Walgreens
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January 27, 2011

Senator Josh Green
Chair, Committee on Health
Hawaii State Capitol, Room 223
Honolulu, Hawaii 96813

Re: S.B. 619 – Relating to Prior Authorizations
Hearing: Friday, January 28, 2011 at 2:45 p.m.

Dear Chair Green and Members of the Committee on Health:

I am Mihoko Ito, an attorney with Goodsill Anderson Quinn & Stifel, submitting comments on behalf of Walgreen Co. ("Walgreens"). Walgreens operates in all 50 states, the District of Columbia and Puerto Rico. In Hawai'i, Walgreens now has 10 stores on the islands of Maui and Oahu.

Walgreens **supports the intent** of S.B. 619, which establishes a statewide standardization of the prescription drug prior authorization process, because it will simplify and streamline the prior authorization process by having one standard form.

However, Walgreens respectfully requests that the Committee consider making the following amendment to this measure. Page 4, lines 3-8, presently provides the following language:

> (b) The commissioner shall consult with the health care insurance providers, prescribers, and the **pharmacy association** in the development of the single, uniform and in promulgating administrative rules, and whenever applicable, shall refer to and utilize any national standards, including those used in the Medicare program.

(Emphasis added).

The reference to "pharmacy association" is confusing because in Hawaii, there is no single pharmacy association that encompasses all of the pharmacy industry's interests. Accordingly, Walgreens would suggest that the language refer to the "pharmacy industry," rather than the "pharmacy association."

We are happy to participate in further discussion on this issue. Thank you very much for the opportunity to testify.

Walgreen Co. Government and Community Relations 104 Wilmot Road, MS 1444 Deerfield, IL 60015
847-315-4653 FAX 847-315-4417 www.walgreens.com

Rafael del Castillo

Attorney at Law

TESTIMONY ON BEHALF OF S.B. 619

From: Rafael del Castillo
Attorney at Law
Personal testimony, not on behalf of any client or organization

To: House Committee on Health,
Hon. Josh Green, M.D., Chair; Hon. Senator Clarence K. Nishihara, Vice Chair

Hearing: January 28, 2011, 2:45 p.m., Conference Room 229
2 paper copies requested

Emailed to: HTHTestimony@Capitol.hawaii.gov Email time: 4:59 p.m., 1/27/2011

I support for the enactment of S.B. 619 into law **with reservations**. For the past three years, I have been engaged in litigation involving our Med-QUEST programs, which highlighted the problems with non-formulary prescriptions that impact disproportionately on a small, but nonetheless very important segment of our most medically needy and vulnerable citizens.

Subsection e of the bill does not go far enough in requiring temporary supplies of non-formulary medications, and I can tell you from the extensive evidence I gathered, wrongful games can still be played with prior authorizations because of the way in which this provision was drafted (and I know the source). The QExA plans have created a situation that essentially excludes pharmacists from managing the prior authorization for the patient. That results in delays because prescribing providers do not all respond with equal promptness on account of the myriad factors that can affect the process once it is bounced back from the pharmacy benefit manager with a rejection. The QExA plans save money when the patients have to endure delays in the prior authorization originating with their prescribing provider.

There is a distinct contrast between the QUEST contractors in the way they handle prior authorizations of non-formulary prescriptions. This issue was litigated, but the court failed to grasp the problems and the existing abuses despite testimony that detailed them. For subsequent hearings on this bill, I will do what I can to secure authoritative testimony for the Committee on this issue, but there is a very simple amendment to subsection e that will solve the problem (and you will have a measure of how significant the abuses can be by the amount of resistance I expect there will be to such an amendment.

