LATE

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TESTIMONY IN STRONG OPPOSITION TO SB 1274

TO: SENATE COMMITTEES ON COMMERCE AND CONSUMER PROTECTION AND ON HEALTH
DATE: FEBRUARY 10, 2011; 8:30AM
Conference Room 229
Re: SB 1274 RELATING TO HEALTH INSURANCE.

Chairs Baker and Green, Vice Chairs Taniguchi and Nishimura, and Distinguished Committee Members:

I urge you, most strenuously, to reject SB1274.

Current law, HRS Sec. 432E-6, of the Patient Rights and Responsibility Act, provides an effective means by which patients who hold health insurance and whose policies are covered by that Act can effectively contest a health insurer's decision to deny them medical, surgical, or drug benefits which have been ordered or prescribed by their own physicians. See H.R.S. Section 432E-6, 6.5. ***That coverage protects nearly 218,000 healthy poor, Medicaid Quest Expanded Access (QExA), covering more than 42,000 Medicade-eligibile aged, blind, and disabled, all State employees, and all people covered under self-insured plans!!!***

Appeals from such denials are usually extremely complex and expensive. The reason is simple: To win such cases the patient must have the assistance of a knowledgeable expert in medicine who is capable of dealing with great complexity and able to convey his or her views understandably to the decision-makers who are not all physicians. In addition, the patient cannot proceed effectively without an attorney who understands this very complex area of law who can also convey his or her views to the decision-makers, who are not all likely to be lawyers. A very clear and simple illustrations of the potential greater complexity of such appeals, should SB 1274 pass, is before you in its extraordinarily complex 33 pages, especially when compared with the appeals provisions in Section 432E-6 of our current law. (Less than 3 pages! Attached to this testimony, below.)

In opposing SB 1274 (and its companion bill, HB1047) I join Dr. Arleen Meyers, a much-admired and beloved Hawaii pediatrician and Master of Public Health (UH); President of the Hawaii Coalition for Health, who was instrumental in effecting passage of the Hawaii Patient Bill of Rights and Responsibilities; President of the Hawaii Congress of Physicians; and a lawyer (UH) who has personally participated in many appeals under 432E-6 brought by patients to enforce their rights after their own physician's orders for medically necessary treatment or surgery were denied by a health plan.

I urge you to read Dr. Meyer's testimony, which I will not repeat in full here, and to adopt her recommendation and conclusions, as follows:

> **The Legislature should first fully inform itself of whether an alternative course of actions that avoids a repeal of HRS 432E-6 and 6.5 is available. The Legislature should also be fully aware of the impact of such a repeal on health care consumers. Please convene a task force or commission of health care consumers and legislators to study the proposal and report back to the Legislature. The task force can meet during the period before the 2012 legislature and accept testimony from consumers, providers and managed care plans, and convey that information to the Legislature in a report of the committee's recommendations.**

If you choose rather to proceed with passage of SB 1274 and companion HB 1047 to replace the external review process in the existing Patients' Bill of Rights and Rsponsibilities Act, HRS 432E-6, 6.5, you will cause dire consequences on health care in Hawaii and on Hawaii's economy in general.

Dr. Meyers' testimony clearly explains why such she believes dire consequences may occur with the passage of SB1274 or HB1047. You may be assured that she really knows whereof she speaks.

Thanks you for considering my views, which are not necessarily those of the UH or its Law School.

Respectfully,

§ 432E-6. External review procedure.

(a) After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a managed care plan's final internal determination to a three-member review panel appointed by the commissioner composed of a representative from a managed care plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee in the following manner:

(1) The enrollee shall submit a request for external review to the commissioner within sixty days from the date of the final internal determination by the managed care plan;

(2) The commissioner may retain:

(A) Without regard to chapter 76, an independent medical expert trained in the field of medicine most appropriately related to the matter under review. Presentation of evidence for this purpose shall be exempt from section 91-9(g); and

(B) The services of an independent review organization from an approved list maintained by the commissioner;

(3) Within seven days after receipt of the request for external review, a managed care plan or its designee utilization review organization shall provide to the commissioner or the assigned independent review organization:

(A) Any documents or information used in making the final internal determination including the enrollee's medical records;

(B) Any documentation or written information submitted to the managed care plan in support of the enrollee's initial complaint; and

(C) A list of the names, addresses, and telephone numbers of each licensed health care provider who cared for the enrollee and who may have medical records relevant to the external review;

provided that where an expedited appeal is involved, the managed care plan or its designee utilization review organization shall provide the documents and information within forty-eight hours of receipt of the request for external review.

