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GORDON I. ITO
INSURANCE COMMISSIONER

TO THE HOUSE COMMITTEES ON ECONOMIC REVITALIZATION & BUSINESS AND HEALTH

TWENTY-SIXTH LEGISLATURE
Regular Session of 2012

Tuesday, January 31, 2012
11:00 a.m.

TESTIMONY ON HOUSE BILL NO. 1896 – RELATING TO INSURANCE.

TO THE HONORABLE ANGUS L.K. MCKELVEY AND RYAN I. YAMANE, CHAIRS, AND MEMBERS OF THE COMMITTEES:

My name is Gordon Ito, State Insurance Commissioner, testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department supports the intent of this bill which in part creates a medical loss ratio, but offers comments and notes concerns.

First, there are other managed care plans in the Hawaii market besides those offered by a mutual benefit society and a health maintenance organization. This bill would create an unlevel playing field in the health insurance market which would be bad for the market and consumers.

The federal Patient Protection and Affordable Care Act ("PPACA") in 2011 imposed a medical loss ratio ("MLR") of 80 to 85 percent, with refunds to be provided in 2012 by insurers that did not meet the MLR. The bill would impose a higher MLR of 90 percent and would require refunds by insurers that do not meet the 90 percent starting in 2013. The concern is in implementing a higher MLR than mandated by PPACA, there is no provision which allows for a waiver if solvency issues arise. There also is an argument to be made that the MLR established at the federal level should not be

amended at the State level so that we may attempt to foster a national market in health insurance.

We also object to the deletion on page 3 at lines 10 to 11 of the words "and shall be reasonable in relation to the costs of the benefits" because this language is needed to clarify that rate regulation is not designed to push premiums below insurers' costs. If we try to push premiums below insurers' costs it will tend to foster both insurer insolvencies and a scarcity of health insurance in the market.

We thank the Committee for the opportunity to present testimony on this matter.

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

January 31, 2012

The Honorable Angus L.K. McKelvey, Chair
The Honorable Ryan I. Yamane, Chair
House Committees on Economic Revitalization & Business and Health

Re: HB 1896 – Relating to Insurance

Dear Chair McKelvey, Chair Yamane and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 1896 which establishes a medical loss ratio of 90 percent for a managed care plan offered in the group or individual coverage market. HMSA supports the intent of this legislation. However, we do have concerns with the Bill as drafted and have recommended amendments to address those concerns. Attached for your consideration is a proposed HD1 version of HB 1896.

Our primary concern with this Bill is with its limited application only to a managed care plan offered by a mutual benefit society or nonprofit health maintenance organization. Equity demands that this provision should apply to all entities offering managed care plans in the individual and group coverage markets. An additional amendment is made to clarify that the medical loss ratio would be calculated separately for the large group, small group, and individual markets.

We understand and appreciate the concern about the rising cost of health care. We at HMSA have made great efforts to control costs from administrative reviews to implementing a new pay for performance model for provider reimbursement. Given that, we appreciate the focus of this legislation and support its intent. We ask for your favorable consideration of the suggested amendments in the attached proposed HB 1896, HD1.

Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

Attachment

HOUSE OF REPRESENTATIVES
TWENTY-SIXTY LEGISLATURE, 2012
STATE OF HAWAII

H.B. NO. 1896 PROP HD1

A BILL FOR AN ACT

RELATING TO INSURANCE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that rising health insurance premium costs are detrimental to businesses in the State during this period of slow economic recovery. Restricting health insurance premium cost increases would assist businesses in expanding or, at least, maintaining operation.

The purpose of this Act is to promote economic revitalization through the temporary reform of the health insurance medical loss ratio and rate regulation provisions of the State's insurance code.

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to article 14G to be appropriately designated and to read as follows:

"§431:14G-A Medical loss ratio for January 1, 2013, to December 31, 2014. (a) For the purpose of this section:

"Health care quality improvement cost" means expenditure for activities to improve health care quality that is subject to section 2718(a)(2) of the Public Health Service Act.

"Medical cost" means expenditure on reimbursement for clinical services that is subject to section 2718(a)(1) of the Public Health Service Act.

"Medical loss ratio" means the ratio of premium revenue expended on medical and health care quality improvement cost to total premium revenue (after certain exclusions such as taxes), as calculated in accordance with section 2718(b)(1)(A) of the Public Health Service Act.

"Public Health Service Act" means the federal Public Health Service Act, as amended and any regulations or guidance issued under that Act.

(b) As authorized under section 2718(b)(1)(A)(i) and (ii) of the Public Health Service Act, the State shall establish a higher medical loss ratio for [~~certain~~] health insurance plans.

(c) This section shall apply to ~~a managed care plan~~policies ~~that~~ with plan years beginning ~~is~~[~~:~~

~~(1) Offered by a mutual benefit society or health maintenance organization not taxed under article 7, part II; and~~

~~(2) Effective~~]~~effective during a plan year, any part of which may fall within the period from~~ January 1, 2013~~, to~~ through December 31, 2014.

