SB658

Measure Title:	**RELATING TO ATTORNEYS' FEES.**
Report Title:	**Managed Care Plans; External Review Process; Attorneys' Fees**
Description:	**Provides for the award of attorneys' fees to the prevailing party in the administrative process for external review of a managed care plan's decision.**
Companion:	
Package:	**None**
Current Referral:	**CPN**

NEIL ABERCROMBIE
GOVERNOR

BRIAN SCHATZ
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TO THE SENATE COMMITTEE ON
COMMERCE AND CONSUMER PROTECTION

TWENTY-SIXTH LEGISLATURE
Regular Session of 2011

Friday, February 25, 2011
9 a.m.

TESTIMONY ON SENATE BILL NO. 658 - RELATING TO ATTORNEYS' FEES

TO THE HONORABLE ROSALYN BAKER AND MEMBERS OF THE COMMITTEE:

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

The Department opposes this measure, which changes the allocation of attorneys' fees in external review cases involving disputes between a health plan and one of its members.

The underlying premise of this bill, that the Commissioner hears frivolous external review cases, is wrong. If the Commissioner deems an external review case to be frivolous, then it is dismissed before a hearing occurs.

The reason for allowing the award of attorneys fees in medical dispute cases is because the dollar amounts involved are sometimes relatively small, making impractical the usual plaintiff's lawyer contingency fee arrangement. We believe the Legislature originally enacted the external review attorneys' fees cost-shifting provision because they didn't want standard lawyer economics to chill the vindication of patients' rights. We don't think it is practical to try to shift any part of the external review attorneys' fees

to plaintiffs in external review cases, particularly when many external review cases involve the Medicaid population. This bill also imposes a complicated attorney fees limitation that involves examination of fee arrangements which will place additional burdens on the Insurance Division and is not within its jurisdiction.

The fact that this bill was introduced, however, raises a larger policy question for the Legislature to consider. Currently, Medicaid cases are permitted to go through an external review process when there is already an administrative hearing process at the Department of Human Services to take care of disputes.

We thank the Committee for the opportunity to provide testimony and ask that this bill be held.

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Friday, February 25, 2011

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

From: 'Ohana Health Plan

Re: Senate Bill 658-Relating to Attorneys' Fees

Hearing: Friday, February 25, 2011, 9:00 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 health 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 testify in support for Senate Bill 658-Relating to Attorneys' Fees.

This bill seeks to amend the statute governing the award of attorneys' fees in the case of external review of the decisions of managed health care plans (§432E-6) to conform to the law governing awards of attorneys' fees in every other instance. This measure will help to reduce the number of frivolous external review cases as well as to ensure equitable treatment for managed health care plans.

While we understand and appreciate the external review process and the ability it has to provide reassurances for patients and consumers, we feel that it has become a mechanism for attorney's to gain income on taxpayer money. It is our understanding that when §432E-6, Patient's Bill of Rights was originally drafted and enacted that the Medicaid plans were never meant to be included. However, an exemption was never included and over the years as the court cases struck down the applicability of the law to certain groups (i.e., ERISA, EUTF, etc.) it has become so that the law now applies almost exclusively to Medicaid, the one group that it was never intended to apply to.

Although external review of a managed care plan's decisions is an administrative process, it is similar to a judicial action in that it is an adversarial evidentiary proceeding that involves a substantial expenditure of time and resources as well as representation by professional counsel for all parties involved. The external review process diverges from a judicial action in the allocation of responsibility for paying attorneys' fees.

When an enrollee requests an external review of a managed health care plan's decision, the current statute allows the reviewing authority to require the managed health care plan to pay any attorneys' fees incurred by an enrollee, regardless of whether or not the enrollee is the prevailing party. In the cases of a QUEST managed health care plan including AlohaCare, Evercare, HMSA, Kaiser and 'Ohana Health Plan, awards of attorneys' fees are absorbed by state taxpayers, regardless of the merits of the underlying claim and outcome of the external review decision.

We understand and support the Administration bills (SB 1274 and HB 1047) that will repeal this section of the law and instead adopt the Independent Review Organization (IRO) process utilized by the National Association of Insurance Commissioners (NAIC), however we feel that this bill is still necessary should those bills not pass, or become repealed, in order to rectify the inequity of awarding attorneys' fees to the enrollees regardless of if they prevail in the case.

We respectfully request that you pass this measure in order to ensure equitable treatment of managed care plans and plan enrollees, as well as to help reduce some of the abusive spending that ends up occurring in the Medicaid program as a result of this current law. Thank you for the opportunity to testify in support of Senate Bill 658-Relating to Attorneys' Fees.

