NEIL ABERCROMBIE
GOVERNOR

SHAN S. TSUTSUI
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: 586-2850
Fax Number: 586-2856
www.hawaii.gov/dcca

KEALI`I S. LOPEZ
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON CONSUMER PROTECTION & COMMERCE

TWENTY-SEVENTH LEGISLATURE
Regular Session of 2014

Wednesday, March 19, 2014
2:10 p.m.

TESTIMONY ON SENATE BILL NO. 2820, S.D. 2, H.D. 1 – RELATING TO INSURANCE.

TO THE HONORABLE ANGUS L.K. McKELVEY, 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 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 H.D.1 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carrier provide at least 30 days advance written notice to a plan enrollee or primary subscriber before coverage may be rescinded under the allowed circumstances.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. The language would make clear that non-payment as a rescission trigger must be in compliance with Federal regulation.

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 and clarifying that Article 10H would override any conflicting provisions in Article 10A. 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 § 431:19-101 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 10 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 11 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 12 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 13 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 14 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 15 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.

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

HAWAII SUBSTANCE ABUSE COALITION

SB2820 SD2 HD1 Insurance: Update Title 24 Including Parity

- COMMITTEE ON CONSUMER PROTECTION & COMMERCE: Representative McKelvey, Chair; Representative Kawakami, Vice Chair
- Wednesday, March 19, 2014 at 2:10 p.m.
- Conference Room 325

HAWAII SUBSTANCE ABUSE COALITION Strongly Recommends Changes to SB2820 SD2 HD1 to meet Federal Parity laws.

Good Morning Chair McKelvey; Vice Chair Kawakami; And Distinguished Committee Members. My name is Alan Johnson, Chair of the Hawaii Substance Abuse Coalition, an organization of more than twenty treatment and prevention agencies across the State.

Recommended Changes:

While most of 431M-4 doesn't violate parity because it establishes quality control, the first part of 431M-4, as well as 431M-3 and 431M-5 do violate parity.

1) **That the provisions for licensure, accreditation, and certification be repealed for 431M-3 and 431M-4: (a) and 431M-5**
2) **Section 11: 431M-2: (a). That "alcohol dependence" and "drug dependence" be changed to current medical language – "alcohol use disorder" and "substance use disorder" as it is correctly used in (b).**

Here are the recommended changes for bill language.

1) **That the provisions for licensure, accreditation, and certification be repealed for 431M-3 and 431M-4: (a) and 431M-5**

SECTION 17. Sections 431M-3, and 431M-4 (a) and 431M-5, Hawaii Revised Statutes, are repealed.

["~~**§431M-3 Peer review.** (a) Covered benefits for alcohol dependence, drug dependence, or mental illness insurance policies, hospital or medical service plan contracts, and health maintenance organization health plan contracts shall be limited to those services certified by the insurance or~~

~~health care plan carrier's physician, psychologist, licensed clinical social worker, marriage and family therapist, licensed mental health counselor, or advanced practice registered nurse as medically or psychologically necessary at the least restrictive appropriate level of care.~~

~~(b) All alcohol dependence, drug dependence, or mental illness treatment or services as set forth in this chapter shall be subject to peer review procedures as a condition of payment or reimbursement, to assure that reimbursement is limited to appropriate utilization under criteria incorporated into insurance policies or health or service plan contracts either directly or by reference. Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review.~~

§431M-4 Mental illness, alcohol and drug dependence benefits. ~~(a) The covered benefit under this chapter shall not be less than thirty days of in-hospital services per year. Each day of in-hospital services may be~~

~~exchanged for two days of nonhospital residential services, two days of partial hospitalization services, or two days of day treatment services. Visits to a physician, psychologist, licensed clinical social worker, marriage and family therapist, licensed mental health counselor, or advanced practice registered nurse shall not be less than thirty visits per year to hospital or nonhospital facilities or to mental health outpatient facilities for day treatment or partial hospitalization services. Each day of in-hospital services may also be exchanged for two outpatient visits under this chapter; provided that the patient's condition is such that the outpatient services would reasonably preclude hospitalization. The total covered benefit for outpatient services in subsections (b) and (c) shall not be less than twenty-four visits per year; provided that coverage of twelve of the twenty-four outpatient visits shall apply only to the services under subsection (c). The other covered benefits under this chapter shall apply to any of the services in subsection (b) or (c). In the case of alcohol and drug dependence benefits, the insurance policy may limit the number of treatment episodes but may not limit the number to less than two treatment episodes per lifetime. Nothing in this~~

~~section shall be construed to limit serious mental illness benefits.~~

~~§431M-5 Nondiscrimination in deductibles, copayment plans, and other limitations on payment.~~ ~~(a) Deductible or copayment plans may be applied to benefits paid to or on behalf of patients during the course of treatment as described in section 431M-4, but in any case the proportion of deductibles or copayments shall be not greater than those applied to comparable physical illnesses generally requiring a comparable level of care in each policy.~~

