FINAL BILL REPORT
SB 5508

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Synopsis as Enacted

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.

Senate Committee on Health & Long Term Care
House Committee on Health Care & Wellness

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 amounts 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 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 of 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 be assessed pro rata or non pro rata. Class B assessments must be made on the basis of

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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: Association Members. Membership of the Association is expanded to include health care service contractors (HCSCs) and health maintenance organizations (HMOs) authorized to transact business 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. Coverage excludes 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 benefit 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.

Association Accounts. The Association must maintain:
- the life insurance and annuity account; and
- 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 non-pro rata class A assessments of $150 per member insurer per calendar year is removed. The amount of the class B assessment, except for assessments related to long-term care insurance, must be allocated for assessment purposes between accounts, including among the sub-accounts 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 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 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.

Votes on Final Passage:

Senate	48	0
House	97	0

Effective: June 9, 2022