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

DATE: **Friday, February 25, 2011**
TIME: **9:00 a.m.**
PLACE: Conference Room 229
State Capitol
415 South Beretania Street

TESTIMONY IN STRONG OPPOSITION TO S.B.658

Honorable Chair Baker, Vice Chair Taniguchi, Members of the committee:

The Hawaii Coalition For Health, an organization advocating for healthcare consumers and the Hawaii Congress of Physicians and Other Professionals, an organization advocating for healthcare providers are strongly opposed to this measure.

The drafter of this Bill has totally misunderstood the purpose of 432E-6(e). It was enacted in an attempt to level the highly discrepant playing field between the seriously ill patient fighting for his/her life and the powerful and rich health insurer which has virtually limitless legal resources to help it prepare a case. Without 432E-6(e), few patients denied medically necessary care would be able to contest an insurer's adverse decision. Also, the unconscionable idea of "loser pays" not only violates the federal health reform law which permits the patient to be charged only a nominal filing fee for external review which may not exceed $75 total per year, but would stamp out the possibility that a patient would seek external review.

How about this as a novel idea? Health plans could cease making arbitrary decisions to deny care that is clearly medically necessary, thereby dramatically minimizing their legal costs and the number of external reviews filed. Health plans cannot argue that cases that have been brought under 432E-6 have been frivolous. I have personal knowledge of 32 cases brought since the inception of 432E, and 75% of these cases either settled before hearing or the health plan's

denial of care was reversed by the commissioner. The health carrier's denial of care was upheld by the 3-person panel in only 8 cases. In one of those cases, the plan later reversed itself and provided, in that case, heart surgery. The circuit court reversed the panel in two of those cases. **Thus, in only 5 cases out of 32 was the patient denied the benefit,** and in one of those cases, about to be appealed, the hearing officer (the commissioner or his designee) dissented. Another is presently on appeal to the circuit court.

Under 432E-13, the legislature is provided this information from the insurance commissioner annually.

It is also noteworthy that an attorney from Alston Hunt Floyd and Ing represented the health plan in 27 of the 32 cases.

Thank you for considering my testimony.

Sincerely,

Arleen Jouxson-Meyers

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

Rafael del Castillo
Attorney at Law

TESTIMONY IN OPPOSITION TO S.B. 658

From:

Rafael del Castillo
Attorney at Law
Personal testimony, not on behalf of any client or organization
Emailed to: CPNTestimony@Capitol.hawaii.gov

To: Senate Committee on Consumer Protection,
Hon. Rosalyn H. Baker, Chair; Hon. Brian T. Taniguchi, Vice Chair

Hearing: February 25, 2011, 9:00 a.m. Conference Room 229

Thank you for the opportunity to testify in opposition to Senate Bill 658. First, I believe that the measure will be preempted by federal law if it is enacted, and will furthermore cause Hawaii's external review to be preempted in its entirety. The Patient Protection and Affordable Care Act emphasizes health care consumer protection to a very substantial extent. The strength of the consumer protection purposes is particularly demonstrated in connection with the right to external review of a denial of coverage for medically necessary care. Interim federal regulations on external review require states to meet, at minimum, sixteen (16) consumer protections. If the state's laws fail to meet any one or more of those requirements, the state external review law is preempted and health plans are required to comply with the federal external review process. I spoke with three Office of Consumer Information and Insurance Oversight (OCIIO) staff in a conference call February 17, 2011, joined by Richard Miller, Professor Emeritus of Law. The OCIIO staff told Professor Miller and me that OCIIO policy makers will be reviewing Hawaii's external review law prior to July 1, 2011 to determine whether it fully complies, and that Hawaii law will be preempted if they determine our laws fail to meet or exceed the 16 minimum consumer protections. Among the sixteen protections is the following express prohibition on burdening health care consumers with the cost of their external review:

> Notwithstanding this requirement, the State external review process may require a nominal filing fee from the claimant requesting an external review. For this purpose, to be considered nominal, a filing fee must not exceed $ 25, it must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review, it must be waived if payment of the fee would impose an undue financial hardship, and the annual limit on filing fees for any claimant within a single plan year must not exceed $ 75.

26 CFR § 54.9815-2719T(c)(2)(iv). Imposition of a plan's attorney's fees and costs on a consumer in connection with the external review would clearly violate the intent of the foregoing subsection (c)(2)(iv). Accordingly, if S.B. 658 is enacted into law, it appears that Hawaii's

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external review law would be preempted until S.B. 658 is repealed.

