeding ten years under to the following table:

Year of Addition	Release
Year 1[1]	Equally over 10 years
Year 2	Equally over 9 years
Year 3	Equally over 8 years
Year 4	Equally over 7 years
Year 5	Equally over 6 years
Year 6	Equally over 5 years

[1](The calendar year following the effective date of this section).

(3) A supplemental reserve shall be established consisting of any other reserves necessary, when taken in combination with the reserves required by subsections (1) and (2) of this section, to cover the company's liabilities with respect to all losses, claims, and loss adjustment expenses.

(4) The supplemental reserve required under subsection (3) of this section shall be phased in as follows: Twenty-five percent of the otherwise applicable supplemental reserve is required until December 31, 2006; fifty percent of the otherwise applicable supplemental reserve is required until December 31, 2007; and seventy-five percent of the otherwise applicable supplemental reserve is required until December 31, 2008.

Sec. 17. RCW 48.29.130 and 1967 c 150 s 30 are each amended to read as follows:

((~~The funds of a domestic title insurer, other than those representing its guaranty fund deposit, shall be invested~~)) A domestic title insurer shall invest its funds as follows:

(1) Funds in an amount not less than its reserve required ((~~special reserve shall~~)) by RCW 48.29.120 must be kept invested in investments eligible for domestic life insurers.

(2) Other funds may be invested in:

(a) The insurer's plant and equipment, up to a maximum of fifty percent of capital plus surplus.

(b) Stocks and bonds of abstract companies when approved by the commissioner.

(c) Investments eligible for the investment of funds of any domestic insurer.

Sec. 18. RCW 48.29.170 and 1981 c 223 s 2 are each amended to read as follows:

Title insurance agents ((~~shall be~~)) are exempt from the provisions of RCW ((~~48.17.090(2) and~~)) 48.17.180(1) ((~~which otherwise~~)) that require that each individual empowered to exercise the authority of a licensed firm or corporation must be separately licensed.

Sec. 19. RCW 48.30.300 and 1993 c 492 s 287 are each amended to read as follows:

Notwithstanding any provision contained in Title 48 RCW to the contrary:

((~~(1) No~~)) A person or entity engaged in the business of insurance in this state ((~~shall~~)) may not refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex or marital status, or the presence of any sensory, mental, or physical handicap of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage ((~~shall~~)) may not be restricted, modified, excluded, increased, or reduced on the basis of the sex or marital status, or be restricted, modified, excluded, or reduced on the basis of the presence of any sensory, mental, or physical handicap of the insured or prospective insured. ((~~Subject to the provisions of subsection (2) of this section these provisions shall~~)) This subsection does not prohibit fair discrimination on the basis of sex, or marital status, or the presence of any sensory, mental, or physical handicap when bona fide statistical differences in risk or exposure have been substantiated.

((~~(2) With respect to disability policies issued or renewed on and after July 1, 1994, that provide coverage against loss arising from medical, surgical, hospital, or emergency care services:~~

~~(a) Policies shall guarantee continuity of coverage. Such provision, which shall be included in every policy, shall provide that:~~

~~(i) The policy may be canceled or nonrenewed without the prior written approval of the commissioner only for nonpayment of premium or as permitted under RCW 48.18.090; and~~

~~(ii) The policy may be canceled or nonrenewed because of a change in the physical or mental condition or health of a covered person only with the prior written approval of the commissioner. Such approval shall be granted only when the insurer has discharged its obligation to continue coverage for such person by obtaining coverage with another insurer, health care service contractor, or health maintenance organization, which coverage is comparable in terms of premiums and benefits as defined by rule of the commissioner.~~

~~(b) It is an unfair practice for a disability insurer to modify the coverage provided or rates applying to an in-force disability insurance~~

~~policy and to fail to make such modification in all such issued and outstanding policies.~~

~~(c) Subject to rules adopted by the commissioner, it is an unfair practice for a disability insurer to:~~

~~(i) Cease the sale of a policy form unless it has received prior written authorization from the commissioner and has offered all policyholders covered under such discontinued policy the opportunity to purchase comparable coverage without health screening; or~~

~~(ii) Engage in a practice that subjects policyholders to rate increases on discontinued policy forms unless such policyholders are offered the opportunity to purchase comparable coverage without health screening.~~

~~The insurer may limit an offer of comparable coverage without health screening to a period not less than thirty days from the date the offer is first made.~~))

Sec. 20. RCW 48.30A.045 and 1997 c 92 s 1 are each amended to read as follows:

(1) Each insurer licensed to write direct insurance in this state, except those exempted in subsection (2) of this section, shall institute and maintain an insurance antifraud plan. ((~~An insurer licensed on July 1, 1995, shall file its antifraud plan with the insurance commissioner no later than December 31, 1995.~~)) An insurer licensed after July 1, 1995, shall file its antifraud plan within six months of licensure. An insurer shall file any change to the antifraud plan with the insurance commissioner within thirty days after the plan has been modified.

