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MA Prescription Drugs -- Prior Authorization (DHFS)

[LFB Summary of the Governor's Budget Reform Bill: Page 51, #5 & #6]

CURRENT LAW

Under federal law, pharmaceutical manufacturers may enter into agreements with the U.S. Department of Health and Human Services (DHHS), on behalf of state medical assistance (MA) programs, to provide rebates for drugs purchased by beneficiaries enrolled in state MA programs. Additionally, state MA programs must provide coverage of prescription drugs produced by manufacturers that enter into rebate agreements with DHHS, except that states may exclude coverage of a drug if the prescribed use is not for a medically accepted indication or used for certain purposes, such as weight loss or gain, promotion of fertility, smoking cessation or cosmetic purposes.

States may subject any drug covered under its MA program to prior authorization requirements, meaning that a pharmacy must receive prior approval from the program before reimbursement would be available for a drug purchased by an MA recipient. Federal law requires that a state's prior authorization process must provide responses to requests by telephone or other telecommunication device within 24 hours of a request's submission and provide for dispensing of at least a 72-hour supply of a covered drug in an emergency situation.

The Department of Health and Family Services (DHFS), in accordance with federal law, requires prior authorization for some prescription drugs purchased by MA recipients to: (a) prevent potential drug abuse or misuse; (b) prohibit reimbursement for drugs used for cosmetic purposes only; and (c) encourage the use of lower cost, therapeutically equivalent drugs when appropriate. Current prior authorization requirements apply to certain prescription drugs used to treat ulcers, pain relief, hypertension and congestive heart failure and stimulants, hormone therapy drugs, and drugs used to promote fertility and to treat impotence. For most drugs, prior authorization is available electronically and a response to a request for prior authorization is available almost immediately.

Many private health plans require enrollees to use certain drugs by creating formularies (a list of drugs covered by a health plan), or encourage enrollees to use certain drugs by requiring enrollees to pay a larger portion of the costs of a drug if it is not considered a preferred drug by the plan. State MA programs are prohibited from using formularies or preferred drug lists in this way, since MA programs must cover all drugs produced by manufacturers that enter into rebate agreements with DHHS on behalf of states and cannot require recipients to make copayments that are more than nominal in amount. However, many states, including Wisconsin, use prior authorization to encourage the use of lower-cost, therapeutically-equivalent drugs by requiring prior authorization for single-source innovator drugs when a therapeutically-equivalent drug is available generically within the same classification. Single-source innovator drugs are drugs for which a patent is pending for the drug's chemical compound.

Therapeutically-equivalent drugs are not the same as generic drugs. A drug is a generic equivalent if, as determined by the U.S. Food and Drug Administration, the chemical compound of the active ingredients are identical to the innovator drug and its manufacturing facility meets standards for quality assurance. Generically-equivalent drugs are only available after an innovator drug no longer has patent protection.

Therapeutically-equivalent drugs are drugs that treat a condition in the same manner as other drugs, but the chemical compound of the drugs' active ingredients are different. Such differences in the chemical compound may affect the types or degree of a side-effect or effect the potential risks associated with a certain type of medication. An example of drugs in a category usually considered to include therapeutically-equivalent drugs would be proton pump inhibitors. These drugs, which block the transport of hydrogen ions into the stomach, can be effective at treating ulcers. Drugs in this category include well-known brand name drugs, such as Prilosec, Prevacid and Nexium.

There is no agreed upon standard for determining when a drug is therapeutically-equivalent to another. Further, a single-source innovator drug may be the most appropriate drug for certain individuals based on certain risk factors and potential side effects. Therefore, states and private health plans that use formularies or prior authorization requirements to encourage the use of lower-cost, therapeutically-equivalent drugs develop standards to determine when the use of a single-source innovator drug is appropriate and should be approved for reimbursement. Most health plans use a committee of medical professionals to identify those drugs to be included on a formulary and the standards used for approving drugs subject to limits. These committees are usually referred to as pharmacy and therapeutics committees.

Currently, DHFS convenes a committee to review proposals to change policies and standards for prior authorization requirements for prescription drugs used by MA recipients before such proposals are acted upon by the DHFS Secretary. This committee includes five pharmacists, three physicians and a nurse. Three of the pharmacists are DHFS consultants, one is a faculty member of the University of Wisconsin-Madison, School of Pharmacy and one is a DHFS employee. The three physicians and the nurse are all DHFS employees. None of the current members are actively practicing their trade, meaning they do not see patients.

