DAVID Y. IGE
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PANKAJ BHANOT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

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

February 8, 2016

TO: The Della Au Belatti, Chair
House Committee on Health

FROM: Rachael Wong, DrPH, Director

SUBJECT: **HB 2740** - **RELATING TO LIABILITY**
Hearing: Monday, February 8, 2016; 1:45 p.m.
Conference Room 329, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) appreciates the opportunity to provide comments on this bill.

PURPOSE: The purpose of this bill prohibits health insurance preauthorization requirements that cause undue delay in receipt of medical treatment or services. Specifies that insurers, but not health care providers, are liable for civil damages caused by undue delays for preauthorization.

The Department of Human Services (DHS) provides medical services for Medicaid recipients through its QUEST Integration (QI) and fee-for-service programs. About 99% of the Medicaid recipients are enrolled in a QI managed care plan. As part of the QI contracts, and in accordance with federally required language, there are specific provisions that outline timeframes in which a health plan must respond to a prior authorization request.

Therefore to provide clarity the DHS respectfully recommends that the measure specify that Medicaid is excluded from this bill's requirements.

Thank you for the opportunity to testify on this measure.

DAVID Y. IGE
GOVERNOR

SHAN S. TSUTSUI
LT. GOVERNOR

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TO THE HOUSE COMMITTEE ON HEALTH

TWENTY-EIGHTH LEGISLATURE
Regular Session of 2016

Monday, February 8, 2016
1:45 p.m.

TESTIMONY ON HOUSE BILL NO. 2740 – RELATING TO LIABILITY.

TO THE HONORABLE DELLA AU BELATTI, 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 purpose of this bill is to prohibit health insurers from requiring preauthorization that causes undue delay in a patient's receipt of medical treatment or services. The bill also purports to grant civil immunity to a licensed health care provider for injury to a patient caused by undue delay in preauthorization, and impose civil liability on an insurer for any patient injury caused by undue delay in the receipt of medical treatment or services. The Department submits the following comments.

There may be a subject-title problem with the bill in violation of Article III, section 14, of the Hawaii State Constitution. The title of this bill is "Relating to Liability." However, the bill's contents addresses several subjects not relating to liability, thereby possibly exceeding the scope of the bill's title.

This bill would add new sections (preauthorization; undue delay; liability) to chapter 431, Hawaii Revised Statutes ("HRS"), applicable to health insurers, and chapter 432, HRS, applicable to mutual benefit societies, as well as amend section 432D-23, HRS, applicable to health maintenance organizations.

Medical determinations are complex, and not conducive to blanket regulation by the Insurance Code. These medical decisions seek to balance patient safety, effectiveness, and medical appropriateness and are outside the purview of the Insurance Code. The Affordable Care Act, as well, recognizes that services, except in the case of emergency and patient access to obstetrical and gynecological care, may require preauthorization.

The granting of immunity to health care providers for injuries and the imposition of liability on insurers regarding medical decisions are likewise outside the purview of the Insurance Code.

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

THE QUEEN'S HEALTH SYSTEMS

To: The Honorable Della Au Belatti, Chair, Committee on Health
The Honorable Richard P. Creagan, Vice Chair, Committee on Health
Members, Committee on Health

From: Paula Yoshioka, Senior Vice President, The Queen's Health Systems
Date: February 5, 2016
Hrg: House Committee on Health Hearing; Monday, February 8, 2016 at 1:45pm in Room 329

Re: **Support intent of HB 2740, Relating to Liability**

My name is Paula Yoshioka and I am a Senior Vice President at The Queen's Health Systems (QHS). I would like to express my **support** for the intent of HB 2740, Relating to Liability.

Delays in insurer preauthorization of medical services lead to delays in treatment and ultimately a delay in discharging of patients. Queen's Medical Center – Punchbowl experiences high census on a daily basis and patients needing an acute level of care may not be able to access a hospital bed if census is full. Delays in discharge delay our ability to place people in need of care into acute-care beds. Thus the need for preventing any delays in treatment and discharge are very important to the continuum of care.

Thank you for your time and consideration.

From: mailinglist@capitol.hawaii.gov
Sent: Sunday, February 07, 2016 8:06 PM
To: HLTtestimony
Cc: bb@cancermd.net
Subject: Submitted testimony for HB2740 on Feb 8, 2016 13:45PM

HB2740
Submitted on: 2/7/2016
Testimony for HLT on Feb 8, 2016 13:45PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Bobby C. Baker, MD	Pacific Cancer Institute of Maui	Support	No

Comments: Dear Representatives CACHOLA, EVANS, LUKE, MIZUNO, SAIKI and SOUKI I am writing to support HB2740. Our organization has had great concern about the recent delays in obtaining pre-authorization for our cancer patients to receive CT scans, MRI's and PET/CT scans especially. Many of our patients have life threatening diseases and often these types of studies are necessary for us to fully evaluate tumor sizes and extent in order for us to adequately plan surgical, chemotherapy and radiation treatment. Significant delays, and even worse, denial of these studies create a significant amount of anxiety in our patients, staff and doctors who's goal is to start the appropriate treatment as soon as possible. Determining the size, extent and the possibility that the tumor may have metastasized is crucial in making appropriate recommendations for cancer treatment. Many patients have significant symptoms, including pain, neurological, gastrointestinal, respiratory, gynecological, etc. In addition, all of the cancer patients require these same types of studies during follow-up visits in order to determine their response to treatment and whether or not additional treatment needs to be administered. This can often times be as important as the initial work-up prior to initiating treatment. The Pacific Cancer Institute uses the NCCN (National Comprehensive Cancer Network) guidelines when determining the type of treatment and studies that are necessary in order to properly manage our cancer patients. We would also like to point out that no physician or staff member in our organization owns any interest in any diagnostic radiologic equipment and has no economic interest in ordering any of these studies. To be perfectly honest, ordering CT Scans, MRI's and PET/CT's adds a significant amount of work for our doctors and staff to evaluate the results of these tests and how best to incorporate this information in the management of our patients. But, it is the right thing to do! The amount of time to submit all of the information necessary for pre-authorizations is becoming overwhelming. It requires precious staff hours that are already stretched in the current medical economics. Often times, the person that approves or denies these procedures (tests) have no experience in oncology what-so-ever. We had a recent experience where the doctor on the other end of the phone who was asked to approve a PET/CT scan for a patient with a cancer in the throat was a retired 89 year old orthopedic surgeon on the east coast. He spent