(2) This section does not apply to:

(a) Health carriers, as defined in RCW 48.43.005((~~,~~));

(b) Life insurers((~~, or~~));

(c) Title insurers; ((~~or~~))

(d) Property or casualty insurers with annual gross written medical malpractice insurance premiums in this state that exceed fifty percent of their total annual gross written premiums in this state; ((~~or all~~))

(e) Credit-related insurance written in connection with a credit transaction in which the creditor is named as a beneficiary or loss payee under the policy, except vendor single-interest or collateral protection coverage as defined in RCW 48.22.110(4); or

(f) Insurers with gross written premiums of less than one thousand dollars in Washington during the reporting year.

Sec. 21. RCW 48.30A.060 and 1995 c 285 s 12 are each amended to read as follows:

By March 31st of each year, each insurer shall ((~~annually~~)) provide to the insurance commissioner a summary report on actions taken under its antifraud plan to prevent and combat insurance fraud. The report must also include, but not be limited to, measures taken to protect and ensure the integrity of electronic data processing-generated data and manually compiled data, statistical data on the amount of resources committed to combatting fraud, and the amount of fraud identified and recovered during the reporting period. The antifraud plans and summary of the insurer's antifraud activities are not public records and are exempt from chapter 42.17 RCW, are proprietary, are not subject to public examination, and are not discoverable or admissible in civil litigation.

Sec. 22. RCW 48.30A.065 and 1995 c 285 s 13 are each amended to read as follows:

An insurer that fails to file a timely antifraud plan or ((~~who does not~~)) summary report or that fails to make a good faith attempt to file an antifraud plan that complies with RCW 48.30A.050 or a summary report that complies with RCW 48.30A.060, is subject to the penalty provisions of RCW 48.01.080, but no penalty may be imposed for the first filing made by an insurer under this chapter. An insurer that fails to follow the antifraud plan is subject to a civil penalty not to exceed ten thousand dollars for each violation, at the discretion of the commissioner after consideration of all relevant factors, including the willfulness of the violation.

Sec. 23. RCW 48.31.100 and 1947 c 79 s .31.10 are each amended to read as follows:

(1) An order to conserve the assets of a foreign or alien insurer ((~~shall~~)) must direct the commissioner ((~~forthwith~~)) immediately to take possession of the property of the insurer within this state and to conserve it, subject to the further direction of the court.

(2) Whenever a domiciliary receiver is appointed for ((~~any such~~)) a foreign or alien insurer in its domiciliary state ((~~which~~)) that is also a reciprocal state, as defined in RCW ((~~48.31.110~~)) 48.99.010, the court shall on application of the commissioner appoint the commissioner as the ancillary receiver in this state, subject to the provisions of the uniform insurers liquidation act.

Sec. 24. RCW 48.38.030 and 1979 c 130 s 8 are each amended to read as follows:

Each charitable annuity contract or policy form ((~~shall~~)) must include the following information:

(1) The value of the property to be transferred;

(2) The amount of the annuity to be paid to the transferor or the transferor's nominee;

(3) The manner in which and the intervals at which payment is to be made;

(4) The age of the person during whose life payment is to be made; and

(5) The reasonable value as of the date of the agreement of the benefits ((~~thereby~~)) created. This value ((~~shall~~)) may not exceed by more than fifteen percent the net single premium for the benefits, determined ((~~in accordance with~~)) according to the standard of valuation set forth in RCW 48.38.020((~~(1)~~)) (3).

Sec. 25. RCW 48.44.240 and 1990 1st ex.s. c 3 s 12 are each amended to read as follows:

Each group contract for health care services ((~~which~~)) that is delivered or issued for delivery or renewed, on or after January 1, 1988, ((~~shall~~)) must contain provisions providing benefits for the treatment of chemical dependency rendered to covered persons by a provider ((~~which~~)) that is an "approved treatment ((~~facility or~~)) program" under RCW 70.96A.020(3).