Other cost-saving measures used by DHFS to reduce prescription drug expenditures include educational efforts to inform prescribers about the costs and relative effectiveness of certain prescription drugs, incentive payments to pharmacies for services provided to MA recipients which result in savings to MA, automatic substitution of a generic drug when available, except in cases where a prescriber indicates that the brand name version of a drug is medically necessary, and payments to pharmacists for disease management activities associated with MA recipients diagnosed with asthma. Additionally, as required under federal law, DHFS operates prospective and retrospective drug utilization reviews which attempt to identify abusive utilization of prescription drugs, over- or underutilization of prescription drugs and identifies circumstances in which a prescription is contraindicated, based on other medications a recipient may be taking.

Under the terms of the two federal waivers under which BadgerCare operates, all MA policies regarding the use of and reimbursement for prescription drugs apply under BadgerCare as well.

GOVERNOR

Reduce funding for MA and BadgerCare benefits by $3,809,200 ($1,551,100 GPR and $2,258,100 FED) in 2001-02 and $29,220,000 ($11,994,200 GPR and $17,225,800 FED) in 2002-03 to reflect reductions in MA and BadgerCare expenditures for prescription drugs used by MA and BadgerCare recipients. The administration indicates that, through the use of prior authorization requirements and other cost-saving measures, MA and BadgerCare costs for prescription drugs would be reduced by these amounts. This item includes: (a) reducing MA benefits funding by $2,477,100 GPR and $2,103,700 FED in 2001-02 and $11,522,900 GPR and $16,219,700 FED in 2002-03; and (b) reducing BadgerCare benefits funding by $74,000 GPR and $154,400 FED in 2001-02 and $471,300 GPR and $1,006,100 FED in 2002-03.

Additionally, require the DHFS Secretary to create a prescription drug prior authorization committee to advise DHFS on issues related to prior authorization decisions made concerning prescription drugs used by MA recipients. Require the Secretary to appoint as members at least all of the following: (a) two physicians who are currently in practice; (b) two pharmacists; (c) one advocate for MA recipients; and (d) one representative of the pharmaceutical manufacturing industry.

DISCUSSION POINTS

Savings Available from the Use of Prior Authorization

1. The administration indicates that the funding reductions included in the bill relate to anticipated savings in prescription drugs expenditures under MA and BadgerCare that would primarily result from the expanded use of prior authorization implemented over this biennium. To the extent such savings are not available from prior authorization, the administration indicates that

DHFS would be required to reduce drug expenditures in other ways.

2. Several opportunities to reduce prescription drug expenditures could be available over the biennium as several drugs are expected to lose patent protection. These include the following well-known drugs: (a) Prilosec, a proton pump inhibitor used to treat ulcers; (b) Prozac, an antidepressant classified as a selective serotonin reuptake inhibitor (SSRI); (c) Mevacor, a cholesterol-lowering drug classified as an antihyperlipidemics; and (d) Claritin, a non-sedating antihistamine. Claritin is not expected to lose patent protection until late in the biennium. Therefore, any potential savings available from prior authorization requirements on similar drugs would not likely be available until the next biennium.

3. DHFS plans to submit proposals to its prior authorization committee supporting the implementation of prior authorization requirements on patented drugs in the proton pump inhibitors category, antihyperlipidemics and non-sedating allergy treatment categories to be implemented once drugs in these categories become available generically. In addition, DHFS is considering recommending to its committee that prior authorization be required for sedative and hypnotic drugs. DHFS indicates that it does not intend to pursue prior authorization requirements for SSRIs due to concerns expressed by advocates for individuals with mental illness that restricting access to prescription drugs is inappropriate for individuals with mental illness. Nonetheless, DHFS expects some savings to be available due to reduced prices on generic Prozac and continues efforts to educate prescribers on the effectiveness of generic Prozac relative to other SSRIs.

4. The MA program is not guaranteed savings from prior authorization for several reasons. First, although patents for all of these drugs are expected to expire over the biennium, court challenges and certain federal provisions that allow for extensions of patent protection could allow these drugs to retain their patent protection beyond the current expiration dates, thereby providing uncertainty about when savings would first be available. Second, prior authorization policies for these new categories of drugs have not yet been reviewed by DHFS' prior authorization committee nor acted upon by the DHFS Secretary. The extent to which savings would be available could vary significantly, depending on the review of this committee and the decisions made by the DHFS Secretary.

