WAC 284-54-800 Unfair or deceptive acts. RCW 48.84.910 authorizes the commissioner to prohibit particular unfair or deceptive acts in the conduct of the advertising, sale, and marketing of long-term care policies and contracts. The purpose of this section is to define certain minimum standards which insurers should meet with respect to long-term care. If the following standards are violated with such frequency as to indicate a general business practice by an insurer, it will be deemed to constitute an unfair method of competition or a deceptive act by such insurer and a violation of this section.

(1) Misrepresenting pertinent facts or insurance contract provisions.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to communications arising under insurance policies or contracts.

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies or contracts.

(4) Refusing to pay claims or provide benefits without conducting a reasonable investigation.

(5) Failing to affirm or deny coverage of claims within a reasonable time.

(6) Compelling an insured to institute litigation to recover amounts due under an insurance contract by offering substantially less than the amounts ultimately recovered in actions brought by such an insured.

(7) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Making claims payments to an insured or beneficiaries not accompanied by an explanation setting forth the coverage under which the payments are being made.

(9) Failing to promptly provide a reasonable explanation of the basis in the insurance contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) Asserting to an insured or claimant a policy of appealing from arbitration awards in favor of an insured or claimant for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by unreasonably requiring an insured, claimant, or the attending physician of the patient to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.

(12) Failure to expeditiously honor drafts given in settlement of claims within three working days of notice of receipt by the payor bank except for reasons acceptable to the commissioner.

(13) Failure to adopt and implement reasonable standards for the processing and payment of claims once the obligation to pay has been established.

(14) Issue checks or drafts in partial payment of a loss or claim under a specific coverage which contain language which appear to release the insurer from its total liability.

(15) Failure to reply to the insurance commissioner within fifteen working days of receipt of an inquiry, such reply to furnish the commissioner with an adequate response to the inquiry.

(16) Failure to settle a claim on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions as permitted by this chapter.

(17) Making statements which indicate the rights of persons may be impaired if a form or release is not completed within a given time unless the statement otherwise is provided by policy provisions or is for the purpose of notifying that person of the provisions of an applicable statute of limitations.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-800, filed 7/9/87.]