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TO THE HOUSE COMMITTEE ON CONSUMER PROTECTION & COMMERCE

TWENTY-SEVENTH LEGISLATURE
Regular Session of 2013

Wednesday, February 6, 2013
2:30 p.m.

**TESTIMONY ON HOUSE BILL NO. 1458 – RELATING TO INSURANCE RATES.**

TO THE HONORABLE ANGUS 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"). If the intended purpose of the proposed bill is to allow the public to provide input and to know when rates are being increased, the Department strongly opposes the intent of this bill, for numerous problems that would result from requiring a "public" rate adjustment recommendation board to oversee the Department and/or the Commissioner. Those reasons include, but are not limited to:

**Increased Transparency and Scrutiny of Rate Activity**. A new layer of increased public transparency and scrutiny to health insurance rate increases is being implemented, in accordance with the Patient Protection and Affordable Care Act of 2010 ("PPACA"). The federal law requires that rates will be monitored by both the State and Federal government[1] showing consumers when and why premiums are going up and

[1] Section 1003 of the PPACA adds a new section 2794 of the Public Health Service Act, which directs the Secretary of the Department of Health and Human Services ("HHS"), in conjunction with the States, to establish a process for the annual review of "unreasonable increases in premiums for health insurance coverage." On September 6, 2011, a Final Rule for more Rate Increase Disclosure and Review, amended a May 23, 2011, final rule, both promulgated by

"unreasonable increases" are to be posted on various federal and insurer websites. Health plans must provide a justification for any increase using templates developed by the Department of Health and Human Services ("HHS").[2] The PPACA ensures that large proposed increases will be evaluated by trained rate reviewers to make sure they are based on reasonable cost assumptions and solid evidence. Insurers must provide easy to understand information to their customers about their reasons for significant rate increases of 10% or more (state specific thresholds may change in subsequent years), as well as publicly justify and post this on their website, and the Centers for Medicare & Medicaid Services ("CMS") will also post this information for a period of three (3) years.[3]

**Confidentiality/Conflicts of Interest**. The composition of the proposed "public" voluntary board would include a "representative of an insurance carrier" and a few members of the business community, as well as others who do not possess experience in regulatory "rate review". This creates inherent problems with respect to confidentiality of competitor insurers and conflicts of interest relating to proprietary information that insurers currently file only with trained rate review regulator staff.

**Intensification of the "Rate Review" Process**. Further, the State's existing "rate review" analysis cannot be performed reasonably by persons who are not trained and experienced in the rating rules[4] who need to review, analyze and communicate with insurers about filings through evaluating completion of templates and specialized industry tools including System for Electronic Rate and Form Filing ("SERFF"). Long-awaited updates on templates from SERFF are expected in late March 2013, and insurers and regulators are working to anticipate the compressed rate filings before October 1, 2013 for insurers who want to have their plans on the Exchange on January 1, 2014. "Rate review" requirements are currently being performed without any

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the Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services ("CMS"), HHS, effective on November 1, 2011. Additional guidances regarding State-specific threshold proposals further outline the processes to be followed by States wishing to propose state-specific thresholds.

[2] 45 CFR 154.215.

[3] For any unreasonable increases, the Insurer and CMS will make available information to the public and post all final justifications for at least three (3) years. 45 CFR 154.230(c)(3) and (d).

[4] Section 2701 of the PHSA specifies the only rating factors that can be used.

procedural or substantive controversy having been brought to the attention of the Commissioner.

**Delays in Processing.** The addition of a new component of specialized “rate review” by a voluntary board is not practicable and it would seriously adversely impact the time-sensitive rate review period, resulting in delays for insurers, employers and the State during a period when the workload demands on the Department are already at a high level due to the time-sensitive implementation of PPACA.

**Proposed Goal Seems Duplicative of Exchange Functions**. Lastly, the presumed role(s) and make-up of the proposed voluntary board would be better suited for some of the functions and efforts of the Hawaii Health Connector to gather and display information to consumers to purchase health plans on a public online Exchange, beginning January 1, 2014. Exchange’s consideration of rate increases is limited to determining whether a Qualified Health Plan should be offered on the Exchange.[5]

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

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[5] 45 CFR §156.210; PPACA; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18, 310, 18, 416 (March 27, 2012).