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DIRECTOR

RYKER WADA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT
235 S. BERETANIA STREET
HONOLULU, HAWAII 96813-2437

February 2, 2017

TESTIMONY TO THE
SENATE COMMITTEE ON JUDICIARY AND LABOR

For Hearing on Tuesday, February 7, 2017
9:00 a.m., Conference Room 016

BY

JAMES K. NISHIMOTO
DIRECTOR

Senate Bill No. 857
Relating to Workers' Compensation

(WRITTEN TESTIMONY ONLY)

TO CHAIRPERSON KEITH-AGARAN. VICE CHAIR RHOADS, AND MEMBERS OF THE COMMITTEE:

Thank you for the opportunity to provide **comments** on S.B. 857.

The purposes of S.B. 857, are to establish that employers shall pay all workers compensation claims for compensable injuries and shall not deny claims without reasonable cause or during a pending investigation; establish that employers shall notify providers of service of any billing disagreements and allows providers to charge an additional rate to employers who fail to adhere to the notification requirements; and establish resolution procedures for employers and providers who have a reasonable disagreement over liability for services provided an injured worker.

The Department of Human Resources Development (DHRD) has a fiduciary duty to administer the State's self-insured workers' compensation program and its expenditure of public funds.

In light of the statutory presumption of compensability in Section 386-85, HRS, DHRD accepts liability for the vast majority of the approximately 600 new workers'

compensation claims it receives each fiscal year. However, a minority of claims do require some additional investigation to confirm that the alleged injury arose out of and in the course of employment. While this bill asserts that the patient is at times unable to use private insurance for medical services during the pendency of the workers' compensation claim, Hawaii's Prepaid Health Care administrative rules, promulgated by the Director of Labor, actually mandates the private insurer to pay for medical care. Section 12-12-45, Controverted workers' compensation claims, HAR, provides:

> In the event of a controverted workers' compensation claim, the health care contractor shall pay or provide for the medical services in accordance with the health care contract and notify the department of such action. If workers' compensation liability is established, the health care contractor shall be reimbursed by the workers' compensation carrier such amounts authorized by chapter 386, HRS, and chapter 10 of title 12, administrative rules. (Emphases added.)

Rather than amending Chapter 386, we respectfully suggest amending this bill by making Section 12-12-45 a statutory provision to give it further weight and enforceability. Thus, whenever a workers' compensation claim is controverted, an individual's private medical insurance will ensure that the injured or ill employee will receive all necessary medical care and the employer can reimburse the private carrier should the claim be accepted or deemed to be work related.

In the alternative, we respectfully request consideration be given to deferring this measure pending completion of the respective reports from the Workers' Compensation Working Group convened by House Concurrent Resolution 168 (2015) for the purpose of streamlining the WC process under chapter 386; and the workers' compensation closed claims study mandated by Act 188 (SLH 2016), wherein the legislature found that "a closed claims study is warranted to objectively review whether specific statutory changes are necessary" to the workers' compensation law. Upon delivery of the respective reports to the legislature, the empirical findings and specific recommendations of the working group and closed claims study can inform any legislative initiatives on workers' compensation.

DAVID Y. IGE
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SHAN S. TSUTSUI
LIEUTENANT GOVERNOR

LINDA CHU TAKAYAMA
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February 7, 2017

To: The Honorable Gilbert Keith-Agaran, Chair,
The Honorable Karl Rhoads, Vice Chair, and
Members of the Senate Committee on Judiciary and Labor

Date: Tuesday, February 07, 2017
Time: 9:00 a.m.
Place: Conference Room 016, State Capitol

From: Linda Chu Takayama, Director
Department of Labor and Industrial Relations (DLIR)

Re: S.B. No. 857 Relating to Workers' Compensation

I. OVERVIEW OF PROPOSED LEGISLATION

This proposal seeks to add a new section to chapter 386, Hawaii Revised Statutes (HRS), relating to payment of bills by the employer and specifies a process for bill dispute resolution by the Director. This bill is similar to section 12-15-94, Hawaii Administrative Rules, which requires the employer to pay for all medical services which the nature of the compensable injury and the process of recovery requires. However, this proposal adds new language that the employer shall not contest a claim for services without reasonable cause or while the claim is pending investigation. This bill also shortens the period for employer to contest and pay for services billed from sixty calendar days to thirty calendar days of receipt or the provider can increase the total outstanding balance owed by one per cent per month. This bill also specifies the process for bill dispute resolution and increases the penalty from $500 to $1,000 that the director may assess for failure to negotiate in good faith.