The medical loss ratio for all policies issued in the ~~managed care plan subject to this section, whether offering~~ group or individual ~~coverage,~~market during the medical loss ratio reporting year shall be ninety per cent. A managed care plan's medical loss ratio must be calculated separately for the large group market, small group market and individual market.

~~[(d) For a managed care plan not subject to subsection (c), the medical loss ratio shall be that established under section 2718(b)(1)(A) of the Public Health Service Act."~~].

SECTION 3. Section 431:14G-103, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Rates shall not be excessive, inadequate, or unfairly discriminatory [and shall be reasonable in relation to the costs of the benefits]; provided[.] that, when reviewing proposed rates, the filing for which is pending on January 1, 2013, or submitted to the commissioner between January 1, 2013, and December 31, 2014, the commissioner shall consider the medical loss ratio applicable to the filer under section 431:14G-A."

SECTION 4. Section 431:14G-105, Hawaii Revised Statutes, is amended by amending subsection (e) to read as follows:

"(e) Rates shall be established in accordance with this article and actuarial principles, based on reasonable assumptions, and supported by adequate supporting and supplementary rating information. After reviewing a managed care plan's filing, the commissioner may require that the managed care plan's rates be based upon the managed care plan's own loss and expense information."

SECTION 5. After the repeal of this Act on December 31, 2014, the rates of a health insurer, to which the criteria of section 431:14G-103(a), Hawaii Revised Statutes, were applied, shall continue in effect until revised in accordance with chapter 431, article 14G, Hawaii Revised Statutes.

SECTION 6. The insurance commissioner shall submit a report to the governor and legislature no later than twenty days prior to the convening of the 2014 regular session. The report shall include information on the impacts of this Act and a recommendation on whether any provision of this Act should be made permanent, with or without modification.

SECTION 7. There is appropriated out of the compliance resolution fund of the State of Hawaii the sum of $, or so much thereof as may be necessary for fiscal year 2012-2013 for the implementation of this Act by the insurance commissioner.

The sum appropriated shall be expended by the department of commerce and consumer affairs for the purposes of this Act.

SECTION 8. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 9. This Act shall take effect on January 1, 2013, and shall be repealed on December 31, 2014; provided that:

(1) Section 7 shall take effect on July 1, 2012;

(2) Section 5 shall not be repealed on December 31, 2014; and

(3) Sections 431:14G-103(a) and 431:14G-105(e), Hawaii Revised Statutes, shall be reenacted in the form in which they read on December 31, 2012.

INTRODUCED BY: _____

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Government Relations

Testimony of
John M. Kirimitsu
Legal and Government Relations Consultant

Before:
House Committee on Economic Revitalization & Business
The Honorable Angus L.K. McKelvey, Chair
The Honorable Isaac W. Choy, Vice Chair
and
House Committee on Health
The Honorable Ryan I. Yamane, Chair
The Honorable Dee Morikawa, Vice Chair

January 31, 2012
11:00 am
Conference Room 329

Re: HB 1896 Relating to Insurance

Chairs, Vice Chairs 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.

Average Single Premium per Enrolled Employee For Employer-Based Health Insurance, 2010

Rank (1=low | 51=high)	Employee Contribution	Employer Contribution	Total
United States	$1,021	$3,919	$4,940
1. Arkansas	$885	$3,293	$4,178
2. Hawaii	$436	$3,858	$4,294
3. Iowa	$930	$3,510	$4,440
4. Utah	$1,086	$3,415	$4,501
5. Idaho	$832	$3,670	$4,502
6. Alabama	$1,092	$3,479	$4,571
7. Missouri	$965	$3,638	$4,603
8. Colorado	$883	$3,747	$4,630
9. Oklahoma	$1,043	$3,615	$4,658
10. Ohio	$952	$3,717	$4,669
11. Kentucky	$886	$3,797	$4,683
12. Mississippi	$1,030	$3,664	$4,694
13. Kansas	$925	$3,785	$4,710
14. Michigan	$951	$3,762	$4,713
15. North Dakota	$891	$3,828	$4,719
16. South Dakota	$948	$3,787	$4,735
17. Tennessee	$970	$3,783	$4,753
18. Nevada	$767	$4,004	$4,771
19. Georgia	$965	$3,821	$4,786
20. New Mexico	$1,179	$3,608	$4,787
21. Maryland	$1,080	$3,719	$4,799
22. California	$1,048	$3,763	$4,811
23. Montana	$1,043	$3,779	$4,822
24. South Carolina	$1,006	$3,829	$4,835
25. West Virginia	$933	$4,002	$4,935
26. Texas	$1,036	$3,915	$4,951
27. Arizona	$891	$4,067	$4,958
28. Pennsylvania	$954	$4,005	$4,959
29. Virginia	$1,114	$3,846	$4,960
30. Minnesota	$1,023	$3,941	$4,964
31. North Carolina	$926	$4,054	$4,980
32. Washington	$746	$4,235	$4,981
33. Nebraska	$1,084	$3,908	$4,992
34. Indiana	$1,127	$3,888	$5,015
35. Illinois	$1,120	$3,947	$5,067
36. Florida	$1,073	$4,047	$5,120
37. New Jersey	$1,098	$4,055	$5,153
38. New Hampshire	$1,086	$4,076	$5,162
39. Vermont	$1,099	$4,071	$5,170
40. Oregon	$848	$4,338	$5,186
41. Wyoming	$802	$4,402	$5,204
42. New York	$1,086	$4,134	$5,220

