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TO THE HOUSE COMMITTEE ON FINANCE

TWENTY-EIGHTH LEGISLATURE
Regular Session of 2015

Friday, February 27, 2015
3:00 p.m.

Agenda #3

TESTIMONY ON HOUSE BILL NO. 1467, H.D. 2 – RELATING TO THE HAWAII HEALTH CONNECTOR.

TO THE HONORABLE SYLVIA LUKE, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is Gordon Ito, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department takes no position on the bill, and submits the following comments on this bill.

The purposes of this bill are to: enable the Hawaii Health Connector ("Connector") to offer large group coverage to insurers beginning on January 1, 2017; end transitional renewal health insurance policies beginning January 1, 2016; require health insurers to provide notice to group health plans offering continuation coverage about options to secure coverage through the Connector; amend the current definition of "small employer" under section 431:2-201.5, Hawaii Revised Statutes ("HRS"); require insurer participation in the Connector with at least one gold level plan and one platinum level plan if an insurer has a share of the small group Hawaii market that exceeds 20 percent; and require qualified health plan issuers to contract with federally qualified health centers.

The Department notes that amending the definition of small employer to increase it to 100 employees, and ceasing transitional renewal health policies will subject certain businesses to rate increases due to the elimination of the use of loss experience in rating. These increases could be significant.

The Department further notes that as drafted, the 20% mandate would apply to all insurers of accident and health or sickness policies, not only health insurers, mutual benefit societies, and health maintenance organizations. The statute should exclude limited benefit health insurance as set forth in section 431:10A-102.5, HRS.

The Department notes that Section 1301 of the Patient Protection and Affordable Care Act ("PPACA') defines the term "qualified health plan." A qualified health plan means a health plan that is offered by a health insurance issuer that agrees to offer at least one qualified health plan at the 'silver' level and at least one plan at the 'gold' level. The proposed bill would appear to conflict with the PPACA.

Additionally, health insurers are required to conform to the PPACA, and the Commissioner has the power to enforce the consumer protections and market reforms under the PPACA. Section 432:1-107, HRS, section 432D-28, HRS, and section 431:10A-105.5, HRS. Under 45 CFR 156.235, qualified health issuers are already required to have essential community providers payment of which is set by federal regulation.

Furthermore, the proposed language regarding health centers may be in conflict with federal law under PPACA section 1301 in that the exchange certifies qualified health plans and not the Commissioner. In addition, PPACA Section 1311 and other federal regulations set forth the requirements for the Connector. Finally, the Insurance Division and the Commissioner do not regulate or oversee the contractual provisions or requirements between health insurers and medical providers.

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

finance1-Kim

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 26, 2015 10:55 AM
To: FINTestimony
Cc: eric@hawaiihealthconnector.com
Subject: Submitted testimony for HB1467 on Feb 27, 2015 15:00PM

HB1467
Submitted on: 2/26/2015
Testimony for FIN on Feb 27, 2015 15:00PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Eric W. Alborg	Hawaii Health Connector	Comments Only	No

Comments: Provided technical comments. Available for any questions that members might have.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Chamber of Commerce HAWAII
The Voice of Business

Testimony to the House Committee on Finance
Friday, February 27, 2015 at 3:00 P.M.
Conference Room 308, State Capitol

RE: HOUSE BILL 1467 HD2 RELATING TO THE HAWAII HEALTH CONNECTOR

Chair Luke, Vice Chair Nishimoto, and Members of the Committee:

The Chamber of Commerce of Hawaii ("The Chamber") **opposes** HB 1467 HD2, which enables the Hawaii health connector to offer large group coverage and requires health insurers with greater than 20 percent share of the State's small group health insurance market to offer gold and platinum level qualified health plans as a condition of participation in the individual market of the Hawaii Health Connector. Also ends transitional renewal policies effective 1/1/2016 and amends state small market parameters to comport with federal law.

The Chamber is the largest business organization in Hawaii, representing about 1,000 businesses. Approximately 80% of our members are small businesses with less than 20 employees. As the "Voice of Business" in Hawaii, the organization works on behalf of members and the entire business community to improve the state's economic climate and to foster positive action on issues of common concern.

The Chamber believes that private companies should have a choice of whether or not to participate in the health connector, rather than being required to participate due to their control of shares. We believe that no company should be forced to participate in a government program.

Thank you for the opportunity to testify.

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An Independent Licensee of the Blue Cross and Blue Shield Association

February 27, 2015

The Honorable Sylvia Luke, Chair
The Honorable Scott Y. Nishimoto, Vice Chair
House Committee on Finance

Re: HB 1467, HD2 – Relating to Hawaii Health Connector

Dear Chair Luke, Vice Chair Nishimoto and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 1467, HD2, which requires (1) an issuer with at least 20 percent of the small group market to offer at least one silver and one gold qualified health plan (QHP), as a condition of participating in the Hawaii Health Connector's (Connector) individual market; (2) an issuer to allow each federally qualified health center (FQHC) the opportunity to contract with the issuer to offer qualified health plans and to reimburse the FQHC at federal Prospective Payment System (PPS) rates; (3) changes to the definition of "small employer" to include businesses with up to 100 employees; (4) end transitional health plans effective January 1, 2016; (5) requires additional notification requirements for plans; and (6) authorizes the Connector to offer large group insurance coverage beginning January 1, 2017.

