Z-0694.2

SENATE BILL 6050

State of Washington 66th Legislature 2020 Regular Session

By Senator Cleveland; by request of Insurance Commissioner

Prefiled 12/05/19.

AN ACT Relating to insurance guaranty fund; and amending RCW 48.32A.015, 48.32A.025, 48.32A.045, 48.32A.055, 48.32A.065, 48.32A.075, 48.32A.085, 48.32A.095, 48.32A.115, 48.32A.135, 48.32A.175, and 48.32A.185.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 48.32A.015 and 2001 c 50 s 2 are each amended to read as follows:

(1) The purpose of this chapter is to protect, subject to certain limitations, the persons specified in RCW 48.32A.025(1) against failure in the performance of contractual obligations, under life ((~~and~~)) insurance, disability insurance ((~~policies~~)), health care benefit agreements, plans, and certificates of coverage, and annuity policies, plans, or contracts specified in RCW 48.32A.025(2), because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts.

(2) To provide this protection, an association of member insurers is created to pay benefits and to continue coverages as limited by this chapter, and members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

Sec. 2. RCW 48.32A.025 and 2001 c 50 s 3 are each amended to read as follows:

(1) This chapter provides coverage for the policies and contracts specified in subsection (2) of this section as follows:

(a) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees, including health care providers and facilities rendering services covered under health care benefit policies or certificates of coverage, of the persons covered under (b) of this subsection;

(b) To persons who are owners of or certificate holders under the policies or contracts, other than unallocated annuity contracts and structured settlement annuities, and in each case who:

(i) Are residents; or

(ii) Are not residents, but only under all of the following conditions:

(A) The insurer that issued the policies or contracts is domiciled in this state;

(B) The states in which the persons reside have associations similar to the association created by this chapter; and

(C) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer, health care service contractor, or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law;

(c) For unallocated annuity contracts specified in subsection (2) of this section, (a) and (b) of this subsection do not apply, and this chapter, except as provided in (e) and (f) of this subsection, does provide coverage to:

(i) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(ii) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents;

(d) For structured settlement annuities specified in subsection (2) of this section, (a) and (b) of this subsection do not apply, and this chapter, except as provided in (e) and (f) of this subsection, does provide coverage to a person who is a payee under a structured

settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(i) Is a resident, regardless of where the contract owner resides; or

(ii) Is not a resident, but only under both of the following conditions:

(A)(I) The contract owner of the structured settlement annuity is a resident; or

(II) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state; and the state in which the contract owner resides has an association similar to the association created by this chapter; and

(B) Neither the payee, nor beneficiary, nor enrollee, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

(e) This chapter does not provide coverage to:

(i) A person who is a payee, or beneficiary, of a contract owner resident of this state, if the payee, or beneficiary, is afforded any coverage by the association of another state; ((~~or~~))

(ii) A person covered under (c) of this subsection, if any coverage is provided by the association of another state to the person; or

(iii) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. Sec. 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective; and

(f) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of this subsection (1)(f) in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, enrollee, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

(2)(a) This chapter provides coverage to the persons specified in subsection (1) of this section for direct, nongroup life, disability,

health benefit, or annuity policies, plans, or contracts and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts. However, any annuity contracts that are unallocated annuity contracts are subject to the specific provisions in this chapter for unallocated annuity contracts.

(b) ((~~This~~)) Except as provided in (c) of this subsection, this chapter does not provide coverage for:

(i) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

(B) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life,

disability, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under:

(A) A multiple employer welfare arrangement as defined in 29 U.S.C. Sec. ((~~1144~~)) 1002;

(B) A minimum premium group insurance plan;

(C) A stop-loss group insurance plan; or

(D) An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

(A) Dividends or experience rating credits;

(B) Voting rights; or

(C) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension benefit guaranty corporation, regardless of whether the federal pension benefit guaranty corporation has yet become liable to make any payments with respect to the benefit plan;

(viii) A portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery;

(ix) A portion of a policy or contract to the extent that the assessments required by RCW 48.32A.085 with respect to the policy or contract are preempted by federal or state law;

