# SB 2271

LINDA LINGLE
GOVERNOR

JAMES R. AIONA, JR.
LT. GOVERNOR

**STATE OF HAWAII**
**OFFICE OF THE DIRECTOR**
**DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS**

335 MERCHANT STREET, ROOM 310
P.O. Box 541
HONOLULU, HAWAII 96809
Phone Number: (808) 586-2850
Fax Number: (808) 586-2856
www.hawaii.gov/dcca

LAWRENCE M. REIFURTH
DIRECTOR

RONALD BOYER
DEPUTY DIRECTOR

TO THE SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION

TWENTY-FIFTH LEGISLATURE
Regular Session of 2010

Friday, February 19, 2010
9:15 a.m.

**TESTIMONY ON SENATE BILL NO. 2271, S.D. 1 – RELATING TO HEALTH INSURANCE PREMIUMS.**

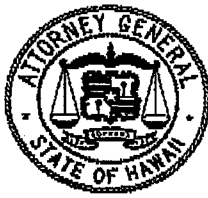
TO THE HONORABLE ROSALYN H. BAKER, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is J.P. Schmidt, State Insurance Commissioner, testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department opposes this bill.

This Department previously supported the original draft of this bill which limited the percentage of health insurance premiums that can be spent on administrative costs and required some additional reporting by insurers. However, we oppose the current version which creates a data clearinghouse which substantially increases the responsibilities of the Insurance Division to perform data collection far beyond its current staffing capabilities and its regulatory mission. These tasks will impose substantial additional costs on the government and on providers, as anyone familiar with database issues will understand. It is not clear to us that there will be any substantial practical benefit resulting from these increased costs, particularly given the lack of detail in the bill on what is to be collected and what purpose it serves. In addition, we cannot establish a data collection mechanism unless there is also an enforcement mechanism to impose penalties when entities do not report data.

If this bill is to move forward, an amendment to existing law should be inserted. Hawaii Revised Statutes section 432:1-305(c) allows a mutual benefit society that is providing health insurance to have administrative costs of up to 35 percent, which conflicts with the lower limits in the bill. The Committee should consider whether the addition of the data clearinghouse creates a subject title problem under the State Constitution by putting two topics under one title.

We thank this Committee for the opportunity to present testimony on this matter and ask that this bill be held.



# COMMENTS OF
# THE DEPARTMENT OF THE ATTORNEY GENERAL
# TWENTY-FIFTH LEGISLATURE, 2010

**ON THE FOLLOWING MEASURE:**
S.B. NO. 2271, S.D. 1, RELATING TO HEALTH INSURANCE PREMIUMS.

**BEFORE THE:**
SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION

**DATE:** Friday, February 19, 2010 **TIME:** 9:15 a.m.

**LOCATION:** State Capitol, Room 229

**TESTIFIER(S):** WRITTEN COMMENTS ONLY. For more information, call James F. Nagle, Deputy Attorney General, at 586-1197.

---

Chair Baker and Members of the Committee:

The Department of the Attorney General is raising a legal concern with this bill.

The purpose of the bill is to provide full transparency as to how health care insurance premiums are spent. The bill would require insurers to annually report how healthcare premiums are spent with emphasis on administrative and medical expenses and to designate a minimum medical expense threshold.

Section 2 of the bill proposes to add to the Hawaii Revised Statutes a new chapter that would establish a medical data clearinghouse with broad duties concerning varied aspects of healthcare with no discernible correlation to health insurance premiums. That section could be unlawful under article III, section 14 of the Hawaii Constitution, which provides that each law shall embrace but one subject, which shall be expressed in its title. The title of the bill relates to "health insurance premiums." This bill could be challenged on the grounds that this title is too narrow to encompass the broad scope of section 2 (creating a medical data clearinghouse). This problem could be avoided by deleting section 2 from the bill.

SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn Baker, Chair

Conference Room 229
Feb. 19, 2010 at 9:15 a.m.

