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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

April 3, 2009

MEMORANDUM

TO: Honorable Marcus R. Oshiro, Chair
House Committee on Finance

FROM: Lillian B. Koller, Director

SUBJECT: **S.B. 1344, H.D. 1 – RELATING TO HEALTH CARE**

Hearing: Friday, April 03, 2009, 2:00 p.m.
Conference Room 308, State Capitol

PURPOSE: The purpose of this bill is to eliminate positive enrollment for QUEST and QUEST Expanded Access recipients. In addition, it requires insurance entities contracting to provide Medicaid services to enter into written contracts with at least fifty percent of hospitals and providers in their coverage areas.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) strongly opposes this bill because it provides no value over current practice, treats QUEST clients differentially, seeks to extinguish competition that improves quality of care for the clients and value for the taxpayers, and places extraordinary burdens on providers.

Positive enrollment is a 60-day period during which clients can select a health plan and occurs only when a new round of contracts has been awarded. (The ten-day period stated in the preamble of this bill is factually incorrect.) During the last positive enrollment, 83% of clients selected a health plan; we have been told that this is the best response of Medicaid clients nationwide selecting their health plans.

For those who do not select a health plan, DHS assigns them to a health plan following the auto-assignment algorithm published in the Request For Proposal (RFP) and incorporated into the contracts with the winning health plans.

All our Medicaid clients get the same opportunity to change their health plan, whether they chose or were auto-assigned to a health plan. Because there is a transition period during which clients can change health plans, all will have an additional opportunity to select the health plan of their choosing. Following the initial 60-day plan selection period, clients are allowed 90 days to change health plans, whether they chose or were auto-assigned to a health plan. During this transition period, the new health plan will pay for care delivered by the patient's usual provider, even if that provider is not participating in the new health plan.

Up until now in our QUEST program, the auto-assignment algorithm has been based on price. The lower the per member per month cost to the State, the higher the number of recipients auto-enrolled to the health plan. Inn our next QUEST procurement, DHS intends to include performance on quality measures as a factor in the algorithm to add an incentive for quality improvement. Auto-assignment is thus an effective tool to increase both quality of care and taxpayer value of care.

We also plan to publicly report health plan quality measures to better inform clients for health plan selection. DHS already provides outreach to clients to educate them of the health plans with information for accessing provider directories. Positive enrollment has had a positive impact on both quality of care and value of care by heightening competition among bidders.

Positive enrollment also creates equity when a health plan enters or leaves the Medicaid program. If an existing health plan decides not to continue or was not awarded a contract, all enrollees would need to be auto-assigned to the remaining health plans. Analogously, a new health plan should be among the health plans receiving auto-assigned enrollees.

Eliminating auto-assignment, as proposed in this bill, makes it difficult for a new health plan to enter the Medicaid program because it makes it more difficult for them to anticipate the

number of initial enrollees. Decreased competition results in decreased quality and value for clients and taxpayers.

Regarding the recently added section of this bill on requiring any insurance entity to contract with 50% of providers within 90 days, this section is merely governmental interference in negotiations between two private sector parties. This requirement offers absolutely no benefit to the State or its clients, and, in fact, has a detrimental effect.

DHS contracts already require that providers must develop an adequate network which must be in place by the implementation date. The Federal Centers for Medicare & Medicaid Services (CMS) must approve network adequacy for our Medicaid programs to commence. This bill seeks to supplant the responsibilities and requirements of the Federal government.

Further, the definition of "insurance entity" in this bill is vague and could include any risk-based contracting such as through pay-for- performance or capitation to a provider such as a Federally Qualified Health Center functioning as a medical home or a case management agency servicing a panel of patients. They would also be subject to the provisions of this bill.

Even if the language is changed to a "health plan", not all health plans are contracted to provide all services. For example, DHS has a contract with a health plan for only outpatient mental health services. There is no reason for them to contract with hospitals. And QUEST plans would be required to contract with nursing facilities, care homes, and other home and community based service providers, all of which is currently not done. It is possible that certain types of services are carved out of the contracts. This bill limits all flexibility for DHS to develop contracts to best serve the needs of all its clients.