NEW SECTION.** **Sec. 26.** **A new section is added to chapter 48.66 RCW to read as follows:

(1) An issuer may not deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this state, or discriminate in the pricing of a

policy or certificate, because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both sixty-five years of age or older and is enrolled for benefits under medicare part B. Each medicare supplement policy and certificate currently available from an insurer must be made available to all applicants who qualify under this subsection without regard to age.

(2) If an applicant qualifies under this section and submits an application during the time period referenced in subsection (1) of this section and, as of the date of application, has had a continuous period of creditable coverage of at least three months, the issuer may not exclude benefits based on a preexisting condition.

(3) If an applicant qualified under this section submits an application during the time period referenced in subsection (1) of this section and, as of the date of application, has had a continuous period of creditable coverage that is less than three months, the issuer must reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date.

**Sec. 26 was vetoed. See message at end of chapter.*

**Sec. 27. RCW 48.66.020 and 1996 c 269 s 1 are each amended to read as follows:*

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

(1) "Medicare supplemental insurance" or "medicare supplement insurance policy" refers to a group or individual policy of disability insurance or a subscriber contract of a health care service contractor, a health maintenance organization, or a fraternal benefit society, which relates its benefits to medicare, or which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. ((~~Such~~)) The term does not include:

(a) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees

or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; ((~~or~~))

(b) A policy issued pursuant to a contract under Section 1876 of the federal social security act (42 U.S.C. Sec. 1395 et seq.), or an issued policy under a demonstration specified in 42 U.S.C. Sec. 1395(g)(1); ((~~or~~))

(c) ((~~Insurance policies or health care benefit plans, including group conversion policies, provided to medicare eligible persons, that are not marketed or held to be medicare supplement policies or benefit plans~~)) Medicare advantage plans established under medicare part C;

(d) Outpatient prescription drug plans established under medicare part D; or

(e) Any health care prepayment plan that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the federal social security act.

(2) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(3) "Medicare advantage plan" means a plan of coverage for health benefits under medicare part C as defined in 42 U.S.C. Sec. 1395w-28(b), and includes:

(a) Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;

(b) Medical savings account plans coupled with a contribution into a medicare advantage plan medical savings account; and

(c) Medicare advantage private fee-for-service plans.

(4) "Medicare eligible expenses" means health care expenses of the kinds covered by medicare, to the extent recognized as reasonable and medically necessary by medicare.

((~~(4)~~)) (5) "Applicant" means:

(a) In the case of an individual medicare supplement insurance policy or subscriber contract, the person who seeks to contract for insurance benefits; and

(b) In the case of a group medicare supplement insurance policy or subscriber contract, the proposed certificate holder.

((~~(5)~~)) (6) "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement insurance policy.

((~~(6)~~)) (7) "Loss ratio" means the incurred claims as a percentage of the earned premium computed under rules adopted by the insurance commissioner.

((~~(7)~~)) (8) "Preexisting condition" means a covered person's medical condition that caused that person to have received medical advice or treatment during a specified time period immediately prior to the effective date of coverage.

((~~(8)~~)) (9) "Disclosure form" means the form designated by the insurance commissioner ((~~which~~)) that discloses medicare benefits, the supplemental benefits offered by the insurer, and the remaining amount for which the insured will be responsible.

((~~(9)~~)) (10) "Issuer" includes insurance companies, health care service contractors, health maintenance organizations, fraternal benefit societies, and any other entity delivering or issuing for delivery medicare supplement policies or certificates to a resident of this state.

(11) "Bankruptcy" means when a medicare advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(12) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three days.

(13)(a) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(i) A group health plan;

(ii) Health insurance coverage;

(iii) Part A or part B of Title XVIII of the social security act (medicare);

(iv) Title XIX of the social security act (medicaid), other than coverage consisting solely of benefits under section 1928 of that act;

(v) Chapter 55 of Title 10 U.S.C. (CHAMPUS);

(vi) A medical care program of the Indian health service or of a tribal organization;

(vii) A state health benefits risk pool;

(viii) A health plan offered under chapter 89 of Title 5 U.S.C. (federal employees health benefits program);

(ix) A public health plan as defined in federal regulation; or

(x) A health benefit plan under section 5(e) of the peace corps act (22 U.S.C. Sec. 2504(e)).

(b) "Creditable coverage" does not include one or more, or any combination, of the following:

(i) Coverage only for accident or disability income insurance, or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Worker's compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) "Creditable coverage" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(iii) Other similar, limited benefits as are specified in federal regulations.