**Opposing Section 2 of SB 2271 SD 1.**

The Healthcare Association of Hawaii represents its member organizations that span the entire spectrum of health care, including all acute care hospitals, as well as long term care facilities, home care agencies, and hospices. We support the intent of Section 2 of SB 2271 SD 1, which requires the Insurance Division to collect, analyze, and disseminate data from health care providers. However, we oppose these sections of the bill because of the ongoing efforts to accomplish the same goals.

Health care providers are aware that consumers want more information about the quality of health care. In recent years, much more information about quality has been made readily available to the public. For example, the Hospital Compare website created by the Centers for Medicare and Medicaid Services (CMS) contains detailed information about how individual hospitals throughout the nation, including Hawaii, compare with each other in treating numerous medical conditions. The Nursing Home Compare website contains information relevant to nursing homes.

Health care providers in Hawaii are doing more. The Healthcare Association recently created a committee that will address issues related to quality and patient safety issues faced by the broad range of providers represented by its members. The Patient Safety and Quality Committee is comprised of quality officers of the members of the Association. These individuals have formal training in, and access to, the most recent information issued by CMS and other national organizations regarding quality and patient safety. We believe that the expertise contained in and the recommendations that flow from this group should be a resource to the Legislature.

The stated purpose of the Committee is to formulate and implement strategies for organizations that belong to the Healthcare Association to collaborate in improving healthcare safety and quality for the citizens of Hawaii. As stated previously, all of Hawaii's hospitals are members of the Healthcare Association, as well as long term care organizations, home care agencies, and hospices.

The Patient Safety and Quality Committee reports directly to the Association's Board of Directors. We would be glad to arrange for the committee to report regularly to the Legislature on its progress.

For the foregoing reasons, the Healthcare Association opposes Section 2 of SB 2271 SD 1.

**HAWAII MEDICAL ASSOCIATION**
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net


**Friday, February 19, 2010, 9:15 a.m., Conference Room 229**

To: COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator David Y. Ige, Vice Chair

From: Hawaii Medical Association
Gary A. Okamoto, MD, Legislative Co-Chair
Linda Rasmussen, MD, Legislative Co-Chair
April Donahue, Executive Director
Lauren Zirbel, Government Affairs
Dick Botti, Government Affairs

Re: SB2271 RELATING TO HEALTH INSURANCE PREMIUMS

In Support if Amended

Chairs & Committee Members:

Hawaii Medical Association supports SB2271 Relating to Health Insurance Premiums, only with the deletion of the newly added Chapter entitled "Medical Data Clearinghouse" under Section 2. This chapter is overly broad and layers a new and burdensome administrative requirement on the Department of Commerce and Consumer Affairs and Hawaii providers. These costly requirements are unnecessary for the implementation of the original language of SB2271 under Section 3, the "Health Insurance Premium Transparency Act".

The DCCA and the insurance commissioner supported the original form of SB2271, retained in Section 3 of the current version. This section does not establish new burdensome requirements for insurers. Insurers already have the requested information available and currently categorize 90% of the data requested in financials that can be publicly downloaded at the National Association of Insurance Commissioners website.

Furthermore, it is difficult to assess "quality" based only on the information requested in Section 2; and those provisions may only encourage providers to take low-risk, young and healthy patients that result in better "outcomes" as assessed under this section. Other bills introduced this year, which HMA supports, more coherently address the topic of provider quality. There is no need to insert these issues into a bill that is "Relating to Health Insurance Premiums". It is also difficult to understand the logic behind placing healthcare provider quality measures inside the insurance division.

By deleting amendments made in the health committee that are burdensome and costly for DCCA, hospitals and providers and passing the original form of this bill, you will help encourage more streamlined health plans and ensure that the money people spend on health care is actually going to health care, as opposed to health plan administration.