(x) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, contract owner, certificate holder, or policy owner, including without limitation:

(A) Claims based on marketing materials;

(B) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(C) Misrepresentations of or regarding policy or contract benefits;

(D) Extra-contractual claims; or

(E) A claim for penalties or consequential or incidental damages;

(xi) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer; ((~~or~~))

(xii) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subsection (2)(b)(xii), the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(xiii) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to parts C and D of subchapter XVIII, chapter 7 of Title 42, United States Code (commonly known as medicare parts C and D) or subchapter XIX, chapter 7 of Title 42, United States Code (commonly known as medicaid), and any regulations issued pursuant thereto, or chapter 74.09 RCW and any regulations issued pursuant thereto; or

(xiv) Structured settlement annuity benefits to which a payee or beneficiary has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. Sec. 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.

(c) The exclusion from coverage referenced in (b)(iii) of this subsection does not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health benefits.

(3) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b)(i) With respect to one life, regardless of the number of policies or contracts:

(A) Five hundred thousand dollars in life insurance death benefits, but not more than five hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(B) In disability insurance and health benefit plan benefits:

(I) Five hundred thousand dollars for coverages not defined as disability income insurance or ((~~basic hospital, medical, and surgical insurance or major medical insurance~~)) health benefit plan coverage including any net cash surrender and net cash withdrawal values;

(II) Five hundred thousand dollars for disability income insurance;

(III) Five hundred thousand dollars for ((~~basic hospital medical and surgical insurance or major medical insurance~~)) health benefit plan coverage;

(IV) Five hundred thousand dollars for long-term care insurance; or

(C) Five hundred thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, except as provided in (b)(ii), (iii), and (v) of this subsection (3)((~~(b)~~));

(ii) With respect to each individual participating in a governmental retirement benefit plan established under section 401, 403(b), or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, one hundred thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(iii) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, five hundred thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(iv) However, in no event shall the association be obligated to cover more than: (A) An aggregate of five hundred thousand dollars in benefits with respect to any one life under (b)(i), (ii), ((~~and~~)) (iii), and (iv) of this subsection (3)((~~(b)~~)) except with respect to benefits for ((~~basic hospital, medical, and surgical insurance and major medical insurance~~)) health benefit plan coverage under (b)(i)(B) of this subsection (3)((~~(b)~~)), in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual; or (B) with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner;

(v) With respect to either: (A) One contract owner provided coverage under subsection (1)(d)(ii) of this section; or (B) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in (b)(ii) of this subsection (3)((~~(b)~~)), five million dollars in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than five million dollars in benefits with respect to all these unallocated contracts; ((~~or~~))

(vi) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights; or

(vii) For purposes of this chapter, 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.

(4) In performing its obligations to provide coverage under RCW 48.32A.075, the association is not required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Sec. 3. RCW 48.32A.045 and 2001 c 50 s 5 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Account" means either of the two accounts created under RCW 48.32A.055.

(2) "Association" means the Washington life and disability insurance guaranty association created under RCW 48.32A.055.

(3) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(4) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan issued pursuant to the requirements of chapter 48.20 RCW that is not a health benefit plan as defined in this section.

(5) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(6) "Commissioner" means the insurance commissioner of this state.

(7) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under RCW 48.32A.025.

(8) "Covered policy" or "covered contract" means a policy or contract or portion of a policy or contract for which coverage is provided under RCW 48.32A.025.

(9) "Extra-contractual claims" includes, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.

(10) "Health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services, except the following:

(a) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(b) Coverage supplemental to the coverage provided under chapter 55 of Title 10 of the United States Code;

(c) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property or casualty liability insurance policy, such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage;

(k) Plans deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the commissioner;

(l) Civilian health and medical program for the veterans affairs administration (CHAMPVA); and

(m) Long-term care insurance as defined under chapter 48.83 or 48.84 RCW, or benefits for home health care, community-based care, or any combination thereof.

(11) "Impaired insurer" means a member insurer which, after July 22, 2001, is not an insolvent insurer, and is placed under an order

of rehabilitation or conservation by a court of competent jurisdiction.

