Washington State Department of Labor & Industries

Self-Insurance Good Faith and Fair Dealing Draft Rules

Summary

This draft of new and amended Washington Administrative Codes (WACs) is for stakeholder input prior to formal rule proposal (CR-102). These rules support a legislative mandate for rule adoption by Substitute House Bill (SHB 1521), Chapter 293, Laws of 2023. The law and supporting rules are expected to take effect July 1, 2024.

This rulemaking will establish a "good faith and fair dealing" standard for self-insured employers (SIEs) and their third-party administrators (TPAs). Establish criteria for determining the appropriate penalty amount for self-insured penalties. Establish or amend criteria for decertification, including corrective action, of a self-insured employer. Establish criteria for providing benefits for workers if an employer is decertified, including payment of benefits if the employer had not provided a surety.

L&I is considering the following WAC additions and amendments, covering three main topics. ***Updated* next to the title indicates WAC sections containing draft language that has been updated since the previous feedback session.**

Good Faith and Fair Dealing Rules	***Updated*** WAC 296-15-270 When repeat behavior is determined to be a violation of the duty of good faith and fair dealing	New
	Updated WAC 296-15-272 When one-time behavior is deemed a violation of the duty of good faith and fair dealing	New
Penalty Rules	***Updated*** WAC 296-15-268 Self-insurance Penalty Calculations	New
	Updated WAC 296-15-266 Penalties	Amendment
Certification, Corrective Action and Surety Rules	WAC 296-15-257 Title to be determined (pertaining to withdrawal of certification and corrective action)	New
	WAC 296-15-260 Corrective action or withdrawal of certification	Amendment
	WAC 296-15-121 Surety for a self-insurance program	Amendment
	WAC 296-15-125 Default by a self-insurer	Amendment
	WAC 296-15-151 Surety for a public entity's self-insurance program	Amendment
	WAC 296-15-161 Surety for a group self-insurance program	Amendment

How to read this document

New WAC sections have headings that begin with "(New WAC)". Headings for WAC sections without the "(New WAC)" preceding it are for amendments to existing rules. Each section begins with a summary of changes based on November 2023 feedback.

Following that, new WAC sections show mark-up based on the November 2023 draft, followed by a clean version after changes.

Amendments to existing WAC sections show mark-up based on the current language, followed by a clean version after changes.

For all mark-up, parts to be removed have a strikethrough, and parts to be added are underlined. Example: ~~This language will be removed.~~ <u>This language will be added.</u>

Good Faith and Fair Dealing Rules

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(New WAC) WAC 296-15-270 When repeat behavior is determined to be a violation of the duty of good faith and fair dealing

Summary of changes based on November 2023 feedback

- Rewrote sub (a), concerning interlocutory order requests.
- Removed sub (b), since it is now addressed in sub (a). Relettered subsequent subsections.
- On sub (b), previously sub (c), added "vocational".
- On sub (j), previously sub (k), added clarifying language.

With mark-up, based on November 2023 draft

If a self-insured employer (SIE) or third party administrator (TPA) subject to the good faith and fair dealing duty repeatedly engages in the following actions with such frequency ~~that it is deemed an established~~ <u>as to indicate a general</u> business practice, the SIE/TPA will be in violation of its duty to engage in good faith and fair dealing:

(a) ~~Unreasonably requests an interlocutory order pursuant to WAC 296-15-420, including to unnecessarily delay a determinative order.~~ <u>Fails to provide a reasonable explanation for an interlocutory order, fails to exercise due diligence while investigating claim determination, and/or fails to provide provisional benefits as entitled during the interlocutory period.</u>

~~(b) Refuses to pay provisional benefits during the interlocutory period.~~

(b) ~~(c)~~ Unreasonably delays or refuses to pay wage replacement benefits without a factual, legal, <u>vocational,</u> or medical basis.

(c) ~~(d)~~ Fails to ensure appropriate handling of claims pursuant to WAC 296-15-350.

(d) ~~(e)~~ Fails to request claim denial or interlocutory order pursuant to WAC 296-15-420 within 60 days.

(e) ~~(f)~~ Fails to authorize medical care pursuant to WAC 296-15-330.

(f) ~~(g)~~ Fails to pay compensation pursuant to WAC 296-15-340.

(g) ~~(h)~~ Fails to adhere to duties and performance requirements pursuant to WAC 296-15-550.

(h) ~~(i)~~ Fails to provide a copy of the claim file in a timely manner pursuant to RCW 51.14.120.
(i) ~~(j)~~ Fails to communicate with injured workers using department-developed templates pursuant to WAC 296-15-425, including use of the templates in the workers preferred language.
(j) ~~(k)~~ Manages the workers' compensation claim in a manner which demonstrates a greater concern for the self-insured employer's interest than the worker's interest.
(k) ~~(l)~~ Fails to notify the worker or beneficiary of their rights and obligation pursuant to WAC 296-15-400, RCW 51.28.010, or RCW 51.28.030.
(l) ~~(m)~~ Requests the department issue an order denying the claim without a factual, legal, or medical basis.
(m) ~~(n)~~ Denies medical coverage without a factual, legal, or medical basis.
(n) ~~(o)~~ Fails to provide a worker or beneficiary a SIF-2 or ability to file a claim pursuant to WAC 296-15-320 and WAC 296-15-405.
(o) ~~(p)~~ Fails to have claims managed by a certified claims administrator in accordance with WAC 296-15-350(2).
(p) ~~(q)~~ Fails to forward an application to reopen a claim within five working days of receipt pursuant to WAC 296-15-470.
(q) ~~(r)~~ Fails to forward a protest or appeal to the department within five working days of receipt pursuant to RWC 51.14.120(2) and WAC 296-15-480.

Clean version

If a self-insured employer (SIE) or third party administrator (TPA) subject to the good faith and fair dealing duty repeatedly engages in the following actions with such frequency as to indicate a general business practice, the SIE/TPA will be in violation of its duty to engage in good faith and fair dealing:

(a) Fails to provide a reasonable explanation for an interlocutory order, fails to exercise due diligence while investigating claim determination, and/or fails to provide provisional benefits as entitled during the interlocutory period.
(b) Unreasonably delays or refuses to pay wage replacement benefits without a factual, legal, vocational, or medical basis.
(c) Fails to ensure appropriate handling of claims pursuant to WAC 296-15-350.
(d) Fails to request claim denial or interlocutory order pursuant to WAC 296-15-420 within 60 days.
(e) Fails to authorize medical care pursuant to WAC 296-15-330.
(f) Fails to pay compensation pursuant to WAC 296-15-340.
(g) Fails to adhere to duties and performance requirements pursuant to WAC 296-15-550.
(h) Fails to provide a copy of the claim file in a timely manner pursuant to RCW 51.14.120.
(i) Fails to communicate with injured workers using department-developed templates pursuant to WAC 296-15-425, including use of the templates in the workers preferred language.
(j) Manages the workers' compensation claim in a manner which demonstrates a greater concern for the self-insured employer's interest than the worker's interest.
(k) Fails to notify the worker or beneficiary of their rights and obligation pursuant to WAC 296-15-400, RCW 51.28.010, or RCW 51.28.030.
(l) Requests the department issue an order denying the claim without a factual, legal, or medical basis.
(m) Denies medical coverage without a factual, legal, or medical basis.
(n) Fails to provide a worker or beneficiary a SIF-2 or ability to file a claim pursuant to WAC 296-

15-320 and WAC 296-15-405.