I further take strong exception to the proposed findings on which S.B. 658 is purportedly based. Under Hawaii law, the legislature's findings are entitled to substantial deference. *Sierra Club v. DOT*, 120 Hawai`i 181, 196 (2009). The United States Supreme Court has held on numerous occasions that legislatures are presumed to have "drawn reasonable inferences based on substantial evidence" in their findings. *Turner Broad. Sys. v. FCC*, 512 U.S. 622, 666 (U.S. 1994). It thus is incumbent upon this Committee and the Legislature to ensure that all findings upon which S.B. 658 is based is are truthful and accurate, and based upon substantial evidence. S.B. 658 states the following:

> This has enabled some instances of attorneys bringing non-meritorious cases through the external review process purely as a means of winning money from managed health plans.

S.B. 658 at 1. The foregoing statement is unfair and offensive to former Commissioners, the Honorable Wayne Metcalf and the Honorable J.P. Schmidt, and their fine service to this State. It is furthermore unfair and offensive to the service of Acting Commissioner Gordon Ito, who has had occasion to award fees and costs, and has complied with the law.

That statement is also more than a little bit false. I am absolutely confident that the Legislature has no evidence whatsoever that either Commissioner has ever awarded fees in a non-meritorious case. Moreover, I am absolutely confident that the Commissioner has never had to hold the hearing he is required by law to hold in the event that it appears a frivolous case has been brought. I can say that with absolute confidence because my law partner and I have personal knowledge of nearly all, if not all, external review cases in which the Commissioner has awarded fees and costs to a consumer. The plans in those cases have lost or have settled before the hearing in over 80% of those cases. In the instances in which the consumer lost, the plan was able to show that the services requested were available in Hawaii, or the plan reversed itself after the hearing, or the consumer was unable to sufficiently prove the efficacy of a very new therapy. In one instance, a case Andrew Winer, Esq. represented the consumer, although the plan prevailed, the consumer received the bone marrow transplant in another state under its Medicaid program, so the transplant was obviously medically necessary. The last I knew, that patient was still alive and a productive member of society. Furthermore, virtually every case I know of has resulted in advances in beneficial plan coverage policies, and in the majority of cases, the plan was criticized for failing to show that it conducted a proper medical necessity analysis or informed itself about the medical intervention the treating physician has prescribed in a reasonable fashion.

For the foregoing reasons, this Committee should decline to pass S.B. 658 on. It should meet its ignominious end on February 25, 2011, never to be heard from again among reasonable persons.

Rafael del Castillo

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TESTIMONY IN OPPOSITION TO SB 658 RELATING TO ATTORNEYS' FEES

Hearing Date: Friday, Feb. 25, 2011

Time: 9:00AM

Place: Conference Room 229, State Capitol

Chair Baker, Vice Chair Taniguchi and Distinguished Committee Members:

Thank you for considering my testimony in very strong opposition to this terrible bill.

The decision of a health plan to deny treatment, surgery, tests, or drugs ordered by a member- patient's licensed physician can be very dangerous, even fatal to the patient. I'm sure you know that. The anguish – that of the patient, the patient's family, and the patient's close friends and business associates – can also be great. It is therefore unthinkable that a health plan, whether partly financed by an employer and employee, or by the State in the case of indigent fellow citizens, should ever – repeat ever -- be allowed to deny such an order by the patient's physician without a full and fair opportunity for the patient, or whoever is charged with the advocacy of her or his position, to show (1) that the denied order is medically necessary and (2) that the treatment, surgery, tests, or drugs being denied are covered.

The fact that the patient in a particular case, who may be indigent, is receiving her or his health care from a public source, such as Medicaid or similar programs, should be, as I believe our caring new Governor has indicated with regard to questions of indigent's rights, irrelevant.

The problem is that appeals from such denials are usually extremely complex and potentially quite expensive. The reason is simple: To win such a case the patient, or whoever advocates for the patient, must have the assistance of a knowledgeable expert in medicine who is capable of dealing with great complexity and able to convey his or her views understandably to the decision-maker who may or may not be a physician. In addition, the patient's case cannot proceed effectively without an attorney who understands this very complex area of law who can also convey his or her views to the decision-maker, who may not be a lawyer.

