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**Human Services Public Hearing  
March 15, 2007**

**Health Net of the Northeast, Inc  
Testimony on RB 1425 and RB 7322**

Good afternoon Senator Harris, Representative Villano and members of the Human Services Committee. My name is Janice Perkins and I am Vice President of Government Relations of Health Net of the Northeast. Health Net has been a HUSKY provider since its inception and currently serves over 83,000 HUSKY A members.

I would like to comment on Raised Bill 1425 AAC Managed Care Organizations Contracting with the Department of Social Services and Raised Bill 7322 AAC Medicaid Managed Care Reform.

**Raised Bill 1425**

Among other things, this bill would require managed care organizations to implement a process that would ensure the dispensing of an immediate 5-day temporary supply even if the drug requires a prior authorization. I am pleased to announce to the committee that all of the managed care plans have a process in place that ensures the immediate dispensing of a 30-day temporary supply of any drug whether or not the need is urgent or emergent and whether or not the drug requires prior authorization. Two important facts to note about this:

- 1) This represents a change from our previous process, which required a certification be made as to whether or not the drug was intended to address an urgent or emergent condition. Our new process eliminates that step and automatically authorizes the pharmacist to dispense the prescribed medication. **This eliminates the need for the pharmacist to call the physician to obtain certification.** Now the pharmacist simply needs to call our Pharmacy Benefit Manager for dispensing. This will prevent members from potentially leaving the pharmacy without their medication.
- 2) DSS called the plans together to explore ways in which we could improve delivery of the HUSKY pharmacy benefit to our members and providers. **We believe this change accomplishes this goal and goes beyond what is contractually required by DSS.**

By implementing this change we have simplified the process and thereby eliminated the need for Section 5 (d) (1) (2) and (3). The 24-hour notification to the provider would not be necessary because a 30-day temporary supply would have already been dispensed to the member. In addition, we do follow-up with the provider following the issuance of a 30-day temporary supply and educate him/her on our prior authorization requirements and formulary alternatives.

## **Raised Bill 7322**

**Pharmacy Rebates.** Section 12 would require managed care organizations to transfer any pharmaceutical rebate it receives to the Department. If the underlying concern of this provision is that the State is not receiving the financial benefit of rebates negotiated by the health plans, let me assure you that this is not the case.

Currently, the value of the rebates received by the MCOs is offset against HUSKY program pharmacy costs and thereby reduces the total costs of the program. The yearly rate-setting process undertaken by the Department incorporates the amount of rebates received by the MCOs when developing the premium rates. In other words, the HUSKY program is already benefiting from the value of rebates received in the form of lower pharmacy costs reported by the MCOs on our financial statements and this is reflected in lowered rates.

If this language were to pass:

- 1) The value of the rebates would then be available to be used for the general “operation” of the HUSKY program while the costs to the plans increases.
- 2) The incentive to the Plans to aggressively negotiate rebates would be removed.

Unlike FFS or large groups that operate their pharmacy benefit through an ASO, the managed care organizations, under a capitated arrangement with the state, are responsible for managing their health care costs. Aggressive rebate negotiation is one way we are able to lower our pharmacy costs.

**Reporting.** Most, if not all of these data elements required in the bill are already reported to the Department in some fashion. I have attached, for your review, a template of a financial report we submit to the state twice each year. This report lists membership, premium revenues, investment income as well as health care expenses and utilization for inpatient, outpatient, emergency room, primary care, specialists, transportation and dental. It also requires us to report administration costs as well pharmacy rebates. In addition, we already report the salaries and compensation of our highest paid employees each year to the Department of Insurance. We submit over 100 reports yearly to the Department. In addition, our encounter data reporting submitted monthly includes the detail of every claim paid by the health plans.

**Medical Director.** We support DSS employing a medical director. A medical director would be helpful in making policy decisions that impact the medical welfare of the population. We would not want this to replace our current ability to use specialists and other standards of medical practice in making medical necessity determinations.

**Pay for Performance.** We support a system that fosters and rewards improvement. However, we don't believe this is possible within existing appropriations. The state should develop a model that rewards performance and is adequately funded. To do otherwise would further exacerbate the chronic underfunding of the HUSKY program.

