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TO THE HOUSE COMMITTEE
ON CONSUMER PROTECTION AND COMMERCE

TWENTY-NINTH LEGISLATURE
Regular Session of 2017

Tuesday, February 14, 2017
2:00 p.m.

TESTIMONY ON HOUSE BILL NO. 914, H.D. 1 – RELATING TO HEALTH INSURANCE.

TO THE HONORABLE ANGUS L.K. McKELVEY, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is Gordon Ito, State Insurance Commissioner, testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department supports the intent of this bill, which is a companion to S.B. 387, and submits the following comments and suggested amendments.

This bill creates a new article under chapter 431, Hawaii Revised Statutes, to help ensure that health insurance issuers are providing health care networks that are sufficient to meet the needs of their enrollees. This bill is based in large part on sections of the National Association of Insurance Commissioners' ("NAIC") Health Benefit Plan Network Access and Adequacy Model Act, MDL-74 ("Model Act").

In proposed subsection 431: - B(c) on page 9, lines 19 to 20 of the bill, we recommend the following amendment to further clarify the types of benefit plans this bill does not intend to cover:

"(c) This article shall not apply to [~~disability and accident-only policies~~] limited benefit health insurance as provided in section 431:10A-102.5."

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

An Independent Licensee of the Blue Cross and Blue Shield Association

February 14, 2017

The Honorable Angus L. K. McKelvey, Chair
The Honorable Linda Ichiyama, Vice Chair
House Committee on Consumer Protection and Commerce

Re: HB 914, HD1 – Relating to Health Insurance

Dear Chair McKelvey, Vice Chair Ichiyama, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 914, HD1 which establishes network adequacy standards for health plans. HMSA supports the intent of this Bill, and we offer comments and suggest an amendment.

The Affordable Care Act (ACA) requires that health plans participating in qualified health plans meet network adequacy standards to ensure consumers have access to needed care without unreasonable delay. In November 2015, the National Association of Insurance Commissioners (NAIC) adopted a new network adequacy Model Act establishing standards for the creation and maintenance of health plan networks and to assure the adequacy, accessibility, transparency and quality of healthcare services offered under a network plan.

HB 914 was Hawaii's adaptation of the Model Act. It is the product of a workgroup established by the State Insurance Commissioner to fashion network adequacy policies that balance the realities of Hawaii's unique provider base with a health plan's ability to provide its members proper access to a sufficient number of in-network primary care and specialty providers.

HB 914, HD1, however, adds two provisions (Section 431__G and Section 431__-H) related to the execution and filing of a plan's provider contracts with the Insurance Commissioner. (See Page 42, Line 15 thru Page 43, Line 18 of the Bill.) During the workgroup deliberations, there was consensus that these provisions would not be appropriate because, while the Insurance Division oversees a carrier's network adequacy plan, it does not oversee carrier contracts. We ask the Committee to consider deleting these two sections of the Bill.

Thank you for the opportunity to testify on this measure. Your consideration of our suggested amendment is appreciated.

Sincerely,

Mark K. Oto
Director, Government Relations

LATE

Hawai'i Psychiatric Medical Association
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Email: office@hawaiipsychiatry.org

Feburary 14, 2017 2:00 pm
Room 329

To: COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Angus L.K. McKelvey, Chair
Rep. Linda Ichiyama, Vice Chair

From: The Hawaii Psychiatric Medical Association
D. Douglas Smith, M.D., Membership Committee Co-chair
Julienne Aulwes, M.D., Chair, Task Force on Improved Access to Psychiatric Care

Re: HB 914, HD1 - RELATING TO HEALTH INSURANCE

We would like to thank Chair McKelvey, Vice Chair Ichiyama and members of the House Committee on Consumer Protection and Commerce for the opportunity to testify on HB 914 HD1.