5. Health care researchers and policymakers across the country advocate the effective use of prior authorization in MA programs to limit the use of higher-cost prescription drugs when lower-cost alternatives are available and appropriate as one of the most effective ways to reduce health care costs for prescription drugs.

6. Prior authorization policies and formularies are often seen as a way to counter manufacturers' direct-to-consumer advertising, which has increased nationally from approximately $790 million in 1996 to almost $2.5 billion in 2000, according to the Kaiser Family Foundation's updated Prescription Drug Trends Chartbook. Many contend that such advertising has unnecessarily increased demand for the most expensive pharmaceuticals. Pharmaceutical manufacturers argue that such advertising simply provides information, which empowers patients and fosters communication between physicians and patients. Ultimately, the manufacturers argue,

the determination of whether a drug is appropriate is up to a patient and his or her physician.

7. DHFS estimates that MA drug costs will be reduced by over $26 million over the 2001-03 biennium as a result of current prior authorization policies which limit the use of certain drugs to treat ulcers (histamine 2 antagonists), high blood pressure (ACE inhibitors) and pain medications primarily used to treat arthritis (nonsteriodal anti-inflammatory drugs, known as NSAIDs). These savings are achieved by moving market share from single-source innovator drugs to multiple-source drugs in the same classification, which are available generically.

8. Critics of prior authorization argue that such policies restrict MA recipients' access to appropriate prescription drugs and do not recognize the value of incremental innovation in medicine. These arguments are based on the premise that MA programs should cover the costs of the most appropriate drug used by an MA recipient, as determined by the patient and his or her physician. Therefore, any policies that place restrictions on access to more expensive drugs inappropriately interfere with the doctor-patient relationship.

9. It does not appear that DHFS' current use of prior authorization ignores the value of incremental innovation. Rather, by allowing single-source innovator drugs to be approved under some circumstances, such as when a lower cost alternative has been tried and found ineffective or inappropriate, or in some circumstances, when an individual is already stabilized on a single source innovator drug, DHFS' current prior authorization policies recognize that these drugs may be appropriate in those instances. However, in many instances, a lower-cost alternative may be just as appropriate.

10. Further, reducing costs for prescription drugs through the use of formularies and prior authorization can be ethical if done appropriately, according to an article by individuals at the Department of Clinical Bioethics at the Warren G. Magnuson Clinical Center at the National Institutes of Health. According to their analysis, accepting resource constraints must be one of the fundamental values of an ethical policy for pharmaceutical benefit management. "Step therapy," which the article defines as a policy that "permits the use of more costly medications only after less expensive drugs with the same indications have been tried and rejected because of therapeutic inefficacy or adverse reactions," is ethical if the policies are "developed through an inclusive, transparent decision-making procedure." By including physicians and patients in the decision-making process for controls on drug utilization, a program can foster trust between patients and physicians "collectively rather than individually," making the policy more ethically permissible.1

11. Other concerns have been raised that drug formularies and prior authorization policies can increase a health plan's costs in other areas, such as increased physician office visits, use of laboratory tests, hospital emergency rooms and inpatient hospital admissions. However, many evaluations of prior authorization and formularies have been inconclusive, criticized by researchers for poor evaluation design, or have focused on specific policies and then used to draw

[1] Burton, Stephan L., Randel, Lauren, Karen Titlow and Emanuel, Ezekiel J.; "The Ethics of Pharmaceutical Benefit Management;" *Health Affairs*, September/October, 2001.

conclusions about prior authorization in general. However, according to several researchers, one evaluation that did provide conclusive findings was based on a sound evaluation design and analyzed the use of prior authorization policies applicable to the types of prior authorization policies used by DHFS to encourage therapeutic substitution. This evaluation, reported in the New England Journal of Medicine, evaluated the use of prior authorization for NSAIDs used by Tennessee MA recipients. This evaluation found that "the prior-authorization program achieved its intended effect of materially decreasing Medicaid expenditures for pharmaceuticals without undesirable changes in the use of other types of medical care."

12. In considering these issues, the Joint Finance Committee may determine it is appropriate that, when a lower-cost alternative is available and appropriate, DHFS should encourage the use of that lower-cost alternative. This would be consistent with current administrative rules that specify that one of the purposes of prior authorization for any MA service includes its use to "determine if less expensive alternative care, services or supplies are usable." As a result, the Committee could adopt the Governor's provision to reduce MA and BadgerCare benefits as a result of possible savings available from prior authorization, despite uncertainty regarding the availability of such savings.

