Senate Health Policy Committee Testimony on SB 823

May 1, 2018

Good Afternoon Chairman Shirkey and members of the committee, my name is Christine Shearer, Deputy Director, of Legislation and Advocacy for the Michigan Association of Health Plans. Our association represents 13 health plans serving over 2.5 million Michigan citizens in Medicaid, Medicare and Commercial products and 55 business and limited members. With me today is Karen Jonas, MAHP Pharmacy Consultant. While we appreciate the importance of ensuring access to drug treatments, we are concerned that the language in SB 823 goes beyond the original intent and instead has over-reaching consequences.

MAHP has a long history of working with DHHS, stakeholders and lawmakers on prior authorization processes for prescription drugs as part of the pharmaceutical benefit offered under the medical assistance program. In 2003, we worked with Senators George and Hammerstrom on PA 248 of 2004, which prohibit FFS from requiring PA for certain drugs such as HIV, cancer, and central nervous system prescription drugs that are classified as anticonvulsants, antidepressants, antipsychotics or antianxiety drugs. After months of work, these two Senators decided NOT to tie the hands of those contracted by the state. Thus, P.A 248 did not apply to drugs provided under contract between DHHS and the Medicaid Health Plans.

We also supported and worked with Senator Schuitmaker in 2013 to develop and implemented a standardized PA form and timeframe for processing these requests.

Michigan developed a Common Formulary in 2016 during which time Medicaid Health Plans and DHHS have spent 1000's of hours developing and maintaining. There are over 23,000 drugs on the common formulary with only 1.5% or 350

requiring prior authorization. Medicaid Health plans have an average 24-hour turnaround time for prior authorization response, which is more stringent than current Medicaid policy and Medicare Part D turnaround times. As the bill is introduced, this would limit health plans to only PA cancer drugs, which would reverse current prior authorization on many drugs such as opioids.

The 21st Century Cures Act modified the FDA Drug Approval process. It has expedited the process by which new drugs and devices are approved by easing the requirements put on drug companies looking for FDA approval on new products or new indications on existing drugs. For instance, under certain conditions, the act allows companies to provide "data summaries" and "real world evidence" such as observational studies, insurance claims data, patient input, and anecdotal data rather than full clinical trial results.

Some reasons drugs need Prior authorization:

- Drugs that have dangerous side effects that required monitoring is needed
- Drugs that are harmful when combined with other drugs
- Drug which lacks clinical data because it's so NEW
- Drugs that should only be used for certain health conditions
- Drugs that are often misused or abused
- Drugs that a doctor prescribes when clinically appropriate and less expensive drugs might work better

It is important to keep in mind that health plan formularies and the states Common Formulary are transparent, while drug prices are NOT. Drugs requiring prior authorization on Michigan's Common Formulary use nationally recognized care criteria, the input of clinical experts, physicians, and pharmacists who serve on our pharmacy and therapeutics committees and are based on the latest, evidence-based clinical guidelines and medical literature.

MAHP is well aware of the behavioral health community concerns regarding integration of services, access to pharmaceuticals currently "carved out" being an area of major angst. Health plans job as vendor and a fiduciary contractor of the state is to build a strong marriage between high quality outcomes and cost. Health Plans have an excellent track record working with young adults, children

and their families to make sure they received the medications they need with the transition of CSHCS program into managed care.

We believe this bill is premature given there are NO plans to move responsibility for “carve-out” drugs to the Medicaid Health Plans. At this time, the bill would remove the health plans ability to prior authorize approximately 350 medications, all of which are currently covered by the health plans. This would likely result in significant cost increases due to the fact that plans would be required to cover more expensive brand name drugs over less costly brand or generic alternatives. For these reasons, we encourage members to vote no on SB 823.

Thank you for your consideration to our comments we would happy to answer any questions members may have.