



Quality is Our Bottom Line

THE CONNECTICUT ASSOCIATION OF HEALTH PLAN URGES OPPOSITION TO:

**SB 147 THE USE OF PREFERRED DRUG LISTS
AND PRIOR AUTHORIZATION PROCEDURES BY
THE DEPARTMENT OF SOCIAL SERVICES
IN THE ADMINISTRATION
OF THE
DEPARTMENTS PRESCRIPTION DRUG PROGRAMS**

**HUMAN SERVICES COMMITTEE
FEBRUARY 6, 2007**

On behalf of the Connecticut Association of Health Plans we ask that you oppose SB 147. This bill would increase pharmacy costs for Medicaid FFS, ConnPace, SAGA, and Medicaid Managed Care without improving access or quality of care. Medicaid managed care plans currently provide a 30 day temporary supply for urgent or emergent drugs.

- ◆ **This bill eliminates generic substitution. Enrollees automatically receive the brand instead of a generic substitution. Compels issuance of brand.**
- ◆ **Does not allow review for medical necessity.**
- ◆ **Language permits enrollees to receive excluded drugs.**
- ◆ **Requires hearing notices when no denial for medical necessity has been made.**
- ◆ **Time frames exceed federal requirements.**
- ◆ **Potentially mandates a notice for every prescription with a refill. Each month new notice and new hearing.**
- ◆ **Would require DSS to open contracts with managed care plans to negotiate the impact.**
- ◆ **Fiscal impact is staggering.**

Section 1(d) 1

- **Entirely eliminates generic substitution by mandating an automatic 15-day supply of any prescribed drug.**
- **Does not allow for review of excluded drugs such as fertility, smoking cessation or weight loss. Theoretically a 12-year-old could obtain a 15-day supply of fertility medication.**
- **Enrollee could remain on an excluded or non-generic medication for the entire fair hearing process, which could be 60 to 90 days. The state or health plan would pay the higher cost.**
- **Does not allow for the pharmacist to call the provider to switch to a generic drug or formulary medication.**

Section 1(d) 2

- **Mandates 24-hour notice to the provider when the member has already obtained the drug as mandated in section 1(d). The notice is unnecessary.**

- Federal regulations provide up to 14 days to make medical necessity decision not 24 hours. It is difficult to receive the information necessary from providers to make a medical necessity determination within 24 hours.

Section 1(d) 3

- If a temporary supply is dispensed there is no denial. This section would mandate a notice to a member and the right to a fair hearing when there hasn't been a denial.

Section 1(e)

- Federal Regulations 438.4008f provides a fair hearing take place in not less than 20 or exceed 90 days. This would mandate a fair hearing in 10 days.

Section 1(f)

- Requires duplicative notices.
- What is the definition of a drug "newly" subjected to prior auth requirements. Does that mean within 30, 60, 90 days?

Section 3

- The Department of Social Services has already retained Mercer to conduct a study of the pharmacy benefit and are currently in discussions with the advocates and the HUSKY plans regarding the design.

The managed care plans and the Department of Social Services are currently in discussions regarding the administration of the pharmacy benefit. This is a very complex and potentially very costly issue to the state. The MCO's are bound to adhere to the contract with the state and the parties should negotiate and mutually agree to any changes to the terms of the contract. That is the surest way to find a solution that will work for everyone in the long run. We respectfully urge your rejection of SB 147.

Thank you for your consideration.