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 SENATE COMMITTEE ON WAYS AND MEANS

TWENTY-SEVENTH LEGISLATURE
Regular Session of 2014

Thursday, February 20, 2014
9:05 a.m.

WRITTEN TESTIMONY ONLY

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

TO THE HONORABLE DAVID Y. IGE, 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 Department does recommend two clarifying amendments to the Senate Draft 1 in the manner set forth below.

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 S.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carrier provide at least 30 days advance written notice to a plan enrollee or primary subscriber before coverage may be rescinded under the allowed circumstances.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. While non-payment as a rescission trigger is not problematic, the Insurance Division would request proposed language that the rescission trigger be in compliance with Federal regulation. We would request the following amendment to proposed S.D.1 subsection (3) on page 1, line 18 to page 2, lines 1 to 15, page 4, lines 2 to 16, and page 6, lines 5 to 19:

(3) The individual fails to timely pay required premiums or contributions towards the cost of [~~coverage; provided that if a qualified health plan elects to rescind coverage based on nonpayment of premiums or contributions:~~

~~(A) The qualified health plan shall establish a standard policy for termination of coverage of enrollees or subscribers due to nonpayment; and~~

~~(B) The standard policy shall include a grace period for recipients of advance payments of the premium tax credit; provided further that:~~

~~(i) The grace period shall be applied uniformly to enrollees or subscribers in similar circumstances; and~~

~~(ii) The advance premium tax credit may involve a three month grace period.~~]
coverage provided that the rescission is in compliance with Federal regulation.

The above 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. The Division would request the following technical change for clarification on page 7, line 18 of the S.D.1: "as defined in section [~~431:1-205, and in addition is insurance:~~] 431:1-205". Deletion of the comma after the statutory reference on page 7, line 18 would make clear incidental with or supplemental to liability insurance refers only to accident and health or sickness insurance.

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.

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

HAWAII SUBSTANCE ABUSE COALITION

SB2820 SD1 Insurance: Update Title 24 Including Parity

- COMMITTEE ON WAYS AND MEANS: Senator David Ige, Chair; Senator Michelle Kidani, Vice Chair
- Thursday, Feb. 20, 2014; 9:05 a.m.
- Conference Room 211

HAWAII SUBSTANCE ABUSE COALITION Strongly Recommends Changes to SB2820 SD1 to meet Federal Parity laws.

Good Morning Chair Ige, Vice Chair Kidani, and Distinguished Committee Members. My name is Alan Johnson. I am the current chair of the Hawaii Substance Abuse Coalition (HSAC), a statewide group of more than twenty non-profit treatment and prevention agencies.

Recommended Changes:

HSAC appreciates Section 11 language that accurately mimics federal parity laws to include substance use disorders and the use of the word, "predominant."

In the original bill, most of 431M-4 was amended to NOT be repealed because most of 431M-4 doesn't violate parity, it establishes quality control; however, 431M-3 and the first part of 431M-4 and 431M-5 does violate parity.

1) **That the provisions for licensure, accreditation, and certification be repealed for 431M-3 and 431M-4: (a) and 431M-5**
2) **That Certified Substance Abuse Counselor (CSAC) be added to the list of qualified providers who can perform an assessment for alcohol or substance use disorders in 431M-4: (b) (2). DHS obtained a waiver for Quest plans so that CSAC can do assessments starting this year so recommend the same for commercial insurance.**
3) **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.~~"]

4) That Certified Substance Abuse Counselor (CSAC) be added to the list of qualified providers who can perform an assessment for alcohol or substance use disorders in 431M-4: (b) (2). DHS obtained a waiver for Quest plans so that CSAC can do assessments starting this year so recommend the same for commercial insurance.