over 30 minutes on the phone trying to find a page in the "rule book" that would give him an idea of whether to approve or disapprove the test that we needed to determine the appropriate treatment for this very serious cancer. This makes no sense at all. We understand that health care costs are increasing and so are insurance premiums of our employees. Although, I am not sure of the best possible solution for this most serious problem, I believe that immediate action needs to be taken and those who are denying procedures that could create life threatening situations for Hawaii's cancer should be held accountable. Asking these patients to pay for these studies if their pre-authorization is denied is not the solution. The committee hearing this bill can rest assured that Hawaii's oncology community receives no benefit for ordering tests for our patients other than providing us with information necessary to recommend appropriate treatment. You must ask yourself, what is our ultimate goal, "to save money or save lives". Me ke aloha, Bobby C. Baker, MD, FACRO, FACR Medical Director, Pacific Cancer Institute Past Chief of Staff 1999 & 2000, Maui Memorial Medical Center

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

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HAWAII RADIOLOGICAL SOCIETY

LETTER OF SUPPORT

WITH REGARD TO HB2740 which would prohibit health insurance preauthorization requirements that cause undue delay in receipt of medical treatment or services. This specifies that insurers, but not health care providers, are liable for civil damages caused by undue delays for preauthorization:

The Hawaii Radiological Society supports this measure.

We acknowledge that Radiologists have an obligation to ensure appropriate utilization of higher imaging, protocol good technical quality of these studies, provide the most careful interpretation, and actively consult with the medical team to determine diagnosis and treatment for patients.

The Hawaii Radiological Society (HRS) then has two primary objectives in mind to facilitate the fulfillment of these responsibilities, specifically with regard to controlling utilization while providing timely service:

-HRS will advocate for any measures that restore and support local decision making for higher diagnostic imaging to the patient's local referring provider in concert with the local radiologist, without the need for pre authorization of imaging requests when the patient's well being is compromised by any delay in diagnosis.

-HRS proposes that non urgent outpatient imaging requests should be completely evaluated by the insurance carrier within 72 hours, either by direct application of American College of Radiology (ACR) Appropriateness Criteria, processed via Clinical Decision Support tool such as ACR Select, or review by a third party e.g. Radiology Benefits Management.

This bill is scheduled to be heard by HLT on Monday,February 8, 2016 at 1:45PM in House conference room 329.

Please contact us with any recommendations, concerns or questions.
Mahalo for your thoughtful consideration of these issues.

With Aloha,

Elizabeth Ann Ignacio MD
President, Hawaii Radiological Society
808.250.7058

To:
COMMITTEE ON HEALTH
Representative Della Au Belatti, Chair
Representative Richard P. Creagan, Vice Chair

DATE: Monday, February 08, 2016
TIME: 1:45 p.m.
PLACE: Conference Room 329

From: Hawaii Medical Association
Dr. Scott McCaffrey, MD, President
Dr. Linda Rasmussen, MD, Legislative Co-Chair
Dr. Ronald Keinitz, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: HB 2740 Relating to Liability

Position: Support

Hawaii Medical Association strongly supports this legislation.

If a doctor orders a necessary test, and that test is delayed or denied by an insurance plan, and that patient suffers as a result of this delay or deny, the physician should not be held liable for the patients injury as it pertains to the delay in treatment.

This bill is a common sense measure and should be enacted as soon as possible to ensure patient safety and encourage health plans approve appropriate care.

This bill has the following admirable goals:

1.) Prohibit insurers from requiring preauthorization that causes undue delay in a patient's receipt of medical treatment or services; and
2.) Clarify liability for patient injuries caused by preauthorization delays.

It is only fair that a licensed health care provider should be immune from civil liability for injury to a patient that was caused by undue delay in preauthorization of medical treatment services. The insurer should be civilly liable for any injury that occurs to a patient because of undue delay in medical treatment.

Thank you for the opportunity to provide testimony in strong support of this measure and thank you for hearing this important bill. This bill will help to make Hawaii a more viable place to practice medicine.

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Hawaii News

HMSA's new rule for imaging exams frustrates physicians

By Kristen Consillio

Posted January 24, 2016

January 24, 2016

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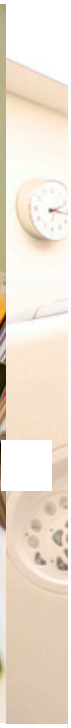
On Wednesday, January 20. Dr. Christopher Marsh filing out paperwork to appeal imaging tests denied by HMSA.



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Hawaii Medical Service Association is imposing a new pre-authorization requirement that doctors say is delaying critical imaging tests and resulting in harmful consequences for patients.

The state's largest health insurer, with 720,000 members, is now requiring physicians to go through a third party on the mainland to approve diagnostic imaging exams including MRI scans and computerized tomography, or CT, scans, and certain cardiac-related procedures in an effort to reduce unnecessary costs. The new rules started on Dec. 1.

"Now HMSA routinely denies most heart and X-ray tests," said Dr. Christopher Marsh, a Honolulu-based internal medicine physician, in a letter to the Honolulu Star-Advertiser. "They think or assume your doctor doesn't know what he/she is doing, and is too stupid to competently order tests on you. Or is a criminal, gaming the system, and benefiting illegally from ordering tests."

Before Dec. 1, physicians deemed to be appropriately ordering scans received a waiver that allowed them to skip the pre-authorization step. But as medical costs escalated, HMSA changed its policy to require all of its 2,800 physicians to get approval for imaging tests. The insurer would not say how many doctors previously had waivers.

ON THE WAIT LIST

Services that require preapproval for HMSA doctors as of Dec. 1:

>> Magnetic resonance imaging

>> Computerized tomography

>> Positron emission tomography

>> Cardiac imaging

>> Myocardial perfusion imaging

>> Stress echocardiography

>> Cardiac catheterization

>> Implantable cardiac devices

The decision on whether a test is necessary is now made by an Arizona-based

company called National Imaging Associates Inc., part of Magellan Health. The company guarantees "multi-year cost savings" for its clients.