**Fee Schedule Increase.** We support adequate reimbursement to all providers of the HUSKY program. It is important that funding for these increases be incorporated into the capitation premium payments to the MCOs. An estimate of the effect of the increases, described in Section 12 of RB 7322, on HN's medical and dental costs alone would be in excess of \$20m.

In conclusion, we are happy to work with you to improve the quality of both services to our members and reporting to the State, but I would caution about enacting legislation that results in duplicating what already exists and driving up overall program costs without any additional benefit to our members.

**State of Connecticut**

Department of Social Services

HUSKY A Medicaid Program

XYX

(Health Plan Name)

John Doe

(Preparer's Name and Phone Number)

For the 12-Month Time Period Ending:

December-05

Rate Cell:	ALL RATE CELLS
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Membership Statistics:		TOTAL
1 Membership		-
2 Member Months		-

REVENUES:		TOTAL \$	PMPM
3 Capitation PMPM Rate		\$ -	
4 Capitation Revenue		\$ -	\$ -
5 Investment Income		\$ -	\$ -
6 Other - Please Explain		\$ -	\$ -
7 Total Revenue		\$ -	\$ -

MEDICAL EXPENSES:		Capitation	Fee-For-Service	Incurred-But-Not-Reported (IBNR)	Other Shared Risk / Incentive Arrangements	TOTAL \$	PMPM
8 Physical Health - Hospital Inpatient		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
9 Physical Health - Hospital Outpatient & E.R.		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10 Behavioral Health - Hospital Inpatient (a)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10a Behavioral Health - Hospital Inpatient Reinsurance Recovery		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10b Behavioral Health - Net Hospital Inpatient (Line 10 + Line 10a)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
11 Behavioral Health - Non-Inpatient (b)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
12 Net Behavioral Health Care Expenditures		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13 Physician - Primary Care		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14 Physician - Specialists & Others		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
15 Pharmacy - (Physical & Behavioral Health)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
16 Emergency Transportation Services		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
17 Non-Emergency Transportation Services		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
18 Dental Services		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
19 All Other Services		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
20 Total Medical Expenses		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
21 Medical Care Ratio% (Line 20 / Line 4)						0.0%	0.0%
22 Reinsurance Premium Expense		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
23 Reinsurance Recoveries (Non-Behavioral Health)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24 Net Reinsurance Expense / Recoveries		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
25 Third Party Liability Recovery		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
26 Net Medical Expenses (Line 20 + 24 + 25)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
27 Net Medical Care Ratio (Line 26 / Line 4)						0.0%	0.0%

OPERATING MARGIN:		TOTAL \$	PMPM
28 Operating Margin - \$ (Line 7 less Line 26)		\$ -	\$ -
29 Operating Margin - % (Line 28 / Line 7)		0.0%	0.0%

Administrative Costs:		TOTAL	PMPM
30 Full-Time Equivalent Employees (FTEs)		-	
31 Salaries and Related Expenses		\$ -	\$ -
32 Other Administrative Expenses		\$ -	\$ -
33 Total Administrative Expenses		\$ -	\$ -
34 Administration Rate% (Line 33 / Line 4)		0.0%	0.0%
35 Premium Tax Credit		\$ -	\$ -
36 Net Administrative Expense (Line 33 less Line 35)		\$ -	\$ -

Income <Loss> on Medicaid Operations:		TOTAL	PMPM
37 Income <Loss> Before Income Taxes (Line 4 less Line 26 less Line 33)		\$ -	\$ -
38 Income <Loss> as Pct% (Line 37 / Line 4)		0.0%	0.0%

Income <Loss> Medicaid Operations + Investment + Other Income + Premium Tax Credit:		TOTAL	PMPM
39 Income <Loss> Before Income Taxes (Line 7 less Line 26 less Line 36)		\$ -	\$ -
40 Income <Loss> as Pct% (Line #39 / Line #7)		0.0%	0.0%

**State of Connecticut**

Department of Social Services

HUSKY A Medicaid Program

XYX

( Health Plan Name )

John Doe

( Preparer's Name and Phone Number )

