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Testimony of the Department of Commerce and Consumer Affairs

**Before the
Senate Committee on Commerce, Consumer Protection, and Health
Tuesday, February 4, 2020
9:30 a.m.
State Capitol, Conference Room 229**

**On the following measure:
S.B. 2284, RELATING TO HEALTH CARE INSURANCE**

Chair Baker and Members of the Committee:

My name is Colin Hayashida, and I am the Insurance Commissioner of the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purpose of this bill is to prohibit a health care insurer, mutual benefit society, or health maintenance organization from requiring an insured, a subscriber, a member, or an enrollee diagnosed with stage two through stage four cancer to undergo step therapy prior to covering the insured for the drug prescribed by the insured's health care provider, under certain conditions.

By prohibiting step therapy under certain conditions, this measure may create the potential for circumvention of medical necessity provisions in Hawaii Revised Statutes (HRS) section 432E-1.4. Section 432E-1.4(a) provides in relevant part, "A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health

interventions that do not meet the definition of medical necessity.” This bill may be construed as prohibiting step therapy without considering whether it is medically necessary.

Further, the Department has concerns that this bill is vague about whether a health plan **must** cover prescribed drugs if they meet **any** one of the requirements described in section 2, page 2, line 13 to page 3, line 2; section 3, page 4, lines 1 to 11; section 4, page 5, lines 10 to 20; or section 5, page 6, line 19 to page 7, line 9.

Additionally, insofar as this bill requires that certain drugs be covered without step therapy and is vague about the conditions under which drugs must be covered, this may be interpreted as establishing a new benefit mandate. The addition of new mandated coverage may trigger section 1311(d)(3) of the federal Patient Protection and Affordable Care Act (PPACA), which requires states to make payments to defray the costs of any benefits, in addition to the essential health benefits of the State’s qualified health plan under the PPACA. 45 Code of Federal Regulations section 155.170(a)(2) also provides that “[a] benefit **required by State action** taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered in addition to the essential health benefits” (emphasis added).

The federal Department of Health and Human Services (HHS) recently proposed rulemaking to the PPACA to address states’ defrayment and obligations. The HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans (HHS Notice)¹ states, in pertinent part: “At [45 CFR] § 156.111, we propose to require states to annually report to HHS . . . any state-required benefits applicable to the individual and/or small group market that are considered in addition to EHB[.]” HHS Notice at page 184. The HHS Notice further provides: “We are also proposing at [45 CFR] § 156.111(d)(2) to specify that if the state does not notify HHS of its required benefits considered to be in addition to EHB . . . HHS will determine which benefits are in addition to EHB for the state for the applicable plan year.” HHS Notice at page 140.

¹ This document is scheduled to be published on February 6, 2020. The unpublished PDF version is available at: <https://www.federalregister.gov/documents/2020/02/06/2020-02021/benefit-and-payment-parameters-notice-requirement-for-non-federal-governmental-plans>.

Furthermore, pursuant to HRS section 23-51, any proposed mandate providing coverage for care 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.

Lastly, the effective date of the bill conflicts with the applicability of certain provisions to plans issued on or after a date certain. While this bill purports to apply to health plans issued or renewed after December 31, 2019, the effective date of the bill is July 1, 2020. Therefore, any plans issued or renewed after December 31, 2019, but before the effective date of the bill may not have considered the bill provisions when establishing premium rates for plans.

Thank you for the opportunity to testify on this bill.

DAVID Y. IGE
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TESTIMONY BY DEREK MIZUNO
ADMINISTRATOR, HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE SENATE COMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND
HEALTH
ON SENATE BILL NO. 2284

February 4, 2020
9:30 p.m.
Room 229

RELATING TO HEALTH CARE INSURANCE

Chair Baker, Vice Chair Chang, and Members of the Committee:

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) Board of Trustees has not been able to take a position on this bill. Their next meeting is scheduled for February 18, 2020. However, please be aware that the EUTF medical and prescription drug plans do not require step therapy in place for oncology drugs.

Thank you for the opportunity to testify.

EUTF's Mission: We care for the health and well being of our beneficiaries by striving to provide quality benefit plans that are affordable, reliable, and meet their changing needs. We provide informed service that is excellent, courteous, and compassionate.

