COALITION FOR WHOLE HEALTH

January 8, 2019

Hoping for a better year. Much to do this year.

Debrief from the Elinore McCance-Katz Discussion in November

The format was a phone call rather than an in-person meeting. That resulted in a very structure process. The ebb and flow of the previous in-person meeting with her was preferred by coalition members.

The assistant secretary left open the opportunity for additional follow-up. The Coalition staff will figure out a mechanism to forward additional comments.

We will renew the request for the next time we get together with the assistant secretary to be an in-person meeting

Proposed Rule on Prescription Drug Pricing--Catherine Findley, Partnership for Part D Access

It's pretty straight forward. Research shows that this rule is unfounded.   There are 3 main components of the proposed rule with regards to protected classes.

1) Health care plans get more authority to managing protected classes except for retro anti-virals. The classes are protected, not conditions within the protected classes. Off label use is done by plans now. What this would say is that plans would be allowed to require prior authorization and may deny access for an off-label use, even if they are currently on it and it's effective. Example, cancer medications used for rheumatoid arthritis. Another component of this is that plans can apply step therapy (fail first) to any beneficiary who changes plans, even if they are stable on a set of medications. Many have to change plans annually because of changes in formularies. Many mental health clients have multiple chronic conditions. This could have wide ranging negative implications.
2) If there is a new tweaked formula for a drug, it would not need to be covered. For example, if you have a medication that it's in pill form and then they develop a long acting injectable, for some this is literally life changing. This would not need to be covered.
3) This new rule creates a standard that puts cost before patients, it would give a plan the authority to choose to not cover a medication if that med in the past (undefined), if the medication cost increases more than CPI urban. How long should the look back be and how long can that decision be in effect? There's also question about when the plan can do it, would it need to be before enrollment? It can be used by plans to avoid patients who need particular medications.

Data from a research group, Avalere, who has access to Medicare Part D medication data.

1) How many drugs are covered? 67% of drugs for the protected classes are being covered. Plans claim that it is 100%. Researchers found this stunning. 60% of all brands are being covered. 85% of generics are being covered.

2) Cost sharing— Peer placement—anti-depressants and anti-psychotics are placed in non-preferred. This results in higher cost shares. The vast majority of patients are finding that not all meds are covered and they are paying higher amounts. The average cost sharing/month is $151/month for anti-depressants and $300/month for anti-psychotics.
3) Utilization management—20-30% are subjected to prior authorization or step therapy.

This is from 2018 Part D data, there are no extrapolations. 178M scrips.

77% of protected classes medications are categorized as non-preferred or specialty. 1% were written on drugs on specialty tier.

The report is available including a 2 page summary.

Plans have the tools they need to achieve the utilization they want and to negotiate with pharmaceuticals. There is no excuse that plans are not able to negotiate rebates. (That's what this is all about.) Currently psychiatric medications get rebates equal to or greater than other meds.

A 10-12 page detailed response to the proposed rule will be completed 1/9. They welcome sign on many organizations. They also have a patient level comment opportunity called Voter Voice. They can share the proposed letter with the Coalition so it can be forwarded to affected constituencies.

They believe this input will not be influential to the Administration but will be to "The Hill."

Proposed Medicaid Managed Care Rule

Comments are due 1/14/19. Not a lot that is specific to behavioral health. Biggest issue is IMD exclusion which allows payment of federal funds up to 15 days. Another related issue is grievances. The Coalition will also make comments to make sure they are aware that parity applies.

Schedule In-Person Meeting

Have a planning session in person focusing on the upcoming year, likely on April 2 at 11AM.