

DAVID Y. IGE  
GOVERNOR

DOUGLAS S. CHIN  
LIEUTENANT GOVERNOR

**STATE OF HAWAII  
OFFICE OF THE DIRECTOR  
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS**

335 MERCHANT STREET, ROOM 310  
P.O. BOX 541  
HONOLULU, HAWAII 96809  
Phone Number: 586-2850  
Fax Number: 586-2856  
cca.hawaii.gov

CATHERINE P. AWAKUNI COLÓN  
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI  
DEPUTY DIRECTOR

**TO THE HOUSE COMMITTEE ON  
FINANCE**

**TWENTY-NINTH LEGISLATURE  
Regular Session of 2018**

Wednesday, April 4, 2018  
1:30 p.m.

**TESTIMONY ON SENATE BILL NO. 287, S.D. 1, H.D. 1, PROPOSED H.D. 2,  
RELATING TO HEALTH INSURANCE.**

TO THE HONORABLE SYLVIA LUKE, CHAIR, AND MEMBERS OF THE  
COMMITTEE:

The Department of Commerce and Consumer Affairs (“Department”) appreciates the opportunity to testify on S.B. 287, S.D. 1, H.D. 1, proposed H.D. 2, Relating to Health Insurance. My name is Gordon Ito, and I am the Insurance Commissioner for the Department’s Insurance Division. The Department takes no position on this bill and offers the following comments.

Proposed H.D. 2 prohibits health insurers from requiring preauthorization that causes undue delay in a patient’s receipt of medical treatment or services. It also purports to grant civil immunity to a licensed health care provider for injury to a patient caused by undue delay in preauthorization, as well as impose civil liability on an insurer for any patient injury caused by undue delay in receiving medical treatment or services. Proposed H.D. 2 also adds a new section (preauthorization; undue delay; liability) to Hawaii Revised Statutes (“HRS”) chapter 431, article 10A to apply to health insurers and amends HRS section 432D to make this new section applicable to health

maintenance organizations. This bill, however, does not amend HRS chapter 432 to make this new section applicable to mutual benefit societies.

Medical determinations are complex and not conducive to blanket regulation by HRS title 24. These medical decisions balance patient safety, effectiveness, and medical appropriateness and are outside the purview of HRS title 24. 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 HRS title 24.

Furthermore, proposed H.D. 2 requires all health insurers to disclose on their public websites any medical policies used in making preauthorization decisions, thereby creating more transparency for members and providers. The Department notes that limited benefit plans, such as long-term care insurance, Medicare supplemental insurance, and disability income, would also be subject to the requirements of the bill.

Thank you for the opportunity to testify on this measure.



## **HAWAII MEDICAL ASSOCIATION**

1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814

Phone (808) 536-7702 Fax (808) 528-2376

www.hawaiimedicalassociation.org

TO:

HOUSE COMMITTEE ON FINANCE

Rep. Sylvia Luke, Chair

Rep. Ty Cullen, Vice Chair

DATE: Wednesday, April 4, 2018

TIME: 1:30 p.m.

PLACE: Conference Room 308

FROM:

Hawaii Medical Association

Dr. Christopher Flanders, DO, Executive Director

Lauren Zirbel, Government and Community Relations

**Re: SB 287**

**Position: SUPPORT**

Hawaii Medical Association strongly supports this legislation.

Anecdotes about the patient care delays and practice burdens caused by health plans' onerous prior authorization (PA) requirements are common across medicine, but quantitative data to substantiate these stories has been limited until recently. Results from the AMA's new physician survey provide strong evidence of the significant impact this burdensome process can have on both patients and physician practices.

Results from the December 2017 survey of 1,000 practicing physicians clearly show the negative effect that PA can have on timely patient care. Among surveyed physicians:

- 64% report waiting at least one business day
- 30% report waiting at least 3 business days
- 92% report delays in receiving necessary care
- 78% report having had patients abandon needed medical care because of PA delays
- 92% report they have seen negative clinical outcomes because of PA delays

Also, of concern is the administrative burden placed on physician practices, especially given the significant shortage of physicians and decreased access to care in Hawaii. Nationally, physicians experience 29.1 prior authorization requests from insurers per week and spend 14.6 hours per week on processing these requests. That adds 0.37 staff FTEs to practice overhead and increased medical costs.

This data reinforces the need for strong advocacy efforts on PA reform. In January 2017, the AMA and a coalition of 16 other organizations representing physicians, hospitals, medical groups, pharmacists and patients released a set of 21 Prior Authorization Utilization Management Reform

### **HMA OFFICERS**

President – William Wong, Jr., MD    President-Elect – Jerry Van Meter, MD    Secretary – Thomas Kosasa, MD

Immediate Past President – Bernard Robinson, MD    Treasurer – Elizabeth A. Ignacio, MD

Executive Director – Christopher Flanders, DO



## **HAWAII MEDICAL ASSOCIATION**

1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814

Phone (808) 536-7702 Fax (808) 528-2376

[www.hawaiimedicalassociation.org](http://www.hawaiimedicalassociation.org)

Principles (<https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf>). These principles, which have been formally supported by over 100 additional provider and patient groups, spurred conversations with health plans about the need for significant reform in PA programs.

