SENATE BILL REPORT
SB 5247

As Reported by Senate Committee On:
Health & Long-Term Care, January 30, 2012

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, 2/21/11; 1/23/12, 1/30/12 [DPS, w/oRec].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5247 be substituted therefor, and the substitute bill do pass.
Signed by Senators Keiser, Chair; Conway, Vice Chair; Frockt, Kline and Pridemore.

Minority Report: That it be referred without recommendation.
Signed by Senators Becker, Ranking Minority Member; Parlette and Pflug.

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

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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: The bill as referred to committee not considered.

Summary of Bill (Recommended Substitute): For rates filed on or after January 1, 2013, the commissioner must review the surplus levels for each nonprofit health insurance carrier offering products in the individual or small group markets, as part of the rate filings as an element in determining the reasonableness of the proposed rate. The commissioner may take into consideration the capital facility needs for carriers maintaining and operating hospital and clinical facilities. The ability to review the surplus does not change the commissioner's rate review authority.

EFFECT OF CHANGES MADE BY HEALTH & LONG-TERM CARE COMMITTEE (Recommended Substitute as Passed Committee): Clarifies the change is for rates filed on or after January 1, 2013. Allows the commissioner to take into consideration the capital facility needs for carriers maintaining and operating hospital and clinical facilities.

Appropriation: None.

Fiscal Note: Not requested.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony as Heard in Committee: PRO: The proposed substitute bill is considerably different from last year's bill. It has a simple purpose to give the Commissioner the authority to review the growing surplus that carriers are accumulating. It is an important consumer protection to ensure rates are appropriate and not just adding to large surpluses. The rates for filed products have doubled over the last six years, and at the same time the surpluses carriers have set aside are growing even faster. Eleven other states provide their insurance commissioner the authority to review the surplus dollars as part of the rate review process. In Oregon we have seen success with the commissioner controlling a rate increase and requiring the use of some extreme surplus accumulation. It is important to note that the carriers do have requirements for reserves – the reserves ensure all the liabilities are covered and all anticipated claims can be paid. The surplus dollars are accumulating over and above the reserve requirements and we believe the carriers should be accountable to the public for these components. We want to make sure consumers are protected with rates that are reasonable to the benefits that will be provided and to ensure the business remains viable and solvent. The carriers are right to point out the requirements for the reserves but the commissioner is talking about looking at surpluses, the money accumulated beyond the reserves that cover the business risks. There needs to be a mechanism to give back to consumers that have over paid.

CON: This is a focus on the nonprofit carriers and may provide an unfair advantage to the for-profit carriers. We believe the National Association of Insurance Commissioners model on reserves is the appropriate focus on the reserves. It is an uncertain time for insurance and not the right time to gamble with changes when carriers may really need the financial strength to face the unknowns and adverse selection risks that are coming with health reform. It is the commissioner's responsibility to ensure business solvency and the risk-based capital standards in the NAIC model provide a sound basis. The commissioner already has broad authority to review rates and the federal requirements for medical loss ratios already requires carriers to pay rebates to consumers if the premiums are set inappropriately. This will limit the amount that can be contributed to the reserves. It took Premera a decade to build back the reserves that were lost in the 1990's market chaos. There is an unquantified risk for 2014 coverage with health reform and we need to be financially strong. The Group Health system is also a delivery system and needs to invest in clinics and care settings and these surplus accounts are necessary to maintain the business. The commissioner has new tools provided under health reform with the review of the medical loss ratios that should be sufficient. The contributions to the reserves are not specific to each line of business and if we artifically suppress the rates for the individual or small group products, the rates will increase for the large groups to ensure the reserve and surplus lines are maintained. I am opposed to this version of the bill because it does not go far enough – there needs to be a cap on surplus of two months of claims, and a mechanisms to refund policy holders.

Persons Testifying: PRO: Senator Conway, prime sponsor; Mike Kreidler, Insurance Commissioner; Brendan Williams, OIC; Curt Fackler, citizen.

CON: Sydney Smith Zvara, Assn. of WA Healthcare Plans; Joe King, Group Health; Mel Sorensen, Assn. of Health Insurance Plans, WA Assn. of Health Underwriters, National Assn. of Insurance and Financial Advisors; Chris Bandoli, Regence Blue Shield; Len Sorrin, Premera Blue Cross; Brian McCulloch, resident of Shoreline.