SENATE BILL REPORT
SB 6451

As of February 2, 2020

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: Senators Frockt, Lovelett, Hunt, Keiser, Salomon, Darneille, Randall, Hasegawa, Nguyen, Wellman, Kuderer, Das, Liias, Conway, Saldaña, Van De Wege and Wilson, C.

Brief History:
Committee Activity: Ways & Means: 1/30/20.

Brief Summary of Bill

- Requires nonprofit health carriers to submit the amount of the carrier's surplus to the insurance commissioner (Commissioner) by July 1, 2021, and annually thereafter.
- Requires the Commissioner to determine if a nonprofit carrier's surplus exceeds 400 percent risk based capital (RBC).
- Requires nonprofit carriers to pay 3 percent of any surplus above 400 percent RBC into a fund to be used for certain individual market subsidies and foundational public health services.

SENATE COMMITTEE ON WAYS & MEANS

Staff: Sandy Stith (786-7710)

Background: Risk Based Capital. The RBC of all health carriers is reported by the carriers to the Commissioner, the National Association of Insurance Commissioners, and in other jurisdictions where a carrier is authorized to do business. The goal is to maintain an excess of capital above the required RBC level.

A carrier's authorized control level RBC is determined by a formula, taking into account the carrier's assets, the risks of adverse experience, interest rate risk, and other business

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risk. There are four statutory RBC levels, representing perceived levels of seriousness of risk, at which the commissioner must take action:

- below 200 percent is the company action level—when a carrier reaches the company action level, the carrier must develop a plan to restore its RBC;
- below 150 percent RBC is the regulatory action level—when a carrier reaches the regulatory action level, the carrier must develop a plan to restore its RBC and perform an examination or analysis to review its RBC plan, and the Commissioner must also issue an order specifying corrective actions to restore the RBC;
- below 100 percent RBC is the authorized control level—when a carrier reaches the authorized control level, the Commissioner may place the carrier under regulatory control; and
- below 70 percent RBC is the mandatory control level—when a carrier reaches the mandatory control level, the Commissioner must place the carrier under regulatory control.

Insurance Subsidies. Individuals may purchase health insurance through the Washington Health Benefit Exchange (Exchange) or in the individual market outside of the Exchange. 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. Foundational public health services are 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 Bill: By July 1, 2021, and annually thereafter, nonprofit health carriers (carriers) must submit the amount of the carrier's surplus to the Commissioner.

By October 1, 2021, and annually thereafter, the Commissioner must determine if the carrier's surplus is excessive. The surplus is excessive if it is greater than 400 percent of the carrier's RBC requirements. If the Commissioner determines the surplus is excessive, then within 90 days the carrier must pay 3 percent of the excessive surplus to the Insurance Commissioner's Office (OIC) for deposit into the nonprofit health carrier community benefit fund (Fund).

Within 30 days of a determination that a carrier's surplus is excessive, a carrier may request a hearing by the Commissioner to consider a reduction in the required payment amount. The Commissioner may only reduce a carrier's required payment if the carrier presents clear and compelling evidence that the required payment would render the carrier financially impaired under the laws of any state where the carrier is authorized to do business.

The Fund is created to accept all receipts from surplus payments collected by the Commissioner. Expenditures from the fund may only be used for:

- subsidies for individuals purchasing individual market insurance coverage who are not eligible for federal insurance subsidies; and
- foundational public health services.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill takes effect on January 1, 2021.

Staff Summary of Public Testimony: PRO: The issue related to the surplus has been around for quite some time. We have a broad concern throughout the Senate with the funding for foundational public health. What this bill does is assess a fee on excessive surplus. Very good questions have been raised about how much risk-based capital (RBC) is needed. We need to make sure we get this number right. We also need to make sure we do not jeopardize Blue accreditation. However, these surpluses have been growing over time, regardless of economic conditions. This bill does not drain the surpluses. This is a fee on them. Potential things this fee would be used for are expanding the subsidies people receive in purchasing insurance. We would also like to know the percent of RBC that the Blue plans are required to maintain for their affiliation. We have heard several numbers and are hoping they can provide this information. Per OIC filings, the amount held in surplus is in excess of $4 billion. As a percent of RBC, Regence is 1551 percent, Premera is 1331 percent, and Kaiser is just under 600 percent. We have spoken before about premiums going up, people having difficulty accessing care, and high out of pocket costs, at the same time these surpluses are growing exponentially. These are premiums that are being paid by consumers that are not being paid back out, but are amassing and earning interest. There are a lot of things these funds could be spent on, but they are not. Because these surpluses continue to grow, it means they are not being reinvested in the community. This bill proposes a small assessment on carriers that helps people access insurance. We are very curious about just how much surplus is enough. Strong foundational public health is extremely important. This is especially true now as county employees are working to address a potential Corona virus outbreak. We join with local and state health partners and appreciate state investments, but these do not meet local health funding needs. Consumers pay premiums to non-profit carriers with the expectation that these funds will be used to improve their health. We do not think it is unreasonable that some small portion of the surplus be returned to communities for this. Michigan, Pennsylvania, and Massachusetts are all states that have a maximum threshold for RBC. Carriers that exceed that cap must either return part of that surplus rate payers to or submit a plan to their insurance commissioner showing how they will reduce RBC to below the maximum. Oregon, Colorado, and Maine use surplus as part of their rate review process. In 2008, Colorado reached an $155 million settlement with one of their carriers that required the carrier to return these funds to underserved parts of the state. Maryland gives their commissioner authority to determine what is an appropriate excess surplus. Carriers that exceed that amount are required to submit a plan to the commissioner. The commissioner may either approve the plan or come up with their own plan. These funds may be returned to rate payers. Under Maryland's statute, non-profit carriers all must have goals, objectives, and strategies for how they accomplish their non-profit mission.

