SB1274

Measure Title:	**RELATING TO HEALTH INSURANCE.**
Report Title:	**Insurance; Health; External Review Procedure**
Description:	**Provides uniform standards for external review procedures based on NAIC Uniform Health Carrier External Review Model Act, in order to comply with the requirements of the federal Patient Protection and Affordable Care Act of 2010.**
Companion:	**HB1047**
Package:	**Gov**
Current Referral:	**CPN/HTH, WAM**

NEIL ABERCROMBIE
GOVERNOR

BRIAN SCHATZ
LT. GOVERNOR

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TO THE SENATE COMMITTEES ON
COMMERCE AND CONSUMER PROTECTION
AND HEALTH

TWENTY-SIXTH LEGISLATURE
Regular Session of 2011

Thursday, February 10, 2011
8:30 a.m.

TESTIMONY ON SENATE BILL NO. 1274 – RELATING TO HEALTH INSURANCE.

TO THE HONORABLE ROSALYN H. BAKER AND JOSH GREEN, M.D., CHAIRS, AND MEMBERS OF THE COMMITTEES:

My name is Gordon Ito, State Insurance Commissioner, testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department supports this Administration bill which replaces the existing external review process for deciding health insurance coverage disputes with a new process based on a review by an independent review organization ("IRO") that conforms to the requirements of the federal Patient Protection and Affordable Care Act ("PPACA"). An IRO is a private organization that contracts with a medical doctor to give a medical opinion on a health insurance coverage dispute.

Hawaii already has an existing external review process located at Hawaii Revised Statutes section 432E-6 which involves review by a 3 member panel, but the process has suffered some serious setbacks. In 2004, the Hawaii Supreme Court ruled that this process was pre-empted by ERISA which means that those members who get their health insurance through their private employers could no longer use the external review process. In 2008, the Department of the Attorney General ruled that the EUTF

was also exempted from the external review process. Today, the external review process only handles individual, non-group members and Medicaid members. Also, we should point out that because Medicaid offers an administrative hearing at the Department Human Services we are offering a duplicative process to Medicaid members. Today, we get about one request per month for an external review, if that. As a result, there is almost nothing left of the original external review process and the process therefore does not help very many of Hawaii's citizens.

The PPACA regulation on external reviews (see Federal Register / Vol. 75, no. 141, July 23, 2010 / Rules and Regulations) requires that by July 1, 2011, Hawaii come into compliance with federal requirements and contemplates an IRO process. The regulation also cites to the National Association of Insurance Commissioner's model act on external reviews using an IRO. This is the model we used in developing HB 1047. In order to meet the federal requirements, and restore a workable process to Hawaii's people, we believe it is advisable to enact HB 1047. Note that we have carved out the EUTF and Medicaid from the proposed IRO program because they both have their own existing administrative appeals process.

The use of an IRO for external reviews is well established. Medicare uses an IRO process as do many other states.

We believe that an IRO can handle a review of Hawaii's medical necessity statute (see HRS section 432E-1.4), which is only applicable in selected cases where there is no specific coverage exclusion. Currently, medical directors of health plans must do a medical necessity review.

Although it is not central to the policy issue we are presenting, the Committee should be aware that the current external review process is very expensive. With lawyers on both sides, the basic external review itself can cost around $80,000. If the external review decision is appealed through the court system, additional attorney's fees will be incurred. An IRO offers a far cheaper way to resolved disputes.

We should also note that the existing external review process has been problematic because it is difficult to get practicing physicians to take the time out to volunteer for service on an external review panel.

We thank this Committee for the opportunity to present testimony on this matter and ask for your favorable consideration.

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 10, 2011

The Honorable Rosalyn H. Baker, Chair
The Honorable Josh Green, M.D., Chair
Senate Committees on Commerce and Consumer Protection and Health

Re: SB 1274 – Relating to Health Insurance

Dear Chair Baker, Chair Green and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 1274 which would provide uniform standards for external review procedures based on a National Association of Insurance Commissioners (NAIC) Act in order to comply with Affordable Care Act (ACA) requirements. HMSA supports the intent of this measure.

The ACA requires that plans in all markets comply with state external review requirements that, at minimum, include the protections in the NAIC's External Review Model Act or for states without an external review process that meets these requirements and for self-funded plans, implement an external review process that meets minimum standards established by HHS through guidance. We appreciate the Insurance Commissioner's intent to ensure that existing state law pertaining to external appeals will be compliant with this ACA requirement.