(o) Fails to have claims managed by a certified claims administrator in accordance with WAC 296-15-350(2).

(p) Fails to forward an application to reopen a claim within five working days of receipt pursuant to WAC 296-15-470.

(q) Fails to forward a protest or appeal to the department within five working days of receipt pursuant to RWC 51.14.120(2) and WAC 296-15-480.

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(New WAC) WAC 296-15-272 When one-time behavior is deemed a violation of the duty of good faith and fair dealing

Summary of changes based on November 2023 feedback

- Removed sub (2), "Fails an audit corrective action plan."
- "Coerces a worker…" became sub (2).
- Added a new sub (3), regarding inadvertent or minor errors or delays.

With mark-up, based on November 2023 draft

(1) If a self-insured employer (SIE) or third party administrator (TPA) subject to the duty of good faith and fair dealing intentionally engages in the following action, the SIE/TPA is in violation of its duty to engage in good faith and fair dealing:

(a) Fails to provide a worker or beneficiary a SIF-2 or ability to file a claim pursuant to WAC 296-15-320 and WAC 296-15-405, with the intent to interfere with the worker's ability to pursue benefits under Title 51 RCW.

(b) Fails to forward an application to reopen a claim within five working days of receipt pursuant to WAC 296-15-470, with the intent to interfere with the worker's ability to reopen a claim or pursuing further benefits.

(c) Fails to forward a protest or appeal to the department within five working days of receipt pursuant to RWC 51.14.120(2) and WAC 296-15-480, with the intent to interfere with the worker's ability to pursue a request for reconsideration, appeal, or further benefits.

~~(2) Fails an audit corrective action plan.~~

(~~3~~2) Coerces a worker to accept less than the compensation due under RCW Title 51.

(3) Errors or delays that are inadvertent or minor are not a violation of the duty of good faith and fair dealing.

Clean version

(1) If a self-insured employer SIE or third party administrator TPA subject to the duty of good faith and fair dealing intentionally engages in the following action, the SIE/TPA is in violation of its duty to engage in good faith and fair dealing:

(a) Fails to provide a worker or beneficiary a SIF-2 or ability to file a claim pursuant to WAC 296-15-320 and WAC 296-15-405, with the intent to interfere with the worker's ability to pursue benefits under Title 51 RCW.

(b) Fails to forward an application to reopen a claim within five working days of receipt pursuant to WAC 296-15-470, with the intent to interfere with the worker's ability to reopen a claim or

pursuing further benefits.

(c) Fails to forward a protest or appeal to the department within five working days of receipt pursuant to RWC 51.14.120(2) and WAC 296-15-480, with the intent to interfere with the worker's ability to pursue a request for reconsideration, appeal, or further benefits.

(2) Coerces a worker to accept less than the compensation due under RCW Title 51.

(3) Errors or delays that are inadvertent or minor are not a violation of the duty of good faith and fair dealing.

Penalty Rules

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(New WAC) WAC 296-15-268 Self-insurance Penalty Calculations

Summary of changes based on November 2023 feedback

- Sub (1)(g), regarding number of requests, replaced the word "compliance" with "action to be taken by the employer or third party administrator".
- Subs (2)(b) and (3)(b), regarding harm done, added "or financial impact".
- Sub (5), added a new sub (a), and relettered subsequent subsections.

With mark-up, based on November 2023 draft

(1) For all penalties assessed per WAC 296-15-266, RCW 51.48.017, RCW 51.48.080, and/or RCW 51.14.180, the penalty amount shall be determined by weighing the following factors:

(a) Amount of delayed payment.

(b) Length of time of the delay.

(c) Employer communication of the basis for or calculation of the payment.

(d) History or past practice.

(e) Whether the department has issued an order directing the payment.

(f) Required adjustments to the amount of the payment.

(g) Number of requests, for ~~compliance~~ action to be taken by the employer or third party administrator, made by the department, worker/beneficiary, or provider.

(h) Efforts by the employer or third party administrator to communicate with the worker.

(2) For all penalties assessed subject to a multiplier of three times the amount of the penalty, the amount of the multiplier will be determined by weighing the following factors:

(a) Number of prior violations in the past year of the same nature.

(b) Harm or financial impact done due to the denial or delay of benefits.

(c) Whether the employer or third party administrator paid the undisputed amount of benefits.

(d) The employer's or third party administrator's timeliness or delay in responses to request from the department, worker/beneficiary, or provider.

(3) For all penalties assessed based on a violation of good faith and fair dealing, subject to a multiplier of up to 52 times the average weekly wage, the amount of the multiplier will be determined by weighing the following factors:

(a) Prior violations of good faith and fair dealing.

(b) Harm or financial impact done due to the denial or delay of benefits.

(c) Amount, or number, of other penalties assessed simultaneously.

(d) Employer's or third party administrator's participation in the investigation.
(e) Whether the violation was based on WAC 296-15-270 or WAC 296-15-272.
(4) The following mitigating factors may be a basis for reduction of penalty calculation, including a multiplier:
(a) Efforts by the employer or third party administrator to correct the actions.
(b) Efforts by the employer or third party administrator to communicate and educate employees and adjudicators of relevant policies and procedures.
(c) Workers failure to provide the employer or third-party administrator necessary documentation to complete a review or investigation.
(d) Investigation attempts made by the employer or third party administrator before it denied benefits.
(e) Employer's or third party administrator's participation in the department's investigation and timeliness of responses.
(f) Any other factors deemed appropriate by the department.
(5) Penalties assessed based on a violation of the duty of good faith and fair dealing, within a 5 year period, will be calculated as follows:
(a) First time results in a minimum penalty of 1 times the average weekly wage.
(b) ~~(a)~~ Second time results in a minimum penalty of 15 times the average weekly wage.
(c) ~~(b)~~ Third time results in a minimum penalty of 25 times the average weekly wage.
(d) ~~(c)~~ Four or more times in a minimum penalty of 40 times the average weekly wage.

Clean version

(1) For all penalties assessed per WAC 296-15-266, RCW 51.48.017, RCW 51.48.080, and/or RCW 51.14.180, the penalty amount shall be determined by weighing the following factors:
(a) Amount of delayed payment.
(b) Length of time of the delay.
(c) Employer communication of the basis for or calculation of the payment.
(d) History or past practice.
(e) Whether the department has issued an order directing the payment.
(f) Required adjustments to the amount of the payment.
(g) Number of requests, for action to be taken by the employer or third party administrator, made by the department, worker/beneficiary, or provider.
(h) Efforts by the employer or third party administrator to communicate with the worker.
(2) For all penalties assessed subject to a multiplier of three times the amount of the penalty, the amount of the multiplier will be determined by weighing the following factors:
(a) Number of prior violations in the past year of the same nature.
(b) Harm or financial impact done due to the denial or delay of benefits.
(c) Whether the employer or third party administrator paid the undisputed amount of benefits.
(d) The employer's or third party administrator's timeliness or delay in responses to request from the department, worker/beneficiary, or provider.
(3) For all penalties assessed based on a violation of good faith and fair dealing, subject to a multiplier of up to 52 times the average weekly wage, the amount of the multiplier will be determined by weighing the following factors:
(a) Prior violations of good faith and fair dealing.
(b) Harm or financial impact done due to the denial or delay of benefits.