OFFICERS
President - Robert Marvit, MD President-Elect – Morris Mitsunaga, MD Secretary - Thomas Kosasa, MD
Immediate Past President – Gary Okamoto, MD Treasurer – Stephen Kemble, MD Executive Director – April Donahue

Section 3 standardizes health plan reporting, fills in the gaps of current reporting, and makes for useful information and its availability to the public. As a result of that legislation, our community will have a more accurate picture of how much of their health plan premium goes to clinical providers for direct patient care. It is anticipated that such transparency will improve the accountability of health plans to purchasers – patients and employers – of health insurance.

Increasing premium transparency would clearly show the amount of money that health insurers spend on patient care versus administrative expenses and profit. A medical loss ratio further encourages insurers to spend more on direct medical benefits and a regulated amount on a detailed list of administrative costs. This could lead to more money from premiums being spent on medical care, and more value to the consumer and employer.

It is critical that employers and consumers have access to a clear understanding of how insurers allocate healthcare premiums. Currently, there is a lack of detailed, consistent, easily accessible information that shows exactly how premium dollars are spent specifically on healthcare services. Cost and payment data should be available and more accessible to patients and employers to enable them to make informed, objective decisions about their health care.

Full transparency of how health insurance premiums are spent will eventually reward insurers that minimize administrative waste. Mandated premium transparency is also essential in order to maximize the value of the healthcare dollar. This is an important step toward controlling spiraling healthcare costs, which are due, in part, to the dramatic rise in premium rates and administrative costs.

The rapidly rising cost of health care and healthcare administration is crippling businesses, forcing layoffs and reductions in pay. It is important that businesses and healthcare consumers have access to all information that will help them decide how to spend their health dollars, especially considering that businesses are mandated to spend money on health insurance and the money they spend is for the purpose of health care, not healthcare administration.

We strongly urge the committee to preserve SB2271 Section 3 and remove Section 2, which lacks merit.

Thank you for your consideration and the opportunity to testify.

AMERICAN COUNCIL OF LIFE INSURERS
TESTIMONY COMMENTING ON SB 2271, SD1,
RELATING TO HEALTH INSURANCE PREMIUMS

February 19, 2010

Via E Mail: cpntestimony@capitol.hawaii.gov
Hon. Senator Rosalyn H. Baker, Chair
Senate Committee on Commerce and Consumer Protection
Hawaii State Capital, Conference Room 229
415 S. Beretania Street
Honolulu, HI 96813

Dear Chair Baker and Committee Members:

Thank you for the opportunity to comment on SB 2271, SD 1, relating to health insurance premiums.

Our firm represents the American Council of Life Insurers ("ACLI"), a national trade association whose three hundred (300) legal reserve life insurer and fraternal benefit society member companies operating in the United States account for over 90% of the assets and premiums of the U.S. life insurance and annuity industry. ACLI member company assets account for 93% of the life insurance premiums and 98% of the annuity considerations paid in the State of Hawaii. Two hundred thirty-six (236) ACLI member companies currently do business in the State of Hawaii.

Section 1 of the bill (at page 2, lines 14-16) states that the purpose of SB 2271, SD 1, is to require insurers to report on how health care premiums are spent on administrative and medical expenses and " . . . to designate a minimum medical expense threshold."

§___-1 of Section 2 of the bill, page 5, at lines 1-5, defines "Insurer" to mean a "health plan" as defined in Article 10A (governing Accident and Health or Sickness Insurance Contracts), Chapter 432 (governing Mutual Benefit societies, including fraternal benefit societies) or Chapter 432D (governing health maintenance organizations). However, my review of Article 10A of chapter 431, chapter 432 and 432D reveals that neither Article 10A of Chapter 431 nor Chapters 432 and 432D have a definition of "health plan".

Chapter 10A, relating to accident and health and sickness insurance includes disability insurance issued by life insurers. §§431: 10A-102 and 431:-1-205, HRS.

