Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Business & Financial Services Committee

HB 1343

Brief Description: Addressing insurance statutes, generally.

Sponsors: Representatives Kirby and Bailey; by request of Insurance Commissioner.

Brief Summary of Bill

- Modifies service of process provisions.
- Modifies provisions related to Long-term Care Partnership policies.
- Changes the dates related to the payment of the regulatory surcharge.

Hearing Date: 1/21/11

Staff: Jon Hedegard (786-7127).

Background:

Service of Process. Service of process is the legal procedure of notifying an affected person or business of a pending legal action. The Insurance Code contains provisions that require a wide variety of nonresident persons and businesses to follow certain procedures in appointing the Insurance Commissioner their attorney for the purpose of receiving service of process. Generally, the person or entity must provide the Commissioner with the name, title, and address of the person who should be contacted about the action. The service of process provisions generally require a $10 fee for service on the Commissioner to be paid by the licensee being served. This fee is apparently not imposed on health discount organizations unless those are also health carriers. In 2010 service of process provisions were changed for nonresident surplus lines brokers.

Insurer Fiscal and Tax Reporting. On or before March 1 of every year, domestic health carriers must file an annual statement regarding the insurer's financial condition, transactions, and affairs with the Office of the Insurance Commissioner (OIC) and the National Association of Insurance Commissioners (NAIC). Foreign (meaning out-of-state) and alien (meaning out-of-country) insurers must file an annual statement with the NAIC. Health carriers pay a premium tax to the

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OIC. The tax is in the amount of 2 percent of premiums and is prepaid in several installments and is reconciled on or before March 1. Certain premiums are exempt from taxation. The OIC remits the money to the State Treasurer (Treasurer). The money is then deposited into the General Fund. In the annual statement, a health carrier is to file a statement of premiums so collected or received according to a form prescribed by the OIC. In every statement, the reporting of premiums for tax purposes must be on a written basis or on a paid-for basis consistent with the basis required by the annual statement.

Regulatory Surcharge Assessment. The annual cost of operating the OIC is determined by legislative appropriation. A pro rata share of the cost is charged to all organizations (including insurers, health care service contractors, health maintenance organizations and others) as a regulatory surcharge. The OIC is authorized to charge a fee of up to 0.125 percent against an organization's premium volume to finance the OIC's operations. The minimum regulatory surcharge is $1,000. The Commissioner must calculate and bill each organization for the regulatory surcharge by June 1 of each year. The bill is due and payable on June 15 of each year. Failure to pay the bill by June 30 may lead to the same penalties as may be incurred by failure to pay premium tax in a timely fashion. If tax is not paid within 45 days after the due date, the penalty is 10 ten percent of the amount of the amount due. If the tax is not paid within 60 days of the due date, penalty is 20 percent of the amount due. After 60 days, interest will accrue at the statutory maximum legal rate of interest. The amount of any penalty collected must be paid to the Treasurer and credited to the general fund. The commissioner may revoke the certificate of authority or registration of any delinquent organization. The certificate of authority or registration will not be reissued until sums are fully paid.

Long-term Care Partnership (LTCP). The Department of Social and Health Services (DSHS) must, in conjunction with the OIC, coordinate a long-term care insurance program entitled the Washington Long-term Care Partnership. The purpose of the program is to use private insurance and Medicaid funds to finance long-term care. The LTCP program allows for the exclusion of some or all of the individual's assets in determination of Medicaid eligibility as approved by the federal Health Care Financing Administration for individuals:

- purchasing a long-term care insurance policy or contract;
- meeting the statutory criteria;
- meeting any other terms as specified by the OIC and the DSHS.

The LTCP statutes provided that the Commissioner must adopt rules for LTCP policies including provisions requiring the policies to:

- be guaranteed renewable;
- provide coverage for nursing home care and provide coverage for an alternative plan of care benefit as defined by the Commissioner;
- provide optional coverage for home and community-based services that coverage is rejected in writing by the applicant;
- provide automatic inflation protection or similar coverage for any policyholder through the age of seventy-nine and made optional at age eighty to protect the policyholder from future increases in the cost of long-term care;
- not require prior hospitalization or confinement in a nursing home as a prerequisite to receiving long-term care benefits; and
- contain at least a six-month grace period that permits reinstatement of the policy or contract retroactive to the date of termination if the policy or contract holder's

nonpayment of premiums arose as a result of a cognitive impairment suffered by the policy or contract holder as certified by a physician.