((~~(11)~~)) (12) "Insolvent insurer" means a member insurer which, after July 22, 2001, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

((~~(12)~~)) (13) "Member insurer" means an insurer, health care service contractor, or health maintenance organization licensed, or that holds a certificate of authority, or a certificate of registration, to transact in this state any kind of insurance for which coverage is provided under RCW 48.32A.025, and includes an insurer, health care service contractor, or health maintenance organization whose license, certificate of registration, or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

(a) ((~~A health care service contractor, whether profit or nonprofit;~~

~~(b) A health maintenance organization;~~

~~(c)~~)) A fraternal benefit society;

((~~(d)~~)) (b) A mandatory state pooling plan;

((~~(e)~~)) (c) A mutual assessment company or other person that operates on an assessment basis;

((~~(f)~~)) (d) An insurance exchange;

((~~(g)~~)) (e) An organization that has a certificate or license limited to the issuance of charitable gift annuities under RCW 48.38.010;

(f) A nonrisk-bearing hospital or medical service organization, whether for profit or not for profit;

(g) A multiple employer welfare arrangement under chapter 48.125 RCW; or

(h) An entity similar to (a) through (g) of this subsection.

((~~(13)~~)) (14) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or any successor thereto.

((~~(14)~~)) (15) "Owner" of a policy or contract and "policy holder," "policy owner," and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. "Owner," "policy holder," "contract owner,"

and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

((~~(15)~~)) (16) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

((~~(16)~~)) (17) "Plan sponsor" means:

(a) The employer in the case of a benefit plan established or maintained by a single employer;

(b) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(c) In the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

((~~(17)~~)) (18) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under RCW 48.32A.025(2), except that assessable premium shall not be reduced on account of RCW 48.32A.025(2)(b)(iii) relating to interest limitations and RCW 48.32A.025(3)(b) relating to limitations with respect to one individual, one participant, and one policy or contract owner. "Premiums" does not include:

(a) Premiums in excess of five million dollars on an unallocated annuity contract not issued under a governmental retirement benefit plan, or its trustee, established under section 401, 403(b), or 457 of the United States Internal Revenue Code; or

(b) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

((~~(18)~~)) (19)(a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction,

control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors in (a)(i) through (v) of this subsection.

However, in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state is the principal place of business of the plan sponsor.

(b) The principal place of business of a plan sponsor of a benefit plan described in subsection ((~~(16)~~)) (17)(c) of this section is the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, is the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

((~~(19)~~)) (20) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

((~~(20)~~)) (21) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an

insolvent insurer, whichever occurs first. A person may be a resident of only one state, which in the case of a person other than a natural person is its principal place of business. Citizens of the United States that are either (a) residents of foreign countries, or (b) residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this chapter, are residents of the state of domicile of the insurer that issued the policies or contracts.

((~~(21)~~)) (22) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

((~~(22)~~)) (23) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

((~~(23)~~)) (24) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, disability, or annuity policy or contract.

((~~(24)~~)) (25) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by ((~~an~~)) a member insurer under the contract or certificate.

Sec. 4. RCW 48.32A.055 and 2001 c 50 s 6 are each amended to read as follows:

(1) There is created a nonprofit unincorporated legal entity to be known as the Washington life and disability insurance guaranty association which is composed of the commissioner ex officio and each member insurer. All member insurers must be and remain members of the association as a condition of their authority to transact the business of insurance, health care service contractor business, or health maintenance organization business in this state. The association shall perform its functions under the plan of operation established and approved under RCW 48.32A.095 and shall exercise its powers through a board of directors established under RCW 48.32A.065. For purposes of administration and assessment, the association shall maintain two accounts:

(a) The life insurance and annuity account which includes the following subaccounts:

(i) Life insurance account;

(ii) Annuity account which includes annuity contracts owned by a governmental retirement plan, or its trustee, established under section 401, 403(b), or 457 of the United States Internal Revenue Code, but otherwise excludes unallocated annuities; and

(iii) Unallocated annuity account, which excludes contracts owned by a governmental retirement benefit plan, or its trustee, established under section 401, 403(b), or 457 of the United States Internal Revenue Code; and

(b) The disability insurance account, which includes health benefit plans, disability benefit policies and contracts, and long-term care policies and contracts.

