THE SENATE
TWENTY-FIFTH LEGISLATURE, 2009
STATE OF HAWAII

S.B. NO. 1140

JAN 28 2009

A BILL FOR AN ACT

RELATING TO HEALTH CARE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that rural hospitals and federally qualified health centers are essential to the State's health care system. All health care providers are hurt by low reimbursement rates, but rural hospital facilities and publicly supported health centers that serve economically disadvantaged persons are especially disadvantaged because of the high cost of providing care in remote areas with low patient volume and of providing comprehensive care to underserved populations with complex health and socio-economic needs. In recognition of these difficulties, the federal government created critical access hospitals and federally qualified health centers to assist states in improving access to essential health care services.

Critical access hospitals and federally qualified health centers serve consumers who are covered under the medicare and medicaid programs as well as those with other types of health coverage. State and federal law determine the reimbursement

rates for medicare and medicaid provided services. The federal Department of Health and Human Services, through the Center for Medicare and Medicaid Services, pays critical access hospitals one hundred and one per cent of costs for acute care service to medicare recipients. The Hawaii department of human services also calculates payments to critical access hospitals for services to medicaid beneficiaries based on the actual cost of the service. Pursuant to state and federal law, reimbursements for medicaid services reflect both an estimated average cost and the actual cost of providing services, with the State making up the difference between managed care payments and the federal reimbursement rate.

The purpose of this Act is to require health plans, other than government payors, licensed to do business in this State, to reimburse critical access hospitals and federally qualified health centers at rates consistent with medicare and medicaid reimbursement rates.

SECTION 2. Chapter 431, article 10A, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§431:10A- Cost-based payments to critical access hospitals and federally qualified health centers.** (a) Health

insurers other than government payors shall reimburse critical access hospitals as defined in section 346D-1 at a rate not less than one hundred and one per cent of costs, consistent with the medicare reimbursement rate, for all services rendered to health plan beneficiaries.

(b) Health insurers other than government payors shall pay federally qualified health centers as defined in section 1905(l) of the Social Security Act (42 USC 1396d) no less than their respective prospective payment system rates determined pursuant to sections 346-53.6 to 346-53.64.

(c) Nothing in this section shall be construed to determine a maximum amount that a health insurer other than a government payor may pay to a critical access hospital or federally qualified health center for services to plan beneficiaries.

(d) The commissioner may adopt administrative rules pursuant to chapter 91 to effectuate the purpose of this section. The commissioner may require health insurers other than government payors to annually demonstrate compliance with this section, including validation of payment rates in accordance with medicare interim rate letters.

The commissioner may require critical access hospitals and federally qualified health centers to provide information as requested by the commissioner to clarify, supplement, or rebut information supplied by a health insurer; provided that the release of information by a critical access hospital or federally qualified health center shall be subject to the provisions of the Health Insurance Portability and Accountability Access Act of 1996.

(e) As used in this section:

"Government payor" means a state or federal government entity that provides medical assistance in the form of payment or reimbursement to a health care provider for the cost of providing health care to an enrollee, or a nongovernmental party contracted by a government entity to do so."

SECTION 3. Chapter 432, article 1, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§432:1- Cost-based payments to critical access hospitals and federally qualified health centers.** (a) Mutual benefit societies shall reimburse critical access hospitals as defined in section 346D-1 at a rate not less than one hundred and one per cent of costs, consistent with the medicare

reimbursement rate, for all services rendered to health plan beneficiaries.

(b) Mutual benefit societies shall pay federally qualified health centers as defined in section 1905(l) of the Social Security Act (42 USC 1396d) no less than their respective prospective payment system rates determined pursuant to sections 346-53.6 to 346-53.64.

(c) Nothing in this section shall be construed to determine a maximum amount that a mutual benefit society may pay to a critical access hospital or federally qualified health center for services to plan beneficiaries.

(d) The commissioner may adopt administrative rules pursuant to chapter 91 to effectuate the purpose of this section. The commissioner may require mutual benefit societies to annually demonstrate compliance with this section, including validation of payment rates in accordance with medicare interim rate letters.

The commissioner may require critical access hospitals and federally qualified health centers to provide information as requested by the commissioner to clarify, supplement, or rebut information supplied by a mutual benefit society; provided that the release of information by a critical access hospital or

federally qualified health center shall be subject to the provisions of the Health Insurance Portability and Accountability Access Act of 1996."