To their and our great credit, our Legislature -- with the help of knowledgeable public servants such as former Senator and Insurance Commissioner Wayne Metcalf and former Commissioner and Judge Ray Graulty, and with the support of a number of important organizations such as the AARP, the HMA and other physician's organizations, and the Hawaii Coalition for Health – in 1998 adopted the Patients' Bill of Rights and Responsibilities which provided both an excellent definition of medical necessity and of what kind of proof can be used to establish it plus an external appeals procedure under the Commissioner of Insurance. The procedure called for a three-person panel composed of the Commissioner or his delegate (usually a lawyer in the office of the Insurance Commissioner), a representative from a health plan other than the one denying the benefits, and a licensed physician.

Very importantly, The Patients' Bill of Rights dealt directly with the very significant problem that many, if not most, of the citizens who seek to overturn a denial of medical benefits cannot afford the significant risk of having to pay the lawyer's fees if they lose. For example, in one case in which the patient managed to win a judgment for a PET scan denied by the health plan, or its value, about $2000 -- $3000, the reasonable attorneys' fees were $40,000. However, without the PET scan the patient would have had to undergo a $25,000

exploratory surgery that entailed substantial risks of complications or death, and a long disability! Even if the patient had lost that case, the patients' lawyers' fees would still have been $40,000 and, unless there was a contingent fee arrangement, the patient would have been liable for that amount. The important thing to note is that the possibility of having to pay such substantial fees could and would deter many, many families from pursuing what may appear to be a winning appeal to the three-person panel set up by the Insurance Commissioner.

In response to this problem, the Patients' Bill of Rights contained this language which *could* require the health plan to pay the patient's attorneys' fees even if the 3-person panel ruled against the patient

> Sec. 432E-6(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*. (Emphases added.)

As stated in the bill, the proponents of SB658 have this as their first and presumably most serious objection to Sec. 432E-6(e):

> When an enrollee requests an external review of a managed health care plan's decision, the current statute allows the reviewing authority to require the managed health care plan to pay any attorneys' fees incurred by an enrollee, regardless of whether or not the enrollee is the prevailing party. *This has enabled some instances of attorneys bringing non-meritorious cases through the external review process purely as a means of winning money from managed health plans.* [1] (Emphasis added.)

This statement is entirely wrong, not only because there have not been any such non-meritorious cases in which attorneys' fees have been required by the health care plan but because the commissioner expressly *has discretion* whether or not to order attorney's fees from the health plan and because the commissioner must not, repeat *must not,* allow such fees if the case is found to be non-meritorious, that is, *if the commissioner determines that the appeal was either "unreasonable, fraudulent, excessive, or frivolous !"*

Because of the complexity of the law and the applicable medicine there will be cases in which the decision turns out to be a close call. These cases are not without merit. *But it is extremely unlikely, virtually impossible, that an insurance commissioner could or ever would defy the law and award attorney's fees to a party who loses a non-meritorious case under Sec. 432E-6(e)!*

To protect Hawaii's patients, please defeat SB 658.

Thank you for considering my personal views, which are not necessarily those of the U.H. or the William S. Richardson School of Law.

[1] This statement unfairly accuses our excellent former commissioners of acting improperly!

To: The Honorable Rosalyn H. Baker, Chair
The Honorable Brian T. Taniguchi, Vice Chair
Senate Commerce and Consumer Protection Committee

From: Carolyn Y. Santo
Kailua, Hawaii
(808) 524-6477

Date: February 23, 2011

Re: **Testimony in opposition to S.B. 658 - Relating to Attorneys' Fees**

I am vehemently opposed to this bill for a number of reasons, namely:

1. The basis for the Bill is flawed.
2. The proposed change implies that the Insurance Commissioner cannot be trusted to properly exercise discretion or isn't able to identify unreasonable, fraudulent, excessive or frivolous appeals.
3. Adding a more onerous financial burden to the patient who seeks to appeal a denial of medical benefit would effectively bar all but independently wealthy patients from the appeals process.
4. The current law helps equalize the inequity inherent in a conflict between an individual with limited financial means and a large corporation with massive financial resources that possesses the ability to make life or death decisions.

Flaws in the basis for the Bill

Section 1 of the Bill implies that the external review process needs to be identical to judicial action without explaining why the change is necessary or desirable. In fact, the proposed change isn't beneficial to anyone except the health insurance carriers and/or HMOs since it would further leverage the disparity between financial resources of the patient and the party who is supposed to provide coverage for medical treatment. The first paragraph states that the external review process "involves a substantial expenditure of time and resources", both things that the business entities possess to a much greater extent than the patient.

In addition, Section 1 implies that we suffer from a profusion of non-meritorious appeals through the external review process. Besides stating the obvious problems with frivolous cases, the Bill doesn't quantify the extent of the problem or why this change needs to be made.

