HOUSE BILL REPORT
HB 2679

As Reported by House Committee On:
Appropriations

Title: An act relating to funding for individuals who are not eligible for federal insurance subsidies and for foundational public health services.

Brief Description: Concerning funding for individuals who are not eligible for federal insurance subsidies and for foundational public health services.

Sponsors: Representatives Robinson, Macri, Cody, Chopp, Tarleton, Frame, Stonier, Ormsby, Riccelli, Tharinger, Ortiz-Self, Davis, Pollet and Kloba.

Brief History:
Committee Activity:
Appropriations: 1/29/20, 2/8/20 [DPS].

Brief Summary of Substitute Bill

- Requires each nonprofit health carrier to annually report the carrier's surplus amounts to the Office of the Insurance Commissioner (OIC) for determination of whether the carrier's surplus is excessive.
- Requires carriers with a surplus greater than 600 percent of the carrier's Risk-Based Capital requirements to pay 3 percent of the excessive surplus to the OIC for deposit into the newly created Nonprofit Health Carrier Community Benefit Fund (Fund).
- Provides that expenditures from the Fund must be used for: subsidies for individuals purchasing individual market insurance coverage who are not eligible for federal insurance subsidies; and Foundational Public Health Services.
- Imposes a 3 percent tax on for-profit health carrier's depreciation deductions taken on the previous tax year's federal income tax return.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 21 members: Representatives Ormsby, Chair; Robinson, 1st Vice Chair;

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Bergquist, 2nd Vice Chair; Stokesbary, Ranking Minority Member; Rude, Assistant Ranking Minority Member; Caldier, Chopp, Cody, Dolan, Fitzgibbon, Hudgins, Kilduff, Macri, Pollet, Ryu, Senn, Steele, Sullivan, Tarleton, Tharinger and Ybarra.

Minority Report: Do not pass. Signed by 8 members: Representatives MacEwen, Assistant Ranking Minority Member; Chandler, Dye, Hansen, Hoff, Kraft, Schmick and Sutherland.

Minority Report: Without recommendation. Signed by 2 members: Representatives Mosbrucker and Pettigrew.

Staff: Meghan Morris (786-7119).

Background:

Office of the Insurance Commissioner.
The Office of the Insurance Commissioner (OIC) has the authority to regulate health insurance companies in Washington. As part of this authority, the OIC is responsible for regulating the solvency of insurance companies and health carriers.

National Association of Insurance Commissioners.
The National Association of Insurance Commissioners (NAIC) is an association of state insurance agencies that creates and recommends certain financial regulation standards and regulatory statutes for the insurance industry. The OIC is a member of the NAIC.

Risk-Based Capital.
Every domestic health carrier must annually file a Risk-Based Capital (RBC) report with the OIC, the NAIC, and with the insurance agency of any state where the insurance carrier is authorized to do business. Risk-Based Capital is based on a formula and measures the minimum amount of capital appropriate for a reporting insurance carrier to support its overall operations in consideration of its size and risk profile. The NAIC RBC formula generates the regulatory minimum amount of capital that a carrier is required to maintain to avoid regulatory action.

Insurance Subsidies.
Individuals may purchase health insurance through the Washington Health Benefit Exchange (Exchange) or in the individual market. Premium subsidies are available to individuals between 100 percent and 400 percent of the federal poverty level who purchase insurance coverage from a qualified health plan through the Exchange.

Foundational Public Health Services.
"Foundational Public Health Services" means a limited statewide set of defined public health services within the following areas:

- control of communicable diseases and other notifiable conditions;
- chronic disease and injury prevention;
- environmental public health;
- maternal, child, and family health;
- access to and linkage with medical, oral, and behavioral health services;

- vital records; and
- cross-cutting capabilities including assessing the health of populations, public health emergency planning, communications, policy development and support, community partnership development, and business competencies.

Summary of Substitute Bill:

By July 1, 2021, and each year thereafter, each nonprofit health carrier (carrier) must submit the amount of the carrier's surplus to the OIC. By October 1, 2021, and each year thereafter, the OIC must determine whether a carrier's surplus is excessive. A carrier's surplus is excessive if the surplus is greater than 600 percent of the carrier's RBC requirements, in accordance with the formula set forth in the RBC instructions.

