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Chairman Hottinger, Vice Chair Bacon, Ranking Member Brown and members of the Senate Insurance Committee, my name is Girish Dighe. I am a pharmacist and resident as part of Health-System Pharmacy Administration with OhioHealth Pharmacy Services.

I am here today to offer support for SB 129, legislation that would modify the prior authorization process. I understand that discussions involving the most current iteration of the bill have been ongoing, so today I would like to share general thoughts on how to improve the prior authorization process.

My work in outpatient settings with patients who are receiving high-cost infusion treatments (i.e. chemotherapy) has afforded unique insight to the challenges of prior authorizations. High cost pharmaceuticals typically correlate with a very strict pre-approval process.

Let me share an example with you all: Remicade is a high-cost drug for patients suffering from gastrointestinal diseases and rheumatoid arthritis. We have a high volume of patients who are administered Remicade in our outpatient infusion clinics. I have been tracking the claims denial rates, and have seen significant increases in claims denials over the past year as a result of prior authorization challenges. The increase in claims denials draws attention to the cost impact both in terms of time and dollars for both providers and patients.

In the instance of Remicade, the patient is usually referred to us from an outside source. We certainly won't hold back treatment to patients in need while waiting for a prior authorization decision, so in the event we find out that prior authorization was denied after treatment has been provided, the cost is assumed by the health system. Our health system seeks other funding streams, in the way of manufacturer and foundation funding and charity care to assist with access to quality treatments.

Vetting prior authorization denials and recouping some of the lost revenue to the health system is a major financial burden to us. More importantly, the financial burden to the patient due to the prior authorization process is at the forefront of the issue.

This example illustrates the need for modification to the current prior authorization system, with a specific need for some parameters on how long an insurer might have to issue a decision. One suggestion that I know has been contemplated in discussions surrounding SB 129 is a 48 hour required turnaround on prior authorization requests that are non-emergent. This would go a long way to ensure patients get the care they need, and providers are informed before care is given, not after.

Thank you for your time. My colleague, Dr. Greg Sawchyn, will also offer testimony on SB 129, so I am happy to take any of your questions in tandem with Greg once he has concluded.