HOUSE OF REPRESENTATIVES
TWENTY-FOURTH LEGISLATURE, 2007
STATE OF HAWAII

H.B. NO. 1698

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

SECTION 1. (a) The legislature finds that access to affordable health insurance is one of the State's most pressing concerns. According to the Hawaii Uninsured Project, about 120,000 Hawaii residents, or ten per cent of the State's population, is without health insurance.

The legislature also finds that significant portions of Hawaii's medically uninsured are individuals who are part-time or are self-employed workers. There are about 2,300 part-time workers and about 11,950 self-employed workers who are uninsured. Those classes of workers are part of the gap group that is not covered under Hawaii's Prepaid Health Care Act. The PrePaid Health Care Act requires employers to provide health insurance to full-time employees, and does not require coverage for self-employed workers.

The Hawaii Uninsured Project also reports that approximately 13,300 part-time workers and 46,500 self-employed workers currently have health insurance. Many of these workers

are subscribers of individual plans provided by Hawaii's insurers. Because individual plans and group health plans with one or only a few employees are not part of larger employee pools, health insurance premiums for individual plans are generally more expensive than large group health plans. Larger employee group health plans are able to spread the health risk more effectively amongst their employees in order to better manage the cost and administration of coverage. The cost of health insurance, particularly for self-employed workers, single employee corporations or partnerships, and small business group health plans with few employees are of significant concern to Hawaii's business and general community.

The legislature further finds that the higher premiums of individual plans result from impediments to insurers more cost-effectively combining various health-related benefits under the same policy. The Hawaii insurance commissioner has chosen to interpret Hawaii law as prohibiting combining different types of health and sickness insurance benefits within the same policy, as a violation of anti-tying statutes described in section 431:13-103(a)(4)(B), Hawaii Revised Statutes. The insurance commissioner does not believe he has discretion under existing law to allow combining of benefits or other measures to

encourage cost-effective policies for self-employed workers and small businesses. The legislature is concerned by the effect of this interpretation, as the public would benefit from having access to health plans that would cover the broadest possible benefits, including but not limited to medical, hospital, surgical, vision, dental, drug, accidental death and dismemberment, naturopathy, and chiropractic, as well as other forms of permissible benefits, to include those pursuant to section 431:10D-208, Hawaii Revised Statutes, which already permits mutual benefit societies to provide group life insurance benefits to their members under certain limited circumstances.

Moreover, numerous other Hawaii laws and regulations already allow or require combining numerous different health-related benefits within an insurance policy:

(1) Employer group plans may include medical care, drugs, and restorative appliances, under section 393-3(6)(A), Hawaii Revised Statutes;

(2) Employer group plans must include both medical coverage and certain drug coverage, under sections 432:1-604.5, 431:10A-116.6(b), and 431M-4(b)(1), Hawaii Revised Statutes;

(3) Prepaid Health Care Act plans may include medical, hospital, dental, optometric, naturopathy, chiropractic, medical equipment and supplies, under section 431:10C-103.5(a), Hawaii Revised Statutes, and Hawaii Administrative Rule 12-12-18;

(4) Hawaii employer-union plans may include medical, prescribed drugs, vision and dental services, under section 87A-1, Hawaii Revised Statutes; and

(5) Group disability insurance may include medical, hospital, dental and other health care services, under section 431:10A-202, Hawaii Revised Statutes.

Without allowing combined benefits in one policy, the cost of coverage for each and every health benefit option results in higher premiums. These problems can become particularly severe for single or few employee and sole proprietor plans, due to adverse selection problems. The cost of administration in providing many different health insurance policies in order to achieve broad health coverage creates an unnecessary increase in costs and premiums for health insurance. Providing a combined health benefits package, where insurers have the ability to aggregate costs and risks for a larger pool of combined benefits, may result in lower health insurance premiums and

broader health coverage for Hawaii's consumers. Accordingly, this measure provides the insurance division in the department of commerce and consumer affairs with the authority and duty to allow broader combinations of insurance benefits in Hawaii.

(b) The legislature finds that many of Hawaii's small insurers provide coverage to individuals, self-employed workers, and small business group plans with one or few employees. The public interest is served by promoting vigorous competition within the health insurance market. Expanded coverage options and lower premiums resulting from combining insurance benefits under a single policy provided by small insurers can not only benefit consumers but increase competition in Hawaii.

