HOUSE BILL REPORT
SSB 6050

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to insurance guaranty fund.

Brief Description: Concerning insurance guaranty fund.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Cleveland, Keiser and Kuderer; by request of Insurance Commissioner).

Brief History:
Committee Activity:
Health Care & Wellness: 2/25/20, 2/27/20 [DPA].

Brief Summary of Substitute Bill
(As Amended by Committee)

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

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 9 members: Representatives Cody, Chair; Macri, Vice Chair; Chopp, Davis, Riccelli, Robinson, Stonier, Thai and Tharinger.

Minority Report: Do not pass. Signed by 3 members: Representatives Schmick, Ranking Minority Member; Chambers and DeBolt.

Minority Report: Without recommendation. Signed by 2 members: Representatives Harris and Maycumber.

Staff: Kim Weidenaar (786-7120).

Background:

Guaranty Associations.

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.

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. Washington's Long-Term Care Guaranty Fund (LTC Fund) is currently supported by life and disability insurers, through the Life and Disability Insurance Guaranty Association (Association).

Washington Life and Disability Guaranty Association.
The Washington Life and Disability Insurance Guaranty 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 non-group 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.

Powers and Duties.
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.

Summary of Amended Bill:

Member Insurers.
"Member insurers" are any insurer, health care service contractor (HCSC), or health maintenance organization (HMO), 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 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 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 the following two accounts: (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. 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 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.

Amended Bill Compared to Substitute Bill:

The amended bill:

- adjusts the methodology for allocating Class B assessments for long-term care insurance from 25 percent for disability and health member insurers and 75 percent for life and annuity member insurers, to 50 percent for disability and health member insurers and 50 percent for life and annuity member insurers;
- modifies the definitions of "benefit plan" and "member insurer;" and
- makes technical changes, such as modifying terms and reordering sentences.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) The bill as passed off the Senate floor is a fair compromise. This version of the bill assesses health carriers at 25 percent. The for-profit life insurers sell products that are meant to compete with long-term care products. However, health maintenance organizations are not permitted to sell long-term care insurance. Under this bill the not-for-profit carriers still pay a significant portion, but it is a fair compromise.

Currently, members of the fund pay assessments over five years and then those assessments are paid back over five years through premium tax credits. Essentially it is an interest-free loan. However, in the early 1990s the Legislature repealed the tax off-set and made it so that it was no longer a loan, but a gift. Accordingly, there is a risk to these carriers that the Legislature may change its mind.

(Opposed) None.

(Other) The purpose of this bill is to make sure that the Guaranty Fund has enough funding if another insurer becomes insolvent. Twenty-seven states have passed the National Association of Insurance Commissioners (NAIC) model law and only Utah has done the 75/25 percent split. There are limitations to how much a carrier can be assessed and this model could still leave a gap, since the life insurers must pay for 75 percent of the assessment. The whole point of this bill is to make sure that there will be enough funding and with this change there may not be.

Only 13 companies offer long-term care insurance and so the vast majority of insurers in the association do not offer long-term care insurance. We need to make sure that funding is available for people who have been paying for their long-term care plans, so that they continue to get benefits.

All insurance companies should be treated the same. Right now, companies that offer health insurance but are licensed differently are treated differently under the fund. This bill would add all of the health insurers to the fund so that they would be treated equally. This bill helps build a level playing field and spreads the assessment across many types of insurers, minimizing the assessment for everyone.

The original version of the bill represented a carefully crafted deal that promotes corporate responsibility and protects consumers. The agreement made when the model law was crafted was that the life insurers would agree to take 50 percent of the assessment so long as the health insurers were included in the pool. That agreement should be upheld. It is not unique that one type of insurer has to pay an assessment for a type of insurance it does not offer. This bill seeks to reduce the impact of insolvency by protecting consumers and spreading the costs across all insurers. Please return the bill to the original form and the NAIC model.

Persons Testifying: (In support) Courtney Smith, Kaiser Permanente; Zach Snyder, Regence Blue Shield; and Gary Strannigan, Premera Blue Cross.

(Other) Lonnie Johns-Brown, Office of the Insurance Commissioner; Mel Sorensen, American Council of Life Insurers and Cigna; Cindy Laubacher, Aetna; and Alexa Silver, UnitedHealthcare.

Persons Signed In To Testify But Not Testifying: None.