DAVID Y. IGE
GOVERNOR

DOUGLAS S. CHIN
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

335 MERCHANT STREET, ROOM 310
P.O. Box 541
HONOLULU, HAWAII 96809
Phone Number: 586-2850
Fax Number: 586-2856
cca.hawaii.gov

CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON
CONSUMER PROTECTION AND COMMERCE

TWENTY-NINTH LEGISLATURE
Regular Session of 2018

Friday, February 9, 2018
2:00 pm

TESTIMONY ON HOUSE BILL NO. 1603, H.D. 1, RELATING TO HEALTH INSURANCE.

TO THE HONORABLE ROY M. TAKUMI, CHAIR, AND MEMBERS OF THE COMMITTEE:

The Department of Commerce and Consumer Affairs ("Department") appreciates the opportunity to testify on H.B. 1603, H.D. 1, Relating to Health Insurance. My name is Gordon Ito, and I am the Insurance Commissioner for the Department's Insurance Division ("Division"). The Department offers the following comments.

The purpose of this bill is to add a mandated health insurance benefit for treatment of opioid dependence at in-network facilities.

The language on page 6, lines 17-21, may cause insurers and service providers to seek remedies from the Division for contractual obligations or restrictions, as it creates a provision in Hawaii Revised Statutes ("HRS") chapter 431M that is directly imposed on providers. The Division may not be the most appropriate entity for regulating service providers, as these providers may already be subject to regulation by other licensing authorities. In addition, the Division does not have processes in place for investigating and bringing enforcement actions against service providers and does not have authority to enforce contractual obligations between insurers and providers.

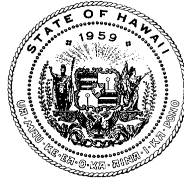
On page 8, lines 12-13 and lines 17-20, the term “medical necessity” may cause confusion with how it is defined in the Patient’s Bill of Rights and Responsibilities Act under HRS section 432E-1.4. Lines 12-13 of the bill state, “medical necessity shall be as determined by the covered person’s physician.” In contrast, HRS section 432E-1.4 provides that a physician’s recommendation is only one element of “medical necessity.” Lines 17-20 of the bill state, “[b]enefits . . . shall be subject to the medical necessity determination of the coverage provider[.]” This may cause confusion as to whether “medical necessity” under HRS section 432E-1.4 applies to the relevant benefits or relies upon the determination of an insurer.

Further, the addition of a new mandated coverage may trigger section 1311(d)(3) of the federal Patient Protection and Affordable Care Act (“PPACA”), which requires states to defray the additional cost of any benefits in excess of the essential health benefits of the State’s qualified health plan under PPACA.

Finally, any proposed mandated health insurance coverage requires the passage of a concurrent resolution requesting the State Auditor to prepare and submit a report assessing the social and financial impacts of the proposed mandate, pursuant to HRS section 23-51. Therefore, we respectfully request that this bill be amended so that the State Auditor is tasked with reporting the economic impact of the expanded coverage on affected insurers.

Thank you for the opportunity to testify on this measure.

DAVID Y. IGE
GOVERNOR OF HAWAII



VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
doh.testimony@doh.hawaii.gov

Testimony COMMENTING on H.B. 1603 H.D. 1
RELATING TO HEALTH INSURANCE

REPRESENTATIVE ROY M. TAKUMI, CHAIR
HOUSE COMMITTEE ON CONSUMER PROTECTION & COMMERCE

Hearing Date: February 9, 2018 Room Number: 329

1 **Fiscal Implications:** Not determined although a cost analysis of the proposed benefits structure
2 should be conducted and compared with the cost of providing treatment for the abuse of non-
3 opioid substances.

4 **Department Testimony:** The Department of Health (DOH) defers to DCCA on the proposed
5 amendments to HRS Chapter 431M regarding a benefits structure for inpatient and outpatient
6 opioid treatment. The DOH, upon further study of the bill respectfully offers the following
7 comments:

8 First, H.B. 1603 H.D.1 appears to favor "inpatient and outpatient treatment" but does not
9 recognize the value of all treatment modalities to treat drug addiction. ADAD employs a
10 continuum of service modalities available statewide to individuals and families with alcohol and
11 other drug problems. The actual continuum of care to combat drug addiction includes: Pre-
12 Treatment and Pre-Recovery Support, Treatment Services which include an Assessment and
13 Updated Assessments on regular intervals, Interim Services, Addiction Care Coordination,
14 Residential Treatment, Day Treatment, Intensive Outpatient and Outpatient Treatment; Opioid
15 Recovery Services; and Recovery Support Services which include Recovery Assessment and
16 Updated Assessment, Therapeutic Living, Clean and Sober Housing and Continuing Care
17 Services and Follow-Up Surveys.

