October 20, 2017

Eric Hargan
Acting Secretary
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C., 20201

Submitted electronically

Re: Comments for Massachusetts 1115 Demonstration Amendment Request

Dear Acting Secretary Hargan:

On behalf of the Chronic Illness and Disability Partnership (CIDP), we are grateful for the opportunity to comment on the MassHealth 1115 Demonstration Waiver Amendment Request posted on September 20, 2017 (the MassHealth Request). For the reasons discussed below, we strongly oppose the MassHealth Request and urge the Department of Health and Human Services (HHS) to reject it.

We particularly urge the following actions with respect to the MassHealth Request:

- **HHS should reject MassHealth's request to eliminate MassHealth eligibility for non-disabled adults with incomes above 100% of the Federal Poverty Level (FPL).**
- **HHS should reject MassHealth's request to use a closed formulary for the selection of preferred and covered drugs.**
- **HHS should reject MassHealth's request to establish narrower networks in the Primary Care Clinician (PCC) plan.**

The Chronic Illness and Disability Partnership consists of national organizations representing individuals living with a wide range of disabilities and chronic illnesses, including cancer, heart, lung, cerebral palsy, HIV, Hepatitis B and C, mental health, and substance use disorders. In 2012, 117 million Americans were living with a chronic illness and/or disability.[1] While our organizations are national in scope, we also affiliate with strong regional, state, and community based advocacy networks. Based on our extensive experience advocating on behalf of the nearly half of all Americans who live with a chronic illness or disability,[2] we strongly oppose the MassHealth Request.

[1] U.S. Centers for Disease Control and Prevention, Chronic Disease Overview (February 23, 2016), available at https://www.cdc.gov/chronicdisease/overview/.
[2] Wu S, Green A., Projection of Chronic Illness Prevalence and Cost Inflation, RAND Corporation (October 2000).

We urge HHS to reject these proposals in order to ensure that the waiver promotes, rather than undermines, the objectives of the Medicaid program and that vulnerable populations retain access to crucial medications and health care services. We share the commitment of MassHealth and HHS to maintaining the gains Massachusetts has made in access to affordable health coverage for all low-income residents. However, we are concerned that certain policies put forth in the MassHealth Request would substantially decrease meaningful access to care for low-income individuals living with chronic illnesses and disabilities. In expressing these concerns, we stand with Massachusetts Senate leaders, who just this week chose not to include *any* of these troubling policies in their proposed package of reforms to control costs in the Massachusetts health care system.

Several of the proposed changes would also violate the basic conditions of a section 1115 waiver, thus, approval of the waiver would be unlawful. Section 1115(a) of the Social Security Act, codified at 42 U.S.C. § 1315(a), allows a federal waiver to facilitate a State's "experimental, pilot, or demonstration project" that, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid program. One of the primary objectives of Medicaid, as explained by § 1901 of the Social Security Act and the courts, is to enable each State to furnish "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." The Centers for Medicare & Medicaid Services (CMS) have further explained that for a demonstration to meet the objectives of the Medicaid program it should: "increase and strengthen overall coverage," "increase access to, stabilize, and strengthen providers and provider networks;" "improve health outcomes," or "increase the efficiency and quality of care."[3] Because several portions of the proposed waiver are not "likely to assist in promoting the[se] objectives," federal law bars HHS from approving those sections of the waiver.[4]

I. HHS should reject MassHealth's request to eliminate MassHealth eligibility for non-disabled adults with incomes above 100% of the Federal Poverty Level (FPL).

The MassHealth Request proposes to eliminate eligibility for approximately 140,000 non-disabled adults with incomes above 100% of FPL. Instead, these individuals would need to enroll in subsidized private health insurance plans available via the ConnectorCare program.

We applaud MassHealth for adjusting its original proposal to lessen the negative health consequences for these 140,000 individuals. MassHealth was correct in recognizing the need to take additional steps to address the substantial increase in out-of-pocket costs for individuals who would lose their MassHealth eligibility. Requiring that the Health Connector extend income eligibility for

[3] Centers for Medicare and Medicaid Services (CMS), *About Section 1115 Demonstrations*, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Oct. 15, 2017).

[4] *See, e.g.*, *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994) (striking down a section 1115 waiver due, in part, to an inadequate determination by HHS that the plan was likely to promote the Act's objectives). Furthermore, the law requires that the Secretary's decision is based solely on a substantive "judgment" as to whether the waiver "is likely to assist in promoting the objectives" of Medicaid. As the Supreme Court has made clear in *Massachusetts v. EPA*, "the use of the word 'judgment' is not a roving license to ignore the statutory text. It is but a direction to exercise discretion within defined statutory limits." 549 U.S. 497, 533 (2007).

