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CONSUMER PROTECTION & COMMERCE
AND
JUDICIARY

TWENTY-FOURTH LEGISLATURE
Regular Session of 2008

Thursday, March 24, 2008
2:30 p.m.

TESTIMONY ON HOUSE CONCURRENT RESOLUTION NO. 146/HOUSE RESOLUTION NO. 125 – URGING THE INSURANCE COMMISSIONER TO INITIATE AN INVESTIGATION AND CORPORATE AUDIT OF THE HAWAII MEDICAL SERVICES ASSOCIATION'S PRACTICE OF MAINTAINING AN EXCESSIVE SURPLUS, PROVIDING LARGE BONUSES TO STAFF, AND REIMBURSEMENT PATTERNS OVER THE PAST TEN YEARS TO DETERMINE IF THE CHARITABLE RETURN TO THE COMMUNITY JUSTIFIES ITS NONPROFIT STATUS.

TO THE HONORABLE ROBERT N. HERKES AND THE HONORABLE TOMMY WATERS, CHAIRS, AND MEMBERS OF THE COMMITTEES:

My name is J.P. Schmidt, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department takes no position on House Concurrent Resolution 146, HD 1 and House Resolution 125, HD 1. We note that the resolutions have been amended in HD 1 to urge the Insurance Commissioner rather than the Attorney General to conduct the investigations and we agree that the Insurance Division is the appropriate agency. We wish, however, to make the following observations.

If the Legislature is contemplating removing the tax exemption for mutual benefit societies found in Hawaii Revised Statutes ("HRS") section 432:1-403, it would affect not only HMSA, but other mutual benefit societies like UHA and HMAA. There is also the question of what would happen to the tax exempt status of HMOs. Whatever the outcome, the Commissioner would be concerned about maintaining a level playing field for market participants. This Committee should also note that many companies pass on the cost of their tax to their customers. If HMSA loses its tax exemption and they end up passing the cost on to consumers, it may not be in the best interests of the public.

We also point out that the tax exemption found in HRS section 432:1-402 is based on the entity being "a nonprofit medical indemnity or hospital service association or society or both". Thus, it is deemed to be a charitable purpose to provide health insurance and no other charitable activities appear to be contemplated by the statute. We are therefore not sure what the resolution means by a "charitable return to the community."

We thank the Committee for this opportunity to testify.

HAWAII MEDICAL ASSOCIATION
1856

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March 24, 2008

PLEASE DELIVER TO:
CPC/JUD Committee
Monday
3/24/08
2:30pm
Room 325

To: Rep. Robert Herkes, Chair
Rep. Angus McKelvey, Vice Chair
House Consumer Protection & Commerce Committee

Rep. Tommy Waters, Chair
Rep. Blake Oshiro, Vice Chair
House Judiciary Committee

From: Cynthia J. Goto, M.D., President
Linda Rasmussen, M.D., Legislative Co-Chair
Philip Hellreich, M.D., Legislative Co-Chair
Paula Arcena, Executive Director
Dick Botti, Government Affairs Liaison

Re: HCR146 HD1 Urging the insurance commissioner to initiate an investigation and corporate audit of the Hawaii medical services association's practice of maintaining an excessive surplus, providing large bonuses to staff, and reimbursement patterns over the past ten years to determine if the charitable return to the community justifies its nonprofit status.

The Hawaii Medical Association appreciates the intent of HCR146 HD1.

In combination, Hawaii's high medical malpractice insurance premiums, high cost of living and low physician reimbursements had made it difficult to recruit and retain an adequate physician workforce.

The Hawaii Medical Association suggests two ways that would have the most meaningful impact on this negative situation.

De-link Physician Reimbursement from the Medicare fee schedule

- The Medicare fee schedule has decreased annually, with a 40% decrease predicted over the next nine years.
- Private and public health plans pay physicians a percentage of the Medicare fee schedule, which is not based on the cost of providing medical care.

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- The Medicare fee schedule is expected to decrease by 40% by the year 2010.
- Decreases in the Medicare fee schedule have been detrimental to elderly patient access to care.