In effect, doctors say, HMSA has basically stripped local physicians of their ordering privileges for imaging exams.

HMSA defended the policy, citing research that shows trends in imaging and related services in Hawaii are higher than national benchmarks. The insurer did not say how much it is spending on excessive imaging tests or how much the program is expected to save.

"Millions of health care dollars are spent each year on unnecessary medical care that doesn't improve the community's health and well-being," said Elisa Yadao, HMSA senior vice president of consumer experience, in a statement. "When we pay for unnecessary services, those costs are eventually passed on to everyone. By requiring pre-authorizations, we can reduce the number of unnecessary procedures, avoid our members being exposed to excessive radiation and lower costs."

The majority of these imaging tests range from $600 to $700, but could be more expensive depending on the type of scan or the number of tests a patient needs, HMSA said.

Nationally, 30 percent of imaging is "non-value-added," resulting in unnecessary exposure to radiation for members and excessive costs for the payer, said Dr. Michael Pentecost, chief medical officer of National Imaging Associates, in a statement.

"In other areas where this program has already been implemented, Magellan has found significant overuse, the management of which has driven significant improvements in patient safety and cost control," he said, adding that HMSA uses national appropriate-use guidelines when making these determinations. "HMSA's prior authorization program has been in place since 2006. However, this newer program will further reduce the number of unnecessary tests, therefore improving patient safety and more efficiently controlling costs."

Still, the practice is disrupting care for patients.

Allen Chun was scheduled on Jan. 13 for a stress echocardiogram, or treadmill test, to determine how well his heart and blood vessels are working. The 60-year-old Honolulu resident had an abnormal electrocardiogram, or EKG, and "huge risk factors" for coronary heart disease, including diabetes and a family history of heart problems. The test was canceled the day before the exam when the procedure was denied.

"The experts at HMSA don't think you need any further heart evaluation," Marsh, Chun's doctor for the past 30 years, told him in a Jan. 16 letter. "They think I am ordering expensive, frivolous tests and don't know what I am doing. Better to just kick the can down the road and hope for the best. Meanwhile, please call me immediately if you develop shortness of breath or chest pain (although diabetics often don't get any chest pain during a heart attack). Good luck!"

Marsh said he doesn't know why the procedure was denied and is seeking to appeal the decision by HMSA.

"They routinely deny these things and require a lot more records. It is called the hassle factor, trying to limit medical care to save them money," Marsh said. "Some idiot wasn't satisfied with a very high-risk patient. We just don't have 60 to 90 minutes to spend on the phone begging HMSA to pay for a semi-urgent test. These are not unusual tests. These are tests that doctors almost always order. I have no stake in ordering these tests. In most of these cases it would be malpractice not to get them. It's been a huge stress and strain on our staff and it harms patient care."

Appeals can take up to 30 days to get approval for a "potentially life-saving, commonly accepted heart test," he added.

"I would want to know how my health is and overall my heart condition," Chun said. "It's something I wouldn't want to take lightly. I want to make sure that I'm OK."

HMSA's initial review can take up to 14 days for determination, according to the Queen's Medical Center. For urgent matters, the hospital said it does not delay the study, but continues to work on securing approval from the insurer. Pre-authorizations for outpatient imaging exams jumped to 49 percent when HMSA's rule took effect in December, from 16 percent in the preceding months, Queen's said.

"It is too early to determine any financial impact this new process may have," said Kristen Bonilla, spokeswoman for Hawai'i Pacific Health, parent company of Kapiolani Medical Center for Women & Children, Pali Momi Medical Center, Straub Clinic & Hospital and Wilcox Health on Kauai. "However, we have taken steps to assist our physicians to minimize any additional administrative burden and ensure our patients continue to receive the care they need when they need it. We have created a dedicated team to assist with and expedite the approval process. We are committed to reducing unnecessary diagnostic testing, from both a cost and patient care perspective, and do support having a review process."

HMSA acknowledged that asking doctors to obtain preapproval for certain procedures

may add to their administrative burden. The insurer said it has "made adjustments to streamline the authorization process while protecting the health of our members" and is offering training and webinars to help doctors through the change.

Because of the delays in getting approval, some doctors are sending patients directly to hospital emergency rooms to obtain routine imaging tests. HMSA's pre-authorization rule is not required for orders in the emergency department or inpatient procedures.

"Physicians are throwing up their hands, frustrated with the delays and sending their patients directly to the ER. In the ER they don't have to wait for pre-authorization," said Dr. Scott Grosskreutz, a diagnostic radiologist in Hilo. "The more it becomes harder to order tests, to see your patients and make decisions in a timely manner, the more office patients are going to end up at the doorstep of the emergency room. That's a lot more expensive."

Imaging costs for insurance companies in Hawaii are much less than the mainland because utilization rates are among the lowest in the nation, and HMSA's reimbursement rates for these services are 25 percent less than other Blue Cross Blue Shield payers, Grosskreutz said.

"It's a problem when it comes down to a money issue," said Dr. Chris Flanders, executive director of the Hawaii Medical Association, representing 1,100 physicians. "There's been a big impact. The specialties that use MRI and CAT scan on a regular basis for diagnostic purposes are being impacted by this quite a bit and they're upset about it. This is delaying patient care and with a delay in patient care comes poorer outcomes. This is damaging to our patients by having an excessive delay in the start of care."

Dr. Linda Rasmussen, an orthopedic surgeon in Kailua, recently diagnosed a patient as having a torn meniscus, one of the most common knee injuries. The patient, a 52-year-old truck driver, had symptoms of the injury for six months, but was denied an MRI. Instead, HMSA is requiring the patient to have physical therapy for four weeks, she said.

"This is a major problem," Rasmussen said. "The PT will cost more than the MRI or knee surgery. The insurance companies are spending more money trying to micromanage physician decisions. This leaves less money for direct patient care. It is a huge waste of money."