Chapter 432 provides that "mutual benefit societies" are authorized to provide "death, sick, disability or other benefits". §432: 1-303 to 1-307, HRS. Fraternal Societies are included in the definition of "mutual benefit societies".

Chapter 432 authorizes fraternals to provide benefits described in §432: 2-401, HRS, including disability benefits, hospital, medical or nursing benefits, and such other benefits as authorized for life insurers, such as long term care insurance.

§___-2 of Section 2 of the bill, relating to Collection and Dissemination of Health Care and Related Information (at page 5, lines 17-22, and at page 6, line 1) states that the Insurance Division may request health care claims information from insurers for the purpose of analyzing and reporting that information as it relates to " . . . the cost, quality and effectiveness of health care."

Section 3 of the bill amends §431:14G, HRS, relating to health insurance rate regulation, to require "insurers" to ". . . expend a minimum of sixty-five per cent of the health insurance premiums earned in a calendar year . . .on medical expenses" (this is the "minimum medical expense threshold" as that term is used in the Bill. However, §431:14G-101, HRS, states that it applies only to health insurance offered by "managed care plans", which is defined in §431:14G-102, HRS, to mean ". . . a health plan as defined in §431:10A, or Chapter 431 or 432D . . . but shall not include disability insurers licensed under chapter 431."

Taking the language of SB 2271, SD 1, as a whole, it appears that the bill's intent and purpose is to apply to "health plans" issued by health care insurers such as HMSA and HMO's such as Kaiser; not life insurers or fraternal societies that provide disability insurance (DI) benefits or long term care (LTC) insurance.

Accordingly, ACLI suggests that the definition of health plan as set forth in §___-1 of Section 2 of the bill, at page 5, at lines 1-5, be amended to include one which will not include DI and LTC. If this Committee is inclined not to use this bill to define a "health plan" and stick with the existing language of the bill then ACLI suggests that §___-1 of Section 2 of the bill, at page 5, at lines 1-5, be amended as follows:

> "Insurer" means a health plan as defined in article 10A of chapter 431, or chapter 432 or 432D, regardless of form, offered or administered by a health care insurer, including but not limited to a mutual benefit society or health maintenance organization, or voluntary employee beneficiary associations, but expressly not including disability income insurance and long term care insurance."

Again, thank you for the opportunity to comment on SB 2271, SD 1.


CHAR HAMILTON
CAMPBELL & YOSHIDA
Attorneys At Law, A Law Corporation

By:
OREN T. CHIKAMOTO
otc@charhamilton.com


cc Joann Waiters, Esq.

94-450 Mokuola Street, Suite 106, Waipahu, HI 96767
808.675.7300 | www.ohanahealthplan.com

February 19, 2010

To: The Honorable Rosalyn H. Baker
Chair, House Committee on Commerce and Consumer Protection

From: 'Ohana Health Plan

Re: Senate Bill 2271, Senate Draft 1-Relating to Health Insurance

Hearing: Friday, February 19, 2010, 9:15 a.m.
Hawai'i State Capitol, Room 229

---

Since February 2009, 'Ohana Health Plan has provided services under the Hawai'i QUEST Expanded Access (QExA) program. 'Ohana is managed by a local team of experienced care professionals who embrace cultural diversity, advocate preventative care and facilitate communications between members and providers. Our philosophy is to place members and their families at the center of the health care continuum.

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.3 million Medicaid and Medicare members nationwide. 'Ohana is able to take the national experience in providing an Ohana care model that addresses local members' healthcare and health coordination needs.

We appreciate this opportunity to submit our comments in opposition to Senate Bill 2271, Senate Draft 1-Relating to Health Insurance.

While we support the intent of this measure to maximize the value of health insurance premiums and enable employers and consumers to gain a clear understanding of how health care premium dollars are allocated by health insurers in Hawaii, we must oppose the bill as written.