What does the number 50% even mean? Many providers licensed in the State do not practice here. Identifying the actual number is challenging. In addition, many providers do not service Medicaid clients or service only a limited number of Medicaid clients. How can health plans be required to contract with a greater number of providers than those who currently serve Medicaid clients?

This bill simply shifts the balance of contract negotiations. The compressed time frame gives leverage to certain providers which would subsequently increase payment rates and therefore, increase cost to the State.

Finally, let us take a look at who this bill proposes to protect. The health plans currently in our Medicaid programs are HMSA, the predominant insurer in Hawaii, Kaiser Permanente whose non-profit QUEST health plan is a non-profit but the parent company is a mainland for-profit company, and AlohaCare, the third largest insurer in Hawaii. This bill will protect the market shares of these three powerful non-profits from future competition in the QUEST and QExA Medicaid programs and from new health plans entering the Medicaid market through positive enrollment.

This bill is tantamount to Legislative market-share fixing which violates antitrust law. This bill will greatly escalate costs in our QUEST program by diminishing competition to benefit a few strong health plans at the State's expense.

The existing health plans in QUEST may be well served by this bill, but at the expense of client quality of care and taxpayer value of care. This bill is fraught with consequences that will increase cost to the State, burden providers, and establish barriers to competition. It is a thin veil, masking the self-interest of the existing QUEST health plans against competition and the best interests of the State.

Thank you for this opportunity to testify.

TESTIMONY OF THE STATE ATTORNEY GENERAL
TWENTY-FIFTH LEGISLATURE, 2009

ON THE FOLLOWING MEASURE:
S.B. NO. 1344, H.D. 1, RELATING TO HEALTH CARE.

BEFORE THE:
HOUSE COMMITTEE ON FINANCE

DATE: Friday, April 3, 2009 **TIME:** 2:00 PM

LOCATION: State Capitol, Room 308

TESTIFIER(S): Mark J. Bennett, Attorney General,
or Cori K. Woo, Deputy Attorney General.

Chair Oshiro and Members of the Committee:

The Department of The Attorney General has concerns regarding section 2 of this bill.

The purpose of section 2 is to add a new section to chapter 346, Hawaii Revised Statutes, that would require the "insurance entities" that contract with the State to provide Medicaid coverage to enter into written contracts with at least fifty percent of hospitals and providers of healthcare services in their coverage areas.

The wording of this new section is unclear and would make implementation difficult. First, the bill does not define the term "insurance entity." The bill should list the specific types of entities that would fall under this term.

Second, the bill does not specify how the fifty percent figure is to be applied to the hospitals and providers. For example, does it apply to fifty percent of all the hospitals and providers in the coverage area, or fifty percent of the participating Medicaid providers? It is also unclear whether the entities must contract with fifty percent of the hospitals and fifty percent of the other providers, or fifty percent of the combined total of hospitals and other providers.

Third, the bill does not specify who should be included in the category of "providers of healthcare services." Without clear specification, there is no way of knowing if the insurance entity has contracted with the required minimum fifty percent of providers. One way to cure this problem would be to state that the insurance entity would be required to enter into contracts only with the providers of the services specified in the contract between the insurance entity and the State.

Fourth, also unclear is how the ninety-day requirement for the insurance entity to enter into written contracts will be implemented. The bill does not specify when the ninety-day period begins.

If this bill is passed we respectfully request that it be amended to address these concerns.