As a result of those discussions, the AMA, along with the American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association, released the Consensus Statement on Improving the Prior Authorization Process in January 2018 (<https://www.ama-assn.org/sites/default/files/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>). This document reflects agreement between provider and health plan organizations to pursue PA reform in several key areas, including reduction in the overall volume of PAs, improved transparency and communication, protection of continuity of care, and automation to increase process efficiency.

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 continue to demonstrate that Hawaii is indeed a leader in healthcare and will help to make Hawaii a healthier place.

### **HMA OFFICERS**

President – William Wong, Jr., MD    President-Elect – Jerry Van Meter, MD    Secretary – Thomas Kosasa, MD  
Immediate Past President – Bernard Robinson, MD    Treasurer – Elizabeth A. Ignacio, MD  
Executive Director – Christopher Flanders, DO



## HAWAII CHAPTER - AMERICAN PHYSICAL THERAPY ASSOCIATION

(800) 554-5569 x13 • [www.hapta.org](http://www.hapta.org) • [info@hapta.org](mailto:info@hapta.org)

**SB287sd1,hd1 Proposedhd2, Relating to Health Insurance  
House FIN Committee Hearing  
Wednesday, April 4, 2018 – 1:30 pm Room  
308  
Position: Support**

Chair Luke and Members of the House FIN Committee:

I am Gregg Pacilio, PT and Board President of the Hawaii Chapter of the American Physical Therapy Association (HAPTA), a non-profit professional organization serving more than 340 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 movement specialists and 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 **supports** the purpose of this measure that would prohibit insurers from requiring preauthorization that causes undue delay in a patient's receipt of medical treatment or services and clarifies insurer and licensed health care provider liability for patient injuries that are caused by preauthorization delays.

It is our experience that prior authorizations are an administrative burden for providers and appears to be arbitrary. For example, some insurance companies require physical therapy to be approved prior to start of care when objective measurements and functional outcomes are not being considered at all. Insurance companies also require physical therapists to pre- authorize procedure codes, which make the therapist "guess" what they are going to do and if you don't "guess" correct and request enough procedural codes, you may not get them paid on the back end. Further, insurance companies can take up to two weeks to render a decision on authorization request. During this time, the patient is waiting to be seen. In addition to delaying care for patients, preauthorization requirements limit access to care because some providers have stopped taking insurances that require extensive pre- authorization paperwork.

Requiring health insurers to publically disclose on their websites any medical policies for making preauthorization decisions will make the process clearer to consumers as well as providers of care. Easy access to such public disclosure of pre-authorization policies on insurers' websites is also needed.

Your support of SB287sd1, hd1 Proposed hd2 is appreciated. Thank you for the opportunity to testify. Please feel free to contact Patti Taira-Tokuuke, HAPTA's Reimbursement Issue Lead at (808) 895-1259 for further information.



April 4, 2018  
1:30pm  
Conference Room 308

The Honorable Sylvia Luke, Chair  
The Honorable Ty J.K. Cullen, Vice Chair  
House Committee on Finance

Re: SB287, SD1, HD1 Proposed HD2 Relating to Health Insurance

AlohaCare appreciates the opportunity to testify on SB287, SD1, HD1 Proposed HD2, which requires all health insurers to disclose on, or have accessible through, their public websites any medical policies used for making preauthorization decisions and prohibits preauthorization requirements if they cause undue delays in the receipt of medical treatment.

AlohaCare **opposes** SB287, SD1, HD1 Proposed HD2.

The preauthorization process is a valuable tool for effectively managing the care of Hawaii's Medicaid and Dual eligible beneficiaries on behalf of the State of Hawaii. Preauthorization ensures that only medically necessary and appropriate services are covered. As a publicly funded program, preauthorizations help to ensure taxpayer dollars are spent on medically necessary care.

We recognize that providers perceive the preauthorization process to be an administrative burden. AlohaCare has made efforts to minimize the burden on providers. Effective January 1, 2018, AlohaCare reduced its preauthorization requirements by 49%.

AlohaCare provides on its website an online preauthorization look up tool and forms to make the process simple and transparent. Further, the tool can be uploaded and integrated with a provider's electronic medical record system. We also post on our website our medical policies. To determine medical necessity as defined by HRS § 432E-1.4, AlohaCare uses medical information submitted by the provider or available in medical records. We utilize nationally developed clinical criteria (such as InterQual® Level of Care Criteria, InterQual® Imaging Criteria, InterQual® Procedures Criteria, InterQual® Level of Care Behavioral Health Criteria, and American Society of Addictive Medicines) for medical necessity determinations.