(c) Amount, or number, of other penalties assessed simultaneously.
(d) Employer's or third party administrator's participation in the investigation.
(e) Whether the violation was based on WAC 296-15-270 or WAC 296-15-272.
(4) The following mitigating factors may be a basis for reduction of penalty calculation, including a multiplier:
(a) Efforts by the employer or third party administrator to correct the actions.
(b) Efforts by the employer or third party administrator to communicate and educate employees and adjudicators of relevant policies and procedures.
(c) Workers failure to provide the employer or third-party administrator necessary documentation to complete a review or investigation.
(d) Investigation attempts made by the employer or third party administrator before it denied benefits.
(e) Employer's or third party administrator's participation in the department's investigation and timeliness of responses.
(f) Any other factors deemed appropriate by the department.
(5) Penalties assessed based on a violation of the duty of good faith and fair dealing, within a 5 year period, will be calculated as follows:
(a) First time results in a minimum penalty of 1 times the average weekly wage.
(b) Second time results in a minimum penalty of 15 times the average weekly wage.
(c) Third time results in a minimum penalty of 25 times the average weekly wage.
(d) Four or more times in a minimum penalty of 40 times the average weekly wage.

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WAC 296-15-266 Penalties

Summary of changes based on November 2023 feedback

- Sub (1)(a)(i), removed the word "medical" before "provider", and restored the "authorized to treat" language.
- Replaced all instances of the word "claimant" with "worker".
- Removed deletion of subs (1) (b), (c), and (d). Relettered subsequent subsections back to original.

With mark-up, based on current WAC

(1) **Under what circumstances will the department consider assessing a penalty for an unreasonable delay of benefits~~, when requested by a worker~~?** Upon a worker's request or based upon its own motion, the department will consider assessment of an unreasonable delay of benefits penalty for:
(a) Time-loss compensation benefits~~: The department will issue an unreasonable delay order, and assess associated penalties based on the unreasonably delayed time-loss as determined by the department,~~ if ~~a self-insurer~~:
(i) The self-insurer ~~H~~has written medical certification based on objective findings from the attending ~~medical~~ provider authorized to treat that the ~~claimant~~ worker is unable to work because of conditions proximately caused by the industrial injury or occupational disease~~;, or~~
(ii) ~~t~~The ~~claimant~~ worker is participating in a department-approved vocational plan~~; and~~
(iii) The self-insurer ~~F~~fails to make the first time-loss payment to the ~~claimant~~ worker within fourteen

calendar days of notice that there is a claim;~~*, or~~

(iv) The self-insurer fails to continue time-loss payments on regular intervals as required by RCW **51.32.190**(3); ~~and~~or

(v~~iii~~) The self-insurer ~~F~~fails to take action per WAC **296-15-425**.

~~* Notice of claim is provided to the self-insured employer when all the elements of a claim are met. The elements of a claim are:~~

~~• Description of incident. Examples: Self-Insurance Form 2 (SIF-2), physician's initial report (PIR), employer incident report.~~

~~• Diagnosis of the medical condition. Examples: PIR, on-site medical facility records if supervised by provider qualified to diagnose.~~

~~• Treatment provided or treatment recommendations. Examples: PIR, on-site medical facility records if supervised by provider qualified to treat.~~

~~• Application for benefits. Examples: SIF-2, PIR, or other signed written communication that evinces intent to apply.~~

(b) Unreasonable delays of loss of earning power compensation payments or permanent partial disability award payments will also be subject to penalty.

(c) Unreasonable delays of payment of medical treatment benefits will also be subject to penalty.

(d) Unreasonable delays of authorization of medical treatment benefits will also be subject to penalty.

(e) Failure to pay benefits without cause: The department will issue an order determining an unreasonable refusal to pay benefits, and assess associated penalties, based on the department's calculation of benefits or fee schedule, if a self-insurer fails to pay a benefit such as time-loss compensation, loss of earning power compensation, permanent partial disability award payments, or medical treatment when there is no medical, vocational, or legal doubt about whether the self-insurer should pay the benefit. Accrued principal and interest will apply to nonpayment of medical benefits.

(f) Paying benefits during an appeal to the board of industrial insurance appeals: The department will issue an unreasonable delay order, and assess associated penalties, based on the department's calculation of benefits or fee schedule, if a self-insurer appeals a department order to the board of industrial insurance appeals, and fails to provide the benefits required by the order on appeal within fourteen calendar days of the date of the order, and thereafter at regular fourteen day or semi-monthly intervals, as applicable, until or unless the board of industrial insurance appeals grants a stay of the department order, or until and unless the department reassumes jurisdiction and places the order on appeal in abeyance, or until the ~~claimant~~ worker returns to work, or the department issues a subsequent order terminating the benefits under appeal.

(g) Benefits will not be considered unreasonably delayed if paid within three calendar days of the statutory due date. In addition, if benefits are delayed due to an underpayment from the monthly wage calculation for time-loss compensation under RCW **51.08.178**, then the department shall presume the benefits are not unreasonably delayed if:

(i) The self-insurer sent a written copy of the wage calculation to the injured worker on a department-developed template; and

(ii) The self-insurer informed the worker, in writing, on a department-developed template that the worker should contact the self-insurer with any questions; and

(iii) The self-insurer notified the worker, in writing, on a department-developed template to write to the department within sixty days if the worker disputed the calculation.

This presumption may be rebutted by a showing of action without foundation or unsupported

by evidence demonstrating an unreasonable delay of benefits despite the notification to the worker and the worker's failure to dispute.

Provided, (g)(i) through (iii) of this subsection will not apply to payments for statutory cost-of-living adjustments, payments that do not use the amount stated in the department-developed template, or a refusal to make payments ordered by the department.

(2) **Under what circumstances will the department consider assessing a penalty for a violation of rules?** Upon a worker's request, or based upon its own motion, the department will consider assessment of a rule violation penalty if the self-insurer or third party administrator fails to meet the requirements of RCW Title 51 and WAC Title 296.

(~~2~~3) **How is a penalty request created and processed?**

(a) An injured worker may request a penalty against his or her self-insured employer by:

(i) Completing the appropriate self-insurance form or sending a written request providing the reasons for requesting the penalty;

(ii) Attaching supporting documents (optional).

(b) Within ten working days of notification of the penalty request from a worker or department review, the self-insurer or third party administrator may file a response ~~receipt of a certified request, the self-insured employer must send its claim file to the department. Failure to timely respond may subject the self-insured employer to a rule violation penalty under RCW **51.48.080**~~. The ~~employer may attach~~ response may include supporting documents~~, or indicate, in writing, if the employer will be providing further supporting documents, which must be received by the department within five additional working days~~. If the employer fails to timely respond to the penalty request, the department will issue an order in response to the injured worker's request based on the available information.

(c) The department will issue an order within thirty days after receiving a complete written request for penalty per (a) of this subsection. The department's review during the thirty-day period for responding to the injured worker's request will include only the records in the department claim file at the time of the request ~~records~~ and supporting documents provided by the worker and the employer per (a) and (b) of this subsection.