(d) "Creditable coverage" does not include the following benefits if offered as independent, noncoordinated benefits:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(e) "Creditable coverage" does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the social security act;

(ii) Coverage supplemental to the coverage provided under chapter 55 of Title 10 U.S.C.; or

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(14) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. Sec. 1002 (employee retirement income security act).

(15) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

**Sec. 27 was vetoed. See message at end of chapter.*

***Sec. 28. RCW 48.66.045 and 2004 c 83 s 1 are each amended to read as follows:**

Every issuer of a medicare supplement insurance policy or certificate providing coverage to a resident of this state issued on or after January 1, 1996, shall:

(1) Unless otherwise provided for in RCW 48.66.055, issue coverage under its standardized benefit plans B, C, D, E, F, ((~~and~~)) G, K, or L without evidence of insurability to any resident of this state who is eligible for both medicare hospital and physician services by reason of age or by reason of disability or end-stage renal disease, if the medicare supplement policy replaces another medicare supplement standardized benefit plan policy or certificate B, C, D, E, F, ((~~or~~)) G, K, or L or other more comprehensive coverage than the replacing policy;

(2) Unless otherwise provided for in RCW 48.66.055, issue coverage under its standardized plans A, H, I, and J without evidence of insurability to any resident of this state who is eligible for both medicare hospital and physician services by reason of age or by reason of disability or end-stage renal disease, if the medicare supplement policy replaces another medicare supplement policy or certificate which is the same standardized plan as the replaced policy. After December 31, 2005, plans H, I, and J may be replaced only by the same plan if that plan has been modified to remove outpatient prescription drug coverage; and

(3) Set rates only on a community-rated basis. Premiums shall be equal for all policyholders and certificate holders under a standardized medicare supplement benefit plan form, except that an issuer may vary premiums based on spousal discounts, frequency of

payment, and method of payment including automatic deposit of premiums and may develop no more than two rating pools that distinguish between an insured's eligibility for medicare by reason of:

(a) Age; or

(b) Disability or end-stage renal disease.

**Sec. 28 was vetoed. See message at end of chapter.*

**Sec. 29. RCW 48.66.055 and 2002 c 300 s 4 are each amended to read as follows:*

(1) Under this section, persons eligible for a medicare supplement policy or certificate are those individuals described in subsection (3) of this section who, subject to subsection (3)(b)(ii) of this section, apply to enroll under the policy not later than sixty-three days after the date of the termination of enrollment described in subsection (3) of this section, and who submit evidence of the date of termination or disenrollment, or medicare part D enrollment, with the application for a medicare supplement policy.

(2) With respect to eligible persons, an issuer may not deny or condition the issuance or effectiveness of a medicare supplement policy described in subsection (4) of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a medicare supplement policy.

(3) "Eligible persons" means an individual that meets the requirements of (a), (b), (c), (d), (e), or (f) of this subsection, as follows:

(a) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(b)(i) The individual is enrolled with a ((~~medicare+choice~~)) medicare advantage organization under a ((~~medicare+choice~~)) medicare advantage plan under part C of medicare, and any of the following circumstances apply, or the individual is sixty-five years of age or older and is enrolled with a program of all inclusive care for the elderly (PACE) provider under section 1894 of the social security act, and there are circumstances similar to those described in this

subsection (3)(b) that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a ((~~medicare+choice~~)) medicare advantage plan:

(A) The certification of the organization or plan ((~~under this subsection (3)(b)~~)) has been terminated((~~, or the organization or plan has notified the individual of an impending termination of such a certification~~));

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides((~~, or has notified the individual of an impending termination or discontinuance of such a plan~~));

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary of the United States department of health and human services, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal social security act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the federal social security act), or the plan is terminated for all individuals within a residence area;

(D) The individual demonstrates, in accordance with guidelines established by the secretary of the United States department of health and human services, that:

(I) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(II) The organization, an agent, or other entity acting on the organization's behalf materially misrepresented the plan's provisions in marketing the plan to the individual; or

(E) The individual meets other exceptional conditions as the secretary of the United States department of health and human services may provide.