While the frame-work for a state LTCP program existed, no LTCP product has ever been filed. LTCP began in 1987 as a demonstration project funded through the Robert Wood Johnson Foundation with four participating states: California, Connecticut, Indiana, and New York. In the Omnibus Budget Reconciliation Act of 1993, the federal government limited the ability of any additional states to create approved state LTCP programs. The federal government made changes to the federal statutes that will allow for the approval of state LTCP programs in the Defense Reauthorization Act of 2005 (DRA).

Examiner Salaries. The Commissioner may examine the affairs, transactions, accounts, records, documents, and assets of each authorized insurer, insurance producer, surplus lines broker, adjuster or title agent as often as he or she deems advisable. The Commissioner must examine each insurer holding a certificate of authority or certificate of registration not less frequently than every five years. The person examined must reimburse the state for travel, salaries living expenses and per diems at a reasonable rate approved by the Commissioner. Per diem salary and expenses for employees examining insurers domiciled outside of the state are established by the Commissioner on the basis of the higher of:

- the NAIC's recommended salary and expense schedule for zone examiners; or
- the salary schedule established by the state Personnel Resources Board (PRB) and the expense schedule established by the Office of Financial Management, whichever is higher.

The PRB consists of three members appointed by the Governor and confirmed by the Washington State Senate. The PRB is staffed by employees who provide legal, technical, administrative, and support services under the direction of the Assistant Director of the Department of Personnel Legal Affairs Division. The PRB is given authority to hear appeals filed by civil service employees of the state of Washington. The PRB strives to adjudicate appeals in a timely, efficient, and objective manner, ensuring the rights of employees and management while protecting the interests of the state's citizens. The Director of Personnel (Director) is the administrative head of the Department of Personnel (DOP). The DOP provides a host of personnel and human resource services to the state of Washington, including classification and compensation consulting. The Director is also the Secretary of the PRB.

Annual Statement Forms. Each domestic, foreign, and alien insurer that is authorized to transact insurance in this state must report on their previous year's finances to the NAIC. This is called an annual statement. Domestic insurers must also file the information with the Commissioner. The Commissioner is required to purchase certain forms with "blanks" for information for insurers. The Commissioner may purchase the forms from any printer manufacturing the forms for various states.

Summary of Bill:

Service of process. Service of process requirements are modified for a number of nonresident persons and entities, including:

- reciprocal insurers;

- unauthorized foreign or alien insurers;
- unauthorized insurers;
- nonresident surplus lines broker;
- nonresident adjuster;
- charitable gift annuities;
- surplus line brokers;
- insurance and title producers;
- fraternal benefit societies;
- reinsurance intermediaries;
- life settlement providers and brokers;
- service contract providers;
- protection product providers; and
- discount plan organizations.

The new requirements for service of process are generally similar to the previous provisions but are standardized. The fee remains $10 and now applies to health discount organizations (that are not health carriers). The persons or entities appointing the Commissioner must designate person who will received the notice from the Commissioner and provide that person's name, address, and e-mail address. The contact person may be changed by filing a new designated person with the appropriate contact information. The Commissioner may now use mail, electronic means, or other means reasonably calculated to give notice. The copy provided by the Commissioner to the person or entity receiving notice must be sent or made available in a manner that is secure and with a receipt that is verifiable. The appointment of the Commissioner is explicitly made to be irrevocable. The appointment binds successors in interest and remains in effect as long as the person or entity has a contract or liabilities in the state. Legal proceedings may not require a licensee to appear, plead, or answer until the expiration of 40 days after the date of service upon the Commissioner. The Commissioner may adopt rules to implement the service or process provisions.

Long-term Care Partnership (LTCP). The policy provisions required by rule are struck. Instead, the Commissioner must adopt rules to incorporate any statutory requirement and any requirements in the DRA. A provision requiring an insurer to demonstrate to the Commissioner that the insurer offers case management services is struck. Other language and technical changes are made.

Regulatory Surcharge Assessment. The billing date of the regulatory assessment, the due date, and the date at which penalties are incurred are all changed. The Commissioner must calculate and bill each organization for the regulatory surcharge by July 1 of each year. The bill is due and payable on July 15 of each year. Failure to pay the owed sum by July 31 of each year may lead to penalties.

Insurer Fiscal and Tax Reporting. The reporting of premiums for tax purposes is intended to be consistent with the basis the health carrier used to report in the insurer's annual statement. The health carrier may report using a written or a paid-for basis. A reference to exempting certain premiums from taxation that are in a Medicaid pilot or demonstration managed care project and were received prior to 2009 is removed.

Examiner Salaries. The PRB will no longer establish a salary schedule for examiners. That duty will be performed by the state Director of Personnel.

Annual Statement Forms. The requirement for the Commissioner to purchase blank forms is removed.

Appropriation: None.

Fiscal Note: Requested on January 19, 2011.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.