~~(d) In deciding whether to assess a penalty, the department will consider only the underlying record and supporting documents at the time of the request which will include documents listed in (a) and (b) of this subsection, if timely available, to determine if the alleged untimely benefit was appropriately requested and if the employer timely responded.~~

(~~e~~d)The department order issued under (c) of this subsection is subject to request for reconsideration or appeal under the provisions of RCW **51.52.050** and **51.52.060**.

Clean version

(1) **Under what circumstances will the department consider assessing a penalty for an unreasonable delay of benefits?** Upon a worker's request or based upon its own motion, the department will consider assessment of an unreasonable delay of benefits penalty for:

(a) Time-loss compensation benefits if:

(i) The self-insurer has written medical certification based on objective findings from the attending provider authorized to treat that the worker is unable to work because of conditions proximately caused by the industrial injury or occupational disease;

(ii) The worker is participating in a department-approved vocational plan;

(iii) The self-insurer fails to make the first time-loss payment to the worker within fourteen calendar

days of notice that there is a claim;

(iv) The self-insurer fails to continue time-loss payments on regular intervals as required by RCW **51.32.190**(3); or

(v) The self-insurer fails to take action per WAC **296-15-425**.

(b) Unreasonable delays of loss of earning power compensation payments or permanent partial disability award payments will also be subject to penalty.

(c) Unreasonable delays of payment of medical treatment benefits will also be subject to penalty.

(d) Unreasonable delays of authorization of medical treatment benefits will also be subject to penalty.

(e) Failure to pay benefits without cause: The department will issue an order determining an unreasonable refusal to pay benefits, and assess associated penalties, based on the department's calculation of benefits or fee schedule, if a self-insurer fails to pay a benefit such as time-loss compensation, loss of earning power compensation, permanent partial disability award payments, or medical treatment when there is no medical, vocational, or legal doubt about whether the self-insurer should pay the benefit. Accrued principal and interest will apply to nonpayment of medical benefits.

(f) Paying benefits during an appeal to the board of industrial insurance appeals: The department will issue an unreasonable delay order, and assess associated penalties, based on the department's calculation of benefits or fee schedule, if a self-insurer appeals a department order to the board of industrial insurance appeals, and fails to provide the benefits required by the order on appeal within fourteen calendar days of the date of the order, and thereafter at regular fourteen day or semi-monthly intervals, as applicable, until or unless the board of industrial insurance appeals grants a stay of the department order, or until and unless the department reassumes jurisdiction and places the order on appeal in abeyance, or until the worker returns to work, or the department issues a subsequent order terminating the benefits under appeal.

(g) Benefits will not be considered unreasonably delayed if paid within three calendar days of the statutory due date. In addition, if benefits are delayed due to an underpayment from the monthly wage calculation for time-loss compensation under RCW **51.08.178**, then the department shall presume the benefits are not unreasonably delayed if:

(i) The self-insurer sent a written copy of the wage calculation to the injured worker on a department-developed template; and

(ii) The self-insurer informed the worker, in writing, on a department-developed template that the worker should contact the self-insurer with any questions; and

(iii) The self-insurer notified the worker, in writing, on a department-developed template to write to the department within sixty days if the worker disputed the calculation.

This presumption may be rebutted by a showing of action without foundation or unsupported by evidence demonstrating an unreasonable delay of benefits despite the notification to the worker and the worker's failure to dispute.

Provided, (g)(i) through (iii) of this subsection will not apply to payments for statutory cost-of-living adjustments, payments that do not use the amount stated in the department-developed template, or a refusal to make payments ordered by the department.

(2) **Under what circumstances will the department consider assessing a penalty for a violation of rules?** Upon a worker's request, or based upon its own motion, the department will consider assessment of a rule violation penalty if the self-insurer or third party administrator fails to meet the requirements of RCW Title 51 and WAC Title 296.

(3) **How is a penalty request created and processed?**

(a) An injured worker may request a penalty against his or her self-insured employer by:
(i) Completing the appropriate self-insurance form or sending a written request providing the reasons for requesting the penalty;
(ii) Attaching supporting documents (optional).
(b) Within ten working days of notification of the penalty request from a worker or department review, the self-insurer or third party administrator may file a response. The response may include supporting documents. If the employer fails to timely respond to the penalty request, the department will issue an order in response to the injured worker's request based on the available information.
(c) The department will issue an order within thirty days after receiving a complete written request for penalty per (a) of this subsection. The department's review during the thirty-day period for responding to the injured worker's request will include only the records in the department claim file at the time of the request and supporting documents provided by the worker and the employer per (a) and (b) of this subsection.
(d) The department order issued under (c) of this subsection is subject to request for reconsideration or appeal under the provisions of RCW **51.52.050** and **51.52.060**.

Certification, Corrective Action and Surety Rules

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(New WAC) WAC 296-15-257 Title to be determined (pertaining to withdrawal of certification and corrective action)

Summary of changes based on November 2023 feedback

- No changes

Clean version

(1) This section applies to withdrawal of certification or corrective action instituted by the director, or the director's designee, pursuant to RCW 51.14.080 and/or RCW 51.14.095.
(2) The director or the director's designee shall, in the director's or designee's sole discretion, take corrective action against a self-insured employer if the director determines that:
(a) The self-insured employer is not following proper industrial insurance claims procedures;
(b) The self-insured employer's accident prevention program is inadequate;
(c) The employer no longer meets the requirements of a self-insurer;
(d) The self-insurer's deposit is insufficient;
(e) The self-insurer intentionally or repeatedly induces employees to fail to report injuries, induces workers to treat injuries in the course of employment as off-the-job injuries, persuades workers to accept less than the compensation due, or unreasonably makes it necessary for workers to resort to proceedings against the employer to obtain compensation;
(f) The self-insurer habitually fails to comply with rules and regulations of the director regarding reports or other requirements necessary to carry out the purposes of this title;
(g) The self-insurer habitually engages in a practice of arbitrarily or unreasonably refusing employment to applicants for employment or discharging employees because of non-disabling bodily conditions; or

(h) A self-insured employer violated the duty of good faith and fair dealing two times within a three-year period.
(3) Corrective action taken shall follow WAC 296-15-260.

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WAC 296-15-260 Corrective action or withdrawal of certification

Summary of changes based on November 2023 feedback

- No changes

With mark-up, based on current WAC

(1) Corrective action against a self-insured employer shall be by order and notice. A notice of corrective action shall include the nature and specifics of the findings and may include the following:
(a) Probationary certification status for the self-insured employer for a period not to exceed one year;
(b) Mandatory training to correct areas of program deficiency to be approved by the department.
(c) The subject matter to be covered shall be specified in the notice of corrective action. Personnel required to attend and the time period within which the training is to be conducted will also be identified.
(d) Monitoring activities of the self-insured employer for a specified period of time to determine progress regarding correction of program deficiencies may be required. The department may require submission of complete and accurate records and/or conduct an audit to verify program compliance.
(e) If there is a contract between the self-insured employer and a service organization which has been filed with the department (WAC **296-15-110**), the corrective action order may specify and require that the service organization be subject to mandatory training and monitoring of activity provisions of the order.
(f) The corrective action order shall specify a time frame for submission of progress reports to the department's self-insurance section.
(g) During the first thirty days following the corrective action order, the self-insured employer shall submit a plan for the implementation of corrective action which shall include specific completion dates. If the plan is determined to be incomplete or inadequate, the department's self-insurance administrator shall notify the self-insurer of the necessary requirements or changes needed, and shall specify the date by which an amended plan shall be submitted.
(2) If sufficient grounds for decertification exist, an order and notice will be issued. The order and notice will include the following:
(a) The grounds upon which the determination is based.
(b) The period of time within which the grounds existed or arose.
(c) The date, not less than ninety days after the self-insured employer's receipt of the order and notice, when certification will be withdrawn.
(d) Provisions as stipulated by RCW **51.14.090**.
(3) Upon conclusion of the probationary certification period in the case of corrective action, the program deficiencies requiring corrective action by the self-insured employer shall be evaluated by the department and a written report sent to affected parties. Program activities may be

reaudited beyond the stated time period in order to assess continuing compliance with the objectives of the corrective action directives.

