HB 2461, HD2, SD1

Testimony

TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
TWENTY-FIFTH LEGISLATURE, 2010

ON THE FOLLOWING MEASURE:
H.B. NO. 2461, H.D. 2, S.D. 1, RELATING TO INSURANCE.

BEFORE THE:
SENATE COMMITTEE ON WAYS AND MEANS

DATE: Wednesday, March 31, 2010 **TIME:** 9:30 a.m.

LOCATION: State Capitol, Room 211

TESTIFIER(S): WRITTEN COMMENTS ONLY. For more information, call Lili A. Funakoshi, Deputy Attorney General, at 587-3050.

Chair Kim and Members of the Committee:

The Department of the Attorney General wishes to point out a constitutional problem in this measure.

This bill, entitled "Relating to Insurance," proposes to (1) place a moratorium on the Hawaii Employer-Union Health Benefits Trust Fund's existing reference-based pricing program for prescription drug plan members through June 30, 2012, while a feasibility study on its long-term effects is conducted; (2) require the Department of Health to execute a budget neutral pilot program that explores the use of a mobile health van equipped with telecommunication services using managed care principles; and (3) require continuing coverage of prescription medication under any policy entered into by an insured or insurer on or after July 1, 2010.

According to its title, this bill relates to insurance. However, part II of the bill relating to a "pilot program that explores the use of a mobile health van equipped with telecommunication services using managed care principles" does not relate to insurance. It is unclear what the pilot program is intended to accomplish (i.e., use of a mobile health van without appropriation of funding, establishing a task force to explore the idea of using a mobile health van, how such a mobile van would

employ managed care principles, etc.), and how it relates to insurance. Therefore, this bill may violate the single subject clause of article III, section 14, of the Hawaii State Constitution, which requires that "[e]ach law shall embrace but one subject, which shall be expressed in its title."

If this bill is to be passed, we respectfully request that the Committee delete part II from the bill.

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The Twenty-Fifth Legislature, State of Hawaii
Hawaii State Senate
Committee on Ways and Means

Testimony by
Hawaii Government Employees Association
March 31, 2010

H.B. 2461, H.D. 2, S.D. 1 – RELATING TO INSURANCE

The Hawaii Government Employees Association, AFSCME Local 152, AFL-CIO, supports the purpose and intent of H.B. 2461, H.D. 2, S.D. 1 with certain amendments. We strongly support placing a moratorium through June 30, 2012 on referenced-based pricing currently used by the Employer-Union Health Benefits Trust Fund (EUTF) until a comprehensive study is completed and submitted to the Legislature.

The EUTF initiated reference-based pricing in January 2010 for three drug classes: statins (cholesterol lowering drugs), proton-pump inhibitors (anti-heartburn and ulcer medications) and low or non-sedating antihistamines (allergy medications). Under reference-based pricing, the most cost effective FDA-approved drug is designated by the company within these drug categories. Referenced-based pricing is used in Canada and certain European countries, but there are no jurisdictions in the United States that have used this program for an extended period.

If employees take the preferred drug, participants pay a generic co-payment of $5-$10. However, if a patient cannot tolerate the generic drug, then the co-payment for one of these three drug classes is no longer be a fixed amount, but is based on the difference in price of the preferred (low cost) drug and the more costly drug.

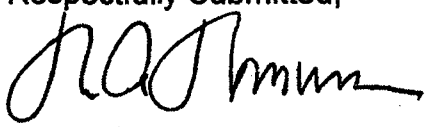
According to the company, co-payments for the non-preferred drug could be as high as $143 for statins, $142 for proton-pump inhibitors and $89 for certain types of antihistamines. It is important to note that all medicines within a specific drug class are not the same. Medications intended to treat the same condition may have different active ingredients and work differently. They also may have different side effects, dosages and risks.