If the OIC determines the carrier's surplus is excessive, the nonprofit health carrier must pay 3 percent of the excessive surplus to the OIC for deposit into the newly created Nonprofit Health Carrier Community Benefit Fund (Fund). Within 30 days of the determination, a carrier may request a hearing for the OIC to consider a reduction to the required payment. The OIC may only reduce a carrier's payment to the Fund if the carrier presents clear and compelling evidence that the required amount of excessive surplus payment would render the carrier financially impaired under the laws of this state or any other state in which the carrier is authorized to do business.

Expenditures from the Fund must be used exclusively for:
- subsidies for individuals purchasing individual market insurance coverage who are not eligible for federal insurance subsidies; and
- Foundational Public Health Services.

For-profit health carriers are subject to a 3 percent tax of all depreciation deductibles, allocated to Washington, on the covered for-profit health carrier's annual federal tax return for the previous tax year. Revenues from the tax will be deposited into the Fund.

Substitute Bill Compared to Original Bill:

The defined baseline for "excessive surplus" is changed from 400 percent to 600 percent of a nonprofit health carrier's risk-based capital requirements.

A tax of 3 percent is imposed on depreciation expenses, allocated to Washington, claimed by for-profit health carriers on the for-profit health carrier's annual federal tax return for the previous tax year. Revenues from the tax will be deposited into the Fund.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 11, 2020.

Effective Date of Substitute Bill: The bill takes effect January 1, 2021.

Staff Summary of Public Testimony:

(In support) The excess surplus of nonprofit carriers in our state is growing while some consumers are having issues purchasing affordable health insurance. The idea is not to drain carrier surpluses, but levy a tax on surpluses to help people buy insurance. There is an obvious level of RBC needed by insurance carriers. Some carriers may be required to have 600 to 650 percent of their RBC level to keep good standing. However, one carrier has in excess of 1,500 percent of RBC; another has in excess of 1,300 percent RBC; and a third has just under 600 percent of RBC. If the bill was amended to tax surpluses over 600 percent of RCB, the third carrier would be exempt. Even still, two major carriers have almost double the excess surplus while consumers are not building surpluses and are faced with increasing premiums. Legislators should question how much surplus is excessive, how much surplus is enough, and how to balance this with expanding access to insurance.

The excess surplus amounts held by insurance carriers are beyond necessary or reasonable. These surplus dollars are not just the cost of doing business, they are consumer premiums not spent on claims as well as investment earnings from unspent premiums. These surpluses are far beyond what carriers are required to hold and are in addition to the exorbitant compensation packages for top executives. Two carriers pay over $4 million per year to their chief executive officers. In 2000 surpluses for the top three carriers totaled $742 million, but the same companies now carry excess surpluses of over $4.4 billion. This is an average increase of almost 500 percent during a time where state public health funding decreased by 40 percent. This is a smart proposal that takes a small fraction of surplus dollars to meet obligations to taxpayers by investing unspent consumer money into crucial public health and health care services.

Other states limit the unrestricted surplus of nonprofit health plans and use it to benefit rate payers. Michigan, Massachusetts, and Pennsylvania all have a maximum threshold for RBC and carriers exceeding the cap must return the money to rate payers or submit a plan to their insurance commissioner to adjust the surplus below the maximum. In Oregon, Colorado, and Maine surplus levels are considered in the rate review process. In 2008 Colorado reached a $150 million settlement with a nonprofit health carrier and required them to use the money to provide premium credits and invest money in underserved parts of the state. Maryland's insurance commissioner has the authority to determine if a surplus is excessive based on RBC levels and carriers have 60 days to submit a plan for distributing the excess. Maryland law also has a provision that requires nonprofit health insurance plans to have goals, objectives, and strategies for carrying out the nonprofit mission. Michigan published a report in 2014 with more information about how other states have tackled this issue, which is not unprecedented.