The department supports the intent of the measure and offers comments below.

II. CURRENT LAW

- Workers' Compensation Medical Fee Schedule (WCMFS) Hawaii Administrative Rule (HAR), section 12-15-94 Payment by employer, allows

for the following:

When a provider of service notifies or bills the employer, the employer shall inform the provider of service within sixty calendar days of such billing should the employer contest the claim for services. Failure by the employer to notify the provider shall make the employer liable for services rendered until the employer contests further services.

The employer, after accepting liability, shall pay all charges billed within sixty calendar days of receipt of the charges, except for items where there is reasonable disagreement. If more than sixty-calendar days lapse between the employer's receipt of an undisputed bill and date of payment, the billing can be increased by one percent per month of the outstanding balance.

If there is a disagreement, within sixty calendar days of receipt of the bill, the employer shall pay for all acknowledged charges and shall notify the provider of service, copying the claimant, of the denial and the reason for the denial. The denial must state that if the provider does not agree with the denial, they may file a bill dispute with the director within sixty calendar days after postmark of employer's denial and failure to do so shall be construed as acceptance of the denial.

If the disagreement cannot be resolved between the employer and provider of service, either party may make a written request for intervention to the Director. The Director shall send the parties a notice and the parties shall negotiate for thirty-one calendar days to resolve the dispute upon receipt of the Director's notice. If the parties fail to come to an agreement during the thirty-one calendar days, then within fourteen calendar days following the thirty-one day negotiating period, either party can request the director review the dispute.

The Director shall send both parties a second notice requesting they submit position statements and documentation within fourteen days following of the receipt of this second notice. The Director shall review the positions of both parties and render an administrative decision. A service fee of $500 will be assessed at the discretion of the Director against either or both parties who fail to negotiate in good faith.

- Prepaid Health Care section 12-12-45 HAR regarding Controverted workers' compensation claims, allows for the following: "In the event of a controverted workers' compensation claim, the health care contractor shall pay or provide for the medical services in accordance with the health care contract and notify the department of such action. If workers' compensation liability is established, the health care contractor shall be reimbursed by the workers' compensation carrier such amounts authorized by chapter 386, HRS, and chapter 10 of title 12, administrative rules."

III. COMMENTS ON THE SENATE BILL

The Department appreciates the intent of SB 857, as it proposes to streamline the investigation and bill dispute process and offers a faster resolution of disputed charges between the employer and the medical provider. DLIR offers the following comments:

- Subsection (b) of this proposal is contradictory to subsection (a) by requiring that the employer not contest a claim for services while the claim is pending investigation. If the claim is under investigation, it may be denied and according to subsection (a), the employer is not required to pay for care unrelated to the compensable injury.

- By increasing the service fee for parties who fail to negotiate in good faith, this bill may potentially ease the administrative burden of resolving billing disputes by encouraging parties to settle their differences before sending their differences to the department to act on.

- The Department has concerns regarding shortening the time period from sixty calendar days to thirty calendar days for the employer/carrier to contest and pay the provider of service. The carrier often has a heavy workload of cases and many claims to monitor, adjust, and pay. If they do not have adequate time to review the case thoroughly, they may tend to contest the claim in order to protect their rights while reviewing the claim in more detail. This may have an unintended consequence leading to further delays in treatment and payment of claims.

- The Department opines that the current administrative rules in section 12-15-94, HAR, are appropriate when properly implemented. Because the Department realizes that certain insurers, attorneys, and claimants may not negotiate in good faith in order to delay the resolution process, the Department is seeking approval in this year's biennial budget for two DCD Facilitator positions with the primary responsibility to ensure proper implementation of the statutes and timely advancement of case investigation.

