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Testimony in Support of S.424

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Dear Committee Members:

I am a solo private practice family physician in Northeastern CT for over 12 years. On behalf of my patients, I am testifying in **support of S424**.

Over a decade ago, under the guise of improving care and controlling costs, insurers introduced a range of new tools such as tiered formularies and prior authorization (PA) requirements. In my opinion, these tools are designed to protect insurer profits and limit patient access to critical medications and care. I am not opposed to reasonable constraints to limit unnecessary or overly costly care, however recently these barriers have become burdensome and costly for patient, providers and the entire healthcare system. Consequently

Over the years it has become evident that formularies and the accompanying burdensome prior authorization processes do little more than benefit the insurance companies and enrich their corporate profits. Health care providers and their staff spend significantly more time on administrative matters rather than patient care. In fact, an insurers goal is to simply limit patient access to medications physicians believe will be most beneficial, without access to the patient's records or history, and with applying little if any evidence-based rationale.

The current process is time consuming and onerous for prescribers and patients due to the use of antiquated systems, lack of transparency or standardization, and variation in the amount of time it takes to review requests.

Over a decade ago, prior authorizations were for "expensive" brand-name medications. However, this is no longer the case. In fact, several insurers require prior authorizations for generic medications. Additionally, there are plans now have 5 and 6 co-payment tiers for medications, with increasing number of medications that require prior authorization, added to an increasing co-pays burden for patients and their families subjected to these plans. Add these challenges to federally administered Medicare Part D plans, which in some cases are so restrictive that entire categories of blood pressure medications are not covered, and the administrative burden increases exponentially.

Patient Burden

Although patients are not always privy to the administrative requirements associated with prior authorization, patients are often caught in the middle. After their office medical evaluation and jointly deciding on a treatment plan with their physician, they learn that they are denied the recommended treatment once they reach the pharmacy. In some instances, days and even weeks can pass without having needed medications, irrespective of whether they suffer from a chronic or acute condition. And of course, the disease does not stop to wait for the cavalier prior authorization process. In many cases, the dollars insurers are attempting to save are spent many times over when patients end up in the emergency room or with an extended stay in the hospital.

Provider Burden

In addition to the obvious health risks prior authorizations present to patients, they also present a financial risk to care givers. The volume of prior authorizations required and the complexity completing prior authorizations has quadrupled in the past 3 years. Not only do insurers and their PBM's (pharmacy benefit managers such as Caremark, Express Scripts, Medco, etc) frequently change formularies without warning, they all have completely different processes for submitting requests. Rarely do any insurers make clinical criteria readily available. Some make it easier to use automated telephone systems or the internet. Most require a range of different forms (over 500 forms are used by one insurer) but some do not. Nevertheless, it is always a struggle to find out what the patient's plan covers and how to initiate a PA process

Delaying tactics are rampant and well thought out. For example, we frequently have to fill out a generic PA form just to get the correct PA form faxed back to us; this second form then frequently asks redundant and medically irrelevant questions all in the guise of delaying approval or increasing the administrative burden.

This growing administrative burden has direct consequences on physician offices. Most offices have to hiring numerous staff dedicated to handling nothing but paperwork such prior authorizations and no patient care duties whatsoever. This is completely inefficient and a waste of shrinking health care resources.

Conclusion

This entire process is cleverly disguised a way to promote "better" patient care. Many insurers and PBM's have the audacity to trumpet statistics that they are protecting the public from harm from careless physicians. I ask the committee to not be fooled by this subterfuge. Nothing can be further from the truth. The entire process is about one thing – increasing profits at patients' expense.

S 424 is the least we can do for all citizens of Connecticut – infants, children, adults and senior citizens alike will benefit from improving these processes. Other states have proposed and passed legislation requiring a universal prior authorization form, a standardized review period, as well as taken steps to prepare for electronic prior authorization processes.

I encourage you to support the pilot program and advance to a full program expeditiously.

Enclosed: Case Discussions

- (1) Elderly nursing home gentleman denied critical cardiac medication by Caremark.
- (2) Middle aged female patient suffering in pain during a 3 week ordeal to approve needed medication rejected by Express Scripts.
- (3) Premature infant denied by Express Scripts for needed vaccine to protect against RSV. My office is saddled with a \$2500.00 purchase price.
- (4) United Healthcare and Oxford subsidiary denies teenage boys the HPV vaccine. The FDA approved vaccine prevents genital warts and transmission of virus that causes cervical cancer. The State Dept of Health has allowed public healthcare funds to be used to vaccinate these adolescents; however, this increases tax payer burden but maximizes profits for United Healthcare.