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TO THE HOUSE COMMITTEE ON HEALTH

TWENTY-SEVENTH LEGISLATURE
Regular Session of 2014

Friday, January 31, 2014
8:30 a.m.

TESTIMONY ON HOUSE BILL NO. 2270 – RELATING TO INSURANCE.

TO THE HONORABLE DELLA AU BELATTI, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is Gordon Ito, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). Thank you for hearing this bill. The Department strongly supports this Administration bill.

The purpose of this bill is to streamline and improve the operations of the Insurance Division and to ensure that the Insurance Division retains its accreditation with the National Association of Insurance Commissioners ("NAIC"), and complies with the federal Patient Protection and Affordable Care Act, Public Law 111-148 ("PPACA") by updating the Insurance Code, Hawaii Revised Statutes ("HRS") chapter 431 ("Insurance Code"), and chapter 432, HRS.

SECTIONS 1, 2, and 3 of the bill add new sections to Article 10A of chapter 431, HRS, chapter 432 ("Mutual Benefit Societies"), HRS, and chapter 432D ("Health Maintenance Organizations"), HRS, to prohibit rescission of coverage under a health benefit plan in most instances and provide written notice prior to rescission in conformance with the PPACA. The PPACA prohibits the rescission of coverage under

a health benefit plan after the individual is covered unless the individual (or representative) performs an act of fraud or makes an intentional misrepresentation of material fact. In addition, the PPACA requires that a health carrier provide at least 30 days advance written notice to a plan enrollee or primary subscriber before coverage may be rescinded under the allowed circumstances. These new sections would ensure conformance with the PPACA, and are modeled after the provisions of the NAIC Model Language for Prohibition on Rescissions of Coverage.

SECTION 4 of the bill amends HRS § 431:1-209 by clarifying that companies with general casualty insurance authority can only write accident and health or sickness insurance as incidental or supplemental coverage. Currently, any insurer with general casualty authority may write accident and health or sickness insurance as primary coverage without an accident and health certificate of authority. Under this scenario a general casualty insurer would be writing health and major medical products and not subject to the same regulations as health insurers and health plans. For instance, state mandated benefits and health rate regulation would not apply. Amending the statute would prevent any disparities in regulation from occurring and make Hawaii's definition similar to other states.

SECTION 5 of the bill amends HRS § 431:2-209(d) by clarifying retention requirements for tax records for surplus lines brokers and independently procured insureds is 3 years after the date filed or within 3 years of the due date for filing of the tax report, whichever is later. Proposed language will provide greater clarity as to the Insurance Division's record retention period for tax records of surplus line brokers and independently procured insureds, to be consistent with requirements for retention of tax records of foreign and alien insureds pursuant to HRS § 431:2-209(d), as well as the time frame in which the Commissioner may assess or levy taxes pursuant to HRS § 431:7-204.6.

SECTION 6 of the bill amends HRS § 431:2-402(c) to allow the Insurance Fraud Investigations Branch to review and take appropriate action on complaints of fraud relating to insurance under title 24, including HRS chapters 431, 432, and 432D, but excluding workers compensation insurance under HRS chapter 386. Amending this

section would clarify that the Insurance Division has jurisdiction to pursue fraud related issues involving activity that the Insurance Division currently regulates, including those where insurance agents defraud clients.

SECTION 7 of the bill amends HRS § 431:10A-102.5 by including long-term care insurance as part of limited benefit health insurance. Long-term care insurance was previously deleted from this section in 2011, impacting the Insurance Division's ability to regulate long-term care effectively. Currently, filing fees and consumer protection provisions that are not in Article 10H, that are applicable to accident, health and sickness insurance contracts, do not apply to long-term care insurance. Amending HRS § 431:10A-102.5 would remedy this problem.

SECTION 8 of the bill amends HRS § 431:11A-101 by amending the definition of "licensed insurer" or "insurer" to include risk retention captive insurance companies. As NAIC accreditation standards require the application of Article 11A of the Insurance Code, HRS chapter 431, to risk retention captive insurance groups, the definition of "licensed insurer" or "insurer" in HRS § 431:11A-101 needs to be amended to ensure that Article 11A applies to risk retention captive insurance companies.