- The intent of the Prepaid Healthcare law is to ensure medical services for the injured worker so they do not suffer a delay in treatment. However, it has been brought to our attention that not all healthcare contracts comply with the rule, as they exclude workers' compensation. Therefore, physicians do not provide medical services until DLIR renders a decision establishing an injury as work related. DLIR will work with the healthcare contractors to ensure all mutual benefit societies comply with the rule and provide treatment to the injured workers when their workers' compensation claims are denied.

HAWAII CHAPTER – AMERICAN PHYSICAL THERAPY ASSOCIATION

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

SB 857, Relating to Workers' Compensation
Senate JDL Committee Hearing
Tuesday, Feb. 7, 2017 – 9:00 am
Room 016
Position: Support

Chair Keith Agaran and Members of the Senate JDL 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 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 supports this measure to allow injured workers access to medical care despite a pending investigation.

While we agree that an insurer has the right to investigate compensability of claims, delaying treatment of legitimately injured workers goes against the intent of the WC law. Prompt and needed care should be afforded all legitimately deserving injured workers.

HAPTA feels that if after investigation a claimant is found to have defrauded the insurer, the insurer should be able to recover any and all costs related to such fraud. The medical provider, unless found to be complicit in the fraud, should not be liable to return any fees for service provided in good faith and appropriately performed, billed, and documented.

This measure would provide incentive for insurers to investigate only cases which are truly questionable.

Thank you for the opportunity to testify. Please feel free to contact Derrick Ishihara, HAPTA's Workers' Compensation Committee Chair at 808-221-8620 for further information.

HAWAII INSURERS COUNCIL
A trade association of property and casualty insurance companies

Pauahi Tower, Suite 2010
1003 Bishop Street
Honolulu, Hawaii 96813
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Alison H. Ueoka
President

TESTIMONY OF LINDA O'REILLY

COMMITTEE ON JUDICIARY AND LABOR
Senator Gilbert S.C. Keith-Agaron, Chair
Senator Karl Rhoads, Vice Chair

Tuesday, February 7, 2017
9:00 a.m.

SB 857

Chair Keith-Agaran, Vice Chair Rhoads, and members of the Committee on Judiciary and Labor, my name is Linda O'Reilly, Assistant Vice President of Claims - Workers Compensation of First Insurance Company of Hawaii. Hawaii Insurers Council is a non-profit trade association of property and casualty insurance companies licensed to do business in Hawaii. Member companies underwrite approximately forty percent of all property and casualty insurance premiums in the state.

Hawaii Insurers Council **opposes** this bill.

SB 857 proposes to limit employers' use of denying a claim pending investigation and impose fines and penalties for those employers who continue doing so without reasonable cause.

The bill states in part, that in many cases, insurers seem to automatically deny claims "pending investigation," while for months, the patient is at times unable to use private insurance or get money in which to live.

HIC respectfully disagrees with this assessment and is unaware of any insurer who imposes such a practice. In fact, the large majority of workers' compensation claims are processed initially without delay and benefits are issued in compliance with H.R.S. 386 and related Administrative Rules.

However, there are a minority of claims that require additional information before a determination of compensability can be rendered. For cases that are denied pending additional information, State laws are in place today for both wage loss and medical treatment. These laws allow for both the employer and employee to have due process.

Specifically, temporary disability insurance (TDI) will compensate lost wages to an employee, and private health carriers are supposed to pay or provide for medical services until such time compensability of the workers' compensation claim is established. Should the workers' compensation claim be determined compensable, the WC Carrier will reimburse the prepaid health Carrier in accordance with Section 12-12-45 of the Hawaii Prepaid Health Care law, as well as the related TDI lien pursuant to Section 392-45 (a) H.R.S.

SB 857 proposes to disallow Employer/Carriers right to dispute medical bills prior to a determination of compensability. This is problematic and inconsistent with the intent of the workers' compensation law, which is to provide benefits to employees who sustain work-related injuries. Should Employer/Carrier be required to pay for medical services on all claims submitted as so defined in SB 857, the bill is silent on any proposed remedy or process for Employer/Carrier to seek reimbursement, and is devoid of any enforcement provision.

