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

LATE TESTIMONY

**Friday February 4, 2011; 4:00 p.m. Conference Room 229**

To: COMMITTEE ON HEALTH
Rep. Ryan Yamane, Chair
Rep. Dee Morikawa, Vice Chair

From: Hawaii Medical Association
Dr. Morris Mitsunaga, MD, President
Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, MD, Executive Director
Lauren Zirbel, Community and Government Relations

Re: HB 1546 RELATING TO PRIOR AUTHORIZATIONS

In Support

Chairs & Committee Members:

Hawaii Medical Association supports HB 1546 Relating to Prior Authorizations.

HMA recognizes that standardizing Prior Authorizations reduces some administrative burden for physicians. This is a step in the right direction. **This bill should be passed.** It applies to all health plans, both public and private, and thus covers a wide range of territory that will decrease burdens for health care providers to provide appropriate care to their patients. **Having different prior authorization forms is completely unnecessary and confusing for providers and patients alike.**

**More helpful for access to timely treatment would be SB645, which establishes a statewide Medicaid formulary.** Any Nurse Practitioner or a Physician who deals directly with patients knows that the biggest roadblock to providing patients with timely and effective prescription drug treatment is the wide variety of formularies offered by Managed Care Organizations, some of which are extremely restrictive. It is painful for providers watch their patients suffer and be denied necessary treatment while they are forced to go through 3 different prior authorizations before they can give their patient the drug they knew would be effective in the first place. The goal of any legislation aiming to reduce administrative burden and improve patient care should be to **reduce the number (not the style) of prior authorization** that need to be completed before a patient can receive effective treatment.

Especially in the case of Medicaid, which is now reimbursing at around 60% of Medicare, the bottom line is that providers lose money whenever they see a Medicaid patients. The least that can be done is to reduce the extra administrative costs associated with treating these patients so that instead of losing money and a lot of extra administrative time for working, providers simply lose money when they see Medicaid patients.

OFFICERS
PRESIDENT - MORRIS MITSUNAGA, MD PRESIDENT-ELECT –ROGER KIMURA, MD
SECRETARY - THOMAS KOSASA, MD IMMEDIATE PAST PRESIDENT – DR. ROBERT C. MARVIT, MD TREASURER – STEPHEN KEMBLE, MD EXECUTIVE DIRECTOR – CHRISTOPHER FLANDERS, MD

LATE TESTIMONY

**A proven way to accomplish a decrease in the number of prior authorizations and an increase in patient satisfaction is to establish a statewide Medicaid formulary. In Ohio, their statewide Medicaid formulary reduced prior authorizations by 70%. In doing so the state saved $243.6 million throughout FY 2011.** Delaware, Illinois, Iowa, Massachusetts, Nebraska, New York, North Carolina, Utah, West Virginia, Ohio and Montana report carving out all drugs from Medicaid managed care contracts.

Comparison charts show that Ohio's Medicaid formulary rates compare favorably with managed care plans in access to drugs for several specific health care conditions. These charts rated the ease of access to medications based on the number of restrictions that an insurer places on a patient's ability to obtain a drug prescribed by a physician or advanced practice nurse prescriber.

Total drug prices paid by MCOs are generally higher than those paid by **state** Medicaid programs, largely due to differences in the last component of drug prices (rebate). **Recent changes to CMS interpretation of PPACA ensure that states will not be disadvantaged drug purchasers.**

Even the intro to this bill states that the National Council of Prescription Drug Plans is in the beginning states of a national pilot project to create a streamlined, **uniform drug formulary** and prior authorization process.

Thank you for the opportunity to testify.

LATE TESTIMONY

February 4, 2011
9:00am
Conference room 329

To: The Honorable Ryan I. Yamane Chair
The Honorable Dee Morikawa, Vice Chair
House Committee on Health

From: Paula Arcena
Director of Public Policy

Re: HB1546 Relating to Prior Authorizations

Thank you for the opportunity to testify on HB1546.

AlohaCare is **strongly opposed** to HB1546 which is intended to simplify prescription drug prior authorization process by mandating the creation and use of a universal prescription coverage request form.

