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TO THE HOUSE COMMITTEE ON CONSUMER PROTECTION AND COMMERCE

TWENTY-FIFTH LEGISLATURE
Regular Session of 2009

Wednesday, February 18, 2009
2:00 p.m.

TESTIMONY ON HOUSE BILL NO. 700, HD1 – RELATING TO NONGOVERNMENT HEALTH PLAN PAYMENTS TO CRITICAL ACCESS HOSPITALS AND FEDERALLY QUALIFIED HEALTH CENTERS.

TO THE HONORABLE ROBERT N. HERKES, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is J.P. Schmidt, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department supports this bill.

We have heard that many hospitals are losing money. This is a perilous situation for the public, particularly as regards critical access hospitals and federally qualified health centers which provide necessary care to the community. Requiring commercial health plans to provide a minimum floor of funding may help to ensure that these facilities can keep operating and provide services.

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

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

"Touching Lives Everyday"

House of Representatives
Committee on Consumer Protection & Commerce
Representative Robert N. Herkes, Chair
Representative Glenn Wakai, Vice Chair

Wednesday, February 18, 2009, 2:00 p.m.
Conference Room #325
Hawaii State Capitol

Testimony Supporting HB 700 H.D. 1 - Relating to Nongovernmental Health Plan Payments to Critical Access Hospitals and federally Qualified Health Centers
Requires mutual and fraternal benefit societies, health maintenance organizations, and health plans other than government payers to pay: (1) critical access hospitals no less than 101% of costs for services; and (2) federally qualified health centers no less than their respective prospective payment system rates.

Thomas M. Driskill, Jr.
President & Chief Executive Officer
Hawaii Health Systems Corporation

On behalf of the Hawaii Health Systems Corporation (HHSC) Corporate Board of Directors, thank you for the opportunity to present testimony in strong support of this bill.

The purpose of this bill is to require mutual and fraternal benefit societies, and health maintenance organizations, and health plans other than government payers to pay: (1) critical access hospitals no less than 101 % of costs for services; and (2) federally qualified health centers no less than their respective prospective payment system rates.

Currently, government is subsidizing the costs for healthcare services provided to beneficiaries of mutual and fraternal benefit societies, health maintenance organizations, and health plans other than government payers by critical access hospitals (CAHs) and federally qualified health centers (FQHC), because health plans in Hawaii are not paying for the full costs of care provided to plan beneficiaries.

It is estimated that the enactment of this legislation could provide for approximately $5 million annually in increased reimbursements to critical access hospitals and an aggregate $47,475,544 in increased reimbursements over eight years to critical access hospitals, assuming same service levels and 5% inflation per year. It is estimated that

the enactment of this legislation could provide for approximately $7.3 million in increased reimbursements to federally qualified health centers, and an aggregate $67,708,495 in increased reimbursements over eight years to federally qualified health centers, assuming same service levels and 5% inflation per year.

All hospitals are adversely affected by declining reimbursement trends, but rural facilities are especially disadvantaged, due to the low volume of patients and high expense of providing care in remote areas. Federally qualified health centers (health centers) are especially disadvantaged due to low payments from commercial health plans, even though enhanced payments from government programs (Medicare and Medicaid) tend to cover operating costs. Recognizing the financial challenges faced by rural hospitals, the federal government passed 42 United States Code 1395i-4, which established the Medicare rural hospital flexibility program, a national program designed to assist states and rural communities in improving access to essential health care services through the establishment of limited service hospitals and rural health networks. The program creates the critical access hospital as a limited service hospital eligible for Medicare certification and reimbursement, and supports the development of rural health networks consisting of critical access hospitals, acute general hospitals, and other health providers.

Congress also established federally qualified health centers as a category of provider that specializes in comprehensive primary health care for underserved communities. Among mandated provisions for federally qualified health centers are cost-related reimbursement for Medicaid and Medicare services.

The U.S. Department of Health and Human Services Medicare and Medicaid Services pay critical access hospitals on the basis of one hundred and one per cent of costs for acute care inpatient and outpatient services. The State of Hawaii department of human services calculates payments to critical access hospitals on a cost basis for acute inpatient and long term care services to beneficiaries of the Medicaid program.

This bill will enable critical access hospitals and federally qualified health centers to continue to provide the current levels of services to patients in rural communities, whose access to limited hospital services and outpatient services is adversely affected by the decreasing amounts of reimbursements from commercial health plans.

The state's ability to provide safety net services will significantly degrade, if commercial health plans continue to refuse to pay amounts that cover the costs for providing care, unless the state continues to provide special subsidies to CAHs and FQHCs to cover operating losses of CAHs and FQHCs from providing services to beneficiaries of mutual and fraternal benefit societies, health maintenance organizations, and health plans other than government payers. Financial and social burdens will fall increasingly on agencies of the state and county governments because of the health and economic impact of declining and degrading healthcare services if government would not continue to subsidize costs of healthcare services provided to beneficiaries of mutual and

fraternal benefit societies, health maintenance organizations, and health plans other than government payers

Original version of HB 700 has been amended in HB 700 HD1 to more specifically and completely identify payers to which the law will apply and to establish the payment requirements will apply to "each individual and group hospital, or medical service plan, policy, contract, or agreement issued, amended, or renewed in this State after December 31, 2009". We support and appreciate these enhancements to the bill.

We respectfully ask that the committee support this initiative by passing this bill forward for further consideration.

TO: Representative Robert N. Herkes, Chair
Committee on Consumer Protection & Commerce

FROM: Summerlin Life & Health Insurance Company, Lori Naylon

DATEL February 16, 2009

RE: HB700, HD1: RELATING TO NONGOVERNMENT HEALTH PLAN PAYMENTS TO CRITICAL ACCESS HOSPITALS AND FEDERALLY QUALIFIED HEALTH CENTERS

Chair Herkes, and Members of the Committees:

Thank you for the opportunity to testify in opposition of HB700, HD1.