I believe that in actuality, the number of unfair denial of benefits far exceeds the number of frivolous cases that are submitted for external review. I would not be surprised if there were 100 to 500 denials of benefits for every truly frivolous case submitted for external review.

Insurance Commissioner's failure to exercise proper discretion and/or lack of competency

Given the fact that one of the Insurance Commissioner's primary duties is to regulate insurance carriers licensed to do business in the state and approve policy language and terms, the Insurance Commissioner or designee would be more qualified than most individuals to determine whether or not a health plan is unfairly denying benefits to a patient. Also, the same perspective would be beneficial in determining whether or not the issue submitted for external review has merit.

The proposed change would shift the Insurance Commissioner's duties from exercising discretion in deciding whether or not a case has merit to reviewing attorney's bills and fee agreements to determine whether or not they are reasonable or correctly executed.

External review as a privilege for the wealthy

As currently written, HRS Section 432E-6 deters health insurance carriers and health plans from unjustly denying benefits. Giving the Insurance Commissioner the ability to assess attorneys' fees (even when the patient ultimately loses the appeal) basically helps a person with limited financial means to appeal a denial of health care benefits. Opening that avenue to people of limited means does not turn them into irrational filers of frivolous disputes any more than allowing shoppers to take things off the shelves in stores turns them into shoplifters.

I am strongly opposed to eliminating any potential avenue for appeal that the individual patient has vis-à-vis a health insurance carrier or health plan. Due to the outrageous cost of medical procedures and care, the vast majority of patients do not have the luxury of opting to pay for treatment out of pocket and fight it out with the insurer later. In fact, the fortunate few who have extra funds, usually opt to spend their hard-earned dollars trying to pay for the medical care instead of financing a legal battle with a health insurance provider that has vast financial resources and a vested interest in dragging out a dispute.

Obtaining a balance of power

I totally agree with the premise that health care costs are spiraling out of control and that everyone must do their part to try to contain these costs, including patients. I do not see how limiting one of the few avenues available to facilitate a patient appeal would help the situation. In fact, I think increasing the potential cost of an appeal to the patient and limiting the avenues to challenge the health insurance carriers and health plans would lead to more egregious examples of them denying costly treatments to patients. The power imbalance between health plans and individual consumers is so uneven, we need ways to ensure that patients' rights to medically necessary benefits are preserved and protected.

Appealing a denial of coverage is not a pleasant experience for a patient and his or her family. The process is emotionally taxing and at times unbearably frustrating and even humiliating because of the unique factors associated with health issues and privacy. The external review is one small way to help individual patients gain access to the care the health plans and/or insurance carriers are obligated to provide. This is especially important because of the issues that are brought to the external review process usually involve costly procedures/treatments that often have life threatening and/or life changing potential.

If the insurance carriers and/or health plans were fiduciaries and held to a fiduciary standard of care, they would have a vested interest in providing all of the benefits that patients are entitled to without forcing them to go through costly, frustrating, and lengthy appeals processes. Instead, the carriers and health plans can deny coverage and wait to see if the patient has the resources, ability, and emotional fortitude to launch and follow through with an appeal.

In many ways, they are just like any other business in that economic reality suggests that it is profitable to deny coverage of the most expensive treatments and pay out the few that are able to withstand the stresses of the appeal process to the end. Furthermore, as in other litigation, it's standard practice for them to settle at the last minute by agreeing to provide the disputed treatment (perhaps with an offer of additional financial compensation) in return for a confidentiality agreement. Since the benefits of the settlement can be withdrawn if a patient or

attorney shares information about the appeal, no one except the insurance carriers and/or health plans know how many times they deny coverage only to provide it later to the few tough patients who survive the appeal process.

In short, I strenuously oppose the proposed amendment to HRS 432E-6. Insured people should have strongly protected rights to appeal decisions which deny health care benefits. The Insurance Commissioner should be allowed to determine whether or not an appeal is meritorious. In addition, the Insurance Commissioner should be allowed to assess and/or deny fees in order to facilitate the proper exercise of patients' rights.

Thank you for your consideration.

Testimony for CPN 2/22/2011 8:30:00 AM SB658

Conference room: 229
Testifier position: oppose
Testifier will be present: No
Submitted by: Margaret Wille
Organization: Individual
Address:
Phone:
E-mail: margaretwille@mac.com
Submitted on: 2/19/2011

Comments:
This is a despicable bill ... shameful.

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