(ii)(A) An individual described in (b)(i) of this subsection may elect to apply (a) of this subsection by substituting, for the date of

termination of enrollment, the date on which the individual was notified by the ((~~medicare+choice~~)) medicare advantage organization of the impending termination or discontinuance of the ((~~medicare+choice~~)) medicare advantage plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

(B) In the case of an individual making the election under (b)(ii)(A) of this subsection, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subsection (1) of this section ((~~shall~~)) is only ((~~become~~)) effective upon termination of coverage under the ((~~medicare+choice~~)) medicare advantage plan involved;

(c)(i) The individual is enrolled with:

(A) An eligible organization under a contract under section 1876 (medicare risk or cost);

(B) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) An organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan); or

(D) An organization under a medicare select policy; and

(ii) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under (b)(i) of this subsection;

(d) The individual is enrolled under a medicare supplement policy and the enrollment ceases because:

(i)(A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(B) Of other involuntary termination of coverage or enrollment under the policy;

(ii) The issuer of the policy substantially violated a material provision of the policy; or

(iii) The issuer, an agent, or other entity acting on the issuer's behalf materially misrepresented the policy's provisions in marketing the policy to the individual;

(e)(i) The individual was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any ((~~medicare+choice~~)) medicare advantage organization under a ((~~medicare+choice~~)) medicare advantage plan under

part C of medicare, any eligible organization under a contract under section 1876 (medicare risk or cost), any similar organization operating under demonstration project authority, any PACE program under section 1894 of the social security act, ((~~an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan),~~)) or a medicare select policy; and

(ii) The subsequent enrollment under (e)(i) of this subsection is terminated by the enrollee during any period within the first twelve months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal social security act); ((~~or~~))

(f) The individual, upon first becoming eligible for benefits under part A of medicare at age sixty-five, enrolls in a ((~~medicare+choice~~)) medicare advantage plan under part C of medicare, or in a PACE program under section 1894, and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment; or

(g) The individual enrolls in a medicare part D plan during the initial enrollment period and, at the time of enrollment in part D, was enrolled under a medicare supplement policy that covers outpatient prescription drugs, and the individual terminates enrollment in the medicare supplement policy and submits evidence of enrollment in medicare part D along with the application for a policy described in subsection (4)(d) of this section.

(4) An eligible person under subsection (3) of this section is entitled to a medicare supplement policy as follows:

(a) A person eligible under subsection (3)(a), (b), (c), and (d) of this section is entitled to a medicare supplement policy that has a benefit package classified as plan A through ((G)) F, including F with a high deductible, K, or L, offered by any issuer;

(b)(i) Subject to (b)(ii) of this subsection, a person eligible under subsection (3)(e) of this section is entitled to the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in (a) of this subsection; ((~~and~~))

(ii) After December 31, 2005, if the individual was most recently enrolled in a medicare supplement policy with an outpatient prescription drug benefit, a medicare supplement policy described in this subsection (4)(b)(ii) is:

(A) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(B) At the election of the policyholder, an A, B, C, F, including F with a high deductible, K, or L policy, that is offered by any issuer;

(c) A person eligible under subsection (3)(f) of this section is entitled to any medicare supplement policy offered by any issuer; and

(d) A person eligible under subsection (3)(g) of this section is entitled to a medicare supplement policy that has a benefit package classified as plan A, B, C, F, including F with a high deductible, K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's medicare supplement policy with outpatient prescription drug coverage.

(5)(a) At the time of an event described in subsection (3) of this section, and because of which an individual loses coverage or benefits due to the termination of a contract, agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, must notify the individual of his or her rights under this section, and of the obligations of issuers of medicare supplement policies under subsection (1) of this section. The notice must be communicated contemporaneously with the notification of termination.

(b) At the time of an event described in subsection (3) of this section, and because of which an individual ceases enrollment under a contract, agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, must notify the individual of his or her rights under this section, and of the obligations of issuers of medicare supplement policies under subsection (1) of this section. The notice must be communicated within ten working days of the issuer receiving notification of disenrollment.

(6) Guaranteed issue time periods are as follows:

(a) In the case of an individual described in subsection (3)(a) of this section, the guaranteed issue period begins on the later of: (i) The date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received,

notice that a claim has been denied because of a termination or cessation, or (ii) the date that the applicable coverage terminates or ceases, and ends sixty-three days thereafter;

(b) In the case of an individual described in subsection (3)(b), (c), (e), or (f) of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three days after the date the applicable coverage is terminated;

(c) In the case of an individual described in subsection (3)(d)(i) of this section, the guaranteed issue period begins on the earlier of: (i) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three days after the date the coverage is terminated;

(d) In the case of an individual described in subsection (3)(b), (d)(ii) and (iii), (e), or (f) of this section, who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty days before the effective date of the disenrollment and ends on the date that is sixty-three days after the effective date;

(e) In the case of an individual described in subsection (3)(g) of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the federal social security act from the medicare supplement issuer during the sixty-day period immediately preceding the initial part D enrollment period and ends on the date that is sixty-three days after the effective date of the individual's coverage under medicare part D; and

(f) In the case of an individual described in subsection (3) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three days after the effective date.

