SB387

Measure Title:	RELATING TO HEALTH INSURANCE.
Report Title:	Health Insurance; Network Access and Adequacy
Description:	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.
Companion:	HB914
Package:	None
Current Referral:	CPH
Introducer(s):	BAKER

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TO THE SENATE COMMITTEE ON
COMMERCE, CONSUMER PROTECTION, AND HEALTH

TWENTY-NINTH LEGISLATURE
Regular Session of 2017

Monday, February 27, 2017
9:30 a.m.

TESTIMONY ON SENATE BILL NO. 387 – RELATING TO HEALTH INSURANCE.

TO THE HONORABLE ROSALYN H. BAKER, 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"). The Department supports the intent of this bill, which is a companion to H.B. 914, 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 on the National Association of Insurance Commissioners' ("NAIC") Health Benefit Plan Network Access and Adequacy Model Act, MDL-74 ("Model Act").

On page 5, lines 7 to 8 and page 6, lines 2 and 6, the terms "comprehensive medical plans" and "comprehensive benefit plans" in the Definitions section of the bill are apparently used to distinguish the types of insurance policies covered by the bill from policies with limited scopes. For improved clarity and readability, the Department

suggests replacing these terms instead with "health benefit plan," which is currently defined in the bill.

In proposed subsection 431: -B(b), on page 9, lines 1 to 18, the Department recommends the following amendments for clarity and deleting reference to sections in the bill that are either not applicable or do not correspond to those in the Model Act:

"(b) The following provisions of this article shall not apply to health carriers' [~~that offer~~] network plans that consist solely of limited scope dental plans or limited scope vision plans:

(1) Section 431: -C(a)(2), on network adequacy;

(2) Section 431: -C(f)(7)(E)[~~,~~] and (f)(8)(B)[~~, and (f)(11)~~], on network adequacy;

(3) Paragraphs (1) and (3) of the definition of 'active course of treatment' under section 431: -A, on definitions, and section 431: -D)(l)(6)(C), on requirements for health carriers and participating providers;

(4) [~~Section 431: -D, on disclosure and notice requirements;~~]

[~~(5)~~] Section 431: -E(a)(3)(B) and (C), on provider directories; and

[~~(6)~~] (5) Section 431: -E(a)(4)(A)(i) and (ii) and (a)(4)(B), on provider directories."

In proposed subsection 431: -B(c), on page 9, lines 19 to 20, the Department recommends 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, except as to limited scope dental plans or limited scope vision plans as set forth in subsection (b)."

Proposed subsection 431: -C(b) on page 10, lines 14 to 21 and page 11, lines 1 to 16 imposes the rigid requirement that the Commissioner consider all of the criteria in paragraphs 431: -C(b)(1) to (b)(9) to determine network sufficiency, regardless of whether certain criteria may be applicable. To provide the Commissioner with a

sufficient level of discretion, as would be provided under the Model Act, the Department respectfully requests that the following proposed amendments be made on page 10, lines 14 to 17:

"(b) The commissioner shall determine sufficiency in accordance with the requirements of this section by [~~taking into account all of the following criteria and~~] considering any [~~other~~] reasonable criteria, which may include, but shall not be limited to:"

In addition, proposed subsection 431: -D(n) on page 32 requires health carriers to use their "best efforts" to ensure that providers are furnishing covered benefits. This "best efforts" standard is vague and would be difficult to enforce. To improve the enforceability of this subsection, remove its vagueness, and make it consistent with the Model Act, we respectfully request that the following proposed amendments be made on page 32, line 15:

"(n) A health carrier [~~shall use its best efforts to ensure~~] is responsible for ensuring"

The Department also requests that language from two sections of the Model Act be incorporated into the bill. The first section relates to filing health carrier access plans with the Commissioner, which will provide the Commissioner with much needed notice of and access to health carrier access plans. The second section relates to contracts and will provide significant consumer protections. To incorporate these Model Act sections into the bill, the Department requests the following proposed language be inserted immediately after proposed section 431: -F Intermediaries, which ends on page 42, line 14:

"§431: -G Filing Requirements and State Administration.

(a) At the time a health carrier files its access plan, the health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

(b) A health carrier shall submit material changes to a contract that would affect any provision required by this article or implement regulations to the commissioner at least thirty days prior to use.

(c) The health carrier shall maintain provider and intermediary contracts at its principal place of business in the State, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty days' prior written notice from the commissioner.

