Medical Cannabis Insurance Reimbursement Working Group

Introduction

Act 161, Session Laws of Hawaii 2018, established the Medical Cannabis Insurance Reimbursement Working Group to address the complexities surrounding the topic of making medical cannabis reimbursable by health insurance. The Working Group was tasked with exploring options and making recommendations on the following issues:

(1) Actions taken in other states;

(2) Potential parallel reimbursement models for other types of non-prescription therapies;

(3) Associated liability issues for health plans;

(4) The potential impact on insurance premiums;

(5) Insurance riders for alternative therapies, which could serve as a model for medical cannabis reimbursement; and

(6) Other relevant issues that may arise, at the discretion of the working group.

The members of the Working Group were as follows:

(1) The Chairs of the Senate Committee on Commerce, Consumer Protection, and Health (Senator Rosalyn Baker) and the House Committee on Consumer Protection and Commerce (Representative Roy Takumi), who served as the Chairs of the Working Group;

(2) The Chair of the House Committee on Health and Human Services (Representative John Mizuno);

(3) A member of the Senate who was selected by the President of the Senate to serve on the Working Group (Senator Stanley Chang);

(4) The Insurance Commissioner (Gordon Ito);

(5) The Administrator of the Department of Human Services, Med-QUEST Division (Judy Mohr Peterson);

(6) One representative each from the following who served at the invitation of the Chairs of the Working Group:

(A) A mutual benefit society (Jennifer Diesman, Hawaii Medical Service Association (HMSA));

(B) A health maintenance organization (Garret Sugai, Kaiser Permanente);

(C) A Medicaid managed care plan (Laura Esslinger, AlohaCare); and

(D) A licensed medical cannabis dispensary (Mike Takano, Pono Life Sciences); and

(7) Two participants in Hawaii's medical cannabis program, one of whom is a qualifying patient eighteen years of age or older (Randy Gonce), and one of whom is a parent or legal guardian of a qualifying patient who is under the age of ten (Monique Chantal).

The Working Group met four times, on October 8 and 23, November 9, and December 12, 2018, to discuss the issues set forth in Act 161.

Discussion of the Issues Set Forth in Act 161

(1) Actions taken in other states

According to information provided by Senator Baker, thirty-one states have medical cannabis programs. Twenty-four of these states have statutes that provide that health insurance reimbursements for medical cannabis are not required. One state, Alaska, prohibits health insurance reimbursements.[1]

Of the states with medical cannabis programs, none has made reimbursements through health insurance. However, five states currently allow reimbursements through workers' compensation insurance.[2] According to a chart prepared by the staff of Senator Baker that summarizes the present status of medical cannabis laws, health insurance reimbursements, and workers' compensation reimbursements in the fifty states, the District of Columbia, and the United States territories, those five states are Delaware, Minnesota, New Jersey, New Mexico, and New York. (The chart also indicates that Maine was a sixth state prior to a judicial overrule.)

The Attorney General's office added that, in light of the withdrawal of the Cole Memorandum,[3] there is a conflict among the states regarding reimbursement for medical cannabis under workers' compensation statutes. Specifically, the Attorney General's office reported that New Mexico allows workers' compensation to cover medical cannabis while Maine prohibits state law from requiring workers' compensation insurers to violate federal law.[4]

The Attorney General's office also pointed out that the states that have allowed reimbursement through workers' compensation insurance have allowed it through the medical necessity standard in their workers' compensation statutes, under which the employer furnishes

the injured employee with all medical care as the nature of the injury requires, or necessitates. One state, New Mexico, has also adopted express language in their administrative rules and fee schedule to allow for reimbursement.[5]

Pursuant to New Mexico Administrative Code section 11.4.7.9(D), which evidently took effect on September 30, 2016, medical cannabis is reimbursable as follows:

> D. Medical cannabis reimbursement
>
> (1) General Provisions
>
> (a) The maximum payment that a worker may be reimbursed for medical cannabis shall be determined by the method and amount set forth in health care provider fee schedule.
>
> (b) Medical cannabis may be a reasonable and necessary medical treatment only where an authorized health care provider certifies that other treatment methods have failed.
>
> (c) At least one physician certifying worker for participation in the cannabis program shall be an authorized health care provider.
>
> (d) The worker must be an enrolled in the cannabis program and provide proof of enrollment and qualifying condition prior to the date of purchase of medical cannabis to be eligible for reimbursement.
>
> (2) Worker shall be reimbursed upon the following conditions:
>
> (a) Only the worker shall be reimbursed for the out of pocket cost of medical cannabis;
>
> (b) Worker shall submit an itemized receipt issued by a licensed producer that includes the name and address of the licensed producer and the worker, the date of purchase, the quantity in grams of dry weight, the form of medical cannabis purchased, and the purchase price;
>
> (c) Worker shall be reimbursed no more than the maximum amount set forth in the fee schedule;
>
> (d) Reimbursement shall be limited to the quantity set forth in the fee schedule;
>
> (e) Reimbursement for paraphernalia, as defined in the Controlled Substances Act, shall not be made; and
>
> (f) Reimbursement is not allowed for expenses related to personal production or cannabis acquired from sources other than a licensed producer.