For the 12-Month Time Period Ending:

December-05

Rate Cell :	ALL RATE CELLS
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UTILIZATION STATISTICS:		STATISTICS	UNITS / 1,000	UNIT COST
A.1	Physical Health - Hospital Inpatient Admissions - Actual	-	-	\$ -
A.2	Physical Health - Hospital Inpatient Admissions - Authorized	-	-	\$ -
A	Physical Health - Hospital Inpatient Admissions (Line A.1 + A.2)	-	-	\$ -
B.1	Physical Health - Inpatient Days - Actual	-	-	\$ -
B.2	Physical Health - Inpatient Days - Authorized	-	-	\$ -
B	Physical Health - Inpatient Days (Line B.1 + B.2)	-	-	\$ -
C.1	Physical Health - Average Length of Stay (ALOS) - Actual	#DIV/0!		
C.2	Physical Health - Average Length of Stay (ALOS) - Authorized	#DIV/0!		
C	Physical Health - Average Length of Stay (ALOS)	#DIV/0!		
D.1	Total Natural Vaginal Deliveries	-	-	
D.2	Total Cesarean Section Deliveries	-	-	
D.3	Total Deliveries (Line D.1 + D.2)	-	-	
D.4	Total Multiple Births	-	-	
E	Physical Health - Outpatient Visits	-	-	
F	Physical Health - Emergency Room Visits	-	-	
G	Physical Health - Outpatient & E.R. Visits (Line E + Line F)	-	-	
H	Physician Visits - Primary Care	-	-	\$ -
I	Physician Visits - Specialty & Others	-	-	\$ -
J	Physician Visits - Total (Line H + I)	-	-	\$ -
K	Pharmacy Claims - Physical and Behavioral Health	-	-	\$ -
L	Emergency Transportation Services - Trips (One-Way)	-	-	\$ -
M	Non-Emergency Transportation Services - Trips (One-Way)	-	-	\$ -
N	Dental Services	-	-	\$ -

**Category of Service Notes:**

(a) Defined as all inpatient claims where primary diagnosis is behavioral health-related. If your definition differs for inpatient behavioral health, please provide your definition.

(b) Defined as all non-inpatient claims where primary diagnosis is behavioral health-related AND the provider is an independent behavioral health practitioner; free standing mental health; substance abuse or methadone maintenance clinic; general hospital outpatient or emergency department; public or private psychiatric hospital; or home health agency; but excluding primary care services, laboratory services, and other ancillary services.

**Encounter File Data Elements by Record Type**

Data Element	Inpatient	Outpatient	Professional	Pharmacy	Dental	Comments
Admission Date & Discharge Date	X					
Admission Source	X	X				Indicates the origin of the admission( e.g. physician referral, transfer from hospital, emergency room)
Admission Type	X					
Allowed/Contracted Amount		X	X	X	X	
Beginning Date of Service & Ending Date of Service	X	X	X		X	
Bill Type	X	X				Identifies type of facility and type of care, e.g. Hospital-Inpatient, Skilled Nursing Facility -Diagnostic Service, Home Health- Outpatient)
Billed Amount	X	X	X	X	X	
Billing Provider Identification Number	X	X	X	X	X	
Claim Line Number	X	X	X		X	Identifies the claim line in which the specific procedure and accompany charge is listed.
Claim Paid Date	X	X	X	X	X	
Claim Received Date	X	X	X	X	X	
COB/TPL/Other Paid Amount		X	X	X	X	
Days Supply				X		
Diagnosis Code - Primary	X	X	X		X	
Diagnosis Code - Additional 2 - 5	X	X	X		X	
Dispensing Provider/Facility Identification Number				X		
Medicare Paid Amount		X	X	X	X	
National Drug Code (NDC)				X		
Oral Cavity						Identifies the dental arches on which services was performed.
Paid Amount	X	X	X	X	X	
Patient Status Code	X	X				Indicates the patient status at the end of the billing period (e.g., discharged to home or self-care).
Payment Type	X	X	X	X	X	Identifies whether a service was capitated, Fee for Service or Informational (e.g., bundled service).
Place of Service			X			
Prescription Filled Date				X		

