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TO HOUSE COMMITTEE ON HEALTH

TWENTY-NINTH LEGISLATURE
Regular Session of 2017

Tuesday, February 7, 2017
9:30 a.m.

TESTIMONY ON HOUSE BILL NO. 248 – RELATING TO HEALTH INSURANCE

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 Department supports the intent on this bill, which is a companion to S.B. 287, and submits the following comments with a suggested amendment.

The purpose of this bill is to require all health insurers to disclose on their public web sites any standards, criteria, or information used in making preauthorization decisions. Limited benefit plans, such as long term care insurance, Medicare supplemental insurance, and disability income, would also be subject to the requirements in the bill.

This bill creates more transparency for members and providers. The Department recommends amending this bill to include a requirement that the internet posting location must be prominently displayed and readily accessible for consumers. Additionally, an advanced posting requirement, prior to the effective date for any material modifications made during the plan year to standards, criteria, or information used for preauthorization, may help to further promote proper patient care.

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

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Friday, February 3, 2017 6:10 PM
To: HLTtestimony
Cc: dshaw@lanaicommunityhealthcenter.org
Subject: Submitted testimony for HB248 on Feb 7, 2017 09:30AM

HB248
Submitted on: 2/3/2017
Testimony for HLT on Feb 7, 2017 09:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Diana Shaw	Lanai Community Health Center	Support	No

Comments: I support this measure and also ask that the information posted on the insurance company's website be in simple terms so that all members can understand what they are reading. It also should be posted in the primary languages of their members.

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 CHAPTER – AMERICAN PHYSICAL THERAPY ASSOCIATION

(800) 554-5569 x13 • www.hapta.org • info@hapta.org

HB248, Health Insurance
House Health Committee Hearing
Tuesday, Feb. 7, 2017 – 9:30 am
Room 329
Position: Support

Chair Belatti and Members of the House Health Committee:

I am Gregg Pacilio, PT and Board President of the Hawaii Chapter of the American Physical Therapy Association, a non-profit professional organization serving more than 300 member Physical Therapists and Physical Therapist Assistants. Our members are employed in hospitals and health care facilities, the Department of Education school system, and private practice. We are part of the spectrum of care for Hawaii, and provide rehabilitative services for infants and children, youth, adults and the elderly. Rehabilitative services are a vital part of restoring optimum functioning from neuromusculoskeletal injuries and impairments.

HAPTA strongly supports this measure that seeks to require all health insurers to disclose on their public websites all standards, criteria, and information they use when making preauthorization decisions related to medical treatment or service.

Such clear and consistent policy standards about how preauthorization decisions are made will help health care providers as well as consumers:

1. Consumers will understand what they are purchasing for their insurance premiums.
2. Consumers will have a better understanding about why their treatment is delayed. There is no liability for injury to the consumer if care is put on hold due to delays in the preauthorization process.
3. Providers will understand why one diagnosis can yield different numbers of authorized treatment visits.
4. Providers will not need to guess at what will get approved by one insurance carrier and not approved by another.

We suggest that insurance companies show out-of-pocket or co-payment amounts on their website. What a consumer may pay for a regular primary doctor for an office visit may be vastly different than when they see a specialist or a physical therapist (PT). For example, a consumer may pay $20 co-payment to see their primary doctor, but may pay $50 for a specialist, and $45 for a PT per visit.

Thank you for the opportunity to testify. Please feel free to contact Patti Taira-Tokuuke, HAPTA's Reimbursement Chair at 808-969-3811 for further information.

Hawaii Association of Health Plans

February 7, 2017
9:30 a.m., Room 329

To: **House Committee on Health**
The Honorable Della Au Belatti, Chair
The Honorable Bertrand Kobayashi, Vice Chair

From: Beth Giesting, Hawai‘i Association of Health Plans

Re: Opposition to HB 248, RELATING TO HEALTH INSURANCE

The Hawai‘i Association of Health Plans (HAHP) respectfully opposes House Bill 248, which would require disclosure of preauthorization standards, criteria, and information.