(4) If, at the conclusion of the probationary period, program deficiencies continue to exist, the department shall decide whether to extend the period of probation, require additional corrective action or proceed with decertification of the self-insured employer. An order and notice stating the decision shall be issued.

(5) The director may delay withdrawing the certification of the self-insured employer while the employer has an enforceable contract with a license third-party administrator that may not be legally terminated. However, the self-insured employer may not renew or extend the contract.

Clean version

(1) Corrective action against a self-insured employer shall be by order and notice. A notice of corrective action shall include the nature and specifics of the findings and may include the following:

(a) Probationary certification status for the self-insured employer for a period not to exceed one year;

(b) Mandatory training to correct areas of program deficiency to be approved by the department.

(c) The subject matter to be covered shall be specified in the notice of corrective action. Personnel required to attend and the time period within which the training is to be conducted will also be identified.

(d) Monitoring activities of the self-insured employer for a specified period of time to determine progress regarding correction of program deficiencies may be required. The department may require submission of complete and accurate records and/or conduct an audit to verify program compliance.

(e) If there is a contract between the self-insured employer and a service organization which has been filed with the department (WAC **296-15-110**), the corrective action order may specify and require that the service organization be subject to mandatory training and monitoring of activity provisions of the order.

(f) The corrective action order shall specify a time frame for submission of progress reports to the department's self-insurance section.

(g) During the first thirty days following the corrective action order, the self-insured employer shall submit a plan for the implementation of corrective action which shall include specific completion dates. If the plan is determined to be incomplete or inadequate, the department's self-insurance administrator shall notify the self-insurer of the necessary requirements or changes needed, and shall specify the date by which an amended plan shall be submitted.

(2) If sufficient grounds for decertification exist, an order and notice will be issued. The order and notice will include the following:

(a) The grounds upon which the determination is based.

(b) The period of time within which the grounds existed or arose.

(c) The date, not less than ninety days after the self-insured employer's receipt of the order and notice, when certification will be withdrawn.

(d) Provisions as stipulated by RCW **51.14.090**.

(3) Upon conclusion of the probationary certification period in the case of corrective action, the program deficiencies requiring corrective action by the self-insured employer shall be evaluated by the department and a written report sent to affected parties. Program activities may be reaudited beyond the stated time period in order to assess continuing compliance with the

objectives of the corrective action directives.

(4) If, at the conclusion of the probationary period, program deficiencies continue to exist, the department shall decide whether to extend the period of probation, require additional corrective action or proceed with decertification of the self-insured employer. An order and notice stating the decision shall be issued.

(5) The director may delay withdrawing the certification of the self-insured employer while the employer has an enforceable contract with a license third-party administrator that may not be legally terminated. However, the self-insured employer may not renew or extend the contract.

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WAC 296-15-121 Surety for a self-insurance program

Summary of changes based on November 2023 feedback

- No changes

With mark-up, based on current WAC

(1) **What is surety?** Surety is the legal financial guarantee each self-insurer must provide to the department for its self-insured workers' compensation program. Failure to provide surety in the amount required by the department will result in the withdrawal of the self insurer's certification. If a self-insurer defaults ~~on (stops payment of) benefits and assessments~~, the department will use its surety to cover these costs.

(a) Surety for all entities must be provided on the department's form. The original will be kept by the department. Surety must cover all self-insurance claims liabilities associated with the claims occurring during the time an employer functions as a self-insurer. ~~Excluding public entities and groups.~~ Surety amounts for public entities and groups are covered by WAC **296-15-151** and **296-15-161** respectively.

(b) Surety may not be used by a self-insurer to:

(i) Pay its workers' compensation benefits; or

(ii) Serve as collateral for any other banking transactions.

(c) Surety is not an asset of the self-insurer and will not be released by the department if the self-insurer files a petition for dissolution or relief under bankruptcy laws.

(d) The department will determine the amount of surety each self-insurer must provide annually. Surety can also be determined by an independent qualified actuary (associate or fellow of the casualty actuarial society). The surety estimate is subject to the approval of the department's actuary.

(e) Surety may be increased by a maximum of twenty-five percent of the estimated claim liabilities. These increases will be based on the self-insurer's credit rating or the director's discretion.

(f) Surety for privately held entities are required to submit audited financial reports prepared by a certified public accountant annually. Failure to provide timely updates will result in increased surety requirements. If the latest financial reports are older than twelve months past their fiscal year, surety will be increased by ten percent over the required surety calculated by the department. If the latest financial reports are older than twenty-four months, surety will be increased by twenty-five percent over the required surety calculated by the department and the department will proceed to decertify the employer from self-insurance.

(2) **What types of self-insurance surety will the department accept?** The department will accept the following types of surety:

(a) Cash, corporate, or governmental securities deposited with a department approved escrow agent and administered by a written agreement L&I form F207-039-000 between the department, self-insurer and escrow agent. Use L&I form F207-137-000 for any rider/amendment to the escrow account.

An escrow account may not be used by the self-insurer to satisfy any other obligation to the bank which maintains the escrow account.

(b) A bond on L&I form F207-068-000 written by a company approved to transact surety business in Washington. Use L&I form F207-134-000 for any rider/amendment to the bond.

(c) An irrevocable standby letter of credit (LOC) on L&I form F207-112-000 if the self-insurer has a net worth of at least 500 million dollars. Use L&I form F207-111-000 for any rider/amendment. LOCs are subject to acceptance by the department. Acceptance includes, but is not limited to, approval of the financial condition of the issuing or confirming bank.

(i) The issuing or confirming bank must have a location in Washington. The bank must provide the department with an audited financial statement or call report made to the banking regulatory agencies for the most recent fiscal year. An audited statement/call report is due at LOC issuance and annually while the LOC is in effect.

(ii) The self-insurer must provide the department a memorandum of understanding on L&I form F207-113-000 showing the self-insurer's agreement with the following conditions:

(A) The department will automatically extend an LOC for an additional year unless notified otherwise by registered mail at least sixty days prior to expiration.

(B) If the department is notified an LOC will not be replaced, and the self-insurer fails to provide acceptable replacement surety within thirty days of notice:

(I) The department will draw the full value of the LOC. All proceeds of the LOC will be deposited with the department;

(II) Accrued interest in excess of the surety requirement will be returned semiannually to the self-insurer; and

(III) If acceptable replacement surety is later provided, the proceeds of the LOC and accrued interest will be returned to the self-insurer.