(7) In the case of an individual described in subsection (3)(e) of this section whose enrollment with an organization or provider described in subsection (3)(e)(i) of this section is involuntarily terminated within the first twelve months of enrollment, and who,

without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment is an initial enrollment as described in subsection (3)(e) of this section.

(8) In the case of an individual described in subsection (3)(f) of this section whose enrollment with a plan or in a program described in subsection (3)(f) of this section is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls in another plan or program, the subsequent enrollment is an initial enrollment as described in subsection (3)(f) of this section.

(9) For purposes of subsection (3)(e) and (f) of this section, an enrollment of an individual with an organization or provider described in subsection (3)(e)(i) of this section, or with a plan or in a program described in subsection (3)(f) of this section is not an initial enrollment under this subsection after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

**Sec. 29 was vetoed. See message at end of chapter.*

***Sec. 30. RCW 48.66.130 and 2002 c 300 s 3 are each amended to read as follows:**

(1) On or after January 1, 1996, and notwithstanding any other provision of Title 48 RCW, a medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition.

(2) On or after January 1, 1996, a medicare supplement policy or certificate shall not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician, or other health care provider acting within the scope of his or her license, within three months before the effective date of coverage.

(3) If a medicare supplement insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(4) No exclusion or limitation of preexisting conditions may be applied to policies or certificates replaced in accordance with the

provisions of RCW 48.66.045 if the policy or certificate replaced had been in effect for at least three months.

(5) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy or certificate for similar benefits to the extent that time was spent under the original policy.

(6) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate that has been in effect for at least three months, the replacing policy must not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy or certificate.

***Sec. 30 was vetoed. See message at end of chapter.**

Sec. 31. RCW 48.92.120 and 1993 c 462 s 101 are each amended to read as follows:

(1) ((~~No~~)) A person may not act or aid in any manner in soliciting, negotiating, or procuring liability insurance in this state from a risk retention group unless the person is licensed as an insurance agent or broker for casualty insurance in accordance with chapter 48.17 RCW and pays the fees designated for the license under RCW 48.14.010.

(2)(a) ((~~No~~)) A person may not act or aid in any manner in soliciting, negotiating, or procuring liability insurance in this state for a purchasing group from an authorized insurer or a risk retention group chartered in a state unless the person is licensed as an insurance agent or broker for casualty insurance in accordance with chapter 48.17 RCW and pays the fees designated for the license under RCW 48.14.010.

(b) ((~~No~~)) A person may not act or aid in any manner in soliciting, negotiating, or procuring liability insurance coverage in this state for a member of a purchasing group under a purchasing group's policy unless the person is licensed as an insurance agent or broker for casualty insurance in accordance with chapter 48.17 RCW and pays the fees designated for the license under RCW 48.14.010.

(c) ((~~No~~)) A person may not act or aid in any manner in soliciting, negotiating, or procuring liability insurance from an insurer not authorized to do business in this state on behalf of a purchasing group

located in this state unless the person is licensed as a surplus lines broker in accordance with chapter 48.15 RCW and pays the fees designated for the license under RCW 48.14.010.

(3) For purposes of acting as an agent or broker for a risk retention group or purchasing group under subsections (1) and (2) of this section, the requirement of residence in this state does not apply.

(4) Every person licensed under chapters 48.15 and 48.17 RCW, on business placed with risk retention groups or written through a purchasing group, ((~~shall~~)) must inform each prospective insured of the provisions of the notice required under RCW 48.92.040(7) in the case of a risk retention group and RCW 48.92.090((~~(3)~~)) (2) in the case of a purchasing group.

Sec. 32. RCW 48.98.015 and 1993 c 462 s 37 are each amended to read as follows:

((~~No~~)) A managing general agent may not place business with an insurer unless there is in force a written contract between the managing general agent and the insurer that sets forth the responsibilities of each party and, where both parties share responsibility for a particular function, that specifies the division of the responsibilities, and that contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of a dispute regarding the cause for termination.

