PUBLIC ACT 20-4 DIABETES AND HIGH DEDUCTIBLE HEALTH PLANS

WORKING GROUP

April 1, 2021

Convened by the State of Connecticut, Department of Social Services, via Microsoft Teams

Members joining via Teams: Bradley Richards (Chair), Christopher McClure, Dave Rackliffe Laura Nally, Marjorie Lazarre, Monica Jensen, Anthony Yoder, Kara Lewis, Suzanne Lagarde, and Sue Veer.

Members not Present: Tizita Fekredengle

DSS Staff joining via Teams: Herman Kranc, Manager, Integrated Healthcare/Pharmacy, and Trish McCooey, Staff Attorney

Members of the public observed the meeting via Teams.

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<u>Call to Order, Introductions and Approval of Minutes</u>

The meeting was called to order at 10:32 am by the Chair, Bradley Richards, M.D.

Anthony Yoder moved to approve the Minutes of the March 19, 2021 meeting. Sue Veer seconded the motion. Motion carried unanimously.

<u>Review of Alternative Approaches to a Referral System</u>

Monica Jensen reviewed a proposal outlining some alternatives to the referral process as contemplated in Public Act 20-4 (attached). A first step could include a statewide portal that would allow for access to all programs that subsidize or support or assist with the cost of insulin, perhaps information on accessing HUSKY eligibility and referral to FQHCs or other entities that could provide care and pharmacy services for . She noted that the portal could draw upon lessons learned from the VAMS implementation for the state's population. The portal would be supplemented by assistance from live staff.

Sue Veer suggested that the group consider taking the portal to the next level as part of a state sponsored care coordination program.

Dave Rackliffe noted that non-profits would need to play a role in promoting the program and raised concern about the extent of DPH's potential involvement given existing resource constraints. While the program may be able to identify federal funding sources initially, it seems state funds would be needed to sustain a program. Dr. Richards noted the program could be a public-private partnership along the lines of community-based HIV programs in Connecticut. Sue Veer noted that metrics and data tracking should be built into any program

Laura Nally noted that a central system sounds helpful, but if patients do not get additional resources for covering insulin, they remain in the same position they are now. She met with her organization (insulin 4 all) and indicated that one way to assure access would be through legislation such as the Alec Smith legislation enacted into law in Minnesota last year. (Summary provided by Ms. Nally, attached). The legislation allows patients with an urgent or emergent need for insulin to get the medication for no more than $35. As previously discussed, such a proposal might need to consider access to diabetes supplies and other drugs.

Dr. Yoder noted that SB 842, the public option, while outside of the Working groups direct purview, would address the insulin problem. In addition, the American Rescue Plan Act of 2021 has increased subsidies available through Access Health CT, which is another route to increased access.

Dr. Richards recapped the recurring themes in the groups discussions: 1) a statewide portal; 2) a care coordination/care management option to complement/supplement the portal and 3) a funding umbrella, perhaps through a partnership with a state entity such as DPH, which also allow organizations to get funding to address the diabetes drug and access issues at a local level, or a public-private partnership; 4) legislation directed to the cost of diabetes drugs and supplies; 5) legislation to increase health care coverage and as a result, decrease costs to individuals.

Ms. Lazarre and the group discussed whether statutory changes, such as a cap on insulin costs, syringes, needles, and other diabetic devices should be across the board or tiered, depending on the patient's income. If the caps are tiered or tied to income, it becomes more difficult to implement and complex at the pharmacy. Dr. Lagarde noted that FQHCs routinely look at family income and use that to arrive at sliding scale cost sharing for FQHC patients.

Kara Lewis noted that they use a flat rate.

Ms. Lazarre suggested the use of Medicaid leverage to create a medical assistance program.

Sue Veer noted that if uninsured and high deductible patients turn to FQHCs in high numbers for diabetes care, including drugs, it may have a negative impact on the pharmacy and cost centers that must serve all patients. She referred to South Carolina legislation related to PBMs that limits the effective copayment amounts patients must pay. She sent the Working Group a copy of the law (attached).

Dr. Richards asked the group to think of any other ideas, that might get at the problem that led to the enactment of the legislation. Ms. Nally mentioned the impact of patent laws in keeping the insulin pen costs high. The group also discussed a Rhode Island proposal that used the Medicaid formulary as a tool to keep the costs of insulin drugs lower. Herman Kranc noted that Connecticut's Medicaid preferred drug list is an open formulary, i.e., all drugs are covered. It did not seem such a proposal would work in Connecticut.

Dr. Lagarde asked whether a care coordination platform or portal would achieve the goals that the Insurance Committee had intended; would it move the needle on the cost of diabetes drugs for the underinsured and uninsured? She also asked what the model would like look like, for

example would there be 5 care coordinators. Ms. Nally said that in Minnesota they found that staffing a phone line did not seem to be an optimal use of resources.

The group discussed the possibility of a "hub and spoke" approach that would combine a central access point with resources at the community level. Ms. Lewis emphasized that a central point with staff who "speak pharmacy" would be a helpful resource given the constraints on community pharmacists' time.

Dave Rackliffe, said that he appreciates the hub and spoke idea and agreed as a former hospital CIO, that any project would need to support metrics.

Dr. Richards asked whether the group generally favored pursing the hub and spoke approach and a majority of the group indicated that they did. Dr. Yoder that this approach would provide some short-term assistance, pending a longer-term solution that would require legislation.

Trish McCooey clarified that the Minnesota legislation provides for more than a one-time emergency supply of insulin. Qualified residents may also receive a 90-day supply of insulin for no more than $50. The group decided to give this legislative approach and the PBM legislation from South Carolina a closer look as part if its final deliberations.

Adjournment:

Noting that the Working Group will hold a final meeting, the meeting was adjourned at 11:57 am.