~~(b) Notwithstanding subsection (a), health maintenance organizations may establish reasonable provisions for enrollee cost-sharing so long as the amount the enrollee is required to pay does not exceed the amount of copayment and deductible customarily required by insurance policies which are subject to the provisions of this chapter for this type and level of service. Nothing in this chapter prevents health maintenance organizations from establishing durational limits which are actuarially equivalent to the benefits required by this chapter. Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers associated with the health maintenance organization.~~

~~(c) A health insurance plan shall not impose rates, terms, or conditions including service limits and financial requirements, on serious mental illness benefits, if similar rates, terms, or conditions are not applied to services for other medical or surgical conditions. This chapter shall not apply to individual contracts; provided further that this chapter shall not apply to QUEST medical plans under the department of human services until July 1, 2002.~~"]

2) Section 11: 431M-2: (a) That "alcohol dependence" and "drug dependence" be changed to current medical language – "alcohol use disorder" and "substance use disorder" as it is correctly used in (b).

SECTION 11. Section 431M-2, Hawaii Revised Statutes, is amended to read as follows:

"**§431M-2 Policy coverage.** (a) All individual and group accident and health or sickness insurance policies issued in this State, individual or group hospital or medical service plan contracts, and nonprofit mutual benefit society, fraternal benefit society, and health maintenance organization health plan contracts shall include within their hospital and medical coverage the benefits of alcohol use disorder ~~dependence~~, substance use disorder ~~drug dependence~~, and mental [~~illness~~] health treatment services [~~provided in section 431M-4~~], except that this section shall not apply to insurance policies

that are issued solely for single diseases, or otherwise limited, specialized coverage.

HSAC appreciates the opportunity to provide testimony and are available for questions.

TESTIMONY OF THE AMERICAN COUNCIL OF LIFE INSURERS
COMMENTING ON SENATE BILL 2820, HD 1, RELATING TO INSURANCE

March 19, 2014

Via e mail

Honorable Representative Angus L. K. McKelvey, Chair
Committee on Consumer Protection and Commerce
State House of Representatives
Hawaii State Capitol, Conference Room 325
415 South Beretania Street
Honolulu, Hawaii 96813

Dear Chair McKelvey and Committee Members:

Thank you for the opportunity to comment on SB 2820, HD 1, 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 stated provisions of Article 10A of Hawaii's Insurance Code relating to Accident and Health or Sickness Insurance Contracts.

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

In 1999 Article 10H was added to Hawaii's Insurance 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 income tax laws, amounts received under a LTC insurance form are generally treated as amounts received for personal injuries and sickness and are, thus, non-taxable. In order for benefits paid for LTC insurance to receive this favorable federal tax treatment the LTC insurance form must provide the consumer safeguards mandated by the Health Insurance Portability and Accountability Act ("HIPAA"). Under the tax laws, a long term care insurance form is deemed to satisfy these requirements if it incorporates certain consumer protection

provisions contained in the NAIC Long-Term Care Insurance Model Act. These consumer protection 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 benefit 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 insurance.

As originally introduced Section 7 of SB 2820 would have once again subjected LTC to all of the regulatory requirements applicable to AHSIC contained in HRS 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).

While some of the Article 10A provisions which the bill seeks to subject LTC insurance forms are benign others may be in conflict with the provisions governing a LTC insurance form in Article 10H; or result in confusion in determining the rights, duties and obligations of the insurer and the insured.

Indeed, HRS Section 431:10A-112 expressly states that "[w]hen any provision in a policy governed by this part is in conflict with any specific provision of this part, the rights, duties and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of this part." Thus, any LTC form with provisions in conflict with Article 10A would be in violation of Article 10A, even though they complied with the provisions of Article 10H.

In recognition that some of the requirements in Article10A should apply to LTC forms, and to assure that the proposed regulatory provisions in the current Bill and any future legislative changes to Article 10A do not conflict with the provisions governing LTC in Article 10H, the bill was amended by the prior Committee by adding to the end of Section 7 of the bill, on page 11, beginning at line 2, the following:

> . . . [P]rovided that if any of the requirements set forth in the foregoing sections as applied to long term care insurance are in conflict with the provisions of article 10H, the provisions of article 10H shall govern and control."

ACLI believes that the revised language in SB 2820, HD 1, insures that the specified sections in Article 10A which are to apply to LTC insurance will not conflict with the provisions of Article 10H. Further, SB 2820, HD 1, will prevent confusion in determining the rights, duties and obligations of the insurer and the insured. The revised language should, therefore, be retained in the bill.

Again, thank you for the opportunity to comment on SB 2820, HD 1, relating to Insurance.