13. The administration indicates DHFS would be required to achieve the savings included in the bill, even if the savings did not materialize from prior authorization policies. Some methods DHFS could use to reduce prescription drug costs in the event savings are not available from prior authorization include increasing existing efforts to educate prescribers about the relative cost effectiveness of certain drug treatments, efforts to increase compliance with cost-savings measures (such as generic substitution) and increased use of pharmaceutical care management services and continued efforts to identify conditions appropriate for disease management efforts with the intention of improving overall health care. Additionally, the administration hopes to achieve savings in prescription drug costs through the availability of generic SSRIs. However, such efforts may not be sufficient to realize the savings assumed in the Governor's bill, particularly if DHFS does not implement prior authorization policies as proposed.

14. Other savings could be available by using mail-order delivery of prescription drugs used to treat chronic conditions or reducing reimbursement rates paid to pharmacies for prescription drugs. However, during the 2001-03 biennial budget debate, the Legislature did not adopt the Governor's recommendations to authorize the use of mail-order delivery of prescription drugs and approved a more limited a reduction in the reimbursement rate for prescription drugs than recommended by the Governor. Therefore, DHFS indicates that it would not implement such provisions without specific legislative approval to do so.

15. If the Joint Finance Committee does not wish to encourage greater use of prior authorization or other means to reduce MA drug costs, or determines that it is not appropriate to reduce the MA and BadgerCare benefits appropriation without the certainty that DHFS will reduce drug costs by corresponding amounts, it could restore MA and BadgerCare benefits funding that would be deleted in the bill ($13,545,300 GPR and $19,483,900 FED over the biennium).

Prior Authorization Committee

16. DHFS indicates that its current process for determining policies for prior authorization requirements is based on a review of scientific research and the clinical effectiveness of prescription medications. In determining whether to support the Governor's provision to require actively practicing physicians, an advocate for MA recipients and a representative of the pharmaceutical manufacturing industry, the Committee should consider the role such members would play on the DHFS committee and what effect the presence of such members would have on the recommendations made by the committee. The Governor's provision to require the DHFS committee to require at least two pharmacists is consistent with the current makeup of the DHFS committee.

17. One significant difference between the current structure of the DHFS committee and many private plans' committees is that DHFS' committee does not include any medical professionals currently in practice. The members are all either DHFS staff or paid consultants. By including at least two practicing physicians, the composition of the DHFS committee would be more similar to many private health plans' pharmacy and therapeutics committees. However, the Governor's recommendations to require that the DHFS committee include a representative of the pharmaceutical manufacturing industry and an advocate for MA recipients would add a perspective to the committee not typically included in pharmacy and therapeutics committees maintained by private health plans.

18. Based on conversations with pharmacy directors at several health maintenance organizations in Wisconsin and an official with the U.S. General Accounting Office (GAO), it appears that many pharmacy and therapeutics committees include actively practicing health care professionals. According to these individuals, actively-practicing medical professionals are most likely to have sufficient experience to consider all of the issues involved in making decisions about formularies and prior authorization, including understanding the needs of patients and the complex technical data associated with determining therapeutic equivalency among drugs.

19. The pharmacy directors also indicated that individuals that solely represent patients were not included on their pharmacy and therapeutics committees and that it is uncommon for patient advocates to be included on such committees. One director indicated that when patient representatives have been included on pharmacy and therapeutics committees, the experience has been disappointing and frustrating for the members on such committees. The information presented at most committee meetings is of such a clinical and technical nature, it is difficult for individuals without a medical background to understand and analyze the data provided to the committee. The pharmacy directors also indicated that actively practicing medical professionals are often the best advocates for the interests of patients because they have the medical expertise to interpret and analyze the data and have sufficient interaction with patients to understand the needs and concerns of patients.

20. Since the current DHFS committee does not include actively practicing medical professionals, the Joint Finance Committee could determine that it is appropriate to support the

Governor's recommendation that the DHFS committee include at least two actively practicing physicians. Additionally, the Joint Finance Committee could delete the provision to include an advocate for MA recipients on the DHFS committee, since actively practicing medical professionals could be the most effective at advocating for the interests of patients.