The legislature also finds that comparable federal antitrust laws regarding anti-tying only apply as against companies which occupy thirty per cent or more of the market. In the seminal decision of *Jefferson Parish Hospital v. Hyde*, 466 U.S. 2 (1984), the United States Supreme Court in applying the Sherman Act concluded that Jefferson Hospital had no market power with an assumed market share of thirty per cent and therefore its tying arrangement was not unlawful. *See Hovenkamp*, Federal Antitrust Policy (3d edition, 2005) 402; *Hack v. President and Fellows of Yale College*, 237 F.3d 81 (2d Cir.

2000); *Marts v. Xerox*, 77 F.3d 1109, 1113 n.6 (8th Cir. 1996) (18% too small); *Shafi v. St. Francis Hosp.*, 937 F.2d 603 (4th Cir. 1991) (11% insufficient); *Grappone, Inc. v. Subarus of New England, Inc.*, 858 F.2d 792, 797 (1st Cir. 1988) (recognizing a general rule of at least 30%). Hence, federal antitrust law reflects the overarching policy and recognition that small insurers are essential in providing consumers with coverage options, and that they operate under more significant market constraints than larger insurers.

(c) In accordance with federal antitrust law, the purpose of this Act is to:

(1) Enable small insurers that occupy less than thirty per cent of the health insurance market to provide the broadest healthcare coverage at the lowest possible rates by permitting different types of insurance to be combined into a single unified policy; and

(2) Encourage broader coverage of sole proprietors and other employer groups with only one employee.

SECTION 2. Section 431:2-201.5, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) All group health issuers shall offer all small group health plans to all small employers whose employees live, work,

or reside in the group health issuer's service areas; provided that the commissioner may exempt a group health issuer if the commissioner determines that the group health issuer does not have the capacity to deliver services adequately to enrollees of additional groups given its obligation to existing employer groups[~~.~~]; and provided further that the commissioner shall exempt from this section group health plans offered to small employer groups that employ only one employee, if the group health insurer offers the groups at least one small group health plan that meets the requirements of chapter 393."

SECTION 3. Section 431:13-103, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

(A) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

(B) Misrepresents the dividends or share of the surplus to be received on any insurance policy;

(C) Makes any false or misleading statement as to the dividends or share of surplus previously paid on any insurance policy;

(D) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(E) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(F) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

(G) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy;

(H) Misrepresents any insurance policy as being shares of stock;

(I) Publishes or advertises the assets of any insurer without publishing or advertising with equal conspicuousness the liabilities of the insurer, both as shown by its last annual statement; or

(J) Publishes or advertises the capital of any insurer without stating specifically the amount of paid-in and subscribed capital;

(2) False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading;

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding,

abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance;

(4) Boycott, coercion, and intimidation.

(A) Entering into any agreement to commit, or by any action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; or

(B) Entering into any agreement on the condition, agreement, or understanding that a policy will not be issued or renewed unless the prospective insured contracts for another class or an additional policy of the same class of insurance with the same insurer; provided that this subsection shall not apply to any accident and sickness insurer with less than a thirty per cent market share;

(5) False financial statements.

(A) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of a material fact as to the financial condition of an insurer; or

(B) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, knowingly omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer;

(6) Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance;

(7) Unfair discrimination.

(A) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract;

(B) Making or permitting any unfair discrimination in favor of particular individuals or persons, or between insureds or subjects of insurance having substantially like insuring, risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the

rate or amount of premium charge therefor, or in the benefits payable or in any other rights or privilege accruing thereunder;

(C) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(D) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk, or the personal

property contained therein, because of the age of the residential property, unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(E) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex or marital status of the individual; however, nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(F) Terminating or modifying coverage, or refusing to issue or renew any property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired; provided that this subparagraph shall not apply to accident and health or sickness insurance sold by a casualty

insurer; provided further that this subparagraph shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract;

(G) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual based solely upon the individual's having taken a human immunodeficiency virus (HIV) test prior to applying for insurance; or

(H) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because the individual refuses to consent to the release of information which is confidential as provided in section 325-101; provided that nothing in this subparagraph shall prohibit an insurer from obtaining and using the results of a test satisfying the requirements of the commissioner, which was taken with the consent of an applicant for insurance; provided further that any applicant for insurance

who is tested for HIV infection shall be afforded the opportunity to obtain the test results, within a reasonable time after being tested, and that the confidentiality of the test results shall be maintained as provided by section 325-101;

