Department of Managed Health Care

State of California

Award # 1158954159203 Details

Proceeding:	2002-0019 Prescription Drug Benefits and Co-payments (SB842)
Date Requested:	9/22/2006 12:42:39 PM
Amount Requested:	$12750

Contribution to the Proceeding: Health Access Foundation provided detailed written testimony on the regulations. Some but not all of the comments made resulted in changes to the proposed regulations.

Task Performed

Activity	Hearing
Activity Date	5/15/2006
Amount Billed:	$12750
Other Parties Involved:	Health Access Foundation acted independently of other parties involved in the proceeding.

Subject Matter and Work Description: Health Access provided recommendations concerning the following sections of the proposed regulations. S. 1300.67.24 c 5 Determining "cost to the plan." Recommending that plans must be required to demonstrate exactly how consumers and purchasers would benefit from this cost reduction. S. 1300.67.24 d 2 and 3 Plan limitations on prescription drug benefits. Health Access requested an amendment to the proposed language in d 2 that would reference S. 1374.33 b of the Health and Safety Code. Health Access continued to OPPOSE the addition of a definition of medical necessity in these regulations. S. 1300.24 e 5 Exclusions applicable to over-the-counter drugs. Opposed to the plan being able to file a notice of material modification as the mechanism of seeking prior approval from the Department for such exclusion. Our objection rests upon our belief that such exclusions should be obtained through an open, public process. Testified in support the provision requiring that exclusions or limitations be made in accordance with evidence-based outcomes and published peer-reviewed literature. Written testimony will be sent as an attachment to this application.

Time Spent:	25.5 hours
Witnesses:	Beth Capell, Capell Assoc., on behalf of Health Access Foundation

Contact Information

Organization	Health Access California
Name	Rick Pavich
Phone	916-497-0923
Extension	203

Email	rpavich@health-access.org
Date Created	7/26/2004 4:18:06 PM
	Address
Address Type	Mailing Address
Address	1127 - 11th Street
Suite	234
City, State, Zip	Sacramento, CA, 95814-
Address Type	Physical Address
Address	1127 - 11th Street
Suite	234
City, State, Zip	Sacramento, CA, 95814-
	Governing Body
Title	Executive Director
Name	Anthony Wright
Address	1127 - 11th Street
City, State, Zip	Sacramento, CA, 95814-

HEALTH ACCESS
1127 11th Street, Suite 234 – Sacramento, CA 95814 – 916-497-0923

May 15, 2006

The Honorable Cindy Ehnes, Director
Department of Managed Health Care
Office of Legal Services
980 9th St., Ste. 500
Sacramento, CA. 95814

Attn: Suzanne Chammout, RN, JD, Regulation Coordinator

Re: Outpatient Prescription Drug Copayments, Coinsurance, Deductibles and Limitations, Control # 2002-0019
As revised May 1, 2006

Dear Ms. Ehnes,

Health Access, a coalition of more than 200 consumer, community and other organizations, offers comments on and amendments to the proposed regulations on prescription drugs as revised May 1, 2006. These regulations result from SB842 (c. 791 of 2002) by Senator Jackie Speier.

We begin by noting that we are generally supportive of the proposed regulations as written. However, we have the following concerns as outlined below:

1. S. 1300.67.24 (c) (5) Determining "cost to the plan."

This section deals with the calculation of the "cost to the plan," including discounts, rebates, and other pricing arrangements. Health Access agrees with the language that requires the plans to have to account for these adjustments which must be applied to reduce costs for the plan's subscribers. Specifically, however, we believe the plans must be required to demonstrate exactly how consumers and purchasers would benefit from this cost reduction. How will the Department determine that the cost savings have been applied to reducing costs to enrollees or to purchasers?

2. S. 1300.67.24 (d) (2) and (3) Plan limitations on prescription drug benefits.

Health Access seeks an amendment to the proposed language in (d) (2) that would reference S. 1374.33 (b) of the Health and Safety Code:

> A plan that requires step therapy shall have an expeditious process in place to authorize exceptions to step therapy when medically necessary consistent with S.1374.33(b) and to conform effectively and efficiently with continuity of care requirements of the Act and regulations.