As noted in the bill, preauthorization and precertification serve important functions to safeguard patients and control over-utilization and excessive costs. Hawai‘i’s health insurers publicly post information detailing the services that require pre-approval and share forms for clinicians who want to provide them. To maintain high-quality utilization management standards, organizations such as NCQA and URAC accredit health plans. This ensures that utilization review programs meet the needs of federal and state government requirements while protecting patients’ rights.

It may be possible to disclose the criteria used for authorizing the most commonly used procedures but the universe of possible health care treatments and medications is voluminous and constantly changing. Providing and updating the information required by this bill would be daunting, if not impossible. We believe that maintaining opportunities to interact with providers about proposed treatments is more practical and educational for both clinician and insurer.

Thank you for the opportunity to share our views on this bill.

HAWAII MEDICAL ASSOCIATION
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FROM:
HAWAII MEDICAL ASSOCIATION
Dr. Chris Flanders, Executive Director
Lauren Zirbel, Community and GovernmSent Relations

TO:
HOUSE COMMITTEE ON HEALTH
Representative Della Au Belatti, Chair
Representative Bertrand Kobayoshi, Vice Chair

DATE:	Tuesday, February 7, 2017
TIME:	9:30 a.m.
PLACE:	Conference Room 329 State Capitol

Position: Support with Amendments

On behalf of the physician and medical student members of the Hawaii Medical Association, we are writing regarding our support for transparency of the prior authorization insurance process. The HMA supports the intent of the prior authorization system to ensure quality and safe health care in Hawaii, however this process must be conducted in a manner that is open and equitable for all parties.

While this bill contains the framework for accomplishing transparency and fairness, the HMA feels that it does not go far enough, and therefore would ask the House to amend the bill to include the attached Prior Authorization and Utilization Management Reform Principles.

Thank you for your consideration in this matter.

American Medical Association

American Academy of Child and Adolescent Psychiatry

American Academy of Dermatology

American Academy of Family Physicians

American College of Cardiology

American College of Rheumatology

American Hospital Association

American Pharmacists Association

American Society of Clinical Oncology

Arthritis Foundation

Colorado Medical Society

Medical Group Management Association

Medical Society of the State of New York

Minnesota Medical Association

North Carolina Medical Society

Ohio State Medical Association

Washington State Medical Association

Prior Authorization and Utilization Management Reform Principles

Patient-centered care has emerged as a major common goal across the health care industry. By empowering patients to play an active role in their care and assume a pivotal role in developing an individualized treatment plan to meet their health care needs, this care model can increase patients' satisfaction with provided services and ultimately improve treatment quality and outcomes.

Yet despite these clear advantages to adopting patient-centered care, health care providers and patients often face significant obstacles in putting this concept into practice. Utilization management programs, such as prior authorization and step therapy, can create significant barriers for patients by delaying the start or continuation of necessary treatment and negatively affecting patient health outcomes. The very manual, time-consuming processes used in these programs burden providers (physician practices, pharmacies and hospitals) and divert valuable resources away from direct patient care. However, health plans and benefit managers contend that utilization management programs are employed to control costs and ensure appropriate treatment.

Recognizing the investment that the health insurance industry will continue to place in these programs, a multi-stakeholder group representing patients, physicians, hospitals and pharmacists (see organizations listed in left column) has developed the following principles on utilization management programs to reduce the negative impact they have on patients, providers and the health care system. **This group strongly urges health plans, benefit managers and any other party conducting utilization management ("utilization review entities"), as well as accreditation organizations, to apply the following principles to utilization management programs for both medical and pharmacy benefits.** We believe adherence to these principles will ensure that patients have timely access to treatment and reduce administrative costs to the health care system.

Clinical Validity

1. Health care providers want nothing more than to provide the most clinically appropriate care for each individual patient. Utilization management programs must therefore have a clinically accurate foundation for provider adherence to be feasible. Cost-containment provisions that do not have proper medical justification can put patient outcomes in jeopardy.

Principle #1: Any utilization management program applied to a service, device or drug should be based on accurate and up-to-date clinical criteria and never cost alone. The referenced clinical information should be readily available to the prescribing/ordering provider and the public.