21. However, as indicated earlier, in their analysis of the ethics of pharmaceutical benefit management, individuals with Department of Clinical Bioethics at the Magnuson Center suggested that including patients in the decision-making process to establish controls on drug utilization makes the process more transparent and therefore, the policies established by that process are more ethically permissible. For this reason, the Committee could determine that it is appropriate to support the Governor's provision to require that the DHFS committee include an advocate for MA recipients. If the Joint Finance Committee adopts this provision, it could consider modifying it to ensure that the advocate for MA recipients has sufficient medical background to effectively evaluate the materials presented to the DHFS committee.

22. In deciding whether to adopt the Governor's recommendations regarding inclusion of a representative of the pharmaceutical manufacturing industry, the Joint Finance Committee may want to evaluate whether the interests of the pharmaceutical manufacturing industry would be consistent with or in conflict with the interests of the MA program and recipients.

23. Representatives of the pharmaceutical manufacturers have expressed concerns that, while pharmaceutical manufacturers are offered the opportunity to provide testimony to the DHFS committee under current practice, the perspectives of the manufacturers are not seriously considered by the DHFS Committee. The administration indicates that including a pharmaceutical manufacturing industry representative on the DHFS committee would provide a more formal role for the industry in deliberations on prior authorization policies.

24. However, DHFS indicates that its current committee does consider the input from pharmaceutical manufacturers and has modified proposals in response to information provided by manufacturer representatives. DHFS indicates that its original proposal to require prior authorization for certain pain reliever drugs known as NSAIDS, which treat the symptoms of arthritis, would have required prior authorizations for NSAIDs prescribed to MA recipients under 75 years of age. Based on evidence provided by manufacturers, the DHFS committee instead recommended prior authorization for NSAID prescriptions for MA recipients under 65 years of age. It was this recommendation that was adopted by the DHFS Secretary.

25. Based on conversations with HMO pharmacy directors and a GAO official, it appears highly unlikely that representatives of the pharmaceutical manufacturing industry would be represented on pharmacy and therapeutics committees that HMOs use to develop and administer drug formularies.

The pharmacy directors expressed concern over having pharmaceutical manufacturing representatives on such committees. They suggested that it would not be appropriate, since most representatives would have a conflict of interest -- a company representative would either represent

the interests of the manufacturer that produces one of the drugs under consideration, or would be a competitor of the manufacturer of one of the drugs in question.

However, one director indicated that having a representative of the industry as a whole (such as a representative from an organization representing pharmaceutical manufacturers), rather than a representative of a specific manufacturing company, would probably not create a conflict of interest and might improve manufacturers' understanding of the basis for decisions by such committees. However, this same director indicated that such representatives would likely not be supportive of most prior authorization or formulary policies, since most prior authorization and formulary policies are in conflict with manufacturers' interest to increase access to and sales of their drugs.

26. Concerns about conflicts of interest with drug manufacturer representatives are reflected in a document entitled "The Principles of a Sound Drug Formulary System," which has been adopted by the Academy of Managed Care Pharmacy, American Society of Health-System Pharmacists, the U.S. Department of Veterans Affairs, the National Business Coalition on Health and U.S. Pharmacopoeia. These principles state that formulary system policies should require pharmacy and therapeutics committee members to reveal, by signing a conflict of interest statement, economic and other relationships with pharmaceutical entities that could influence committee decisions. Further, these principles state that these committees should exclude product sponsor representatives from committee membership and from attending committee meetings.

27. Based on concerns about potential conflicts of interest, DHFS has indicated that the ideal candidate to represent the pharmaceutical manufacturing industry under the Governor's recommendations would be an individual not directly affiliated with one company, but rather, would be representative of the industry as a whole.

28. It is unclear whether an individual representing the industry as a whole would be able to be participate in deliberations on prior authorization policies to the extent the deliberations consider pricing information on drugs under consideration. According to a GAO official, representatives of the manufacturing industry are usually very careful to avoid participating in discussions about drug pricing policies in order to avoid potential violations of federal anti-trust laws. According to this official, the Federal Trade Commission has required pharmaceutical manufacturers that own pharmacy benefit management companies to establish fire walls between the manufacturing component of the business and the benefit management component of the business to ensure that the manufacturing component does not influence the benefit management component's process for making decisions about which drugs the benefit manager should cover. This issue has been similarly reported in the Wall Street Journal.