This measure is lengthy and we do have questions on some of the language within the measure including:

- Structuring of Processes: The measure seems to allow a member to pursue an expedited external review at the same time as applying for an expedited internal appeal. It is unclear how this process would work and if these review processes would run concurrently
- Notification Timeframes: The measure requires that when a plan reverses a decision the member, Independent Review Organization (IRO) and the Insurance Commissioner be notified within one day. It may be prudent to change this to verbal notification within one day and allow the plan up to three days to provide written notification to ensure that all the information is provided
- Multiple Reviewers: The measure allows the IRO to elect to use more than one reviewer. Since the plan is responsible for paying for the cost of the review, requiring the IRO to justify this action may be warranted

We realize that this is only the first hearing for this measure and we will work closely with the Insurance Commissioner to address these issues prior to SB 1274 being heard by the next Committee. Thank you for the opportunity to testify in support of SB 1274.

Sincerely,

Jennifer Diesman
Vice President
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TESTIMONY ON S.B.1274 RELATING TO HEALTH INSURANCE

COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator Brian T. Taniguchi, Vice Chair

COMMITTEE ON HEALTH
Senator Josh Green, M.D., Chair
Senator Clarence K. Nishihara, Vice Chair

Thursday February 10, 2011
8:30 a.m.
State Capitol, Conference Room 229

Testimony from Dr. Arleen Jouxson-Meyers,
President,
Hawaii Coalition for Health and
Hawaii Congress of Physicians and Other Healthcare Providers

Dear Committee Chairs and Members:

THE HCFH AND HCOP STRONGLY OPPOSE PASSAGE OF SENATE BILL 1274 AND COMPANION HOUSE BILL 1047.

We appreciate the opportunity to submit testimony on this measure.

Since 1996, the Hawaii Coalition For Health has advocated to protect the rights of healthcare consumers in Hawaii, and later joined by HCOP, to advocate for healthcare providers in Hawaii.

There is no good reason, at this time, for the Legislature to make such a sweeping change in our laws, repealing long-standing rights that will cost more than 250,000 of its most needy and vulnerable constituents access to quality healthcare, and undoubtedly for some their lives. The fate of federal healthcare reform is up in the air, and the insurance commissioner has admitted that no decision must be made this year as long as we are making progress to provide healthcare

consumers with uniform and meaningful mechanisms to review adverse healthcare decisions made by health insurers. **Passage of SB 1274 or HB 1047 does not offer such alternatives.**

The Legislature should first fully inform itself of whether an alternative course of action that avoids a repeal of HRS 432E-6 and 6.5 is available. The Legislature should also be fully aware of the impact of such a repeal on health care consumers. Please convene a task force or commission of health care consumers and legislators to study the proposal and report back to the Legislature. The task force can meet during the period before the 2012 legislature, and accept testimony and information from consumers, providers, and managed care plans, and convey that information to the Legislature in a report of the committee's recommendations.

If you choose rather to proceed with passage of SB 1274 and companion HB 1047 to replace the external review process in the existing Patients' Bill of Rights and Responsibilities Act (PBR), HRS 432E-6, 6.5, you will cause dire consequences on health care in Hawaii and on Hawaii's economy in general.

Please let me explain:

Presently, all Medicaid Quest, covering nearly 218,000 healthy poor, Medicaid Quest Expanded Access (QExA), covering more than 42,000 Medicaid-eligible aged, blind, and disabled, all State employees, and all people covered under self insured plans are entitled to access to a 432E-6, 6.5 external review by a 3-person panel headed by the Insurance Division. With President Obama's health insurance mandate and the weak economy leading to job-loss and more people becoming Quest eligible, these numbers are expected to grow even larger.

