

SENATE BILL REPORT

SB 6031

As of January 19, 2026

Title: An act relating to enhancing public safety and enforcement of crimes that impact insurance.

Brief Description: Enhancing public safety and enforcement of crimes that impact insurance.

Sponsors: Senators Lovick, Fortunato, Conway, Cortes, Frame, Lias, Riccelli, Shewmake, Trudeau, Warnick, Wellman, Wilson, C. and Wilson, J.; by request of Insurance Commissioner.

Brief History:

Committee Activity: Business, Trade & Economic Development: 1/21/26.

Brief Summary of Bill

- Expands the definition of insurance fraud, the scope of the Insurance Fraud Program (Program), and the Insurance Commissioner's powers under the Program.
- Increases criminal penalties for insurance fraud, specifies how insurance fraud may be charged and prosecuted, and specifies a time limitation on prosecution.
- Revises, and adds entities subject to, the duty to report insurance-related crimes.
- Requires business entities financing insurance premiums to provide certain information to the Insurance Commissioner.

SENATE COMMITTEE ON BUSINESS, TRADE & ECONOMIC DEVELOPMENT

Staff: John Kim (786-7453)

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Background: Definition of Insurance Fraud. Insurance fraud is defined as an act or omission committed by a person who, knowingly and with intent to defraud, commits or conceals any material information concerning one or more of the following:

- presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by an insurer, insurance producer, or surplus line broker, false information as part of, in support of, or concerning a fact material to one or more of the following:
 1. an application for the issuance or renewal of an insurance policy;
 2. the rating of an insurance policy or contract;
 3. a claim for payment or benefit pursuant to an insurance policy;
 4. premiums paid on an insurance policy;
 5. payments made in accordance with the terms of an insurance policy; or
 6. the reinstatement of an insurance policy;
- willful embezzlement, abstracting, purloining, or conversion of moneys, funds, premiums, credits, or other property of an insurer or person engaged in the business of insurance; or
- attempting to commit, aiding or abetting in the commission of, or conspiracy to commit any of the foregoing acts or omissions.

Criminal Penalties for Insurance Fraud. A person who knowingly presents, or causes to be presented, a false or fraudulent claim, or any proof in support of such a claim, for the payment of a loss under a contract of insurance; or prepares, makes, or subscribes any false or fraudulent account, certificate, affidavit, or proof of loss, or other document or writing, with intent that it be presented or used in support of such a claim is subject to punishment as a gross misdemeanor for a claim \$1,500 or less. For a claim over \$1,500, the violation is a class C felony. In a criminal prosecution in which the insurance company is a victim, the insurance company is entitled to be considered as a victim in any restitution ordered by the court.

Insurance Fraud Program. A 2006 law created the Insurance Fraud Program (Program) within the Office of the Insurance Commissioner (OIC). The Program's stated purpose is to detect insurance fraud, reduce the occurrence of fraud through criminal enforcement and deterrence, require restitution of fraudulently obtained insurance benefits and expenses incurred by an insurer in investigating fraudulent claims, and reduce the amount of premium dollars used to pay fraudulent claims. Its stated primary focus is on organized fraudulent activities committed against insurance companies.

The OIC is authorized to employ supervisory, legal, and investigative personnel for the Program and may fund, out of the program's budget, one or more state patrol officers and assistant attorney generals to work with the Program. The OIC may also make grants to or reimburse local prosecuting attorneys to assist in the prosecution of insurance fraud.

Insurance Fraud Account. The annual cost of the Program is funded from the OIC's fraud account, which is funded through an insurance fraud surcharge imposed on specified

organizations regulated under the Washington Insurance Code. The surcharge is calculated by the OIC annually for the ensuing fiscal year and is based on an organization's portion of the receipts collected or received by all organizations within the organization's class of business in this state during the previous calendar year. Unexpended funds in the fraud account at the close of a fiscal year are carried forward to the succeeding fiscal year and are used to reduce future insurance fraud surcharges. Each insurer may annually collect the surcharge remitted in preceding years by means of a policyholder surcharge on premiums charged for all kinds of insurance.

Duty to Furnish and Disclose Insurance Fraud Knowledge and Information. Any insurer or licensee of the OIC that has reasonable belief that an act of insurance fraud, which is or may be a crime under state law, has been, is being, or is about to be committed must furnish and disclose the knowledge and information to the OIC or the National Insurance Crime Bureau, the National Association of Insurance Commissioners, or similar organization, who must disclose the information to the OIC and cooperate fully with any OIC investigation.