It also is impacting the finances of imaging centers as fewer tests are approved, said

Dr. Scott McCaffrey, an occupational medicine specialist and president-elect of the Hawaii Medical Association.

"This new measure is undermining the economic well-being of major imaging centers in our state as well as the hospitals," he said. "For all those reasons it's neither good medicine nor good cost control."

HMSA's pre-authorization rule is "causing a significant disruption in clinic work flows" for Dr. Byron Izuka, a pediatric orthopedic doctor and director of orthopedic research at the University of Hawaii Division of Orthopaedic Surgery. Izuka said it is taking his patients at least a week to get approvals for imaging tests.

"Normally patients get an MRI within two or three days," he said. "Once approval is received, they still have to make an appointment. For most orthopedists the vast majority of MRIs confirm injury diagnoses, tumors and cancers. It's detrimental in the sense that it changes the standard form and usual expectations. The sooner you get into rehab, the quicker you can recover."

The biggest concern, he said, is that the new process creates another step in which patients can get forgotten and fall through the cracks.

"This is how human mistakes occur," said Izuka, who previously had a waiver from HMSA's approval process. "They have all the data on anyone who is an HMSA physician. They could, at any time, retroactively review my behavior. I don't disagree with the spirit of what they're trying to do, but we disagree with the actual approach itself. I don't want bad apples ordering MRIs that are not medically needed. Everyone pays for wasted health care."

UHA HEALTH INSURANCE

February 8, 2016

Representative Della Au Belatti, Chair
Representative Richard P. Creagan, Vice Chair
Committee on Health
Conference Room 329

RE: HB2740 Relating to Liability

Dear Chair Belatti, Vice Chair Creagan and Members of the Committee:

We respectfully oppose HB2740 which proposes to prohibit health insurance preauthorization requirements that cause undue delay in receipt of medical treatment or services and specifies that insurers, but not health care providers, are liable for civil damages caused by undue delays for preauthorization.

This bill will result in a dramatic shift in the oversight and monitoring conducted by health insurers and it will likely significantly drive up costs of health care generally.

The bill's definition of "undue delay" is vague and will likely only result in more disputes and litigation. The bill defines "undue delay" to mean "an unreasonable delay in medical treatment or services that may cause the exacerbation or worsening of a health condition due to:

(1) The unwarranted rejection by an insurer of a first-time preauthorization;

(2) Administrative difficulties or delays in receiving preauthorization from insurers; and

(3) Difficulties arising from the non-communication by insurers on the tests and procedures that require preauthorization."

These factors are not clear and provide the health insurer with no guidelines by which we can create reasonable policies.

More worrisome is the bill's creation of additional liability upon the health insurer for "any injury that occurs to a patient because of undue delay in the receipt of medical treatment or services." There is already existing tort liability under common law for injuries proximately caused by the wrongful party. Here however, there is a new liability created that specifically exempts the provider from their liability.

Liability for any injury oftentimes arises from a complex aggregate of a multitude of factors. It is for that reason we have a system where each of the several parties can be included in a case to ensure that all of these factors can be considered by the fact-finder and decision maker as to who is the ultimately contributed to the alleged injury. This new liability would dramatically change this landscape, but more importantly, will place most of any burden upon the health insurer.

The unintended consequence of this bill would be that insurers would diminish or eliminate any prior authorization process. This will result in little to no oversight and ultimately lead to increased costs for all.

It is for these reasons we oppose HB2740. Thank you for the opportunity to submit written comments.

Respectfully submitted,

Howard Lee
President, CEO

TESTIMONY OF ROBERT TOYOFUKU ON BEHALF OF THE HAWAII ASSOCIATION FOR JUSTICE (HAJ) IN OPPOSITION TO H.B. NO. 2740

Date: Monday, February 8, 2016
Time: 1:45 pm

To: Chair Della Au Belatti and Members of the House Committee on Health:

My name is Bob Toyofuku and I am presenting this testimony on behalf of the Hawaii Association for Justice (HAJ). This OPPOSITION to H.B. No. 2740, Relating to Liability is focused on the immunity provisions of this measure as currently drafted.

The Hawaii Association for Justice SUPPORTS the INTENT of this measure to place the responsibility for harm to patients caused by unreasonable delays in treatment authorization with the insurance company which causes those delays. The measure as presently drafted, however, can be improved by making clear that a health care provider must provide needed treatment in emergency situations notwithstanding a lack of preapproval. As currently drafted, this measure can be read [unintentionally] to provide that a health care provider need do nothing where preauthorization has not been obtained and be immune for failing to treat people who need immediate treatment – even though such inaction will result in harm to the patient or even death. If this committee intends to pass this bill forward, HAJ suggests that the following amendment will assure that patients receive necessary treatment while clarifying insurance reimbursement procedures and health care provider responsibilities.

The following suggested amendment to the bill is as follows:

"§431:10A- Preauthorization; undue delay; liability. (a) Notwithstanding any provision of the law to the contrary, no insurer shall require preauthorization of medical services or treatments so as to cause an undue delay in a patient's receipt of medical treatment or services.

(b) For the purposes of this section, "undue delay" means an unreasonable delay in medical treatment or services that may cause the exacerbation or worsening of a health condition due to:

(1) The <u>insufficient time to obtain or</u> unwarranted rejection by an insurer of a first-time preauthorization;

(2) Administrative difficulties or delays in receiving preauthorization from insurers; and

(3) Difficulties arising from the non-communication by insurers on the tests and procedures that require preauthorization.

(c) Notwithstanding any provision of the law to the contrary, a licensed health care provider shall be defended and indemnified by an insurer for civil liability for injury to a patient that was caused by the insurer's undue delay in preauthorization of medical treatment or services.

(d) An insurer that violates subsection (a) shall be civilly liable for any injury that occurs to a patient because of undue delay in the receipt of medical treatment or services.

(e) A licensed heath care provider shall provide treatment or services without waiting for preauthorization whenever an unreasonable delay in medical treatment or services may cause the exacerbation or worsening of a health condition. An insurer which disputes that it was reasonable to proceed without preauthorization has the burden of proof to show that a licensed health care provider did not have a reasonable belief that it was necessary to provide treatment or services without waiting for preapproval."

