LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

March 25, 2010

MEMORANDUM

TO: Honorable Marcus R. Oshiro, Chair
House Committee on Finance

FROM: Lillian B. Koller, Director

SUBJECT: **S.B. 2494, S.D. 2, H.D. 2 – RELATINGTO INSURANCE**

Hearing: Thursday, March 25, 2010, 11:00 A.M.
Conference Room 308, State Capitol

PURPOSE: The purpose of Part I of this bill is to require EUTF health benefits plans to allow enrollees to continue the same prescription drug coverage for current enrollees, and applies this provision retroactively to the 2009 EUTF open enrollment period. Part II of this bill would prohibit the Department of Human Services (DHS) from requiring its approval for a Medicaid or QUEST health plan to deliver services through telehealth, and from requiring in-person health care visits to qualify telehealth services for coverage under these health plans.

DEPARTMENT'S POSITION: The DHS strongly opposes Part II of this bill regarding telehealth services for Medicaid and QUEST health plan patients. Part II of this bill potentially jeopardizes patient safety and exploits a low-income vulnerable population as well as requiring a new State general fund appropriation.

Any service provided by a contracted health plan that has not been authorized by DHS will not be reimbursed. Any service not approved by the federal Centers for Medicare and Medicaid Services will not be eligible for federal funding. This bill would require a new service and would need to be State-only funded, requiring a new general fund appropriation.

The provisions for telehealth in this bill eliminate DHS authority for oversight of an emerging technology. As with any new technology there are risks and benefits, and DHS has the responsibility to ensure the safety of its recipients. It is critical for DHS to be able to review scientific evidence in order to make informed decisions about patient safety.

DHS supports the use of telemedicine that has been demonstrated to be safe and effective, and we are quite willing to review data on safety, effectiveness, and cost-effectiveness for any new telemedicine technology. To date no data that demonstrate the safety and effectiveness of a new telemedicine technology have been shared with DHS. Although data have been shared by one health plan on an emerging technology, those data raised concerns rather than reassurances.

Telemedicine does have an important and growing role, when done in a safe and coordinated manner. A report by the federal Agency for Healthcare Research and Quality found that "studies of office/hospital-based telemedicine suggest that telemedicine is most effective for verbal interactions, e.g., videoconferencing for diagnosis and treatment in specialties like neurology and psychiatry." DHS has an ongoing telepsychiatry program through the University of Hawaii's John A. Burns School of Medicine Department of Psychiatry. DHS requires an initial face-to-face visit and then ongoing care occurs remotely. Requiring an initial face-to-face visit is important to establish the provider-patient relationship for ongoing care.

Through QUEST and QUEST Expanded Access, DHS medical assistance programs adhere to the concept of managed or coordinated care. The value of a primary care provider has been repeatedly demonstrated. An individual's direct consumption of healthcare resources outside of the primary care provider hamstrings efforts to coordinate care and instead further fragments healthcare. Online care is unmanaged care that allows patients to self refer to any provider available online. We would support telemedicine that enhanced managed care, but online care fragments it.

We should not be increasing access to harm. Although telemedicine can improve access, it is important that safety and quality should not be compromised. The quality of healthcare that can be provided is substantially limited in the absence of an established patient-provider relationship and without having clinical information including progress notes, laboratory data, and the ability to perform a physical examination. Given patient expectations and providers potentially being evaluated, there is a risk for increased prescribing and thereby an increased risk for adverse drug events. Unmanaged telemedicine could also increase inappropriate utilization and increase costs without improving outcomes.

DHS would be interested in pursuing the role of telemedicine to communicate with an individual's primary care provider or for a scheduled remoted consultation when referred by the primary care provider. These provisions would help ensure patient safety. Removing DHS' responsibility to ensure patient safety under this bill is dangerous.

Thank you for this opportunity to provide testimony.

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

ON THE FOLLOWING MEASURE:
S.B. NO. 2494, S.D. 2, H.D. 2, RELATING TO INSURANCE.

BEFORE THE:
HOUSE COMMITTEE ON FINANCE

DATE: Thursday, March 25, 2010 **TIME:** 11:00 a.m.