Approximately 2 years ago, as we watched in horror, our Department of Human Services awarded two huge contracts to Evercare and Ohana to coordinate and pay for the medical care of the QExA patients. Evercare and Ohana entered the community with tornado-type force alienating healthcare providers, previously loyal and dedicated to their community and profession, tearing apart families, and arbitrarily withholding medical care from desperately needy patients. Some patients may even have lost their life as a result. Our prior administration stood by motionless, merely attempting to correct isolated problems on a case-by-case basis as problems were brought to their attention. (I personally brought many cases to Patti Bazin's attention.) Our DHS failed miserably in its oversight of Evercare and Ohana's systemic conduct or apparently to demand performance from these plans. The only thing that brought some accountability to Evercare and Ohana's decision-making was HRS 432E-1.4, 6, and 6.5, clearly the reason health insurers are now seeking its repeal. Two years later, many patients still have not found a primary care physician (PCP) suitable to take care of them, many cannot find specialists, and are continuing to experience difficulties getting medications, services, or equipment they need to endure life. Service coordination, the corner stone of managed care, remains non-existent.

Fortunately, The PBR was in effect at this time. The PBR external review process enables patients to promptly appeal wrongfully denied care to the Insurance Commissioner and provides them the resources to put on a well-prepared case which frequently results in preservation of necessary services. In addition, this external review process creates appropriate consequences to the health plan that makes arbitrary coverage decisions without applying Hawaii's Medical Necessity Statute. By reversing the denial, plan medical directors were held accountable for paying no attention to Hawaii's Medical Necessity statute, HRS 432E-1.4, and denying care without applying statutory principles as required. They sometimes appeared to not even know that the statute existed. But for the existence of 432E-1.4, 6, and 6.5, more patients would have been wrongfully denied care.

These external review hearings of the PBR serve another important function, that of monitoring health plan performance. Without these hearings conducted according to Chapter 91, the Commissioner may never know what plan medical directors have considered when denying care or whether their process was consistent with state law.

None of these safeguards exist in SB 1274 or HB 1047.

The significant effect on Hawaii's health care in general will come if the present administration adds other categories of patients, such as Quest (and they are expected to do this at the end of this year), or state employees to Evercare and Ohana (and others) membership rolls, and there is no more external review in 432E-6, 6.5 or medical necessity standard in 432E-1.4. Then health plans have unfettered power to deny medically necessary care with impunity, further burdening hospitals and other providers with having to provide uncovered care, and increasing the social costs of poorer health.

DO YOU WANT TO SUPPORT THAT? NO, NOR DO I.

THANK YOU FOR KILLING THIS BILL.

Sincerely,

Arleen Jouxson-Meyers, M.D., J.D., M.P.H.,
President

SB1274
CPN/HTH
Wednesday, February 10, 2011
8:30 a.m.
Room 229

KOKUA COUNCIL

Hawaii's Voice for a Better Future

COMMITTEE ON COMMERCE AND
CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator Brian T. Taniguchi, Vice Chair

COMMITTEE ON HEALTH
Senator Josh Green, M.D., Chair
Senator Clarence K. Nishihara, Vice Chair

February 9, 2011

Re: SB1274 — Relating to Health Insurance

In Opposition

Senators Baker, Taniguchi, Green, Nishihara and members of the Committee:

My opposition to this bill is based on two main points: (1) it is unnecessary, and (2) it will harm those who now have a recourse when essential or life-saving procedures are denied by health insurers.

You have received other more expert testimony on this bill and so I need not repeat that this measure would gut the external review process by leaving the determination of medical necessity in the hands of the health insurers. The current provisions of the Patients' Bill of Rights and Responsibilities should be left as-is to continue to protect patients rights. The medical necessity standard is there for good reasons.

My understanding of the federal requirement is that states put in place a review process, but that states that already have one in place need not change it. If this is correct, then Hawaii is not under any pressure to change its existing law and this bill is unnecessary.

As to the harm it can cause, let me be blunt. If this bill passes, legislators will be cutting their own throats. Should you or your family need some life-saving treatment and your health insurance company thinks otherwise, you will lose the right to have the decision reviewed. You could end up dead. I am not exaggerating. Some of the cases that come up for external review involve life and death. The determine of medical necessity should not be left with insurers as this bill would require, or the review process is effectively nullified.

Kokua Council joined with other organizations in originally fighting for passage of the Patients' Bill of Rights and Responsibilities. Hawaii has taken a leadership position on healthcare largely as a result of this forward-looking legislation. We do not want to see its protections removed.

Kokua Council urges the Committee to reject these changes. If for no other reason, think about what you are taking away from yourselves, your spouses and children.