Furthermore, in New Mexico's workers' compensation fee schedule, medical cannabis is reimbursable in the following amounts and payments, effective January 1, 2019, as follows:

> Maximum quantity subject to reimbursement is 230 units (1 unit is approximately 1 gram dry weight equivalent) per calendar quarter (January-March, April-June, July-September, and October-December of the relevant year).
>
> Reimbursement shall be made using the following conversion:
>
> - 1 unit ≈ 200 mg THC (≈ 1 gram dry weight equivalent)

- Maximum Reimbursable Amount = $12.02 per unit (i.e., per 1 gram dry weight equivalent)

Reimbursement of medical cannabis should be included in the carriers' Annual Expenditure Report (AER) submission per WCA rules.[6]

(2) Potential parallel reimbursement models for other types of non-prescription therapies

See discussion below in section (5) regarding insurance riders for alternative therapies, which could serve as a model for medical cannabis reimbursement.

(3) Associated liability issues for health plans

According to Senator Baker and the Attorney General's Office, cannabis is an illegal Schedule I drug under the federal Controlled Substances Act. Providers risk losing their licenses if they were to prescribe it.[7]

Med-QUEST reported that no state Medicaid program reimburses medical cannabis, either through state funds or federal funds. A state Medicaid program risks losing their federal funding if those federal funds are used to reimburse medical cannabis.[8]

Furthermore, both Medicaid and Medicare managed care plans are required to cover drugs that are both approved by the federal Food and Drug Administration (FDA) and eligible for rebates under the Medicaid drug rebate program. That list of drugs is established by the federal Centers for Medicare and Medicaid Services. Federal law prohibits Medicaid and Medicare from covering a drug or service that is not "reasonable and necessary" for the diagnosis or treatment of illness or injury. Whether a drug or service is "reasonable and necessary" means whether the drug or service is "safe and effective, not experimental, and appropriate."[9]

Med-QUEST further reported that, because cannabis is an illegal drug under federal law, using federal funds to reimburse for medical cannabis would result in the federal government cutting off that stream of revenue to the State, creating an enormous budgetary shortfall, and adversely affecting Medicaid patients in Hawaii. Thus, reimbursements for medical cannabis can only be paid out using state funds. Furthermore, if Medicaid and Medicare managed care plans were required to cover medical cannabis in that manner, it would be necessary to take extraordinary measures to prevent the co-mingling of federal funds with state funds used to reimburse for medical cannabis.[10]

Med-QUEST reported that, in order to protect Hawaii's federal Medicaid funding, it would need to create a firewall of separation between the part of the department that was required to deal with medical cannabis and the part of the department that handled federal funds. A firewall would mean an office in a separate location, separate bank accounts, and staff that dealt only with medical cannabis. Additionally, Med-QUEST stated that reimbursements would have to be dispersed directly to members of managed care plans rather than to the managed care plans, due to federal law dealing with financial institutions. Med-QUEST does not currently

provide direct reimbursement to members of managed care plans and would need to develop a model for doing so.[11]

HMSA reported that, even if no prescriptions are involved with medical cannabis, FDA approval is required for an insurer to put a drug on the formulary. The insurers noted concern about their contractual obligations with Federally Qualified Healthcare Centers and the potential impact on federal funds that those providers receive, in connection with the classification of cannabis as a Schedule I controlled substance under the federal Controlled Substances Act.[12]

According to HMSA, the two federal law issues that HMSA cannot ignore when deciding whether it can provide reimbursement for medical cannabis are:

(1) The lack of FDA approval for medical cannabis; and

(2) The Schedule I classification of marijuana.