The Hawaii Psychiatric Medical Association (HPMA) **strongly supports** the intent of this measure and provides suggested amendments to improve the ability of health plan members to access care and covered benefits. We support the legislature's intent to implement significant and encouraging improvements to our state's current process for the evaluation, approval and ongoing monitoring of the adequacy of health plan provider networks.

The purpose of HB914 HD1 is to require health carriers with network plans to maintain networks that are sufficient in numbers with appropriate types of providers to ensure that covered persons have access to covered services. The bill has sections focused on ensuring the accuracy of the health plan network listings/directories members rely on to access in-network care, and on helping members to afford out-of network care. It is based on the Model Law from the National Association of Insurance Commissioners which spent considerable time and effort to draft thoughtful approach to this all important aspect of our health care system. The most important aspect of a health carrier's operations is whether or not plan networks are sufficient to allow all members to reliably access medically necessary care. Little else about a health plan operations matter to members who cannot access care.

We have identified several ways to improve the part of the bill that focuses on Provider Directories. The utility and accuracy of these directories is critical for members needing to access services, for potential members to evaluate network plans before deciding to enroll, and for regulators to determine whether or not plans have met network adequacy standards. We have focused primarily on ways to make the directory listings for individual practitioners, such as the physicians specializing in psychiatry, more useful to those seeking care. It is unfortunate that none of these suggested

improvements were included in the HD1 draft, and it is hoped that this committee will do so.

The current draft of the bill requires the following provider information in searchable format:

- Name;
- Gender;
- Participating office locations;
- Specialty, if applicable;
- Medical group affiliations, if applicable;
- Facility affiliations, if applicable;
- Participating facility affiliations, if applicable;
- Languages spoken other than English, if applicable; and
- Whether accepting new patients.

And it requires online access to other information (not required to be searchable):

- Contact information;
- Board certifications; and
- Languages spoken other than English by clinical staff, if applicable.

The following are our specific concerns about the accuracy and utility of this information, along with suggested amendments:

1. Board Certification. The bill only requires plans to list provider board certification status using the binary YES/NO format. This is misleading to health plan members. It obscures the fact that there are two categories of certified physicians and two categories of non-certified physicians. "Certified" physicians include those who were last certified less than 10 years ago (Grade A), and those who were certified more than 25 years ago (grade C). "Non-certified" physicians include those certified between 10 and 25 years ago (Grade B) and those who were never certified (Grade D). This is the unfortunate artifact of the American Board of Medical Specialties' decision to require 10 year re-certification while grandfathering in lifetime certificate holders. While some may question the merits of these decisions, few would argue against the public's interest in having a more meaningful appreciation of individual physicians' board certification than a binary YES/NO that is often misleading.

> The simple solution is transparency, in this case HB914 HD1 should require health plans to list "the date on which the provider first received certification, or if re-certified, the date of most recent recertification."

2. Telemedicine availability. Given Hawaii's unique geography as an island state, our policy-makers have made telemedicine a priority. The bill requires health plans to include telemedicine in their access plans, but this is not included in the required directory elements. This omission makes the directory listings less useful for members in rural and underserved areas who would most benefit from this modality.

> The solution is to require that network provider listings indicate whether or not the provider is available via telemedicine, and this should be part of the searchable data elements.

3. Whether accepting new patients. Again, this binary YES/NO data can be misleading and therefore less useful to members. For example, some network providers are primary care physicians (PCPs), some are specialty physicians, and some are both. Some specialty physicians see all types of problems in their specialty area, and some only treat or prefer to treat a narrower range of conditions (i.e. cardiologists specializing in electrical conduction problems). Some network providers see any members in the community, but others only see members enrolled in specific programs or facilities. Some are available to see members full-time, and others are mainly administrators who provide consultation or coverage on a part-time basis. Some are semi-retired. Some are at a particular office location full-time, and some only once a month. Some periodically commute from the mainland. Some are available for telemedicine statewide, and some are not. Some can accommodate a high volume of new patients, and some only a few each month.