(2) The association is under the immediate supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

Sec. 5. RCW 48.32A.065 and 2001 c 50 s 7 are each amended to read as follows:

(1) The board of directors of the association consists of the commissioner ex officio and not less than ((~~five~~)) seven nor more than ((~~nine~~)) eleven member insurers serving terms as established in the plan of operation. The insurer members of the board are selected by member insurers subject to the approval of the commissioner.

Vacancies on the board are filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

(2) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board are not otherwise compensated by the association for their services.

Sec. 6. RCW 48.32A.075 and 2001 c 50 s 8 are each amended to read as follows:

(1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the

association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(a) ((~~Guaranty~~)) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, reissued, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; or

(b) Provide such moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate (a) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under (a) of this subsection.

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)(A) ((~~Guaranty~~)) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer; or

(B) Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

(b) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to ((~~life and disability insurance~~)) policies and ((~~annuities~~)) contracts, assure payment of benefits ((~~for premiums identical to the premiums and benefits, except for terms of conversion and renewability,~~)) that would have been payable under the policies or contracts of the insolvent insurer((~~,~~)) for claims incurred:

(A) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to the policies and contracts;

(B) With respect to nongroup policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds, enrollees, or annuitants, for nongroup policies and contracts, or group policy or contract owners with respect to group policies and

contracts, thirty days notice of the termination of the benefits provided;

(iii) With respect to nongroup ((~~life and disability insurance~~)) policies ((~~and annuities~~)) or contracts covered by the association, make diligent efforts to make available to each known insured, enrollee, or annuitant, or owner if other than the insured, enrollee, or annuitant, and with respect to an individual formerly insured, formerly an enrollee, or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make diligent efforts to make available substitute coverage on an individual basis in accordance with the provisions of (b)(iv) of this subsection, if the insureds, enrollees, or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer, health care service contractor, or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;

(iv)(A) The substitute coverage under (b)(iii) of this subsection, must be offered through a solvent, admitted member insurer. In the alternative, the association in its discretion, and subject to any conditions imposed by the association and approved by the commissioner, may reissue the terminated coverage or issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the commissioner;

(B) Substituted coverage must be offered without requiring evidence of insurability, and may not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract;

(C) The association may reinsure any alternative or reissued policy or contract;

(v) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium must be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to approval of the ((~~domiciliary insurance~~)) commissioner ((~~and the receivership court~~));

(vi) If the association elects to issue alternative coverage:

(A) Alternative policies or contracts adopted by the association must be subject to the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(B) Alternative policies or contracts must contain at least the minimum statutory provisions required in this state and provide benefits that cannot be unreasonable in relation to the premium charged. The association must set the premium in accordance with a table of rates that it must adopt. The premium must reflect the amount of insurance benefits or coverage to be provided and the age and class of risk of each insured, but must not reflect any changes in the health of the insured after the original policy or contract was last underwritten.

(C) Any alternative policy or contract issued by the association must provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;

(vii) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued policy or contract cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the association; or

((~~(vii)~~)) (viii) When proceeding under this subsection (2)(b) with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with RCW 48.32A.025(2)(b)(iii).

(3) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy, contract, or coverage under this chapter with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for

unearned premiums due to policy or contract owners arising after the entry of the order.

(5) The protection provided by this chapter does not apply when any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6) In carrying out its duties under subsection (2) of this section, the association may:

(a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, are in the public interest; and

(b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of ((~~an~~)) a member insurer domiciled in this state or in a reciprocal state, under RCW 48.31.171, shall be promptly paid to the association. The association is entitled to retain a portion of any amount so paid to it equal to the percentage

determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association and not retained under this subsection. Any amount so paid to the association less the amount not retained by it shall be treated as a distribution of estate assets under RCW 48.31.185 or similar provision of the state of domicile of the impaired or insolvent insurer.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (2) of this section, the commissioner has the powers and duties of the association under this chapter with respect to the insolvent insurer.