HMSA opposes this Bill, because, among other things, it raises serious Constitutional concerns. The Constitutional questions raised in HB 1467, HD2, begs a referral to and review by the House Committee on Judiciary.

<u>Constitutional Concern: 20 Percent Market Share Mandate</u>
HMSA opposes the provision in this Bill that requires an issuer with at least 20 percent of the small group market to sell a silver and gold QHP, as a condition of participating in the Connector's individual market. We fail to understand why this State provision only would apply to an issuer with at least 20 percent of the small group market. Given that threshold, this provision of the Bill only would apply to HMSA and to no other issuer.

We are advised that applying this condition solely on HMSA raises constitutional issues.

- First, the uncompensated economic impact on HMSA of being forced to participate in the SHOP in order to sell products in the individual market may be an unconstitutional regulatory taking

- HMSA's decision to leave the SHOP was driven by serious business concerns. The right to join or leave groups of a person's own choosing has been held to be an essential part of the freedom of speech under the First Amendment to the U.S. Constitution. By effectively compelling HMSA's participation in the SHOP marketplace, SB 1467, SD1, also violates HMSA's freedom of association.

- HMSA is not the only plan which has chosen not to participate in the SHOP. However, by focusing solely on HMSA – which is the effect of the 20 percent market share trigger in Hawaii – this legislation is singling out one insurer to bear the burden of financing the Connector's sustainability. We believe that may constitute a violation of the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution, which provides that no state shall deny to any person within its jurisdiction "the equal protection of its laws.

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Constitutional Concern: Impermissible Interference with Contracts

HMSA opposes the provision in this Bill mandating issuers to offer to contract with any willing FQHC and to reimburse that FQHC at PPS rates. We believe this requirement raises additional Constitutional concerns. Specifically, this provision is a substantial impairment of an issuer's contract rights under the Contracts Clause of the U.S. Constitution

HMSA has existing contracts with FQHCs that are the product of previous negotiations for services based on mutually agreed upon rates. The essential terms of these contracts include specific financial terms that set forth the reimbursement rates to FQHCs. By requiring HMSA to pay Medicaid PPS rates to FQHCs, HB 1467, HD2, substantially impairs HMSA's Constitutional contract rights by precluding the performance of an essential term of the existing contracts with FQHCs and by attempting to alter a specific financial term.

Appropriation Required

Reimbursements at the PPS level is higher than our contracted commercial reimbursement level. The provision in this Bill requiring reimbursement to the FQHCs at the PPS level will drive up costs. And, it require a General Fund appropriation to cover the additional cost that will accrue to HMSA members who are part of a State-funded plan and who use the services of the FQHCs.

"Small Employer" Definition and Large Employers

The Bill changes the definition of a "small employer" to include a company with up to 100 employees. And, the Bill mandates large group coverage thru the Connector beginning January 1, 2017. We believe that these provisions should not be mandated in statute. Rather, to the extent allowed under the Affordable Care Act, the Insurance Commissioner should be afforded the flexibility in determining the markets that the Connector serves. Contemporaneous consideration must be given to overall market conditions in 2017 to determine (1) whether a change would disrupt and undermine an already successful large employer market; and (2) whether the required investment in time and money needed to accommodate any changes is appropriate.

Thank you for the opportunity to testify in opposition to HB 1467, HD2. Your consideration of our concerns is appreciated.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

LATE

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

House Committee on Finance
The Hon. Sylvia Luke, Chair
The Hon. Scott Y. Nishimoto, Vice Chair

Testimony on House Bill 1467 HD 2

Relating to the Hawaii Health Insurance Exchange
Submitted by Nani Medeiros, Public Affairs and Policy Director
February 27, 2015, 3:00 pm, Room 308

The Hawaii Primary Care Association (HPCA), which represents the federally qualified community health centers (FQHC) in Hawaii, supports House Bill 1467, which calls for a number of measures to strengthen the Hawaii Health Connector.

Under the Affordable Care Act (ACA), the intent behind creating state health insurance exchanges was to have a venue for competitive insurance plan comparison so as to provide for better premium rates to consumers. The HPCA finds House Bill 1467 to be very much in line with that goal, mandating that all plans in the state carrying a 20% market share of the SHOP program or better participate in the exchange.

The HPCA supports changing the definition of "small employers" in Hawaii from 50 to the nationally accepted threshold of 100 employees. Such measures will encompass a greater number of businesses in the state, providing a stronger Connector and a better marketplace for consumers.

Finally, the HPCA strongly support section 4 of the bill, which calls for an amendment to HRS §435H-6(b) to state:

> (b) The commissioner shall require that each qualified plan, as a condition of certification, shall:
>
> > (1) Offer to any willing federally-qualified health center providing services in geographic areas served by the qualified plan, the opportunity to contract with the qualified plan to provide to the qualified plan's enrollees all ambulatory services that are covered by the qualified plan that the federally-qualified health center offers to provide; and
> >
> > (2) Reimburse each federally-qualified health center for services as provides in 42 USC §1396a(bb).

This language serves to codify several key factors for community health centers. First, it affirms payment methodology for health centers providing services to qualified health plan enrollees. Second, it protects continuity of care for enrollees, including the 7,500 legal COFA migrants recently removed from the Medicaid program. Finally, it helps to ensure financial sustainability for an essential community provider moving forward.

For these reasons we strongly support this bill and thank you for the opportunity to testify.

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