Minnesota Department of Health did a study on this several years ago, and there are several other states that also have policies on how they deal with excessive surplus. We are open to other ideas. These are not the funds used for claims and are not related to insolvency. These surplus dollars are far beyond what are reasonable and necessary. These are in addition to the exorbitant compensation packages paid by non-profit carriers.

CON: It is not just the non-profit carriers that find this bill problematic. It is also the for profit carriers and the managed care organizations. It has been assumed that this bill affects the three non-profit companies testifying today, however, there are also three smaller non-profit carriers operating in Washington. This type of bill disincentives those smaller companies from developing the fiscal strength they would need to grow and compete in this state. We need to consider not just the impact on the three carriers that currently meet the criteria under this bill, but also other potential market players. To the extent this bill is about setting up subsides in the individual insurance market or foundational public health, those are conversations we support. There are other entities that benefit from a strong public health system and we believe this should be a broad-based conversation. We are opposed to this legislation, but support the broad policy goals. This bill would be damaging to the non-profit business model. This is because this is based on RBC. Last time Washington looked at this method, the OIC had a study done by the Lewin Group. That report showed there isn't one RBC percentage that should apply to all insurance companies. This is consistent with findings from the National Association of Insurance Commissioners (NAIC) and the American Academy of Actuaries. Non-profit carriers typically have a higher RBC than their for profit counterparts, even though for profit companies are better resourced. Non-profit companies provide a great deal of local benefits. We would like to be at the table to work on solutions cooperatively. We view this as an untested and unvetted funding method. We believe this would be devastating. This would eliminate our ability to respond to changes in the competitive landscape as our national insurers are aligning vertically. This would limit our ability to rebuild infrastructure, so we can prospectively lower prices. This is a current billion dollar project. We are concerned that this focuses on too narrow a segment of the health care sector. This will create an unlevel playing field with the for profit carriers. This risks stability with the promises we make to our rate payers. We are willing to work on equitable solutions to meet the goals of the bill. Our business model requires a financing model that allows us to operate 45 clinics across the state and employ over 10,000 people. We have opened five new clinics since 2019 in an effort to expand access to care. We have two new clinics in progress. Our reserves are used to pay our members medical expenses, support our communities through low income medical financial assistance, care for our Medicaid patients, and provide community grants for social determinants of health. We use our reserves to directly promote the health and well being of our members. In acquiring Group Health, part of the funds were used to create the Group Health Foundation.

OTHER: It is difficult to stand before a policy committee and say you do not support funding foundational community health or finding ways to make insurance more affordable. We do not believe the RBC formula in this bill is correct and more importantly, we do not believe it does anything to direct how plans handle their money. There are a lot of places plans can put their money, for example, surplus, holding companies, capital. Funding foundational public health requires stable funding. This does not provide that. Also, RBC was never intended to be a measure of strength. Instead, it is a measure for the OIC to determine weakly capitalized companies. We do not think it should be used for purposes

other than what was intended. We are here to comment on Section 3 only. Affordability in the individual market has been an issue we have dealt with for the last few sessions. About 80 percent of the individual market is enrolled through the Exchange. We are supportive of establishing a funding source that would help consumers afford their coverage. We have consumers that are paying up to 30 percent of their income. We are seeing consumers shift from silver plans to lower priced bronze products. This is not just related to premiums. Over 60,000 families on the Exchange have a deductible over $9,000. Surveys of consumers leaving the Exchange show that 30 percent leave because they can not afford coverage. The uninsured rate has gone up for the first time since 2014. We are supportive of the policy goal of this bill and we hope implementation of Cascade Care helps to reverse this trend. Cascade Care requires us to submit a plan by November regarding subsidies for people under 500 percent of the federal poverty level who purchase insurance through the Exchange. Language in Section 3 does not align with this. We have submitted language to address this.

Persons Testifying: PRO: Senator David Frockt, Prime Sponsor; Erin Dziedzic, Bleeding Disorder Foundation for Washington; Foundation for Healthy Generations; Mac Nicholson, King County; Amy Brackenbury, Public Health Roundtable; Washington State Nurses Association; Sam Hatzenbeler, Economic Opportunity Institute.

CON: Chris Bandoli, Association of Washington Healthcare Plans; Zach Snyder, Regence BlueShield; Gary Strannigan, Premera Blue Cross; Courtney Smith, Kaiser Permanente.

OTHER: Lonnie Johns-Brown, Office of the Insurance Commissioner; Joan Altman, Washington Health Benefit Exchange.

Persons Signed In To Testify But Not Testifying: No one.