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GOVERNOR

JAMES R. AIONA, JR.
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LAWRENCE M. REIFURTH
DIRECTOR

RONALD BOYER
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON CONSUMER PROTECTION AND COMMERCE

TWENTY-FIFTH LEGISLATURE
Regular Session of 2009

MONDAY, MARCH 23, 2009
2:15 p.m.

TESTIMONY ON SENATE BILL NO. 1140, S.D. 2, H.D. 1 – RELATING TO HEALTH CARE.

TO THE HONORABLE ROBERT N. HERKES, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is J.P. Schmidt, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department supports this bill.

Hospitals in Hawaii have been losing money over the past several years, particularly in rural areas. We have had numerous complaints that the reimbursements to doctors and hospitals do not recover their costs. Kahuku Hospital almost closed and the State Hospital has had to request emergency appropriations. This is a perilous situation for the public, particularly as regards critical access hospitals and federally qualified health centers which provide necessary care to the community.

Requiring commercial health plans to provide a minimum reimbursement level is one step to help ensure that these facilities can keep operating and provide services. This bill is limited to critical access facilities which are particularly important to our communities.

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

PRESENTATION OF THE
HAWAII MEDICAL BOARD

TO THE HOUSE COMMITTEE ON CONSUMER PROTECTION AND COMMERCE

AND

TO THE HOUSE COMMITTEE ON JUDICIARY

TWENTY-FIFTH LEGISLATURE
Regular Session of 2009

Monday, March 23, 2009
2:00 p.m.

WRITTEN TESTIMONY ONLY

TESTIMONY ON SENATE BILL NO. 1142, S.D. 1, RELATING TO PHYSICIAN ASSISTANTS.

TO THE HONORABLE ROBERT N. HERKES, CHAIR,
TO THE HONORABLE JON RIKI KARAMATSU, CHAIR,
AND MEMBERS OF THE COMMITTEES:

Thank you for the opportunity to provide written testimony on S.B. No. 1142, S.D. 1, Relating to Physician Assistants. The purpose of this bill is to authorize physician assistants to sign certain documents; to provide emergency medical care without supervision; to administer immunizations; to prescribe medications for patients suffering from human immunodeficiency virus or acquired immune deficiency syndrome without preauthorization; and to limit liability of physician assistants under good Samaritan laws.

The Hawaii Medical Board ("Board") supports the intent of this bill.

Thank you for the opportunity to provide written comments on this bill.

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

March 23, 2009

The Honorable Robert Herkes, Chair
The Honorable Glenn Wakai, Vice Chair

House Committee on Consumer Protection and Commerce

Re: SB 1140 SD2 HD1 – Relating to Health Care

Dear Chair Herkes, Vice Chair Wakai and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 1140 SD2 HD1. This measure will require health plans to pay Critical Access Hospitals (CAH) no less than 101% of costs for services and Federally Qualified Health Centers (FQHC) at rates considerably higher than independent practicing physicians.

HMSA values the inclusion of both CAHs and FQHCs in both our government programs and private networks. This bill, however, would favor these facilities over all other existing health care resources thereby creating an inequity in the way we manage our network relationships. Several issues in particular are noted below:

Self-Reporting of Costs
The bill mandates health plans reimburse CAHs for their costs that are self-reported. The measure contains no quality control or standardization criteria to verify that costs being reported by each facility are appropriate and in-line with other similarly situated health care facilities in the community.

Inequity of Payments
For a health plan to pay a CAH or an FQHC at a reimbursement rate that is greater than that of any other nearby health care provider is difficult, if not impossible, to justify to the greater provider community. These facilities are providing the same basic services to our members regardless of the government's designation of a CAH or FQHC.

The point has been made that the FQHCs are providing more services than an individual may typically be able to receive at a physician's office. While this may be the case under programs such as QUEST and Medicaid, it's important to note that such services are not included in HMSA's private business health plans. When FQHCs provide services to HMSA's private plan members for benefits which are not covered under the individual's plan we do not believe that employers should have to pay additional costs since these are not plan benefits. For example, if an HMSA private plan member were to visit their physician's office and the physician had arranged transportation for the member to visit a specialist, HMSA would not cover that cost. Under this bill, if that same member visited an FQHC, HMSA would be forced to pay for this service.

Thank you for the opportunity to testify on SB 1140 SD2 HD1.