We oppose reference-based pricing because it can interfere with a physician's ability to tailor treatments to individual patients, and the potential to cause differential access to care based upon a patient's ability to pay. Most people cannot afford these expensive co-payments and may go without medication resulting in more expensive hospitalization and emergency room visits.

However, we are very concerned about the changes made to Part III of the bill, which inserts the provisions of S.B. 2494, S.D. 2. but with certain amendments. In S.B. 2494, S.D. 2, EUTF members were covered under the proposed statutory changes to Chapters 431 and 432, HRS that protect patients by requiring that if they need a life-saving medication, they must receive it under any health insurance policy issued on or after July 1, 2010. Under H.B. 2461, H.D. 2, S.D. 1, members of the EUTF are excluded from similar protection. We are unsure about the rationale for such exclusion, but strongly recommend that the original language in S.B. 2492, S.D. 2 be reinserted to ensure that public employees are treated equally.

We also suggest reinserting the amendment to Section 87A-16, HRS which requires the EUTF during enrollment periods to continue the same prescription drug coverage for currently enrolled employee-beneficiaries and their dependents. Thank you for the opportunity to testify in support of H.B. 2461, H.D. 2, S.D. 1 with the suggested amendments.

Respectfully Submitted,



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Deputy Executive Director

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Wednesday March 31, 2010, 9:30am, Conference Room 211

To: COMMITTEE ON WAYS AND MEANS
Senator Donna Mercado Kim, Chair
Senator Shan S. Tsutsui, Vice Chair

From: Hawaii Medical Association
Gary A. Okamoto, MD, Legislative Co-Chair
Linda Rasmussen, MD, Legislative Co-Chair
April Donahue, Executive Director
Lauren Zirbel, Government Affairs
Dick Botti, Government Affairs

Re: HB2461 RELATING TO INSURANCE

Chairs & Committee Members:

HMA supports the intent of and would like to provide comments on HB2461 Relating to Insurance.

HMA supports the intent of Part I that creates a moratorium on reference-based pricing in the EUTF prescription drug plan while research is conducted. Reference-based pricing is a policy that often creates unreasonable administrative burdens on physicians, and can create delays in treatment that put patient safety at risk. More rounds of prior authorization and switches in drug formularies disrupt the flow of treatment and steal time away from direct patient contact. These administrative hurdles discourage the most dedicated physicians, leading them to reconsider or withdraw their participation.

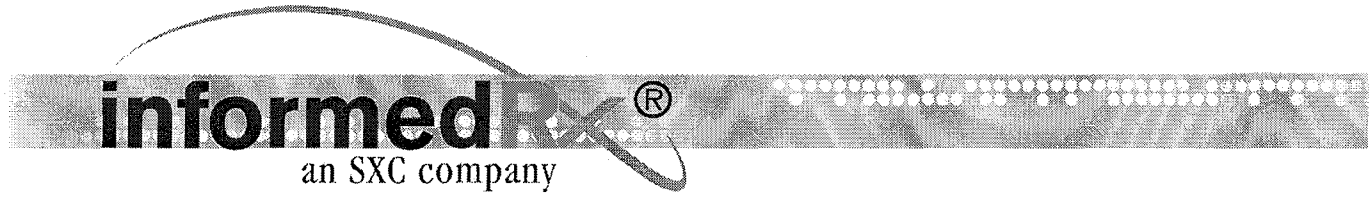
HMA appreciates amendments made to telehealth provisions from prior versions of HB2461 to create Part II, which relates to a mobile health van pilot program. Proceeding with caution will allow Hawaii to ensure that state programs in telehealth are implemented appropriately and to the benefit of patients. We would like to comment that it may be suitable to insert language encouraging the Department of Health to consult healthcare stakeholders such as HMA during the development of the program.

