LATE TESTIMONY

HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 18, 2009

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

Re: HB 700 HD1 – Relating to Nongovernment Health Plan Payments to Critical Access Hospitals and Federally Qualified Health Centers

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

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 700 HD1 which requires health plans pay Critical Access Hospitals (CAH) no less than 101% of costs for services Federally Qualified Health Centers (FQHC) no less than their respective prospective payment system rates. HMSA has concerns with this measure.

While HMSA supports assisting CAHs and FQHCs, we do foresee some issues with the way in which payment determinations would be calculated. This measure is addressing two different payment methodologies which are worth outlining.

CAHs are limited to 25 beds and primarily operate in rural areas. Unlike traditional hospitals (which are paid under prospective payment systems), Medicare pays CAHs based on each hospital's reported costs. Each CAH receives 101 percent of its costs for outpatient, inpatient, laboratory and therapy services, as well as post-acute care in the hospital's swing beds. For Medicare beneficiaries the government pays 101% of the self-reported costs incurred for services after performing reviews and audits to validate the costs before making a final payment. This measure would require that private plans pay CAHs the same way that Medicare does. The problem with implementing this payment structure is that the reporting of cost is left up to each facility with no standardization in place to ensure accuracy.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 established a prospective payment system for FQHCs. This system, which has been in place since January 2001, replaced the previous cost-based reimbursement system for health centers under Medicaid. The prospective payment system establishes a per visit payment rate for each FQHC in advance. The 2001 payment rate was based on the average of each FQHC's reasonable costs per visit in FY 1999 and FY 2000. Since FY 2002, payments made under this system have been adjusted annually for inflation using the Medicare Economic Index. Payments also are adjusted based on increases or decreases in change in scope of services provided. The problem with implementing this payment structure is that the reimbursement rate would be set in statute.

The changes in payments to CAHs and FQHCs raise many issues including:

Self-Reporting of Costs
Under the payment structure outlined in HB 700 HD1, the payments for CAHs would be tied to their costs which are self-reported. On the surface this may seem to make sense, however the measure contains no quality control or standardization to verify the costs being reported by each facility are appropriate. Without any oversight or standardization the cost of the same item could vary from facility to facility. For example an aspirin at Ka'u Hospital could be reported at a cost of 1 dollar while an aspirin at Kohala Hospital could be reported at a cost 5 dollars. Health plans would have to reimburse based on these variable costs.

A More Systemic Approach
We would also argue that the majority of these facilities are not unlike others operating in proximity to them. While a handful of the CAHs are in areas that do not have health care alternatives, others are within minutes of larger facilities which may be better equipped to provide less costly services. We would argue that for a health plan to pay a CAH or an FQHC at a rate that is greater than that of any other nearby provider is difficult, if not impossible, to justify to the greater provider community. These facilities are providing the same services to our members regardless of the government's designation of a CAH or FQHC.

We believe that rather than taking a piecemeal approach that attempts to force private plans, and by extension employers, to subsidize these facilities, a more comprehensive examination of the system is needed. We would begin by requesting data from both the CAHs and the FQHCs so that we can examine the true impact of the language in HB 700 HD1. Without this information, it is difficult to determine how this measure might affect HMSA.

Regulating Reimbursements
A health plan's reimbursement rates to providers are not in statute. We believe that a health plan should have the ability to set its own rates. Additionally, placing reimbursement rates in statute may cause problems in the long run as they will be difficult to revise to react to changes in the health care environment.

Additionally, reported costs from each facility may not be relevant to the services being provided to the member. For example, the health plan would not know if the cost for a member who receives a blood test at a facility includes direct charges for staffing.

Additional Administrative Burden
Both health plans and facilities must comply with a myriad of state and federal regulations. Including the Insurance Commissioner as the entity which would have to reconcile cost reimbursements would be an additional administrative and regulatory burden to health plans and the facilities.

It is also important to note that the administrative burden for HMSA to comply with HB 700 HD1 could be quite large while the number of HMSA members who utilize services from CAHs is quite small. It is unlikely that changes to the payments to CAHs for private plan members would change enough to truly make a difference for the facilities themselves. Below you will find a table showing HMSA's private plan discharges

from Critical Access Hospitals. As you can see, the overall utilization for our members for these facilities is quite low.

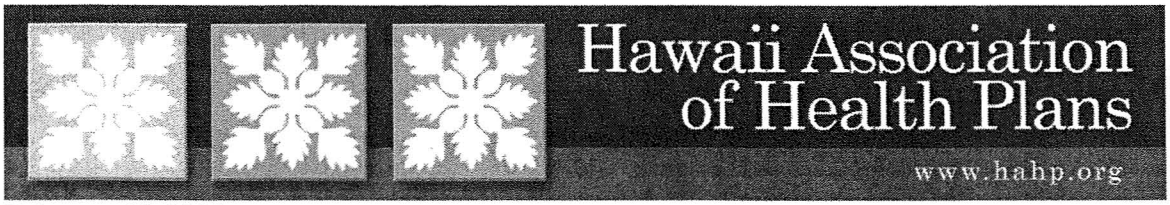
Critical Access Hospital	Total Facility Discharges	HMSA Commercial Plan Discharges
Lanai Community Hospital	27	0
Ka'u Hospital	17	1
Samuel Mahelona Memorial Hospital	170	31
Kohala Hospital	13	3
Kauai Veterans Memorial Hospital	1,210	368
Kula Hospital	8	3

*2007 HHSC Data

While we appreciate the legislature's proactive approach in assisting CAHs and FQHCs we do not believe that this measure will be able to accomplish this worthy goal. Thank you for the opportunity to testify on HB 700 HD1.

Sincerely,

Jennifer Diesman
Assistant Vice President
Government Relations



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Re: HB 700 HD1 – Relating to Relating to Nongovernment Health Plan Payments to Critical Access Hospitals and Federally Qualified Health Centers

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 HB 700 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 HB 700 HD1.

Sincerely,

Rick Jackson, President