(2) The managing general agent shall render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(3) The managing general agent shall hold funds collected for the account of an insurer in a fiduciary capacity in ((~~a~~)) an FDIC insured financial institution ((~~located in this state that is a member of the federal reserve system~~)). This account must be used for all payments on behalf of the insurer. The managing general agent may retain no more than three months' estimated claims payments and allocated loss adjustment expenses.

(4) The managing general agent shall maintain separate records of business written for each insurer. The insurer has access to and the right to copy all accounts and records related to its business in a form usable by the insurer, and the commissioner has access to all books, bank accounts, and records of the managing general agent in a form usable to the commissioner. Those records ((~~shall~~)) must be retained according to the requirements of this title and rules adopted under it.

(5) The managing general agent may not assign the contract in whole or part.

(6)(a) Appropriate underwriting guidelines must include at least the following: The maximum annual premium volume; the basis of the rates to be charged; the types of risks that may be written; maximum limits of liability; applicable exclusions; territorial limitations; policy cancellation provisions; and the maximum policy period.

(b) The insurer has the right to cancel or not renew any policy of insurance, subject to the applicable laws and rules, including those in chapter 48.18 RCW.

(7) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(a) All claims must be reported to the insurer in a timely manner((~~.~~));

(b) A copy of the claim file must be sent to the insurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed an amount determined by the commissioner, or exceeds the limit set by the insurer, whichever is less;

(ii) Involves a coverage dispute;

(iii) May exceed the managing general agent's claims settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment in excess of an amount set by the commissioner or an amount set by the insurer, whichever is less((~~.~~));

(c) All claim files are the joint property of the insurer and the managing general agent. However, upon an order of liquidation of the insurer, those files become the sole property of the insurer or its liquidator or successor. The managing general agent has reasonable access to and the right to copy the files on a timely basis((~~.~~)); and

(d) Settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the managing general agent's settlement authority during the pendency of a dispute regarding the cause for termination.

(8) ((~~Where~~)) When electronic claims files are in existence, the contract must address the timely transmission of the data.

(9) If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments or in any other manner, interim profits ((~~shall~~)) may not be paid to the managing general agent until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified under RCW 48.98.020.

(10) The managing general agent may not:

(a) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind automatic reinsurance contracts under obligatory automatic agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(b) Commit the insurer to participate in insurance or reinsurance syndicates;

(c) Use an agent that is not appointed to represent the insurer in accordance with the requirements of chapter 48.17 RCW;

(d) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, that ((~~shall~~)) may not exceed one percent of the insurer's policyholder surplus as of December 31st of the last-completed calendar year;

(e) Collect a payment from a reinsurer or commit the insurer to a claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report ((~~shall~~)) must be promptly forwarded to the insurer;

(f) Permit an agent appointed by it to serve on the insurer's board of directors;

(g) Jointly employ an individual who is employed by the insurer; or

(h) Appoint a submanaging general agent.

Sec. 33. RCW 48.110.030 and 1999 c 112 s 4 are each amended to read as follows:

(1) A person ((~~shall~~)) may not act as, or offer to act as, or hold himself or herself out to be a service contract provider in this state, nor may a service contract be sold to a consumer in this state, unless the service contract provider has a valid registration as a service contract provider issued by the commissioner.

(2) Applicants to be a service contract provider ((~~shall~~)) must make an application to the commissioner upon a form to be furnished by the commissioner. The application ((~~shall~~)) must include or be accompanied by the following information and documents:

(a) All basic organizational documents of the service contract provider, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, bylaws, and other applicable documents, and all amendments to those documents;

(b) The identities of the service contract provider's executive officer or officers directly responsible for the service contract provider's service contract business, and, if more than fifty percent of the service contract provider's gross revenue is derived from the sale of service contracts, the identities of the service contract provider's directors and stockholders having beneficial ownership of ten percent or more of any class of securities;

(c) Audited annual financial statements or other financial reports acceptable to the commissioner for the two most recent years which prove that the applicant is solvent and any information the commissioner may require in order to review the current financial condition of the applicant. If the service contract provider is relying on RCW 48.110.050(2) (a) or (c) to assure the faithful performance of its obligations to service contract holders, then the audited financial statements of the service contract provider's parent company may be substituted for the audited financial statements of the service contract provider;

(d) An application fee of two hundred fifty dollars, which shall be

deposited into the ((~~insurance commissioner's regulatory account under RCW 48.02.190~~)) general fund; and

(e) Any other pertinent information required by the commissioner.