Approve direct payment legislation

- Currently, health care insurers make payment to contracted network providers only. HMSA dominates Hawaii's health plan market with a 70% plus share of the market. This gives physicians little choice but to sign an agreement with HMSA and accept contractual conditions because physicians have little leverage for negotiation.
- Benefits to consumers include:
    1. Ability to choose physicians within or outside a health plan network;
    2. Physicians will need to provide patients with the prices for their services; and
    3. Patients will become much more aware of how much health services cost.
- The incentive to physicians to remain in-network will continue because it provides a competitive advantage.
- Health plans will continue to have the ability to review physician claims and they will continue to have the ability to reject requests for reimbursement. Like now, the insurer will have the ability to report suspicious activity to appropriate authorities.
- It will encourage competitive services and charges.
- It will not disrupt the Hawaii State Board of Medical Examiners authority to penalize doctors for licensure violations and the Regulated Industries Complaint Office investigation of patient complaints.

In our opinion, these two actions improve Hawaii's healthcare significantly by addressing root problems with meaningful solutions. They would create a fair and stable environment for physicians by making it economically feasible to practice medicine in Hawaii. The result would be a stable supply of physicians to serve Hawaii's residents.

Thank you for the opportunity to provide this testimony.

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

March 24, 2008

The Honorable Robert N. Herkes, Chair
The Honorable Tommy Waters, Chair

House Committees on Consumer Protection and Commerce and Judiciary

Re: HCR 146 HD1/HR 125 HD1

Urging the Insurance Commissioner to initiate an investigation and corporate audit of the Hawaii Medical Services Association's practice of maintaining an excessive surplus, providing large bonuses to staff, and reimbursement patterns over the past ten years to determine if the charitable return to the community justifies its nonprofit status.

Dear Chair Herkes, Chair Waters and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HCR 146 HD1 and HR 125 HD1 which urge the Insurance Commissioner to perform an investigation and corporate audit of HMSA. HMSA opposes these measures.

For 68 years, HMSA has served its members and the local community, honorably and responsibly. We have delivered health care in times of crisis and assisted members and employers who were unable to meet their payments during economic down-cycles. With such a long-standing history of reliability and integrity, we feel that targeting our organization in this manner is unwarranted.

Firstly we would like to state that HCR 146 HD1 and HR 125 HD1 are rife with language which is biased and prejudicial and do not outline an impartial study by anyone's standards. Many of the "whereas" statements contained in both resolutions request an investigation of HMSA and seem to have already concluded the findings of the study. Not only are these resolutions targeted, they are inherently biased.

We also have concerns that the resolutions seemingly expand the Insurance Commissioner's authority. Chapter 432 of Hawaii Revised Statutes gives the Insurance Commissioner examination, enforcement and oversight authority over mutual benefit societies. However, the scope of the study contained in these resolutions and the type of information that the Insurance Commissioner would need to receive in order to conduct the study seems to expand the regulatory powers awarded to the Insurance Commissioner beyond his current statutory authority. We believe that this may not be within the purview of a resolution as it contains no power of law.

It is also possible that since an action of this type is targeted only at HMSA and no other health plan in the state, that this could potentially raise constitutional questions under the Equal Protection clause.

It should also be noted that at least triennially the Insurance Commissioner is required to conduct a comprehensive examination of all health plans. These exams are performed in accordance with Hawaii Revised Statutes and NAIC guidelines. The stated objective of these exams is to assess a health plan's financial condition and compliance with laws and regulations. Importantly, the Insurance Division completed its 2003 through 2005 examination of HMSA in the third quarter of 2007 and found **no significant findings** or accounting adjustments. Additionally, under the NAIC's new risk-focused examination guidance, the Division's examination will incorporate corporate governance, prospective risk and internal controls as part of its proactive surveillance process. An audit using these new parameters will be performed on HMSA in 2009 for fiscal years 2006-2008.

We would also like to reiterate that the Insurance Commissioner already retains discretionary powers to conduct examinations and audits of health plans in the state, especially if the Insurance Division believes that fraud is being perpetrated or consumers are being harmed.

In conclusion, we believe that these measures unfairly single out HMSA and smack of targeted and discriminatory legislation. We respectfully request the committee hold these measures.

Thank you for the opportunity to testify in opposition to HCR 146 HD1 and HR 125 HD1.

Sincerely,

Jennifer Diesman
Assistant Vice President
Government Relations