ConnectorCare Plan Type 1 from 100% of the FPL to 133% of the FPL will help ensure these individuals continue to have affordable access to care.[5] MassHealth was also correct in removing its employer-sponsored insurance (ESI) gate that would bar non-disabled adults with access to "affordable" employer-sponsored or student-health insurance from enrolling in MassHealth. Finally, we applaud MassHealth for responding to public comments to expand exemptions to the elimination of MassHealth eligibility in order to include veterans ineligible for federal subsidies through ConnectorCare as well as the medically frail.[6]

However, we remain concerned that these changes do not go far enough. The elimination of MassHealth eligibility for most non-disabled adults with incomes above 100% FPL will still worsen access to care for tens of thousands of Massachusetts residents. Some MassHealth members are simply ineligible for ConnectorCare plans and will end up uninsured. Current enrollment rates suggest that roughly 54,000 others will struggle with the transition and fail to enroll, despite being eligible for the ConnectorCare program.[7] Finally, those who do enroll in ConnectorCare plans may face more restrictive coverage and utilization management policies, impeding access to crucial services. As a result, individual and public health in the state will suffer, undermining the progress that Massachusetts has made on these issues and placing residents at unnecessary risk.

a. Not all individuals eliminated from MassHealth eligibility are eligible for ConnectorCare

Not all individuals eliminated from MassHealth are allowed to enroll in ConnectorCare. As a result, these individuals would lose access to affordable health insurance, endangering their health and placing additional strain on Massachusetts' safety net systems.

For example, individuals with Deferred Action Status (Deferred Action for Childhood Arrivals (DACA)) currently may be eligible for MassHealth Family Assistance, Limited, or the Health Safety Net[8] but are not allowed to enroll in any qualified health plan through a state exchange.[9] With MassHealth's proposed changes, affected individuals with DACA status would be left without a way to purchase insurance.

Additionally, MassHealth's proposed change would affect other individuals who do not have access to advance premium tax credits or cost-sharing reductions (CSRs). Currently, married couples who file separately (for example, married couples who are separated or are obtaining a divorce) are not

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[5] *See* MASS. EXEC. OFF. OF HEALTH AND HUMAN SERVS., *FY18 MassHealth and Commercial Market Reform Package Updates* at 2 (SEPT. 2017), http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/fy18-masshealth-and-commercial-market-reform-package-updates-09-08-2017.pdf.

[6] MASS. EXEC. OFF. OF HEALTH AND HUMAN SERVS., OFF. OF MEDICAID, *MassHealth Section 1115 Demonstration Amendment Request* at 21 (Sept. 8, 2017).

[7] The estimate of 54,000 individuals is calculated by applying the current rate of eligible but unenrolled individuals in Plan Type 1, *see infra* note 13, the same plan types the individuals who lose MassHealth eligibly would qualify for, to MassHealth's estimate that ~140,000 individuals would lose MassHealth eligibility as a result of this proposed change, MASS. EXEC. OFF. OF HEALTH AND HUMAN SERVS., *supra* note 5 at 2.

[8] *See* MASS. EXEC. OFF. OF HEALTH AND HUMAN SERVS., *Member Booklet for Health and Dental Coverage and Help Paying Costs* at 42 (JULY 2017), http://www.mass.gov/eohhs/docs/masshealth/membappforms/aca-1-english-mb.pdf.

[9] To enroll in a qualified health plan (QHP) through the Exchange, an individual must be lawfully present. 45 C.F.R. § 155.305(a)(1). (2016). However, the definition of lawfully present does not include individuals with deferred action for childhood arrivals (DACA). 45 C.F.R. § 152.2(8) (2016).

eligible for advance premium tax credits or CSRs unless they attest to be victims of domestic abuse or spousal abandonment.[10] Under MassHealth's current proposal, couples filing separately will not have the assistance they need to afford health insurance, or even access ConnectorCare,[11] during an already traumatic, stressful period in their lives.

b. At current rates, over 54,000 individuals who are eliminated from MassHealth, but become eligible for ConnectorCare, will end up uninsured

Individuals who are eligible for ConnectorCare often struggle to enroll, leaving them without access to any coverage at all. As HHS is aware, enrolling in the Affordable Care Act (ACA) state exchanges is a persistent challenge both across the country[12] and within Massachusetts. The subsidized ConnectorCare program faces this same challenge. As of July 14, 2017, of the 24,627 individuals who were then eligible for ConnectorCare Plan Type 1, thirty-nine percent (9,606) were not enrolled in a plan.[13]

Navigating the health insurance enrollment process can be particularly challenging for low-income populations. Individuals with lower incomes often face pervasive stress, insecurity, and instability in their lives, including concerns about housing, nutrition, income, and childcare. People living with chronic conditions furthermore juggle multiple appointments with providers and the need to adhere to complex treatment plans.