SECTION 4. Chapter 432, article 2, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§432:2- Cost-based payments to critical access hospitals and federally qualified health centers.** (a) Fraternal benefit societies shall reimburse critical access hospitals as defined in section 346D-1 at a rate not less than one hundred and one per cent of costs, consistent with the medicare reimbursement rate, for all services rendered to health plan beneficiaries.

(b) Fraternal benefit societies shall pay federally qualified health centers as defined in section 1905(l) of the Social Security Act (42 USC 1396d) no less than their respective prospective payment system rates determined pursuant to sections 346-53.6 to 346-53.64.

(c) Nothing in this section shall be construed to determine a maximum amount that a fraternal benefit society may pay to a critical access hospital or federally qualified health center for services to plan beneficiaries.

(d) The commissioner may adopt administrative rules pursuant to chapter 91 to effectuate the purpose of this section. The commissioner may require fraternal benefit societies to annually demonstrate compliance with this section, including validation of payment rates in accordance with medicare interim rate letters.

The commissioner may require critical access hospitals and federally qualified health centers to provide information as requested by the commissioner to clarify, supplement, or rebut information supplied by a fraternal benefit society; provided that the release of information by a critical access hospital or federally qualified health center shall be subject to the provisions of the Health Insurance Portability and Accountability Access Act of 1996."

SECTION 5. Chapter 432D, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§432D- Cost-based payments to critical access hospitals and federally qualified health centers.** (a) Health maintenance organizations other than government payors shall reimburse critical access hospitals as defined in section 346D-1 at a rate not less than one hundred and one per cent of costs, consistent

with the medicare reimbursement rate, for all services rendered to health plan beneficiaries.

(b) Health maintenance organizations other than government payors shall pay federally qualified health centers as defined in section 1905(l) of the Social Security Act (42 USC 1396d) no less than their respective prospective payment system rates determined pursuant to sections 346-53.6 to 346-53.64.

(c) Nothing in this section shall be construed to determine a maximum amount that a health maintenance organization other than a government payor may pay to a critical access hospital or federally qualified health center for services to plan beneficiaries.

(d) The commissioner may adopt administrative rules pursuant to chapter 91 to effectuate the purpose of this section. The commissioner may require health maintenance organizations other than government payors to annually demonstrate compliance with this section, including validation of payment rates in accordance with medicare interim rate letters.

The commissioner may require critical access hospitals and federally qualified health centers to provide information as requested by the commissioner to clarify, supplement, or rebut

information supplied by a health maintenance organization other than a government payor; provided that the release of information by a critical access hospital or federally qualified health center shall be subject to the provisions of the Health Insurance Portability and Accountability Access Act of 1996.

(e) As used in this section:

"Government payor" means a state or federal government entity that provides medical assistance in the form of reimbursement to a health care provider for the cost of providing health care to an enrollee, or a nongovernmental party contracted by a government entity to do so."

SECTION 6. New statutory material is underscored.

SECTION 7. This Act shall take effect on July 1, 2009.

INTRODUCED BY: _____

By Request

S.B. NO. 1140

Report Title:
Health Plan Payments; Critical Access Hospitals; Federally Qualified Health Centers

Description:
Requires commercial health plans licensed to do business in the State to pay no less than 101% of costs for all services provided to plan beneficiaries by critical access hospitals and federally qualified health centers.

LINDA LINGLE
GOVERNOR

JAMES R. AIONA, JR.
LT. GOVERNOR

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LAWRENCE M. REIFURTH
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RONALD BOYER
DEPUTY DIRECTOR

TO THE SENATE COMMITTEES ON HEALTH
AND COMMERCE AND CONSUMER PROTECTION

TWENTY-FIFTH LEGISLATURE
Regular Session of 2009

Tuesday, February 10, 2009
8:30 a.m.

TESTIMONY ON SENATE BILL NO. 1140 – RELATING TO HEALTH CARE.

TO THE HONORABLE DAVID Y. IGE AND ROSALYN H. BAKER, CHAIRS, AND MEMBERS OF THE COMMITTEES:

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.

