

May 17, 2016

HOUSE INSURANCE COMMITTEE
TESTIMONY OF PATRICK BEATTY, ESQ. ON S.B. 129

Good morning Chair Sears, Vice Chair Brinkman, Ranking Member Bishof, and Members of the Committee. On behalf of Equitas Health, and the Ohio AIDS Coalition, we thank the House Insurance Committee for the opportunity to offer testimony regarding S.B. 129 and its implications for state strategies for halting HIV transmission in Ohio.

Equitas Health, formerly AIDS Resource Center Ohio, is one of the nation's premier providers of a comprehensive, holistic, and coordinated response to HIV, from prevention, to diagnosis, and treatment. The Ohio AIDS Coalition is a division of Equitas Health. The Coalition provides education and advocacy, appearing as a voice for Ohioans with HIV.

My name is Patrick Beatty. I am the Chief Public Policy and Government Affairs Officer for Equitas Health, and I am Director of the Ohio AIDS Coalition. I took this job one and one half years ago. Prior to that I was the Deputy Director and Chief Policy Officer for Ohio's Medicaid agency, and before that I was counsel for the state Medicaid program. When I look at health policy, I like to consider challenges from all perspectives, because healthcare is never a one sided equation. All parts have to be able to function, and the equation has to be balanced, or the end product will not work. This is the approach that I have taken in our whitepaper in January that sets forth a comprehensive strategy for ending HIV transmission in Ohio. The following is a link to the proposal. <http://ohioaidscoalition.org/wp-content/uploads/The-Plan.pdf>

I like to present you with the fact about HIV in Ohio.

- Each year in Ohio there are on average over 1,000 newly reported cases of people infected with HIV.

- More than 90 percent of those newly HIV infections could be averted by ensuring people living with HIV receive prompt, ongoing care and treatment.
- A person with a viral load that is undetectable is 96 percent less likely to transmit the infection to someone else.
- Viral suppression through medication is the most effective tool to prevent new infections.
- After 2014 all Ohioans with HIV now have full access to healthcare coverage.
- In 2014 there were 21,612 individuals living with an HIV diagnosis in Ohio.

The advent of highly active antiretroviral therapies, i.e. HIV medications, changed HIV/AIDS from being a fatal disease to being increasingly a chronic disease. Historically, prevention of new infections focused on behaviorally based models to reduce HIV transmission. Advances in treatment have shifted the public health strategy to one of “treatment as prevention”. Today, with early diagnosis and retention in treatment, individuals with HIV can reach viral suppression, reducing or nearly eliminating the risk of transmitting the virus. That is a cornerstone of the larger public health strategy for ending HIV transmission. The key to success lies in removing barriers to accessing those medications, and ensuring adherence to a medication regimen.

S.B. 129 proposes to impose prior authorization time frames for drugs as well as other services. I’m here to state that categorically for HIV medication, prior authorization is always inappropriate because it suggests - incorrectly - that HIV medications are commonly interchangeable.

Disruptions or delay in treatment can have life-threatening consequences to individuals living with HIV. Studies available through the National Institute of Health (NIH) show that in a virally suppressed individual the virus will become detectable in a matter of days of missing medication. The virus will rebound at an exponential rate. I have provided here a citation to one such study. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3655551/> According to the NIH, missing several days of HIV medicines increases the risk that the virus will mutate and produce drug-resistant HIV. <https://aidsinfo.nih.gov/education-materials/factsheets/21/56/drug-resistance>

Drug-resistance testing is done to identify which, if any, HIV medicines won't be effective against a person's strain of HIV. This testing is done when a person first begins receiving care for HIV infection and shows whether the person was initially infected with a drug-resistant strain of HIV. The testing results are used to decide which HIV medicines to include in a person's first HIV regimen. After treatment is started, drug-resistance testing is repeated if viral load testing indicates that a person's HIV regimen isn't controlling the virus. The new test results can be used to select a new HIV regimen.

As a result of drug resistance, one or more HIV medicines in a person's HIV medication regimen may no longer be effective. This is why HIV drugs must be treated differently than other drugs in coverage formularies. Cumbersome authorization requirements for HIV treatment can actually lead to disruptions in medication adherence, https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/care_com_mittee/medication_access/barriers_to_medication.pdf viral drug resistance, more medical complications, higher treatments costs, and worse health outcomes. Ultimately, this represents a "cost" to the health plans.

Prior authorization is a cost containment tool. And for HIV medication prior authorization is not a good health outcomes tool. Drug resistance and viral load testing are the only appropriate tools for selecting HIV medication. So our request as part of this legislative process is to provide an exemption for any HIV medications prescribed to individuals with a diagnosis of HIV positive.

I am a realist, and recognize that this request may not find its way into final legislation. So in addition, I would like to note that the time frames used in the Medicaid program, are very short, and are operational. They are found in Ohio Administrative Code 5160-26-03.1.

(viii) "Prior authorization decisions for covered outpatient drugs as defined in 42 U.S.C. 1396 r - 8(k)(2) (May 1, 2013) must be made by telephone or other telecommunication device within twenty-four hours of the initial request. When

an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized. If the MCP is unable to obtain the information needed to make the prior-authorization decision within seventy-two hours, the decision timeframe has expired and the MCP must give notice to the member as specified in paragraph (B)(2)(d) of rule 5101:3-26-08.4 of the Administrative Code. All other pharmacy prior authorization decisions must be made by no later than the end of the second working day following receipt of the request, or as expeditiously as the member's condition warrants.”

I believe that to the extent those time frames are shorter or provide greater protections for Medicaid enrollees than what is being proposed today, I would ask they not be altered. I would be concerned about operational changes to Medicaid that would create any disruption to individuals who are already familiar with the process and time frames as they stand today.

Qualified Health Plans will be required to follow the provisions of 42 CFR 156.122. Contained in that regulation is terms governing exception requests for non-covered drugs, and expedited exception requests, which are bound to follow a shorter review time line. Given the nature of the disease and its ability to rebound, and its ability to become drug resistant, I believe that exception requests for non-covered HIV medication should always be subject to the shorter time frames contained in that regulation.

Finally, I believe that urgent care services should be changed to 24 hours versus one business day. Healthcare events happened 24/7 365 days.

Thank you for hearing our testimony today. I would be happy to take any questions.