# SENATE BILL REPORT
# SB 5247

As of January 26, 2011

**Title**: An act relating to health insurance rates.

**Brief Description**: Determining health insurance rates by comparing premiums and benefits.

**Sponsors**: Senators Conway, Keiser and Kline; by request of Insurance Commissioner.

**Brief History:**
**Committee Activity**: Health & Long-Term Care: 1/26/11.

## SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

**Staff**: Mich'l Needham (786-7442)

**Background**: Insurance carriers are licensed and regulated under Title 48 RCW. All carriers file financial documents with the Office of the Insurance Commissioner (OIC) and the National Association of Insurance Commissioners that include reports of total assets, total liabilities, total capital and surplus, net income, net change in surplus, premiums earned, premiums written by line of business, losses incurred, and medical loss ratio.

Carriers offering medical benefit plans are required to maintain a minimum net worth to ensure claims can be paid and the business will remain viable. In general, carriers are required to maintain the greater of $3 million, or 2 percent of annual earned premium for the first $150 million, and 1 percent of annual earned premium above $150 million.

Carriers offering individual and small group medical benefit plans submit detailed premium and rate calculation information to allow the OIC to review the proposed premium rates and verify they are appropriate for the benefits that are provided. For example, filings for individual plans must include the ratemaking methodology including an estimate of earned premium, percent of premium attributable to non-claims expenses, claims reserves (liability for claims reported but not yet paid), incurred (paid) claims, the expected medical loss ratio (the percent of premium that is anticipated to be spent on medical claims expenses), and the actual medical loss ratio for the preceding calendar year.

**Summary of Bill**: Beginning January 1, 2012, all insurance carriers licensed as nonprofit health care service contractors or health maintenance organizations must submit additional

---

*This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.*

information for the individual and small group rate filings to allow the OIC to evaluate the surplus and investment earnings relative to the premiums charged and expected claims.

Carrier's must submit information that indicates whether the surplus exceeds a three month average of the expected claims. If it does, the carrier must submit the actual net underwriting gain for the line of business for the three preceding calendar years; a comparison of the underwriting gains with the prior projections of contribution to surplus, contingency charges or risk charges for the rate filings for the three previous years; and a report on the investment income for each year, apportioned by premium volume. The investment income must be included in the net underwriting gain.

The OIC must disallow the rate filings under certain conditions. The rate filing must be disallowed if the total net underwriting gain is greater than the proposed contribution to surplus, unless the carrier has reduced the rate by the three year averaged difference, and reduced its proposed contribution to surplus to zero. The rate filing must be disallowed if the net underwriting gain is the same or less than the proposed contribution to surplus, unless the carrier has reduced the contribution to surplus to zero.

Rate filings must include investment earnings, allocated proportionally to each product line; information on rate calculation that includes any fines, remittances, penalties, or administrative sanctions; and any calculation in the rates that reflects a direct or indirect net loss incurred on a self-funded plan for which the carrier provides administrative services only. Rate filings that do not include the required data must be disallowed.

The commissioner has authority to approve a rate that would otherwise be disallowed if the failure to allow the proposed rate unreasonably impairs the financial health of the carrier.

**Appropriation**: None.

**Fiscal Note**: Not requested.

**Committee/Commission/Task Force Created**: No.

**Effective Date**: The bill takes effect on January 1, 2012.

**Staff Summary of Public Testimony**: PRO: The OIC needs tools to evaluate rapidly increasing premium rates. The standard used in the Taft Hartley plan is to require three months of reserves and that has been working for a long time and ensured stability for those plans. Consumers apply a lot of pressure when they see rate increases, and they want answers. The three largest carriers in this state are nonprofit plans and they have built up considerable surplus accounts, $2.4 billion in excess of required reserves for claims. The surpluses have been building up for years, faster than premiums have increased. We need a mechanism to ensure the nonprofit plans are not stock-piling surpluses. Nonprofits should be accountable to the public. This approach does not touch the existing surpluses that have been built up, it just allows OIC to not approve rate increases that will add to the surpluses above the new threshold. Some believe the nonprofits should be accountable to past enrollees and provide refunds of excess premiums that contributed to surpluses. It is important to think about who owns the surplus. In the past, when the Public Employees Benefits Board had a

surplus that money was assigned back to the employees. We would like an amendment to require a lower threshold of two months of average claims instead of three in the bill now. And to require past enrollees to receive a refund, rather than have any reduction of premiums from surplus apply to future enrollees. The additional premium component adding to the surplus has significantly increased the premiums charged to enrollees. AARP members are most concerned about maintaining access to affordable health care, and already today too many of our members between 50-64 cannot afford insurance and they bear extreme risk. We do want companies to be solvent but we also want reasonable scrutiny of health premium increases.

CON: I can't support this version of the bill but would support a bill that provided refunds to past enrollees and limited the surplus accumulation to two months of claims, above the two months for reserves required now. It is only equitable if those over-charged for premiums are refunded. Over regulation of carriers led to collapse of the market in the 1990s and we do not want to see a return to that approach. The new federal requirements for reporting medical loss ratios will help manage the premiums. Health plans are preparing for federal reform and the addition of thousands of new covered lives. This preparation takes capital and investments. Many of the newly covered persons will bring risk and exposure, and plans need to have sufficient reserves to remain solvent and stable. Artificially holding down some premium increases relative to a company's surplus may destabilize the market by driving people to the artificially lower prices. Guidelines issued by the National Association of Insurance Commissioners suggests rate review should not take reserves into account. Carriers do need to be prepared to remain solvent and strong through any crisis like a pandemic or earthquake. We do not believe that a blanket standard should be applied across the board. Solvency standards should be tailored to each individual carriers and their unique risk-based profile. Carriers need to be ready to weather the new federal health reform requirements, many will have additional costs such as providing guarantee coverage with no pre-existing condition limitations, benefits with no lifetime or annual benefit maximums, new benefit requirements with the essential health benefits, and medical loss ratio requirements. All of these will eat into reserves. It is parallel to preparing for the 100 year flood – it is better to be prepared with appropriate reserves. It is not appropriate to target just nonprofit regulated carriers.

**Persons Testifying**: PRO: Senator Conway, prime sponsor; Commissioner Mike Kreidler, Office of Insurance Commissioner; Senator Chase; Curt Fackler, agent; Karen Lee, AARP.

CON: Brian McCulloch, individual; Abby Kaplan, Health Care Forum; Sydney Smith Zvara, Association of Washington Healthcare Plans; Mel Sorensen, America's Health Insurance Plans, Washington Association of Health Underwriters, National Association of Insurance and Financial Advisers; Brett Meyers, Group Health; Kent Marquardt, Premera Blue Cross; Dr. Joe Gifford, Regence Blue Shield; Donna Steward, Association of Washington Business.