Summary of Bill: Definition of Insurance Fraud. The definition of insurance fraud is expanded to add knowingly, and with intent to defraud, committing or concealing any material information concerning:

- submitting of a bill or claim to an insurer or insurance consumer:
 1. for medical, vehicle, or property services not rendered, vehicle or property repairs not made, or supplies not provided;
 2. using a Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code not reasonably appropriate to the service provided or procedure performed; or
 3. using the name, credentials, or National Provider Identifier of a health care provider who neither rendered nor supervised the billed service;
- submitting a statement, estimate, invoice, bid, proposal, proof of loss, or any other document that misrepresents the scope of damages or costs of repairs associated with a property insurance claim;
- falsifying diagnostic or treatment information in a patient's medical file to bill for treatments or prescriptions that would not otherwise have been covered by the insurer;
- misrepresenting the identity of or impersonating a person, government representative, or business in connection with an insurance policy application, premium payment, claim, or the solicitation or performance of mitigation, restoration, or repair services;
- procuring or handling funds intended for payment of premium in any of the following ways:
 1. collecting or receiving funds intended for the payment of premium from an individual or entity, or under a premium finance agreement, but misappropriating or converting the funds, or failing to remit the funds to the insurer in a prompt manner;
 2. misrepresenting the amount of premium owed or the terms of a premium finance agreement; or

3. submitting falsified or forged premium finance agreements or insurance policy information to obtain premium finance loan proceeds;
- when appraising or umpiring under the appraisal clause of an insurance contract, failing to do so in an impartial manner, including:
 1. in a self-interested manner, such as on a contingency fee basis, or to secure additional appraisal or umpiring opportunities; or
 2. according to influence from an insurer, policyholder, claimant, or other.

The act of embezzlement or conversion is revised to specify embezzling, abstracting, purloining, or engaging or conspiring in conversion of moneys, funds, premiums, credits, benefits, or other property of an insurer, person engaged in the business of insurance, or insurance consumer or beneficiary.

The bill strikes a sentence stating that the definition is for illustrative purposes only and is not intended to create or modify the definition of any existing criminal acts nor to create or modify the burdens of proof in any criminal prosecution brought as a result of an investigation.

For purposes of determining whether a CPT code was reasonably appropriate for the service provided or procedure performed, the trier of fact must consider any evidence presented and the applicable CPT code set published by the American Medical Association. For purposes of determining whether a HCPCS code was reasonably appropriate for the service provided or the procedure performed, the trier of fact must consider any evidence presented and the applicable CPT code set published by the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Criminal Penalties for Insurance Fraud. The bill specifies that insurance fraud is a class B felony. Each instance of insurance fraud constitutes a separate offense.

Insurance fraud may be charged and prosecuted in any county where the crime occurred, the accused resides, an insurance consumer or beneficiary victimized by the crime resides, or an impacted insurer has its primary place of business within the state.

In addition to insurance companies, other persons who are entitled to be considered as a victim in any restitution ordered by a court include an insured person, a consumer, or a beneficiary.

Statute of Limitation. The bill specifies an insurance fraud violation may not be prosecuted more than ten years after its commission or discovery, whichever is later.

Insurance Fraud Program. The purpose of the Program is expanded to include, in addition to insurance fraud, other crimes that impact the insurance industry or insurance consumers or beneficiaries in this state. The addition of these other crimes is added in references to insurance fraud throughout the Program statutes. The primary focus of the Program is

revised to include collusive criminal schemes and fraudulent activities committed against insurance companies or insurance consumers.

In addition to supervisory, legal, and investigative personnel, the OIC may employ other personnel for the Program. A limit, which expired in 2010, on staff levels for the Program is removed.

Definition of an Insurer. The definition of an insurer under the Program is expanded. In addition to current law, which defines an insurer under the Program as an authorized insurance company, a registered health care service contractor, and a registered health care maintenance organization, the bill adopts the definition of an insurer defined for the Washington Insurance Code and includes, but is not limited to, the foregoing as well as a disability insurer.

Powers of the Insurance Commissioner. In addition to existing powers under the Program, the Insurance Commissioner is authorized to:

- contract for goods and services;
- employ financial or digital forensic staff;
- share records and evidence with federal, state, or local prosecutorial entities and report insurance-related crimes to a county or federal prosecuting authority;
- acquire and use technology to accomplish the purposes of this chapter including, but not limited to, detecting crime and collusive schemes, and organizing and analyzing data, evidence, investigations, and exhibits; and
- receive documents, materials, or information from any source, in addition to specified entities under current law.

Duty to Furnish and Disclose Insurance Fraud Knowledge and Information. The duty to report insurance fraud knowledge and information is revised as follows:

- an insurer's or OIC licensee's duty to report acts of insurance fraud which is or may be a crime under state law is revised to a duty to report acts of insurance fraud or other crimes that impact the insurance industry or insurance consumers or beneficiaries.
- such duty to report also applies to any certified public accountant, state or local law enforcement agency, public safety entity, or regulatory entity for health care or financial service providers.

Duty of Business Organizations to Provide Premium Finance Information to the Office of the Insurance Commissioner. Any business entity registered to do business in this state that executes an agreement to finance the payment of a premium for an insurance policy must send a copy of the executed agreement and the associated insurance policy to the OIC within 30 calendar days of executing the agreement.

Severability. The bill specifies if any provision of the bill or its application to any person or circumstance is held invalid, the remainder of the bill or the application of the provision to

other persons or circumstances is not affected.

Appropriation: None.

Fiscal Note: Requested on January 13, 2026.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.