Larry Geller

President, Kokua Council

The **Kokua Council** is one of Hawaii's oldest advocacy groups. Kokua Council seeks to empower seniors and other concerned citizens to be effective advocates in shaping the future and well-being of our community, with particular attention to those needing help in advocating for themselves. "We embrace diversity and extend a special invitation to any senior or intergenerational minded individual interested in advocating for these important issues in Hawaii."

Rafael del Castillo

Attorney at Law

TESTIMONY IN OPPOSITION TO S.B. 1274

From: Rafael del Castillo
Attorney at Law
Personal testimony, not on behalf of any client or organization

To: House Committee on Health,
Hon. Ryan I. Yamane Chair, Hon. Dee Morikawa, Vice Chair

Hearing: February 10, 2011, 8:30 a.m., Conference Room 229

Emailed to: CPNTestimony@Capitol.hawaii.gov
Faxed to: 1-800-586-6659

Thank you for the opportunity to testify IN OPPOSITION to this injurious bill which repeals an essential provision of the Patient Bill of Rights and Responsibilities. I feel certain you recognize that during the last decade the State of Hawai`i has been able to implement important consumer protections and public policy with minimal cost by relying upon what is essentially private attorneys general H.R.S. § 432E-6 provides. That statute, which S.B. 1274 repeals, levels the playing field for patients who have to reckon with exceptionally to retain an expert patient advocate and such medical experts and other assists that may be necessary to demonstrate the medical necessity of care or services prescribed by the patient's treating providers.

Based upon the hearing I attended before the House Health Committee, I believe that this Committee and other legislators may have been given the MISINFORMATION that federal law mandates repeal of Hawaii's law. If so, you have been grossly misled. As set forth further below, you should not take the precipitous course of repealing substantial and important rights without investigating that question and what is truly best for Hawaii thoroughly. I strongly urge you to table S.B.1274 for this session and assemble an ad hoc committee/commission, made up of yourselves and consumers, to further consider this measure and the proper course of action once this session is concluded. I am more than happy to assist with organizing testimony from providers and patients, as well as getting opinions from the federal agency in charge of external reviews, in due course so that you have complete information. DHHS has just assigned Steve Larsen to head the national effort. His office should be consulted about the application of section 2719A of the health care reform act, assuming it survives challenges and attempts to dismantle it in the House, in Hawaii's case (we do, after all, have an EXPRESS EXEMPTION). In support of this recommendation, the Commissioner's representative advised the House Health Committee at its hearing on H.B. 1047 that Hawaii does not have to pass this legislation this year – it simply has to demonstrate that it is making progress according to the Commissioner.

One thing this Committee can be certain of, as discussed further below, THIS MEASURE WILL NOT ACHIEVE "UNIFORMITY" AS THE ADMINISTRATION HAS ALLEGED IN ITS "JUSTIFICATION." Virtually half of Hawaii's plan members will not have

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access to the proposed review. More importantly, because the health reform act modified ERISA preemption, we actually have an opportunity to achieve GREATER UNIFORMITY BY KEEPING OUR PRESENT EXTERNAL REVIEW LAW. S.B. 1274 assumes the Commissioner can require plans to offer ERISA members Hawaii's mandated external review. That is consistent with my analysis of the health reform act. THEREFORE, THE COMMISSIONER SHOULD REQUIRE ERISA PLANS TO OFFER OUR PRESENT EXTERNAL REVIEW PROCESS TO THEIR ERISA MEMBERS. That would achieve greater uniformity. ("Uniformity" is not achievable because Medicare, Tricare, and federal employees have their own mandatory external review processes – all different.) Further, this Legislature could achieve greater uniformity by making EUTF expressly subject to H.R.S. § 432E-6.

As a result of the past hearings, in most of which the patient has prevailed, we have demonstrated that managed care organizations—HMSA, Kaiser, HMAA, Evercare, Ohana—have treated Hawaii's most excellent medical necessity section of the Patient Bill of Rights and Responsibilities, H.R.S. § 432E-1.4, like a dead letter, ignoring their responsibility to apply the criteria in the law when they conduct a review of a request for care or services or in their INTERNAL appeals. In other words, the internal appeals are largely being conducted any old way the plan feels like conducting them. We believe that is because it pays. It has taken years for word to get around to patients about the nature of their rights to go beyond the internal appeal process. Things are changing in that regard. Word has gotten around and you will receive petitions and testimony opposing S.B. 1274 to demonstrate that fact.