(C) If the self-insurer defaults on the payment of workers' compensation benefits and has failed to provide acceptable replacement surety for an expired LOC:

(I) The title to the proceeds will be transferred to the department; and

(II) The proceeds and accrued interest will be used to pay the self-insurer's workers' compensation benefits.

(D) If the self-insurer defaults on the payment of workers' compensation benefits and has an LOC in force:

(I) The department will draw the full value of the LOC. All proceeds of the LOC will be deposited with the department; and

(II) The proceeds and accrued interest will be used to pay the self-insurer's workers' compensation benefits.

(iii) If the self-insurer provides another acceptable type of surety in the amount required by the department, the department's interest in the LOC will be released.

(iv) All legal proceedings regarding a self-insurer's LOC will be subject to Washington laws and courts.

(3) **When could a self-insurer's surety level change?**

(a) Surety will be maintained at the current level unless the department's estimate or an independent qualified actuary's estimate of the self-insurer's outstanding claim liabilities changes by more than one hundred thousand dollars.

(b) Surety changes are due by July 1 of each year.

(4) **How does the department determine the required surety level?** The department analyzes each self-insurer's loss history using incurred development, paid development or other department approved actuarial methods of loss development.

(5) **What is considered reinsurance?** For the purposes of Title **51** RCW, excess insurance and reinsurance mean the same thing.

(6) **May a self-insurer reinsure part of its liability?**

(a) A self-insurer may reinsure up to eighty percent of its liability under Title **51** RCW.

(b) The reinsuring company and its personnel are prohibited from participating in the administration of the responsibilities of the self-insurer.

(c) Reinsurance policies issued after July 1, 1975, must include endorsements which state (a) and (b) of this subsection.

(d) The self-insurer must:

(i) Notify the department of the name of the insurance carrier, the extent and coverage period of the policy; and

(ii) Submit copies of all reinsurance policies in force including all modifications and renewal provisions.

(e) The department may accept a certificate of insurance on L&I form F207-095-000 in place of the policy if the certificate certifies all coverage conditions and exceptions and that the reinsurance company and its personnel do not participate in the administration of the responsibilities of the self-insurer under Title **51** RCW.

(7) **What if a self-insurer ends its self-insured workers' compensation program?** If a self-insurer voluntarily surrenders certification or has its certificate involuntarily withdrawn by the department, the former self-insurer must continue to do all of the following:

(a) Manage and ~~P~~pay benefits on claims incurred during its period of self-insurance. Claim reopenings and new claims filed for occupational diseases incurred during the period of self-insurance remain the obligation of the former self-insurer.

(b) File quarterly and annual reports as long as quarterly reporting is required; and submit audited financial reports prepared by a certified public accountant annually. A former self-insurer may ask the department to release it from quarterly reporting after it has had no claim activity with the exception of pension or death benefits for a full year.

(c) Provide surety at the department required level. The department may require an increase in surety based on annual reports as they continue to be filed. Surety will not be reduced from the last required level (while self-insured) until no sooner than three full calendar years after the certificate was terminated. A bond may be canceled for future obligations, but it continues to provide surety for claims occurring prior to its cancellation.

(d) Pay insolvency trust assessments for three years after surrender or withdrawal of certificate.

(e) Pay all expenses for a final audit of its self-insurance program.

(8) **When could the department consider releasing surety to a former self-insurer or its successor?**

(a) The department may consider releasing surety to a former self-insurer or its successor when all of

the following have occurred:

(i) All claims against the self-insurer are closed; and

(ii) The self-insurer has been released from quarterly reporting for at least ten years.

(b) If the department releases surety, the former self-insurer remains responsible for claim reopenings and new claims filed for occupational disease incurred during the period of self-insurance.

Clean version

(1) **What is surety?** Surety is the legal financial guarantee each self-insurer must provide to the department for its self-insured workers' compensation program. Failure to provide surety in the amount required by the department will result in the withdrawal of the self insurer's certification. If a self-insurer defaults, the department will use its surety to cover these costs.

(a) Surety for all entities must be provided on the department's form. The original will be kept by the department. Surety must cover all self-insurance claims liabilities associated with the claims occurring during the time an employer functions as a self-insurer. Surety amounts for public entities and groups are covered by WAC **296-15-151** and **296-15-161** respectively.

(b) Surety may not be used by a self-insurer to:

(i) Pay its workers' compensation benefits; or

(ii) Serve as collateral for any other banking transactions.

(c) Surety is not an asset of the self-insurer and will not be released by the department if the self-insurer files a petition for dissolution or relief under bankruptcy laws.

(d) The department will determine the amount of surety each self-insurer must provide annually. Surety can also be determined by an independent qualified actuary (associate or fellow of the casualty actuarial society). The surety estimate is subject to the approval of the department's actuary.

(e) Surety may be increased by a maximum of twenty-five percent of the estimated claim liabilities. These increases will be based on the self-insurer's credit rating or the director's discretion.

(f) Surety for privately held entities are required to submit audited financial reports prepared by a certified public accountant annually. Failure to provide timely updates will result in increased surety requirements. If the latest financial reports are older than twelve months past their fiscal year, surety will be increased by ten percent over the required surety calculated by the department. If the latest financial reports are older than twenty-four months, surety will be increased by twenty-five percent over the required surety calculated by the department and the department will proceed to decertify the employer from self-insurance.

(2) **What types of self-insurance surety will the department accept?** The department will accept the following types of surety:

(a) Cash, corporate, or governmental securities deposited with a department approved escrow agent and administered by a written agreement L&I form F207-039-000 between the department, self-insurer and escrow agent. Use L&I form F207-137-000 for any rider/amendment to the escrow account.

An escrow account may not be used by the self-insurer to satisfy any other obligation to the bank which maintains the escrow account.

(b) A bond on L&I form F207-068-000 written by a company approved to transact surety business in Washington. Use L&I form F207-134-000 for any rider/amendment to the bond.

(c) An irrevocable standby letter of credit (LOC) on L&I form F207-112-000 if the self-insurer has a net worth of at least 500 million dollars. Use L&I form F207-111-000 for any rider/amendment.

LOCs are subject to acceptance by the department. Acceptance includes, but is not limited to, approval of the financial condition of the issuing or confirming bank.

(i) The issuing or confirming bank must have a location in Washington. The bank must provide the department with an audited financial statement or call report made to the banking regulatory agencies for the most recent fiscal year. An audited statement/call report is due at LOC issuance and annually while the LOC is in effect.

(ii) The self-insurer must provide the department a memorandum of understanding on L&I form F207-113-000 showing the self-insurer's agreement with the following conditions:

(A) The department will automatically extend an LOC for an additional year unless notified otherwise by registered mail at least sixty days prior to expiration.

(B) If the department is notified an LOC will not be replaced, and the self-insurer fails to provide acceptable replacement surety within thirty days of notice:

(I) The department will draw the full value of the LOC. All proceeds of the LOC will be deposited with the department;

(II) Accrued interest in excess of the surety requirement will be returned semiannually to the self-insurer; and

(III) If acceptable replacement surety is later provided, the proceeds of the LOC and accrued interest will be returned to the self-insurer.

(C) If the self-insurer defaults on the payment of workers' compensation benefits and has failed to provide acceptable replacement surety for an expired LOC:

(I) The title to the proceeds will be transferred to the department; and

(II) The proceeds and accrued interest will be used to pay the self-insurer's workers' compensation benefits.