§431: -H Contracting. (a) The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, or of its responsibility for compliance with the law or applicable regulations.

(b) All contracts shall be in writing and subject to review.

(c) All contracts shall comply with applicable requirements of the law and applicable regulations."

With the insertion of the two sections above, the remaining proposed sections 431: -G through -J should be re-lettered accordingly.

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

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February 27, 2017

TO: The Honorable Senator Rosalyn Baker
Senate Committee on Consumer Protection, Commerce and Health

FROM: Pankaj Bhanot, Director

SUBJECT: **SB 387 RELATING TO HEALTH INSURANCE**

Hearing: February 27, 2017, 9:30 a.m.
Conference Room 229, 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 require that 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 person have access to covered services.

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. Health plans contracted with DHS must submit reports to DHS on their network regularly. Thus, if passed, this bill would 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).

Additionally, in May of 2016, new federal regulations were passed that included new provider network adequacy requirements, including the publishing of provider directories on

websites, for Medicaid managed care plans. Thus, MQD is in the process of updating contract language to comply with the new federal regulatory language.

The criteria to be considered by the Insurance Commissioner for network adequacy outlined in the bill, aligns in some areas with criteria of DHS MQD and CMS; however, the bill's proposed criteria also include additional 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 MQD Medicaid is able to continue its own network adequacy standards, and that health plans are not reporting to separate state agencies using potentially conflicting criteria. For those reasons, we respectfully request that the bill be amended so that Medicaid managed care plans continue to report on their provider network adequacy to DHS MQD, and only DHS MQD, so the State remains compliant with CMS regulations, and the health plans are not doubly regulated with potentially contradictory standards.

DHS respectfully requests Section 1 of the bill be amended to include the following:

- Notwithstanding any other provisions of this article, health plans contracted with DHS MQD to provide services for Medicaid beneficiaries shall continue to be subject to the network provider adequacy standards and oversight of the Medicaid program;
- DHS and the Insurance Commissioner will collaborate to align such standards wherever possible; and
- Nothing in this article is intended to change, delegate or diminish the sole responsibility to monitor and regulate the Medicaid managed care plans from the single state Medicaid agency.

Thank you for the opportunity to testify on this bill.

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

February 27, 2017

The Honorable Rosalyn H. Baker, Chair
The Honorable Clarence K. Nishihara, Vice Chair
Senate Committee on Consumer Protection and Health

Re: SB 387 – Relating to Health Insurance

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

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 387, which establishes network adequacy standards for health plans. HMSA supports this Bill.

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.

SB 387 is 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.

Thank you for the opportunity to testify on this measure.

Sincerely,

Mark K. Oto
Director, Government Relations

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Government Relations

Testimony of
Jonathan Ching
Government Relations Specialist

Before:
Senate Committee on Commerce, Consumer Protection, and Health
The Honorable Rosalyn H. Baker, Chair
The Honorable Clarence K. Nishihara, Vice Chair

February 27, 2017
9:30 a.m.
Conference Room 229

Re: SB387 Relating to Health Insurance

Chair Baker, Vice-Chair Nishihara, and committee members, thank you for this opportunity to provide testimony on SB387, 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 SB387.

SB387 fairly and creatively addresses network adequacy concerns to ensure that network plans are providing accessible, high quality care to their members. SB387 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 Hawai‘i’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 SB387 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 O‘ahu. Finally, Kaiser Permanente Hawaii has been at the forefront of utilizing telehealth, both in our clinics, such as our Līhu‘e Clinic’s tele-dermatology capabilities, which allows a patient to have a suspicious mole photographed and reviewed by a dermatologist on O‘ahu, as well as

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

Therefore, Kaiser Permanente Hawaii urges the committee to **PASS** SB387. Mahalo for the opportunity to testify on this important measure.

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Feburary 27, 2017 - 9:30 am
Room 229

To: COMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND HEALTH
Senator Rosalyn H. Baker, Chair
Senator Clarence K. Nishihara, 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: SB 387 - RELATING TO HEALTH INSURANCE

We would like to thank Chair Baker, Vice Chair Nishihara and members of the Senate Committee on Commerce, Consumer Protection and Health for the opportunity to testify on SB 387.

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 SB 387 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. Legislators and advocates who are truly concerned about improving access to care should incorporate these sensible improvements into this bill.

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 SB 387 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. And also 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 SB 387. 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, SB 387 is a welcomed bill of considerable significance 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.

SB 387 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.

SB 387 is a significant bill that deserves to be carefully considered, amended 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