Summerlin has established contracts with hospitals and health centers. Facilities are contracted individually and the reimbursement rate is a negotiated rate. Summerlin has always been open to negotiating with our providers, including critical care facilities and health centers. HB700, HD1 would invalidate existing contracts. Is it the intent of this bill to set a standard "cost" for all group health insurance carriers?

At issue is at what rate should Critical Care Access Hospitals and Federally Qualified Health Centers be reimbursed. The ambiguous nature of "cost" is a major concern. HB700, HD1 would allow individual facilities to charge one hundred and one per cent of cost. Who determines "cost" and "101% of cost"? Does "cost" change from day to day and location to location?

To properly administer payment, parameters and guidelines must be established. If the payment rate, "cost", is ambiguous, then reimbursement at the correct rate will be difficult.

Group health insurance subscribers pay a percentage of the charges. If the charges increase then the subscriber's portion would increase. Employers would see the rate increase in higher premiums. During these tough economic times, drastic increases in rates will hurt both businesses and subscribers.

I urge you to not pass HB700, HD1. Thank you very much for the opportunity to testify on this measure.

Hawai'i Primary Care Association

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To: **The House Committee on Consumer Protection & Commerce**
The Hon. Robert N. Herkes, Chair
The Hon. Glenn Wakai, Vice Chair

Testimony in Support of House Bill 700, HD 1
Relating to Nongovernment Health Plan Payments to Critical Access Hospitals and Federally Qualified Health Centers
Submitted by Beth Giesting, CEO
February 18, 2009, 2:00 p.m. agenda, Room 325

The Hawaii Primary Care Association asks your support for this measure, which would provide appropriate compensation for Hawaii's health care safety net. Both Critical Access Hospitals and Federally Qualified Health Centers (FQHCs) are recognized by the federal government as essential community providers and are guaranteed enhanced reimbursement rates from public insurance (Medicare and Medicaid) to cover costs.

Speaking for FQHCs, these enhanced rates are provided both so that they won't have to use federal grants to subsidize the cost of public insurance programs but also in recognition of the additional services that are needed by and provided to FQHC patients. These include offering care with linguistic and cultural competence; ensuring that transportation is available; and providing extensive care management that includes outreach, follow-up, referral arrangements, and application assistance. FQHCs also provide medical, behavioral health, and dental care all on the same site, which increases the likelihood that patients will get all the primary care they need in a timely and appropriate way. The integration of behavioral health with medical care is particularly clinically and financially effective. Some FQHCs serve geographically isolated places where it isn't economically feasible for other care providers to practice and this may result in higher unit costs as well.

IN 2007, 24% of FQHC patients – 25,000 individuals – had private insurance. Neighbor island FQHCs tend to have higher percentages of privately insured patients because they are more frequently the only providers in the communities they care for. We estimate that FQHCs earn about $7 million less per year from private insurers than it costs to deliver care to their patients. At the same time the FQHCs saved more than $46 million[1] for the plans because of the care they delivered to privately insured patients. These savings are due to the FQHC model of care that provides comprehensive and timely primary clinical and management services which greatly reduce duplicative diagnostic testing, specialty referrals, ER use, and hospitalization.

We believe this measure deserves your thoughtful consideration and appreciate the opportunity to provide this testimony.

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[1] A study prepared by the Robert Graham Center using Medical Expenditure Panel Survey data for 2007 shows that FQHCs save an average of $1,914 per privately insured patient per year when compared to the private practice system. $1,914 x 24,364 privately insured patients served by FQHCs in 2007 = $46.6 million.

LĀNA'I WOMEN'S CENTER DBA LĀNA'I COMMUNITY HEALTH CENTER

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House Consumer Protection & Commerce hearing
Wednesday, February 18, 2009
2:00-pm
Conference room 325

To: **The House Committee on Health**
The Hon. Robert Herkes, Chair
The Hon. Glenn Wakai, Vice Chair

Testimony in Support of House Bill 700
Relating to Nongovernment Health Plan Payments to Critical Access Hospitals and FQHCs
Submitted by Diana V. Shaw, PhD, MPH, MBA, FACMPE, Executive Director

The **Lāna'i Women's Center dba Lāna'i Community Health Center** asks your support for this measure, which would provide appropriate compensation for Hawaii's health care safety net. Our Center is recognized by the federal government as an essential community provider and is guaranteed enhanced reimbursement rates from public insurance (Medicare and Medicaid) to cover costs.

The enhanced rates that we receive are provided both so that we won't have to use federal grants to subsidize the cost of public insurance programs but also in recognition of the additional services that are needed by and provided to our patients. These include offering care with linguistic and cultural competence; ensuring transportation is available; and providing extensive care management that includes outreach, follow-up, referral arrangements, and application assistance. Our community health center also provides medical, behavioral health, and dental care which increases the likelihood that patients will get all the primary care they need in a timely and appropriate way. The integration of behavioral health with medical care is particularly clinically and financially effective. The community of Lāna'i is very isolated and is a medically underserved population — as such our unit costs are higher than other areas where isolation is not an issue.

Our services create savings in the health care systems due to the model of care that we provide — comprehensive and timely primary clinical and management services which greatly reduce duplicative diagnostic testing, specialty referrals, ER use, and hospitalization.

I strongly urge your thoughtful consideration and appreciate the opportunity to provide this testimony.

E Ola nō Lāna'i
LIFE, HEALTH, and WELL-BEING FOR LĀNA'I