Sincerely,

Jennifer Diesman
Assistant Vice President
Government Relations

Hawaii Association of Health Plans
www.hahp.org

March 23, 2009

The Honorable Robert Herkes, Chair
The Honorable Glenn Wakai, Vice Chair
House Committee on Consumer Protection and Commerce

Re: SB 1140 SD2 HD1 – Relating to Health Care

Dear Chair Herkes, Vice Chair Wakai and Members of the Committee:

My name is Rick Jackson and I am President of the Hawaii Association of Health Plans ("HAHP"). HAHP is a non-profit organization consisting of seven (7) member organizations:

AlohaCare
Hawaii Medical Assurance Association
HMSA
Hawaii-Western Management Group, Inc.
MDX Hawai'i
University Health Alliance
UnitedHealthcare

Our mission is to promote initiatives aimed at improving the overall health of Hawaii. We are also active participants in the legislative process. Before providing any testimony at a Legislative hearing, all HAHP member organizations must be in unanimous agreement of the statement or position.

HAHP appreciates the opportunity to testify in opposition to SB 1140 SD2 HD1 which would establish in statute a reimbursement level for private health plans to reimburse Critical Access Hospitals (CAHs) at no less than 101% of their self-reported costs and Federally Qualified Health Centers (FQHCs) at no less than their respective prospective payment system rates.

HAHP members agree with the federal government in its belief that CAHs and FQHCs provide vital services to segments of the community. In Hawaii, these facilities often provide services to QUEST and Medicaid populations who may have difficulty accessing health care in more traditional settings. That said, HAHP member organizations fundamentally disagree with the notion of setting reimbursement rates for providers of any type in employer sponsored health plans in Hawai'i statute. We believe instead that rate negotiations which determine the cost of covered services in commercial insurance plans, which are in place today, are the appropriate method to deal with this subject.

Thank you for the opportunity to offer comments today. We respectfully request the Committee hold SB 1140 SD2 HD1.

Sincerely,

Rick Jackson
President

Hawai'i Primary Care Association

345 Queen Street | Suite 601 | Honolulu, HI 96813-4718 | Tel: 808.536.8442 | Fax: 808.524.0347
www.hawaiipca.net

To: **The House Committee on Consumer Protection & Commerce**
The Hon. Robert N. Herkes, Chair
The Hon. Glenn Wakai, Vice Chair

Testimony in Support of Senate Bill 1140, SD 2, HD 1
Relating to Health Care
Submitted by Beth Giesting, CEO
March 23, 2009, 2:15 p.m. agenda, Room 329

The Hawaii Primary Care Association asks your support for this measure, which would provide appropriate compensation for Hawaii's health care safety net. Both Critical Access Hospitals and Federally Qualified Health Centers (FQHCs) are recognized by the federal government as essential community providers and are guaranteed enhanced reimbursement rates from public insurance (Medicare and Medicaid) to cover costs.

Speaking for FQHCs, these enhanced rates are provided both so that they won't have to use federal grants to subsidize the cost of public insurance programs but also in recognition of the additional services that are needed by and provided to FQHC patients. These include offering care with linguistic and cultural competence; ensuring that transportation is available; and providing extensive care management that includes outreach, follow-up, referral arrangements, and application assistance. FQHCs also provide medical, behavioral health, and dental care all on the same site, which increases the likelihood that patients will get all the primary care they need in a timely and appropriate way. The integration of behavioral health with medical care is particularly clinically and financially effective. Some FQHCs serve geographically isolated places where it isn't economically feasible for other care providers to practice and this may result in higher unit costs as well.

IN 2007, 24% of FQHC patients – 25,000 individuals – had private insurance. Neighbor Island FQHCs tend to have higher percentages of privately insured patients because they are more frequently the only providers in the communities they care for. We estimate that FQHCs earn about $7 million less per year from private insurers than it costs to deliver care to their patients. At the same time the FQHCs saved more than $46 million[1] for the plans because of the care they delivered to privately insured patients. These savings are due to the FQHC model of care that provides comprehensive and timely primary clinical and management services which greatly reduce duplicative diagnostic testing, specialty referrals, ER use, and hospitalization.

We believe this measure deserves your thoughtful consideration and appreciate the opportunity to provide this testimony.

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[1] A study prepared by the Robert Graham Center using Medical Expenditure Panel Survey data for 2007 shows that FQHCs save an average of $1,914 per privately insured patient per year when compared to the private practice system. $1,914 x 24,364 privately insured patients served by FQHCs in 2007 = $46.6 million.