These amendments will assure that patients receive necessary treatment and services in a timely manner, protect doctors from adverse consequences caused by unreasonable delays in preapproval by insurance companies, and protect health care providers from unreasonable reimbursement denials by placing the burden of proof on the insurance company whenever it denies payment for treatment because no preauthorization was obtained.

HAJ recognizes that this measure is well intended and necessary to ensure that patients receive needed treatments and services on a timely basis. It is requested that this measure be amended as provided above.

Thank you very much for allowing me to testify regarding this measure. Please feel free to contact me should you have any questions or desire additional information.

An Independent Licensee of the Blue Cross and Blue Shield Association

February 8, 2016

The Honorable Della Au Belatti, Chair
The Honorable Richard P. Creagan, Vice Chair
House Committee on Health

Re: HB 2740 – Relating to Liability

Dear Chair Au Belatti, Vice Chair Creagan, and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 2740, which seeks to (1) limit the ability of plans to require preauthorizations, and (2) clarifies liability for patient injuries caused by preauthorization delays. HMSA opposes this Bill.

HMSA and providers share the same goal – protecting the health and safety of people who trust us with their care. We work together to reach that goal but sometimes disagree on how to get there. While we work every day to balance the needs of our members, providers, employer groups, and government partners, our first priority always is the needs and safety of our members.

We seriously are concerned that HB 2740 will encourage plans to minimize preauthorization requirements, resulting in potentially dangerous health consequences for members and increase costs to Hawaii's healthcare system.

Preauthorizations

A preauthorization requirement is designed to (1) improve a patient's health and well-being by preventing overuse of medical services that could unintentionally cause harm, and (2) prevent wasteful services that people do not truly need.

Preauthorizations are required not only of imaging services, but they are required for many other medical services and procedures, medications, and durable medical equipment. With public concern over rising drug costs, preauthorizations can help identify an appropriate generic medication in lieu of a more expensive brand named drug. And, a preauthorization for a new prescription may help prevent potentially dangerous drug interactions.

Virtually every health plan, including Medicare and Medicaid, require preauthorizations for numerous services. To comply with Medicare requirements, HMSA's Akamai Advantage plans require preauthorization for the following advancing imaging studies when provided on an outpatient basis (not emergency room or inpatient):

- CT scans
- Coronary CT angiography
- CT colonography (virtual colonoscopy)
- Functional Magnetic Resonance Imaging
- MRI, MRA, MRV
- Nuclear cardiology
- PET scans
- Cardiac Related Procedures

The Centers for Medicare & Medicaid Services (CMS), The State of Hawaii MedQUEST Division, and the National Committee for Quality Assurance (NCQA) all have guidelines and definitions on urgent versus non-urgent requests, specific turnaround times for decision making, and approval and denial processes. HMSA's utilization management program/prior authorization processes comply with these guidelines and definitions.

HMSA's Advanced Imaging Preauthorization Program

Despite the recent media focus on preauthorization for imaging services, as with virtually all other plans, HMSA actually has a preauthorization program for other medical services and procedures, durable medical equipment, and medications.

HMSA's preauthorization program for advanced imaging services has been in place for at least 10 years. HMSA's imaging preauthorization vendor, National Imaging Associates (NIA), provided us data indicating that 30 percent of imaging services ordered nationally are non-value added tests that fall outside of national clinical guidelines. Imaging services can be valuable in diagnosing and caring for patients. However, many imaging services use radiation and their use must be carefully monitored to protect patients' health and safety. There are other imaging services such as ultrasound and MRIs that do not use radiation. These can also be overused and lead to "false positive" findings that begin another round of unnecessary testing.

Since Hawaii's utilization numbers are higher than the national average, we were concerned that more than 30 percent of our imaging is not medically necessary, potentially jeopardizing the safety of our members.

Last December, to help protect our members from excessive exposure to radiation and to get a better grasp on utilization, HMSA began requiring all of our providers to file preauthorization requests for some imaging services. This includes providers who already had standing waivers for preauthorization, called "gold cards." Since those providers with gold cards simply were able to order and have tests done, we have no clinical data on these cases and are unable to make any judgments as to their medical appropriateness.

We appreciate that the preauthorization process may be inconvenient, particularly for those who are not familiar with the process. However, the online preauthorization process takes about 5-to-7 minutes to complete, with a response provided within two calendar days. And, it does not place our members at risk. It does not apply to emergencies. If a provider feels that an imaging service is needed for an emergency situation, we do not require a preauthorization. Providers and patients also have the right to appeal any decision we make.

Impact of HB2740

There are numerous specific concerns with HB 2740, many of which require clarification. For example, the Bill implies that there are circumstances under which an insurer will require a preauthorization to cause "undue delay." A preauthorization program is in place to ensure the safety of our members. No credible plan would conceivably require a preauthorization with the intention of causing "undue delay."

That said, we are more gravely concerned about the overall impact of this legislation. It will create an environment of uncertainty and confusion where plans ultimately may resist requiring preauthrizations just to avoid the negative legal consequences contemplated in this Bill. And, this measure generates even more uncertainly with respect to its impact on preauthorizations required under Medicare and Medicaid.

An Independent Licensee of the Blue Cross and Blue Shield Association

While the safety of our members is paramount, that safety is jeopardized by this Bill. At the same time, this HB 2470 does nothing but to impede efforts to control the ever-rising cost of our healthcare system.

Thank you for allowing us to testify on HB 2740. Your consideration of our concerns is appreciated.

Sincerely,

Jennifer Diesman
Vice President, Government Relations.

TESTIMONY OF THE AMERICAN COUNCIL OF LIFE INSURERS
COMMENTING ON HOUSE BILL HB 2740 RELATING TO LIABILITY

February 8, 2016

Via e mail: capitol.hawaii.gov/submittestimony.aspx
Honorable Representative Della Au Belatti, Chair
Committee on Health
State House of Representatives
Hawaii State Capitol, Conference Room 329
415 South Beretania Street
Honolulu, Hawaii 96813

Dear Chair Au Belatti and Committee Members:

Thank you for the opportunity to comment on HB 2740, relating to Liability.