(9) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

(10) The association has standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing extends to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reissuing, reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association also has the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(11)(a) A person receiving benefits under this chapter is deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the

extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment to it of such rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the person.

(b) The subrogation rights of the association under this subsection have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(c) In addition to (a) and (b) of this subsection, the association has all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, enrollee, beneficiary, or payee of a policy or contract with respect to the policy or contracts, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the United States Internal Revenue Code.

(d) If (a) through (c) of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts, or portion thereof, covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the association.

(12) In addition to the rights and powers elsewhere in this chapter, the association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under RCW 48.32A.085 and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the association not in default are legal investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;

(e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(f) Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life ((~~or~~)) insurer, disability insurer, health care service contractor, or health maintenance organization, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;

(g) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(h) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; ((~~and~~))

(i) In accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this chapter; and

(j) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

(13) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(14)(a) At any time within one year after the coverage date, which is the date on which the association becomes responsible for the obligations of a member insurer, the association may elect to

succeed to the rights and obligations of the member insurer, that accrue on or after the coverage date and that relate to policies, contracts, or annuities, covered((~~,~~)) in whole or in part((~~,~~)) by the association, under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement. The election is effective when notice is provided to the receiver, rehabilitator, or liquidator and to the affected reinsurers. If the association makes an election, the following provisions apply with respect to the agreements selected by the association:

(i) The association is responsible for all unpaid premiums due under the agreements, for periods both before and after the coverage date, and is responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to policies, contracts, or annuities, covered((~~,~~)) in whole or in part((~~,~~)) by the association. The association may charge policies, contracts, or annuities, covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association;

(ii) The association is entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to policies, contracts, or annuities, covered by the association((~~,~~)) in whole or in part. However, upon receipt of any such amounts, the association is obliged to pay to the beneficiary under the policy ((~~or~~)), contract, or annuity on account of which the amounts were paid a portion of the amount equal to the excess of: The amount received by the association, over the benefits paid by the association on account of the policy ((~~or~~)), contract, or annuity, less the retention of the impaired or insolvent member insurer applicable to the loss or event;

(iii) Within thirty days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by either the member insurer, or its receiver, rehabilitator, or liquidator, or the indemnity reinsurer during the period between the coverage date and the date of the

association's election. Either the association or indemnity reinsurer shall pay the net balance due the other within five days of the completion of this calculation. If the receiver, rehabilitator, or liquidator has received any amounts due the association pursuant to (a)(ii) of this subsection, the receiver, rehabilitator, or liquidator shall remit the same to the association as promptly as practicable; and

(iv) If the association, within sixty days of the election, pays the premiums due for periods both before and after the coverage date that relate to policies, contracts, or annuities, covered by the association((~~,~~)) in whole or in part, the reinsurer is not entitled to terminate the reinsurance agreements, insofar as the agreements relate to policies, contracts, or annuities, covered by the association((~~,~~)) in whole or in part, and is not entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the association;

(b) In the event the association transfers its obligations to another member insurer, and if the association and the other member insurers agree, the other member insurer succeeds to the rights and obligations of the association under (a) of this subsection effective as of the date agreed upon by the association and the other member insurers and regardless of whether the association has made the election referred to in (a) of this subsection. However:

(i) The indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other member insurers agree to the contrary;

(ii) The obligations described in (a)(ii) of this subsection no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party member insurer; and

(iii) This subsection (14)(b) does not apply if the association has previously expressly determined in writing that it will not exercise the election referred to in (a) of this subsection;

(c) The provisions of this subsection supersede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator, or rehabilitator of the insolvent ((~~member~~)) insurer. The receiver, rehabilitator, or liquidator remains entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in

periods prior to the coverage date, subject to applicable setoff provisions; and

(d) Except as set forth under this subsection, this subsection does not alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent ((~~member~~)) insurer. This subsection does not abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. This subsection does not give a policy or contract owner, an enrollee, or a beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

(15) The board of directors of the association has discretion and may exercise reasonable business judgment to determine the means by which the association provides the benefits of this chapter in an economical and efficient manner.