LOCATION: State Capitol, Room 308

TESTIFIER(S): Mark J. Bennett, Attorney General, or
Brian Aburano, Deputy Attorney General

Chair Oshiro and Members of the Committee:

The Department of the Attorney General has comments on this bill as currently drafted.

The bill amends section 87A-16, Hawaii Revised Statutes (HRS), to require the board of trustees of the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) to offer employee-beneficiaries and dependent-beneficiaries currently enrolled in EUTF health benefits plans coverage for prescription drug benefits that is identical to the coverage provided under their current plan. The bill also adds a new section to HRS chapter 346 to preclude the Department of Human Services from requiring: (1) the department's approval for health plans under the department's Medicaid or QUEST program to deliver services using a telehealth service, or (2) in-person visits to qualify any telehealth service under the department's Medicaid or QUEST program.

First, the bill provides that: (1) the provisions of the bill in section 1 that amend section 87A-16(c) shall retroactively apply to prescription drug plans of EUTF employee-beneficiaries and dependent-beneficiaries who enrolled in EUTH health plans during the open enrollment periods ending on December 7, 2009 (for active employees) and November 30, 2009

(for retirees); and (2) notwithstanding the close of such open enrollment periods, prior to an as yet unspecified date, such beneficiaries are to be offered the "identical" coverage for prescription drug benefits required under section 1 of the bill. See page 4, lines 8-22. The bill is not clear as to whether employee-beneficiaries and dependent-beneficiaries who elect the "identical" coverage are to have such coverage on a retroactive basis or only on a going forward basis. This should be clarified so that the parties involved may properly implement the bill if it is enacted.

Second, for purposes of the offering of identical prescription drug coverage, the bill defines coverage to mean "benefits, costs, and requirements for patient access to medical products and services as enumerated in the written explanation of benefits document issued by the board or pharmacy benefit manager". See page 2, lines 2-5. To avoid confusion in implementing the bill if enacted, it should be clarified that "costs" means those costs other than the premiums for the prescription drug coverage. This could be done by amending page 2, line 2 of the bill as follows:

> "Coverage" means the benefits, costs other than premiums, and requirements for ..."

Third, under article III, section 14 of the State Constitution, "[e]ach law shall embrace but one subject, which shall be expressed in its title." Given the liberal construction of this constitutional requirement, the title of this bill would probably be held to fairly indicate its subject or object. However, it should be noted that the EUTF prescription drug plan for active employees is self-funded or self-insured and that self-insurance is not "insurance". See Simmons v. Puu, 105 Haw. 112, 127, 94 P.3d 667 (2004).

AFSCME
LOCAL 152, AFL-CIO

888 Mililani Street, Suite 601
Honolulu, Hawaii 96813-2991

Telephone: 808.543.0000
Facsimile: 808.528.4059

www.hgea.org

The Twenty-Fifth Legislature, State of Hawaii
Hawaii State House of Representatives
Committee on Finance

Testimony by
Hawaii Government Employees Association
March 25, 2010

S.B. 2494, S.D. 2, H.D. 2 – RELATING TO INSURANCE

The Hawaii Government Employees Association, AFSCME Local 152, AFL-CIO, strongly supports the purpose and intent of S.B. 2494, S.D. 2, H.D. 2. The purpose of this bill is to require the Employer Union Health Benefits Trust Fund (EUTF) Board of Trustees to offer, during open enrollment and other enrollment periods, prescription drug coverage that is identical to the employee's or employee's dependent's current plan.

There is a need for this type of legislation because the trustees EUTF approved a prescription drug benefit plan which requires employees to fill their prescriptions for maintenance drugs with a company in Florida. In addition to the complaints from our members about poor service and delays in receiving medications, this same company 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.

Although we support ways to reduce health care costs, we cannot support a policy that forces our members to use a less effective drug because of financial considerations. Thank you for the opportunity to testify in support of S.B. 2494, S.D. 2, H.D. 2.

Respectfully Submitted,

Nora A. Nomura
Deputy Executive Director

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

Thursday, March 25, 2010, 11:00 A.M., Conference Room 308

To: COMMITTEE ON FINANCE
Rep. Marcus R. Oshiro, Chair
Rep. Marilyn B. Lee, 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: SB2494 RELATING TO INSURANCE

Chairs & Committee Members:

Hawaii Medical Association would like to provide comments on SB2494 Relating to Insurance.

