TESTIMONY BY GEORGINA K. KAWAMURA
DIRECTOR, DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE HOUSE COMMITTEE ON CONSUMER PROTECTION AND COMMERCE
ON
SENATE BILL NO. 2494, S.D. 2, H.D. 1

March 17, 2010

RELATING TO INSURANCE

Senate Bill No. 2494, S.D. 2, H.D. 1, requires the Employer-Union Health Benefits Trust Fund plans to allow enrollees to continue the same prescription drug coverage for current enrollees, and applies this provision retroactively to the 2009 Employer-Union Health Benefits Trust Fund open enrollment period. The bill also prohibits the Department of Human Services 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.

We strongly oppose the bill as the amendments in Section 87A-16(c) will restrict the Employer-Union Health Benefits Trust Fund's ability to contract and/or bargain for the most cost-effective plans for its members.

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
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HENRY OLIVA
DEPUTY DIRECTOR

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

March 17, 2010

MEMORANDUM

TO: Honorable Robert N. Herkes, Chair
House Committee on Consumer Protection and Commerce

FROM: Lillian B. Koller, Director

SUBJECT: **S.B. 2494, S.D. 2, H.D. 1 – RELATINGTO INSURANCE**

Hearing: Wednesday, March 17, 2010, 2:00 P.M.
Conference Room 325, 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 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 Department of Human Services (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.

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 despite DHS voiced opposition, would be state-only funded, and would require a new 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.

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.

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.

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.

The Official Sponsor of Birthdays

March 15, 2010

Committee on Consumer Protection & Commerce
Representative Robert Herkes, Chair
Representative Glenn Wakai, Vice Chair

Hearing:
2:00 P.M. Wednesday, March 17, 2010
Hawaii State Capitol, Room 325

RE: SB2494, SD2, HD1 – Relating to Insurance

Testimony in Partial Support with Recommendations

Chair Herkes, Vice Chair Wakai, and members of the Committee on Consumer Protection & Commerce. Thank you for the opportunity to testify in partial support of SB2494, SD2, HD1 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 also prohibits the Department of Human Services 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.

The American Cancer Society is limiting its testimony and recommendations to those portions of the bill that address the continuity of drug coverage. The original intent of this bill and Senate bill SB2494 would ensure prescription drug coverage for 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.

The Cancer Society believes it is crucial that all patients, 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. A similar situation may also occur for EUTF members. 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

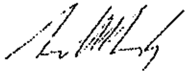
Because of the now limited scope of both SB2492 and the House measure HB2461 in providing continuity of prescription drug coverage to the population at large, we strongly recommend that the committee reinsert the language of the Senate measure, SB2494, SD2, to once again include all insured individuals while retaining the amended language regarding EUTF members.

Having reviewed testimony submitted by the opponents of this measure and HB2461, we do not fully concur that ERISA is preemptive in this situation because of our Prepaid Heath Care Act.

We believe that this measure, as **originally intended,** would be extremely beneficial for patients undergoing active chemotherapy, and would assure them that their drug regimen will not change because of changes in their health insurance carriers.

We strongly urge you to reinsert the amended language included in SB2494, SD2 as passed earlier by the full Senate.

Thank you for your consideration.



George Massengale, J.D.
Director of Government Relations

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Wednesday, March 17, 2010, 2:00 pm, Conference Room 325

To: COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Robert N. Herkes, Chair
Rep. Glenn Wakai, 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 HB2461 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. 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, and may lead providers to refuse to accept patients who are moved to plans with overly restrictive policies.

Please 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.

HMA would like to suggest amendments to Part II, which relates to telehealth. The language is currently unclear and too broad, and 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.

OFFICERS
President - Robert Marvit, MD President-Elect – Morris Mitsunaga, MD Secretary - Thomas Kosasa, MD
Immediate Past President – Gary Okamoto, MD Treasurer – Stephen Kemble, MD Executive Director – April Donahue

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.

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[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

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

March 17, 2010

The Honorable Robert Herkes, Chair
The Honorable Glenn Wakai, Vice Chair
House Committee on Consumer Protection and Commerce

Re: SB 2494 SD2 HD1– Relating to Insurance

Dear Chair Herkes, Vice Chair Wakai and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 2494 SD2 HD1. Part I of this measure would require EUTF to provide their members with prescription drug coverage which is identical to the prescription drug coverage they had been offered prior to changes being made to their prescription drug benefits. Part II of this measure would permit QUEST members gain access to telehealth services. We take no position on Part I of this measure and strongly support Part II.

Part II of this measure would allow health plans to offer telehealth services to QUEST members. As you are aware, the Department of Human Services (DHS) stated that due to budgetary shortfalls, they will delay payments to contracted QUEST plans, beginning in April and extending through June. This announcement has spurred discussions centered around the long term viability of the QUEST program and how to rein in costs in order to ensure it is sustainable in the future.

A project being planned on the Big Island of Hawaii may provide additional opportunities for QUEST members to access care in their communities which could help to decrease the incidence of individuals visiting the emergency room for non-emergent services. A medical van designated to operate on the Big Island has been funded and is currently in the planning stages. One large component of this effort is to enable the van to connect to specialists and other providers via telehealth services. Currently DHS will not allow QUEST members to access certain types of telehealth services such as HMSA's Online Care. We believe that the provision of services through this method could end up containing costs for the QUEST plans by ensuring that members with chronic diseases maintain their good health and those needing to see a physician are able to do so instead of potentially visiting the ER. We strongly support the language contained in Part II and would request the Committee see fit to pass this language as a means to increase access for QUEST members and to assist in containing cost.

Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

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The Twenty-Fifth Legislature, State of Hawaii
Hawaii State House of Representatives
Committee on Consumer Protection & Commerce

Testimony by
Hawaii Government Employees Association
March 17, 2010

S.B. 2494, S.D. 2, H.D. 1 – 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. 1. 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. 1.

Respectfully Submitted,

Nora A. Nomura
Deputy Executive Director