DAVID Y. IGE
GOVERNOR

SHAN S. TSUTSUI
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
335 MERCHANT STREET, ROOM 310
P.O. Box 541
HONOLULU, HAWAII 96809
Phone Number: 586-2850
Fax Number: 586-2856
www.hawaii.gov/dcca

CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON FINANCE

TWENTY-EIGHTH LEGISLATURE
Regular Session of 2016

Tuesday, April 5, 2016
2:31 p.m.

TESTIMONY ON SENATE BILL NO. 2667, S.D. 1, H.D. 2 – RELATING TO INSURANCE.

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

My name is Gordon Ito, State Insurance Commissioner, testifying on behalf of the Department of Commerce and Consumer Affairs ("Department").

The Department supports the intent of ensuring that Medicaid providers receive prompt payments for services rendered upon their submission of clean claims. The Department notes that the Department of Human Services has indicated that the exemption of Medicaid from the definition of a "clean claim" is not necessary.

H.D. 2 of this bill, however, proposes repealing the current exemption of self-insured employer groups from the definition of "clean claim" (page 6, line 8) in section 431:13-108, Hawaii Revised Statutes ("HRS"). Self-employer groups enjoy this exemption since section 431:1-201(b)(3), HRS, specifically exempts self-insured employer groups' plans from regulation under the Insurance Code. Therefore, unless self-insured employer groups' plans are underwritten by insurers, the Insurance Division will not be able to enforce this proposal on self-employer groups.

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

DAVID Y. IGE
GOVERNOR

RACHAEL WONG, DrPH
DIRECTOR

PANKAJ BHANOT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

P. O. Box 339
Honolulu, Hawaii 96809-0339

April 4, 2016

TO: The Honorable Representative Sylvia Luke, Chair
House Committee on Finance

FROM: Rachael Wong, DrPH, Director

SUBJECT: **SB 2667 SD 1 HD 2** - **RELATING TO INSURANCE**
Hearing: April 5, 2016; 2:31 p.m.
Conference Room 308, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) provides comments on this measure.

PURPOSE: The purpose of this bill is to require health insurers to promptly pay clean claims for services and repeals the exemption of Medicaid claims from the clean claims definition.

The Med-QUEST Division's (MQD) QUEST Integration (QI) contracts, as well as previous QUEST and QExA contracts, already include language to require the managed care health plans to pay 90% of claims within 30 days and 99% of claims within 90 days. These contract requirements follow the Centers for Medicare and Medicaid Services (CMS) federal rules (42 CFR §447.45) governing timely payments for medical services under the Medicaid program.

The health plans have consistently exceeded the minimum required timelines in their contracts. Plans are required to submit timeliness of claims payments reports on a quarterly basis to MQD. For the quarter ending December 31, 2015, 99.2% of claims were paid within 30 days and for the remaining claims, 99.95% were paid within 90 days. Reports indicate that the average processing time for claims is 14 days. Comparing claims payment information from a year ago, for the quarter ending December 31, 2014, 95.3% of claims were paid within 30 days, and 99.9% were paid within 90 days.

The Med-QUEST Division (MQD) believes that all providers participating in our Medicaid programs are very important as they provide vital services for the Department's recipients. Without their participation, the Department would not be able to provide needed medical services in a timely manner—this is the reason for existing reporting requirements and why these metrics are closely monitored by MQD.

The proposed amendment to current statutes that grants an exemption to the Medicaid program is not needed. In addition, should CMS revise its requirements for the Medicaid program in the future, it could result in a conflict with federal requirements and the Hawaii Revised Statutes. The Med-QUEST Division is committed to working with plans and providers to continually improve services to recipients.

Thank you for the opportunity to testify on this measure.

April 5, 2016 at 2:31 PM
Conference Room 308

House Committee on Finance

To: Chair Sylvia Luke
Vice Chair Scott Y. Nishimoto

From: George Greene
President and CEO
Healthcare Association of Hawaii

Re: Testimony in Support
SB 2667 SD1 HD 2, Relating to Insurance

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 180 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

We would like to thank the committee for the opportunity to **support** SB 2667 SD1 HD 2, which would create parity under Hawaii's clean claims law and require Medicaid insurers to promptly pay providers caring for enrollees. Specifically, this legislation would remove the exemption that Medicaid insurers have from the clean claims portion of section 431:13-108 of the Hawaii Revised Statutes (HRS). This change will help to mitigate the adverse impacts of delayed action on clean claims on providers.