Hawai'i Primary Care Association

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www.hawaiipca.net

To: **House Committee on Finance**
The Hon. Marcus R. Oshiro, Chair
The Hon. Marilyn B. Lee, Vice Chair

Testimony in Support of Senate Bill 1344, HD1
Relating to Health Care
Submitted by Beth Giesting, CEO
April 3, 2009, 2:00 p.m. agenda, Room 308

The Hawaii Primary Care Association supports this bill. We strongly champion the rights of QUEST enrollees to choose their health plan and provider; however, when literacy and language challenges meet letters from DHS misunderstandings are likely to result. In addition, QUEST enrollees are fairly mobile and mailed notices often do not reach them. We believe that so-called positive enrollment should be minimized as it causes confusion for clients, additional work for both state and private workers to sort out unintended reassignments, and likely disruption of patient/plan/provider relationships.

We support the process outlined in this measure will help ensure that patient care is not sacrificed unnecessarily for relatively modest economic benefits. Thank you for the opportunity to testify in support of this measure.

Hawaii Pacific Health

55 Merchant Street • Honolulu, Hawaii 96813 • hawaiipacifichealth.org

Friday – April 03, 2009
Conference Room 308
2:00 pm

The House Committee on Finance

To: Representative Marcus R. Oshiro, Chair
Representative Marilyn B. Lee, Vice Chair

From: Hilton Raethel
Vice President – Contracting & Decision Support

RE: Testimony in Strong Support of SB 1344 HD1

My name is Hilton Raethel, Vice President of Contracting and Decision Support for Hawaii Pacific Health which is the four-hospital system of Kapi'olani Medical Center for Women & Children, Kapi'olani Medical Center at Pali Momi, Straub Clinic & Hospital, and Wilcox Memorial Hospital. For more than a century, families in Hawaii and the Pacific Region have relied on the hospitals, clinics, physicians and staff of Hawaii Pacific Health as trusted healthcare providers. Our non-profit integrated healthcare system is the state's largest healthcare provider and is committed to improving the health and well-being of the people of Hawaii and the Pacific Region through its four hospitals -- Kapi`olani Medical Center for Women & Children, Kapiolani Medical Center at Pali Momi, Straub Clinic & Hospital and Wilcox Memorial Hospital -- 18 outpatient centers and a team of 1,100 physicians on the islands of Oahu, Kauai and Lanai.

We are writing in strong support of Senate Bill 1344 HD1 which will require insurance entities contracting with the State to provide Medicaid coverage to have written contracts with at least 50% of the hospitals and providers in the coverage area within 90 days of contracting with the State, thereby ensuring an operable network for recipients.

We support this measure because it will help ensure a smooth transition for QUEST and QUEST Expanded Access plan participants and ensure that prospective Medicaid plans have a viable and operable network of hospitals and providers of healthcare services in place *prior* to contracting with the State.

Thank you for the opportunity to testify. We ask that you pass SB 1344 HD1 from this committee.

AlohaCare
Aloha is the difference

2009 APR -2 A 11: 28

April 2, 2009

The Honorable Marcus Oshiro
Chair, House Committee on Finance
House of Representatives
Hawaii State Capitol, Room 306
415 South Beretania Street
Honolulu, HI 96813

Re: SB1344, HD1 Relating to Health Care

Aloha Rep. Oshiro:

Thank you for scheduling SB1344, HD1 for a Finance Committee hearing on April 6, 2009 at 2:00pm.

We are writing to request your support for the bill.

SB1344, HD1 has been amended and approved by the House Human Services/Health Committees and requires approval from the Finance Committee in order to remain viable. SB1344's current referrals are to HUS/HLT, FIN.

AlohaCare initiated this measure in order to put an end the Hawaii Department of Human Services (DHS) policy of positive enrollment, which has disrupted the delivery of medical and related services to the enrollees of the State of Hawaii QUEST Program. As you know, Hawaii's QUEST and QUEST Expanded Programs represent some of Hawaii's most medically fragile and vulnerable residents, including low-income families, the aged, the disabled and many other groups.