AlohaCare's turn-around times are faster than required by the Hawaii Medicaid program and NCQA (National Committee for Quality Assurance) accreditation standards. The Hawaii Medicaid program and NCQA requirements are as follows:

- Non-urgent pre-service decisions – Med-QUEST requires 14 calendar days for standard authorization decisions, and three business days for expedited requests. The NCQA standard is 15 calendar days of receipt of the request for non-urgent pre-service decisions.
- Emergency services – no preauthorization allowed.
- Emergent and urgent – no preauthorization allowed.

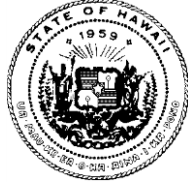
With respect to the proposed provision that removes civil liability for injury to a patient, it is unclear how a direct connection between a patient's injury and any preauthorization delay can be established. Medical conditions and care are often complex, each case bearing its own unique facts, and should be evaluated accordingly.

We appreciate the willingness of providers to partner with us to assure access to quality care for the most disadvantaged members of our community.

AlohaCare is a non-profit Hawaii based health plan founded in 1994 by Hawaii's community health centers. We serve Medicaid and Medicare Special Needs beneficiaries in all counties.

Thank you for the opportunity to testify on this measure.

DAVID Y. IGE  
GOVERNOR



PANKAJ BHANOT  
DIRECTOR

CATHY BETTS  
DEPUTY DIRECTOR

STATE OF HAWAII  
DEPARTMENT OF HUMAN SERVICES  
P. O. Box 339  
Honolulu, Hawaii 96809-0339

**LATE**

April 3, 2018

TO: The Honorable Representative Sylvia Luke, Chair  
House Committee on Finance

FROM: Pankaj Bhanot, Director

SUBJECT: **SB 287 SD1 HD1 Proposed HD2 – RELATING TO HEALTH INSURANCE**

Hearing: Wednesday, April 4, 2018, 1:30 p.m.  
Conference Room 308, State Capitol

**DEPARTMENT'S POSITION:** The Department of Human Services (DHS) offers comments with concerns.

**PURPOSE:** The purpose of the bill is to require all health insurers in the State to disclose on, or have accessible through, their public websites all medical policies that the health insurers use when making preauthorization decisions related to medical treatment or service; prohibit insurers from requiring preauthorization that cause undue delay in a patient's receipt of medical treatment or services; and clarify insurer and licensed health care provider liability for patient injuries caused by preauthorization delays.

The provision of medical care, including the use of preauthorization services, is complicated. However, we share the goal that all care should be provided at the right time, in the right amount to achieve the health and wellness outcome for the people we serve. We need to ensure that services are provided at the right time, right setting etc., to ensure optimal care with the best health outcomes. We also note that the American health care system is the most costly health care system in the world with only adequate health outcomes. There are also estimates that about 20 percent of all care is unnecessary. While



Hawaii may be one of the most efficient in the United States, it still has seen concerning increases in health care costs.

For these reasons, and per federal Medicaid regulations, the Medicaid program has requirements that services provided are medically necessary. Thus Medicaid has requirements for utilization management tools such as prior authorizations. Nearly 100 percent of Medicaid recipients are enrolled in a QUEST Integrated (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 authorizations, to utilization management programs, as well as to access standards for emergent, urgent, and other care. This is to help ensure that care is provided timely. MQD monitors and provides oversight of the QI plans' adherence to these requirements. The QI plans are also to use the best clinical evidenced based guidelines for their utilization management. We support transparency as much as feasible. This may mean that most if not all guidelines could be made available on the insurer's websites for most services.

Finally, there are concerns that the proposed bill language regarding liability does not take into consideration that the provider may contribute to delays in prior authorization.

Thank you for the opportunity to provide comments on this measure.



HAWAII RADIOLOGICAL SOCIETY

LETTER OF SUPPORT

**LATE**

Apr 3, 2018

The Honorable Sylvia Luke, Chair  
The Honorable Ty Cullen, Vice Chair  
House Committee on Finance  
RE: HB 287 HD 2

Dear Chair Luke, Vice Chair Cullen and Finance Committee members:

WITH REGARD TO **SB 287** which would require all health insurers, including health benefits plans under chapter 87A, HRS, to disclose on, or have accessible through, their public web sites any medical policies used for making preauthorization decisions,

**the Hawaii Radiological Society (HRS) supports this measure.**

Prior authorization (PA) is overused and the existing processes are costly, inefficient, opaque and responsible for patient care delays, particularly when advanced imaging is requested such as MRI or CT scan. These processes frequently obstruct the patient's access to necessary imaging in a timely fashion, effectively stalling the work up and preventing the prompt delivery of appropriate medical therapy.

