HMSA
Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 13, 2008

The Honorable David Ige, Chair
The Honorable Carol Fukunaga, Vice Chair

Senate Committee on Health

Re: SB 2314 – Relating to Insurance

Dear Chair Ige, Vice Chair Fukunaga and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 2314 which would exempt small health plans that occupy less than ten per cent of the health care market from adhering to a portion of the Insurance Code dealing with unfair methods of competition and unfair or deceptive acts or practices. HMSA opposes this measure in its current form.

Unfortunately, the current language of this measure would allow health plans with less than a 10 percent share of the local market to engage in an activity that would be prohibited for both HMSA and Kaiser Permanente. We believe that this would create an unlevel playing field for plans operating in the State.

It is also important to note that while the legislation seems to be dealing specifically with health plans, the placement and language of the proposed changes would seem to apply to any class of insurer in the state. This does not seem to be the intent of SB 2314 and therefore this language may in fact be too broad.

If however, it is the Committee's will to move this measure forward we would request a small amendment to ensure that the measure only applies to health plans and that all are regulated fairly. This would be accomplished by replacing the current language contained on Page 5, Lines 17 – 19 with the following:

provided that this subparagraph shall not apply to any accident and sickness insurer.

This would ensure that all health plans in the State are operating under the same regulatory guidelines. Thank you for the opportunity to testify on SB 2314.

Sincerely,

Jennifer Diesman
Director, Government Relations

REVISED TESTIMONY

BEFORE THE

SENATE COMMITTEE ON HEALTH
Senator David Y. Ige, Chair
Senator Carol Fukunaga, Vice Chair

SB 2314 RELATING TO INSURANCE

TESTIMONY OF
JOHN HENRY FELIX
Chairman of the Board and Chief Executive Officer

February 13, 2008, 1:25 pm
State Capitol Conference Room 016

Chair Ige and Vice Chair Fukunaga, and Committee Members:

My name is John Henry Felix, Chairman of the Board and Chief Executive Officer of Hawaii Medical Assurance Association (HMAA). HMAA **STRONGLY SUPPORTS** SB 2314, which would enable small insurers that occupy less than ten percent of the health insurance market to continue combining different types of health and sickness-related insurance benefits into a single unified policy. **HMAA requests permission to amend SB 2314 to limit its application to health insurers only, as reflected in the addition of the applicable statutory language "accident and health or sickness" insurers.**

By way of background, HMAA is a non-profit mutual benefit society which provides health insurance to over 30,000 Hawaii residents. HMAA occupies about three percent of Hawaii's health insurance market. As a small insurer, HMAA takes special pride in providing health insurance to sole-proprietors and small businesses, a segment of Hawaii's market which has a difficult time obtaining affordable health related insurance. Because these types of businesses are unable to take advantage of larger risk pools characteristic of larger employers, their insurance premiums tend to be more costly.

SB 2314 is intended to help self-employed workers and small businesses by allowing broader coverage for less cost. This bill is necessary because the current administration has recently chosen to interpret Hawaii law in a different way than it has ever been interpreted, to prohibit the combination of drug and medical coverage, or the

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combination of medical, dental and drug coverage, or any other combination of health related coverages, into one insurance policy. Numerous Hawaii laws already permit the combination of various types of health coverages under one policy, and this should be encouraged, not discouraged, to help provide the broadest health coverage possible for Hawaii's residents.

The current administration has deemed these combined benefits as a violation of state anti-tying laws, even though the U.S. Supreme Court has made clear that a company with less than 30% market share has no coercive power in the marketplace and cannot violate federal anti-tying laws. *Jefferson Parish Hospital v. Hyde*, 466 U.S. 2 (1984). Consistent with the federal standard, SB 2314 will encourage the existing practice by smaller accident and sickness insurers to "bundle" together different classes of insurance, such as health, dental, and vision, thereby continuing the State's historical acceptance of this practice by small insurers who lack coercive power in the marketplace. In these circumstances, bundling provides broader health care coverage in single unified policies, ultimately resulting in lower overall premiums, fostering greater competition within the Hawaii insurance marketplace, and providing consumers with greater flexibility, coverage and pricing options.