City Financial Tower, 201 Merchant Street, Suite 1700, Honolulu, Hawaii 96813



February 2, 2020

The Honorable Rosalyn H. Baker, Chair
The Honorable Stanley Chang, Vice Chair
Senate Committee on Commerce, Consumer Protection, and Health

Re: SB 2284 – Relating to Health Care Insurance

Dear Chair Baker, Vice Chair Chang, and Committee Members:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 2284, which prohibits a health care insurer, mutual benefit society, or health maintenance organization from requiring an insured, subscriber, member, or enrollee diagnosed with stage two through stage four cancer to undergo step therapy prior to covering the insured for the drug prescribed by the insured's health care provider, under certain conditions.

HMSA does not require step therapy for oncology treatment. HMSA works to ensure our members have the care and treatment they need that is safe and efficacious. We appreciate the sensitivity and skill necessary to treat cancer and defer treatment decisions to oncologists. We foster open discussion and dialogue with local oncologists whom we meet with annually for feedback on our internal policies and guidelines.

Our policies follow evidence-based clinical guidelines and are in line with national best practice guidelines issued by the American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN). The ASCO is a professional organization representing physicians of all oncology sub-specialties who care for people with cancer and the NCCN is a not-for-profit alliance of the 28 leading cancer centers including **MD Anderson**, **Mayo Clinic Cancer Center**, and **Memorial Sloan Kettering Cancer Center**. Our medical policies are not intended to dictate to providers how to practice medicine in this area.

HMSA believes that this measure impedes our ability to continue to establish medical policies based on evidence-based medicine and best practices. Should this bill move forward, we respectfully ask that the measure be amended to remove the mandate and request the State Auditor to first conduct an impact assessment report pursuant to Section 23-51 of the Hawaii Revised Statutes.

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

Sincerely,

Pono Chong
Vice President, Government Relations



Hawaii Association of Health Plans

February 3, 2020

The Honorable Rosalyn H. Baker, Chair
The Honorable Stanley Chang, Vice Chair
Senate Committee on Commerce, Consumer Protection, and Health

LATE

Senate Bill 2284 – Relating to Health Care Insurance

Dear Chair Baker, Vice Chair Chang, and Members of the Committee:

The Hawaii Association of Health Plans (HAHP) appreciates the opportunity to testify on SB 2284, which prohibits a health care insurer, mutual benefit society, or health maintenance organization from requiring an insured, subscriber, member, or enrollee diagnosed with stage two through stage four cancer to undergo step therapy prior to covering the insured for the drug prescribed by the insured's health care provider, under certain conditions.

We would like to express concerns on this legislation as it goes against policies as determined by the health plan's medical director and generally accepted evidence based medical practice.

As this is a new mandated benefit, it is subject to an impact assessment report by the Legislative Auditor pursuant to Sections 23-51 of the Hawaii Revised Statutes.

Thank you for allowing us to testify expressing concerns on SB 2284.

Sincerely,

HAHP Public Policy Committee



LATE

SENATE COMMITTEE ON CONSUMER PROTECTION AND HEALTH

Sen. Rosalyn Baker, Chair

Sen. Stanley Chang, Vice Chair

Date: February 4, 2020

Time: 9:30 a.m.

Place: Conference Room 229

From: Hawaii Medical Association

Michael Champion, MD, President

Christopher Flanders, DO, Executive Director

Re: SB2284 Relating to Health Care Insurance

Position: SUPPORT

On behalf of Hawaii's physician and student members, the HMA supports SB2284 which would prohibit health care insurers from requiring an insured diagnosed with Stage II – IV cancer from undergoing step therapy prior to covering the insured for the drug prescribed by the insured's health care provider.

Step therapy, or "fail first" therapy is a form of prior authorization that requires preferred drugs be prescribed first until proven ineffective before physicians can try other, potentially higher cost agents. For cancer patients, selecting the proper personalized treatment as quickly as possible can be critical to survival. Delays in getting patients the right treatments at the right time many times leads to unnecessary complications in the physician-patient decision-making process.

Step therapy likewise places a significant administrative burden on physician practices. Physicians do not currently have ready access to patient benefit and formulary information, as there is currently not the capability of making this information available through electronic health records or other means at the point of prescribing. This lack of transparency makes it exceedingly difficult to determine what treatments are preferred by a particular payor at the point of care and places practices at financial risk for the cost of administered drugs if claims are later denied for unmet (yet unknown) step therapy requirements.

Furthermore, payor exemption and appeals processes can be complicated and lengthy, making them burdensome for both busy physician practices and patients awaiting treatment. It is our hope that another layer of administrative complication will not be added on an already strained system.

Thank you for allowing the Hawaii Medical Association to testify on this issue.

HMA OFFICERS

President – Michael Champion, MD President-Elect – Angela Pratt, MD Secretary – Thomas Kosasa, MD

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