Prompt payment of claims is vital to the operations of healthcare providers who rely on timely reimbursements to keep their doors open. Delays in cash flow jeopardize operations for all healthcare providers, but are especially problematic for smaller providers and those that care for a disproportionate share of Medicaid patients.

Under Hawaii's clean claims law, insurers must pay non-Medicaid clean claims within 15 days of receipt of an electronic claim, and within 30 days of a paper claim. Medicaid insurers do not have to follow those guidelines. Instead, the Department of Human Services only requires Medicaid insurers to pay 90 percent of claims within 30 days, and 99 percent of claims within 90 days.

This standard is problematic for two reasons. First, the ten percent of Medicaid claims outstanding after 30 days and the one percent of Medicaid claims outstanding after 90 days

typically represent a significant amount of dollars. After surveying our members, we found that the respondents have unpaid Medicaid clean claims that, in aggregate, total millions of dollars. Hospital respondents indicated that they have unpaid clean claims that total around $25 million. This is because those last one percent of Medicaid claims tend to be for bigger-cost services.

Second, in the current situation, Medicaid insurers do not have to come to a resolution on a Medicaid claim within a set period of time. While Medicaid insurers are required *pay* a percentage of their clean claims within certain time frames, there are no similar requirements for *resolving* Medicaid claims. Instead, our providers attest that Medicaid insurers will often mark a claim as insufficient and delay payment with no explanation. This means that providers must follow up for months in order to get resolution on claims for services already provided.

On the other hand, the clean claims law requires insurers to provide a resolution within a reasonable time frame on non-Medicaid claims. Under the regulations in HRS Section 431:13-108, insurers must either deny a payment within 30 days or request the specific information needed to process the non-Medicaid claim. This allows providers to get resolution on submitted non-Medicaid claims in a reasonable time frame, rather than having to pursue delayed claims for months on end. Medicaid insurers are not currently bound by this requirement, and are subsequently able to "sit on" and delay payments for long periods of time.

Providers should not be expected to "float" the costs of care. This is especially important since the *Affordable Care Act* expanded eligibility for the Medicaid program. Enrollees in the program total over 325,000 individuals, meaning that one out of every four patients in Hawaii treated by providers are covered by Medicaid insurers. Delays in payments for this population can be very difficult for providers to endure.

This legislation is also necessary to ensure that Medicaid insurers are consistently held to high standards regarding prompt payment of Medicaid claims. The issue ebbs and flows depending on the amount of oversight exercised by outside agencies over this process. However, no permanent solution has been reached, much to the disservice of physicians and providers in the state.

In order to support providers and ensure that payment for services for Medicaid enrollees is provided promptly, HAH requests your support for this legislation. Thank you for your consideration of this important matter.

55 Merchant Street
Honolulu, Hawai'i 96813-4333

www.hawaiipacifichealth.org

April 5, 2016 at 2:31 PM
Conference Room 308

House Committee on Finance

To: Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair

From: Michael Robinson
Vice President, Government Relations & Community Affairs

Re: SB 2667, SD1, HD2 Relating to Insurance -- Testimony in Support

My name is Michael Robinson, and I am the Vice President of Government Relations and Community Affairs at Hawai'i Pacific Health (HPH). Hawai'i Pacific Health is a not-for-profit health care system, and the state's largest health care provider and non-governmental employer. Hawai'i Pacific Health is committed to providing the highest quality medical care and service to the people of Hawai'i and the Pacific Region through its four hospitals, more than 50 outpatient clinics and service sites, and over 1,600 affiliated physicians. Hawai'i Pacific Health's hospitals are Kapi'olani Medical Center for Women & Children, Pali Momi Medical Center, Straub Clinic & Hospital and Wilcox Memorial Hospital.

HPH is writing in **support** of SB 2667 SD1, HD2. This legislation would remove the exemption that Medicaid insurers have from the clean claims portion of section 431:13-108 of the Hawaii Revised Statutes. This change will help to mitigate the adverse impact of payment delays on clean claims across our four hospitals and affiliated providers.