Schedule I classification is a barrier. However, a possible resolution to the issue of medical cannabis' lack of FDA approval could instead be a finding of medical necessity under section 432E-1.4, Hawaii Revised Statutes (HRS). A medical doctor is required to recommend a non FDA-approved drug as being medically necessary.[13]

(4) The potential impact on insurance premiums

Dispensaries have some information and the Department of Health may have additional information via their tracking system regarding the average monthly cost of medical cannabis for patients with qualifying conditions. However, it is important to ascertain the types of de-identified information that are available. Dispensary representatives indicated a willingness to work toward getting this information together.[14]

The Department of Health reported that it is not clear why health care providers are not charging a patient's office visit to insurance when the patient's visit is for the purpose of becoming certified as a medical cannabis patient. In some cases, people are paying $300 or more for the visit, and this is a significant cost for people on disability or a fixed income. According to the department, these office visits are allowed to be billed under insurance.[15]

HMSA explained that if a provider chose to make a certification of a debilitating condition, the office visit to make that certification could possibly be billed to insurance. However, if a provider submitted a claim for compensation for anything other than the office visit, reimbursement would likely be denied, and the certification would then be an out-of-pocket expense for the patient.[16]

The Department of Health suggested that this might be an area where provider education and reassurance is needed. Providers need to know that the option of billing for the office visit itself is available and that there is no risk associated with making the certification to their license. Senator Baker suggested that the Board of Medicine could be instrumental in disseminating training and education materials. Pono Life Sciences noted that the dispensaries have already

taken the initiative to meet with provider groups who have reviewed the certification process and are comfortable with billing visits for certifications.[17]

According to HMSA, there are three components for reimbursement by insurers:

(1) The health care provider visits and the physical examination required for certification as a medical cannabis patient, which are probably reimbursable under the present system;

(2) A health care provider's completion of the certification paperwork for submission to the Department of Health, the reimbursability of which is unclear under the present system; and

(3) Medical cannabis from a dispensary (the product), which is the most complicated component and does not appear to be reimbursable under the present system.[18]

Senator Baker raised the possibility of using the average cost of reimbursements for opioids in the state workers' compensation system in order to peg reimbursements for medical cannabis. HMSA questioned whether there are standard dosages of medical cannabis for each qualified condition, and how a doctor interacts with the patient to titrate dosage.[19] Pono Life Sciences suggested a $350 - $390/month benchmark for cost modeling, both because the prices of medical cannabis in Hawaii will go down as the dispensaries refine and streamline their production processes, and because of the variance in bioavailability of cannabis metabolites between individuals.[20] Med-QUEST noted there may be some cost modelling available from Rhode Island, a state with a similar population to Hawaii.[21] Mr. Gonce, the Qualifying Patient member of the Working Group, offered a simplified model for product reimbursement via a cooperative, or co-op, model, and likened it to health plans offering gym membership reimbursements to members.[22] For example, a dispensary could create a group with a membership fee of $350/month, and a member would be entitled to be gifted with a certain quantity of medical cannabis. Insurers would then be free to reimburse their members for their membership fees, and avoid the complications of dealing financially with a cannabis-based business.[23]

(5) Insurance riders for alternative therapies, which could serve as a model for medical cannabis reimbursement

Med-QUEST and AlohaCare stated that Medicaid and Medicare typically will not cover alternative or ancillary insurance products, such as acupuncture, and in many cases are prohibited from doing so by federal regulations. Managed care plans in Hawaii have offered coverage for ancillary products with well-established standards of care (such as dental care), but these services are not reimbursed through Medicaid and Medicare; it is up to the individual plan to determine how they will reimburse for these services.[24]

HMSA reported that the decision to offer a plan that covers an ancillary product hinges first on whether there is a market for plans covering that product. Most health plans are purchased by employers, and not all employers have compelling reasons to purchase plans that

cover ancillary products. Before a plan with coverage for ancillary products is offered for sale, insurers go through an internal process to determine how to price, package, and market the plan. The process can take a significant amount of time to complete.[25]

The working group discussed whether there could be more of a market for medical cannabis riders, since medical cannabis is marketed to individuals rather to employers. Riders exist for chiropractic and acupuncture care, which could serve as a model for medical cannabis.[26]

Senator Baker asked the health plans about insurance coverage of an experimental drug. HMSA responded that most plans have an explicit prohibition on coverage for experimental drugs, although there is some gray area if the drug requested is FDA-approved. Sen. Baker asked what would be required for the approval process if the Legislature chose to mandate coverage for medical cannabis. HMSA responded that the Legislature might need to legislate that medical cannabis is covered under a health plan as a medical necessity under Chapter 432E, Hawaii Revised Statutes, relating to the Patients' Bill of Rights. HMSA, however, indicated that it may experience administrative difficulties in implementing such legislation.[27]