Positive enrollment is a policy whereby QUEST recipients are involuntarily dis-enrolled from their health care plan and consequently from their Primary Care Provider (PCP). QUEST recipients then must select a plan and PCP, either their former plan and PCP or new ones. Those who do not select a health plan are automatically assigned one by DHS, which can be a different plan. At our request, the HD1 version of the bill applies to the QUEST and QUEST Expanded Program due to our concern that positive enrollment will be applied to that program as well. DHS supports positive enrollment because their goal is to encourage competition among health plans. DHS opposes SB1344, HD1.

In 2006, DHS implemented positive enrollment and caused unnecessary confusion among QUEST beneficiaries and providers, delays in necessary medical care, disruption to case management, loss of contact between enrollees and their primary care providers and unnecessary expense for all involved. SB1344 will ensure that this disruptive practice will not occur again.

On March 23, the House Human Services/Health Committees made the following substantive amendments, improving the bill by eliminating rather than just modifying positive enrollment:

- Removed language that details limitations on the positive enrollment policy;
- Adds a provision that prohibits DHS from requiring a QUEST or QUEST Expanded Care recipient to re-enroll in a health plan unless their chosen plan no longer actively provides services and coverage;
- Requires insurance entities contracting with the State to provide Medicaid coverage to enter into written contracts with a minimum of 50 percent of hospitals and providers in their coverage area; and
- Changes the effective date to January 1, 2050, to encourage further discussion.

AlohaCare supports the elimination of positive enrollment, despite the fact that we benefited from the 2006 auto assignment of approximately 20,000 enrollees who did not select a health plan as a result of positive enrollment. These enrollees were assigned to AlohaCare because we were the lowest bidder. As the result of our low bid, AlohaCare will save the State of Hawaii approximately $23 million over the current four year contracted period.

It is important to note that the elimination of positive enrollment does not prevent QUEST enrollees from changing health plans under the QUEST Program. Annually, as does any Hawaii health plan, including employer purchased and State employee plans, QUEST beneficiaries have the right to stay in their current plan or choose a new one. In addition, as a matter of policy, AlohaCare assists enrollees to change to alternative plans anytime of year, above and beyond the annual open enrollment period required by QUEST. We do this because we believe that offering QUEST enrollees a choice of health plans that best meet their individual needs is optimal. Thus, positive enrollment is not needed.

Again, our goal is to prevent positive enrollment from jeopardizing the care of some of Hawaii's most vulnerable and medically fragile population. AlohaCare is a non-profit health insurance company, founded in 1994 by Hawaii's community health centers, to serve the needy. Serving the healthcare needs of the people of Hawaii with aloha is our mission. AlohaCare has more than 60,000 health plan members, of which 1,200 Medicare members.

We appreciate the opportunity to share our concerns with you and we appreciate your attention to this important matter.

Please contact Paula Arcena at (808) 973-6426 or at parcena@alohacarehawaii.org, should you have any questions or comments.

Sincerely,

John McComas
Chief Executive Officer

Paula Arcena
Legislative and Community Liaison

Report Title:
Medicaid; QUEST; DHS; Positive Enrollment; Insurance Entities

Description:
Eliminates positive enrollment for QUEST and QUEST Expanded Access recipients. Requires insurance entities contracting to provide Medicaid services to enter into written contracts with at least fifty per cent of hospitals and providers in their coverage areas. Takes effect January 1, 2050. (SB1344 HD1)

THE SENATE
TWENTY-FIFTH LEGISLATURE, 2009
STATE OF HAWAII

S.B. NO. 1344 H.D. 1

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 the department of human services has instituted a positive enrollment policy whereby a QUEST and QUEST Expanded Access recipient must reenroll in the recipient's health plan within ten days. If the recipient fails to do so, the department of human services automatically assigns the individual to a health plan, which may or may not be the recipient's existing plan.

These positive enrollment requirements cause confusion, delay needed health care procedures, disrupt case management, and result in the loss of contact between QUEST and QUEST Expanded Access recipients and their current primary care providers. Further, positive enrollment incurs additional costs and imposes additional administrative burdens on QUEST and QUEST Expanded Access providers and the department of human services.