SB 2314 codifies into Hawaii law the same rules applicable to similar federal anti-tying laws, though using a more conservative standard of 10% market share. SB 2314 does not change the Prepaid Health Care Act in any way, but rather simply provides that HMAA's 18 year practice of providing broad, cost- effective benefits to Hawaii's smallest business groups is not an unfair insurance practice. Without passage of SB 2314, hundreds of sole-proprietors, small businesses, and their families currently insured by HMAA could be forced to shop for more expensive individual policies with much less coverage.

HMAA **STRONGLY SUPPORTS** SB 2314 and urges the passage of this measure. Thank you for the opportunity to testify.

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SD1 proposed

Report Title:

Insurance

Description:

Brings Hawaii into compliance with Federal law by recognizing that small market share health insurers lack coercive power in the marketplace and cannot violate state or federal anti-tying laws, following the U.S. Supreme Court Holding in Jefferson Parish Hospital v. Hyde, U.S. 466 U.S. 2, 26-27 (1984) (finding 30 percent market share insufficient market power for an antitrust violation). In doing so, benefits Hawaii consumers by enabling small health insurers, occupying less than ten percent of the market, to provide the broadest coverage at the lowest possible rates by permitting different types of insurance to be combined into a single unified policy.

THE SENATE

TWENTY-FOURTH LEGISLATURE, 2008

STATE OF HAWAII

S.B. NO. 2314

A BILL FOR AN ACT

Relating to insurance

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. (a) The Hawaii insurance commissioner has recently chosen to interpret Hawaii law as prohibiting combining different types of accident and health or sickness insurance benefits within the same policy, as a violation of anti-tying statutes described in section 431:13-103(a)(4)(B), Hawaii Revised Statutes. The legislature, recognizing that access to affordable health insurance is one of the State's most pressing concerns,

finds that small accident and health or sickness insurers lack coercive power and that a prohibition on tying arrangements by small insurers hurts consumers by preventing small insurers from offering different types of benefits in a single unified policy. Accordingly, this measure provides the insurance division in the department of commerce and consumer affairs with the authority and duty to allow broader combinations of health insurance benefits in Hawaii.

(b) The legislature finds that comparable federal antitrust laws regarding anti-tying only apply as against companies which occupy thirty percent or more of the market. In the seminal decision of *Jefferson Parish Hospital v. Hyde*, 466 U.S. 2 (1984), the United States Supreme Court in applying the Sherman Act concluded that Jefferson Hospital had no market power with an assumed market share of thirty percent and therefore its tying arrangement was not unlawful. *See Hovenkamp*, Federal Antitrust Policy (3d edition, 2005) 402; *Hack v. President and Fellows of Yale College*, 237 F.3d 81 (2d Cir. 2000); *Marts v. Xerox*, 77 F.3d 1109, 1113 n.6 (8th Cir. 1996) (18% too small); *Shafi v. St. Francis Hosp.*, 937 F.2d 603 (4th Cir. 1991) (11% insufficient); *Grappone, Inc. v. Subarus of New England, Inc.*, 858 F.2d 792, 797 (1st Cir. 1988) (recognizing a general rule of at least 30%). Hence, federal antitrust law reflects the overarching policy and recognition that small insurers are essential in providing

consumers with coverage options, and that they operate under more significant market constraints than larger insurers.

(c) The intent of this Act is to bring Hawaii into compliance with the foregoing well-settled federal standards, and thereby encourage the longstanding practice by smaller accident and health or sickness insurers to "bundle" different classes of insurance, such as health, dental, and vision together, thereby continuing the historical acceptance of this practice by small insurers who lack coercive power in the marketplace. In these circumstances, bundling provides broader health care coverage in single unified policies, ultimately resulting in lower overall premiums, fostering greater competition within the Hawaii insurance marketplace, and providing consumers with greater flexibility, coverage and pricing options.