Maintaining adequate and affordable coverage in ConnectorCare plans is also more difficult for individuals with the lowest incomes as cost increases in plans particularly affect these populations. More than twenty-five percent of individuals in Plan Type 1 who renewed ConnectorCare coverage switched plans in December 2016, nearly double the switching rate of ConnectorCare members in

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[10] "If you are considered married for federal income tax purposes, you must file a joint return with your spouse to take the PTC [premium tax credits]." There are two exceptions: if individuals are married but "meet the requirements for married persons who live apart under head of household in the instructions for Form 1040 or 1040A" or are the victims of domestic abuse or spousal abandonment. DEP'T OF THE TREASURY, INTERNAL REVENUE SERV., Pub. No 974, *Premium Tax Credit: For Use in Preparing 2016 Returns* 6-7 (Jan. 3, 2017), https://www.irs.gov/pub/irs-pdf/p974.pdf. To qualify as a married person living apart, an individual must live apart from their spouse for the last 6 months of the year, file a separate return from their spouse, pay over half the cost of keeping their home, and have their home be the main home of their child, stepchild, or foster child for more than half of 2016. *See* DEP'T OF THE TREASURY, INTERNAL REVENUE SERV., *1040 Instructions 2016* 15 (Dec. 15, 2016), https://www.irs.gov/pub/irs-pdf/i1040gi.pdf. Additionally, if they are ineligible for premium tax credits, married individuals filing jointly are also ineligible for cost-sharing reductions. One of the requirements for receiving cost sharing-reductions is meeting the requirements for eligibility for advance payments of the premium tax credit. *See* 45 C.F.R. § 155.305(g)(1)(i)(B) (2016).

[11] *See* 956 C.M.R. §§ 12.04, 12.08.

[12] *See generally* THE HENRY J. KAISER FAMILY FOUND., *Marketplace Enrollment as a Share of the Potential Marketplace Population* (Mar. 31, 2016), https://www.kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[13] Data from Health Connector presented in the Massachusetts Law Reform Institute public comment. MASS. EXEC. OFF. OF HEALTH AND HUMAN SERVS., *Public Comments to Proposed MassHealth Section 1115 Demonstration Amendment Request July 20, 2017 – August 21, 2017* 134 http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/public-comments-to-proposed-masshealth-section-1115-demonstration-amendment-request.pdf.

other plans.[14] These shifts in plans can affect continuity of care and coverage, important factors in effective treatment of chronic illness.

The effects of this general instability will be compounded by the repeated disruptions in insurance coverage that individuals will face under the current proposal. In 2018, many of these individuals will already have to navigate new insurance and health care delivery systems with the introduction of MassHealth's Accountable Care Organization (ACO) program.[15] But then, in 2019, with the current proposal, these vulnerable populations will once again be asked to navigate new systems and requirements as they lose MassHealth coverage altogether and must find insurance through the ConnectorCare program.

Given these many challenges, we believe it is conservative to assume that eligible but unenrolled rates in ConnectorCare will be reflected among individuals who lose MassHealth eligibility at around forty percent.[16] With around 140,000 individuals estimated to lose MassHealth eligibility under the Amendment Request,[17] over 54,000 individuals are projected to not successfully enroll in ConnectorCare and instead become uninsured. MassHealth chose not to address these issues in their response to public comments, [18] and has not explained how over 54,000 individuals ending up uninsured furthers the purposes of the Medicaid Act or is an allowable outcome of an 1115 waiver.

HHS should be appropriately skeptical of any MassHealth claims that it will improve enrollment rates for individuals who lose MassHealth eligibility. First, Massachusetts is already experiencing difficulty in increasing enrollment in ConnectorCare, especially among individuals who are uninsured.[19] Furthermore, other states that have had large-scale eliminations of Medicaid eligibility have seen many of those affected individuals fail to successfully enroll in a Qualified Health Plan. In Rhode Island, twenty-nine percent of those who lost Medicaid either never applied for a Qualified Health Plan or applied but never submitted their first premium payment.[20] Other states have done far worse: seventh months after Connecticut rolled back eligibility, about three in four parents either

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[14] *See* MASS. HEALTH CONNECTOR, *MA Health Care Learning Series* 7 (Apr. 2017), https://www.masshealthmtf.org/sites/masshealthmtf.org/files/Learning%20Series%20Apr%202017.pdf.