Since 2009, the number of Medicaid enrollees has increased by over 100,000 individuals—a remarkable 45 percent increase in a few short years. Approximately 44% of all Medicaid/Quest discharges on O'ahu and 71% on the island of Kaua'i are discharged from a Hawai'i Pacific Health facility. This population often represents the most medically complex patients requiring the most intensive levels of care. At the same time, Medicaid/Quest plans are also the lowest reimbursing amongst our contracted plans. Therefore, the impact of delayed payment – particularly of a clean claim for care already deemed medically necessary and provided to Medicaid/Quest members – has a significant impact on both our organization and potentially access to care for the broader community.

At HPH we have an outstanding balance of more than $10 million in QUEST-related claims. These claims have been outstanding for more than 12 months.

We welcome this proposed legislation and believe it will better incentivize the plans to promptly reimburse providers for care that is medically necessary and already provided.

Thank you for the opportunity to provide testimony on this matter.

THE QUEEN'S HEALTH SYSTEMS

LATE

To: The Honorable Sylvia Luke, Chair
The Honorable Scott Y. Nishimoto, Vice Chair
Members, Committee on Finance

From: Paula Yoshioka, Senior Vice President, The Queen's Health Systems
Date: April 4, 2016
Hrg: House Committee on Finance Hearing; Tuesday, April 5, 2016 at 2:31PM in Room 308

Re: **Support for SB 2667, SD1, HD2, Relating to Insurance**

My name is Paula Yoshioka, and I am a Senior Vice President at The Queen's Health Systems. I would like to express my **support** for SB 2667, SD1, HD2, Relating to Insurance. This bill requires health insurers to promptly pay clean claims for services and repeals the exemption of Medicaid claims from the clean claims definition.

At Queen's we are committed to providing care for Hawaii's most underserved. We concur with the testimony provided by the Healthcare Association of Hawaii (HAH) that prompt payment of clean claims is important to an efficient and effective health care system in Hawaii.

This bill will help to mitigate the adverse impacts of delayed health insurer payments on clean claims that we and other health care providers submit. The need for this legislation has become increasingly important since the *Affordable Care Act* has swelled the ranks of the state's Medicaid program. Since 2009, the number of Medicaid enrollees has increased by over 100,000 individuals, a 45 percent increase, to over 320,000 individuals. This measure will help to ensure that Queen's can continue to serve Hawaii's underserved without needing to float the costs of their care.

I commend the legislature for introducing this measure and urge you to continue supporting prompt payment for clean claims.

Thank you for your time and attention to this important issue.

LATE

949 Kamokila Boulevard, 3rd Floor, Suite 350, Kapolei, HI 96707
808.675.7300 | www.ohanahealthplan.com

April 5, 2016

To: The Honorable Sylvia Luke
Chair, House Committee on Finance

From: ‘Ohana Health Plan
Wendy Morriarty, State President

Re: SB 2667, SD1, HD2, Relating to Insurance; Oppose
April 5, 2016; Conference Room 308

‘Ohana Health Plan (‘Ohana) is a member of the WellCare Health Plans, Inc.’s (“WellCare”) family of companies and provides healthcare for Hawai’i residents statewide. Since 2009, ‘Ohana has utilized WellCare’s national experience to develop a Hawai’i -specific care model that addresses local members’ healthcare and health coordination needs. By focusing on the state’s Medicaid and Medicare population, ‘Ohana serves Hawaii’s most vulnerable residents: low-income, elderly, disabled, and individuals with complex medical issues. ‘Ohana’s mission is to help our members’ lead better, healthier lives.

‘Ohana Health Plan appreciates the opportunity to submit testimony in opposition to SB 2667, SD1, HD2. We share the same goal as the State to ensure that all clean claims are paid timely. Hawaii’s Medicaid health plans are required to submit monthly claims reports to the Department of Human Services, and data shows that nearly all clean claims are paid on time. ‘Ohana Health Plan pays approximately 99% of clean claims on time with an average turnaround time of about 7 days (paper and electronic). When a delay occurs on our end in the processing and payment of a clean claim, we pay an interest rate of 5.25%.

The Medicaid claims process is more complicated than others, and requiring plans to pay 100% of claims within the bill’s specified timeframe is an unrealistic standard. We believe that our current contractual requirement from the state to pay 99% of claims within 90 days is fair.

Finally, this bill would not address to root of the issue, which is disagreements between providers and plans over when a submitted claim is considered “clean.”

Thank you for the opportunity to submit testimony on this measure.