Health Access strongly supports the inclusion of all medically necessary prescription drugs as the basic principle upon which this regulation rests. It is consistent with the statutory authority that refers to the "department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits".

Health Access does not oppose the concept of step therapy in general, but seeks further consumer protections in the proposed regulations, including basing step therapy on the most current evidence-based outcomes and scientific literature as well as periodic review of step therapy.

Step therapy is essentially a means of denying immediate access to a drug or class of drugs and requiring that enrollees try other medications or steps equally likely to be effective but that are less expensive for the plan. Step therapy protocols should be subject to review to assure that they are consistent with the requirements in these regulations regarding clinical efficacy and clinical effect.

Health Access recognizes that the amended regulations provide for an expeditious process for modifying step therapy and for continuing existing drug therapy for a stabilized patient or for a patient changing plans.

Health Access continues to OPPOSE the addition of a definition of medical necessity in these regulations and is pleased to note that these draft regulations do not include a definition of medical necessity. This is a very difficult policy area: such a definition would require extensive discussion and might well still fail to meet the standard of clarity. Existing law already provides a functional definition of medical necessity in the criteria for independent medical review, specifically Sec.1374.33 (b) of the Health and Safety Code. Health Access commends the department for not adding a definition of medical necessity to the proposed regulations.

3. S. 1300.24 (e) (5) Exclusions applicable to over-the-counter drugs.

Health Access generally believes this new language is an improvement to the regulation. Specifically, we find it is beneficial that a plan cannot exclude an entire class of prescription drugs when one drug within the class becomes available over-the-counter. However, we are opposed to the plan being able to file a notice of material modification as the mechanism of seeking prior approval from the Department for such an exclusion. Our objection rests upon our belief that such exclusions should be obtained through an open, public process that is subject to scrutiny and such a non-public process, such as requesting a material modification, does not serve consumers or the public well.

In general, we support the provision requiring that exclusions or limitations be made in accordance with evidence-based outcomes and published peer-reviewed literature. This is an important protection for consumers: it requires a health plan that desires to exclude a drug or limit its use to demonstrate that it has good evidence of the reasons

for that exclusion or limitation. Otherwise, the default is that medically necessary drugs are covered. Again, this inclusiveness of all medically necessary drugs (except those for which scientific evidence supports limitation or exclusion) is consistent with the legislative history and the language of the statute.

As supporters of the original legislation, Health Access offers these comments. For information, please contact Beth Capell, Capell & Assoc., at (916) 497-0760.

Sincerely,

/s/
Anthony Wright
Executive Director

CC: Senator Jackie Speier, Chair, Senate Banking, Finance and Insurance Committee
Assemblymember Wilma Chan, Chair, Assembly Health Committee
Cindy Ehnes, Director, Department of Managed Health Care

HEALTH ACCESS
INTERVENER FEES : DEPARTMENT OF MANAGED HEALTH CARE
Regulation Number: 2002-0019
Prescription Drug Benefits and Co-payments (SB842)