18 Second, ADAD requires its contracted care providers utilize the most current version of
19 the American Society for Addiction Medicine Patient Placement Criteria (ASAM PPC) for
20 determining the most appropriate and effective level of care. ASAM is the "industry standard"

1 for determining level of care placement and also informs length of stay based on six
2 "dimensions". The six dimensions:

- 3 Explore an individual's past and current experiences of substance use and
4 withdrawal;
- 5 Explore an individual's health history and current physical condition;
- 6 Explore an individual's thoughts, emotions, and mental health issues;
- 7 Explore an individual's readiness and interest in changing;
- 8 Explore an individual's unique relationship with relapse or continued use or
9 problems; and
- 10 Also explore an individual's recovery or living situation, and the surrounding
11 people, places, and things.

12 These decisions are based on the individual's response to treatment, and similar to many other
13 chronic illnesses are generally not static and are not easily generalized to an arbitrary timeframe.

14 Third, substance use services are already covered under most insurance plans, including
15 Medicaid, based on clinical necessity. Pre-proscribing levels of care and lengths of stay may
16 cause unforeseen impacts on the overall availability of services for persons struggling with
17 chronic substance abuse. The DOH continues to work with the Medicaid administrator of the
18 Department of Human Services to address barriers to access and quality of care. The Hawaii
19 Opioid Action Plan released in December, 2017 outlines a comprehensive and multisystemic
20 roadmap for addressing opioids and other substance abuse in the state from a balanced public
21 health/public safety approach.

22 Finally, the DOH would respectively point out that opioid misuse represents only one
23 facet of the broader addiction problem in Hawaii, since those who suffer from addiction often
24 misuse more than one substance. According to the Hawaii Opioid Action Plan (Dec. 2017):

- 25 There are an average of nearly 400 nonfatal overdose incidents each year, nearly
26 half of which require hospitalization; and
- 27 The issue of opioid misuse and addiction cannot be fully appreciated unless seen
28 from a broader context of a chronic illness perspective, which shows that

1 substance misuse and addiction represents significant public health and economic
2 burdens for Hawaii:

3 - Workplace drug tests positive for methamphetamine were 410% higher
4 than the national average in 2011;
5 - Impaired driving deaths in Hawaii (2010-2014) were 39.4% compared to
6 the national average of 30.0%; and
7 - Data from ADAD-funded providers suggests that methamphetamine was
8 reported as the primary drug of choice upon admission for 53.4% of adults
9 receiving substance misuse treatment in FY2017.

10 Treatment admission data from 2010-2016 in Hawaii further underscores the need for a
11 focus on the broader addiction issue in the state and for a coordinated and comprehensive
12 approach to addiction in Hawaii.

13 The DOH, Alcohol and Drug Abuse Division (ADAD) believes that focusing on the
14 overall system of substance abuse prevention, treatment and recovery is paramount and that
15 creating policy focused on one substance of abuse does not adequately encompass this goal.
16 This stance is presented in more detail in the Hawaii Opioid Action Plan.

17 Thank you for the opportunity to provide testimony.

HB-1603-HD-1
Submitted on: 2/8/2018 1:55:43 PM
Testimony for CPC on 2/9/2018 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Melodie Aduja	OCC Legislative Priorities	Support	No

Comments:

February 9, 2018

The Honorable Roy M. Takumi, Chair
The Honorable Linda Ichiyama, Vice Chair
House Committee on Consumer Affairs and Commerce

Re: HB 1603, HD1 – Relating to Health Insurance

Dear Chair Takumi, Vice Chair Ichiyama, and Committee Members:

The Hawaii Medical Association (HMSA) appreciates the opportunity to testify on HB 1603, HD1, which would require health insurers, mutual benefit societies, and health maintenance organizations to provide health care coverage and benefits for a minimum of six months of inpatient and outpatient treatment for opioid dependence beginning after December 31, 2018. We appreciate the intent of this measure and provide the following comments.

