Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

SB 5508

Brief Description: Concerning the insurance guaranty fund.

Sponsors: Senators Liias, Muzzall, Cleveland, Frockt, Hunt, Lovick, Mullet, Randall, Robinson and Stanford; by request of Insurance Commissioner.

Brief Summary of Bill

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

Hearing Date: 2/16/22

Staff: Kim Weidenaar

Background:

Guaranty Associations.
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. Members are assessed following an insolvency to keep the fund primed for possible future payments. Members may offset any payments made to the guaranty fund against premium taxes due over a five-year period. In Washington there are two guaranty associations: one to protect property and casualty policy holders, and one for life and disability policies. Washington's Long-Term Care Guaranty Fund (LTC Fund) is currently supported by life and disability insurers through the Washington Life and Disability Insurance Guaranty Association

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(Association).

Washington Life and Disability Guaranty Association.
The Association includes all insurers who write the covered policies and contracts, and the Insurance Commissioner (Commissioner), ex officio. Insurers must remain members as a condition of authority to transact insurance business. Two accounts are maintained by the Association: the Life Insurance and Annuity Account and the Disability Insurance Account. The Association is under the immediate supervision of the Commissioner. It exercises its powers through a board of directors and performs its function under a plan of operation. The Association's Board of Directors (Board) consists of five to nine member insurers.

Coverage.
The types of policies and contracts covered by the Association are: direct nongroup life and certain group life; disability or annuity policies and their supplements; and unallocated annuity contracts, with some exclusions. Benefits the Association may become obligated to cover are the lesser of the contractual obligations of the impaired or insolvent insurer, or $500,000, in the case of individual policies. For unallocated annuity policies, the limit is $5 million.

In the case of an impaired insurer, the Association may assume or reinsure any or all of its policies and provide financial assistance or guarantees. With respect to an insolvent member, the Association may guarantee, assume, or reinsure any or all of its policies, provide a variety of forms of financial assistance, or may provide benefits and coverage to policyholders, subject to a number of limitations. The Association has certain broad powers, subject to court approval, with respect to administration of the assets of the insolvent member. The Commissioner has the authority to act on behalf of the Association in the event of unreasonable delays. The Association has the authority to appear or intervene before any court or state agency on behalf of any impaired or insolvent member. All court proceedings involving an insolvent insurer as a party are stayed 60 days from the date an order of liquidation, rehabilitation, or conservation is final, to permit legal action to be taken by the Association.

Assessments.
Two classes of assessments are provided: 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 Board 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. An insurer may offset premium taxes due to the state by the amount of assessments paid to the fund. The offset is to be spread evenly over the five-year period following the payment of the assessment.

Plan of Operation.
The Association must submit a plan of operation for approval by the Commissioner to assure the

proper administration of the Association. The plan must include methods of operation, methods for handling assets and meeting obligations, times and places of meetings, and other administrative functions.

Role of the Commissioner.
The Commissioner must provide the necessary premium information, make proper demands upon impaired or insolvent insurers, and serve as liquidator or rehabilitator as necessary. The Commissioner may suspend or revoke the certificate of authority of any member who fails to pay an assessment. The Commissioner hears and determines appeals from members of any final action by the Association with respect to that member. The Commissioner must take certain steps to aid in the prevention of insolvencies or impairments. The Association is subject to examination and supervision by the Commissioner and must submit an annual financial report.

Court Proceedings.
All court proceedings involving an insolvent insurer as a party are stayed 60 days from the date an order of liquidation, rehabilitation, or conservation is final, to permit legal action to be taken by the Association.

Summary of Bill:

Association Members.
Membership of the Association is expanded to include health care service contractors (HCSCs) and health maintenance organizations (HMOs) authorized to transact in Washington. Member insurers do not include nonrisk-bearing 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. Coverage is not provided for 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, except for any portion of the policy or contract, including a rider, that 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 member insurer is liable, or for individual policies:

- $500,000 for life insurance death benefits;
- $500,000 for disability income insurance;
- $500,000 for health plans;
- $500,000 for long-term care insurance; or
- $500,000 in the present value of annuity benefits.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract must be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

Accounts.
The Association must continue to maintain: (1) the Life Insurance and Annuity Account; and (2) the Disability Insurance Account, which is expanded to include 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 seven 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 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 non pro 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, pursuant to an allocation formula which may be based on premiums or reserves of the impaired or insolvent insurer or other standard determined by the Associations' Board of Directors.

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 Commissioner. The methodology must provide for 50 percent of the assessment to be allocated to disability and health member insurers and 50 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 existing 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's 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.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

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