DAVID Y. IGE
GOVERNOR

SHAN S. TSUTSUI
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
335 MERCHANT STREET, ROOM 310
P.O. Box 541
HONOLULU, HAWAII 96809
Phone Number: 586-2850
Fax Number: 586-2856
www.hawaii.gov/dcca

CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON
CONSUMER PROTECTION AND COMMERCE

TWENTY-NINTH LEGISLATURE
Regular Session of 2017

Thursday, March 23, 2017
2:05 p.m.

TESTIMONY ON SENATE BILL NO. 387, S.D. 1, H.D. 1 – RELATING TO HEALTH INSURANCE.

TO THE HONORABLE ROY M. TAKUMI, 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 and submits the following comments.

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' Health Benefit Plan Network Access and Adequacy Model Act, MDL-74.

We thank the Committee for the opportunity to present testimony on this matter.

Hawaii Association of Health Plans

March 23, 2017
2:05 p.m., Room 329

To: **House Committee on Consumer Protection & Commerce**
The Honorable Roy M. Takumi, Chair
The Honorable Linda Ichiyama, Vice Chair

From: Beth Giesting, Hawai'i Association of Health Plans

Re: Comments on SB 387, SD 1, HD 1, RELATING TO HEALTH INSURANCE

The Hawaii Association of Health Plans (HAHP) is generally supportive of SB387, SD1, HD1, which conforms model legislation on network adequacy to Hawai'i standards.

All carriers that would be subject to this measure meet stringent standards for network adequacy as required by the accrediting bodies with which they work and/or with CMS. Moreover, each commercial carrier already submits an annual Network Adequacy Report/Access Plan to the Commissioner. Such plans include details on the following:

- Types of services provided
- Numbers and characteristics of population served
- Analysis of needs and access measurements by geographic area
- Carrier's network adequacy goals and actual performance based on DLIR or other network standards
- Network improvement plan, if needed
- Description of monitoring and action between reports, including identifying departing providers and recruiting new providers to the network
- Description of how clinical and case management needs are met for population with chronic diseases
- Description of how clinical and case management needs are met for population with special health and access needs
- Other information as requested by the Commissioner

In addition, all plans make public their processes for allowing, arranging, and paying for out-of-network services and for covering services for members who need care when they are out of state.

It is clearly in the best interest of every carrier to maintain a robust network that meets the needs of its members in order to remain competitive, retain satisfied and loyal members, and reduce out-of-network services. However, there may be circumstances in which providers are unable to add to their patient panels or provide care in a timely manner. In this case, carriers help patients find appropriate providers to meet their needs. Accordingly, HAHP supports amending SB387, SD1, HD1 as follows (page 33, line 1):

Instead of **"A health carrier <u>shall be responsible for ensuring</u> that a participating provider furnishes covered benefits to all covered persons…."**

the requirement be

"A health carrier <u>shall use its best efforts to ensure</u> that a participating provider furnishes covered benefits to all covered persons…."

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

March 23, 2017 at 2:05pm
Conference Room 329

House Committee on Consumer Protection & Commerce

To: Representative Roy M. Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Michael Robinson
Vice President – Government Relations & Community Affairs

Re: SB387, SD1, HD1 – Testimony in Support

My name is Michael Robinson, Vice President, Government Relations and Community Affairs at Hawaiʻi Pacific Health (HPH). Hawaiʻi Pacific Health is a not-for-profit health care system with over 70 locations statewide including medical centers, clinics, physicians and other caregivers serving Hawaiʻi and the Pacific Region with high quality, compassionate care. Its four medical centers – Kapiʻolani, Pali Momi, Straub and Wilcox – specialize in innovative programs in women's health, pediatric care, cardiovascular services, cancer care, bone and joint services and more. Hawaiʻi Pacific Health is recognized nationally for its excellence in patient care and the use of electronic health records to improve quality and patient safety.

I am writing in support of SB387, SD1, 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.

At Hawaiʻi Pacific Health, we recognize that a developed provider network is important to ensure that people have sufficient access to health care. This bill enhances the networks that enable providers to meet patients' needs, and in turn is aligned with our mission to create a healthier Hawaiʻi.

Thank you for the opportunity to testify.

