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Chief Health Policy Advisor
Office of Lt. Governor Nancy Wyman
State Capitol
Hartford, CT 06106

Comments to Health Care Cabinet's Draft Recommendations on Pharmaceutical Costs

Dear Ms. Veltri:

The three undersigned legal services programs represent low income residents throughout Connecticut. Lacking resources, these are individuals who cannot afford any cost-sharing for prescription drugs or other health care goods and services, and most of whom are on the Medicaid program which, for very good policy reasons, prohibits such cost sharing. We also represent some low income individuals who must buy insurance on the exchange (AHCT). We are pleased to submit these joint comments mostly in support of the Health Care Cabinet's draft recommendations related to prescription drug costs, along with some suggestions for improvements to a few of those recommendations, and a strong objection to one of them.[1]

I. Introduction

We agree about the excessive prices of prescription drugs, and that we need to control drug prices for the benefit of everyone, including, indirectly, Medicaid enrollees who do not pay, and cannot afford to pay, drug copays, co-insurance or deductibles. Although Connecticut's Medicaid program has been a major cost and quality success since we wisely jettisoned the capitated managed care system in January 2012, we recognize that pharmaceutical costs still represent a large, and increasing, percentage of total Medicaid costs due to high prices, and this could cause pressure to cut Medicaid benefits or eligibility in the future. We also agree with most of the ideas set forth in the draft report for addressing those high prices. These should be adopted, so long as they do not restrict access to any prescription drugs required by federal law to be covered for Medicaid enrollees, who have no other resources to gain access to such drugs, where medically necessary for the individual. Our objections to one proposal which would not meet that test are set forth below.

[1] In full disclosure, one of us, Sheldon Toubman, was on the work group which dealt with consumer education issues and produced recommendations related to such education.

We also support the proposals for ameliorating the effects of high drug prices on low income consumers **not** on Medicaid who are subject to cost-sharing, some of which are quite creative. As noted in the report, while some of those protections may cause a small increase in premium costs, the avoidance of high point of service costs is critical to avoid financially-related lack of adherence, and we note that, for our low-income clients on the exchange with premium tax credit subsidies, they are largely insulated from those premium increases. We will not comment on all of the various proposals in the draft report but highlight a few which we support or support but for which we suggest modification. And then we address the one recommendation that we cannot support because of its direct threat to Medicaid enrollees.

II. Specific Recommendations Supported (with some modifications suggested)

We particularly support these recommended legislative or administrative recommendations which can help to drive down drug prices overall:

- Create a Drug Review Board to investigate high drug prices and consider referrals to the Attorney General where prices cannot be justified by the market or clinical value (# 1.a, pages 7-8).
- Require manufacturers, PBMs and health insurers to disclose to the Office of State Ethics the funding they provide to non-profit patient advocacy groups (but putting the reporting obligation on these large corporate entities and not on the often small non-profit recipients) (#1.b., pages 8-9)
- Require advance reporting to the CT Insurance Department, and thus to the public and legislators, of any planned drug price increases exceeding certain thresholds (#2.a, page 12)
- Require facilities and physician offices to publicly post already publicly available information about gifts and monetary compensation accepted from drug manufacturers (#3.d., pages 14-15)
- Review the potential for wholesale importation from Canada (#3.r.)(page 23)

We also support these proposals which will or may help to **directly** lower out-of-pocket costs for low income consumers, or make cost-sharing more manageable:

- Require that consumer coinsurance and deductibles payments be based not the list price but on the net price after rebates, negotiated between PBMs, manufacturers and payers (#1.d., page 10)
- Require on-line availability of information from insurers about out-of-pocket net drug cost to consumers to allow for informed decision-making during open enrollment periods (#3.a., page 13)

- Explore creating a state-administered revolving loan program that allows patients with high deductible plans or with significant coinsurance responsibilities the ability to amortize the upfront costs incurred at the start of each plan year. (#3.c., page 14). *We suggest consideration of a means test so limited funds can go to lower income individuals*.
- Set co-payment and co-insurance maximums per month (#3.e., page 15)
- Ensure a robust exception process based on medical necessity in any situation where a ban on manufacturer coupons is imposed because of overall harm to drug price control from the manufacturers' use of such coupons (#3.f., pages 15-16)
- Eliminate co-pays for asthma, high blood pressure, diabetes and high cholesterol medications. (#3.p., page 22). *We should go beyond considering this and also require eliminating this for congestive heart failure and COPD, and we should consider the same for psychiatric medications, where adherence is a significant issue*.

A very important requirement for any of these proposals to work is to ensure that decision-makers are not conflicted. The proposed Drug Review Board, which we support, includes a recommendation to "*consider developing* conflict-of interest rules for the membership similar to those employed by the Federal Drug Administration to avoid conflicts of interest." (#1.a.i., page 7)(emphasis added). The FDA rules, while not perfect, are a strong model and there is no reason to merely "consider developing" such rules. The recommendation should be changed to **require adoption of COI rules at least as stringent as those applied by the FDA**.