2002-0019	**Time recorded for:**	**Beth Capell, Health Care Policy Expert**			
Date	Time	Activity	Time Elapsed Number of Hour	Hourly Rate	Billed Amount
1/24/2005	8:30am- 9:30am	Preparation for meeting	1.5	$ 500.00	$ 750.00
1/25/2005	1pm-4pm:	meeting with DMHC staff and other parties, post-meeting discussion	3	$ 500.00	$ 1,500.00
1/28/2005	8am-9am:	Preparation of written testimony	3	$ 500.00	$ 1,500.00
1/31/2005	9am-9:30am, 10:30am-11:30am, 1:30pm-3pm, 4pm-5pm:	Preparation of written testimony	4	$ 500.00	$ 2,000.00
9/26/2005	11:30am-12:30pm	preparation of written testimony	1	$ 500.00	$ 500.00
10/26/2005	6pm-7pm:	preparation of written testimony	1	$ 500.00	$ 500.00
10/27/2006	5am-5:30am:	preparation of written testimony	0.5	$ 500.00	$ 250.00
10/31/2005	9am-10:30am:	preparation of written testimony	1	$ 500.00	$ 500.00
11/1/2005	9am-9:30am, 11-11:30am:	preparation of written testimony	1	$ 500.00	$ 500.00
3/19/2006	7am-7:30am	preparation of written testimony	0.5	$ 500.00	$ 250.00
4/2/2006	6pm-6:30pm:	preparation of written testimony	0.5	$ 500.00	$ 250.00
5/12/2006	10am-10:30am:	preparation of written testimony	0.5	$ 500.00	$ 250.00
		Total; Beth Capell	*17.5*		*$ 8,750.00*
2002-0019	**Time recorded for:**	**Elizabeth Abbott, Health Care Policy Expert**			
5/12/2006	10:00am - Noon	preparation of written testimony	2	$ 500.00	$ 1,000.00
5/15/2006	9:00am – 1:00pm; 2:00pm - 3:00pm	preparation of written testimony	5	$ 500.00	$ 2,500.00

5/16/2006	9:00 – 10:00am	preparation of written testimony	1	$ 500.00	$ 500.00
		Total; Elizabeth Abbott	*8*		$ 4,000.00
		Total Time &Amount Billed	**25.5**		**$ 12,750.00**

Beth Capell, Ph.D., Capell & Assoc., has been the principal and owner of Capell & Assoc. since its founding in 1995. She has thirty years of experience in Sacramento, working in the Legislature, various Administrations, and with various interest groups.

She represents Health Access California; Health Access Foundation; the California Physicians Alliance; State Council of Service Employees International Union, AFL-CIO; and other consumer and labor organizations in both legislative activity and regulatory action.

Health Access California sponsored the package of legislation known as the HMO Patient Bill of Rights from 1995 to its enactment in 1999. Health Access Foundation led a collaborative of consumer groups that monitored initial implementation of the more than 20 pieces of legislation enacted between 1995 and 2000 intended to protect consumers from HMOs. Health Access Foundation has continued to work on implementation and ongoing monitoring of the law with respect to consumer protections against HMOs. Beth Capell has been an architect and active advocate throughout this decade of efforts.

Beth Capell has worked on issues including prescription drugs, universal access, hospital overcharging, balance billing by physicians, nursing home regulations, hospital standards, health insurance regulation, and other health care issues.

Prior to establishing Capell & Assoc. Beth Capell represented the California Nurses Association from 1986 to 1995, first as the legislative advocate and later as the Director of Government Relations for the association. From 1983 to 1986, Ms. Capell worked at the California Manufacturers Association, working on job training and human resource issues, including health insurance. From 1977 to 1983, Ms. Capell worked in various positions in the Legislature, the Administration, and other efforts.

Ms. Capell has Ph.D. in political science from the University of California, Berkeley, and continues to publish articles and present papers on political science, specifically interest groups, legislatures, and the impact of legislative term limits.

ELIZABETH CAROLYN ABBOTT

PROFESSIONAL EXPERIENCE

- 1995-2003 CMS, San Francisco, California
  Regional Administrator
  I served as the senior career executive for the Centers for Medicare and Medicaid Services (CMS) for Regional IX, which is responsible for the oversight of the Medicare, Medicaid, and Childrens' Health Insurance Program. The regional office had jurisdiction for the states of CA, AZ, NV, HI and the Far Pacific. I supervised 175 staff, including 19 managers and a Chief Medical Officer located in San Francisco, Honolulu, Sacramento, and Baltimore, MD. In addition, I was also responsible for 1500+ contractor employees who processed Medicare claims and answered inquiries from our beneficiaries and providers. Because I was the senior representative of the largest purchaser of health care in the country, I spoke extensively to outside groups. These included elected representatives, employers, associations, providers, advocates, states, counties, contractors, the press, representatives from foreign governments, and the public in order to explain our policies, listen to concerns from our constituencies, and increased knowledge of and gained support for the programs we administered. I frequently resolved conflicts over policies, reimbursement, and personnel issues by forging regional solutions to national problems, fashioning compromises among our constituencies, and mediating disputes between individuals and groups. I acted as the lead regional manager on national and local Partnership Councils and advised agency teams on national negotiating strategy during protracted labor-management contract talks. I also was responsible for national customer service responsiveness for five months in CMS headquarters in Baltimore, MD, where I expanded and managed agency and contractor staff working on the national "1-800-MEDICARE" toll free telephone lines.