2. The most appropriate course of treatment for a given medical condition depends on the patient's unique clinical situation and the care plan developed by the provider in consultation with his/her patient. While a particular drug or therapy might generally be considered appropriate for a condition, the presence of comorbidities or patient intolerances, for example, may necessitate an alternative treatment. Failure to account for this can obstruct proper patient care.

Principle #2: Utilization management programs should allow for flexibility, including the timely overriding of step therapy requirements and appeal of prior authorization denials.

3. Adverse utilization management determinations can prevent access to care that a health care provider, in collaboration with his/her patient and the care team, has determined to be appropriate and medically necessary. As this essentially equates to the practice of medicine by the utilization review entity, it is imperative that these clinical decisions are made by providers who are at least as qualified as the prescribing/ordering provider.

Principle #3: Utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues.

Continuity of Care

4. Patients forced to interrupt ongoing treatment due to health plan utilization management coverage restrictions could experience a negative impact on their care and health. In the event that, at the time of plan enrollment, a patient's condition is stabilized on a particular treatment that is subject to prior authorization or step therapy protocols, a utilization review entity should permit ongoing care to continue while any prior authorization approvals or

step-therapy overrides are obtained.

Principle #4: Utilization review entities should offer a minimum of a 60-day grace period for any step-therapy or prior authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the plan. During this period, any medical treatment or drug regimen should not be interrupted while the utilization management requirements (e.g., prior authorization, step therapy overrides, formulary exceptions, etc.) are addressed.

5. Many patients carefully review formularies and coverage restrictions prior to purchasing a health plan product in order to ensure they select coverage that best meets their medical and financial needs. Unanticipated changes to a formulary or coverage restriction throughout the plan year can negatively impact patients' access to needed medical care and unfairly reduce the value patients receive for their paid premiums.

Principle #5: A drug or medical service that is removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year.

6. Many conditions require ongoing treatment plans that benefit from strict adherence. Recurring prior authorizations requirements can lead to gaps in care delivery and threaten a patient's health.

Principle #6: A prior authorization approval should be valid for the duration of the prescribed/ordered course of treatment.

7. Many utilization review entities employ step therapy protocols, under which patients are required to first try and fail certain therapies before qualifying for coverage of other treatments. These programs can be particularly problematic for patients—such as those purchasing coverage on the individual marketplace—who change health insurance on an annual basis. Patients who change health plans are often required to disrupt their current treatment to retry previously failed therapeutic regimens to meet step therapy requirements for the new plan. Forcing patients to abandon effective treatment and repeat therapy that has already been proven ineffective under other plans' step therapy protocols delays care and may result in negative health outcomes.

Principle #7: No utilization review entity should require patients to repeat step therapy protocols or retry therapies failed under other benefit plans before qualifying for coverage of a current effective therapy.

Transparency and Fairness

8. Prior authorization requirements and drug formulary changes can have a direct impact on patient care by creating a delay or altering the course of treatment. In order to ensure that patients and health care providers are fully informed while purchasing a product and/or making care decisions, utilization review entities need to be transparent about all coverage and formulary restrictions and the supporting clinical documentation needed to meet utilization management requirements.

Principle #8: Utilization review entities should publically disclose, in a searchable electronic format, patient-specific utilization management requirements, including prior authorization, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by providers and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers what supporting documentation is needed to complete every prior authorization and step therapy override request.

9. Incorporation of accurate formulary data and prior authorization and step therapy requirements into electronic health records (EHRs) is critical to ensure that providers have the requisite information at the point of care. When prescription claims are rejected at the pharmacy due to unmet prior authorization requirements, treatment may be delayed or completely abandoned, and additional administrative burdens are imposed on prescribing providers and pharmacies/pharmacists.

Principle #9: Utilization review entities should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing.

10. Data are critical to evaluating the effectiveness, potential impact and costs of prior authorization processes on patients, providers, health insurers and the system as a whole; however, limited data are currently made publically available for research and analysis. Utilization review entities need to provide industry stakeholders with relevant data, which should be used to improve efficiency and timely access to clinically appropriate care.