Failure by the managed care plan or its designee utilization review organization to provide the documents and information within the prescribed time periods shall not delay the conduct of the external review. Where the plan or its designee utilization review organization fails to provide the documents and information within the prescribed time periods, the commissioner may issue a decision to reverse the final internal determination, in whole or part, and shall promptly notify the independent review organization, the enrollee, the enrollee's appointed representative, if applicable, the enrollee's treating provider, and the managed care plan of the decision;

(4) Upon receipt of the request for external review and upon a showing of good cause, the commissioner shall appoint the members of the external review panel and shall conduct a review hearing pursuant to chapter 91. If the amount in controversy is less than $500, the commissioner may conduct a review hearing without appointing a review panel;

(5) The review hearing shall be conducted as soon as practicable, taking into consideration the medical exigencies of the case; provided that:

(A) The hearing shall be held no later than sixty days from the date of the request for the hearing; and

(B) An external review conducted as an expedited appeal shall be determined no later than seventy-two hours after receipt of the request for external review;

(6) After considering the enrollee's complaint, the managed care plan's response, and any affidavits filed by the parties, the commissioner may dismiss the request for external review if it is determined that the request is frivolous or without merit; and

(7) The review panel shall review every final internal determination to determine whether the managed care plan involved acted reasonably. The review panel and the commissioner or the commissioner's designee shall consider:

(A) The terms of the agreement of the enrollee's insurance policy, evidence of coverage, or similar document;

(B) Whether the medical director properly applied the medical necessity criteria in section 432E-1.4 in making the final internal determination;

(C) All relevant medical records;

(D) The clinical standards of the plan;

(E) The information provided;

(F) The attending physician's recommendations; and

(G) Generally accepted practice guidelines.

The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision within thirty days of the hearing.

(b) The procedure set forth in this section shall not apply to claims or allegations of health provider malpractice, professional negligence, or other professional fault against participating providers.

(c) No person shall serve on the review panel or in the independent review organization who, through a familial relationship within the second degree of consanguinity or affinity, or for other reasons, has a direct and substantial professional, financial, or personal interest in:

(1) The plan involved in the complaint, including an officer, director, or employee of the plan; or

(2) The treatment of the enrollee, including but not limited to the developer or manufacturer of the principal drug, device, procedure, or other therapy at issue.

(d) Members of the review panel shall be granted immunity from liability and damages relating to their duties under this section.

(e) An enrollee may be allowed, at the commissioner's discretion, an award of a reasonable sum for attorney's fees and reasonable costs incurred in connection with the external review under this section, unless the commissioner in an administrative proceeding determines that the appeal was unreasonable, fraudulent, excessive, or frivolous.

(f) Disclosure of an enrollee's protected health information shall be limited to disclosure for purposes relating to the external review.

§ 432E-6.5. Expedited appeal, when authorized; standard for decision.

(a) An enrollee may request that the following be conducted as an expedited appeal:

(1) The internal review under section 432E-5 of the enrollee's complaint; or

(2) The external review under section **432E-6** of the managed care plan's final internal determination.

If a request for expedited appeal is approved by the managed care plan or the commissioner, the appropriate review shall be completed within seventy-two hours of receipt of the request for expedited appeal.

(b) An expedited appeal shall be authorized if the application of the sixty day standard review time frame may:

(1) Seriously jeopardize the life or health of the enrollee;

(2) Seriously jeopardize the enrollee's ability to gain maximum functioning; or

(3) Subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the expedited appeal.

(c) The decision as to whether an enrollee's complaint is an expedited appeal shall be made by applying the standard of a reasonable individual who is not a trained health professional. The decision may be made for the managed care plan by an individual acting on behalf of the managed care plan. If a licensed health care provider with knowledge of a claimant's medical condition requests an expedited appeal on behalf of an enrollee, the request shall be treated as an expedited appeal.

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TESTIMONY IN OPPOSITION TO S.B. 1274

From: Summer Harrison
Occupation: Small business owner and mother of a child with multiple disabilities.

To: Senate Committee on Health,
Senator Josh Green, M.D., Chair Senator Clarence K. Nishihara, Vice-Chair

Hearing: February 10, 2011, 8:30 a.m., Conference Room 229

Sent by Email to CPNTestimony@Capitol.hawaii.gov PAGE 1 OF 2

I am **strongly opposed** to Senate Bill 1274 (and the companion House Bill 1047), which will unjustifiably and irreversibly damage health care consumer protection in Hawaii.

My daughter Hannah may only be alive today because of our external review law, H.R.S. § 432E-6. She suffers from two rare seizure syndromes, one while she is awake and a completely different one when sleeping. She is at a very high risk for something called SUDEP, Sudden Death in Epilepsy, and her only alternative to getting 24/7 nursing at home is to be shut away in a hospital for the rest of her life. Every time her seizures have been bad enough to result in her being medivaced to Kapiolani, it has been when there was not a trained nurse with her to intervene. When Hannah's health plan, Evercare, tried to reduce her home nursing hours the external review process was the only thing standing between her potential death and Evercare trying to spend as little as possible of the capitation fee the state gives them for Hannah every month.