SECTION 9 of the bill amends HRS § 431:14G-103(c) to require that 80% of investment income on reserves be applied to rate determination and filing of a managed care plan. In the past, investment income was part of the law; however, that law sunseted. Amending the section would provide that all investment income on the reserves net of investment manager fees would be applied to the rate determination unless the Commissioner determined that it would impair the minimum reserve requirement or solvency of the managed care plan. Restoring this provision could result in lower premiums for consumers.

SECTION 10 of the bill amends HRS § 431:19-101 to include "captive insurer" in the definition of "captive insurance company." The terms "captive insurance company" and "captive insurer" are used interchangeably throughout Article 19, HRS chapter 431. HRS § 431:19-101 defines "captive insurance company"; however, "captive insurer" is not defined in Article 19, HRS chapter 431. Amending the definition of "captive

insurance company" in HRS § 431:19-101 to also refer to "captive insurer" will provide greater clarity.

SECTION 11 of the bill amends HRS § 431M-2 ("Mental Health and Alcohol and Drug Abuse Treatment Insurance Benefits") to conform to the PPACA which mandates parity between medical and surgical benefits and benefits for alcohol dependency, drug dependence, and mental health treatment services. Hawaii has designated these treatment services an essential health benefit under the PPACA. Section 11 of the bill adds a new part (b) to section 431M-2 to mandate parity between medical and surgical benefits and alcohol dependency, drug dependence, and mental health treatment benefits.

SECTION 12 of the bill amends HRS § 432:1-406 by amending the definition of "uncovered expenditure" to include out-of-area services, referral services, and hospital services, as applicable to mutual benefit societies. Currently, the statute specifies what are not deemed "uncovered expenditures." Amending the statute would clarify what services are included in the definition of an "uncovered expenditure," and includes examples of "uncovered expenditures" set forth in the NAIC Health Maintenance Organization Model Act Drafting Note.

SECTION 13 of the bill amends HRS § 432:2-102 to extend to fraternal benefit societies the same immunity and confidentiality protections set forth in HRS §§ 431:3-303, 4313-304, and 431:3-305 that are currently provided to insurers. Amending the statute will ensure consistency in applying these protections to fraternal benefit societies.

SECTION 14 of the bill amends HRS § 432D-1 by amending the definition of "uncovered expenditure" to include out-of-area services, referral services, and hospital services, as applicable to health maintenance organizations. Currently, the statute specifies what are not deemed "uncovered expenditures." Amending the statute would clarify what services are included in the definition of an "uncovered expenditure," and includes examples of "uncovered expenditures" set forth in the NAIC Health Maintenance Organization Model Act Drafting Note.

SECTION 15 of the bill amends HRS § 432D-19 to extend to health maintenance organizations the same immunity and confidentiality protections set forth in HRS §§ 431:3-303, 4313-304, and 431:3-305 that are currently provided to insurers. Amending the statute will ensure consistency in applying these protections to health maintenance organizations.

SECTION 16 of the bill amends HRS § 432G-1 ("Dental Insurers") by amending the definition of "uncovered expenditure" to include out-of-area services, referral services, and hospital services, as applicable to dental insurers. Currently, the statute specifies what are not deemed "uncovered expenditures." Amending the statute would clarify what services are included in the definition of an "uncovered expenditure," and includes examples of "uncovered expenditures" set forth in the NAIC Health Maintenance Organization Model Act Drafting Note.

SECTION 17 of the bill repeals HRS §§ 431M-3, 431M-4, and 431M-5 to comply with PPACA's mandate of parity between medical and surgical benefits and benefits for alcohol dependency, drug dependence, and mental health treatment services. By prescribing and proscribing benefits, these sections do not allow for parity of benefits as mandated.

SECTION 18 of the bill repeals HRS §§ 431M-6 and 431M-7 to comply with the PPACA's mandate of parity between medical and surgical benefits and benefits for alcohol dependency, drug dependence, and mental health treatment services. By setting up a different set of rules solely applicable to the latter benefits, these sections do not allow for parity of benefits as mandated.

We thank this Committee for the opportunity to present testimony on this matter and ask for your favorable consideration.