The importance of a strong public health system cannot be understated. Access to care in a strong public health system can have a great impact on health outcomes. An estimated 470,000 Washingtonians remain without health care coverage. Funding for public health in our state has decreased while the population of Washington has grown by more than 1 million people. The state needs a public health infrastructure system that works and is adequately funded. Those seeking coverage need the financial and system level supports that

enable them to obtain coverage. Local governments are overburdened, underfunded, and in crisis mode trying to meet the obligation of maintaining a healthy population. State investments are appreciated but not sufficient to fill the gaps for growing populations and increasing costs of providing health services. The bill infuses the public health system with needed revenue that does not come from the State General Fund. There is a direct nexus between the revenue in the bill and improving the health of our communities. This small percentage of the excess surplus dollars held by nonprofit health insurance companies will help fund the state's foundational public health services to improve the ability of public health officials to effectively function and prevent costly food and water contamination, disease outbreaks, and other public health crises. Coronavirus is the latest example of the importance of strong public health. This investment helps ensure local governments have the tools to fight outbreaks that affect the health and economic vitality of communities across the state.

(Opposed) All of the health plans in Washington are opposed to the bill. Nonprofit carriers and many players in the health care industry in Washington should be part of the conversation to find equitable and broad-based funding sources for individual market subsidies or foundational public health activities. The Legislature should work with the carriers to find solutions for public health and for individual tax credits.

The funding mechanism at the heart of the bill would be disastrous to the integrated, nonprofit health plan business model because it narrowly bases the tax on RBC. Carriers need financial structures that support operating costs. Carriers are making significant investments to expand access to care. In addition to supporting buildings and staff, carriers hold reserves to pay members' medical expenses and support communities with low-income medical financial assistance, care for Medicaid patients, and provide community grants to improve social determinants of health. One carrier is in the middle of a $1 billion capital construction campaign to build infrastructure to better serve members and partner with providers. Other investments include expanding primary care clinics in response to a primary care provider shortage. The nonprofit carriers provide community benefits and provide good paying jobs for thousands of people across the state. With an average operating margin of 1.4 percent for some carriers, only a sliver is diverted into reserves, which take a long time to build up. Reserves are used to maintain solvency and to regulate and promote the health and wellbeing of the members. For-profit competitors have far greater resources and see this proposal as a tremendous business opportunity.

The state commissioned a study in 2007 through the OIC which found that no uniform RBC level should be applied to every insurance company. This is consistent with other experts in the industry including the NAIC and the American Academy of Actuaries.

Nonprofit health insurers do pay taxes, including a 2.1 percent premiums tax which is akin to about triple the average business and occupations tax rate. One carrier paid $35 million into the state treasury in 2019.

(Other) There is strong support for a funding source for state subsidies to help people in the individual market afford coverage. Affordability is a challenge for both the subsidized and the unsubsidized people in our market. About 40 percent of the 200,000 individual market enrollees through the Exchange, which is about 80 percent of the entire individual market,

are unsubsidized. Some people pay up to 30 percent of their income on premiums. Premiums are not the only issue, as nearly 60,000 families are spending over $9,000 on their deductibles. When people leave the Exchange, survey responses show they are not getting other coverage, but rather 30 percent of the respondents leave because they cannot afford coverage. The uninsured rate in Washington is increasing for the first time since 2014. Hopefully Cascade Care implementation next year will help change this trend. Cascade Care requires the Exchange to develop a plan to implement and fund state subsidies for individuals with less than 500 percent of the federal poverty level who purchase individual market coverage on the Exchange. Section 3 of the bill does not align with Cascade Care requirements, which should be addressed.

Persons Testifying: (In support) Erin Dziedzic, Bleeding Disorder Foundation of Washington and Foundation for Healthy Generations; Amy Brackenbury, Public Health Roundtable; Rob Gelder, Kitsap County, Washington Association of Counties, and Washington State Association of Local Health Officials; Sam Hatzenbeler, Economic Opportunity Institute; and Justin Gill, Washington State Nurses Association.

(Opposed) Chris Bandoli, Association of Washington Healthcare Plans; Zach Snyder, Regence BlueShield; Gary Strannigan, Premera; and Courtney Smith, Kaiser Permanente.

(Other) Joan Altman, Washington Health Benefit Exchange.

Persons Signed In To Testify But Not Testifying: None.