Our external review process has served health care consumers well for over a decade. It gives health care consumers a more level playing field against powerful insurance companies. Consumers have access to experienced advocates to assist them with preparing and presenting their cases in a manner consistent with Hawaii's medical necessity law. Decisions are made by a local expert panel, and consumers are able to present expert testimony and other evidence in a fair, but efficient, hearing process.

Instead of repealing our existing external review statute, it should be expanded to include ERISA plan members now that the health care reform act has made that possible. The Insurance Commissioner should be directed to require ERISA plans to make our existing external review available to their members. (If the Commissioner can order ERISA plans to use the outsource review process proposed in S.B. 1274 and H.B. 1047, he can order them to use our existing process.)

Decisions on health care in Hawaii should be made in Hawai`i, not outsourced to mainland doctors who are not in touch with our values, our culture, and our people.

Moreover, the Legislature should not make such a sweeping change in our laws, repealing long-standing rights, when the fate of federal healthcare reform is up in the air. The Legislature should fully inform itself of whether an alternative course of action that avoids a

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TESTIMONY IN OPPOSITION TO S.B. 1274

From: Summer Harrison PAGE 2 OF 2
Hearing: February 10, 2011, 8:30 a.m., Conference Room 229

repeal is available. The Legislature should also be fully aware of the impact of such a repeal on health care consumers. Please convene a task force or commission of health care consumers and legislators to study the proposal and report back to the Legislature. The task force can meet during the period before the 2012 legislature, and accept testimony and information from consumers, providers, and managed care plans, and convey that information to the Legislature in a report of the committee's recommendations.

The Administration has inaccurately described SB1274 as providing "uniform standards for external review procedures." In fact, more than a quarter of a million people who now have the right to external review under H.R.S. § 432E-6 will lose it. Nearly half of Hawaii's population will have to use various other forms of external review. Under the S.B. 1247 proposed review, the process is far more complex (you have only to compare the length of our existing law, H.R.S. § 432E-6 with S.B. 1274 and H.B. 1047 to see how much more complex it will be), and, ironically, health care consumers will have a lot less help.

S.B. 1274 and H.B. 1047 simply cannot be seen as anything more than a huge favor for insurers. Considering Evercare and Ohana, along with Medquest, have been under one form of Federal scrutiny or another for almost eighteen months, now is not the time to eliminate the only protection that stands between health care consumers, particularly our most vulnerable, and the insurance companies who make medical decisions based on profit margin.

I want you to know that I consider this a VERY IMPORTANT issue, and I ask you to heed the voices of those of us who oppose S.B 1274. Vote "No" on S.B. 1274 because of the irreversible damage it will do to an inestimable number of Hawai`i citizens when they are sick and need our wholehearted support.

Thank you for the opportunity to express my strong opposition to this measure.

Very truly yours,

Summer Harrison

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LATE

Private-Citizen Testimony
February 9, 2011

To the Chair and all Members of the Hawaii Senate Health Committee:

A retired citizen and resident of Hawaii for 40 years, I strongly oppose Senate Bill 1274. From my study and conclusion, passage of it would constitute a long step backward to health-care consumer protection in Hawaii. Existing law (HRS para 432E-6) has provided adequate health-care review for consumers for years. The system that has been developed and employed allows consumers to be directly involved in cases affecting them in a fair, efficient, effective, local-oriented hearing process.

Your Committee, and the Senate, should be loath to consider effecting such a sweeping change in our laws, repealing long-standing rights, at a time when the fate of federal healthcare reform is in flux. Should you not explore whether an alternative course of action(s) is available? It is incumbent on you to apprise yourselves in depth of the impact of such a repeal on health-care consumers. I recommend that you convene a task force or commission of health-care consumers and legislators to study the proposal and report back to you. The task force or commission could meet during the period between now and the 2012 legislative session; accept testimony and information from consumers, providers, and managed care plans; and convey that information to you via a task force or committee-compiled record of proceedings and recommendation(s).

I cannot understand the Abercrombie Administration's advocacy of S.B. 1274. I must expect that it, and your Committee, have the best interests of consumers at heart; accordingly, you cannot vote this bill out of committee!

Thank you for taking my opposition to this misguided measure seriously.

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PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

Section 2719 Appeals Process:

"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum, ... provide an external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans."

(§1001 PPACA, amending §2719 of the Public Health Services Act)

UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT

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Submitted by Ellen Godbey Carson, Esq., Alston Hunt Floyd & Ing
On Behalf of Kaiser Foundation Health Plan, Inc.

In support of SB 1274 2/10/11