HMSA acknowledges and appreciates the detrimental impact that opioid addiction has on our state. As such, we continue to work with stakeholders at all levels to prevent and treat opioid addiction and commend the state for its interim report on addressing opioid addiction. While we do support the intent of HB 1603, we urge the Committee to consider the following:

- HMSA currently covers addiction associated services; however, this Bill would require plans to potentially include new and "unlimited" services under a formal benefit;
- Requiring that services be rendered at a treatment facility within a twenty-four hour period regardless of whether that facility is in-network could pose challenges for managing the benefit and also result in a member paying more out-of-pocket if the facility is not par;
- This bill would prevent plans from standard health management reviews for the first twenty-eight days of treatment; this deviates from normal medical review processes which are in place to protect the health and safety of our members;
- Medically necessary treatment should be determined by a healthcare provider. Current HMSA policy defers to the member's primary care physician, or appropriate provider, to determine what is medically necessary treatment;
- Finally, we would urge the Committee to consider whether this Bill would potentially conflict with existing federal regulations that govern mental health requirements.

Thank you for allowing us to testify on HB1603, HD1.

Sincerely,

Jennifer Diesman
Senior Vice-President-Government Relations

Testimony of
John M. Kirimitsu
Legal & Government Relations Consultant

Before:
House Committee on Consumer Protection & Commerce
The Honorable Roy M. Takumi, Chair
The Honorable Linda Ichiyama, Vice Chair

February 9, 2018
2:00 pm
Conference Room 329

Re: HB 1603, HD1, Relating to Health Insurance

Chair, Vice Chair, and committee members, thank you for this opportunity to provide testimony on this measure regarding mandated health coverage for a minimum of six months of outpatient and inpatient treatment for opioid dependency.

Kaiser Permanente Hawaii appreciates the intent of this bill, but nevertheless opposes this bill as drafted.

Kaiser Permanente appreciates the legislative efforts to tackle the serious issues affecting people with substance use disorders and their ability to get effective treatment. We agree that people with substance use disorders need to have access to effective treatments with minimal barriers. However, we question whether the current gaps in access are due to insurance coverage barriers and we fear the proposed legislation may have the unintended consequence of worsening these gaps.

1. <u>The Federal And State Mental Health Parity Laws Already Require Health Plans To Provide Substance Abuse Coverage At Parity With Medical Coverage.</u>

Today, the federal Mental Health Parity and Addiction Equity Act of 2008 as well as Hawaii's mental parity law (HRS §431M-2) already require health insurers to provide mental health/substance abuse coverage <u>at parity</u> with medical/surgical coverage. *At parity* means that health plans coverage for mental health/substance abuse and for medical treatment/surgery are comparable. Thus, health plans ensure that coverage is at parity for: co-pays, coinsurance, and out-of-pocket maximums, limits on the number of and length of covered inpatient/outpatient visits, out-of-network coverage, and medical necessity criteria. In other words, health plans cannot make mental health and substance abuse coverage *more difficult* and *more expensive* to

711 Kapiolani Blvd
Honolulu, Hawaii 96813
Telephone: 808-432-5224
Facsimile: 808-432-5906
Mobile: 808-282-6642
E-mail: John.M.Kirimitsu@kp.org

obtain than standard medical or surgical coverage. The parity law recognizes that mental health treatment was often limited in the past due to practices that made mental health coverage more restrictive.

2. Utilization Review Is Essential To Ensure: (1) Access To Available Treatment For Substance Abuse Patients and (2) Substance Abuse Patients Are Receiving The Proper Evidenced-Based Care.

Substance abuse disorders are chronic health conditions. Evidence supports sustained, long-term treatments for these chronic conditions, typically provided in outpatient settings, are most effective. This legislation would encourage the use of short-term, intensive treatments, i.e., 28 days inpatient – even for patients who could and should be treated in other care settings, leaving fewer spots available for other substance abuse patients who actually need the intensive, inpatient treatment. This would also divert more resources, workforce and investment to provide higher-intensity short-term treatments, which are not those associated with the best outcomes for opioid abuse patients, i.e., primary treatment for opiates is longer term outpatient. Therefore, utilization review and payer-administered medical necessity review are essential to ensure availability for those most in need of these short term, intensive care.

Additionally, a leading report published in 2012 by the National Center on Addiction and Substance Abuse (CASA) at Columbia University concluded that "the vast majority of people in need of addiction treatment do not receive anything that approximates evidence-based care" and "Only a small fraction of individuals receive interventions or treatment consistent with scientific knowledge about what works." A copy of this CASA report can be found at https://www.centeronaddiction.org/addiction-research/reports/addiction-medicine-closing-gap-between-science-and-practice. In short, evidence-based practices are treatments that integrate professional research and clinical expertise to achieve the best outcome for an individual. Within the standards of evidence-based medicine, health care professionals are generally expected to provide treatment with the best current scientific evidence of efficacy.