The administration argues that because the DHFS committee is only advisory to the DHFS Secretary, concerns about anti-trust issues or potential conflicts of interest are minimized. If it is necessary to address concerns about conflicts of interest or anti-trust issues, the administration indicates that one possible solution would be to establish two separate committees, one that would evaluate the clinical effectiveness of drugs under consideration for prior authorization and one that would consider pricing and coverage issues and the pharmaceutical representative could be included

on the committee evaluating clinical effectiveness of drugs but not pricing and coverage issues.

29. If the Joint Finance Committee decides not to adopt the Governor's recommendation to require the inclusion of a pharmaceutical manufacturer representative on the DHFS prior authorization committee, but wishes to ensure that the interests of manufacturers are considered by the committee, it could amend the bill to require the DHFS committee to consider input from representatives of a drug's manufacturer before submitting recommendations to the DHFS Secretary. This would be consistent with current DHFS practice.

30. In summary, DHFS' current approach to prior authorization appears to have yielded cost-savings to the MA program without adversely affecting the health of MA recipients by recognizing the value of more expensive drugs when appropriate. Additionally, under its current approach, DHFS has been responsive to the concerns of advocates for MA recipients with mental illness by not pursuing prior authorization on SSRIs and instead, is pursuing other efforts to maximize potential savings from generically-available SSRIs. Finally, modifying the makeup of the DHFS committee may make it more difficult for DHFS to generate savings in the MA and BadgerCare programs through the use of prior authorization. For these reasons, the Committee could determine that the Governor's provision is undesirable and delete it from the bill.

31. The alternatives under "A" in this paper relate to the Governor's recommendation to reduce MA and BadgerCare benefits funding to reflect savings DHFS would be required to generate in drug costs, either through increased use of prior authorization or other means. The alternatives under "B" relate to the Governor's recommendations regarding the prior authorization committee. The first alternative under "B" would approve all of the Governor's recommendations regarding the prior authorization committee. The second alternative presents several options to modify the Governor's recommendations and the third alternative would delete all of the Governor's recommendations relating to the DHFS prior authorization committee.

ALTERNATIVES TO BILL

A. Funding

1. Adopt the Governor's recommendation to reduce MA and BadgerCare benefits by $3,809,200 ($1,551,100 GPR and $2,258,100 FED) in 2001-02 and $29,220,000 ($11,994,200 GPR and $17,225,800 FED) in 2002-03 to reflect anticipated reductions in MA and BadgerCare expenditures for prescription drugs used by MA and BadgerCare recipients.

Alternative A2	GPR	FED	TOTAL
2001-03 FUNDING	$13,545,300	$19,483,900	$33,029,200

2. Delete the Governor's recommendation to reduce MA and BadgerCare benefits to reflect anticipated reductions in MA and BadgerCare expenditures for prescription drugs used by

MA and BadgerCare recipients.

B. Prior Authorization Committee

1. Adopt the Governor's provisions to require DHFS to establish a prescription drug prior authorization committee with members including at least two physicians, who are currently in practice, two pharmacists, one advocate for MA recipients and one representative of the pharmaceutical manufacturing industry.

2. Modify the Governor's provisions by adopting one from each of the following sections:

a. Actively-Practicing Physicians

(1) Adopt the Governor's provision requiring DHFS to include at least two physicians who are currently practicing on its prior authorization committee.

(2) Delete the Governor's provision regarding actively-practicing physicians.

b. Advocate for MA Recipients

(1) Adopt the Governor's provision requiring DHFS to include an advocate for MA recipients on its prior authorization committee.

(2) Adopt the Governor's provision regarding an advocate for MA recipients, but specify that the advocate have sufficient medical background to evaluate a drug's clinical effectiveness, as determined by DHFS.

(3) Delete the Governor's provision regarding the advocate for MA recipients and instead require the DHFS committee to accept testimony from such advocates in its review of prior authorization policies.

(4) Delete the Governor's provision regarding the advocate for MA recipients.

c. Representative of the Pharmaceutical Manufacturing Industry

(1) Adopt the Governor's provision requiring DHFS to include a representative of the pharmaceutical manufacturing industry on its prior authorization committee.

(2) Delete the Governor's provision regarding the representative of the pharmaceutical manufacturing industry. Instead require the DHFS committee to accept testimony from such representatives in its review of prior authorization policies.

(3) Delete the Governor's provision regarding a representative of the pharmaceutical manufacturing industry.

3. Delete all of the Governor's recommendations relating to the prior authorization committee.

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