We support the intent of Part III that allows continuity of drug benefits and would help protect patients, particularly those with chronic conditions. Allowing patients to retain coverage of their current life-saving medications when they are forced to change from one health plan to the next will protect those who may suffer from interrupted care. When a patient's health coverage changes, new formularies can be very disruptive to their care, sometimes with life-threatening implications. Additionally, expecting providers to go through a new round of prior authorization requests and demands to switch drugs due to differing formularies can be very time consuming and burdensome for busy practitioners. It may lead providers to refuse to accept patients who are moved to plans with overly restrictive policies.

We would like to note that it may not be appropriate to require a health insurer or like entity to offer the same prescription drug benefits to insured individuals who voluntarily elect to change plans.

Problems with the administrative burdens of restrictive and cumbersome formularies are becoming severe, and the only practical way physicians can cope with them, especially those in solo practice, is to limit participation to only a few plans with manageable policies. It is no longer possible for physicians to participate in all plans because they would spend a quarter of their time (and lose a quarter of their income) trying to deal with prior authorizations and formulary restrictions. Attempts to minimize these burdens can help improve access to care and choice of physician for Hawaii residents.

Thank you for this opportunity to provide comments.



The Twenty-Fifth Legislature, State of Hawaii
Hawaii State Senate
Committee on Ways and Means

Testimony by
InformedRx
March 29, 2010

In consideration of
HOUSE BILL 2461 HD2 SD1
RELATING TO INSURANCE

InformedRx would like to provide comments on House Bill HB2461 HD2 SD1 Relating to Insurance.

House Bill HB2461 HD2 SD1 includes statements regarding the Reference Based Pricing program that the Hawaii Employer-Union Health Benefits Trust Fund has recently implemented in their prescription drug program for which we would like to provide information for your consideration. We would like to take this opportunity to provide clarification on components of the program and examples of similar programs that have been successfully implemented by other entities on the mainland.

The Reference Based Pricing program defines a ceiling or upper limit price based on the market price of a particular product within a broadly dispensed therapeutic category of drugs. This product is defined as the "Preferred Drug" in the category and provides a low cost co-payment to the participant and the plan sponsor. While the participants of the drug plan have the choice to take any of the products within the therapeutic class, the plan benefits will only cover up to the ceiling or upper limit price in the category. If participants remain on a product that is not defined as the "Preferred Drug" within a category, their cost share consists of any cost of the medication above the ceiling or upper limit price. This program does not force the participants to switch to the "Preferred Drug" nor does it shift the full cost of the prescription to the participant.

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All products within the reference based category are considered covered benefits of the plan up to the ceiling or upper limit price. Should a participant choose to switch to the "Preferred Drug" within the category, the plan benefits allow them to acquire up to three 30-day fills at the local retail pharmacy prior to moving to mail order. This allows the participant and their physician the time to determine if the newly prescribed alternative product is medically correct for them and addresses the possibility of wastage should a participant and physician determine the particular medications is not providing the desired benefit or outcome.

While managing the cost of prescription benefits is a service that is provided by Pharmacy Benefit Management organizations, providing high quality of health care is a key component of our business. The ability to effectively manage prescription drug costs are based on a multitude of decisions as to how tightly to control the participants access to certain medication through restricted networks or mail order to achieve the lowest price for the medications, as well as the EUTF's desire to implement step-edits or increased member payments to incent members to more cost effective, physician prescribed treatments. In this regard the EUTF, and its national advisor AON worked in a consultative manner with InformedRx to assess the most appropriate solution for the EUTF and its participants. These steps, although new to EUTF, reflect the economic realities facing the plan, and are plan design changes used by other plans throughout the United States. InformedRx further recognizes that health care is not a "one size fits all" industry and there are situations where the "Preferred product" in a program may not provide the best health outcome for a patient. For these exception cases, informedRx offers a review process known in the PBM industry as (Prior Authorizations) that are available for physicians to request any specific drug for any of their patients. The Prior Authorization process allows physicians to request coverage of a specific product for their patient based on medical necessity at the standard copayment. This Prior Authorization process has been in place since 2007 for the Hawaii Employer – Union Health Benefits Trust Fund.