For its inpatient substance abuse treatments, Kaiser Permanente outsources these services by contracting with the only three evidenced-based residential receiving treatment facilities on Oahu: Poalani, Hina Mauka, and The Salvation Army. Therefore, following Kaiser Permanente's practice of only referring substance abuse patients to evidenced-based treating facilities, such utilization review is necessary to ensure that these substance abuse patients are receiving the proper evidenced-based care.

3. A Frequent Barrier To Treatment of Substance Abuse Disorders Is The Lack Of Access To Evidenced-Based Treatment Facilities.

It is well-recognized that the wait listing of substance abuse patients is a frequent barrier to effective treatment. A copy of the NCBI publication,"Waiting Time as a Barrier to Treatment Entry: Perceptions of Substance Users" (May 27, 2008), can be found at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2396562/. That NCBI report concluded:

> *Many substance users report that they experience multiple barriers that produce significant challenges to linking with treatment services. Being on a waiting list is frequently mentioned as a barrier, leading some people to give up on treatment and to continue using[.]"*

Similarly, Kaiser Permanente recognizes a lack of access as an impediment to its treatment of substance abuse disorders, including opioid abuse. Notably, it is the receiving treating facility, not the provider, who has the sole discretion/decision-making as to who is accepted into their treating program. As such, through no fault of Kaiser Permanente, these substance abuse patients are oftentimes wait listed if the receiving facilities reject the admission request. Consequently, this lack of access to available receiving facilities would also prevent providers from meeting this bill's stringent requirement of ensuring admission in a treatment facility within twenty-four hours (if there is no in-network facility immediately available). See Page 6, Lines 12-16.

Furthermore, this bill's prioritization of the opioid illness over other substance abuse disorders would create even a greater gap in access because opioid admissions would displace other substance abuse admissions, i.e. alcohol, cocaine, amphetamines, etc. This would create an even greater wait listed time due to an increased unavailability of treatment facility resources.

In conclusion, Kaiser Permanente continues to practice preventative health care in an attempt to prevent substance abuse addictions by promoting prevention methods such as overdose prevention, education, counseling, and disease management, as part of its preventative practices. An alternative to this bill, Kaiser Permanente encourages the legislature to consider alternatives such as:

- Increasing integration of treatment availability in primary care and other non-specialty care settings;
- Improving access to long-term, out-patient evidenced-based treatment options; and
- Increasing the supply of trained workforce and qualified providers.

For the above-referenced reasons, Kaiser Permanent asks that this bill be deferred.

Thank you for the opportunity to comment.

Dedicated to safe, responsible, humane and effective drug policies since 1993

TO: House Committee on Health and Human Services
FROM: Carl Bergquist, Executive Director
HEARING DATE: 9 February 2018, 2PM
RE: HB1603 HD1, Relating to Health Insurance, **STRONG SUPPORT**

Dear Chair Takumi, Vice Chair Ichiyama, Committee Members:

The Drug Policy Forum of Hawai'i (DPFHI) **strongly supports** this amended measure to require health insurers, mutual benefit societies, and health maintenance organizations to provide health care coverage and benefits for diagnosed with opioid dependence. There can be little doubt that health insurers have played a significant role in creating the opioid epidemic, and that they have to date been resistant to playing a constructive role in resolving it. Hawai'i, via the Office of the Attorney General has joined other states in tackling the opioid epidemic, e.g. via a multistate probe targeting drug manufacturers and in a letter urging the health insurance industry to change their practices.

We believe that this bill is a complement to these ongoing efforts by the State as well as the implementation of the Hawai'i Opioid Initiative, a statewide plan informed by a hui of which DPFHI is part. That plan clearly states the opioid use, including heroin, is increasing among many groups including those with private health insurance. Indeed, the likelihood of anyone already addicted to prescription painkillers becoming addicted to heroin is 40x than the average person, compared to 2x for someone addicted to alcohol. With the increasing frequency of the even more potent fentanyl, which has almost entirely replaced heroin in some areas of the US, the urgency keeps growing.

Finally, we recognize that in their letter to the health insurers, Hawaii's and others attorneys-general call for the "non-opioid" pain management options. One of those options is medical cannabis, a medicine recognized by Hawai'i since 2000 and now becoming more widely available in different forms via the nascent dispensary system. HB1893, which proposes to add "opioid use disorder" as a qualifying debilitating condition for certification of the use of medical cannabis, helps address this. Both of these bills thus form part of a broader, holistic approach to the opioid epidemic, and can help Hawaii's suffering community members and their families battle addiction.

Thank you for the opportunity to testify.