TESTIMONY OF THE AMERICAN COUNCIL OF LIFE INSURERS
IN OPPOSITION TO HOUSE BILL 2270, RELATING TO INSURANCE

January 31, 2014

Via e mail

Honorable Representative Della Au Belatti, Chair
Committee on Health
State House of Representatives
Hawaii State Capitol, Conference Room 329
415 South Beretania Street
Honolulu, Hawaii 96813

Dear Chair Au Bellati and Committee Members:

Thank you for the opportunity to testify in opposition to HB 2270, relating to Insurance.

Our firm represents the American Council of Life Insurers ("ACLI"), a Washington, D.C., based trade association with approximately 300 member companies operating in the United States and abroad. ACLI advocates in federal, state, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers' products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing more than 90 percent of industry assets and premiums. Two hundred twenty-five (225) ACLI member companies currently do business in the State of Hawaii; and they represent 92% of the life insurance premiums and 90% of the annuity considerations in this State.

Section 7 of the bill would amend existing law to subject LTC to all of the provision of Article 10A of Hawaii's Insurance Code relating to Accident and Health or Sickness Insurance.

Currently, the laws governing LTC are contained in Article 10H of the Insurance Code.

Article 10H was added to the Code as the receptacle for the laws pertaining to LTC as a result of the passage by the Legislature of SB 131, relating to long term care (the "Long Term Care Insurance Bill"). This bill was enacted into law as Act 93 during the 1999 Legislative Session.

The stand-alone Article 10H, pertaining to long-term care insurance, was intentional.

Under the Federal tax laws, amounts received under a LTC contract are generally treated as amounts received for personal injuries and sickness and are, thus, non-taxable. In order for the LTC contract to receive this favorable tax treatment the contract must provide the consumer safeguards mandated by the Health Insurance Portability and Accountability Act ("HIPAA"). Under the tax laws, a long term care insurance contract is deemed to satisfy these requirements if it incorporates certain provisions contained in the NAIC Long-Term Care Insurance Model Act. Section 7702B, Internal Revenue Code. These provisions were incorporated into Hawaii's Long Term Care Insurance Bill

When the Bill was introduced in 1999, its provisions were originally added to Part V of Article 10A , relating to accident, health or sickness insurance contracts ("AHSIC"). Part V was the original receptacle for the then existing laws pertaining to long term care insurance. In recognition that later amendments to Article 10A relating to AHSIC products might inadvertently be applied to a LTC contract and thereby disqualify it as being a "qualified long-term care insurance contract" under the tax laws, the Senate Ways and Means Committee repealed Part V of Article 10A and enacted new Article 10H to serve as the separate receptacle for LTC contracts.

Section 7 of HB 2270 would subject LTC to all of the regulatory requirements applicable to AHSIC contained in Section 431:10A-104 through and including 114, 117, 118 and 601 through and including 604.

The justification stated for LTC's inclusion in Article 10A is that ". . . long-term care insurance may not be subject to the standard policy provisions in article 10A . . . . Justification Sheet, page 5 (Emphasis added).

The bill's sponsor does not, however, identify the "standard policy provisions in article 10A" which LTC contracts must be subject to.

It is unknown, therefore, whether the policy provisions the bill seeks LTC to include are different than or contradictory to those set forth in Article 10, which as stated above complies with the NAIC Long-Term Care Insurance Model Act and HIPAA. If they are, an LTC contract issued in Hawaii under the proposed bill may not be deemed a "qualified long-term care insurance contract" under the tax laws; and if it is not, the benefits payable would then be fully taxable as income under both the federal and Hawaii income tax laws.

Moreover, the need for LTC contracts to be governed by both Article 10A and Article 10H may be questioned.

Article 10H already sets forth stringent regulatory requirements separate and apart from Article 10A.

Moreover, subjecting LTC contracts to both Articles may likely be confusing and/or contradictory.

For the foregoing reasons, ACLI requests that this Committee remove Section 7 from the proposed Bill.

Again, thank you for the opportunity to testify in opposition to HB 2270, relating to Insurance.