Now is not the time to repeal the law because we have seen positive effects from the decade of experience the Insurance Division, private counsel, and the managed care organizations have accumulated. Recently I received a report from an attorney who appeared before an HMSA internal appeals committee about a very expensive therapy. He was versed in the application of H.R.S. § 432E-1.4. He had to sit by while the medical director gave a (grandiose) presentation, but he was accorded a few moments to speak. In that few moments he simply demonstrated to the committee that the medical director had not applied the H.R.S. § 432E-1.4 criteria, something the Commissioner's panels have repeatedly criticized medical directors about. He did not hold out much hope, and he was in the unfortunate position of having an ERISA plan, which would have required a federal court suit. To his complete surprise, the committee applied H.R.S. § 432E-1.4 and reversed the medical director's denial.

In keeping with the foregoing experience, we have had many cases settle before every going to a hearing. Most recently in a case in which the plan prevailed, we have learned that the plan is attempting to hire one of our experts to help it improve its evaluation of its members' needs. Previously, we have had cases in which the plan was denying a procedure or therapy, but revised its coverage following an external review hearing and reversal by the Commissioner. Thus, when an elderly patient wanted to avoid the substantial risks of complications from exploratory abdominal surgery for possible colon cancer by having a PET scan, Commissioner Wayne Metcalf's reversal of the denial of the PET scan led the way for this relatively inexpensive diagnostic procedure becoming more routine, as an alternative to an expensive surgery and hospital stay. Likewise, Commissioner Schmidt reversed the denial of coverage for

(more expensive) intensity modulated radiation treatment for prostate cancer (IMRT is used for brain cancer radiation on account of its extremely precise targeting of the irradiated area), so that the relatively young patient was able to avoid wearing a colostomy bag for the rest of his life. That led to the plan reaching an agreement with the IMRT facility for future treatments of prostate cancer. In another case, HMSA had excluded coverage of allogeneic stem cell transplantation for symptomatic multiple myeloma. We proved that a tandem autologous/allogeneic transplant had been proven to be the gold standard for treating Stage IV disease although the BlueCross/BlueShield review committee was still in the dark ages on treatment for the disease and recommending a autologous with chemotherapy. HMSA subsequently deleted the exclusion even though it ultimately prevailed on the question that it was excluded (according to a curious determination by the Intermediate Court of Appeals).

Our external review law is responsible for these advances and many others. The IRO process proposed by the replacement legislation is simply not going to achieve these results, and the 67-page monster will tilt the playing field back in favor of the managed care organizations, because patients will LOSE THEIR ADVOCACY RIGHTS.

S.B. 1274 TAKES AWAY PATIENT RIGHTS for well north of a quarter of a million of Hawaii's people. Before this Legislature takes such a drastic step, it should study the matter thoroughly. There is certainly no lack of evidence that can be considered. Furthermore, this measure is based on a new federal law that is subject to interpretation and little understood.

One thing is, however, clear. The Administration's legislation, the companion bill for which was introduced as H.B. 1047, is substantially injurious to patient rights, a giant step backwards in Hawaii's nation leading health care consumer rights public policies, and incapable of achieving the justification the Administration has offered. I expect the Legislature to hear from very concerned health care consumers across the State as long as these bills are under consideration, and I will be presenting this Committee at the hearing with the signatures of hundreds of consumers who urge you to oppose S.B. 1274. S.B. 1274 should not make it out of this Committee.

> Full disclosure: External review cases have comprised a portion of my practice for the past ten years and I have several cases in the process at the present time. On account of the fee shifting provision, H.R.S. § 432E-6(e), the Commissioner has awarded my firm fees and costs. We have reinvested those proceeds in patient advocacy, assisting patients with internal appeals which, if successful, eliminate the need for an external review. Through that advocacy, which is a product of the private-attorney-general design, we have been able to successfully settle at least twice as many cases as we have presented to an external review panel over the past decade. If H.R.S. § 432E-6 is repealed, that advocacy will no longer be funded and we will have to discontinue it.

The external review has proved over and over again that health plans do not conduct proper reviews before denying benefits and denying appeals of those denials. I will be providing the Committee, at the hearing, with a notebook containing copies of the decisions we have received over the years, highlighted to identify the Commissioner's findings which illustrate that plans

have, over and over again, failed to apply Hawaii's medical necessity criteria, codified at H.R.S. § 432E-1.4.

