Inter-Agency Council for Immigrant Services
C/O 1117 Kaili Street
Honolulu, Hawaii 96819

November 1, 2005

Governor's Task Force on Healthcare
c/o Laurel Johnston
Hawaii Uninsured Project
American Savings Bank Tower
1001 Bishop Street, Suite 1132
Honolulu, Hawaii 96813

Re: **Governor's Task Force on Healthcare**

Dear Chairperson and Members of the Governor's Task Force on Healthcare:

Many in the immigrant community read the recent news releases on Task Force proposals to ensure health care for "all" of Hawai'i's residents. We applaud the Task Force for its vision and commitment to insuring access to health care. By virtue of experience, however, we are necessarily cautious when any proposal purports to provide for "all" in the community. It has been our experience that "all" does not necessarily include the immigrant community. We are writing to urge the Task Force to truly include the immigrant community in any proposals under consideration.

As you are aware, in 1996 Congress stripped away immigrant entitlement to federally funded health care from large tracts of the immigrant population. While many states across the nation stepped in to fill the gap, Hawaii has done little for its immigrant community. Indeed, only a select group of individuals are entitled to state funded health care: legal permanent resident children, children from the Compact States of Free Association, PRUCOL children, and pregnant legal permanent residents. Left uncovered are hundreds of undocumented children not entitled to PRUCOL status, undocumented pregnant women, and all legal permanent resident adults as well as undocumented adults. The state's voluntary coverage for adults from the Compact States of Free Association is an interesting contrast to its refusal to provide health care for legal permanent residents and raises substantial issues of equal protection as there is no rational basis for the disparity in treatment.

Significantly, immigrant health care issues will not disappear by throwing more money at the community health care system. It is after all, a system for primary health care only. All too frequently immigrant service providers field difficult telephone calls from hospital social workers, family members, and others seeking health care options for adult legal permanent residents and others diagnosed with cancer, heart failure, kidney disease and other ailments requiring specialized care and treatment unavailable at the community

health care centers. Tragically, no services are available for otherwise income qualified undocumented residents as well as legal permanent residents with less than five (5) and sometimes ten (10) year's residency in the United States.

Health care study after health care study has noted the disparities in health care for immigrants and the tragic consequences for the failure to provide the same. This Task Force has the opportunity to ensure meaningful access to health care by "all" of Hawaii's residents. We hope "all" includes immigrants.

The undersigned and interested members of the immigrant advocate community strongly desire an opportunity to address the Governor's Task Force on Healthcare to bring attention to existing disparities for immigrants in Hawaii's healthcare system. We look forward to hearing from you.

Sincerely,

Dominic Inocelda, President
Inter-Agency Council for Immigrant Services

Patricia McManaman, CEO
Na Loio

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November 14, 2005

Temporary Health Care Task Force
Rep. Josh Green, M.D.,
Chair
Rep. Patricia Blanchette, M.D.
Vice Chair

By Fax: 585-7932

DATE: **Wednesday, November 16, 2005.**
TIME: 4:30 p.m. – 6:00 p.m.
PLACE: State Capitol, Room 211, 415 Beretania Street, Honolulu, HI 96813

TESTIMONY OF STEPHEN M. SHAW
SUPPORTING SINGLE PAYER INSURANCE
EXHIBITS "A" AND "B"

Dear Chairman Green, Vice Chair Blanchette, and Members Of The Task Force:

There was a question raised that is, a new state agency should not be created to administer a single payer system. This writer also warned about extremely low physician reimbursement in the U.S. Dept of Labor, Office of Worker's Compensation Programs (OWCP).

Solutions to the competing need to centralize claims intake and adjudication must be written into your report/proposal submitted to the legislature.

As a practical matter, there are at least three agencies which are deeply involved in health provider claims disputes. A proposal transferring and centralizing claims intake and resolution to an existing agency might work in the long-term if electronic filing is used statewide. But there should be some recognition that a separate executive department may be required.

Centralization of claims intake and adjudication will achieve lower administrative costs and benefit from economies of scale. There will also be immeasurable benefits to having a state agency charged with this function, because providers and insureds will have prompt access to evolving claims payment criteria under the Uniform Information Practices Act.

Whichever agency becomes home base for health claims administration will need to adopt new, provider-friendly rules to avoid becoming itself a barrier to health care for all Hawaii residents.