LAW OFFICES OF
OREN T. CHIKAMOTO
A Limited Liability Law Company

Oren T. Chikamoto
1001 Bishop Street, Suite 1750
Honolulu, Hawaii 96813
Telephone: (808) 531-1500
Facsimile: (808) 531-1600
E mail: otc@chikamotolaw.com

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Testimony of
John M. Kirimitsu
Legal and Government Relations Consultant

Before:
House Committee on Consumer Protection & Commerce
The Honorable Angus L.K. McKelvey, Chair
The Honorable Derek S.L. Kawakami, Vice Chair

March 19, 2014
2:10 pm
Conference Room 325

Re: SB 2820, SD1, HD1, Relating to Insurance

Chair, Vice Chair, and committee members, thank you for this opportunity to provide testimony on this bill regarding the updating of Title 24, relating to insurance.

Kaiser Permanente supports this bill, as amended.

Kaiser Permanente supports this bill as amended, with the deletion of Section 9 requiring 80 percent of all investment income on the reserves net of investment manager fees to be applied to rate determination and filing of a managed care plan**.** Kaiser Permanente does not believe that Section 9 is necessary to fulfill its intended purpose of lowering premiums for consumers, because, in comparison to other states, employers in Hawaii already pay the lowest premium rates for both single employee and family plans. The Kaiser Family Foundation reported that 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. Likewise, in 2013, Hawaii's Insurance Division reported that the individual health plan rates approved for the Hawaii Health Connector were amongst the lowest in cost in the nation. The Insurance Commission's article (September 20, 2013), in its entirety, can be found at: http://cca.hawaii.gov/ins/news-release-hawaiis-average-rates-for-insurance-exchange-among-lowest/ Therefore, Hawaii's consumers have not needed the state's intervention to advocate for more favorable rates.

711 Kapiolani Blvd
Honolulu, Hawaii 96813
Telephone: 808-432-5224
Facsimile: 808-432-5906
Mobile: 808-282-6642
E-mail: John.M.Kirimitsu@kp.org

Furthermore, adding further complications to rate determinations for consumer protection purposes does not make sense where Hawaii consumers are already afforded a high level of protection under the newly enacted federal Patient Protection and Affordable Care Act of 2010 (ACA) and existing state regulations. The ACA already affords an unprecedented level of scrutiny, consumer protection, and transparency to health insurance rate increases. It ensures that every state's proposed increases of ten percent or more will be evaluated by experts to assess whether they are based on reasonable cost assumptions and solid evidence. This highly regulated review and scrutiny process is expected to prevent unjustified premium hikes by insurance companies and provide consumers with greater value for their premium dollar by enacting more stringent rate review regulations, including: (1) significantly greater disclosure regarding rate development / rating assumptions, including standardized templates that have to be completed for all lines of business subject to the new rules; (2) actuarial certification of rates, along with an actuarial memorandum detailing the rate development, will be required for these lines starting in 2014; (3) a threshold for rate increases, above which these are subject to greater scrutiny (including more data requirements) and may be deemed "unreasonable"; and (4) a standardized risk pools and rating factors to facilitate greater transparency and direct comparison of rates between carriers.

Additionally, Hawaii has its own rate review process through the Department of Insurance (DOI) which regulates rate increases. The DOI's rate review process was subject to a rigorous CMS evaluation and was deemed to have satisfied "effective rate review" standards that were established under ACA. Therefore, given that there is already an effective rate review process in place under the ACA, and Hawaii's own DOI, the layering of an additional state requirement, i.e. 80% of investment income for rate determinations, is clearly unnecessary, burdensome, and creates confusion.

Finally, the medical loss ratio rating (MLR) also regulates insurance rate increases under the ACA by requiring insurance companies to meet new stricter MLR ratios (large group insurers at 85% and individual and small group subscribers at 80%) to ensure that the percentage of premium dollars is primarily spent on health care and improving the quality of care, versus administrative and overhead costs, i.e., high salaries or bonuses. In short, the MLR means that more of the consumer's premium payments will go towards actual health care, and to improving the quality of that health care. The MLR rating standard is consistent with the goals of the ACA in making insurance more affordable and more transparent and holding insurance companies accountable, while increasing the quality of health care.

Thank you for this opportunity to testify on this bill.

LATE

kawakami3-Benigno

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 18, 2014 8:59 PM
To: CPCtestimony
Cc: paulakomarajr@yahoo.com
Subject: *Submitted testimony for SB2820 on Mar 19, 2014 14:10PM*

SB2820
Submitted on: 3/18/2014
Testimony for CPC on Mar 19, 2014 14:10PM in Conference Room 325

Submitted By	Organization	Testifier Position	Present at Hearing
Paul A. komara, Jr.	Individual	Support	No

Comments:

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