P.O. Box 83, Honolulu, HI 96810-0083 Phone: 808-518-3213 Email: info@dpfhi.org
Website: www.dpfhi.org

HB-1603-HD-1
Submitted on: 2/7/2018 2:32:17 PM
Testimony for CPC on 2/9/2018 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
pat gegen		Support	No

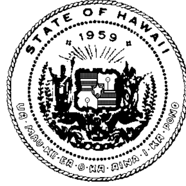
Comments:

HB-1603-HD-1
Submitted on: 2/7/2018 12:32:35 PM
Testimony for CPC on 2/9/2018 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Margaret Maupin		Support	No

Comments:

DAVID Y. IGE
GOVERNOR



LATE

PANKAJ BHANOT
DIRECTOR

CATHY BETTS
DEPUTY DIRECTOR

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

February 9, 2018

TO: The Honorable Representative Roy M. Takumi, Chair
House Committee on Commerce and Consumer Protection

FROM: Pankaj Bhanot, Director

SUBJECT: **HB 1603 HD1 – RELATING TO HEALTH INSURANCE**

Hearing: Friday, February 9, 2018, 2:00 p.m.
Conference Room 329, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) appreciates the intent. However, we offer comments with some concerns.

PURPOSE: The purpose of the bill requires health insurers, mutual benefit societies, and health maintenance organizations to provide health care coverage and benefits for a minimum of 6 months of inpatient and outpatient treatment for opioid dependence beginning after 12/31/2018.

The State's Medicaid program, QUEST Integration (QI), already provides coverage for substance use disorders in general, and opioid use disorder treatments, specifically. The managed care health plans provide a variety of services for inpatient services including detoxification, partial hospitalization, and prescription access to naloxone (that reverses life-threatening effects of opioid overdose) as well as medications for medication-assisted treatment and counseling.

DHS has reservations as to implementation of the conditions articulated in measure. Opioid dependency treatment should take into consideration the medical and health needs of the individual. Thus, diagnoses and co-occurring disorders do affect the best practices for the treatment of the opioid addiction, and should be taken into

consideration for treatment. Prescribing treatment modalities of inpatient and outpatient for the treatment of opioids does not take into consideration the multiple evidence-based clinically appropriate treatment options. Additionally, any length of inpatient or outpatient treatment should be based on the individual's needs, not set at arbitrary lengths. Finally, there are other substance use disorders that are at a higher prevalence in the state. Thus, DHS would support continued focus on substance use disorders in general in which the opioid disorder treatments are one facet. This is the approach that is outlined in the state's Hawaii Opioid Action Plan (Dec. 2017)

Thank you for the opportunity to provide comments on this measure.

DAVID Y. IGE
GOVERNOR

PANKAJ BHANOT
DIRECTOR

CATHY BETTS
DEPUTY DIRECTOR

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

LATE TESTIMONY

February 9, 2018

TO: The Honorable Representative Roy M. Takumi, Chair
House Committee on Commerce and Consumer Protection

FROM: Pankaj Bhanot, Director

SUBJECT: **HB 1603 HD1 – RELATING TO HEALTH INSURANCE**

Hearing: Friday, February 9, 2018, 2:00 p.m.
Conference Room 329, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) appreciates the intent. However, we offer comments with some concerns.

PURPOSE: The purpose of the bill requires health insurers, mutual benefit societies, and health maintenance organizations to provide health care coverage and benefits for a minimum of 6 months of inpatient and outpatient treatment for opioid dependence beginning after 12/31/2018.

The State's Medicaid program, QUEST Integration (QI), already provides coverage for substance use disorders in general, and opioid use disorder treatments, specifically. The managed care health plans provide a variety of services for inpatient services including detoxification, partial hospitalization, and prescription access to naloxone (that reverses life-threatening effects of opioid overdose) as well as medications for medication-assisted treatment and counseling.

DHS has reservations as to implementation of the conditions articulated in measure. Opioid dependency treatment should take into consideration the medical and health needs of the individual. Thus, diagnoses and co-occurring disorders do affect the best practices for the treatment of the opioid addiction, and should be taken into

consideration for treatment. Prescribing treatment modalities of inpatient and outpatient for the treatment of opioids does not take into consideration the multiple evidence-based clinically appropriate treatment options. Additionally, any length of inpatient or outpatient treatment should be based on the individual's needs, not set at arbitrary lengths. Finally, there are other substance use disorders that are at a higher prevalence in the state. Thus, DHS would support continued focus on substance use disorders in general in which the opioid disorder treatments are one facet. This is the approach that is outlined in the state's Hawaii Opioid Action Plan (Dec. 2017)

Thank you for the opportunity to provide comments on this measure.