Hospitals in Hawaii have been losing money over the past several years, particularly in rural areas. We have had numerous complaints that the reimbursements to doctors and hospitals do not recover their costs. Kahuku Hospital almost closed and the State Hospital has had to request emergency appropriations. 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 reimbursement level is one step to help ensure that these facilities can keep operating and provide services. This bill is limited to critical access facilities which are particularly important to our communities.

We thank these Committees 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"

Joint Hearing

Senate Committee on Health
Senator David Y. Ige, Chair
Senator Josh Green, M.D., Vice Chair
Senate Committee on Commerce and Consumer Protection
Senator Rosalyn H. Baker, Chair
Senator David Y. Ige, Vice Chair

Tuesday, February 10, 2009, 8:30 a.m.
Conference Room 229
Hawaii State Capitol

Testimony Supporting SB1140 Relating to Healthcare
Requires commercial health plans licensed to do business in the State to pay no less than 101% of costs for all services provided to plan beneficiaries by critical access hospitals and federally qualified health centers.

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

On behalf of the Hawaii Health Systems Corporation (HHSC) Corporation Board of Directors, thank you for the opportunity to present testimony in strong support of SB 1140.

The purpose of this bill is to require health plans, other than government payers, licensed to do business in this state, to reimburse critical access hospitals and federally qualified health centers at rates consistent with Medicare and Medicaid reimbursement rates. The bill would require insurers other than government payers to reimburse critical access hospitals as defined in section 346D-1 at a rate not less than one hundred and one percent of costs, consistent with the Medicare reimbursement rate, for all services rendered to health plan beneficiaries and to pay federally qualified health centers as defined in section 1905 (1) of the Social Security Act (42 USC 1396d) no less than their respective payment system rates determined pursuant to sections 346-53.6 to 346-53.64.

Currently, government is subsidizing the costs for healthcare services provided to beneficiaries of health plans, other than government payers, by critical access hospitals (CAHs) and federally qualified health centers (FQHCs), because health plans in Hawaii, other than government payers, 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 o 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 pays 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.

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

In recent discussions with the Department of Health and the Department of the Attorney General, we were advised that, instead of stating the provisions of this bill are applicable to “health plans, other than government payers”, it would be more technically correct and inclusive to make the bill applicable to “mutual and fraternal benefit societies, and health maintenance organizations, and health plans other than government payers”. We respectfully request this technical amendment be made to SB 1140 and that SB 1140 be passed forward for further consideration.

HMSA
Blue Cross Blue Shield of Hawaii
An Independent Licensee of the Blue Cross and Blue Shield Association

February 9, 2009

The Honorable David Ige, Chair
The Honorable Rosalyn Baker, Chair

Senate Committees on Health and Commerce and Consumer Protection

Re: SB 1140 – Relating to Health Care

Dear Chair Ige, Chair Baker and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 1140 which requires health plans pay Critical Access Hospitals (CAH) no less than 101% of costs for services Federally Qualified Health Centers (FQHC) no less than their respective prospective payment system rates. HMSA has concerns with this measure.

While HMSA supports assisting CAHs and FQHCs, we do foresee some issues with the way in which payment determinations would be calculated. This measure is addressing two different payment methodologies which are worth outlining.

CAHs are limited to 25 beds and primarily operate in rural areas. Unlike traditional hospitals (which are paid under prospective payment systems), Medicare pays CAHs based on each hospital's reported costs. Each CAH receives 101 percent of its costs for outpatient, inpatient, laboratory and therapy services, as well as post-acute care in the hospital's swing beds. For Medicare beneficiaries the government pays 101% of the self-reported costs incurred for services after performing reviews and audits to validate the costs before making a final payment. This measure would require that private plans pay CAHs the same way that Medicare does. The problem with implementing this payment structure is that the reporting of cost is left up to each facility with no standardization in place to ensure accuracy.

Currently FQHCs do not use the same cost based payment structure that CAHs use. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 established a prospective payment system for FQHCs. This system, which has been in place since January 2001, replaced the previous cost-based reimbursement system for health centers under Medicaid. The prospective payment system establishes a per visit payment rate for each FQHC in advance. The 2001 payment rate was based on the average of each FQHC's reasonable costs per visit in FY 1999 and FY 2000. Since FY 2002, payments made under this system have been adjusted annually for inflation using the Medicare Economic Index. Payments also are adjusted based on increases or decreases in change in scope of services provided. The problem with implementing this payment structure is that the reimbursement rate would be set in statute.