Rank (1=low | 51=high)	Employee Contribution	Employer Contribution	Total
United States	$1,021	$3,919	$4,940
43. Connecticut	$1,234	$4,068	$5,302
44. Louisiana	$1,241	$4,069	$5,310
45. Wisconsin	$1,174	$4,210	$5,384
46. Massachusetts	$1,200	$4,213	$5,413
47. Maine	$1,207	$4,347	$5,554
48. Rhode Island	$1,147	$4,410	$5,557
49. District of Columbia	$1,080	$4,564	$5,644
50. Delaware	$1,180	$4,473	$5,653
51. Alaska	$832	$5,253	$6,085

(show/hide notes)

Notes: Figures may not sum exactly due to rounding.

Sources: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2010 Medical Expenditure Panel Survey (MEPS) -Insurance Component. Tables II.C.1, II.C.2, II.C.3 available at: Medical Expenditure Panel survey (MEPS), accessed July 13, 2011.

Definitions and descriptions of the methods used for this survey can be found in the Technical Appendix.

Definitions: **MEPS:** The Medical Expenditure Panel Survey IC is an annual survey of establishments that collects information about employer-sponsored health insurance offerings in the United States.

Average Family Premium per Enrolled Employee For Employer-Based Health Insurance, 2010

Rank (1=low | 51=high)	Employee Contribution	Employer Contribution	Total
United States	$3,721	$10,150	$13,871
1. Idaho	$3,701	$7,678	$11,379
2. Arkansas	$3,967	$7,849	$11,816
3. Hawaii	$3,155	$8,907	$12,062
4. Montana	$2,992	$9,320	$12,312
5. Alabama	$3,758	$8,651	$12,409
6. Nevada	$3,379	$9,117	$12,496
7. South Dakota	$3,793	$8,749	$12,542
8. North Dakota	$3,492	$9,052	$12,544
9. Utah	$3,545	$9,073	$12,618
10. Tennessee	$3,461	$9,268	$12,729
11. Missouri	$3,280	$9,474	$12,754
12. Oklahoma	$3,715	$9,185	$12,900
13. Ohio	$3,286	$9,797	$13,083
14. Georgia	$3,702	$9,412	$13,114
15. Michigan	$2,879	$10,269	$13,148
16. Nebraska	$3,703	$9,518	$13,221
17. Louisiana	$3,962	$9,268	$13,230
18. South Carolina	$3,641	$9,593	$13,234
19. Iowa	$3,781	$9,459	$13,240
20. Kentucky	$3,060	$10,292	$13,352
21. Colorado	$3,618	$9,775	$13,393
22. Kansas	$3,257	$10,203	$13,460
23. Pennsylvania	$3,013	$10,537	$13,550
24. Vermont	$2,997	$10,591	$13,588
25. North Carolina	$3,492	$10,151	$13,643
26. Mississippi	$4,105	$9,635	$13,740
27. Oregon	$3,888	$9,868	$13,756
28. California	$3,845	$9,974	$13,819
29. Arizona	$4,133	$9,738	$13,871
30. Indiana	$3,462	$10,422	$13,884
31. Wyoming	$3,178	$10,721	$13,899
32. Minnesota	$3,233	$10,670	$13,903
33. Virginia	$4,477	$9,430	$13,907
34. Maryland	$3,728	$10,224	$13,952
35. New Jersey	$4,010	$10,048	$14,058
36. New Mexico	$3,952	$10,131	$14,083
37. Washington	$3,685	$10,503	$14,188
38. West Virginia	$3,139	$11,055	$14,194
39. Alaska	$3,079	$11,153	$14,232
40. Texas	$4,500	$10,026	$14,526
41. Wisconsin	$3,359	$11,183	$14,542
42. Maine	$4,465	$10,111	$14,576

Rank (1=low | 51=high)	Employee Contribution	Employer Contribution	Total
United States	$3,721	$10,150	$13,871
43. Massachusetts	$3,444	$11,162	$14,606
44. Delaware	$4,267	$10,404	$14,671
45. Illinois	$3,928	$10,775	$14,703
46. New York	$3,630	$11,100	$14,730
47. Rhode Island	$3,308	$11,504	$14,812
48. Connecticut	$3,824	$11,064	$14,888
49. Florida	$4,685	$10,347	$15,032
50. New Hampshire	$3,849	$11,355	$15,204
51. District of Columbia	$3,822	$11,384	$15,206

(show/hide notes)

Notes: Figures may not sum exactly due to rounding.

Sources: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2010 Medical Expenditure Panel Survey (MEPS) -Insurance Component. Tables II.D.1, II.D.2, II.D.3 available at: Medical Expenditure Panel survey (MEPS), accessed July 13, 2011.

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