HMSA QUEST issues an **automatic 7-day override for all** non-formulary drugs. That works. It ensures that the patient will receive the medication the patient's doctor prescribed. The plans should not be second-guessing the doctors and other prescribing providers, nor should we be doing so through a law that creates situations that could adversely affect patients when they need immediate intervention. We cannot reasonably project just how important a medication may be to a particular patient's wellbeing, even if the medication is not a behavioral

289 Kawaihae Street
No. 222
Honolulu, Hawai`i 96825
Phone: (808) 782-1262/(808) 660-1033
Fax: (866) 528-8371
Email Rafael: *rafa@hawaii.rr.com*

health drug. Neither do we want to create a situation in which there must be a debate, at a critical time, about whether a condition is sufficiently life threatening to warrant the emergency dispensation. The patient will **never** win. HMSA surely recognized this in establishing its sensible policy. The bill should be amended to require it.

Thank you for the opportunity to comment upon this essential measure. I look forward to further opportunities to provide the Committee with relevant information about this important issue.

Very truly yours,

Rafael del Castillo

HMSA

Blue Cross
Blue Shield
of Hawaii

An independent Licensee of the Blue Cross and Blue Shield Association

January 28, 2011

The Honorable Josh Green M.D., Chair
The Honorable Clarence K. Nishihara., Vice Chair
Senate Committee on Health

Re: SB 619 – Relating to Prior Authorizations

Dear Chair Green, Vice Chair Nishihara and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 619 which would mandate the Insurance Commissioner to establish a single, standard prescription coverage request form. While we understand the intent of the Bill, HMSA opposes this measure.

While standardization is an ideal, the form must be structured to provide sufficient information for reasonable and appropriate decisions to be made, and in a timely manner. Sufficiency of information is paramount to avoiding denials. For example, how would a single form be designed to allow us to distinguish between a $100 per month drug for hypertension, as opposed to a $20,000 per month drug for a rare condition?

For the provider and patient alike, timeliness is imperative. That is why HMSA has made great strides to have information and processes available electronically. The formularies and application and appeals forms and procedures are available on-line for providers. All of this will be altered with the change proposed in this Bill, and there will be immediate, if not long-term, financial consequences as new programming and staff will be required to execute the change.

In addition, the Bill would have the form developed under the State's administrative rules process. Given that the amendment of administrative rules historically has taken months, and in some cases years, timeliness is jeopardized. HMSA appreciates the need for timeliness

The Bill would insert government into an administrative process, and its enactment would prove to be an unnecessary statutory mandate. We respectfully recommend that this Bill not move forward.

Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

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

Friday, January 28, 20112:45 PM Conference Room 229

To: COMMITTEE ON HEALTH
Senator Josh Green, M.D., Chair
Senator Clarence K. Nishihara, 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: SB 619 RELATING TO PRIOR AUTHORIZATIONS

In Support

Chairs & Committee Members:

Hawaii Medical Association supports HB 598 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.

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.

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Government Relations

Testimony of
Phyllis Dendle
Director of Government Relations

Before:
Senate Committee on Health
The Honorable Josh Green, M.D., Chair
The Honorable Clarence K Nishihara, Vice Chair

January 28, 2011
2:45 pm
Conference Room 229

SB 619 RELATING TO PRIOR AUTHORIZATIONS

Chair Green and committee members, thank you for this opportunity to provide testimony on SB 619 which would create a standard form for requests for prior authorization for prescription drugs.

Kaiser Permanente Hawaii has some concerns about this bill and requests an amendment.

In reviewing this measure we can appreciate the desire to standardize this process across health plans in the hope of simplifying it. However, as written, this bill would significantly complicate the internal processes for Kaiser Permanente. Our care is integrated and our electronic medical information system spans our program. Because of this it is possible for a physician to request an exception to the formulary by direct contact with the pharmacy through our electronic system. This does not require any interaction with our health plan. We don't think it was the intention of the proposer of this measure to complicate our functional internal system.

For this reason we request that the bill be amended to exempt Kaiser Permanente. We don't think it is anyone's interest to make health care any more complicated.

Thank you for your consideration.

711 Kapiolani Blvd
Honolulu, Hawaii 96813
Telephone: 808-432-5210
Facsimile: 808-432-5906
Mobile: 808-754-7007
E-mail: phyllis.dendle@kp.org