The changes in payments to CAHs and FQHCs raise many issues including:

Regulating Reimbursements
A health plan's reimbursement rates to providers are not in statute. We believe that a health plan should have the ability to set its own rates. Additionally, placing reimbursement rates in statute may cause problems in the long run as they will be difficult to revise to react to changes in the health care environment.

Self-Reporting of Costs
Under the payment structure outlined in SB 1140, the payments for CAHs would be tied to their costs which are self-reported. On the surface this may seem to make sense, however the measure contains no quality control or standardization to verify the costs being reported by each facility are appropriate. Without any oversight or standardization the cost of the same item could vary from facility to facility. For example an aspirin at Ka'u Hospital could be reported at a cost of 1 dollar while an aspirin at Kohala Hospital could be reported at a cost 5 dollars. Health plans would have to reimburse based on these variable costs.

Additionally, reported costs from each facility may not be relevant to the services being provided to the member. For example, the health plan would not know if the cost for a member who receives a blood test at a facility includes direct charges for staffing.

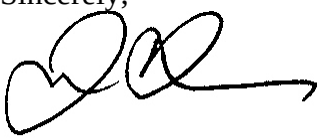
Additional Administrative Burden
Both health plans and facilities must comply with a myriad of state and federal regulations. Including the Insurance Commissioner as the entity which would have to reconcile cost reimbursements would be an additional administrative and regulatory burden to health plans and the facilities.

It is important to note that the administrative burden for HMSA to comply with SB 1140 could be quite large while the number of HMSA members who utilize services from CAHs is quite small. It is unlikely that changes to the payments to CAHs for private plan members would change enough to truly make a difference for the facilities themselves.

While we appreciate the legislature's proactive approach in assisting CAHs and FQHCs we do not believe that this measure will be able to accomplish this worthy goal. Thank you for the opportunity to testify on SB 1140.

Thank you for the opportunity to testify.

Sincerely,



Jennifer Diesman
Assistant Vice President
Government Relations

Ka'u Hospital
Ka Hale Ola Ka'u

Joint Hearing
Senate Committee on Health
Senator David Y. Ige, Chair
Senator Josh Green, M.D. Vice Chair
Senate Committee on Commerce and Consumer Protection
Senator Rosalyn H. Baker, Chair
Senator David Y. Ige, Vice Chair

Tuesday, February 10, 2009, 8:30 a.m.
Conference Room 299
Hawaii State Capitol

Testimony Supporting SB1140 Relating to Healthcare

Merilyn Harris, Administrator
Ka'u Hospital

Critical Access Hospitals and Federally Qualified Health Centers serve a very special need in our communities by providing health care to people who have federally recognized barriers to receiving that care.

Ka'u Hospital is the only hospital in an area as large as the entire island of Oahu. It has the only emergency department, the only radiology department, the only long-term care, and the only acute beds. Our hospital is unique in that we also provide primary health care through our rural health clinic. The physician we employ in our clinic and the physician at the local FQHC in Naalehu are the only practicing physicians in the district.

Our hospital is the entry point to the health care system for the majority of the people of Ka'u. Most of our patients have strong roots in this area. Our community has demonstrated time and time again their commitment to supporting our hospital in spite of the difficult economic conditions that have always characterized this district. Nearly all of the new equipment purchased for our emergency department over the past few years has been paid for by bake and craft sales, spaghetti dinners and golf tournaments put on by volunteers who believe in our mission. This month our hospital will take possession of a new wheelchair accessible van for our long-term care residents, entirely paid for by the fundraising efforts of the people of Ka'u.

This community is giving all it can to ensure that our hospital remains viable and continues to enhance the services we provide. I would respectfully request that our commercial payers be required to do the same.

KONA
COMMUNITY HOSPITAL
Care You Can Count On

Committee on Health
Senator David Y. Ige, Chair
Senator Josh Green, Vice-Chair

Committee on Commerce and Consumer Protection
Senator Rosalyn H. Baker, Chair
Senator David Y. Ige, Vice-Chair

Tuesday, February 10, 2009
8:30 a.m.
Conference Room 229
Hawaii State Capitol

SB 1140 - Relating to Nongovernmental Health Plan Payments to Critical Access Hospitals and federally Qualified Health Centers Requires health plans other than government payers, mutual and fraternal benefit societies, and health maintenance organizations to pay: 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

On behalf of the West Hawaii Region of HHSC, thank you for the opportunity to provide testimony in strong support of SB 1140.