SECTION 2. Section 431:13-103, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

(A) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

(B) Misrepresents the dividends or share of the surplus to be received on any insurance policy;

(C) Makes any false or misleading statement as to the dividends or share of surplus previously paid on any insurance policy;

(D) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(E) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(F) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

(G) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy;

(H) Misrepresents any insurance policy as being shares of stock;

(I) Publishes or advertises the assets of any insurer without publishing or advertising with equal conspicuousness the

liabilities of the insurer, both as shown by its last annual statement; or

(J) Publishes or advertises the capital of any insurer without stating specifically the amount of paid-in and subscribed capital;

(2) False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading;

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an

insurer, and which is calculated to injure any person engaged in the business of insurance;

(4) Boycott, coercion, and intimidation.

(A) Entering into any agreement to commit, or by any action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; or

(B) Entering into any agreement on the condition, agreement, or understanding that a policy will not be issued or renewed unless the prospective insured contracts for another class or an additional policy of the same class of insurance with the same insurer; provided that this subsection shall not apply to any accident and health or sickness insurer with less than ten percent market share.

(5) False financial statements.

(A) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of a material fact as to the financial condition of an insurer; or

(B) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer with intent to

deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, knowingly omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer;

(6) Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance;

(7) Unfair discrimination.

(A) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract;

(B) Making or permitting any unfair discrimination in favor of particular individuals or persons, or between insureds or subjects of insurance having substantially like insuring,

risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charge therefor, or in the benefits payable or in any other rights or privilege accruing thereunder;

(C) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(D) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property, unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(E) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex or marital status of the individual; however, nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(F) Terminating or modifying coverage, or refusing to issue or renew any property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired; provided that this subparagraph shall not apply to accident and health or sickness insurance sold by a casualty insurer; provided further that this subparagraph shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract;

(G) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual based solely upon the individual's having taken a human

immunodeficiency virus (HIV) test prior to applying for insurance; or

(H) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because the individual refuses to consent to the release of information which is confidential as provided in section 325-101; provided that nothing in this subparagraph shall prohibit an insurer from obtaining and using the results of a test satisfying the requirements of the commissioner, which was taken with the consent of an applicant for insurance; provided further that any applicant for insurance who is tested for HIV infection shall be afforded the opportunity to obtain the test results, within a reasonable time after being tested, and that the confidentiality of the test results shall be maintained as provided by section 325-101;

(8) Rebates. Except as otherwise expressly provided by law:

(A) Knowingly permitting or offering to make or making any contract of insurance, or agreement as to the contract other than as plainly expressed in the contract, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to the insurance, any rebate of premiums payable on the contract, or any special favor or

advantage in the dividends or other benefits, or any valuable consideration or inducement not specified in the contract; or

(B) Giving, selling, or purchasing, or offering to give, sell, or purchase as inducement to the insurance or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value not specified in the contract;

(9) Nothing in paragraph (7) or (8) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(A) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any bonus or abatement of premiums shall be fair and equitable to policyholders and in the best interests of the insurer and its policyholders;

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense;

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for the policy year; and

(D) In the case of any contract of insurance, the distribution of savings, earnings, or surplus equitably among a class of policyholders, all in accordance with this article;

(10) Refusing to provide or limiting coverage available to an individual because the individual may have a third-party claim for recovery of damages; provided that:

(A) Where damages are recovered by judgment or settlement of a third-party claim, reimbursement of past benefits paid shall be allowed pursuant to section 663-10;

(B) This paragraph shall not apply to entities licensed under chapter 386 or 431:10C; and

(C) For entities licensed under chapter 432 or 432D:

(i) It shall not be a violation of this section to refuse to provide or limit coverage available to an individual because the entity determines that the individual reasonably appears to have coverage available under chapter 386 or 431:10C; and

(ii) Payment of claims to an individual who may have a third-party claim for recovery of damages may be

conditioned upon the individual first signing and submitting to the entity documents to secure the lien and reimbursement rights of the entity and providing information reasonably related to the entity's investigation of its liability for coverage.