The department of human services advocates the policy of positive enrollment as a means of increasing competition among service providers, lowering the cost of healthcare overall, allowing for new plans to enter into the market, and expanding the scope of services provided to QUEST and QUEST Expanded Access Recipients.

The purpose of this Act is to minimize confusion and the disruption of health care services to QUEST and QUEST Expanded Access

recipients by eliminating the positive enrollment policy and requiring insurance entities who contract with the State to provide Medicaid coverage to enter into written contracts with at least fifty per cent of hospitals and providers in their coverage area.

SECTION 2. Chapter 346, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§346- Requirements for participating insurance entity.** Within ninety days any insurance entity contracted by the State to provide medicaid coverage shall enter into written contracts with a minimum of fifty per cent of the hospitals and providers of healthcare services in the insurance entity's coverage areas. For purposes of this section, a letter of intent shall not be deemed a written contract."

SECTION 3. Section 346-59, Hawaii Revised Statutes, is amended to read as follows:

"**§346-59 Medical care payments.** (a) The department shall adopt rules under chapter 91 concerning payment to providers of medical care. The department shall determine the rates of payment due to all providers of medical care, and pay such amounts in accordance with the requirements of the appropriations act and the Social Security Act, as amended. Payments to critical access hospitals for services rendered to medicaid beneficiaries shall be calculated on a cost basis using medicare reasonable cost principles.

(b) Rates of payment to providers of medical care who are individual practitioners, including doctors of medicine, dentists, podiatrists, psychologists, osteopaths, optometrists, and other individuals providing services, shall be based upon the Hawaii

medicaid fee schedule. The amounts paid shall not exceed the maximum permitted to be paid individual practitioners or other individuals under federal law and regulation, the medicare fee schedule for the current year, the state limits as provided in the appropriation act, or the provider's billed amount.

The appropriation act shall indicate the percentage of the medicare fee schedule for the year 2000 to be used as the basis for establishing the Hawaii medicaid fee schedule. For any subsequent adjustments to the fee schedule, the legislature shall specify the extent of the adjustment in the appropriation act.

(c) In establishing the payment rates for other noninstitutional items and services, the rates shall not exceed the current medicare payment, the state limits as provided in the appropriation act, the rate determined by the department, or the provider's billed amount.

(d) Payments to health maintenance organizations and prepaid health plans with which the department executes risk contracts for the provision of medical care to eligible public assistance recipients may be made on a prepaid basis. The rate of payment per participating recipient shall be fixed by contract, as determined by the department and the health maintenance organization or the prepaid health plan, but shall not exceed the maximum permitted by federal rules and shall be less than the federal maximum when funds appropriated by the legislature for such contracts require a lesser rate. For purposes of this subsection, "health maintenance organizations" are entities approved as such, and "prepaid health plans" are entities designated as such by the Department of Health and Human Services; and "risk" means the possibility that the health

maintenance organization or the prepaid health plan may incur a loss because the cost of providing services may exceed the payments made by the department for services covered under the contract.

(e) The department shall prepare each biennial budget request for a medical care appropriation based upon the most current Hawaii medicaid fee schedule available at the time the request is prepared.

The director shall submit a report to the legislature on or before January 1 of each year indicating an estimate of the amount of money required to be appropriated to pay providers at the maximum rates permitted by federal and state rules in the upcoming fiscal year.

(f) The department shall not require an enrolled member of the QUEST and QUEST expanded access programs to re-enroll and select a QUEST or QUEST expanded access health plan unless the QUEST or QUEST expanded access health plan ceases to actively continue providing services and coverage to its members.

(g) The department shall conduct a public awareness campaign to educate medicaid QUEST and QUEST expanded access recipients about their new plan options, including a provider directory of fully contracted providers in each plan to assist beneficiaries in their decision-making.

(h) The director of human services shall adopt, amend, or repeal rules, pursuant to chapter 91, to provide for the request for proposal requirements included in this section."