As part of the implementation of the Reference Based Pricing program for the Hawaii Employer-Union Health Benefits Trust Fund, informedRx created special Prior Authorization forms

specifically for the Reference Based Pricing program. Our Customer Care Center as well as our Honolulu office is available to facilitate prior authorization requests and have assisted many EUTF participants by providing the necessary form and information to their physician. All informedRx Prior Authorizations are reviewed and determined by our clinical staff within a 3 business day turnaround time.

We would also like to comment on concerns that have been expressed that Reference Based Pricing programs have not been used in the United States. Of our client base we have a number of clients that have successfully implemented the Reference Based Pricing program for their membership and many clients that are looking to implement the program in the future. These clients consist of government programs similar to the EUTF, Managed Care organizations and individual employer groups. Safeway, a large employer both on the mainland and in Hawaii implemented this program with employees in California and Hawaii and has developed a robust Reference Based Pricing program within their pharmacy drug benefits. The Safeway Reference Based Program, began on November 26, 2007. Safeway implemented their program on two therapeutic categories, Statins & Proton Pump Inhibitors similar to the EUTF. Over the last few years, Safeway has added many therapeutic categories to their Reference Based Pricing program and currently have well over 20 categories. In measuring the success of the program, Safeway has publically reported that they have been able to keep their healthcare cost trend flat over the last 4 years while most other employers have experienced a 38% increase due in large part to the management of pharmaceuticals and other very innovative programs. In addition the State of Arkansas has also implemented Reference Based Pricing.

Thank you for this opportunity to provide comments on HB2461 HB2 SD1

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Senior Vice President, Sales and Account Management
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March 31, 2010

To: The Honorable Donna Mercado Kim
Chair, Senate Committee on Ways and Maeans

From: 'Ohana Health Plan

Re: House Bill 2461, House Draft 2, Senate Draft 1-Relating to Insurance

Hearing: Wednesday, March 31, 2010, 9:30 a.m.
Hawai'i State Capitol, Room 211

Since February 2009, 'Ohana Health Plan has provided services under the Hawai'i QUEST Expanded Access (QExA) program. 'Ohana is managed by a local team of experienced care professionals who embrace cultural diversity, advocate preventative care and facilitate communications between members and providers. Our philosophy is to place members and their families at the center of the health care continuum.

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.3 million Medicaid and Medicare members nationwide. 'Ohana is able to take the national experience in providing an 'Ohana care model that addresses local members' healthcare and health coordination needs.

Our comments of concern on this measure are limited to Part III only. We have no position on the other positions of this bill.

Part III of this measure was modified to put the prescriber in control of an insurance plan's drug formulary. 'Ohana Health Plan (OHP) allows for a 30-day transition period for new members, whereas Part III of this measure would allow the prescriber the ability to extend the transition period six months deferring health plan care management.

Part III is contradictory to OHP's mission of quality managed care. When a new patients switches over to 'Ohana from another plan, our local, Hawai'i-based staff conducts a full Health and Functional Assessment within 30 days to ensure that their Care Plan is current. Non-formulary medications are reviewed for safety, effectiveness and appropriateness. These clinical quality assurance steps are essential to providing good care for 'Ohana members and should not be delayed for up to 6 months.

As a managed care health plan, OHP's pharmacy services' mission is to provide safe, effective, appropriate medication therapy for our members. Providing medications needed to treat members' medical conditions helps prevent emergency room visits and hospitalizations which leads to overall cost savings. Denying appropriate medication therapy raises costs. 'Ohana's prior authorization process is thoughtful and applies national clinical standards for the benefit of 'Ohana members. Delays in quality assurance reviews will only delay the quality of care.

For the aforementioned reasons we respectfully request that you delete Part III of this measure. Thank you for the opportunity to provide these comments regarding Part III of House Bill 2461, House Draft 2, Senate Draft 1.