The result of this shift in burden is expected to produce medical and indemnity payments that were paid for injuries not compensable under the workers' compensation law, but the workers' compensation insurer could not recover monies from the health insurer or the claimant. This would of course, result in higher costs for the system which will be passed on to businesses.

We believe the intent of the bill is to ensure medical treatment is available to injured workers specifically during the period when it is not clear whether the injury is work-

related or not. We ask that this bill be amended to include specific language from administrative rules under HAR 12-12-45 and to remove other amendments relating to disputes which is adequately addressed in HAR 12-15-94. In the alternative, we ask that this bill be held. Finally, we ask that the Legislature pursue reasons why health insurers may not be adhering to their requirement to pay while there is no determination of cause of injury.

Thank you for the opportunity to testify.

KAUAI COMMUNITY HEALTH ALLIANCE
HALE LEA MEDICINE

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winkler@kauai-medical.org (email)

February 3, 2017

Re: **SUPPORT** of SB857

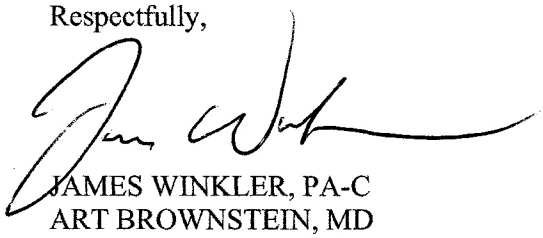
Hale Lea Medicine has been serving Kauai's residents for over 25 years, and is one of the few remaining clinics still accepting Workers Compensation insurance ("WC") on the island of Kauai.

It is critical that the employer (WC insurance carrier) pay for treatment should the case be pending investigation. When a patient comes in requiring medical care and the WC carrier will not pay for treatment stating the case is being investigated, the patient will languish untreated. This happens way too often. Because the patient is not permitted to use their private medical insurance and is unable to afford the cost themselves, they simply go untreated—for months or even years. This is unconscionable and borders on inhumane.

If we require the WC carrier to pay, and the case is later found to be uncovered, the WC carrier could easily recoup its payments from the patient's private insurance after the case is settled. Further, this would take away the incentive of the WC insurer to "stall" treatment in the hopes of financial benefit at the patient's expense.

We in family practice medicine have become very cynical of WC insurers, seeing these awful tactics used over and over again on the people of Hawaii.

Respectfully,



JAMES WINKLER, PA-C
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STEVE ROGOFF, MD
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Hawaii State Legislature
Senate Committee on Judiciary and Labor

February 6, 2017

Filed via electronic testimony submission system

RE: SB 857, WC: Prompt Pay - NAMIC's Written Testimony IN OPPOSITION

Dear Senator Gilbert S.C. Keith-Agaran, Chair; Senator Karl Rhoads, Vice-Chair; and honorable committee members:

Thank you for providing the National Association of Mutual Insurance Companies (NAMIC) an opportunity to submit written testimony to your committee for the February 7, 2017, public hearing. Unfortunately, I will not be able to attend the public hearing, because of a previously scheduled professional obligation. NAMIC's written comments need not be read into the record, so long as they are referenced as a formal submission and are provided to the committee for consideration.

The National Association of Mutual Insurance Companies (NAMIC) is the largest property/casualty insurance trade association in the country, with more than 1,400 member companies. NAMIC supports regional and local mutual insurance companies on main streets across America and many of the country's largest national insurers. NAMIC members represent 40 percent of the total property/casualty insurance market, serve more than 170 million policyholders, and write nearly $225 billion in annual premiums. NAMIC has 84 members who write property/casualty/workers' compensation in the State of Hawaii, which represents 28% of the insurance marketplace.

Although NAMIC members appreciate the importance of providing injured workers with timely medical diagnostic and treatment care, worker's compensation claims adjusting often takes time, especially if the injured worker is unwilling or unable for medical reasons to provide the employer and the workers' compensation carrier with prompt information necessary for the insurer to make a determination as whether the claim is compensable, the injuries are work related, and the initial medical treatment is reasonable and consistent with customary medical care and pricing.