LAW OFFICES OF
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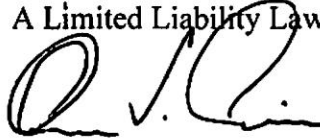
A Limited Liability Law Company



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Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

LATE

January 31, 2014

The Honorable Della Au Belatti, Chair
The Honorable Dee Morikawa, Vice Chair
House Committee on Health

Re: HB 2270 – Relating to Health Insurance

Dear Chair Belatti, Vice Chair Morikawa and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 2270, which seeks to amend several sections of the State Insurance Code. HMSA opposes Section 9 of this Bill, but supports the remainder of the Bill with comments

Section 9

Of particular concern to HMSA is the amendment found in Section 9 of the Bill, which requires the Insurance Division to consider 80 percent of all investment income in the rate determination of a health plan. We believe it is unnecessary and will detract from the real issue of rising health care costs.

HMSA understands and shares the concerns over increases in health care premiums, which are intrinsically tied to increases in health care costs. HMSA uses the trends in health care costs to determine rates which are sufficient to keep up with health care cost increases. Historically these costs have been increasing at a rate of eight percent annually. Our rates are a reflection of these health care trends. Cost increases directly impact all health care providers and facilities in the state, which in turn affect employers who purchase health care coverage for their employees. Health plans are in the difficult role of balancing the needs of these two constituencies.

HMSA is a non-profit mutual benefit society with 75 years of experience setting adequate premium rates to cover the cost of health care for our members. Our responsibility is to set rates that cover the cost of our members' health benefits. But, we must ensure we have the financial capacity to pay for our members' needs - when they need them. Consequently, HMSA's goal is to have at least a three-month's financial reserve available to protect members and the community against unexpected increase in health care costs due to events such as a flu outbreak. That goal has been difficult to achieve given the ever escalating cost of health care. Between 2008 and 2012, the years for which audited information is available, our reserve dropped from 3.05 months to 2.19 months. That represents a drop from $732 to $645 per member, which is less than the cost of an average emergency room visit and a fraction of the cost of an average hospital day. (Attachment A)

Despite the rising cost of health care, HMSA has been able to exceed national standards of ensuring premium revenue go to paying for members' health care needs and not for overhead costs. The Affordable Care Act requires 80 percent of individual member and small business plan dues and 85 percent of large employer dues go to paying for member benefits. If those standards are not met, the plan must issue rebates to its members. HMSA far exceeded those standards. On average, we spend only seven to eight percent for administrative costs – one of the lowest in the nation – with more than 92 percent going to pay for medical services for our members and their families.

While we take pride in achieving those numbers, the struggle to contain the rising cost of health care remains a priority of HMSA. We have been working with our providers and others in the health care community to move away from a fee-for-

service model of health care service to a patient-centered medical home model (PCMH) which compensates providers based on quality of care delivered rather than patient volume. To date, approximately 57 percent (635) of our primary care providers are in our PCMH program, serving 71 percent (490,000) of our members.

HMSA recognizes that Hawaii's families and businesses feel the impact of rising health care costs in their premiums. But, additional regulation of rates is not the answer. We are hopeful that dramatic systemic changes in the health care system, through programs such as PCMH and pay-for-quality, will help to contain health care costs and reap benefits for the community.

Should this measure move forward, we would like to work with the Committee to address several other concerns in other sections of the Bill.

- **Sections 1, 2, and 3** - These amendments specify conditions under which a plan may not rescind coverage of a member. We believe non-payment of a premium should be included as a "trigger" for rescission.
- **Section 11** - In adopting the new federal mental health requirements, this amendment prohibits requirements which are more restrictive "than the predominant financial requirements and treatments limitations" in the federal law. This raises the issue of defining "predominant."
- **Section 17** – This amendment repeals most of the State mental health/substance abuse mandate, in lieu of the federal mental health parity law. This substantial change raises questions regarding parity between mental health/substance abuse benefits and medical benefits. Since we are still reviewing the impact of this amendment, with the Committee's indulgence, we ask that we be allowed to provide additional comments in the future.

Thank you for the opportunity to testify on HB 2270, and we hope you will consider the concerns we have raised regarding this legislation.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

Attachment

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

Attachment A

Hawaii Medical Service Association
Statutory - End of Year Reporting

	2008	2009	2010	2011	2012
Reserves ($ in millions)	$406.7	$356.1	$389.6	$406.2	$452.2
Reserves per Member	$731.97	$629.29	$689.17	$702.16	$645.02
Months in Reserve	3.05	2.45	2.61	2.39	2.19
Reserves per Annual Costs	25.4%	20.4%	21.8%	19.9%	18.3%
RBC	701%	609%	659%	547%	502%