Hawai'i Psychiatric Medical Association
4348 Waialae Avenue #472
Honolulu, Hawaii 96816
Phone: 1-800-572-3015
Email: office@hawaiipsychiatry.org

March 23, 2017 – 2:20 pm
Room 329

To: COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Roy M. Takumi, 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: SB 387 - RELATING TO HEALTH INSURANCE

We would like to thank Chair Takumi, Vice Chair Ichiyama and members of the House Committee on Consumer Protection and Commerce 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.

We have identified several ways to improve the part of the bill that focuses on Provider Directories, particularly the need to include whether or not providers are available via **Telemedicine**. 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 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.

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**. 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.

2**. 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."

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

An Independent Licensee of the Blue Cross and Blue Shield Association

March 23, 2017

The Honorable Roy M. Takumi, Chair
The Honorable Linda Ichiyama, Vice Chair
House Committee on Consumer Protection and Commerce

Re: SB 387, SD1, HD1 – Relating to Health Insurance

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

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 387, SD1, HD1, which establishes network adequacy standards for health plans. HMSA supports the intent of this Bill, but we do have a concern and offer comments.

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. SD1, HD1, 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.

That said, we do have a concern with one provision in the Bill related to a health carrier's obligations (Page 33, Lines 1-9). Section 431 D(n) provides in part as follows:

> (n) A health carrier **shall be responsible for ensuring** that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services…. [Emphasis added.]

While we certainly want our members to receive the healthcare services from a provider of choice within a network, there are times when a contracted provider simply is unable to accommodate additional patient workload. We make every effort to assist our affected members find an appropriate provider to obtain the services they need. We ask that the Committee consider replacing that provision with the original language of SB 387:

> (n) A health carrier **shall use its best efforts to ensure** that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services….

An Independent Licensee of the Blue Cross and Blue Shield Association

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

Sincerely,

Mark K. Oto
Director, Government Relations

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Government Relations

Testimony of
Jonathan Ching
Government Relations Specialist

Before:
House Committee on Consumer Protection & Commerce
The Honorable Roy M. Takumi, Chair
The Honorable Linda Ichiyama, Vice Chair

March 23, 2017
2:05 p.m.
Conference Room 329

Re: SB387 SD1 HD1 Relating to Health Insurance

Chair Takumi, Vice-Chair Ichiyama, and committee members, thank you for this opportunity to provide testimony on SB387 SD1 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 SB387 SD1 HD1.

SB387 SD1 HD1 fairly and creatively addresses network adequacy concerns to ensure that network plans are providing accessible, high quality care to their members. SB387 SD1 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 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 SD1 HD1 allows the insurance commissioner to consider “integrated delivery systems," among any reasonable 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

711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Office: (808) 432-5210
Facsimile: (808) 432-5906
Email: jonathan.l.ching@kp.org

dermatologist on O‘ahu, as well as 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 SD1 HD1. Mahalo for the opportunity to testify on this important measure.

Kelley Withy, MD, PhD
Hawaii Physician Workforce Researcher

Testimony Presented Before the
Committee on Consumer Protection & Commerce
March 23, 2017
2:05 pm

Aloha Chair Takumi, Vice Chair Ichiyama and members of the committee:

I am writing to provide comment on the Network Adequacy Bill SB387. As a Physician Workforce researcher in Hawaii, I can tell you that we currently have a physician shortage of 500-700 that is greatest in primary care specialties and on neighbor islands and rural Oahu. As a part of performing this work, my staff, volunteers and I call many provider offices from numbers we find in online directories to confirm their hours of patient care. We have unfortunately found these directories are often out of date. Therefore, I would be happy to assist with the assessment of network adequacy at the same time as updating our physician workforce database using publically available data or network lists provided by the insurers working in Hawaii. None of the confidential information provided by physicians on their licensure survey would be utilized in this research as that is strictly confidential by law and carefully protected. However the act of calling the offices would not only make our research more effective, but also be beneficial to the patients and the insurers for whom we could provide regular updates on network listings. This could be done at no new costs as long as the sunset is lifted on the Physician Workforce Assessment Special Fund SB141 and HB428, and could be beneficial to patients, providers and insurers across Hawaii.

Thank you for the chance to share my thoughts with you.

Kelley Withy, MD, PhD