- 1993-1995 CMS, San Francisco, CA
  Associate Regional Administrator for Medicare
  I served as the senior manager in CMS responsible for administering the fee-for-service Medicare program in Region IX for the states of CA, AZ, NV, HI, and the Far Pacific. I supervised a staff of 60 agency employees, including 3 managers. I was also responsible for 7 large insurance companies under contract to Medicare and their over 1500 employees who paid claims, audited providers, set local reimbursement and coverage policy, and answered questions from providers and beneficiaries. This included interpretation of national policy and resolution of problems, dealing with Congressional offices, professional associations, providers, advocacy groups, and members of the public. I set up and ran a successful, collaborative total quality initiative council in the division

3218 CHESAPEAKE BAY AVENUE • DAVIS, CA 95616
PHONE (530) 756-8826 • E-MAIL EABBOTT2003@HOTMAIL.COM

which elicited staff input to resolve division-wide problems. I conducted extensive training and workshops on negotiating skills modeled on the Harvard University "Getting to Yes" curriculum. I also spent five months in CMS headquarters in Baltimore, MD overseeing national contracting, financial accountability, and quality assurance.

- 1990-1993 Social Security Administration, Sacramento, California
  District Manager
  I served as the Manager for the Sacramento Social Security District consisting of one district office, two branches, and a teleservice center. I oversaw in-person and telephone applications for Social Security retirement, survivors', disability and Supplemental Security Income (SSI) benefits. I supervised 160 employees in the four offices, including 14 managers. I represented SSA to beneficiary groups, advocates, employers, the press, elected representatives, and state and local agencies to advise them of the fiscal soundness of the Trust Funds. I was also temporarily assigned for seven months to the SSA Regional Office in San Francisco as the Deputy Associate Regional Commissioner for Management and Budget. During that detail I supervised 75 staff in the regional office who were responsible for contracting, labor/employee relations, budget, telephone, space, training, and security for 187 SSA field offices throughout CA, AZ, NV, HI, the Far Pacific, and the Western Program Service Center in Richmond, CA.

CIVIL SERVICE GRADES

- ✓ Entered federal service under a competitive appointment as a GS-7 Spanish-speaking interviewer for the Social Security Administration in southern California.
- ✓ Served in progressively more responsible staff and management positions at grades GS-11 through GS-15 in offices in Illinois, Indiana, Massachusetts, and throughout California within the Department of Health and Human Services.
- ✓ As a result of a nationwide competitive search, appointed to the federal Senior Executive Service (SES) as the Regional Administrator of the Centers for Medicate and Medicaid Services from 1996-2003.

EDUCATION

- 1964-1968 University of Redlands, Redlands, California
  Bachelor of Arts with distinction in Psychology, Minor in Sociology and Spanish
- 1968-1991 University of Southern California, Sacramento, California

Coursework towards Masters in Public Administration

TRAINING

- Received Mediator training from the Federal Mediation and Conciliation Services
- Granted Federal Contract Officer's Warrant
- Received National Partnership Training
- Received Media Relations Training
- Received Managing Diversity Training

LANGUAGES

- *Spanish*
- *Some French*

AWARDS RECEIVED

- Secretary of Health and Human Services Distinguished Service Award for Y2K
- Centers for Medicare and Medicaid Services Administrator's Citation for Managed Care
- Centers for Medicare and Medicaid Services Administrator's Monetary Award for outstanding performance
- Social Security Administration Commissioner's Citation for outstanding performance
- Social Security Administration Regional Administrator's Citation for outstanding performance
- Selected as the Social Security Administration regional employee to attend USC's Master of Public Administration Program