NAMIC is concerned that the proposed legislation places greater emphasis upon speed over accuracy in the claims adjusting process. Naturally, employers and workers' compensation insurers want the injured worker to be treated quickly so as to elevate their pain, prevent exacerbation of the worker's medical injuries, and promptly start them on the road to medical recovery and timely return to gainful employment. However, a "rush to claims decision-making"

is not in the best interest of injured workers, employers, the worker's compensation system, and even treating medical providers.

NAMIC has the following concerns with the proposed legislation:

1) In regard to the new proposed provision, "§386 – Payment by employer; duty to service provider; disagreement with service provider; resolution procedures", NAMIC is concerned with this title, because it arguably creates a legal duty of care owed to the medical provider by the employer and workers' compensation carrier.

Employers have workers' compensation act legal duties to their workers and workers' compensation insurers have contractual and statutory legal duties to the employers they insurer. Neither employers nor insurers owe a legal duty, nor should they, to the medical provider (a professional services vendor). Creating an independent legal duty of care owed to the medical provider by the employer or insurer could create a serious conflict of interest problem that could ultimately be detrimental to the injured worker.

2) NAMIC is concerned with the proposed provision that states, "b) The employer shall not controvert a claim for services: (1) Without reasonable cause; or (2) While the claim is pending investigation."

The problem with this provision is that it would require an insurer to make payment for medical services before the claim has been fully evaluated as to whether workers' compensation coverage is applicable and/or the injuries were caused by the work related incident. Payment should only be required once the workers' compensation statutory duty has been accepted by the employer/insurer or the facts of the case have been properly evaluated by the employer/insurer. The proposed payment requirement is a classic "put the cart before the horse."

NAMIC members appreciate and share the bill sponsor's desire to make sure that claims processing doesn't needlessly drag on to the detriment of the injured worker. Employers and insurers share this public policy desire and also have an economic incentive to get the claim adjusted in a timely manner. The more claims adjusting time invested into each claim, the more administrative expenses there are for the insurer. Claims adjusting delays are expensive and problematic for insurers, so they try to expedite the resolution of claims. However, life is complex, and work related injuries may be complex, factually and/or legally, in regard to issues of "scope of employment", whether the worker's injures are in fact work related, and whether the proposed medical treatment is reasonable and medically appropriate.

Additionally, NAMIC is concerned that the bill does not define what "without reasonable cause" means. Such a concept is rife with potential for differing opinions as to what it specifically entails and requires from the insurer. Since SB 857 imposes a very rigid payment/contest disputed bills deadline, creates "automatic liability" for an insurer if the medical service is not contested within 30 days of insurer receiving medical bill, and imposes financial penalties on the insurer, NAMIC believes that it makes sense from an administrative due process standpoint for the bill to define what is meant by "without reasonable cause".

3) NAMIC is concerned with the following provision in the proposed legislation:

"In the event of reasonable disagreement, the employer shall pay for all acknowledged charges and shall notify the provider of the denial of any payment including the reason for the denial within thirty calendar days of receipt of a bill *or notification of services rendered* and provide **a** copy of the denial to the claimant." [Emphasis added]

NAMIC is concerned that the "or notification of services rendered" is likely to create confusion as to when the payment or objection deadline begins. Specifically, what does "notification" mean? Could an informal oral communication by the injured worker to the employer that he had received medical treatment be construed as "notification"? NAMIC believes that any payment or objection deadline should be based on a clear and easily determined activity, like the insurer's or employer's receipt of a medical services invoice.

Additionally, NAMIC believes that the thirty days deadline is unworkable and impractical, and likely to lead to needless conflict between the interested parties and force insurers and employers to deny certain "rushed-through" medical charges so as not to become "automatically liable" for them as a result of failing to formally contest them within the abbreviated response deadline.

4) NAMIC believes that the following suggested provision would deny an insurer or employer with important administrative due process protections:

"The director shall review the positions of both parties and render an administrative decision *without hearing.*" [Emphasis added].

Why should the insurer or employer be denied the right to a hearing on the director's decision, especially when a $1,000 penalty, called a "service charge" in the bill, could be imposed upon the party for failing to negotiate "in good faith", whatever that nebulous legal standard actually means?