Our firm represents the American Council of Life Insurers ("ACLI"), a Washington, D.C., based trade association with approximately 300 member companies operating in the United States and abroad. ACLI advocates in federal, state, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers' products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing more than 90 percent of industry assets and premiums. Two hundred sixteen (216) ACLI member companies currently do business in the State of Hawaii; and they represent 93% of the life insurance premiums and 88% of the annuity considerations in this State.

Section 2 of HB 2740 seeks to amend Article 10A of Hawaii's Insurance Code relating to Accident and Health or Sickness Insurance Contracts by adding a new section to that Article that would (among other matters) prohibit an insurer under an Accident and Health or Sickness Insurance Contract from requiring its preauthorization of medical services or treatments "so as to cause an undue delay" in the insured's receiving medical treatment or services. For violation, the insurer is made liable for the insured's injury caused by the undue delay in receiving medical treatment.

By its terms, *Article 10A of the Code (by reference to HRS §431:1-205) defines "accident and health or sickness insurance" to include disability insurance*.

ACLI submits that the intent and purpose that these provisions apply only to health insurers – not insurers issuing disability insurance.

Disability insurance provides cash payments designed to help individuals meet ongoing living expenses in the event they are unable to work due to illness or injury. Unlike health insurance, disability income insurance does not provide coverage for the insured's health care or medical treatment; further, the cash payments are made directly to the insured – not to the insured's health care providers or suppliers. Finally, the disability insurance policy typically does not dictate how the cash payments received by the insured are to be used by the insured.

Consistent with the bill's stated purpose as set forth in Section 1 of the bill ACLI suggests that paragraph (a) of the new section proposed to be added to §431: 10A (beginning at line 11, page 2 of the bill) be amended to dispel any confusion that disability insurers are subject to the bill's provisions as set forth below:

> "§431:10A-____ Preauthorization; undue delay; liability. (a) ~~Notwithstanding any provision of the law to the contrary, n~~No insurer that provides health care coverage shall require preauthorization of medical services or treatments so as to cause an undue delay in a patient's receipt of medical treatment or services.

Again, thank you for the opportunity to comment on HB 2740, relating to Liability.

LAW OFFICES OF
OREN T. CHIKAMOTO
A Limited Liability Law Company

Oren T. Chikamoto
1001 Bishop Street, Suite 1750
Honolulu, Hawaii 96813
Telephone: (808) 531-1500
E mail: otc@chikamotolaw.com

From: mailinglist@capitol.hawaii.gov
Sent: Sunday, February 07, 2016 10:46 PM
To: HLTtestimony
Cc: gutt@hilo.net
Subject: Submitted testimony for HB2740 on Feb 8, 2016 13:45PM

HB2740
Submitted on: 2/7/2016
Testimony for HLT on Feb 8, 2016 13:45PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Edward Gutteling, M.D.	Individual	Support	No

Comments: As a practicing physician, orthopedic surgeon, in Hilo, I can speak from experience that there is a lack of accountability for insurance companies to out-source clinical decision making to other entities, rather than rely on the doctors actually caring for the patients. Their objectives are to to lower costs. Their method is claimed to be both rational and efficient, but it is frequently neither. The result is frequently arbitrary and irrational, and it harms patients at times. The insurance companies and thief designated agencies need to be responsible for the harm they do. Those catastrophic ones are tragic and obvious: the MRI denied, the cancer missed for months, the delay in treatment, and the life list as a result, those are obvious and quite frankly not very common. Certainly, the insurance companies and their designated agents of authority must be legally responsible, lushly for damages from such. However, much more common and also damaging too stints, are the delays in medical care that result from denials of care, that result in significant but less severe and tragic outcomes. Consider the working person denied an MRI, but unable to work due to disability, and so whose delay in treatment cost them income or their job due to this shortsighted delay. The ultimate medical harm might be resolved, eventually, but the financial injury is not recovered. The insurance companies and their designated agents need to held liable for those actions, also. This sort of harm is much more widespread , and preventable. With accountability, these sorts of capricious decisions without responsibility will be prevented.

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Linda Rasmussen, MD
Windward Orthopedic Group, Inc
30 Aulike St #201
Kailua, HI 96734
808-261-4658
lindamd1@juno.com

Feb 7, 2016

Hawaii State Legislature
Committee on Health
Della Au Belatti, Chair
Richard Creagan, Vice Chair

RE: Support for HB2740 Relating to Liability - Insurers rather than health care professionals are liable if there is a delay in diagnostic tests due to preauthorization.

Hearing in Health, 2/8/16 1:45 in room 329.

Dear Honorable Representatives Bellatti and Creagan and committee members,

Frustrating delays in being able to obtain necessary studies for a medical diagnosis are common due to HMSA's requirement for pre authorization. HMSA outsourced this to a Mainland company on December 1, 2015.

You need to know that this is a real problem. I have had 2 MRI's denied in December and I only ordered 4. The Mainland company that makes the decision claimed that I needed to do 4 weeks of physical therapy or chiropractic care. This would cost more money than the MRI and was contraindication in both cases. I am not going to write for something that is not medically necessary. After hours of back and forth hassles with paperwork, I had to talk to the Mainland company's physician and was able to get approval on both denials. The delay resulted in additional time off work and potential increased risk of injury. My speciality is not life and death, but many delays can result in irreversible complications. What about cardiologist where a delay can result in devastating complications, including death?

In 21 years of practice in Hawaii, I have only one malpractice case that went to trial. I was sued for not getting a MRI earlier on a chronic back pain patient who had a rare tumor. The insurer would not approve the MRI, but I was sued. I won the case, but still had to deal with the trauma of being sued.

Please pass this critical bill to remove the liability related to delays from the physician to the insurer.