[15] *See* MASS. EXEC. OFF. OF HEALTH AND HUMAN SERVS., *MassHealth Partners with 18 Health Care Organizations to Improve Health Care Outcomes for Members* (JUNE 8, 2017), http://www.mass.gov/eohhs/gov/newsroom/press-releases/eohhs/masshealth-partners-with-18-health-care-organizations.html.

[16] *See supra* note 13.

[17] *See supra* note 7.

[18] In response to public comments, MassHealth addresses concerns about affordability and coverage on commercial plans, but it does not address the likelihood that many current MassHealth members will not make it onto commercial plans in the first place. *See* MASS. EXEC. OFF. OF HEALTH AND HUMAN SERVS., OFF. OF MEDICAID, *supra* note 6 at 21.

[19] The Health Connector's outreach strategy for the 2016 – 2017 Open Enrollment period focused on populations that disproportionally comprised the uninsured. *See* MASS. HEALTH CONNECTOR, *Open Enrollment 2017 Outreach Strategy* 2 (Sept. 8, 2016), https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2016/2016-09-08/Open-Enrollment-2017-Outreach-Strategy-090816.pdf.

[20] Of 6,574 individuals expected to lose Medicaid eligibility, 1,271 (19%) never submitted an application to enroll in a QHP and likely became uninsured. *See* Kate Lewandowski, Cmty. Catalyst, *Patient Eligibility Roll-Back in Rhode Island: Causes, Effects, and Lessons Learned,* 5 (2013), https://www.communitycatalyst.org/resources/publications/document/RI-parent-rollback-081215-KL.pdf?1439834245.

had not enrolled in a Qualified Health Plan or had since lost coverage;[21] while in Wisconsin, about two in three did not enroll in a subsidized health plans in the federal marketplace.[22]

c. ConnectorCare provides worse treatment options for individuals living with serious medical issues, negatively impacting the public health of Massachusetts

Finally, the proposal to eliminate MassHealth eligibility for non-disabled adults with incomes above 100% of the FPL will also significantly impact access to care *even* for individuals who successfully transition to ConnectorCare. By pushing these vulnerable populations into plans with less comprehensive coverage and fewer consumer protections than MassHealth, the proposed change will undermine not only individual care but also the state's broader public health goals.

For example, the Massachusetts Office of Medicaid recently mandated that all enrollees participating in MassHealth via the fee-for-service program, PCC plan, or a managed care organization (MCO) be provided with the same treatment policy for HCV: open access without the imposition of restrictions related to disease severity, alcohol and/or substance use abstinence, or prescriber specialty.[23] In adopting this policy, MassHealth eliminated the potential for arbitrary or discriminatory restrictions and created a uniform system in which low-income individuals have equal access to necessary HCV treatment. In contrast, health plans offered through the ConnectorCare program do not appear to share this uniform open access policy. Each participating ConnectorCare insurer may manage their prescription drug benefits as they see fit, and impose far more restrictive coverage and utilization management rules for HCV medications than currently allowed in MassHealth.[24] As a result, many individuals may be unable in practice to access the cure for HCV, leading to additional transmissions and eroding the progress made to date towards eradicating the virus in Massachusetts.

Similar access issues may arise for many individuals living with chronic and serious conditions such as cancer, cerebral palsy, and mental health or substance use disorders. As these individuals leave MassHealth—a program designed to recognize the particular vulnerability of sick or disabled low-income populations—they will be at the mercy of private insurers and have to navigate each insurer's treatment policy and drug coverage rather than relying on MassHealth's open formulary and consumer protections.

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[21] Conn. Voices for Child., *HUSKY Program Coverage for Parents* at 2 (Apr. 2016), https://www.cga.ct.gov/med/council/2016/0520/20160520ATTACH_%20CT%20Voices%20for%20Children;%20HUSKY%20Income%20Eligibility%20Cut.pdf.

[22] *See* Guy Boulton, *One-third Who Lost BadgerCare Coverage Bought Plans on Federal Marketplace*, MILWAUKEE J. SENTINEL (Jul. 16, 2014), http://archive.jsonline.com/business/almost-19000-badgercare-plus-recipients-enrolled-in-obamacare-b99312352z1-267339331.html/.

[23] *See* Daniel Tsai, *MassHealth Managed Care Organization Bulletin 6* (July 2016), http://www.mass.gov/eohhs/docs/masshealth/bull-2016/mco-6.pdf.

