RCW 48.32A.085 Assessments. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments are due not less than thirty days after prior written notice to the member insurers and accrue interest at twelve percent per annum on and after the due date.

(2) There are two classes of assessments, as follows:

(a) Class A assessments are authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer; and

(b) Class B assessments are authorized and called to the extent necessary to carry out the powers and duties of the association under RCW 48.32A.075 with regard to an impaired or an insolvent insurer.

(3)(a) The amount of a class A assessment is determined by the board and may be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future class B assessments.

(b) The amount of a class B assessment, except for assessments related to long-term care insurance, must be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity accounts, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard determined by the board to be fair and reasonable under the circumstances.

(c) The amount of the 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 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.

(d) Class B assessments against member insurers for each account and subaccount must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the insurer became impaired, bears to premiums received on business in this state for those calendar years by all assessed member insurers.

(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (2) of this section and computation of assessments under this subsection must be made with a reasonable degree of accuracy, recognizing that exact determinations are not always possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an

assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a)(i) Subject to the provisions of (a)(ii) of this subsection, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the disability insurance account may not in one calendar year exceed two percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(ii) If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation in (a)(i) of this subsection must be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated under this section.

(iii) If the maximum assessment, together with the other assets of the association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon thereafter as permitted by this chapter.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment is insufficient to cover anticipated claims.

(c) If the maximum assessment for a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the association, then under subsection (3)(d) of this section, the board shall access the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in (a) of this subsection.

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses claims.

(7) Any member insurer may when determining its premium rates and policy owner dividends, as to any kind of insurance, health care service contractor business, or health maintenance organization business within the scope of this chapter, consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(8) The association shall issue to each member insurer paying an assessment under this chapter, other than a class A assessment, a

certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment paid. All outstanding certificates must be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

(9)(a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment is available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment must be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess must be returned to the member insurer. Interest on a refund due a protesting member must be paid at the rate actually earned by the association.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request. [2022 c 151 § 7; 2001 c 50 § 9.]