SENATE BILL REPORT
SB 6050

As of February 10, 2020

Title: An act relating to insurance guaranty fund.

Brief Description: Concerning insurance guaranty fund.

Sponsors: Senators Cleveland, Keiser and Kuderer; by request of Insurance Commissioner.

Brief History:
Committee Activity: Health & Long Term Care: 1/24/20, 2/05/20 [DPS-WM, w/oRec, DNP].
Ways & Means: 2/10/20.

Brief Summary of First Substitute Bill

- Adds health care service contractors and health maintenance organizations to Washington's Life and Disability Insurance Guarantee Association.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 6050 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Cleveland, Chair; Randall, Vice Chair; Conway, Dhingra, Frockt, Keiser and Van De Wege.

Minority Report: That it be referred without recommendation.
Signed by Senator Muzzall.

Minority Report: Do not pass.
Signed by Senators O'Ban, Ranking Member; Becker and Rivers.

Staff: Evan Klein (786-7483)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Sandy Stith (786-7710)

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

Background: Insurance guaranty associations are organizations created by statute for reimbursing policy holders and beneficiaries for losses resulting from the financial impairment or insolvency of insurance companies. Members of these associations are the individual companies authorized to write particular types of insurance within a state. They are governed by a board of directors made up of representatives of the industry, the state regulator, and in some cases, policy holders. There are statutory provisions governing assessments, eligibility for payment and maximum amount of benefits. Members are assessed following an insolvency to keep the fund primed for possible future payments. Assessments in most states, including Washington, are based on the percentage of total premium for the type of insurance written by each member.

In Washington there are two guaranty associations, one to protect property and casualty policy holders and one for life and disability policies. Members of both associations may offset any payments made to the guaranty fund against premium taxes due over a five-year period. A member is exempt from a payment otherwise due if the payment would render them insolvent. Washington's Long-Term Care Guarantee Fund (LTC Fund) is currently supported by life and disability insurers, through the Life and Disability Insurance Guarantee Association (Association).

Insurers that are members of the Association are required to pay two classes assessments. Class A assessments are administrative, and Class B assessments are those necessary to carry out the substantive duties of the Association. Class A assessments may either be assessed pro rata or non pro rata. Class B assessments must be made on the basis of percentage of total premiums written for that type of insurance in the state by the member. Assessments may be abated or deferred at the discretion of the Association's board of directors if immediate payment would endanger the ability of the member to meet its contractual obligations. Assessments are limited to 2 percent of the average annual premiums of the member for the past three years.

Summary of Bill (First Substitute): Member Insurers. Member insurers are any insurer, HCSC, or HMO, authorized to transact in Washington. Member insurers do not include non-risk-baring hospital or medical service organizations, or multiple employer welfare arrangements. All member insurers must be and remain members of the Association to transact business as an insurer, HCSC, or HMO in Washington.

Coverage. The persons covered by the Association is expanded to include:

- health care providers and facilities rendering services covered under health care benefit policies or certificates of coverage; and
- persons who acquire rights to receive payments through a structured settlement factoring transaction that is in compliance with the Internal Revenue Code.

The Association does not provide coverage for:

- a policy or contract providing a hospital, medical, prescription drug, or other health care benefits under Medicare parts C or D, or under Medicaid;
- structured settlement annuity benefits to which a payee or beneficiary has transferred their rights in a structured settlement factoring transaction; or

- a portion of a policy or contract to the extent that the rate of interest on which it is based exceeds a rate as calculated in statute based on the Moody's bond yield, unless any portion of the policy or contract provides long-term care or health benefits.

The benefits the Association may become obligated to cover may not exceed the lesser of the contractual obligation for which the insurer is liable, or for individual policies:

- $500,000 for coverage not defined as disability income insurance or health benefit plan coverage;
- $500,000 for disability income insurance;
- $500,000 for health benefit plan coverage;
- $500,000 for long-term care insurance; or
- $500,000 in the present value of annuity benefits.

Accounts. The Association must maintain the following two accounts: (1) the life insurance and annuity account; and (2) the disability insurance account, which includes health benefit plans, disability benefit policies and contracts, and long-term care policies and contracts.

Association Board. The Association's board of directors is expanded to consist of 7 to 11 member insurers.

Insurer Policies. If a member insurer is impaired, the Association may reissue any or all of the policies or contracts of the impaired insurer. If a member insurer becomes insolvent, the Association must either guarantee, assume, reissue, or reinsure the policies or contracts of the insolvent insurer, or assure payment of the contractual obligations of the insolvent insurer. If the Association elects to issue alternative contracts, the policies or contracts must be subject to the approval of the insurance commissioner, provide benefits that are not unreasonable in relation to the premium charged, and provide coverage of a type similar to the policy or contract issued by the impaired or insolvent insurer.

Assessments. The cap on nonpro rata class A assessments of $150 per member insurer per calendar year is removed.

The amount of Class B assessment, except for assessments related to long-term care insurance, must be allocated for assessment purposes between accounts, including among the subaccounts for life insurance and annuities. The amount of a Class B assessment for long-term care insurance written by an impaired or insolvent insurer must be allocated according to a methodology included in the Association's plan of operation and approved by the insurance commissioner. The methodology must provide for 25 percent of the assessment to be allocated to disability and health member insurers and 75 percent to be allocated to life and annuity member insurers.