Rules found for the DCCA hearings processes are at Hawaii Adminsitrative Rules 16-201-1 et seq and form a valuable point of beginning since they are already in use for outpatient billing disputes applying the AMA's CPT. The rules are readily transferable to the department of health, for example.

To avoid becoming another OWCP (federal) or Hawaii Department of Labor, which drives health providers away from treating persons within their jurisdiction, there is a simple rule from Social Security at "A". Adopted to Hawaii, a similar rule provides a floor from which you can add to your proposal long overdue respect for Hawaii's treating health providers when there is a dispute over claims. The crucial parts of the rule (Ex. A) are found at subsection (d) and (f). To see how the rule works in practice, I attach some excerpts from a case. Ex. B.

Respectfully Submitted,

Stephen M. Shaw

Encls. Exhibits "A" & "B"

TITLE 20 -- EMPLOYEES' BENEFITS
CHAPTER III -- SOCIAL SECURITY ADMINISTRATION
PART 416 -- SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED
SUBPART I -- DETERMINING DISABILITY AND BLINDNESS
MEDICAL CONSIDERATIONS

Go to the CFR Archive Directory

20 CFR 416.927

@ 416.927 Evaluating opinion evidence.

(a) General. (1) If you are an adult, you can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (See @ 416.905.) If you are a child, you can be found disabled only if you have a medically determinable physical or mental impairment(s) that causes marked and severe functional limitations and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. (See @ 416.906.) Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. (See @ 416.908.)

(2) Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(b) How we consider medical opinions. In deciding whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive.

(c) Making disability determinations. After we review all of the evidence relevant to your claim, including medical opinions, we make findings about what the evidence shows.

(1) If all of the evidence we receive, including all medical opinion(s), is

consistent, and there is sufficient evidence for us to decide whether you are disabled, we will make our determination or decision based on that evidence.

(2) If any of the evidence in your case record, including any medical opinion(s), is inconsistent with other evidence or is internally inconsistent, we will weigh all of the evidence and see whether we can decide whether you are ' abled based on the evidence we have.

(3) If the evidence is consistent but we do not have sufficient evidence to decide whether you are disabled, or, if after weighing the evidence we decide we cannot reach a conclusion about whether you are disabled, we will try to obtain additional evidence under the provisions of @@ 416.912 and 416.919 through 416.919h. We will request additional existing records, recontact your treating sources or any other examining sources, ask you to undergo a consultative examination at our expense, or ask you or others for more information. We will consider any additional evidence we receive together with the evidence we already have.

(4) When there are inconsistencies in the evidence that cannot be resolved, or when despite efforts to obtain additional evidence the evidence is not complete, we will make a determination or decision based on the evidence we have.

(d) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not ex=mined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if 't were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more

knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(e) Medical source opinions on issues reserved to the Commissioner. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) Other opinions on issues reserved to the Commissioner. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter, your residual functional capacity (see @@ 416.945 and 416.946), or the application of vocational factors,

the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (e)(1) and (e)(2) of this section.

(f) Opinions of nonexamining sources. We consider all evidence from nonexamining sources to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (e) of this section. In addition, the following rules apply to State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult in connection with administrative law judge hearings and Appeals Council review:

(1) At the initial and reconsideration steps in the administrative review process, except in disability hearings, State agency medical and psychological consultants are members of the teams that make the determinations of disability. A State agency medical or psychological consultant will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or equals the requirements for any impairment listed in Appendix 1 to subpart P of part 404 of this chapter, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case record but are not themselves evidence at these steps.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. They will consider opinions of State agency medical or psychological consultants, other program physicians and psychologists, and medical experts as follows:

(i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. However, State agency medical and psychological consultants and other program physicians and psychologists are highly qualified physicians and psychologists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings of State agency medical and psychological consultants or other program physicians or psychologists as opinion evidence, except for the ultimate determination about whether you are disabled. See @ 416.912(b)(6).

(ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician or psychologist, the administrative law judge will evaluate the findings using relevant factors in paragraphs (a) through (e) of this section, such as the physician's or psychologist's medical specialty and expertise in our rules, the supporting evidence in the case record, supporting explanations provided by the physician or psychologist, and any other factors relevant to the weighing of the opinions. Unless the treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency medical or psychological consultant or other program physician or psychologist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from me cal experts on the nature and severity of your impairment(s) and on whether your impairment(s) equals the requirements of any impairment listed in appendix

1 to subpart P of part 404 of this chapter. When administrative law judges consider these opinions, they will evaluate them using the rules in paragraphs (a) through (e) of this section.