(3) The applicant shall appoint the commissioner as its attorney to receive service of legal process in any action, suit, or proceeding in any court. This appointment is irrevocable and shall bind the service contract provider or any successor in interest, shall remain in effect as long as there is in force in this state any contract or any obligation arising therefrom related to residents of this state, and shall be processed in accordance with RCW 48.05.210.

(4) The commissioner may refuse to issue a registration if the commissioner determines that the service contract provider, or any individual responsible for the conduct of the affairs of the service contract provider under subsection (2)(b) of this section, is not competent, trustworthy, financially responsible, or has had a license as a service contract provider or similar license denied or revoked for cause by any state.

(5) A registration issued under this section is valid, unless surrendered, suspended, or revoked by the commissioner, or not renewed for so long as the service contract provider continues in business in this state and remains in compliance with this chapter. A registration is subject to renewal annually on the first day of July upon application of the service contract provider and payment of a fee of two hundred dollars, which shall be deposited into the ((~~insurance commissioner's regulatory account under RCW 48.02.190~~)) general fund. If not so renewed, the registration expires on the June 30th next preceding.

(6) A service contract provider shall keep current the information required to be disclosed in its registration under this section by reporting all material changes or additions within thirty days after the end of the month in which the change or addition occurs.

Sec. 34. RCW 48.110.040 and 1999 c 112 s 5 are each amended to read as follows:

(1) Every registered service contract provider that is assuring its faithful performance of its obligations to its service contract holders by complying with RCW 48.110.050(2)(b) ((~~shall~~)) must file an annual report for the preceding calendar year with the commissioner on or

before March 1st of each year, or within any extension of time the commissioner for good cause may grant. The report ((~~shall~~)) must be in the form and contain those matters as the commissioner prescribes and shall be verified by at least two officers of the service contract provider.

(2) At the time of filing the report, the service contract provider ((~~shall~~)) must pay a filing fee of twenty dollars which shall be deposited into the ((~~insurance commissioner's regulatory account under RCW 48.02.190~~)) general fund.

(3) As part of any investigation by the commissioner, the commissioner may require a service contract provider to file monthly financial reports whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the service contract provider. Monthly financial statements ((~~shall~~)) must be filed in the commissioner's office no later than the twenty-fifth day of the month following the month for which the financial report is being filed. These monthly financial reports ((~~shall be~~)) are the internal financial statements of the service contract provider. The monthly financial reports that are filed with the commissioner constitute information that might be damaging to the service contract provider if made available to its competitors, and therefore shall be kept confidential by the commissioner. This information ((~~shall~~)) may not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner.

NEW SECTION. **Sec. 35.** The following acts or parts of acts are each repealed:

(1) RCW 48.05.360 (Special surplus requirements for certain combinations) and 1963 c 195 s 9;

(2) RCW 48.29.030 (Amount of deposit) and 1957 c 193 s 16 & 1947 c 79 s .29.03;

(3) RCW 48.29.060 (Impairment of deposit) and 1947 c 79 s .29.06;

(4) RCW 48.29.070 (Levy of execution against deposit) and 1955 c 86 s 14 & 1947 c 79 s .29.07;

(5) RCW 48.29.090 (Purpose of deposit) and 1955 c 86 s 16 & 1947 c 79 s .29.09;

(6) RCW 48.29.100 (Termination of deposit) and 1947 c 79 s .29.10;

(7) RCW 48.29.110 (Release of securities) and 1955 c 86 s 17 & 1947 c 79 s .29.11; and

(8) RCW 48.34.910 (Small loan act [Consumer finance act] not affected) and 1961 c 219 s 14.

Passed by the House March 3, 2005.
Passed by the Senate April 13, 2005.
Approved by the Governor April 28, 2005, with the exception of certain items that were vetoed.
Filed in Office of Secretary of State April 28, 2005.

Note: Governor's explanation of partial veto is as follows:

"I am returning, without my approval as to Sections 26-30, Substitute House Bill No. 1197 entitled:

"AN ACT Relating to insurance."

Sections 26-30 of Substitute House Bill No. 1197, which concern Medicare supplemental insurance, are redundant and already covered in Senate Bill 5198 (Implementing changes to Medicare supplemental insurance requirements as mandated by the Medicare Modernization Act of 2003 and other federal requirements). I signed Senate Bill 5198 on April 13, 2005.

For these reasons, I have vetoed Sections 26-30 of Substitute House Bill No. 1197.

With the exception of Sections 26-30, Substitute House Bill No. 1197 is approved."