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TO THE HOUSE COMMITTEE ON HEALTH

TWENTY-NINTH LEGISLATURE
Regular Session of 2017

Tuesday, March 14, 2017
8:30 a.m.

TESTIMONY ON SENATE BILL NO. 287, S.D. 1 – 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 of this bill and submits the following comments.

The purpose of this bill is to require all health insurers to disclose on their public web sites any medical policies 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 of the bill.

This bill creates more transparency for members and providers. The Department notes that the bill was amended to include a requirement that the internet posting location must be prominently displayed and readily accessible for consumers.

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

Hawaii Association of Health Plans

March 14, 2017
8:30 a.m., Room 329

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

From: Beth Giesting, Hawaiʻi Association of Health Plans

Re: Opposition to SB 287, SD 1, RELATING TO HEALTH INSURANCE

The Hawaiʻi Association of Health Plans respectfully opposes Senate Bill 287, SD1.

Hawaiʻi's health insurers already publicly post policies and procedures detailing the services that require pre-approval and share forms for clinicians who want to provide them. All health plans maintain high-quality utilization management standards that meet the requirements of NCQA and URAC. This also ensures that utilization review programs meet the needs of federal and state government requirements while protecting patients' rights.

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

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

TO:
COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

DATE: Tuesday, March 14, 2017
TIME: 8:30 AM
PLACE: Conference Room 329

SB 287
Position: Comments

The Hawaii Medical Association ("HMA") wishes to comment on SB287. We support the intent of this bill; however, we think that there is a need to address greater problems with prior authorization. Simply disclosing on a web site medical policies will not solve the issues at hand. We find it hard to believe that the insurance companies would oppose posting their prior authorization policies online. This seems like a policy that should already be in place and should be very simple to implement. We support the provisions in this bill and find it deeply troubling that there is any opposition to what is currently contained in this measure.

In its current form, SB287 does not go far enough to lay out an equitable prior authorization process for health care. We would support the language contained within HB248, HD2. That language specifies procedural, disclosure, notice, and other requirements for prospective reviews required by health carriers or utilization review organizations prior to certification of coverage for health care services. The language in that measure is in line with recommendations for best practices for prior authorization that actual medical providers see as the best way to improve patient care and ensure safe and timely access to needed healthcare.

Thank you for allowing the HMA to participate in this discussion.

HMA OFFICERS
President – Bernard Robinson, MD President-Elect – William Wong, Jr., MD Secretary – Thomas Kosasa, MD
Immediate Past President – Scott McCaffrey, MD Treasurer – Michael Champion, MD
Executive Director – Christopher Flanders, DO

March 14, 2017

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

Re: SB 287, SD1 – 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 SB 287, SD1, which mandates each health plan to disclose preauthorization standards on the plan's website. HMSA offers comments on 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. 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. All responsible health plans already do that. 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:

<u>HMSA Medical Policies - Standards</u>
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.

<u>HMSA Medical Policies - Transparency</u>
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.

<u>HMSA Medical Policies - Denials & Appeals</u>
All final denials resulting from our policies are rendered by licensed physicians 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 in Hawaii review the decision against medical necessity statute.

Given all of this, we believe this Bill may be unnecessary. Thank you for the opportunity to testify on this measure.

Sincerely,

Jennifer Diesman
Vice President, Government Relations

HAWAII CHAPTER - AMERICAN PHYSICAL THERAPY ASSOCIATION

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SB287sd1, Health Insurance
House HLT Committee Hearing
Tuesday, March 14, 2017 – 8:30 am
Room 329
Position: Support

Chair Belatti and Members of the House HLT 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.

<u>**We suggest that insurance companies show out-of-pocket or co-payment amounts on their website.**</u> 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.