With Aloha,
Linda Rasmussen, MD
Past President, Hawaii Medical Association
Past President, Hawaii Orthopedic Association
Past President, Western Orthopedic Association

From: mailinglist@capitol.hawaii.gov
Sent: Sunday, February 07, 2016 10:56 AM
To: HLTtestimony
Cc: radsurfer2@hawaiiantel.net
Subject: Submitted testimony for HB2740 on Feb 8, 2016 13:45PM

HB2740
Submitted on: 2/7/2016
Testimony for HLT on Feb 8, 2016 13:45PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Scott Grosskreutz, M.D.	Individual	Support	No

Comments: Long delays in pre authorization are common in Hawaii, and possibly even a design feature. Most local physicians personally have had patients lost to follow up due to delays in the continuity of care. That can result in tragic consequences. That is why radiologists feel that even non-urgent should be reviewed for approval within 72 hours

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Prior authorizations limit access to care and delay patient access to physicians. This delays treatment and puts patients' lives at risk. I recently diagnosed a patient with a brain tumor from changes to his vision, I needed an MRI to confirm my exam findings. My staff and I spent hours to obtain authorization for this test and the test was delayed by about a week waiting for clearance from the insurance company. Unfortunately this was probably an example of the insurance companies acting quickly. There are times they reject the study, or take weeks, or the study prior authorization is lost in cyberspace. Meanwhile the patient is waiting for treatment. Another example of prior authorizations being ridiculous is angle closure glaucoma. We see patients with angle closure glaucoma regularly and need an authorization to do a iridotomy to cure their condition. In acute angle closure glaucoma the patient is blind in hours, prior authorizations will result in these patients going blind waiting to get a referral to see me. Then when I see the patient I need to get another authorization to treat them, further delaying treatment.

NANCY CHEN, MD
511 Manawai St, unit 401
Kapolei, HI 96707
808-674-2273

February 6, 2016

RE: HB2740 regarding

To whom it may concern,

I am coming via this letter to support the proposed bill HB2740.
We as physicians have enough administrative burdens to worry about, PQRS, escribe, ARRA, etc. Taking care of patients and make sure we make the right diagnosis and initiate the right treatment is our duty and we went to school many years in order to achieve that knowledge.

We do not need an insurance company to tell us what to do or not to do. A delay in diagnosis will generate a much bigger bill at the end than the order of a simple imaging study.

I believe that physicians should have the right to choose rather or not a study needs to be performed depending on the history and clinical findings.
I will be willing to listen to their desires and protocol, if the insurance company will take care of my professional liability insurance cost and guarantee immunity to any lawsuit.

Sincerely yours,

Nancy Chen, MD

From: mailinglist@capitol.hawaii.gov
Sent: Saturday, February 06, 2016 9:36 PM
To: HLTtestimony
Cc: davidhwmai@gmail.com
Subject: Submitted testimony for HB2740 on Feb 8, 2016 13:45PM

HB2740
Submitted on: 2/6/2016
Testimony for HLT on Feb 8, 2016 13:45PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
David Mai, M.D.	Individual	Support	No

Comments: Pre-authorization delays care and delayed care can be detrimental to the health of a patient.

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February 6, 2016

Representative Della Au Belatti
Chair
House Committee on Health

HB 2740: Relating to Liability

Letter in SUPPORT

Dear Representative Belatti and Committee Members:

Thank you for the opportunity to comment on HB 2740.

In late 2015, HMSA reconfigured its preauthorization program for non-emergent imaging studies. While time has not allowed for well-designed studies to be completed demonstrating effects of the policy change, anecdotal evidence from emergency physicians in the state finds that there was a widespread increase in patients presenting to our emergency departments because their primary providers were not able to navigate the preauthorization process in a timely fashion, leading the patients to seek care from the emergency department.

Insurance companies site the importance of preauthorization in their efforts to decrease costs for their members. Left out of their equations are the increased administrative costs to physician practices, increased physician time directed to paperwork rather than patient care, and the economic impact of patients remaining out of work while the diagnosis is delayed by the preauthorization process.

Furthermore, very little attention is given to dubious view that preauthorization does not constitute the practice of medicine, and health care plans are not held liable for potential ramifications related to delayed or missed diagnoses. Health care plans and those that they contract with are directly determining whether or not tests and procedures are being provided to patients after a physician who has examined a patient first-hand has ordered said test or procedure. Yet if an untoward event occurs because of that delay or denial, only the provider may face civil liability claims.

The current system unnecessarily shifts administrative burdens to health care providers while inappropriately protecting health care plans from civil liability. Preauthorization is direct patient care. As such, we should require that health care

plans prove that their actions are truly in our patient's best interest and end its civil liability protections.

Sincerely,

William Scruggs, MD, RDMS, FACEP
Emergency Physician
HMA Councilmember

From: mailinglist@capitol.hawaii.gov
Sent: Saturday, February 06, 2016 3:41 PM
To: HLTtestimony
Cc: srhee@hawaiianeye.com
Subject: *Submitted testimony for HB2740 on Feb 8, 2016 13:45PM*

HB2740
Submitted on: 2/6/2016
Testimony for HLT on Feb 8, 2016 13:45PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Steven Rhee	Individual	Support	No

Comments:

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I am an ophthalmologist who specializes in retina. I ask you to support HB2470 which prohibits the need for preauthorization. There are many cases where intravitreal injection of medication, prompt laser treatment, or emergent surgery is required to prevent vision loss. We know that time until treatment matters. The requirement to obtain preauthorization delays treatment and harms patient care.

I support HB2470 and request that you do, too.

Thank you,

Raymond Wee, MD

Ophthalmologist

808-487-8928

From: mailinglist@capitol.hawaii.gov
Sent: Saturday, February 06, 2016 12:31 PM
To: HLTtestimony
Cc: radsurfer2@hawaiiantel.net
Subject: Submitted testimony for HB2740 on Feb 8, 2016 13:45PM

HB2740
Submitted on: 2/6/2016
Testimony for HLT on Feb 8, 2016 13:45PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Scott Grosskreutz, M.D.	Individual	Support	No

Comments: In some cases, the pre authorization program has resulted in long delays in care and documented patient injury in Hawaii. Former Mayor Harry Kim has agreed to let his recent experience be shared. He came to HMC as an outpatient for a requested CT of the abdomen and pelvis with contrast and a lower extremity CT run off. I protocalled the study as a CTA to evaluate for AAA and atherosclerosis as appropriate. Because the radiologist protocaled a CTA, rather then CT with contrast, he was asked to wait for three hours in our department trying to get HMSA to approve the code change He was finally sent home when HMSA declined to approve the study, and he underwent the imaging procedure two weeks later when NIA finally authorized his study, for which he has many obvious and well documented clinical indications. I called as Department Chair to speak to him apologize for his delay in care. He was most gracious and appreciative, and stated he strongly wishes his imaging decisions to be made by his physicians in Hawaii. We have also noted a increase in the number of patients presenting to the ER, due to delays in obtaining preauthorization for outpatient imaging. One recent patient was unable to obtain authorization for an outpatient CT for a week after his physician palpated a large abdomen tumor, he became lost to follow-up for 6 weeks when he presented to the ER with severe pain and an emergent CT confirmed a large tumor filling the abdomen cavity.