This bill requires mutual and internal benefit societies, health maintenance organizations, and health plans other than government payers to pay: 1) critical access hospitals (CAHs) no less than 101 % of cost for services; and 2) federally qualified health centers (FQHCs) no less than their respective prospective payment system rates.

This bill will enable CAHs and FQHCs 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.

Currently, government subsidizes the cost of providing healthcare services to beneficiaries of mutual and fraternal benefit societies, and health maintenance organizations, and health plans other than government payers by CAHs and FQHCs, because health plans in Hawaii do not pay the full cost of care provided to plan beneficiaries.

Hawaii's ability to provide safety net services will significantly degrade, if commercial health plans continue to pay amounts that do not cover the costs for providing care, unless the state provides increased subsidies to CAHs and FQHCs to cover operating losses. 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

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would not continue to subsidize costs of healthcare services provided to beneficiaries of mutual and fraternal benefit societies, and health maintenance organizations, and health plans other than government payers.

It is estimated that the enactment of this legislation would provide approximately $5 million annually in increased reimbursements to CAHs and over $47 million over eight years assuming same service levels and 5% inflation per year. For FQHCs, the annual increase in reimbursement would be $7.3 million, and almost $68 million over eight years.

Your support of this bill is greatly needed and appreciated.

Respectfully submitted,

Earl Greenia
Chief Executive Officer
West Hawaii Region - Hawaii Health Systems Corporation
Kona Community Hospital and Kohala Hospital

MCCORRISTON MILLER MUKAI MACKINNON LLP

ATTORNEYS AT LAW

February 5, 2009

Honorable David Y. Ige, Chair
Honorable Josh Green, M.D., Vice Chair
Committee on Health
Honorable Rosalyn H. Baker, Chair
Honorable David Y. Ige, Vice Chair
Committee on Commerce and Consumer Protection
Senate
State Capitol
415 South King Street
Honolulu, Hawaii 96813

Re: S.B. No. 1140, RELATING TO HEALTH CARE

Dear Chairs Ige and Baker, Vice Chair Green, and Committee Members:

On behalf of the American Family Life Assurance Company of Columbus (AFLAC), we respectfully submit the following written testimony with respect to Senate Bill No. 1140, relating to health care which is to be heard by your Committees on Health and on Commerce and Consumer Protection on February 10, 2009.

S.B. No. 1140 is intended to require that commercial health plans licensed to do business in the State pay no less than 101% of the costs for all services provided to plan beneficiaries by critical access hospitals and federally qualified health centers. While this requirement may be appropriate for primary managed-care health insurance policies, there are certain types of supplementary health insurance for which such a requirement clearly would not be appropriate. Specifically, there are certain types of limited benefit insurance which are fixed indemnity policies that pay a specific fixed amount directly to the policy holders, based on specific occurrences of treatment or disease, regardless of the costs incurred, *i.e.*, are not reimbursement policies.

At present, limited benefit insurance policies allow consumers to acquire supplemental insurance coverage for a fixed amount regardless of the costs incurred, for example for hospital confinement, at a low cost. Requiring limited benefit insurance to pay on a cost basis will harm consumer by either unnecessarily increasing the cost of limited benefit insurance and/or causing such insurance to become unavailable altogether.

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For the foregoing reasons, we support the amendment of Section 2 of S.B. No. 1140 to delete from its coverage "limited benefit insurance" by adding to the new section to be added to Hawaii Revised Statutes chapter 431, Article 10, the following subsection, which is based upon the language currently contained in Hawaii Revised Statutes section 431:10A-121:

> "(f) This section shall not apply to an accident-only, specified disease, hospital indemnity, medicare supplement, long-term care, or other limited benefit health insurance policy."

(Additional language underscored.)

As noted, these types of policies are supplemental to an insured's primary health insurance policy and are not reimbursement policies. Applying the requirements of S.B. No. 1140 to limited benefit health insurance will only deprive consumers of the ability to purchase such supplemental insurance coverage, without any benefit to the consumers.

Thank you for your consideration of the foregoing.

Very truly yours,

McCORRISTON MILLER MUKAI MacKINNON LLP

Peter J. Hamasaki