TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
TWENTY-EIGHTH LEGISLATURE, 2015

ON THE FOLLOWING MEASURE:
S.B. NO. 1028, S.D. 1, RELATING TO THE HAWAII HEALTH CONNECTOR.

BEFORE THE:

SENATE COMMITTEE ON WAYS AND MEANS

DATE: Friday, February 27, 2015 **TIME:** 1:00 p.m.

LOCATION: State Capitol, Room 211

TESTIFIER(S): Russell A. Suzuki, Attorney General, or
Lili A. Young, Deputy Attorney General

Chair Tokuda and Members of the Committee:

The Department of the Attorney General raises the following concerns.

This measure seeks to establish certification criteria for health plan issuers for implementation by the State's health insurance exchange known as the Hawaii Health Connector (Connector), and addresses self-sustainability of the Connector by authorizing it to issue debentures and provide other services in addition to what is required under the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (ACA), by amending chapter 435H, Hawaii Revised Statutes (HRS).

Section 2, on page 5, lines 8-20, through page 6, lines 1-8, amends chapter 435H, HRS, by adding a new section that requires a health plan issuer to offer to contract with any willing federally qualified health center (FQHC) for a provision of services, and requires the issuer to reimburse the FQHC at Medicaid rates pursuant to the Social Security Act section 1902(bb) [42 U.S.C. section 1396a], as a condition of certification by the insurance commissioner.

ACA section 1311(d)(4) requires that the Connector implement procedures for certification consistent with guidelines developed by the U.S. Secretary of Health and Human Services (Secretary). Pursuant to ACA section 1311(c), the Secretary is responsible for establishing, via regulations, minimum criteria for the certification of health plans as qualified health plans (QHP). The minimum certification standards are found at 45 C.F.R. part 156, subpart C, and require that a health plan issuer's provider network include essential community providers. FQHCs fall within this category of listed providers.

In relevant part 45 C.F.R. section 156.235 provides:

> (a) *General requirement*. (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.
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> (d) *Payment rates*. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.
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> (e) *Payment of federally-qualified health centers.* If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.

As worded, it appears that the bill establishes criteria for certification of a qualified health plan that do not allow the flexibility for a health plan issuer to choose which FQHC it would offer to contract with, or to negotiate and mutually agree upon rates other than the Medicaid reimbursement rate, inconsistent with the federal law.

Any criteria established should include a provision that these amendments do not affect the rights and duties of parties for contracts or agreements already in existence prior to the effective date of this Act, and include wording that any criteria established shall be in compliance with federal law.

Section 6, on page 10, lines 1-7, amends section 435H-12(b), HRS, by adding wording relating to compensation of agents and brokers that sell a "non-qualified health plan" through the Connector. ACA section 1311(d)(2)(B)(i) provides that "An Exchange may not make available any health plan that is not a qualified health plan." We recommend amending section 6, on page 10, lines 1-7, by deleting the reference to the "non-qualified health plan" as follows:

> "(b) If a health insurance plan utilizes and compensates an insurance agent or broker, the Hawaii health connector shall not be responsible for any compensation to that agent or broker that sells a qualified health plan [~~or non-qualified health plan~~] through the

connector. The issuer of the qualified health plan shall bear all compensation to an agent or broker that sells a qualified health plan through the connector."

We respectfully request that this Committee consider our comments.