III. Objection to Proposed New Restrictions on Access to FDA-Approved Drugs Covered for Medicaid Enrollees Under Federal Law

The Report proposes to create a work group "to evaluate the potential risks and benefits of ***adding exclusions or more onerous prior authorizations to the Medicaid formulary*** in order to drive toward value based pricing.*"* (#3.l., pages 19-20)(emphasis added). Unlike almost all of the other proposals, this proposal attempts to get at high drug prices through the indirect means of restricting, or possibly outright blocking, access to prescribed drugs. Worse, it does this for **Medicaid** enrollees who are by definition low income and do not have credit cards and other alternate resources, unlike most middle class patients, and who therefore generally have no other means of obtaining a drug denied Medicaid payment at the pharmacy. While well-intentioned, this proposal, unlike proposals which seek to educate prescribers and consumers with objective comparative effectiveness information, would actually harm a vulnerable group which the rest of the report seeks to protect.

We in legal services have extensive experience with low income Medicaid clients who are blocked from needed and prescribed medications because of prior authorization (PA) requirements already imposed on them. While DSS claims that these burdensome requirements merely require a little paperwork from their providers, the reality is that prescribers routinely fail to do this, resulting in denials at the pharmacy which the patient is powerless to get around due to lack of resources. We are aware of cases where such denials of drugs at the pharmacy have resulted in hospitalizations—at great expense to the taxpayers under Medicaid.

The proposal presumes that it is okay to impose still "more onerous" PA requirements on Medicaid enrollees because the goal is to discourage the use of high cost drugs in favor of lower cost ones. But, apart from the fact that often the higher cost drug is superior to the lower cost one, and that is why it was prescribed, the reality is that the PA requirements DSS **already** imposes routinely result in Medicaid patients at the pharmacy, lacking any alternative resources, going without **any** treatment, even the lower cost drug. Indeed, the whole point of prior authorization is to create bureaucratic obstacles to that particular prescribed treatment, whatever the ultimate motive is (though saving money by discouraging use of the drug is almost always the goal).

And this is exactly what PA requirements produce. It is often assumed that prescribers check PA lists before prescribing and then rationally decide whether to go through the burden of seeking PA or just choose a different drug that does not require PA. This is largely a false assumption as applied to very busy providers. The latest available data from DSS, for 2016, as presented to the MAPOC Consumer Access Committee in May of 2017, shows that a one-time 14 day temporary supply was provided for PA-only drugs, for which PA had not been sought at the time a script was presented at the pharmacy by a Medicaid enrollee, 5,983 times. Of these 5,983 cases, 797 returned to the pharmacy and were **denied any drug at all** the second time around. This is because their providers still had not requested PA 14 days later, indicating that PA requirements are inherently burdensome.

The Report suggests the creation of a work group to explore the use of these "more onerous" PA requirements and to evaluate "adding exclusions," including "a rigorous examination of whether the proposed change would result in discrimination to individuals with high-cost chronic or rare diseases." This is beside the point because PA and certainly out and out exclusions **will** result in denials of prescribed medications for anyone with a medical condition requiring these high cost drugs.

For all of these reasons, imposing still "more onerous" PA requirements on low income Connecticut Medicaid recipients should be rejected, no matter what other states may unwisely plan on doing with their Medicaid populations. And, of course, the even more harsh proposal, to **exclude entirely** FDA approved drugs required to be covered under federal Medicaid law, should be rejected as a dangerous proposal needlessly imposing denials on the most vulnerable group of patients in the state.

We also note that imposing such exclusions would require a waiver from the federal Medicaid agency, CMS, since federal law does not otherwise permit such exclusions. Under a different administration it might be possible to get a clean approval of such a proposal, ill-advised as it is, from CMS. But the Trump Administration is aggressively pushing very harmful Medicaid waiver ideas on the states, including mandatory work requirements in order to receive Medicaid, and it is recommending states include these clearly harmful ideas when they are approached with other waiver ideas, making the submission of **any** Medicaid waiver proposal to CMS a fraught endeavor.

Finally, if the Cabinet were to disregard our strong objections to either "more onerous" PA requirements or a federal waiver to impose absolute exclusions on Medicaid-covered drugs,

the proposed work group intended to be "inclusive of all stakeholders including consumer representation" would need to be substantially beefed up with independent consumer voices. The report declares that, "[i]n order to ensure adequate consumer representation, the Consumer Advisory Board (CAB) should be consulted when appointing consumer stakeholders to the workgroup." While we have no objection to asking the CAB, which includes some of our advocate colleagues, to appoint a representative to the workgroup, looking to the CAB will clearly **not** accomplish the goal of "ensur[ing] adequate consumer representation." The CAB members are appointed, directly or indirectly, by the executive branch, unlike most official bodies which have many other legislative or other appointments.

Accordingly, to "ensure adequate consumer representation," it is necessary to look beyond the CAB to broad representation from independent consumer advocates. Based on our extensive experience representing Medicaid enrollees with drug access issues, and particularly related to the already burdensome PA requirements under the Connecticut Medicaid drug benefit, we urge that advocates from legal services be included on any such workgroup.

Thank you for your attention to our comments.

Sincerely,

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