Hawaii's medical necessity criteria provide Hawaii consumers and their health care plans with the best and most objective measure conceived anywhere in the nation. That section of the law was two years in the making. It was formulated by a task force the Legislature tasked with determining ways of implementing the Patient Bill of Rights and Responsibilities in the most effective fashion to achieve its public policy. Hawaii's leading health plans were well represented on that task force, which unanimously recommended the measure to the Legislature in 2000, and it was enacted without modification. In particular, the plans gave up resort to denying medical services recommended by a treating health care provider on the basis that the procedure or therapy was "experimental."

Nonetheless, today I receive numerous complaints, primarily from our neighbor island consumers and providers, that the plans are continuing to resort to those bases for denying recommended services. The most disturbing matter, however, is the fact that in most of the decisions the plan has been criticized for failing to consider medical records, other evidence available including medical literature, and for failing to properly apply the medical necessity criteria. In other words, over and over again the plan's decision has been arbitrary. That is the greatest danger of relegating patients to the very complex IRO process contemplated under S.B. 1274, in particular when they have no assistance from a competent advocate, and no right to appeal their case to the courts.

Probably the most alarming aspect of S.B. 1274, however, is the fact that over a half million of Hawaii's citizens will not have the right to the external review that measure proposes because they are eliminated from it on its face. There is nothing we can do about the fact that Medicare and FEBA beneficiaries cannot utilize Hawaii's review, but we can ensure that our Medicaid patients continue to have that right and are not segregated and treated differently from their cohorts in commercial coverage. As the foregoing demonstrates, the justification offered for S.B. 1274 is simply not believable, that it will establish a "uniform" review.

As previously stated, if uniformity in the external review is an important goal, more uniformity can be achieved far more simply. Under Federal health care reform, the Commissioner has the power to compel E.R.I.S.A. plans to comply with the proposed bill if it became law. For that reason, the Commissioner has the power now to compel the E.R.I.S.A. plans to comply with our present, existing external review in H.R.S. § 432E-6.

Thank you for the opportunity to express my strong opposition to this measure. I apologize that I have not had sufficient time to commit all of my comments, based on many years of experience with patient advocacy, to this testimony. If this bill makes it out of this Committee, I will provide additional testimony in subsequent hearings, but I believe you have sufficient justification for subjecting this bill to further study.

Rafael del Castillo

ALSTON HUNT FLOYD & ING LAWYERS

Attorneys at Law • A Law Corporation

Testimony of
Ellen Godbey Carson
on behalf of Kaiser Foundation Health Plan, Inc.

Before:
Senate Committee on Commerce and Consumer Protection
Senator Rosalyn H. Baker, Chair
Senator Brian T. Taniguchi, Vice Chair

Senate Committee on Health
The Honorable Josh Green, M.D., Chair
The Honorable Clarence K Nishihara, Vice Chair

February 10, 2011
8:30 a.m.
Conference Room 229

Ellen Godbey Carson
E-mail:
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SB 1274 RELATING TO HEALTH INSURANCE

Chairs and committee members, thank you for this opportunity to provide testimony on behalf of Kaiser on SB 1274, which would create a new external review law to comply with mandates of the new Federal Patient Protection and Affordable Care Act of 2010 ("Act").

Kaiser Permanente Hawaii supports the purpose and most terms of this bill but has several requested amendments for compliance and clarity.

First, I would like to address the legal necessity for this bill. The new Federal Act mandates this form of external review. Contrary to some of the testimonies you have received, Hawaii cannot continue to use the existing State external review law in HRS 432E-6 for health insurance benefit disputes. That is why the Insurance Division has sought enactment of a new external review law that will both comply with the new Federal Act and promote uniformity in treatment of health benefit disputes.

Second, I would like to request the following amendments for compliance and clarity:

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(1) State and Federal remedies of health carriers should be preserved, just as they are for enrollees, in Section 432E-B(a), to comply with 29 CFR 147.136(c)(2)(xi).

(2) Any request for expedited external review of experimental or investigational treatment should be accompanied by a written certification by a Treating Healthcare Provider, to verify that the requested treatment would be significantly less effective if not promptly initiated, as required by NAIC Model Act, §5(B)(1)(b)(ii)(II) and Appendix B, p. 76-78, due to the extraordinary efforts required for expedited review.

