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Testimony of
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Before:
House Committee on Finance
The Honorable Marcus R. Oshiro, Chair
The Honorable Marilyn B. Lee, Vice Chair

February 28, 2012
11:00 am
Conference Room 308

Re: HB 1896, HD1 Relating to Insurance

Chair, Vice Chair, and committee members, thank you for this opportunity to provide testimony on this bill regarding a temporary increase in the federal medical loss ratio requirement.

Kaiser Permanente opposes this bill.

Beginning January 1, 2011, the Patient Protection and Affordable Care Act of 2010 (PPACA) established the minimum medical loss ratio (MLR) for large group insurers at 85% and individual and small group subscribers at 80%. To streamline the process, PPACA required the National Association of Insurance Commissioners (NAIC) to establish uniform definitions and standardized methodologies for calculating MLR, subject to the U.S. Department of Health and Human Services certification. In setting the national MLR rating, the NAIC spent months in deliberations with state insurance regulators, the federal government and the insurance industry to ensure its appropriateness for the consumer and insurance markets. The NAIC has a long standing history of helping develop these types of rules through a transparent process so everyone is at the table.

First and foremost, we do not believe that the intent of the bill to reduce insurance premium costs would be met by raising the MLR. On the contrary, implementing this higher MLR could have a counterproductive impact of raising premiums by hindering the development of more affordable insurance options, such as high-deductible health plans (plans with higher deductibles end up being disadvantaged by the MLR because they cannot count claims incurred

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below the deductible as "medical claims" expenses), and reducing competition in both the individual and large group market (from plans that exit the market, driving up prices). All of these issues could lead to higher premiums for consumers.

There is also a misconception of how the MLR might impact premiums. The MLR is used as a lookback on the prior year's financial performance, and therefore, it has only retroactive applicability once the premium rates have already been established. The health plans establish its premium rates well in advance, and the MLR rating is set after the fact. Therefore, the MLR rating does not have a prospective impact on premiums.

Secondly, we believe that this bill is unnecessary because, in comparison to other states, employers in Hawaii already pay the lowest premium rates for both single employee and family plans. The most recent data available, from 2010, was used by the Kaiser Family Foundation to produce the tables provided with my testimony. In 2010, Hawaii had the second lowest premiums for employer based single plans, and third lowest premiums for employer based family plans, compared to the national average. Therefore, Hawaii's consumers have not needed the state's intervention to advocate for more favorable rates.

Moreover, it is important to recognize that a study conducted by America's Health Insurance Plans (AHIP) in April, 2010, shows that no other state set its MLR as high as 90%. The AHIP findings showed that the MLR ratings set by other states did not exceed the federal MLR rating of 85%:

California – 70% MLR

Michigan and New Hampshire – MLR similar to NAIC Guidelines

Nine states (CO, KY, ME, MD, MN, NJ, NY, OK, and WV) – 60 to 82% MLR

Four states (CA, FL, ND, and SD) – 65% to 75% MLR

Colorado – 85% MLR

New Mexico – 85% MLR

The entire AHIP report may be viewed at
http://www.naic.org/documents/committees_e_hrsi_comdoc_ahip_chart_mlr.pdf.

Lastly, we believe that since the ink has barely dried on the recent enactment of the national MLR standard, the state should give a fair opportunity to implement this national standard and assess its actual consequences before implementing a conflicting state requirement. To layer state requirements on top of the very complex federal requirements creates confusion. Given the great lengths the federal NAIC has already demonstrated to arrive at this national MLR rating, we believe it is more prudent at this early stage of PPACA to defer to this federal decision making authority. Since HB 1896 also proposes to make changes over a very short period of

time prior to 2014, this will create significant workload for health plans and insurers at a time when preparation for full implementation of ACA is of utmost importance.

Based on the foregoing, we urge the committee to hold this bill. Thank you for your consideration.