(3) When the Appeals Council makes a decision, it will follow the same rules for considering opinion evidence as administrative law judges follow.

HISTORY:
[56 FR 36968, Aug. 1, 1991; 62 FR 6408, 6428, Feb. 11, 1997, as corrected at 62 FR 13537, 13538, Mar. 21, 1997; 62 FR 38448, 38454, July 18, 1997; 65 FR 11866, 11880, Mar. 7, 2000]

AUTHORITY:
AUTHORITY NOTE APPLICABLE TO ENTIRE SUBPART:
Secs. 702(a)(5), 1611, 1614, 1619, 1631(a), (c), and (d)(1), and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382, 1382c, 1382h, 1383(a), (c), and (d)(1), and 1383b); secs. 4(c) and 5, 6(c)-(e), 14(a), and 15, Pub. L. 98-460, 98 Stat. 1794, 1801, 1802, and 1808 (42 U.S.C. 421 note, 423 note, 1382h note).

NOTES:
[EFFECTIVE DATE NOTE: 65 FR 11866, 11880, Mar. 7, 2000, amended this section, effective Apr. 6, 2000.]
[PUBLISHER'S NOTE: UNITED STATES SUPREME COURT CASES SIGNIFICANTLY DISCUSSING SECTION -- Sullivan v Zebley (1990) 493 US 521, 107 L Ed 2d 967, 110 S Ct 885]
NOTES APPLICABLE TO ENTIRE TITLE:
EDITORIAL NOTE: Other regulations issued by the Department of Labor appear in 20 CFR chapters IV, V, VI, VII and IX, 29 CFR subtitle A and chapters II, IV, V, XVII and XXV, 30 CFR chapter I, 41 CFR chapters 50, 60, and 61, and 48 CFR chapter 29.

NOTES APPLICABLE TO ENTIRE SUBPART:
[1 LISHER'S NOTE: FEDERAL CASES CITING @@ 416.901 to 416.998 -- Surkand v. Massanari, 2001 U.S. Dist. LEXIS 14421]

2198 words

LEVEL 1 - 6 OF 62 CASES

ALBERT SHAW, Plaintiff-Appellant, v. SHIRLEY S. CHATER, as Commissioner of the Social Security Administration, Defendant-Appellee.

Docket Nos. 96-6134, 99-6119

UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

221 F.3d 126; 2000 U.S. App. LEXIS 18017; 70 Soc. Sec. Rep. Service 583

October 27, 1999, Submitted
July 20, 2000, Decided

SUBSEQUENT HISTORY: [**1] As Amended October 6, 2000.

PRIOR HISTORY: Appeal from two judgments of the United States District Court for the Eastern District of New York (Spatt, J.). The judgment entered on March 21, 1996 denied plaintiff mandamus review of the Commissioner's refusal to

clinically acceptable diagnostic[**17] techniques."). Dr. Lewis noted that these X-rays could indicate a deteriorating problem in the spine, which is an example of a vertebrogenic disorder. The district court refused to give weight to this evidence because it concluded that Dr. Lewis' observations did not constitute a true retrospective diagnosis and therefore was not probative of plaintiff's disability.

It is not clear to us why Dr. Lewis' December 1985 observations fail to provide a "true retrospective diagnosis." The district court relied on cases where the utility of retrospective diagnoses was limited because the record already contained ample evidence of the claimant's condition at the relevant time period, see <=48> Pratts v. Chater, 94 F.3d 34, 36 (2d Cir. 1996), or when the claimant sought the introduction of new evidence after the ALJ had reached a decision, see <=49> Jones v. Sullivan, 949 F.2d 57, 60 (2d Cir. 1991). Since neither of these circumstances is present in the instant case, there was no basis to discount Dr. Lewis' observation of plaintiff's condition.

[*134] C. ALJ's Refusal to Follow Treating Physician Rule

Plaintiff appears to rely on Dr. Lewis' observations, in part, because[**18] th ALJ gave little weight to the probative value of plaintiff's own treating ph ician's diagnosis. By failing to give Dr. Cassvan's opinions controlling or

B.1

at least greater weight, the ALJ violated the SSA regulation's "treating physician" rule. That rule mandates that the medical opinion of a claimant's treating physician is given controlling weight if it is well supported by dical findings and not inconsistent with other substantial record evidence. It ovides:

Generally, we give more weight to opinions from your treating sources . . . if we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight.