HRS supports PA reform like this that can improve transparency and communication, protect the continuity of care, and allow for timely efficient electronic PA transactions based on national standards.

HRS further supports quality initiatives of Hawaii physician groups as effective alternative solutions to promote appropriate utilization of services, and maintain the highest standards of care for Hawaii's patient ohana.

Thank you for the opportunity to provide testimony in support of this measure. Please contact us with any concerns or questions. Mahalo for your thoughtful consideration of these issues.

With Aloha,

Elizabeth Ann Ignacio MD  
President, Hawaii Radiological Society  
808.250.7058



HAWAII RADIOLOGICAL SOCIETY

LETTER OF SUPPORT

**LATE**

Apr 3, 2018

The Honorable Sylvia Luke, Chair  
The Honorable Ty Cullen, Vice Chair  
House Committee on Finance  
RE: HB 287 HD 2

Dear Chair Luke, Vice Chair Cullen and Finance Committee members:

WITH REGARD TO **SB 287** which would require all health insurers, including health benefits plans under chapter 87A, HRS, to disclose on, or have accessible through, their public web sites any medical policies used for making preauthorization decisions,

**the Hawaii Radiological Society (HRS) supports this measure.**

Prior authorization (PA) is overused and the existing processes are costly, inefficient, opaque and responsible for patient care delays, particularly when advanced imaging is requested such as MRI or CT scan. These processes frequently obstruct the patient's access to necessary imaging in a timely fashion, effectively stalling the work up and preventing the prompt delivery of appropriate medical therapy.

HRS supports PA reform like this that can improve transparency and communication, protect the continuity of care, and allow for timely efficient electronic PA transactions based on national standards.

HRS further supports quality initiatives of Hawaii physician groups as effective alternative solutions to promote appropriate utilization of services, and maintain the highest standards of care for Hawaii's patient ohana.

Thank you for the opportunity to provide testimony in support of this measure. Please contact us with any concerns or questions. Mahalo for your thoughtful consideration of these issues.

With Aloha,

Elizabeth Ann Ignacio MD  
President, Hawaii Radiological Society  
808.250.7058



**LATE**

April 4, 2017

The Honorable Sylvia Luke, Chair  
The Honorable Ty J. K. Cullen, Vice Chair  
House Committee on Finance

Re: SB 287, SD1, HD1, PROPOSED HD2 – Relating to Health Insurance

Dear Chair Luke, Vice Chair Cullen, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) **opposes** SB 287, SD1, HD1, Proposed HD2, which mandates each health plan to disclose preauthorization standards on the plan's website, prohibits preauthorization requirements that could cause undue delays in the receipt of medical treatment, and sets forth specific liability provisions.

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.

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. We already provide transparency of critical information for our members such as our medical policies, including the preauthorization processes.

Given the manner in which we develop and employ our medical policies, we believe this Bill may be unnecessary for the following reasons:

#### HMSA Medical Policies - Standards

All of HMSA's medical policies are based on national standards and evidence based guidelines. We consider community standard of care if requested by our local providers and supported by medical evidence. And, policies are reviewed at least annually and more frequently if there is a change in evidence or literature, or upon recommendation of national societies/experts.

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.

#### HMSA Medical Policies - Transparency



Our medical policies are already available either directly on our HMSA website or via a link provided on our website, and we will send a hard or soft copy out to any member, authorized member representative, or provider who requests them.

#### HMSA Medical Policies - Denials & Appeals

All final denials resulting from our policies are rendered by medical directors who follow the requirements of the medical necessity statute in making their determinations. The reason for the denial and relevant language from the medical policy are provided on both the denial letter and any further correspondence related to an appeal.

All members have rights to appeal any decision, including the right to request either an Independent Review Organization review the decision against medical necessity statute OR a committee of volunteer independent practicing physicians to review the decision against medical necessity statute.

Furthermore, SB 287, SD1, HD1, Proposed HD2 unfairly gives the provider immunity from civil liability for “injury to a patient that was caused by undue delay in preauthorizing medical treatment or services.” This provision does not account for situations under which the physician may have contributed to the delay during the preauthorization process. As an example a provider may not provide all the required information or not provide follow up information in a timely manner.

Also, while not explicitly stated, we believe it can be inferred that the health plan may be held responsible for injury as it relates to this Bill. This will increase legal and administrative costs to health plans that will borne by employers, government agencies and consumers.

Furthermore, this measure generates more uncertainty with respect to its impact on preauthorizations required under Medicare and Medicaid.

Given these facts, we believe this Bill is unnecessary and respectfully request it be deferred. Thank you for the opportunity to testify on this measure.

Sincerely,

Pono Chong  
Vice-President, Government Relations