Member insurers may consider the amounts reasonably necessary to meet assessment obligations when determining its premium rates and policy owner dividends.

Plan of Operation. The Association's plan of operation must, among other requirements:

- establish procedures whereby a director may be removed for cause, including in the case where a member insurer becomes an impaired or insolvent insurer; and

- require the Association board of directors to establish policies and procedures for addressing conflicts of interest among the board of directors and member insurers.

Court Proceedings. All court proceedings involving an insolvent insurer as a party are stayed 180 days from the date an order of liquidation, rehabilitation, or conservation is final, to permit legal action to be taken by the Association.

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Adjusts the allocation of the Class B assessments from 50 percent allocated to life and annuity member insurers and 50 percent allocated to disability and health member insurers, to 25 percent allocated to health and disability insurers and 75 percent allocated to life and annuity member insurers.

Appropriation: None.

Fiscal Note: Available.

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

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

Staff Summary of Public Testimony on Original Bill (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: Similarly situated insurers in this market should be treated the same in supporting the market. Since the passage of the Affordable Care Act, many distinctions between the carriers have been flattened out. Disability insurers that do not write long-term care insurance are already paying into the Guaranty Association, and it is important that other health care insurers similarly support the Association to make assessments fair. This bill is part of a compromise from insurers to strengthen the health insurance safety net system, and to help ensure the solvency of long term care insurance policies. The burden is currently disproportionately placed on life insurers to support the stability of long term care insurance. Going forward, most long-term care insurance is sold in a hybrid cash-value product that has strengthened the industry. This is a modernization of the Guaranty Association, which has been adopted by the NAIC and by 27 states. There is a hope to have some technical changes made to the definitions in the bill, but the suggestions would not affect the substance of the legislation. Retired public employees with long term care insurance are very concerned about threats of insolvency and uncertainty due to rising health care costs and a lack of COLA in their pensions. Insurers that pay into this Association are permitted to lower their premium tax payments to the state to offset the costs of the Association assessments over time.

CON: This represents a major shift to fund the Guaranty Fund to the not for profit health plans in Washington. Regence Blue Shield alone would be liable for up to 10 percent of the assessments, and the not for profits would in total be required to pay 40 percent of the total assessments. Long term care insurers have made poor choices over time, and health insurers should not be liable for these poor choices. Health insurance carriers and their enrollees should not be liable for insolvencies in an industry that health carriers do not participate in.

HMOs are specifically prohibited from offering long-term care insurance. This will lead to higher premiums for health insurance in Washington. If the Legislature were to get rid of the premium tax credit in statute, than the assessments by health plans would go from no interest loans to the state, to free gifts of funds to the state, for the state to support insolvencies. There are other states that split the assessments in a formula other than 50 percent for health carriers and 50 percent for life and disability carriers.

Persons Testifying (Health & Long Term Care): PRO: Senator Annette Cleveland, Prime Sponsor; Joanna Grist, AARP; Emily Murphy, Retired Public Employees Council; Mel Sorensen, Cigna; American Council of Life Insurers; John Mangan, American Council of Life Insurers; Sheela Tallman, UnitedHealthcare; Cindy Laubacher, CVS Health, Aetna; Lonnie Johns-Brown, Office of the Insurance Commissioner; Walt Bowen, Washington Senior Lobby.

CON: Gary Strannigan, Premera Blue Cross; Zach Snyder, Regence Blue Shield; Amber Ulvenes, Kaiser Permanente.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means): PRO: This bill expands the current fund. This is the result of several years of work at the national level. Penn Treaty is currently insolvent with $120 million liability over 20 years. Current enrollees are paying to cover this liability. The current version of the bill includes a 75/25 split between life and annuity members and disability and health members. The NAIC model is a 50/50 split. The purpose of this legislation is to support enrollees in the event of insolvency. Plans that pay into the fund are able to claim a credit against their premium tax. This is how the state makes sure this works. We support the amendment that makes this a 75/25 split. We believe this is a fair compromise. For non-profit insurers, such as Kaiser, that are legally prohibited from offering long term care insurance, this is fair. For non-profit carriers that make up about 40 percent of the health insurance market, this is equitable, even though these companies do not sell these products. We support a 50/50 split. Cigna and other life insurance carriers also do not write long term care policies, but think a 50/50 split is more fair. NAIC determined long term care was a health product. Life insurance carriers agreed to take on 50 percent, even though they do not write these policies. It is not fair to take on 75 percent. It is not fair when similarly situated carriers are not regulated similarly. The NAIC model has been adopted by 27 states. This levels the playing field and minimizes the impact to everyone. This is a highly negotiated national model. This is a consumer protection bill.

Persons Testifying (Ways & Means): PRO: Lonnie Johns-Brown, Office of the Insurance Commissioner; Steve Gano, Premera Blue Cross; Courtney Smith, Kaiser Permanente; Amber D. Lewis, Aetna; Alexa Silver, UnitedHealthCare; Mel Sorenson, Cigna, American Council of Life Insurers.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.