We support the intent of Part I that allows continuity of drug benefits and would help protect EUTF patients, particularly those with chronic conditions. HMA would like to point out, however, that continuity of drug benefits is an issue that affects more patients in Hawaii than just EUTF, and while these provisions are a step in the right direction, they do not adequately address the entire situation.

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. Health insurers may consider it worthwhile to make their prescription drug benefits proprietary and a part of their competitive positioning. However, when a patient's health coverage changes, new formularies can be very disruptive to their care, sometimes with life threatening implications. New rounds of prior authorization requests and demands to switch drugs due to differing formularies can be very time consuming and burdensome for busy practitioners, and may lead providers to refuse to accept patients who are moved to plans with overly restrictive policies.

HMA would like to suggest amendments to Part II, which relates to telehealth. The language is currently unclear and too broad, and may create an unsustainable financial burden for Hawaii's Medicaid program. We recommend the committee review the Centers for Medicare and Medicaid Services (CMS) policy on telehealth for appropriate wording. Please see attached. Using this as a basis for Medicaid will ensure parity with national policies.

Thank you for this opportunity to provide comments.

The official CMS policy reads as follows:

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management. These services and corresponding current procedure terminology (CPT) codes are listed below.[1]

- Consultations (CPT codes 99241 - 99275).
- Office or other outpatient visits (CPT codes 99201 - 99215).
- Individual psychotherapy (CPT codes 90804 - 90809).
- Pharmacologic management (CPT code 90862).
- Psychiatric diagnostic interview examination (CPT code 90801).
- End stage renal disease related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318).
- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803).
- Neurobehavioral status exam (CPT code 96116).

Only the following health professionals may claim reimbursement for remote telehealth services:[2]

- Physician;
- Nurse practitioner;
- Physician assistant;
- Nurse midwife;
- Clinical nurse specialist;
- Clinical psychologist;*
- Clinical social worker;* and
- Registered dietitian or nutrition professional.

* Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

Only the following facilities are eligible to be an originating site under the rules of the program:[3]

- The office of a physician or practitioner.
- A hospital.
- A critical access hospital.
- A rural health clinic.
- A federally qualified health center.
- A Skilled nursing facility (as of January 1, 2009).
- A hospital-based dialysis center (as of January 1, 2009).
- A community mental health center (as of January 1, 2009).

Remote Non Face-to-Face Services[4]
A service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.

For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of a verbal description) is a covered service.

---

[1] CMS Internet Only Manual 100-02, Medicare Benefit Policy Manual, Chapter 15-Covered Medical and Other Health Services, Part 270.02 - List of Medicare Telehealth Services
[2] Ibid, Part 270.4 – Payment – Physician/Practitioner at a Distant Site
[3] Ibid, Part 270.01 – Eligibility Criteria
[4] Medicare benefit policy manual, Part 15 – Covered Medical and Other Health Services, 30-Physician Services pp 10-11.

Use of Telehealth in Delivery of Home Health Services
(Rev. 1, 10-01-03)
PM A-01-02, HHA-201.13

Section 1895(e) of the Act governs the home health prospective payment system (PPS) and provides that telehealth services are outside the scope of the Medicare home health benefit and home health PPS.

This provision does not provide coverage or payment for Medicare home health services provided via a telecommunications system. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the home health PPS, or any covered home health service paid outside of the home health PPS. As stated in 42 CFR 409.48(c), a visit is an episode of personal contact with the beneficiary by staff of the home health agency (HHA), or others under arrangements with the HHA for the purposes of providing a covered service. The provision clarifies that there is nothing to preclude an HHA from adopting telemedicine or other technologies that they believe promote efficiencies, but that those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit. This provision does not waive the current statutory requirement for a physician certification of a home health plan of care under current §§1814(a)(2)(C) or 1835(a)(2)(A) of the Act. [5]