SECTION 4. New statutory material is underscored.

SECTION 5. This Act shall take effect on January 1, 2050.

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Government Relations

Testimony of
Frank P. Richardson
Vice President and Regional Counsel

Before:
House Committee on Finance
The Honorable Marcus R. Oshiro, Chair
The Honorable Marilyn B. Lee, Vice Chair

April 3, 2009
2:00 pm
Conference Room 308
Agenda #1

SB 1344 HD1 RELATING TO HEALTH CARE

Chair Oshiro, Vice Chair Lee, and committee members, thank you for this opportunity to provide testimony on this bill which would, among other things, require every "insurance entity" that provides Medicaid coverage to contract with fifty percent of hospitals and health care providers in the coverage area.

Kaiser Permanente Hawaii opposes Section 2 of this bill.

This bill makes the assumption that all insurance entities that participate in Medicaid are organizations that pay claims. Kaiser Permanente Hawaii is an integrated group model health maintenance organization. We provide services directly to the participants of Medicaid though our medical care program that includes 18 clinics, 450 doctors throughout the state, and a full service hospital on Oahu. For our members who get care at our neighbor island clinics and who need specialty care, we have physicians located there or based on Oahu who regularly go to these clinics to provide care. In some cases, our neighbor island patients come to our hospital on Oahu. In addition, we contract for some services for our members at the neighbor island hospitals.

Currently, Kaiser provides health care for approximately 20,000 QUEST members. Because of Kaiser's unique structure and model it is not necessary, nor does it make sense, for

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Kaiser to contract with 50 percent of all providers in its service area in order to provide complete service to its members.

If the purpose of this bill is to assure adequate providers for Medicaid patients without disrupting delivery of care to the patients, the method described in Section 2 is not necessary, nor does it make sense, for Kaiser's integrated model of care to fulfill that purpose.

We urge this committee to remove section 2 of the bill. Thank you for your consideration.

April 3, 2009

Hon. Marcus R. Oshiro, Chair
Hon. Marilyn B. Lee, Vice Chair
House Committee on Finance

Re: SB 1344 HD1 – Relating to Health Care

Dear Chair Oshiro, Vice Chair Lee and Members of the Committee:

My name is Rick Jackson and I am Chief Operating Officer of MDX Hawai'i, a third party administrator of Hawai'i health benefit plans since 1985. Our health care clients include The Queen's Health Systems, Longs Drug, Aetna, Cigna, Deseret Mutual, United Healthcare and Wellpoint.

MDX Hawai'i appreciates the opportunity to testify in opposition to the new Section 346 "Requirements for participating insurance entity" which would mandate certain new contracting requirements for Medicaid health plans. These new requirements are not consistent with DHS RFPs for Medicaid health plans issued during the last fifteen (15) years and, if implemented, would serve only to limit competition for Medicaid health plans to the current incumbent QUEST Plans.

DHS RFPs for QUEST have, since 1994, permitted approximately six (6) months from contract award for network contracts to be in place. The recent QExA RFP process allowed winning plans a full twelve (12) months to establish networks (February 2008 award, February 1, 2009 startup). The provisions of the new Section 346 would, if in place in 2008, have required an arbitrary number (50% of Hawai'i providers) to have been contracted by May 2008, fully eight (8) months before the actual start up of QExA operations. Neither winning bidder (Ohana and Evercare) could possibly have met this arbitrary requirement; in fact, only a bidder with an existing Medicaid Plan network would have a realistic opportunity had this bill been State law.

In summary, whatever the real purpose or intention of new Section 346, the actual effect of this legislation favors incumbent QUEST Plans. We hope the Legislature agrees that robust competition for Medicaid procurement programs is a good thing and that unnecessary hurdles like Section 346 discourage competition, compromise quality and raises the cost of services. If you decide to move this bill, please delete new Section 346.

Thank you for the opportunity to offer comments today.

Sincerely,

Rick Jackson, Chief Operating Officer

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