(3) Any request for external review should be accompanied by a written authorization for release of relevant medical records, compliant with HIPAA, to assure relevant information can be obtained for the external review, to comply with NAIC Model Act §8(B)(4) and §5(B)(3).

(4) Persons requesting the external review should pay a filing fee of $25.00, refundable if they prevail on the review, with waiver of this fee if it poses undue financial hardship, as authorized by 29 CFR 147.136(c)(2)(iv).

(5) Selection of independent review organizations to contract with the Division of Insurance should be subject to chapter 103D procurement rules to assure prudent purchasing procedures are followed, as applies to other state contracts.

(6) Conflict of interest determinations must be quickly made upon receipt of each external review request, so both persons filing requests for external review and health carriers should be required to complete forms that disclose all relevant conflict-related information. Any group plan administrator(employer or plan sponsor) and any named plan fiduciary should be included in the conflict evaluation.

(7) A provision should be added that the commissioner must deny a request for external review that is not within the stated scope of the external review law.

(8) Definitions should be clarified to eliminate ambiguities in ch 432E, as "health carriers" (i.e, entities) should be defined as the entities that offer "health benefit plans" (i.e, policies and contracts), to distinguish it from the policies and contracts. "Health information" and "protected health information" should be defined in reference to HIPAA or the NAIC Model Act language.

In summary, we support the purpose of SB 1274 but request these amendments for compliance and clarification purposes. I would be glad to assist the committee or Division of Insurance in incorporating these amendments into the pending bill.

Thank you for your consideration.

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Thursday, February 10, 2011

To: The Honorable Rosalyn H. Baker
Chair, Senate Committee on Commerce and Consumer Protection

The Honorable Joshua B. Green, M.D.
Chair, Senate Committee on Health

From: 'Ohana Health Plan

Re: Senate Bill 1274-Relating to Health Insurance

Hearing: Thursday, February 10, 2011, 8:30 a.m.
Hawai'i State Capitol, Room 229

Since February 2009, 'Ohana Health Plan has provided services under the Hawai'i QUEST Expanded Access (QExA) program. 'Ohana is managed by a local team of experienced care professionals who embrace cultural diversity, advocate preventative care and facilitate communications between members and providers. Our philosophy is to place members and their families at the center of the health care continuum.

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.3 million Medicaid and Medicare members nationwide. 'Ohana has utilized WellCare's national experience to develop an 'Ohana care model that addresses local members' healthcare and health coordination needs.

We appreciate this opportunity to submit testimony in strong support of Senate Bill 1274-Relating to Health Insurance, as it necessary in order to help the State of Hawai'i conform to requirements under the Patient Protection and Affordable Care Act of 2010 (ACA).

This bill seeks to update Hawai'i's insurance laws to conform to the requirements relating to external medical reviews as established under the ACA, also known as National Healthcare Reform, and is based on the National Association of Insurance Commissioners (NAIC)'s Uniform Health Carrier External Review Model Act. Passage of this bill will provide a uniform and consistent external review procedure and will make the insurance statutes governing the external review of adverse determinations by health plans consistent and available to enrollees, while reducing confusion and inefficiencies in implementing Hawaii law.

The external review process, through an independent review organization (IRO) is very clearly laid out in the bill and ensures the protection of rights for plan enrollees, while balancing the necessity of proper and timely medical treatment. According to this bill, the IRO shall be comprised of physicians or other health care professionals who meet the minimum qualifications described in 432E- C and, through clinical experience in the past three years, are experts in the treatment of the enrollee's condition and knowledgeable about the recommended or requested health care service or treatment.

Additionally, neither the enrollee, the enrollee's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review and in reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process or internal appeals process, thus preserving the integrity of the medical decisions being made in the best interest of the patient.

To ensure timely accessibility and transparency the IRO is required, under this bill to maintain a toll-free telephone service to receive information on a twenty-four-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours, and must agree to maintain and provide to the commissioner the information required by this part.