(16) When the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(17) Venue in a suit against the association arising under this chapter is in the county in which liquidation or rehabilitation proceedings have been filed in the case of a domestic member insurer. In other cases, venue is in King county or Thurston county. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

(18) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsection (1) or (2) of this section, the association may((~~, subject to approval of the receivership court,~~)) issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for: (i) A fixed interest rate; (ii) payment of

dividends with minimum guarantees; or (iii) a different method for calculating interest or changes in value;

(b) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Sec. 7. RCW 48.32A.085 and 2001 c 50 s 9 are each amended to read as follows:

(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. ((~~The total of all nonpro rata assessments may not exceed one hundred fifty dollars per member insurer in any one calendar year.~~))

<u>(b)</u> The amount of a class B assessment ((~~may~~))<u>, except for assessments related to long-term care insurance, must</u> be allocated for assessment purposes ((~~among~~)) <u>between</u> the accounts <u>and among the subaccounts of the life insurance and annuity accounts,</u> 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.

((~~(b)~~)) <u>(c) The amount of the class B assessment for long-term care insurance written by an impaired or insolvent insurer must be</u>

allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology must provide for fifty percent of the assessment to be allocated to disability and health member insurers and fifty 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.

((~~(c)~~)) (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 ((~~health~~)) disability and health 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)((~~(b)~~)) (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

((~~company~~)) 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.

Sec. 8. RCW 48.32A.095 and 2001 c 50 s 10 are each amended to read as follows:

(1)(a) The association shall submit to the commissioner a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments are effective upon the commissioner's written approval or unless it has not been disapproved within thirty days.

(b) If the association fails to submit a suitable plan of operation within one hundred twenty days following July 22, 2001, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules as necessary or advisable to effectuate the provisions of this chapter. The rules continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation must, in addition to requirements enumerated elsewhere in this chapter:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under RCW 48.32A.065;

(c) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(e) Establish the procedures whereby selections for the board of directors are made and submitted to the commissioner;

(f) Establish any additional procedures for assessments under RCW 48.32A.085; ((~~and~~))

(g) Establish procedures whereby a director may be removed for cause, including in the case where a member insurer becomes an impaired or insolvent insurer;

(h) Require the board of directors to establish policies and procedures for addressing conflicts of interests among the board of directors and the member insurers they represent; and

(i) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under RCW 48.32A.075(12)(c) and 48.32A.085, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association, or organization must be reimbursed for any payments made on behalf of the association and must be paid for its performance of any function of the association. A delegation under this subsection takes effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

Sec. 9. RCW 48.32A.115 and 2001 c 50 s 12 are each amended to read as follows:

The commissioner shall aid in the detection and prevention of insurer insolvencies or impairments.

(1) It is the duty of the commissioner to:

(a) Notify the commissioners of all the other states, territories of the United States, and the District of Columbia within thirty days following the action taken or the date the action occurs, when the commissioner takes any of the following actions against a member insurer:

(i) Revocation of license;

(ii) Suspension of license; or

(iii) Makes a formal order that the ((~~company~~)) member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners, certificate holders, contract owners, or creditors;

(b) Report to the board of directors when the commissioner has taken any of the actions set forth in (a) of this subsection or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board of directors must contain all significant details of the action taken or the report received from another commissioner;

(c) Report to the board of directors when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer; and

(d) Furnish to the board of directors the national association of insurance commissioners insurance regulatory information system ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information must be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

(2) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the commissioner regarding the financial condition of member insurers and ((~~companies~~)) insurers, health care service contractors, or health maintenance organizations seeking admission to transact ((~~insurance~~)) business in this state.

(3) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any ((~~company~~)) insurer, health care service contractor, or health maintenance organization seeking to do an insurance business in this state. The reports and recommendations are not public documents.