<=50> 20 C.F.R. @ 416.927(d)(2); see <=51> Rosa v. Callahan, 168 F.3d 72, 78-79 (2d Cir. 1999); <=52> Clark v. Commissioner of Soc. Sec., 143 F.3d 115, 118 (2d Cir. 1998).

The factors that must be considered when the treating physician's opinion is not given controlling weight include: "(i) the frequency of examination[**19] and the length, nature, and extent of the treatment relationship; (ii) the evidence in support of the opinion; (iii) the opinion's consistency with the record as a whole; and (iv) whether the opinion is from a specialist." <=53> Clark, 143 F.3d at 118. The regulations also require the ALJ to set forth her reasons for the weight she assigns to the treating physician's opinion. See id.

The district court believed that the ALJ properly decided not to give ntrolling weight to Dr. Cassvan's medical opinion because his "limited findings and the intermittent nature of his treatment" did not support a finding of disability. Such falls far short of the standard for contradictory evidence required to override the weight normally assigned the treating physician's opinion. Dr. Cassvan had treated plaintiff for at least seven years and had made medical observations far more extensive than those of any other consulting physician. The record contains no indication that Dr. Cassvan's observations were unsupported by medical evidence or that his opinion is inconsistent with the record as a whole. In fact, the bulk of the record in this case is drawn exclusively from Dr. Cassvan's[**20] medical assessments.

For the ALJ to conclude that plaintiff presented no evidence of disability at the relevant time period, yet to simultaneously discount the medical opinion of his treating physician, violates his duty to develop the factual record, regardless of whether the claimant is represented by legal counsel. See

<=54> Schaal, 134 F.3d at 505 ("Even if the clinical findings were inadequate, it was the ALJ's duty to seek additional information from [the treating physician] sua sponte."); <=55> Pratts, 94 F.3d at 37 ("The rule in our circuit [is] that 'the ALJ, unlike a judge in a trial, must herself affirmatively develop the record' in light of 'the essentially non-adversarial nature of a benefits proceeding'. . . . Even when, as here, claimant is represented by counsel.") (quoting <=56> Echevarria, 685 F.2d at 755).

In addition, the district court improperly characterized the fact that Dr. Cassvan recommended only conservative physical therapy, hot packs, EMG testing -- not surgery or prescription drugs -- as substantial evidence that plaintiff was not physically disabled during the relevant period. Neither the trial judge nor the[**21] ALJ is permitted to substitute his own expertise or view of the medical proof for the treating physician's opinion. See <=57> Balsamo v. Chater, 142 F.3d 75, 81 (2d Cir. 1998). Essentially, the ALJ and trial court imposed their notion that the severity of a physical impairment directly correlates [*135] with the intrusiveness of the medical treatment ordered. This is not the overwhelmingly compelling type of critique that would permit the Commissioner to overcome an otherwise valid medical opinion. See <=58> Wagner v. Secretary of Health and Human Servs., 906 F.2d 856, 862 (2d Cir. 1990) (explaining that while a physician's opinion might contain inconsistencies and be subject to attack, "a circumstantial critique by non-physicians, however thorough or responsible, must be overwhelmingly compelling in order to overcome a medical opinion").

Significantly, both the ALJ and the district court rejected Dr. Cassvan's medical opinion when it supported a finding that plaintiff was disabled; yet at the same time relied on Dr. Cassvan's January 1986 and 1987 observations, that plaintiff's condition was improving to provide proof that plaintiff was not disabled in 1985. Such an[**22] inconsistent use of the medical evidence undermines any argument that Dr. Cassvan's opinion was so unreliable that it should not have been assigned controlling weight.

Given these deficiencies in the ALJ's analysis the record lacked substantial evidence to support its finding that Shaw was not disabled on March 31, 1985. A remand for a step five analysis that places the burden of proof on the Commissioner to show that the claimant could perform other work in the economy, even if he could not perform his past work, is appropriate in cases where there is more uncertainty regarding the claimant's condition. But here because the record provides overwhelming proof that Shaw suffered from a vertebrogenic disorder -- one of the "severe impairments" enumerated by Listing 1.05(C) -- as of March 31, 1985, rendering him "disabled" for the purposes of SSD benefits, a remand for further proceedings is unnecessary.

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