Forcing members to call through a list of providers only to learn that many are not actually available wastes precious provider resources on unnecessary call-backs and delays access to care for members. It creates frustration for members and their families, and can contribute to overuse of emergency room services or to untreated illness.

The lack of useful information about network provider availability also makes it difficult for regulators to properly evaluate the adequacy of plan networks. In general, vague network listings tend to make provider availability appear to be more robust than is really is.

> One solution would be for the searchable listings to include if the PCP or specialist is taking (a) all new patients; (b) limited new patients; (c) no new patients; or (d) unknown. Then include a non-searchable section(s) to require network providers to specify any limitations on their availability to new patients.
These limitations should include (a) limited days/hours; (b) limited to 'X' new members per month; (c) limited/preferred conditions or diagnoses; (d) any limitations on telemedicine services; and (e) limited to members admitted to a particular facility or enrolled in a particular program, mobile clinic, Center of Excellence, integrated delivery system, or other way of delivering care.

4. Referral Needed. Members can be potentially misled into thinking that their care from a listed participating provider will be covered when this is not the case because of the network plan's restrictions and requirements, such as pre-approval.

> The solution for this should be easy. Network plans know the rules which of their participating providers require pre-approval for some or all services, and this information should also be made available in directory listings, along with instructions for how to go about getting approval.

HPMA encourages committee members to us know if you have any comments, concerns, suggestions for these proposed improvements to the provider directories section of HB914 HD1. We are interested, willing, and able to provide support to the committee staff in developing the specific language for amendments that would allow these improvements to maximize the usefulness of network directories for health plan members seeking to access care.

Overall, HB914 HD1 is a welcomed bill of considerable significance. It is relevant to many of the

problems facing our state, including the overall physician shortage, the need for better access to psychiatric physicians, the burden of untreated mental illness, homelessness, criminalization of the mentally-ill, and other policy challenges.

HB914 HD1 promises to reduce incentives for minimizing access to care and for shedding high cost members that some plans may have taken advantage of, and to restore healthier market forces for our privatized state health system. Some of our health plans will undoubtedly be faced with having to improve their operations in order to better recruit and retain participating providers. Others are likely to find their networks are better positioned in meeting these new requirements, and they will be rewarded for this as they develop and submit plans for how they will achieve and maintain adequate participating provider networks and access to care for members.

HB914 HD1 is a significant bill that deserves to be carefully considered, ammended to improve the ability to improve access to care for health plan members, and implemented into law.

Thank you for the opportunity to testify,

D. Douglas Smith, M.D.
Membership Committee Co-chair
Hawaii Psychiatric Medical Association

Julienne Aulwes, M.D.
Chair, Task Force on Improved Access to Psychiatric Care
Hawaii Psychiatric Medical Association

LATE

Government Relations

Testimony of
Jonathan Ching
Government Relations Specialist

Before:
House Committee Consumer Protection & Commerce
The Honorable Angus McKelvey, Chair
The Honorable Linda Ichiyama, Vice Chair

February 14, 2017
2:00 p.m.
Conference Room 329

Re: HB914 HD1 Relating to Health Insurance

Chair McKelvey, Vice-Chair Ichiyama, and committee members, thank you for this opportunity to provide testimony on HB914 HD1, which requires a health carrier with a network plan to maintain a network that is sufficient in numbers with appropriate types of providers to ensure that covered persons have access to covered services.

Kaiser Permanente Hawaii supports the intent of HB914 HD1 and offers the following COMMENTS.

HB914 HD1 fairly and creatively addresses network adequacy concerns to ensure that network plans are providing accessible, high quality care to their members. HB914 HD1 utilizes the state-level network adequacy initiative, proposed by the National Association of Insurance Commissioners, as a base model, but takes into consideration other factors given Hawaiʻi's severe shortage of physicians and its unique geographical layout of several islands, containing large rural areas that are separated by mountains and ocean.