(4) The board of directors may, upon majority vote, notify the commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

(5) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

Sec. 10. RCW 48.32A.135 and 2001 c 50 s 14 are each amended to read as follows:

(1) This chapter does not reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records must be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under RCW 48.32A.075. The records of the association with respect to an impaired or insolvent insurer may not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. This subsection does not limit the duty of the association to render a report of its activities under RCW 48.32A.145.

(3) For the purpose of carrying out its obligations under this chapter, the association is a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee under RCW 48.32A.075(11). Assets of the impaired or insolvent insurer attributable to covered policies must be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) As a creditor of the impaired or insolvent member insurer as established in subsection (3) of this section, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty days of a final determination of insolvency of ((~~an~~)) a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association is entitled to make

application to the receivership court for approval of its own proposal to disburse these assets.

(5)(a) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, ((~~the~~)) shareholders, contract owners, certificate holders, enrollees, and ((~~the~~)) policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration must be given to the welfare of the policy owners, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.

(b) A distribution to stockholders, if any, of an impaired or insolvent insurer shall not be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under RCW 48.32A.075 with respect to the member insurer have been fully recovered by the association.

(6)(a) If an order for liquidation or rehabilitation of ((~~an~~)) a member insurer domiciled in this state has been entered, the receiver appointed under the order has a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of (b) through (d) of this subsection.

(b) A distribution is not recoverable if the member insurer, health care service contractor, or health maintenance organization shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid is liable up to the amount of distributions received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared, is liable up to the amount of distributions which would have been received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(e) If any person liable under (c) of this subsection is insolvent, all its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Sec. 11. RCW 48.32A.175 and 2001 c 50 s 18 are each amended to read as follows:

All proceedings in which the insolvent insurer is a party in any court in this state are stayed ((~~sixty~~)) one hundred eighty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default the association may apply to have such a judgment set aside by the same court that made such a judgment and must be permitted to defend against the suit on the merits.

Sec. 12. RCW 48.32A.185 and 2005 c 274 s 313 are each amended to read as follows:

(1) No person, including ((~~an~~)) a member insurer, agent, or affiliate of ((~~an~~)) a member insurer may make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by the Washington life and disability insurance guaranty association act. However, this section does not apply to the Washington life and disability insurance guaranty association or any other entity which does not sell or solicit insurance or coverage by a health care service contractor or health maintenance organization.

(2) ((~~Within one hundred eighty days after July 22, 2001, the~~)) The association shall prepare a summary document describing the general purposes and current limitations of this chapter and complying with subsection (3) of this section. This summary document must be submitted to the commissioner for approval. The summary document must also be available upon request by a policy owner, contract owner, certificate owner, or enrollee. The distribution, delivery, contents, or interpretation of this document does not guarantee that either the policy or the contract or the ((~~owner of the policy or contract~~)) policy owner, contract owner, certificate holder, or enrollee is covered in the event of the impairment or insolvency of a member insurer. The ((~~description~~)) summary document must be revised by the association as amendments to this chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this chapter.

(3) The summary document prepared under subsection (2) of this section must contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer must:

(a) State the name and address of the life and disability insurance guaranty association and insurance department;

(b) Prominently warn the ((~~policy or contract owner~~)) policy owner, contract owner, certificate holder, or enrollee that the life and disability insurance guaranty association may not cover the policy or contract or, if coverage is available, it is subject to substantial limitations and exclusions and conditioned on continued residence in this state;

(c) State the types of policies or contracts for which guaranty funds provide coverage;

(d) State that the member insurer and its agents are prohibited by law from using the existence of the life and disability insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance, health care service contractor coverage, or health maintenance organization coverage;

(e) State that the policy ((~~or~~)) owner, contract owner, certificate holder, insured, or enrollee should not rely on coverage under the life and disability insurance guaranty association when selecting an insurer, health care service contractor, or health maintenance organization;

(f) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter; and

(g) Provide other information as directed by the commissioner including but not limited to, sources for information about the financial condition of member insurers provided that the information is not proprietary and is subject to disclosure under chapter 42.56 RCW.

(4) A member insurer must retain evidence of compliance with subsection (2) of this section for as long as the policy or contract for which the notice is given remains in effect.

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