§431M-4 Mental illness, alcohol and drug dependence benefits. (b) Alcohol and drug dependence benefits shall be as follows: (2) Alcohol or drug dependence treatment through in-hospital, nonhospital residential, or day treatment substance abuse services as a covered benefit under this chapter

shall be provided in a hospital or nonhospital facility. Before a person qualifies to receive benefits under this subsection, a qualified physician, psychologist, licensed clinical social worker, marriage and family therapist, licensed mental health counselor, certified substance abuse counselor, or advanced practice registered nurse shall determine that the person suffers from alcohol or drug dependence, or both; provided that the substance abuse services covered under this paragraph shall include those services that are required for licensure and accreditation and shall be included as part of the covered in-hospital services as specified in subsection (a). Excluded from alcohol or drug dependence treatment under this subsection are detoxification services and educational programs to which drinking or drugged drivers are referred by the judicial system and services performed by mutual self-help groups;

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 disorders ~~dependence~~, substance use disorders ~~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.

HMSA Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 20, 2014

The Honorable David Y. Ige, Chair
The Honorable Michelle N. Kidani, Vice Chair
Senate Committee on Ways and Means

Re: SB 2820, SD1 – Relating to Health Insurance

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

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 2820, SD1, which seeks to amend several sections of the State Insurance Code. HMSA opposes Section 9 of this Bill, as it may impact HMSA's financial stability.

Section 9

Of particular concern to HMSA is the amendment found in Section 9 of the Bill, which requires health plans to apply 80 percent of all investment income in premium rate development. We believe this potentially will impact our financial ratings.

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. The State Insurance Commissioner already has broad regulatory oversight on health plans' rate filings.

HMSA's responsibility is to set rates that cover the cost of our members' health benefits. But, we also must ensure we have the financial capacity to pay for our members' needs in the event of a "rainy day." Consequently, HMSA's goal is to have at least a three-month's financial reserve available to protect members and the community against unexpected increases in health care costs due to events such as a flu outbreak. The attached chart shows reserves dropping between 2008 and 2012, 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 continues to exceed national standards of ensuring premium revenue go to paying for members' health care needs. The ACA requires 80 percent of individual member and small business plan dues and 85 percent of large employer dues go to paying for member benefits. HMSA far exceeds 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.

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, as it may unintentionally place HMSA's membership at financial risk.

We ask that Section 9 be deleted in its entirety from the Bill.

Thank you for the opportunity to testify on SB 2820, SD1, and we hope you will consider the concerns we have raised regarding this legislation.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

Attachment

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%**

KAISER PERMANENTE®

Government Relations

Testimony of
John M. Kirimitsu
Legal and Government Relations Consultant

Before:
Senate Committee on Ways and Means
The Honorable David Ige, Chair
The Honorable Michelle Kidani, Vice Chair

February 20, 2014
9:05 am
Conference Room 211

Re: SB 2820, SD1 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 opposes Section 9 of this bill.

First, we do not believe that Section 9, requiring that 80% of investment income on reserves be applied to rate determination and filing of a managed care plan, is necessary for its intended purpose of lowering premiums for consumers. Currently, the Patient Protection and Affordable Care Act of 2010 (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

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

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.

Secondly, 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.

Finally, we believe that this additional rate determination requirement under Section 9 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 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 Division added that, compared to the results of a study published by the Kaiser Family Foundation, Hawaii's rates before tax credits and reimbursement estimates for a 40-year-old resident at $217 would be the third lowest:

1. Portland, Ore. $201
2. Albuquerque, NM $212
3. **Honolulu $217**

19. Burlington, VT $413

Furthermore, in a comparison of analysis done by Avalere Health, the Insurance Division's actuaries found that Hawaii has **the lowest average monthly plan rate in each of the four metal levels before tax credits and reimbursement estimates**:

Avalere Health Study Comparison (40-year-old Nonsmoker)				
State	**Bronze**	**Silver**	**Gold**	**Platinum**
Hawaii	**$154**	**$216**	**$262**	**$306**

Maryland	$211	$260	No plan	No plan
Washington	$236	$299	$299	No plan
Virginia	$254	$299	$353	$484
New York (high)	$364	$444	$521	$608

Avalere Health Study Comparison (Silver Level Nonsmoker)			
State	**21-Year-Old**	**40-Year-Old**	**60-Year-Old**
Hawaii	**$169**	**$216**	**$458**
Maryland	$203	$260	$552
Washington DC	$206	$276	$593
Rhode Island	$227	$290	$615
Connecticut (high)	$280	$358	$764

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/

Thank you for this opportunity to testify on this bill.