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March 17, 2008

LATE TESTIMONY

The Honorable Robert N. Herkes, Chair
The Honorable Angus L.K. McKelvey, Vice Chair

House Committee on Consumer Protection and Commerce

**Re: SB 3016 SD1 HD1 – Relating to Mutual Benefit Societies**

Dear Chair Herkes, Vice Chair McKelvey and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 3016 SD1 HD1 which would delete the requirement that health plans must maintain a fund equal to "one half of twenty times the maximum benefits paid in 30 days" and caps the deposit requirement at $20 million. HMSA supports this language.

However, this measure also contains language that requires the Insurance Commissioner to appoint an independent auditor to conduct a financial and operational audit of HMSA. HMSA opposes the additional language inserted into this measure which only applies to a mutual benefit society formed before 1950, namely HMSA. This language unfairly singles out HMSA to be audited while exempting every other health plan operating in the State. It should also be pointed out that the Insurance Commissioner already audits all Hawaii health plans.

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.

The purpose of a financial audit is to examine revenue and expenses to determine if an organization is using funds properly. Health care premiums are calculated based on the cost of physician and hospital services provided to members plus administrative overhead of the health plan. When health plans submit premium rates for review by the Insurance Commissioner under the rate regulation statute, the Division, to some degree, reviews the appropriateness of monies being expended on a global level.

Health care is one of the most regulated industries both locally and nationally. The State Insurance Division already has significant regulatory oversight over health plans. Chapter 432 of Hawaii Revised Statutes gives the Insurance Commissioner broad examination, enforcement and oversight authority over mutual benefit societies, including:

- HRS Chapter 431:2-301.8: The Commissioner may conduct examinations and investigations with immunity from liability whenever the Commissioner deems appropriate
- HRS Chapter 431:2-301.7: Mutual benefit societies must produce and give free access to the Commissioner to all accounts, records, documents and files

Additionally, HMSA is required to make rate filings with the Insurance Division which are scrutinized by the Insurance Commissioner and his staff. HMSA is also audited by the Insurance Division on a regular basis, and is required to submit financial statements to the Insurance Division each quarter. Importantly, the Insurance Division completed its 2003 through 2005 examination of HMSA in the third quarter of 2007 with no significant findings or accounting adjustments.

HMSA is also audited by multiple Federal government agencies, private employers and State government agencies as well. Some of these audits include:

State of Hawaii Insurance Division Examination

At least triennially DCCA conducts a comprehensive examination of HMSA. 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. With 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.

SAS 70 Audits

Statement on Auditing Standards (SAS) No. 70, Service Organizations, is a widely recognized auditing standard developed by the American Institute of Certified Public Accountants. An examination performed in accordance with a SAS 70 Audit is widely recognized, because it represents that an organization has been through an in-depth audit of their control objectives and control activities. HMSA began SAS 70 audits in 2005 and they are now conducted on an annual basis by an independent CPA firm.

Contract Compliance Reviews

HMSA has entered into contracts with both the State and Federal Governments to offer health care services to different populations. Some contracts require annual audits such as the Fed 87 Plan which requires an annual Federal Plan 87 Independent Public Accountant Audit and the State's QUEST Plan which requires a Healthcare Effectiveness Data and Information Set (HEDIS) audit and quality improvement monitoring review annually. (HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.) Other plans such as the Federal Employee Program, EUTF and 65C Plus (HMSA's Medicare Cost Plan) undergo reviews by government auditors on a regular basis.

Financial Statements Audits

Accuity LLP (an independent CPA - formerly PricewaterhouseCoopers) annually audits HMSA's consolidated Generally Accepted Accounting Principals (GAAP) financials and HMSA's stand-alone Statutory Financial Statements.

In addition, HMSA is subject to Employee Retirement Income Security Act (ERISA) reviews, monitoring by the Blue Cross Blue Shield Association, individual group health plan administrative audits (for certain unions in the state) and meeting the oversight of private accrediting agencies such as the National Committee for Quality Assurance (NCQA). NCQA is a private not-for-profit organization dedicated to improving health care quality.

We would also like to reiterate that the Insurance Commissioner already retains broad 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. The language in this measure is unnecessary in terms of the Insurance Commissioner's current regulatory scope.

In conclusion, we believe that this measure unfairly singles out HMSA and smacks of targeted and discriminatory legislation. We respectfully request the committee hold this unnecessary measure.

Thank you for the opportunity to testify in opposition to SB 3016 SD1 HD1.

Sincerely,

Jennifer Diesman
Assistant Vice President
Government Relations