HAWAII HEALTH SYSTEMS
CORPORATION

"Touching Lives Everyday"

House Committee on Consumer Protection and Commerce
Representative Robert N. Herkes, Chair
Representative Glenn Wakai, Vice Chair

Monday, March 23, 2009
2:15 p.m.
Conference Room 325
Hawaii State Capitol

Testimony on SB 1140, SD2, HD1 Relating to Health Care
Requires commercial health plans licensed to do business in the State to pay no less than 101per cent of costs for all services provided to plan beneficiaries by critical access hospitals and federally qualified health centers. Exempts limited benefit health insurance policies from the minimum reimbursement requirement.

Thomas M. Driskill, Jr.
President & Chief Executive Officer
Hawaii Health Systems Corporation

On behalf of the Hawaii Health Systems Corporation (HHSC) Corporation Board of Directors, thank you for the opportunity to present testimony in strong support of the intent of SB 1140, SD2, HD1.

The purpose of this bill is to require health plans, other than government payers, licensed to do business in this state, to reimburse critical access hospitals and federally qualified health centers at rates consistent with Medicare and Medicaid reimbursement rates. The bill would require insurers other than government payers to reimburse critical access hospitals as defined in section 346D-1 at a rate not less than one hundred and one percent of costs, consistent with the Medicare reimbursement rate, for all services rendered to health plan beneficiaries and to pay federally qualified health centers as defined in section 1905 (1) of the Social Security Act (42 USC 1396d) no less than their respective payment system rates determined pursuant to sections 346-53.6 to 346-53.64.

Currently, government is subsidizing the costs for healthcare services provided to beneficiaries of health plans, other than government payers, by critical access hospitals (CAHs) and federally qualified health centers (FQHCs), because health plans in Hawaii, other than government payers, are not paying for the full costs of care provided to plan beneficiaries.

It is estimated that the enactment of this legislation could provide for approximately $5 million annually in increased reimbursements to critical access hospitals and an aggregate $47,475,544 in increased reimbursements over eight years to critical access hospitals, assuming same service levels and 5% inflation per year. It is estimated that the enactment of this legislation could provide for approximately $7.3 million in increased reimbursements to federally qualified health centers, and an aggregate $67,708,495 in increased reimbursements over eight years o federally qualified health centers, assuming same service levels and 5% inflation per year.

All hospitals are adversely affected by declining reimbursement trends, but rural facilities are especially disadvantaged, due to the low volume of patients and high expense of providing care in remote areas. Federally qualified health centers (health centers) are especially disadvantaged due to low payments from commercial health plans, even though enhanced payments from government programs (Medicare and Medicaid) tend to cover operating costs. Recognizing the financial challenges faced by rural hospitals, the federal government passed 42 United States Code 1395i-4, which established the Medicare rural hospital flexibility program, a national program designed to assist states and rural communities in improving access to essential health care services through the establishment of limited service hospitals and rural health networks. The program creates the critical access hospital as a limited service hospital eligible for Medicare certification and reimbursement, and supports the development of rural health networks consisting of critical access hospitals, acute general hospitals, and other health providers.

Congress also established federally qualified health centers as a category of provider that specializes in comprehensive primary health care for underserved communities. Among mandated provisions for federally qualified health centers are cost-related reimbursement for Medicaid and Medicare services.

The U.S. Department of Health and Human Services Medicare and Medicaid Services pays Critical Access Hospitals on the basis of one hundred and one per cent of costs for acute care inpatient and outpatient services. The State of Hawaii department of human services calculates payments to critical access hospitals on a cost basis for acute inpatient and long term care services to beneficiaries of the Medicaid program.

The state's ability to provide safety net services will significantly degrade, if commercial health plans continue to refuse to pay amounts that cover the costs for providing care, unless the state continues to provide special subsidies to CAHs and FQHCs to cover operating losses of CAHs and FQHCs from providing services to beneficiaries of mutual

and fraternal benefit societies, and health maintenance organizations, and health plans other than government payers. Financial and social burdens will fall increasingly on agencies of the state and county governments because of the health and economic impact of declining and degrading healthcare services if government would not continue to subsidize costs of healthcare services provided to beneficiaries of mutual and

fraternal benefit societies, and health maintenance organizations, and health plans other than government payers.

Limited benefit health insurance policies should not be exempted from the minimum reimbursement requirement as proposed in SB 1140, SD2, HD1. It is particularly inappropriate to exclude Medicare supplement plans from paying same as Medicare. We respectfully request that SB 1140, SD2, HD1 be amended to remove this exemption and that the measure be passed with an effective date of July 1, 2009.