(D) If the self-insurer defaults on the payment of workers' compensation benefits and has an LOC in force:

(I) The department will draw the full value of the LOC. All proceeds of the LOC will be deposited with the department; and

(II) The proceeds and accrued interest will be used to pay the self-insurer's workers' compensation benefits.

(iii) If the self-insurer provides another acceptable type of surety in the amount required by the department, the department's interest in the LOC will be released.

(iv) All legal proceedings regarding a self-insurer's LOC will be subject to Washington laws and courts.

(3) **When could a self-insurer's surety level change?**

(a) Surety will be maintained at the current level unless the department's estimate or an independent qualified actuary's estimate of the self-insurer's outstanding claim liabilities changes by more than one hundred thousand dollars.

(b) Surety changes are due by July 1 of each year.

(4) **How does the department determine the required surety level?** The department analyzes each self-insurer's loss history using incurred development, paid development or other department approved actuarial methods of loss development.

(5) **What is considered reinsurance?** For the purposes of Title **51** RCW, excess insurance and reinsurance mean the same thing.

(6) **May a self-insurer reinsure part of its liability?**

(a) A self-insurer may reinsure up to eighty percent of its liability under Title **51** RCW.

(b) The reinsuring company and its personnel are prohibited from participating in the administration of the responsibilities of the self-insurer.
(c) Reinsurance policies issued after July 1, 1975, must include endorsements which state (a) and (b) of this subsection.
(d) The self-insurer must:
(i) Notify the department of the name of the insurance carrier, the extent and coverage period of the policy; and
(ii) Submit copies of all reinsurance policies in force including all modifications and renewal provisions.
(e) The department may accept a certificate of insurance on L&I form F207-095-000 in place of the policy if the certificate certifies all coverage conditions and exceptions and that the reinsurance company and its personnel do not participate in the administration of the responsibilities of the self-insurer under Title **51** RCW.
(7) **What if a self-insurer ends its self-insured workers' compensation program?** If a self-insurer voluntarily surrenders certification or has its certificate involuntarily withdrawn by the department, the former self-insurer must continue to do all of the following:
(a) Manage and pay benefits on claims incurred during its period of self-insurance. Claim reopenings and new claims filed for occupational diseases incurred during the period of self-insurance remain the obligation of the former self-insurer.
(b) File quarterly and annual reports as long as quarterly reporting is required; and submit audited financial reports prepared by a certified public accountant annually. A former self-insurer may ask the department to release it from quarterly reporting after it has had no claim activity with the exception of pension or death benefits for a full year.
(c) Provide surety at the department required level. The department may require an increase in surety based on annual reports as they continue to be filed. Surety will not be reduced from the last required level (while self-insured) until no sooner than three full calendar years after the certificate was terminated. A bond may be canceled for future obligations, but it continues to provide surety for claims occurring prior to its cancellation.
(d) Pay insolvency trust assessments for three years after surrender or withdrawal of certificate.
(e) Pay all expenses for a final audit of its self-insurance program.
(8) **When could the department consider releasing surety to a former self-insurer or its successor?**
(a) The department may consider releasing surety to a former self-insurer or its successor when all of the following have occurred:
(i) All claims against the self-insurer are closed; and
(ii) The self-insurer has been released from quarterly reporting for at least ten years.
(b) If the department releases surety, the former self-insurer remains responsible for claim reopenings and new claims filed for occupational disease incurred during the period of self-insurance.

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WAC 296-15-125 Default by a self-insurer

Summary of changes based on November 2023 feedback

- No changes

With mark-up, based on current WAC

(1) What is a default? A default occurs when a self-insured employer no longer provides benefits to its injured workers in accordance with Title 51 of the Revised Code of Washington, or is determined to otherwise fail to meet the requirements of a self-insured employer under Title 51 RCW. A default can be a voluntary action of the self-insured employer, ~~or~~ an action brought on by the employer's inability to pay the obligation, or an action brought on by the department.

(2) What happens when the department first learns a self-insured employer has discontinued meeting its obligations under Title 51 RCW ~~defaulted on its obligation~~? The department ~~first corresponds with the self-insured employer to determine if the self-insurer will resume the provision of benefits~~ will send notice to the self-insurer that if it does not send confirmation within 10 calendar days that it intends to continue to meet its obligations under Title 51 RCW, the department will determine that the self-insurer has defaulted. If the self-insurer does not respond to the department and resume the provision of benefits within ten days, the self-insured employer is determined to have defaulted.

(3) What happens when the department determines that the self-insured employer has defaulted ~~confirms that a self-insurer has defaulted on its obligation~~? ~~There are two actions that the department takes~~ The following actions occur when a default by a self-insured employer is ~~confirmed~~ determined:

(a) ~~First, t~~The department assumes jurisdiction of the claims of the defaulting self-insurer and begins to provide benefits to those injured workers.

(b) ~~Second,~~ If the self-insurer is a private entity, or a public entity or group that has provided surety consistent with WAC 296-15-121, the department makes demand upon the surety provided by that self-insurer for the full amount of the surety. The proceeds of the surety are deposited with the department and accrue interest, which will be used to supplement the surety in providing benefits to those injured workers.

(4) What happens to a self-insured employer's certification when it defaults? The employer surrenders its self-insurance certification when it defaults. Any remaining employment in the state would need industrial insurance coverage through the state fund effective with the default by the employer.

Clean version

(1) What is a default? A default occurs when a self-insured employer no longer provides benefits to its injured workers in accordance with Title 51 of the Revised Code of Washington, or is determined to otherwise fail to meet the requirements of a self-insured employer under Title 51 RCW. A default can be a voluntary action of the self-insured employer, an action brought on by the employer's inability to pay the obligation, or an action brought on by the department.

(2) What happens when the department first learns a self-insured employer has discontinued meeting its obligations under Title 51 RCW? The department will send notice to the self-insurer that if it does not send confirmation within 10 calendar days that it intends to continue to meet its obligations under Title 51 RCW, the department will determine that the self-insurer has defaulted. If the self-insurer does not respond to the department and resume the provision of benefits within ten days, the self-insured employer is determined to have defaulted.

(3) What happens when the department determines that the self-insured employer has defaulted? The following actions occur when a default by a self-insured employer is determined:

(a) The department assumes jurisdiction of the claims of the defaulting self-insurer and begins to provide benefits to those injured workers.
(b) If the self-insurer is a private entity, or a public entity or group that has provided surety consistent with WAC 296-15-121, the department makes demand upon the surety provided by that self-insurer for the full amount of the surety. The proceeds of the surety are deposited with the department and accrue interest, which will be used to supplement the surety in providing benefits to those injured workers.
(4) What happens to a self-insured employer's certification when it defaults? The employer surrenders its self-insurance certification when it defaults. Any remaining employment in the state would need industrial insurance coverage through the state fund effective with the default by the employer.