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HLTtestimony

From: Margie <richmar@hawaii.rr.com>
Sent: Sunday, February 07, 2016 12:19 PM
To: HLTtestimony
Subject: Testimony for HB NO. 2740

H.B NO. 2740
RELATING TO LIABILITY
Some Hawaii health care providers have unilaterally decided to impose a preauthorization requirement on all high technology diagnostic imaging procedures. This includes Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and nuclear cardiac imaging procedures as well as the prescription of some medications.

Physicians and hospitals have an incentive to perform imaging studies in providing state of the art healthcare, while payers for healthcare generally have an incentive to control cost or raise premiums to be profitable. The challenge is always to allow alignment of all incentives without endangering patients lives and well being and insuring the best outcomes for patients.
Diagnostic imaging utilization has increased significantly in recent years. This increased use clearly demonstrates the positive role imaging is playing in redefining medical practice through safer, less invasive, and more accurate means of collecting diagnostic information.

Prior authorization's effectiveness in reducing imaging utilization is not uniformly accepted. The Medicare Payment Advisory Committee, in its 2005 report to Congress, wrote that prior authorization was costly and ineffective in controlling imaging utilization. The US Department of Health and Human Services has pointed out that "there is no independent data–other than self-reported–on the success of radiology business management companies in managing imaging services". Although there may be savings to the insurance companies associated with preauthorization by denying care, there is an associated cost shift to the other stakeholders in the healthcare system.

Insurance companies have utilized preauthorization of physicians orders as a gatekeeper tool intended to restrict the physicians lawful right to practice medicine in the legitimate way in which they are trained and licensed and restrict the timely delivery of health care.
Prior authorization is a more stringent process for imaging utilization management that is being used by insurance companies and their hired radiology benefit management associates . Prior authorization requires an ordering physician to obtain approval from the insurance company before a study is performed in order to receive payment for that service. The ordering physician is required to contact the management company, often located on the mainland, to obtain authorization on the basis of that company's proprietary guidelines. This approach, without ever having seen or examined the patient, involves reckless endangerment of the patients wellbeing at the least and potentially risking the complication of an unstable medical condition.

Prior authorization programs introduce barriers to patient care by introducing a layer of administrative complexity that creates additional burdens for referring physicians . These requirements seem intentionally burdensome and discourage utilization. Because of its cumbersome structure, prior authorization leads to the inappropriate redirection of patient care toward Emergency Rooms or inpatient hospitals which do not require preauthoriation. This significantly increases the cost of health care.

High technology imaging facilities presently require American College of Radiology (ACR) accreditation. This accreditation process is an educationally focused evaluation of imaging practices. There is also a peer review

assessment of image quality and radiation safety. Qualifications of personnel, equipment performance, and the effectiveness of quality control and assurance measures as well as outcomes data are also evaluated in this process. Radiation protection is a key element of an ACR accredited practice, not the role of an insurance carrier. MRI examinations do not utilize ionizing radiation at all.

Diminishing the inappropriate utilization of diagnostic examinations is the goal of the American College of Radiology standards and guidelines which define standard practices (ACR Appropriateness Criteria). This standardized system coupled with commercially available order entry programs allows for physician education at the time of order entry. It provides the means to order the most appropriate tests for the presenting clinical complaints at the time of initiating an order for a procedure.
serve as the HMSA gatekeeper intruding on the traditional physician patient relationship.

Commercially available Order entry and decision support systems based on the American College of Radiology Guidelines are the appropriate venue for proper control of imaging utilization, not the preauthorization gatekeeper system mandated by some insurance carriers. Most insurance carriers in Hawaii do not utilize this obstructive process that interferes with the orderly practice of medicine. All medical insurance carriers would be wise to implement physician initiated order entry systems to the mutual benefit of all physicians and their patients.

Any delay in the delivery of health care is an undue delay.

Passage of this bill will place the responsibility of delay in access to health care squarely on the shoulders of the insurance carriers and their agents where it rightfully belongs.

I strongly support the passage of this legislation.

Richard DeJournett M.D.

From: mailinglist@capitol.hawaii.gov
Sent: Sunday, February 07, 2016 9:23 AM
To: HLTtestimony
Cc: kennethkchang@yahoo.com
Subject: Submitted testimony for HB2740 on Feb 8, 2016 13:45PM

HB2740
Submitted on: 2/7/2016
Testimony for HLT on Feb 8, 2016 13:45PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
kenneth chang	Individual	Comments Only	No

Comments: Please disregard my prior testimony as it was in regards to HB1740. I am in favor of HB2740 as this bill allows providers to provide the necessary care in a timely manner. The problem with prior authorizations is that patients have to come back just for testing and procedures, which is a burden for them in lost work hours. Return visits also use up visit slots and delay visits for others.

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From: mailinglist@capitol.hawaii.gov
Sent: Saturday, February 06, 2016 12:51 PM
To: HLTtestimony
Cc: hhiga@pobox.com
Subject: Submitted testimony for HB2740 on Feb 8, 2016 13:45PM

HB2740
Submitted on: 2/6/2016
Testimony for HLT on Feb 8, 2016 13:45PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
hugo higa	Individual	Comments Only	No

Comments: As a practicing physician I have seen preauthorization delays increase this past year. Insurance organizations need to bear the consequences of delayed or denied preauthorization requests and reconsider their position regarding this issue. Thank you

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