Principle #10: Utilization review entities should make statistics regarding prior authorization approval and denial rates available on their website (or another publically available website) in a readily accessible format. The statistics shall include but are not limited to the following categories related to prior authorization requests:

i. Health care provider type/specialty;
ii. Medication, diagnostic test or procedure;
iii. Indication;
iv. Total annual prior authorization requests, approvals and denials;
v. Reasons for denial such as, but not limited to, medical necessity or incomplete prior authorization submission; and
vi. Denials overturned upon appeal.

These data should inform efforts to refine and improve utilization management programs.

11. A planned course of treatment is the result of careful consideration and collaboration between patient and physician. A utilization review entity's denial of a drug or medical service requires deviation from this course. In order to promote provider (physician practice, hospital and pharmacy) and patient understanding and ensure appropriate clinical decision-making, it is important that utilization review entities provide specific justification for prior authorization and step therapy override denials, indicate any covered alternative treatment and detail any available appeal options.

Principle #11: Utilization review entities should provide detailed explanations for prior authorization or step therapy override denials, including an indication of any missing information. All utilization review denials should include the clinical rationale for the adverse determination (e.g., national medical specialty society guidelines, peer-reviewed clinical literature, etc.), provide the plan's covered alternative treatment and detail the provider's appeal rights.

Timely Access and Administrative Efficiency

12. The use of standardized electronic prior authorization transactions saves patients, providers and utilization review entities significant time and resources and can speed up the care delivery process. In order to ensure that prior authorization is conducted efficiently for all stakeholders, utilization review entities need to complete all steps of utilization management processes through NCPDP SCRIPT ePA transactions for pharmacy benefits and the ASC X12N 278 Health Care Service Review Request for Review and Response transactions for medical services benefits. Proprietary health plan web-based portals do not represent efficient automation or true administrative simplification, as they require health care

providers to manage unique logins/passwords for each plan and manually re-enter patient and clinical data into the portal.

Principle #12: A utilization review entity requiring health care providers to adhere to prior authorization protocols should accept and respond to prior authorization and step-therapy override requests exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits. Facsimile, proprietary payer web-based portals, telephone discussions and nonstandard electronic forms shall not be considered electronic transmissions.

13. Providers have encountered instances where utilization review entities deny payment for previously approved services or drugs based on criteria outside of the prior authorization review process (e.g., eligibility issues, medical policies, etc.). These unexpected payment denials create hardship for patients and additional administrative burdens for providers.

Principle #13: Eligibility and all other medical policy coverage determinations should be performed as part of the prior authorization process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.

14. Significant time and resources are devoted to completing prior authorization requirements to ensure that the patient will have the requisite coverage. If utilization review entities choose to use such programs, they need to honor their determinations to avoid misleading and further burdening patients and health care providers. Prior authorization must remain valid and coverage must be guaranteed for a sufficient period of time to allow patients to access the prescribed care. This is particularly important for medical procedures, which often must be scheduled and approved for coverage significantly in advance of the treatment date.

Principle #14: In order to allow sufficient time for care delivery, a utilization review entity should not revoke, limit, condition or restrict coverage for authorized care provided within 45 business days from the date authorization was received.

15. In order to ensure that patients have prompt access to care, utilization review entities need to make coverage determinations in a timely manner. Lengthy processing times for prior authorizations can delay necessary treatment, potentially creating pain and/or medical complications for patients.

Principle #15: If a utilization review entity requires prior authorization for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information.

16. When patients receive an adverse determination for care, the patient (or the physician on behalf of the patient) has the right to appeal the decision. The utilization review entity has a responsibility to ensure that the appeals process is fair and timely.

Principle #16: Should a provider determine the need for an expedited appeal, a decision on such an appeal should be communicated by the utilization review entity to the provider and patient within 24 hours. Providers and patients should be notified of decisions on all other appeals within 10 calendar days. All appeal decisions should be made by a provider who (a) is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider and (b) was not involved in the initial adverse determination.