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WAC 296-15-151 Surety for a public entity's self-insurance program

Summary of changes based on November 2023 feedback

- No changes

With mark-up, based on current WAC

(1) Surety for public entities must be provided on a department developed form consistent with WAC **296-15-121**(2). The original will be kept by the department. Required surety must cover at a minimum one hundred twenty-five percent of the expected workers' compensation claim costs occurring in the next calendar year or five hundred thousand dollars, whichever is higher. The surety required may be increased up to the total outstanding liabilities associated with claims occurring during the time an employer functions as a self-insurer based on the credit rating of the employer.
(2) Public entities must provide a public entity surety certification which will provide an estimate of the next calendar year's expected claim costs and the current estimate of the outstanding claim liabilities.
(3) If the public entity is found to have violated the duty of good faith and fair dealing within RCW 51.14.080, two times within a three year period, it may be required to provide surety consistent with WAC 296-15-121.
(~~3~~4) Credit rating evaluation for financial monitoring.
(a) For entities with acceptable credit ratings above B+/B1, the surety requirement will be one hundred twenty-five percent of the next calendar year's expected claim costs or five hundred thousand dollars, whichever is higher.
(b) For entities with credit ratings at or below B+/B1, the surety requirement will be the highest of the above amount, but not less than fifty percent of the current estimate of outstanding claim liabilities.
(c) For entities with credit ratings at or below CCC+/Caa1, the surety requirement will be the highest of the above amount, but not less than one hundred percent of the current estimate of outstanding claim liabilities.
(d) In addition to the actions and other relevant information utilized in (a) through (c) of this subsection, the department, with the director's discretion, may consider general economic

conditions to evaluate whether a self-insurer's certification may be maintained or withdrawn.

Clean version

(1) Surety for public entities must be provided on a department developed form consistent with WAC **296-15-121**(2). The original will be kept by the department. Required surety must cover at a minimum one hundred twenty-five percent of the expected workers' compensation claim costs occurring in the next calendar year or five hundred thousand dollars, whichever is higher. The surety required may be increased up to the total outstanding liabilities associated with claims occurring during the time an employer functions as a self-insurer based on the credit rating of the employer.
(2) Public entities must provide a public entity surety certification which will provide an estimate of the next calendar year's expected claim costs and the current estimate of the outstanding claim liabilities.
(3) If the public entity is found to have violated the duty of good faith and fair dealing within RCW 51.14.080, two times within a three year period, it may be required to provide surety consistent with WAC 296-15-121.
(4) Credit rating evaluation for financial monitoring.
(a) For entities with acceptable credit ratings above B+/B1, the surety requirement will be one hundred twenty-five percent of the next calendar year's expected claim costs or five hundred thousand dollars, whichever is higher.
(b) For entities with credit ratings at or below B+/B1, the surety requirement will be the highest of the above amount, but not less than fifty percent of the current estimate of outstanding claim liabilities.
(c) For entities with credit ratings at or below CCC+/Caa1, the surety requirement will be the highest of the above amount, but not less than one hundred percent of the current estimate of outstanding claim liabilities.
(d) In addition to the actions and other relevant information utilized in (a) through (c) of this subsection, the department, with the director's discretion, may consider general economic conditions to evaluate whether a self-insurer's certification may be maintained or withdrawn.

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WAC 296-15-161 Surety for a group self-insurance program

Summary of changes based on November 2023 feedback

- No changes

With mark-up, based on current WAC

(1) **How does the department determine the required surety level for a group self-insurer?** The department will require that each group provide an actuarial report prepared by an independent qualified actuary (associate or fellow of the casualty actuarial society) that shows the following:
(a) Development of the next year's rates and allocation to members;
(b) Calculation of outstanding claims liabilities cover all years after being certified to self-insure; and
(c) Statement of the adequacy of the group's contingency reserve (assets and liabilities).

(2) If the group is found to have violated the duty of good faith and fair dealing within RCW 51.14.080, two times within a three year period, it may be required to provide surety consistent with WAC 296-15-121.

(~~2~~3) **May a group self-insurer pay expenses from its reserve fund?** A group self-insurer may pay only the following items from its cash reserve fund:

(a) Administrative expenses for operating the group self-insurance program, including claims handling expenses, legal, investigative or administrative costs and department administrative assessments.

(b) Claim expenditures. Supplemental pension fund (SPRF) benefits may also be paid from the reserve fund if the group redeposits SPRF reimbursements into the reserve account. Interest earned by the reserve account must remain in the account while this method is in effect.

(c) Reinsurance premiums. All recoveries from these policies must be redeposited into the reserve fund. Within eighteen months of premium payment, the group must return the amount paid for premiums if reinsurance recoveries were not sufficient to return the account to its original amount.

(~~3~~4) **How can a group self-insurer assess its members for reserve fund costs?** A group self-insurer may determine how it will assess members for required reserve fund costs. The group's bylaws must describe the procedures it will use to collect these costs.

(~~4~~5) **Must a group self-insurer purchase reinsurance?** A group self-insurer must obtain reinsurance for each year of operation to ensure adequate protection against catastrophic or unexpected loss.

(~~5~~6) **What if a group self-insurer collects excess premiums during a fund year and has a surplus?** A group self-insurer may refund surplus money from a fund year if it retains sufficient money to fulfill all of its workers' compensation obligations. This includes maintaining the required reserve fund.

(~~6~~7) **What if a group self-insurer collects insufficient premiums during a fund year and has a deficit?** The department will demand a group self-insurer to cover a deficit by:

(a) Unencumbered surplus from a different fund year;

(b) An alternative method; or

(c) Assessing the membership.

Clean version

(1) **How does the department determine the required surety level for a group self-insurer?** The department will require that each group provide an actuarial report prepared by an independent qualified actuary (associate or fellow of the casualty actuarial society) that shows the following:

(a) Development of the next year's rates and allocation to members;

(b) Calculation of outstanding claims liabilities cover all years after being certified to self-insure; and

(c) Statement of the adequacy of the group's contingency reserve (assets and liabilities).

(2) If the group is found to have violated the duty of good faith and fair dealing within RCW 51.14.080, two times within a three year period, it may be required to provide surety consistent with WAC 296-15-121.

(3) **May a group self-insurer pay expenses from its reserve fund?** A group self-insurer may pay only the following items from its cash reserve fund:

(a) Administrative expenses for operating the group self-insurance program, including claims

handling expenses, legal, investigative or administrative costs and department administrative assessments.

(b) Claim expenditures. Supplemental pension fund (SPRF) benefits may also be paid from the reserve fund if the group redeposits SPRF reimbursements into the reserve account. Interest earned by the reserve account must remain in the account while this method is in effect.

(c) Reinsurance premiums. All recoveries from these policies must be redeposited into the reserve fund. Within eighteen months of premium payment, the group must return the amount paid for premiums if reinsurance recoveries were not sufficient to return the account to its original amount.

(4) **How can a group self-insurer assess its members for reserve fund costs?** A group self-insurer may determine how it will assess members for required reserve fund costs. The group's bylaws must describe the procedures it will use to collect these costs.

(5) **Must a group self-insurer purchase reinsurance?** A group self-insurer must obtain reinsurance for each year of operation to ensure adequate protection against catastrophic or unexpected loss.

(6) **What if a group self-insurer collects excess premiums during a fund year and has a surplus?** A group self-insurer may refund surplus money from a fund year if it retains sufficient money to fulfill all of its workers' compensation obligations. This includes maintaining the required reserve fund.

(7) **What if a group self-insurer collects insufficient premiums during a fund year and has a deficit?** The department will demand a group self-insurer to cover a deficit by:

(a) Unencumbered surplus from a different fund year;

(b) An alternative method; or

(c) Assessing the membership.