

Statement



Comments on H. B. No. 5450, An Act Establishing a Basic Health Program

March 12, 2012

PhRMA appreciates this opportunity to comment on Connecticut's Basic Health Program (BHP). The BHP presents Connecticut with a new option for expanding health insurance coverage that is distinct from Medicaid and the Health Insurance Exchange. Below, we outline a few key elements that we urge Connecticut to consider as it implements an optimal basic health program.

- First, federal law requires that BHPs are distinct from the Medicaid program as well as from the Exchange.
- At a minimum, Connecticut residents who qualify for BHP enrollment should have a choice of multiple plans within the BHP program.
- The requirements for a standard health plan should mirror the minimum requirements for qualified health plans available under the exchanges. If individuals eligible for a BHP will not have the option to enroll in an exchange plan, they should be assured that the plan in which they enroll under the BHP meets at least the same standards. This includes the criteria set forth in PPACA § 1311(c), such as requirements related to marketing, non-discrimination, accreditation, quality improvement, and uniformity in enrollment procedures and presentation of plan options.
- BHP options should meet the same requirements for network adequacy to assure good access to care. Plans should be certified as meeting such standards for other qualified health plans in the Exchange.
- While standard health plans participating in the BHP will be required at a minimum to offer a package equivalent to the "essential health benefits," we note that comprehensive coverage of prescription drugs is a particularly important aspect of the high quality coordinated medical care that BHPs aspire to offer. Prescription drug coverage is particularly important for patients with chronic conditions, as medication adherence tends to suffer when needed medicines are not covered or cost sharing is unaffordable. As benefit packages are developed for BHPs it will be crucial to recognize the role that prescription drugs can play in reducing long term costs of care by avoiding unnecessary hospitalization and institutional costs.¹ In addition, it is critical that individuals enrolled in the BHP be granted protections similar to those that are afforded to beneficiaries in Medicaid or in the exchanges so as not to disadvantage this population simply based on their income.

Critical patient protections for BHP enrollees include the following best practices in the private market and Medicaid as well as some requirements in place for the Medicare Part D program:

Pharmacy and Therapeutics Committee:

- To the extent that the BHP is offered through multiple competing private plans, the formularies should be developed and reviewed by independent P&T Committees that balance objectives

¹ J.M. McWilliams et al. "Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage," *Journal of the American Medical Association*, 27 July 2011.

related to quality of care and cost containment. A useful starting point for appropriate standards are those applicable in Medicare Part D.²

Formulary Requirements:

- Plan formularies should provide coverage for drugs in categories and classes for all disease states,³ with a broad range of therapeutic options in each category. Particular care should be taken to assure that there is a range of treatment options for conditions that disproportionately affect vulnerable individuals.
- Plan formulary management tools should be no more restrictive than industry standards or relevant guidelines from expert organizations.⁴

Procedures for Prior Authorization and Utilization Management:

- Plans should provide physicians with a standardized form for seeking prior authorization for a covered drug, and should establish a uniform, streamlined process for handling requests for expedited review (i.e., within 72 hours or more expeditiously as the patient's condition requires).⁵
- Plans should approve a prior authorization request if the prescriber certifies the medical necessity of the drug.⁶
- All denials of prior authorization requests should be provided to the prescriber and/or patient in writing.⁷
- If a medicine requires prior authorization, plans should cover a 72-hour supply and process prior authorization requests within 24 hours.⁸
- Any plan that restricts medications with a step therapy or fail first protocol should provide prescribing physicians with a clear and convenient process to expeditiously request an override of the restriction from the insurer.⁹ Such an override may be granted in any of the following circumstances: (i) there is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative; (ii) the alternatives have been ineffective in the treatment of the beneficiary's disease; or (iii) based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.¹⁰

Continuity of Care:

- If an individual has met requirements for prior authorization or similar utilization management while enrolled in Medicaid, or in another state program (such as a BHP plan), the individual should not be required to meet the same or similar requirements again in order to continue on the same medication.
- In the event a drug is removed from a plan's formulary, the plan should continue to cover the prescription drug if requested by the patient and prescriber while the patient is enrolled in the plan.
- For individuals changing plans, the plan should provide a transition process, including a transition fill of medications that are part of ongoing drug therapy.¹¹

² See generally 42 C.F.R. § 423.120; Centers for Medicare & Medicaid Services, Medicare Part D Manual (Part D Manual), Chapter 6 (setting forth the requirements for the P&T Committees required of Medicare Part D plans) (Rev. February 19, 2010).

³ 42 C.F.R. § 423.120(b)(2).

⁴ Part D Manual, Chapter 6, § 30.2.2.

⁵ 42 C.F.R. § 423.568(b). See also 42 C.F.R. § 423.572(a) (requiring a Part D Plan sponsor that approves a request for expedited determination to make its determination and notify the enrollee of its decision "as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's or other prescriber's supporting statement."); 42 C.F.R. § 438.210(d) (requiring Medicaid MCOs to "make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service" where the provider indicates or the MCO determines that "following the standard timeframe could seriously jeopardize the enrollee's life or ability to attain, maintain, or regain maximum function").

⁶ See 42 C.F.R. § 423.578(b).

⁷ 42 C.F.R. § 423.568(d)(f). See 42 C.F.R. § 438.210(c) (requiring Medicaid MCOs to provide a notification of any decision to deny a service authorization request to the enrollee and provider; the enrollee's notification must be in writing).

⁸ SSA § 1927(d)(6).

⁹ 42 C.F.R. § 423.578(b). See 42 C.F.R. §§ 438.236 (requiring Medicaid MCOs to have in effect a grievance system); 438.400, et seq. (setting forth requirements for a grievance system).

¹⁰ See 42 C.F.R. § 423.578(b)(5).

¹¹ Part D Manual, Chapter 6, § 30.2.2.