SB 2598

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

February 23, 2010

MEMORANDUM

TO: Honorable Rosalyn H. Baker, Chair
Senate Committee on Commerce and Consumer Protection

FROM: Lillian B. Koller, Director

SUBJECT: **S.B. 2598, S.D.1 – RELATING TO INSURANCE**

Hearing: Tuesday, February 23, 2010, 10:00 A.M.
Conference Room 229, State Capitol

PURPOSE: The purpose of this bill is to require health insurers to promptly pay claims for services to Medicaid recipients, by repealing the exemption for Medicaid claims from the clean claims law and requires the Department of Human Services to pay health plans with interest when payment is delayed, except under certain circumstances beyond the Department's control.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) strongly opposes SB2598, S.D. 1. The addition of the requirement that DHS shall pay the health plans interest on any unpaid amounts will place an economic strain on the State budget, both now and in the future. We estimate that this will increase next year's shortfall by $7.5 million due to interest payments from a three-month delay in health plan capitation payments.

As the Med-QUEST Division faces a biennium budget shortfall of nearly $150 million in State general funds at the end of State Fiscal Year 2011, not including the $7.5 million described above, difficult decisions will need to be made to close this budget gap. Adding a payment of 15% per year to health plans, when payments are already overdue, further compounds this problem.

As an entitlement, the Medicaid program is probably the most difficult budget in the State to predict for a biennium. Predictions can be made about growth and actuarially sound rate increases, but it is often factors beyond the State's ability to control, including the state of the economy and unemployment rate as well as the percentage of funds that the Federal government will contribute, that ultimately impact this budget the most.

If this bill passes with this amendment, it will have long-lasting adverse cost impacts that exceed and compound our current budget crisis.

While we understand the intent of this bill and support providers who care for our clients, this bill could have an unintended bad consequence. Instead of health plans working to resolve claims, they might deny them. Increasing the denial rate merely increases the burden on providers.

DHS believes that health care providers, with whom the health plans contract to create the plans' provider networks, should receive prompt payment for their services. For that reason, DHS included prompt payment requirements in its contracts with the health plans. The health plans contracted by DHS are required to pay 90% of clean claims in thirty days and 99% in ninety days. This is the same prompt payment requirement that the Federal government imposed on Medicaid fee-for-service under the American Recovery and Reinvestment Act (ARRA). Health plans that do not meet these requirements are subject to sanctions.

No health plan has failed to meet this prompt provider payment contractual requirement. In other words, all our health plans have been complying with our contractual prompt provider payment requirement, even last year when DHS had to defer to July the payments to health plans for the two months of May and June.

Typically DHS pays capitation payments in a month for services provided during that month. Because providers frequently do not bill the health plans immediately when they provide services, DHS is, in effect, currently giving the health plans an advance on the amount needed to pay their providers. Therefore, **DHS may need to adjust the capitation rates downward** for advance payment based on the interest rate in this bill.

This bill would also result in DHS needing to impose new reporting requirements upon the contracted health plans. DHS will need to begin tracking when each claim is received and paid relative to the date of service. DHS would also likely need to institute prompt pay reporting requirements of the health plans consistent with the guidance issued by the Centers for Medicare and Medicaid Services for the ARRA provisions. This is a daily analysis of the percentage of clean claims received within the prior thirty days and the prior ninety days. Presently we review only aggregate monthly reports.

This bill would require DHS to know that a health plan payment to a provider was delayed because of a delay in payment from DHS to the health plan. This means that DHS would need to receive the date of service and the date of claim receipt for each individual clean claim for a service provided in a month with a payment deferred from the payment schedule in the contract. Because the health plans have thirty days to pay a clean claim, a delay in payment to the provider could not be considered to result from a delay in payment to the health plans unless DHS payment to the health plan was not made within thirty days of receipt of a claim by the health plan for a service provided

during the month during which the capitation payment was not made in accordance with the contract.

We also recognize that a health plan new to a program or an existing health plan adding new services would be potentially contracting with a new array of provider types. Testing claims processing systems is difficult until providers actually begin submitting claims. Therefore, if this bill is passed, it should be amended to include a period of six months after beginning a new contract or a new service in a program during which a health plan should remain exempt from the proposed State prompt pay requirement.

DHS understands the implications to a contracted health plan if monthly capitated payments by DHS to the health plan are delayed. Health plans may need to access their reserve. In order to be licensed, a health plan is required to have funds in reserve in the unexpected event of a period in which expenditures exceed revenue so that it can continue to pay providers and medical care can continue without interruption to its Medicaid members. The DHS contracted health plans are facing such a situation now.

While a health plan might decide not to utilize its reserve and stop payments to providers in its network, this could have a negative impact on Medicaid patients. It is the responsibility of the health plans to ensure timely access to quality health care for Medicaid recipients. And it is the responsibility of DHS to ensure that the health plans meet this responsibility.

DHS is currently working on options to not have to defer health plan payments starting April.

Thank you for the opportunity to provide testimony on this bill.

SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn Baker, Chair

Conference Room 229
Feb. 23, 2010 at 10:00 a.m.

Supporting SB 2598 SD 1 with an amendment.