Kaiser Permanente Hawaii appreciates that HB914 HD1 allows the insurance commissioner to consider "integrated delivery systems," among other criteria for demonstrating network adequacy, as this is the delivery system that we provide to our members. Through our integrated health system, we are committed to providing our members with greater access to quality doctors and reducing patient wait times. We currently have clinics on all major islands that provide members with comprehensive, high quality care, including pharmacy and lab services under one roof. Many of these clinics also provide x-ray and radiology services. Furthermore, we routinely fly our specialists to service members on neighbor islands, as well as fly our members to specialists on Oʻahu. Finally, Kaiser Permanente Hawaii has been at the forefront of utilizing telehealth, both in our clinics, such as our Līhuʻe Clinic's tele-dermatology capabilities, which allows a patient to have a suspicious mole photographed and reviewed by a dermatologist on

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O'ahu, as well as allowing members to communicate directly with physicians in remote locations, sometimes even from the convenience of their homes.

We express concern on the language in HB914 HD1, Section - G Filing Requirements and State Administration. As drafted, Section –G *may* create additional administrative burdens on health carriers and raises concerns over the requirement for the filing and review of contracts, which may contain sensitive and proprietary information. We have the following questions on Section –G, as drafted:

1. On page 42, line 17: We request clarification on whether "sample contract forms" refers to a "contract template" or actual "signed contracts"? Furthermore, would this include "Letter of Agreement" templates?

2. On page 42, lines 20-21 and page 43, lines 1-3: If material changes to a contract need to be submitted to the Commissioner at least 30 days prior to the initial use of the contract, how soon can health carriers expect a response from the Commissioner for an approval or disapproval of the filing?

3. On page 43, lines 4-9: We request clarification on if the Commissioner would be reviewing only "contract templates" or actual "signed contracts"? Furthermore, if actual "signed contracts" are submitted, would this include rates, which are highly sensitive and proprietary?

Mahalo for the opportunity to testify on this important measure. We hope you would favorably consider our comments.

DAVID Y. IGE
GOVERNOR

PANKAJ BHANOT
DIRECTOR

BRIDGET HOLTHUS
DEPUTY DIRECTOR

LATE

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
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February 14, 2017

TO: The Honorable Representative Angus L.K. McKelvey
House Committee on Consumer Protection & Commerce

FROM: Pankaj Bhanot, Director

SUBJECT: **HB 914 RELATING TO HEALTH INSURANCE**

Hearing: February 14, 2017, 2:00 p.m.
Conference Room 329, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) appreciates the intent of the bill and offers comments.

PURPOSE: The purpose of the bill is to ensure that health carriers with a network, plan to maintain a network that provides sufficient practitioners and services to meet the needs of the enrollees or members.

DHS would like to clarify that health plans that serve Medicaid beneficiaries currently have network adequacy standards that have to meet criteria of the DHS state Medicaid program and the criteria of the federal Medicaid regulatory agency, the Centers for Medicare and Medicaid Services (CMS). As the single-state Medicaid agency, DHS is required to monitor these standards and report to CMS. In May of 2016, new federal regulations were passed on Medicaid managed care plans. It is unclear from current guidance whether Medicaid can delegate responsibilities to another agency. Thus if passed, this proposed bill may require the Medicaid managed care plans to report on provider network adequacy to both the Insurance Division of the Department of Commerce and Consumer Affairs (DCCA), and to DHS Med-QUEST Division (MQD). We respectfully request that the Medicaid managed care plans continue to report the network provider adequacy to DHS (MQD) so the State remains compliant with CMS regulations.

The criteria for network adequacy outlined in the bill, while they align in some areas with criteria of DHS and CMS, the proposed criteria also cover other items. DHS will work with DCCA Insurance Division to strive for aligned network adequacy standards wherever possible; however, we would like to ensure that where not possible, that Medicaid is able to continue its own network adequacy standards.

Thank you for the opportunity to testify on this bill.