Any individual who knows or reasonably should know that the individual may have a third-party claim for recovery of damages and who fails to provide timely notice of the potential claim to the entity, shall be deemed to have waived the prohibition of this paragraph against refusal or limitation of coverage. Third-party claim for purposes of this paragraph means any tort claim for monetary recovery or damages that the individual has against any person, entity, or insurer, other than the entity licensed under chapter 432 or 432D;

(11) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(B) With respect to claims arising under its policies, failing to respond with reasonable promptness, in no case more than fifteen working days, to communications received from:

(i) The insurer's policyholder;

(ii) Any other persons, including the commissioner; or

(iii) The insurer of a person involved in an incident in which the insurer's policyholder is also involved.

The response shall be more than an acknowledgment that such person's communication has been received, and shall adequately address the concerns stated in the communication;

(C) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(D) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(F) Failing to offer payment within thirty calendar days of affirmation of liability, if the amount of the claim has been determined and is not in dispute;

(G) Failing to provide the insured, or when applicable the insured's beneficiary, with a reasonable written explanation for any delay, on every claim remaining unresolved for thirty calendar days from the date it was reported;

(H) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(I) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(J) Attempting to settle a claim for less than the amount to which a reasonable person would have believed the person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(K) Attempting to settle claims on the basis of an application which was altered without notice, knowledge, or consent of the insured;

(L) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(M) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(N) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the

subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(O) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage to influence settlements under other portions of the insurance policy coverage;

(P) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and

(Q) Indicating to the insured on any payment draft, check, or in any accompanying letter that the payment is final or is a release of any claim if additional benefits relating to the claim are probable under coverages afforded by the policy; unless the policy limit has been paid or there is a bona fide dispute over either the coverage or the amount payable under the policy;

(12) Failure to maintain complaint handling procedures. Failure of any insurer to maintain a complete record of all the complaints which it has received since the date of its last examination under section 431:2-302. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each

complaint. For purposes of this section, complaint means any written communication primarily expressing a grievance; and

(13) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, producer, or individual."

SECTION 3. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 4. This Act shall take effect upon its approval.

INTRODUCED BY: _____

TESTIMONY OF THE AMERICAN COUNCIL OF LIFE INSURERS
COMMENTING ON S.B. 2314 RELATING TO INSURANCE

February 13, 2008

Via E Mail: testimony@capitol.hawaii.gov
Senator David Y. Ige, Chair
Committee on Health
Senator Suzanne Chun Oakland, Chair
Committee on Human Services and Public Housing
State Senate
Hawaii State Capital, Conference Room 016
415 S. Beretania Street
Honolulu, HI 96813

Dear Chair Ige, Chair Chun Oakland and Committee Members:

Thank you for the opportunity to comment on Senate Bill 2314, relating to Insurance.

Our firm represents the American Council of Life Insurers ("ACLI"), a national trade association whose three hundred fifty-three (353) member companies account for 93% of the life insurance premiums and 94% of the annuity considerations in the United States among legal reserve life insurance companies. ACLI member company assets account for 93% of legal reserve company total assets. Two hundred sixty-one (261) ACLI member companies currently do business in the State of Hawaii.

ACLI is in the process of reviewing Senate Bill 2314 with its member companies and may submit additional testimony on this bill in the future.

The apparent purpose of Senate Bill 2314 is to exempt bundling by "small insurers" as an unfair and deceptive act or practice under Article 13 of Hawaii's Insurance Code.

ACLI notes that while Section 1 of the Bill suggests that its provisions are intended to apply to the bundling of different classes of health insurance (". . . such as health, dental and vision . . . ."), Section 2 exempts bundling by *all insurers* "with less than ten percent of the market share".

Again, thank you for the opportunity to comment on Senate Bill 2314.

CHAR HAMILTON
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