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Testimony of

District of Columbia Insurance Federation

before

The Department of Insurance Securities and Banking

in re:

**Review of GHMSI Surplus Pursuant to the Medical Insurance
Empowerment Amendment Act of 2008**

441 4th Street, NW

Suite 220 South

10 September 2009

Good morning Chairperson Purcell. My name is Wayne E. McOwen. I represent the District of Columbia Insurance Federation (DCIF), a state insurance trade association whose members provide property, casualty, life and health insurance products and services to residents and businesses in the District of Columbia. On behalf of the DCIF, I am pleased to offer remarks on matters before this hearing, which has been convened by the Commissioner pursuant to the "Medical Insurance Empowerment Amendment Act of 2008."

DCIF member companies have a history of working together to create progressive and balanced business and regulatory climates that enable insurers, agents and brokers to provide quality, affordable insurance coverage to District consumers. A component of that objective is the avoidance of, and/or the elimination of, onerous and unnecessary laws and regulations which make it more difficult for insurers to operate and which may have the potential to add more cost to the system to the detriment of all stakeholders. It is in this context that I offer comments today.

I am not here today to speak to the adequacy or inadequacy of the reserves at issue in the debate before this body. However, as a spokesperson for an organization representing diverse segments of the insurance industry in the District of Columbia, I am here to suggest that the many and varied mechanisms currently in place – and which follow universally recognized processes for the protection of consumers – should be given careful consideration. These mechanisms include the following:

- The chief regulator in all jurisdictions – in this instance the DC Insurance Commissioner – is required to review, and has inherent authority to approve or disallow, insurer-proposed rate levels by a process which ensures the adequacy of capital reserves held for the protection of policyholders. That rates are approved by the chief regulator speaks to the adequacy of insurer reserves in the District.**
- Regulators follow a process which includes a Risk Based Capital analysis, a tool essentially enabling the evaluation of the potential for financial risk via mathematical calculation. Industry accepted formulas operate as an "early warning system" to identify potential financial pitfalls and benchmark levels for regulatory intervention. In extreme cases the regulator is empowered to take over a troubled company and may initiate rehabilitative processes. But, it is important to note that every company risk profile is different. Thus, "meeting the numbers" is not the same for all carriers. Similarly, every dollar above RBC limits may not necessarily be "excessive."**
- Like other corporate entities insurers are governed by a Board of Directors with the fiduciary responsibility for ensuring the financial soundness of their company. They are charged with making decisions regarding rates and reserves, as well as how much the**

company can afford to contribute in good works to the community. Most importantly, the fiduciary responsibility of directors comes with legal accountability for ensuring the reasonableness of cost projections and claims trends, and for setting rates sufficient to cover these costs.

- Annual Yellow Book filings, documenting the financial condition of insurers, require sign-off by independent actuaries attesting to the validity of management recommendations and, most critically, that reserves are adequate – neither understated nor excessive.**
- Public hearings enable multiple stakeholders to weigh-in on prospective rate changes, ensuring that consumers have a voice in the process.**

Of course there are other factors to consider. Profit versus not-for-profit status influences the above mechanism. But, like all companies selling a product or service, a loading is built into the price. For insurers, this loading enables the accumulation of reserves over time. For non-profits this loading may be the only available avenue by which to secure future operations to the extent such companies may not have access to the traditional financial resources available to “for-profit” entities. In the case of health insurers, this may mean that the accumulation of reserves through policyholder premiums is the only way to attempt to keep pace with medical inflation as claims spike up; and, it may be the only way to protect such companies from the catastrophic exposure of a pandemic. Add the as-yet-to-be-determined federal reconstruction of our nation’s health insurance landscape, and you have a surplus mystery worthy of Dr. John H. Watson and his more famous colleague. With apologies to Sir Arthur Conan Doyle, call it the “Case of How Much is not Enough”!

As we have seen over the past six to nine months, the fortunes of very large and, in some cases, industry icons can change quickly. At a time when the financial markets are challenged because of a lack of capital, it makes sense to consider every traditional solvency analysis to be certain that policyholder protections are not compromised, that availability of coverage is not put at risk, and that the perception of DC as a less than business-friendly environment does not become an unintended consequence. Ultimately, through the functions of the Chief Regulator, the fiduciary responsibility of a company’s Board of Directors and the consultative oversight of the actuarial community, reliable mechanisms are in place to provide appropriate and critical protections for consumers. We believe it is not in the best interests of consumers to overlook even one of these mechanisms as these deliberations continue to go forward.

Thank you for this opportunity to provide comments. I would be pleased to answer questions regarding any aspect of my testimony.