5) NAMIC believes that the July 1, 2017, effective date would create unnecessary administrative costs and burdens for insurers and employers. NAMIC believes that insurers should be granted a year from enactment of the bill for proper implementation of the law and the new prompt payment compliance requirements. Therefore, NAMIC respectfully requests a July 1, 2018 effective date.

Thank you for your time and consideration. Please feel free to contact me at 303.907.0587 or at crataj@namic.org, if you would like to discuss NAMIC's written testimony.

Respectfully,

Christian John Rataj, Esq.
NAMIC Senior Director – State Affairs, Western Region

Advocacy. Leadership. Results.

To: The Honorable Gilbert S.C. Keith-Agaran, Chair
The Honorable Karl Rhoads, Vice Chair
Senate Committee on Judiciary and Labor

From: Mark Sektnan, Vice President

Re: **SB 857 – Relating to Workers' Compensation**
PCI Position: OPPOSE

Date: Tuesday, February 7, 2017
9:00 a.m., Conference Room 016

Aloha Chair Keith-Agaran, Vice Chair Rhoads and Members of the Committee:

The Property Casualty Insurers Association of America (PCI) is opposed to SB 857 which would, among other things, require employers to pay all workers compensation claims for compensable injuries and not deny claims without "reasonable cause" or during a pending investigation. In Hawaii, PCI member companies write approximately 42.3 percent of all property casualty insurance written in Hawaii. PCI member companies write 44.7 percent of all personal automobile insurance, 65.3 percent of all commercial automobile insurance and 76.5 percent of the workers' compensation insurance in Hawaii.

PCI strongly supports efforts to ensure that injured workers get appropriate medical care in a timely and efficient manner. Determining the appropriate care for an injured worker is a time consuming process often complicated by an inability to gather necessary information to determine whether the injuries are work related and to develop a treatment plan best designed to getting the injured worker back to work. Deadlines and rules that do not recognize the complexity of most workers' compensation claims are not in the best interest of the injured worker who may receive inadequate or inappropriate care.

SB 857 seems to create a new legal duty of care owed to the medical provider by the employer and workers' compensation carrier beyond the terms of the contract. Creating an independent legal duty of care owed to the medical provider by the employer or insurer could create a serious conflict of interest problem that could ultimately be detrimental to the injured worker. The bill also states that employers and insurers will have to pay for disputed claims without completing their investigation. This requirement presents serious issues in cases where the liability has not yet been accepted or the medical provider may be providing services that do not meet evidence based standards and are therefore not appropriate, and in many cases may even be dangerous to the injured worker.

The bill, as written, may also foster additional disputes since many of the key terms are undefined such as “notification.” There are many communications between workers’ compensation insurers, employers, medical providers and injured workers. Which of these communications constitutes a notification and therefore triggers the deadline mandated in this bill?

The provisions of the bill which grant the director the power to review the positions of both parties and render an administrative decision ***without hearing*** is also a problem. Removing an insurers administrative rights and then imposing a $1,000 penalty is problematic. Finally, the bill will create a significant administrative burden for insurers and therefore, should contain a delayed implementation date of no earlier than July 1, 2018.

PCI asks the committee to hold this measure for the aforementioned reasons.

From: mailinglist@capitol.hawaii.gov
To: JDLTestimony
Cc:
Subject: *Submitted testimony for SB857 on Feb 7, 2017 09:00AM*
Date: Friday, February 3, 2017 7:20:11 PM

SB857
Submitted on: 2/3/2017
Testimony for JDL on Feb 7, 2017 09:00AM in Conference Room 016

Submitted By	Organization	Testifier Position	Present at Hearing
Terri Pacheco APRN	Individual	Support	No

Comments:

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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From: mailinglist@capitol.hawaii.gov
To: JDLTestimony
Cc:
Subject: *Submitted testimony for SB857 on Feb 7, 2017 09:00AM*
Date: Thursday, February 2, 2017 4:44:05 PM

SB857
Submitted on: 2/2/2017
Testimony for JDL on Feb 7, 2017 09:00AM in Conference Room 016

Submitted By	Organization	Testifier Position	Present at Hearing
Timothy McNulty	Individual	Support	No

Comments:

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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