To further protect impartiality, under this proposal an IRO may also not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers, nor have a material professional, familial or financial conflict of interest with any of the health carriers that is the subject of the external review, the covered person whose treatment is the subject of the external review or the covered person's authorized representative, any officer, director, or management employee of the health carrier that is the subject of the external review, the health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review, the facility at which the recommended health care service or treatment would be provided, or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

The process and procedures laid out under this bill are consistent with the model utilized by the NAIC on a national level, and strike the necessary balance to best ensure patient protection and timely access to medical treatment and supplies. More importantly, passage of this measure is necessary in order to conform Hawai'i's insurance laws to provisions of ACA.

Thank you for the opportunity to provide these comments in support of Senate Bill 1274- Relating to Health Insurance.

TESTIMONY IN OPPOSITION TO S.B. 1274

To: Senate Committee on Health,
Hon. Josh Green Chair
From: Tred R. Eyerly
Occupation: Attorney
Hearing: February 10, 2011, 8:30 a.m.

I **strongly oppose** Senate Bill 1274 (and the companion House Bill 1047), which will unjustifiably and irreversibly damage health care consumer protection in Hawaii. Hawaii's external review law, Haw. Rev. Stat. § 432E-6, has served health care consumers well for over a decade. It gives health care consumers a more level playing field against powerful insurance companies. Consumers have access to experienced advocates to assist them with preparing and presenting their cases in a manner consistent with Hawaii's medical necessity law. Decisions are made by a local expert panel, and consumers are able to present expert testimony and other evidence in a fair, but efficient, hearing process.

Instead of repealing our existing external review statute, it should be expanded to grant external review to ERISA plan members who, under the health care reform act, currently have no such rights. Without an external review before the Insurance Division, ERISA plan members must file a lawsuit in federal court. The expense of going immediately to court is prohibitive for many, if not most, of our citizens. The Insurance Commissioner should be directed to require ERISA plans to make our existing external review available to their members. Decisions on health care in Hawaii should be made in Hawaii, not outsourced as contemplated by S.B. 1274 to mainland doctors who are not in touch with our values, our culture, and our people.

The process for proposed review under S.B. 1274 is far more complex (you have only to compare the length of our existing law, Haw. Rev. Stat. § 432E-6 with S.B. 1274 to see how much more complex it will be), and, ironically, health care consumers will have a lot less help. S.B. 1274 simply cannot be seen as anything more than a huge favor for insurers. How is this bill fair to your constituents and patients across Hawaii?

The Legislature should not make such a sweeping change in our laws, repealing long-standing rights, especially when the fate of federal healthcare reform is up in the air. The Legislature should fully inform itself of whether an alternative course of action that avoids a repeal is available. The Legislature should also be fully aware of the impact of such a repeal on health care consumers. Please convene a task force or commission of health care consumers and legislators to study the proposal and report back to the Legislature. The task force can meet during the period before the 2012 legislature, and accept testimony and information from consumers, providers, and managed care plans, and convey that information to the Legislature in a report of the committee's recommendations.

Vote "No" S.B. 1274 because of the irreversible damage it will do to an inestimable number of Hawai`i citizens when they are sick and need your wholehearted support.

Thank you for the opportunity to express my strong opposition to this measure.

Very truly yours,

Tred R. Eyerly

Address: 1164 Kaeleku St., Honolulu, HI 96825

From: mailinglist@capitol.hawaii.gov
Sent: Saturday, February 05, 2011 8:14 AM
To: CPN Testimony
Cc: einew@hotmail.com
Subject: Testimony for SB1274 on 2/10/2011 8:30:00 AM

Categories:

Testimony for CPN/HTH 2/10/2011 8:30:00 AM SB1274

Conference room: 229
Testifier position: oppose
Testifier will be present: No
Submitted by: Irene Newhouse
Organization: Individual
Address: 129 Walua Place Kihei Hi
Phone: 808 891 2252
E-mail: einew@hotmail.com
Submitted on: 2/5/2011

Comments:
(e) An enrollee may be allowed, at the commissioner's discretion, an award of a reasonable sum for attorney's fees and reasonable costs incurred in connection with the external review under this section, unless the commissioner in an administrative proceeding determines that the appeal was unreasonable, fraudulent, excessive, or frivolous.

The above section is crossed out. What are you thinking? How is an ordinary person going to get an external review? Is this aloha, pono or malama? I don't think so. Can this possibly be good for voters? I hardly think so. This gives insurers free reign to deny claims right & left, because individuals can't afford to fight it.