[5] Medicare Benefit Policy Manual Chapter 7 Home Health Services, Part 110

Mental Health America of Hawai`i

. . . Helping Hawai`i Live Life Well

1124 Fort Street Mall, Suite 205. Honolulu, HI 96813
Accessible Entrance: 67 South Pauahi off Bethel Ph. 808.521.1846
F: 808.533.6995 E: info@mentalhealth-hi.org W: www.mentalhealth-hi.org

March 24, 2010
TO: House Finance Committee Rep. Marcus Oshiro, Chair; Rep. Marilyn Lee, Vice Chair, and members
Re: Hearing March 25, 11 am, room 308

STRONG SUPPORT FOR SB2494 SD2 HD2

Dear Representatives:

Mental Health America of Hawaii strongly supports SB2494 SD2HD2, which enables patients who enroll in new health plans to continue coverage for their same prescription medications.

Medications for mental illnesses they vary greatly in their effectiveness in treating specific symptoms or disorders as well as in their side effects. There are great difference in responses to medications by different individuals. Not everyone responds the same to a given treatment. Treatment decisions are complex, combining both a thorough understanding of pharmacology and a detailed knowledge of a patient's unique condition and medical history.

It can take months and many trials with many different medications to stabilize a mental health patient on the right medication or combination of medications. Therefore, mental health patients who are suddenly switched to a different medicine may suffer both physically and psychiatrically, and this could trigger more costly treatment, such as additional physician visits, ER visits, and even hospitalization.

That is why Mental Health America of Hawai`i urges your support for SB2464, which would insure stability and continuity in medication if there is a change in the patient's health insurance. Mahalo for the opportunity to provide testimony.

Sincerely yours,

Marya Grambs, Executive Director

American Cancer Society®

The Official Sponsor of Birthdays

March 24, 2010

Committee on Finance
Representative Marcus Oshiro, Chair
Representative Marilyn Lee, Vice Chair

Hearing:
11:00 A.M. Thursday, March 25, 2010
Hawaii State Capitol, Room 308

RE: SB2494, SD2, HD2 – Relating to Insurance

Testimony in Support with Comments

Chair Oshiro, Vice Chair Lee, and members of the Committee on Finance. Thank you for the opportunity to testify in support and provide comments regarding SB2494, SD2, HD2, which requires EUTF health benefits plans to allow enrollees to continue the same prescription drug coverage for current enrollees, and applies this provision retroactively to the 2009 EUTF open enrollment period. It would also prohibit the Department of Human Services from requiring its approval for a Medicaid or QUEST health plan to deliver services through telehealth, and requiring in-person health care visits to qualify telehealth services for coverage under these health plans.

We are limiting our testimony to Part I that addresses EUTF plan benefits. The original intent of this bill was to ensure prescription drug coverage for all patients who, through no fault of their own, would experience a change in their health insurance plan and may not be able to obtain the same medications that they were on with their previous health plan provider. This intent was inclusive, unlike the HD2 which is now exclusive to EUTF members.

However, the Cancer Society believes it is crucial for <u>all patients</u>, actively undergoing chemotherapy, retain their prescribed treatment regimen, and depending upon the type of cancer, may require a specific cocktail of anticancer drugs consisting of both brand name and generic drugs; as well adjunct medications that treat the uncomfortable side effects of chemotherapy. To change a patient's drug treatment regimen to meet the prescription formulary of a new insurance carrier could be life-threatening.

We would also like to point out to the committee members of the possible financial consequences that this may cause by forcing cancer patients to pay full price for critical medications at a time when their financial resources are limited. This burden echoes a similar situation for EUTF members. It is our understanding is that current EUTF policy limits access to some medications used to treat the side effects of chemotherapy such a gastric reflux.

American Cancer Society Hawai'i Pacific, Inc., 2370 Nu'uanu Avenue, Honolulu, Hawaii 96817-1714
•Phone: (808) 595-7500 •Fax: (808) 595-7502 •24-Hour Cancer Info: (800) 227-2345 •http://www.cancer.org

In closing, we would note that we continue to believe that this measure, as **originally intended,** would have been extremely beneficial for all patients regardless of insurance plan coverage undergoing active chemotherapy, and would assure them that their drug regimen will not change because of changes in their health insurance carriers.

Thank you for the opportunity to offer testimony here today.

George Massengale, J.D.
Director of Government Relations