17. Prior authorization requires administrative steps in advance of the provision of medical care in order to ensure coverage. In emergency situations, a delay in care to complete administrative tasks related to prior authorization could have drastic medical consequences for patients.

Principle #17: Prior authorization should never be required for emergency care.

18. There is considerable variation between utilization review entities' prior authorization criteria and requirements and extensive use of proprietary forms. This lack of standardization is associated with significant administrative burdens for providers, who must identify and comply with each entity's unique requirements. Furthermore, any clinically based utilization management criteria should be similar—if not identical—across utilization review entities.

Principle #18: Utilization review entities are encouraged to standardize criteria across the industry to promote uniformity and reduce administrative burdens.

Alternatives and Exemptions

19. Broadly applied prior authorization programs impose significant administrative burdens on all health care providers, and for those providers with a clear history of appropriate resource utilization and high prior authorization approval rates, these burdens become especially unjustified.

Principle #19: Health plans should restrict utilization management programs to "outlier" providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.

20. Prior authorization requirements are a burdensome way of confirming clinically appropriate care and managing utilization, adding administrative costs for all stakeholders across the health care system. Health plans should offer alternative, less costly options to serve the same functions.

Principle #20: Health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways.

21. By sharing in the financial risk of resource allocation, providers engaged in new payment models are already incented to contain unnecessary costs, thus rendering prior authorization unnecessary.

Principle #21: A provider that contracts with a health plan to participate in a financial risk-sharing payment plan should be exempt from prior authorization and step-therapy requirements for services covered under the plan's benefits.

hmsa

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LATE

February 7, 2017

The Honorable Della Au Belatti, Chair
The Honorable Bertrand Kobayashi, Vice Chair
House Committee on Health

Re: HB 248 – Relating to Health Insurance

Dear Chair Au Belatti, Vice Chair Kobayashi, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 248, which mandates each health plan to disclose preauthorization standards on the plan's website. HMSA certainly appreciates the intent of the Bill, but we do have a concern and offer comments.

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. The use of preauthorization is integral to helping our members secure the safest and most efficient care.

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 procedures, medications, and durable medical equipment. Most notably 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 advanced imaging studies when provided on an outpatient basis (not emergency room or inpatient).

The Centers for Medicare & Medicaid Services (CMS), the National Committee for quality Assurance (NCQA), and the Health Services Advisory Group (HSAG), which oversees Medicaid in Hawaii, all have prior authorization guidelines and definitions on urgent versus non-urgent requests, specific turnaround times, and approval and denial processes. HMSA follows these guidelines and definitions.

Concerns with HB 248

We understand and agree that transparency is important, and it is appropriate and desirable to have information about the preauthorization process readily accessible for our members. However, Section 2 of the Bill provides for a health insurer or mutual benefit society "…that requires preauthorization of a medical treatment or service shall disclose on its public web site any standards, criteria, or information…" it uses for preauthorization decisions.

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As described above, the breadth of policies and guidelines governing preauthorizations is wide-ranging. These guidelines also are fluid and change with medical research driving advances. We are uncertain about the scope of information for the website contemplated under the Bill and seek clarification.

Thank you for the opportunity to testify on this measure.

Sincerely,

Mark K. Oto
Director, Government Relations

LATE

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, February 7, 2017 4:57 AM
To: HLTtestimony
Cc: leolinda@resqconsultants.com
Subject: Submitted testimony for HB248 on Feb 7, 2017 09:30AM

HB248
Submitted on: 2/7/2017
Testimony for HLT on Feb 7, 2017 09:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Leolinda Parlin	Hilopaa Family to Family Health Information Center	Support	No

Comments: The Hilopa'a Family to Family Health Information stands in support of this measure. As we assist families in try to navigate the health care systems, often times we are having to instruct families to request prior authorization criteria "after the fact" to prepare an appeal. this concept of appeals is not intuitive. By having the prior authorization criteria available ahead of time, it allows physicians to submit more specific requires for prior authorization which are in alignment with the payor. It allows provides a clear criteria in which families may reconsider their requests early in the process, instead of when its further along and may have emotional and financial implications.

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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