HMSA suggested that reimbursement levels for opioids, such as benzodiazepine, under worker's compensation programs could be used as precedent for determining appropriate reimbursement levels for medical cannabis.[28]

(6) Other relevant issues that may arise, at the discretion of the Working Group

Several other issues were discussed at the meetings. (See the minutes for a fuller discussion of issues that were not specifically required under Act 161.) Among these were the following:

(a) The certification and registration process of patients qualifying for medical cannabis;[29]

(b) The licensure of medical cannabis dispensaries;[30]

(c) The tracking system for medical cannabis patients;[31]

(d) Privacy protection under the federal Health Insurance Portability and Accountability Act of 1996, Pub.L. 104–191, for the status of a patient as a medical cannabis user;[32]

(e) Protections for employees who are qualifying patients from sanctions imposed by employers;[33]

(f) Protections for health care providers who certify qualifying patients for the medical use of cannabis;[34]

(g) Dosing standards for optimal usage for various strains and strengths of medical cannabis;[35]

(h) Medical cannabis and the opioid crisis;[36] and

(i) The white paper of the Cannabis Insurance Working Group of the National Association of Insurance Commissioners, which is expected to be published in the spring of 2020, that will outline the issues and contain recommendations relating to regulatory guidance over the legalized cannabis business.[37]

Recommendations

At its final meeting, the Working Group made the following recommendations:

(1) Med-QUEST recommended that the Med-QUEST program should be exempted from any coverage requirements if legislation goes forward. Senator Baker agreed that the Working Group does not wish to jeopardize the State's receipt of federal Medicaid assistance;

(2) Pono Life Sciences recommended legislation for medical cannabis reimbursements under workers' compensation insurance, but not under health insurance. Senator Baker agreed;

(3) There was general agreement that data should be obtained from workers' compensation insurers regarding pain management for chronic pain;[38] and

(4) Senator Baker recommended that the Working Group should continue its work during the interim of 2019 through the adoption of a legislative concurrent resolution.

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[1] October 8, 2018, meeting minutes.
[2] October 8, 2018, meeting minutes.
[3] The Cole Memorandum, issued by the United States Department of Justice, on August 29, 2013, offered guidance to federal prosecutors concerning marijuana enforcement under the federal Controlled Substances Act, given that states were enacting laws relating to the medical use of marijuana. The memorandum did not expressly list the medical use of marijuana as an enforcement priority. The Department of Justice rescinded the memorandum in January 2018.
[4] December 12, 2018, meeting minutes.
[5] December 12, 2018, meeting minutes.
[6] State of New Mexico Workers' Compensation Administration Health Care Provider Fee Schedule and Billing Instructions, *available at* https://workerscomp.nm.gov/sites/default/files/documents/publications/fee_schedules/NewMexicoPFS2018.pdf
[7] October 8, 2018, meeting minutes.
[8] October 8, 2018, meeting minutes.
[9] October 8, 2018, meeting minutes.
[10] October 8, 2018, meeting minutes.
[11] October 8, 2018, meeting minutes.
[12] October 8, 2018, meeting minutes.
[13] November 9, 2018, meeting minutes.
[14] October 8, 2018, meeting minutes.

[15] October 23, 2018, meeting minutes.
[16] October 23, 2018, meeting minutes.
[17] October 23, 2018, meeting minutes.
[18] November 9, 2018, meeting minutes.
[19] November 9, 2018, meeting minutes.
[20] November 9, 2018, meeting minutes.
[21] November 9, 2018, meeting minutes.
[22] November 9, 2018, meeting minutes.
[23] November 9, 2018, meeting minutes.
[24] October 8, 2018, meeting minutes.
[25] October 8, 2018, meeting minutes.
[26] October 8, 2018, meeting minutes.
[27] November 9, 2018, meeting minutes.
[28] November 9, 2018, meeting minutes.
[29] October 8 and October 23, 2018, meeting minutes.
[30] October 23, 2018, meeting minutes.
[31] October 23, 2018, meeting minutes.
[32] October 23, November 9, and December 12, 2018, meeting minutes.
[33] December 12, 2018, meeting minutes.
[34] December 12, 2018, meeting minutes.
[35] October 23 and December 12, 2018, meeting minutes.
[36] October 23 and December 12, 2018, meeting minutes.
[37] December 12, 2018, meeting minutes.
[38] December 12, 2018, meeting minutes.