(8) Rebates. Except as otherwise expressly provided by law:

(A) Knowingly permitting or offering to make or making any contract of insurance, or agreement as to the contract other than as plainly expressed in the contract, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to the insurance, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits, or any valuable consideration or inducement not specified in the contract; or

(B) Giving, selling, or purchasing, or offering to give, sell, or purchase as inducement to the insurance or in connection therewith, any stocks, bonds, or other securities of any insurance

company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value not specified in the contract;

(9) Nothing in paragraph (7) or (8) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(A) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any bonus or abatement of premiums shall be fair and equitable to policyholders and in the best interests of the insurer and its policyholders;

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense;

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for the policy year; and

(D) In the case of any contract of insurance, the distribution of savings, earnings, or surplus equitably among a class of policyholders, all in accordance with this article;

(10) Refusing to provide or limiting coverage available to an individual because the individual may have a third-party claim for recovery of damages; provided that:

(A) Where damages are recovered by judgment or settlement of a third-party claim, reimbursement of past benefits paid shall be allowed pursuant to section 663-10;

(B) This paragraph shall not apply to entities licensed under chapter 386 or 431:10C; and

(C) For entities licensed under chapter 432 or 432D:

(i) It shall not be a violation of this section to refuse to provide or limit coverage

available to an individual because the entity determines that the individual reasonably appears to have coverage available under chapter 386 or 431:10C; and

(ii) Payment of claims to an individual who may have a third-party claim for recovery of damages may be conditioned upon the individual first signing and submitting to the entity documents to secure the lien and reimbursement rights of the entity and providing information reasonably related to the entity's investigation of its liability for coverage.

Any individual who knows or reasonably should know that the individual may have a third-party claim for recovery of damages and who fails to provide timely notice of the potential claim to the entity, shall be deemed to have waived the prohibition of this paragraph against refusal or limitation of coverage. "Third-party claim" for purposes of this paragraph means any tort claim for monetary recovery or damages that the

individual has against any person, entity, or insurer, other than the entity licensed under chapter 432 or 432D;

(11) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(B) With respect to claims arising under its policies, failing to respond with reasonable promptness, in no case more than fifteen working days, to communications received from:

(i) The insurer's policyholder;

(ii) Any other persons, including the commissioner; or

(iii) The insurer of a person involved in an incident in which the insurer's policyholder is also involved.

The response shall be more than an acknowledgment that such person's communication has been received, and shall adequately address the concerns stated in the communication;

(C) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(D) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(F) Failing to offer payment within thirty calendar days of affirmation of liability, if the amount of the claim has been determined and is not in dispute;

(G) Failing to provide the insured, or when applicable the insured's beneficiary, with a reasonable written explanation for any delay, on every claim remaining unresolved for thirty calendar days from the date it was reported;

(H) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(I) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(J) Attempting to settle a claim for less than the amount to which a reasonable person would have believed the person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(K) Attempting to settle claims on the basis of an application which was altered without notice, knowledge, or consent of the insured;

(L) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(M) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or

compromises less than the amount awarded in arbitration;

(N) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(O) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage to influence settlements under other portions of the insurance policy coverage;

(P) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and

(Q) Indicating to the insured on any payment draft, check, or in any accompanying letter that the payment is "final" or is "a release" of any claim

if additional benefits relating to the claim are probable under coverages afforded by the policy; unless the policy limit has been paid or there is a bona fide dispute over either the coverage or the amount payable under the policy;

(12) Failure to maintain complaint handling procedures. Failure of any insurer to maintain a complete record of all the complaints which it has received since the date of its last examination under section 431:2-302. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this section, "complaint" means any written communication primarily expressing a grievance; and

(13) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, producer, or individual."

SECTION 4. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 5. This Act shall take effect upon its approval.

INTRODUCED BY: Josh Green

JAN 24 2007

Report Title:
Health Insurance; Small Insurers

Description:
Enables small insurers that occupy less than thirty per cent of the health insurance market to provide the broadest healthcare coverage at the lowest possible rates by permitting different types of insurance to be combined into a single unified policy; encourages broader coverage of sole proprietors and other employer groups with only one employee.