We are concerned the measure does not adequately address a number of issues. We believe it will be difficult to develop a universal prior authorization request form that accommodates the wide range of health plan formularies and the diversity of memberships each plans serves. The standardized form would need to meet the needs of commercial, Medicare, Medicaid insurers and integrated systems, such as Kaiser. Specialty non-formulary prescription drugs, which are the most costly, require unique clinical information for medical review.

AlohaCare's prior authorization process for non-formulary prescription drugs is designed to provide quick a turn-around. For prior authorization requests received after-hours or in emergency situations, AlohaCare members receive a three-day emergency supply of non-formulary medications or a ten-day supply for antibiotics and providers are asked to follow up with a prior authorization request to continue the non-formulary prescription. Expedited requests are processed within 72-hours. We review prior authorizations for medical necessity and verify the member's eligibility and benefits.

AlohaCare is a non-profit, Hawaii based health plan founded in 1994 by Hawaii's community health centers to serve low-income families and medically vulnerable members of our community through government sponsored health insurance programs. We serve beneficiaries of Medicaid and Medicare on all islands.
AlohaCare has been contracted by the Hawaii Department of Human Services since the QUEST program started in 1994 to provide insurance coverage for Medicaid eligible beneficiaries through the QUEST program. We serve approximately 75,000 QUEST enrollees statewide.

Thank you for this opportunity to testify.

1357 Kapiolani Blvd, Suite 1250, Honolulu, Hawaii 96814
www.AlohaCare.org

LATE TESTIMONY

94-450 Mokuola Street, Suite 106, Waipahu, HI 96767
808.675.7300 | www.ohanahealthplan.com

Friday, February 4, 2011

To: The Honorable Ryan I. Yamane
Chair, House Committee on Health

From: 'Ohana Health Plan

Re: House Bill 1546-Relating to Prior Authorizations

Hearing: Friday, February 4, 2011, 9:00 a.m.
Hawai'i State Capitol, Room 329

---

Since February 2009, 'Ohana Health Plan has provided services under the Hawai'i QUEST Expanded Access (QExA) program. 'Ohana is managed by a local team of experienced health care professionals who embrace cultural diversity, advocate preventative care and facilitate communications between members and providers. Our philosophy is to place members and their families at the center of the health care continuum.

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.3 million Medicaid and Medicare members nationwide. 'Ohana has been able to take the national experience and develop an 'Ohana care model that addresses local members' healthcare and health coordination needs.

We appreciate this opportunity to testify in **strong support** of House Bill 1546-Relating to Prior Authorizations.

The purpose of this bill is to establish a statewide prior authorization (PA) process and universal request form for all health care plans to minimize the cumbersome administrative burden on physicians that contributes to delays in patients getting their medications in a timely manner. This bill requires the Insurance Commissioner, with the input of health care plans, prescribing providers and pharmacists, to establish a statewide standardized PA process and universal PA form, using Medicare processes and forms as a baseline.

Understandably, there will be advocates who believe that the drug formulary itself is the problem. However, establishing a single, statewide drug formulary will not eliminate the need for prior authorizations, the most effective means of clinical oversight for patient safety and cost-effectiveness. This bill will streamline the PA process that protects patients and assures responsible drug therapy.

**LATE TESTIMONY**

The State of Minnesota encountered similar complaints from advocates regarding timely access to prescription drugs. The Minnesota State Legislature passed the "Prescription Drug Prior Authorization (PA) Standardization and Transmission Project" under the Administrative Simplification Act of 2009 in order "to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency".

Since its passage and implementation, the number of provider and advocate complaints regarding timely access to prescriptions drugs have dropped significantly according to an official from the Minnesota Department of Health.

The National Council of Prescription Drugs Plans (NCPDP) also acknowledges that the issue is not the drug formulary, but rather the PA process and forms that is the root cause of a lack of timely access.

We respectively request that you pass House Bill 1546-Relating to Prior Authorizations. Thank you for the opportunity to provide these comments on this measure.