The Healthcare Association of Hawaii represents its member organizations that span the entire spectrum of health care, including all acute care hospitals, as well as long term care facilities, home care agencies, and hospices. Thank you for this opportunity to testify in support of SB 2598 SD 1, which requires health plans contracted by the State for Hawaii's Medicaid program to pay clean claims submitted by health care providers in a timely manner. The bill also requires the State to pay Medicaid health plans in a timely manner. The Healthcare Association supports the bill with an amendment.

Medicaid operates in partnership with Hawaii's health care providers, as it does not employ health care practitioners, but rather, provides the financing to health care providers for services rendered to Medicaid participants. Prior to 1994, Medicaid paid providers directly on a fee-for-services basis. In 1994, the Quest program was implemented to provide health care to many Medicaid participants using a managed care approach. The State now contracts with health care insurance plans and pays each plan a capitated amount for each participant. The health plans in turn pay providers that deliver care to Medicaid participants.

QuestEx was implemented about a year ago to provide care on a managed care basis to the Medicaid aged, blind, and disabled population. Since QuestEx began operating, health care providers have experienced increases in delayed payments from health care plans contracted by the State.

The Healthcare Association is conducting a survey of its provider members to determine the dollar amount of claims submitted by providers that have not been paid by the health plans contracted under QuestEx. The survey also asks for the lengths of delays in payments. The survey has not yet been completed, but based on responses from about half of our members, Hawaii's health care providers have experienced delayed claims totaling millions of dollars that have not yet been paid. These unpaid claims reduce providers' working capital and limit their capacity to pay employees and purchase equipment and supplies. If this trend continues it could endanger providers' ability to deliver quality care.

The clean claims act that appears in Section 431:13-108, Hawaii Revised Statutes, requires health plans to pay providers on a timely basis when uncontested claims are submitted. Specifically, the law requires payments to be made within thirty days for clean claims submitted in writing, and within fifteen days for clean claims submitted electronically.

However, the law contains an exemption for Medicaid. As a result, health plans contracted by the State under Medicaid, including QuestEx, may delay payments without penalty. This bill repeals the exemption for health plans contracted by the State under Medicaid from the clean claims law, which requires health plans to pay 15% interest on delayed payments

It has been reported that the State has on occasion delayed payments to Medicaid health plans. To be fair to the plans, this bill also requires the State to pay Medicaid health plans 15% interest on delayed payments, the same rate of interest that the clean claims act requires health plans to pay providers on late payments.

The Healthcare Association is currently hosting meetings with Medicaid health plans to discuss delays by the State in making payments to Medicaid health plans. Regarding this bill in particular, preliminary discussions indicate that the health plans may support it with an amendment. The amendment would incorporate the language of SB 2030, which eliminates the obligation of Medicaid health plans to pay interest to providers on delayed payments if the State has delayed payments to the health plans. The Healthcare Association understands the concern of the health plans regarding this issue and supports the amendment.

With the suggested amendment the Healthcare Association supports SB 2598 SD 1.

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 23, 2010

The Honorable Rosalyn Baker, Chair
The Honorable David Ige, Vice Chair
Senate Committee on Commerce and Consumer Protection

Re: SB 2598 SD1 – Relating to Insurance

Dear Chair Baker, Vice Chair Ige and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 2598 SD1 which would repeal the clean claims exemption for Medicaid claims and require the State to pay interest on delayed payments.

As you are aware, recently the Department of Human Services (DHS) stated that due to budgetary shortfalls, they will delay payments to contracted QUEST plans, beginning in April and extending through June. While we understand the budgetary restrictions the State is facing, DHS' decision significantly impacts a health plan's ability to pay for services in the timeframes noted in this measure.

Additionally, we appreciate the language added by the previous Committee to require DHS to pay interest on outstanding payments to health plans. HMSA is committed to working with the other stakeholders affected by DHS' statement of delayed payments.

Thank you for the opportunity to provide testimony.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

Tuesday, February 23, 2010, 10:00 a.m., Conference Room 229

To: COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator David Y. Ige, Vice Chair

From: Hawaii Medical Association
Gary A. Okamoto, MD, Legislative Co-Chair
Linda Rasmussen, MD, Legislative Co-Chair
April Donahue, Executive Director
Lauren Zirbel, Government Affairs
Dick Botti, Government Affairs

Re: SB2598 RELATING TO INSURANCE

In Support

Chairs & Committee Members:

Hawaii Medical Association supports SB2598, which would repeal the exemption for Medicaid claims from the clean claims law.

Physicians are increasingly reluctant to participate in Medicaid. Unlike hospitals, which may have large cash reserves, private practice physicians cannot afford continual losses from patients on Medicaid. These losses stem from delayed payment, lagging cash flow, large discounted rates, time-consuming prior authorizations, and a fee structure that does not come close to meeting operating costs. The net effect, intended or not by Medicaid, is a strong disincentive for physicians to participate in the care of underserved patients.

HMA urges the Committee on Consumer Protection and Commerce to pass SB2598. The bill helps to improve the timeliness and promptness of Medicaid payment for professional services -- an important factor in supporting physicians who participate in the care of patients on Medicaid.

Thank you for the opportunity to testify.