The use of Medical Loss Ratio (MLR) is problematic when considering health plan quality, plan efficiency/administrative expenses, and the health plan underwriting cycle. According to the American Academy of Actuaries, "Minimum loss ratios do no help contain health care spending growth, ensure that health care services are appropriate and accurately billed, or address directly the quality and efficiency of health care services."

Quality should be judged on the basis of comprehensive, reliable, and statistically relevant measures of clinical outcomes and processes. MLR only represents the number of dollars paid for medical care, not how well those dollars are spent.

Additionally, setting a minimum fixed MLR interferes with the insurance underwriting cycle and creates an unstable and unsustainable marketplace. Health insurance plans set their premiums based on their best estimates about where health care cost trends will be six to 12 months in the future. Some

years, the plans estimate accurately and are profitable, while in other years they face steep losses due to unplanned medical expenses.

Both for-profit and non-profit plans are required by state laws and insurance regulators to allocate a portion of their premiums to support their surplus reserves to minimize the down periods of the underwriting cycle. Health plans face major financial difficulties when they must simultaneously meet strict MLR requirements and rebuild their state-mandated surplus levels after periods of sustained losses.

In order to remain financially viable, plans must continue to target actuarially-sound surplus reserve levels that will sustain their financial performance during naturally occurring downturns in the underwriting cycle. Given the inherent need to meet variations in the underwriting cycle, having a low margin of error with a minimum MLR level will likely result in certain plans becoming insolvent.

We respectfully request that the committee hold this measure. Thank you for the opportunity to testify in opposition to Senate Bill 2271, Senate Draft 1, Relating to Health Insurance.

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 19, 2010

The Honorable Rosalyn Baker, Chair
The Honorable David Ige, Vice Chair
Senate Committee on Commerce and Consumer Protection

**Re: SB 2271 SD1 – Relating to Health Insurance Premiums**

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

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 2271 SD1 which would increase premium transparency, require an annual premium transparency report, and create a health information data clearinghouse. HMSA supports this measure.

We appreciate the language included in SB 2271 SD1 by the previous Committee to increase its scope. At HMSA, for every dollar paid in member dues, an average of 93 cents is paid to health care providers with only 7 cents going to pay for our administrative costs. The amended version is a more comprehensive approach to examining all of the cost within the health care system, not just those paid by health plans.

We believe that in order to initiate meaningful reform throughout the system, transparency must be a shared goal of all stakeholders in our health care system and that change is necessary to require transparency on the price and quality of health care. SB 2271 SD1 will give consumers the tools to know what their services will cost, their provider's experience in relation to their medical needs, and how Hawaii's doctors and hospitals perform against accepted quality measures. With the entire system participating in transparency efforts, consumers only stand to benefit.

Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

**Hawaii Medical Service Association** 818 Keeaumoku St.• P.O. Box 860 Honolulu, HI 96808-0860 (808) 948-5110 Branch offices located on Hawaii, Kauai and Maui Internet address www.HMSA.com

**From:** hedgesew@comcast.net
**Sent:** Tuesday, February 16, 2010 8:05 PM
**To:** CPN Testimony
**Subject:** SB 2271 Testimony

Senator Rosalyn H. Baker and Senator David Y. Ige,

Speaking as a private citizen and licensed physician in Hawaii, I wish to extend my support for SB2271 Relating to Health Insurance Premiums if amended to delete the newly added Part II, "Health Care System Transparency". While I am supportive of the concept of system-wide transparency, Part II is overly broad and creates a new and burdensome requirement for the Department of Commerce and Consumer Affairs, as well as, providers without creating a means to track healthcare costs and quality.

Part I of the legislation standardizes health insurer reporting, fills in the gaps in the current reporting system, and makes this information more available to the public. The increased transparency in Part I will help patients and employers make more informed objective decisions about their health insurance plans. By passing Part I and deleting Part II you will help encourage health plans to minimize administrative expenses and ensure that the majority of health care premium dollars goes to health care.

Thank you for the opportunity to testify.

Jerris Hedges, MD