[24] *See, e.g.,* Fallon Health, *Prior Authorization Approval Criteria: Harvoni (ledipasvir and sofosbuvir),* http://www.fchp.org/providers/pharmacy/~/media/Files/FCHP/Imported/harvoni_ledipasvirsofosbuvir.ashx (restricting access to Harvoni to only those patients with advanced liver disease who are abstinent from drug and alcohol use for 12 months prior to treatment).

For all of the reasons described above, HHS should reject MassHealth's request to eliminate eligibility for MassHealth for non-disabled adults above 100% of the FPL as it will likely result in roughly 54,000 individuals becoming uninsured and thousands of others receiving more restrictive coverage that limits their access to treatment for chronic illnesses.

II. HHS should reject MassHealth's request to use a closed formulary for the selection of preferred and covered drugs.

a. MassHealth's Proposed Waiver of Formulary Requirements Is Unlawful

MassHealth proposes to adopt a closed formulary with as little as a single drug per therapeutic class. Section 1927(d)(4) of the Social Security Act, codified at 42 U.S.C. § 1396r–8(d)(4), establishes rigid requirements for drug coverage in a state's formulary under the rebate program. MassHealth proposes to waive these requirements in order to implement the closed formulary,[25] but federal case law precludes this sort of waiver. Section 1115 of the Social Security Act, codified at 42 U.S.C. § 1315, permits waivers of only certain specified sections, which do not include any part of the rebate provisions. The D.C. Circuit made this clear in *PhRMA v. Thompson*: "Although the Act authorizes the Secretary to waive certain Medicaid requirements for such demonstration projects, it does not authorize him to waive any requirements of section 1396r–8's rebate provision . . ."[26]

Moreover, the proposed closed formulary rests entirely on an economic justification of cost-cutting, which does not qualify as an "experimental, pilot, or demonstration project" as required by section 1115 of the Social Security Act, codified at 42 U.S.C. § 1315(a). As the Ninth Circuit explained: "The Secretary's obligation under § 1315 to 'make some judgment that the project has a research or a demonstration value' cannot be satisfied by '[a] simple benefits cut, which might save money, but has no research or experimental goal.'"[27] MassHealth does not even gesture toward any research or experimental objective, but rather candidly explains its request in purely economic terms: "Adopting a closed formulary with at least a single drug per therapeutic class would enable MassHealth to negotiate more favorable rebate agreements with manufacturers."[28] Accordingly, HHS should reject this proposal as failing to meet the law's requirements for an experimental or demonstration project.

b. *Closed Formularies Negatively Impact Individual Health and Do Not Save Money*

Aside from conflicting with current law, MassHealth's proposal to impose a closed formulary is severely misguided even as a cost-cutting measure. Reviews of over 90 recent studies demonstrate that formulary restrictions are a lose-lose proposition: they are harmful to people's health *and* they do not save money.[29] For some medications, such as atypical antipsychotics, the cost-benefit analysis

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[25] *See* MASS. EXEC. OFF. OF HEALTH AND HUMAN SERVS., OFF. OF MEDICAID, *MassHealth Section 1115 Demonstration Amendment Request* at 15 (Sept. 8, 2017).
[26] 251 F.3d 219, 222 (D.C. Cir. 2001).
[27] *Newton-Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011) (citing *Beno v. Shahala*, 30 F.3d 1057, 1069 (9th Cir. 1994)).
[28] MASS. EXEC. OFF. OF HEALTH AND HUMAN SERVS., OFF. OF MEDICAID, *MassHealth Section 1115 Demonstration Amendment Request* at 8 (Sept. 8, 2017).
[29] *See* Yujin Park et al., *The Effect of Formulary Restrictions on Patient and Payer Outcomes: A Systematic Literature Review* 23 J. MANAGED CARE & SPECIALTY PHARM. 893, 898 (2017) (reviewing 59 unique studies and finding a negative association of 92% between formulary

of formulary restrictions is *extremely* unfavorable: the pharmaceutical savings are negligible while other health and social costs are enormous, with estimates "that restrictive formulary policies in Medicaid led to over $350 million in prison costs per year" in addition to "poorer health outcomes."[30] If this is true of formulary policies that are merely restrictive, a fully closed formulary, as MassHealth proposes to allow, would likely exacerbate this dynamic, yielding even higher costs and worse health outcomes.

Furthermore, a closed formulary plan would not significantly add to MassHealth's negotiating leverage. MassHealth already has adequate leverage to negotiate with pharmaceutical manufacturers through the existing tiered formulary system, which provides substantial incentive for manufacturers to offer competitive rebates. A closed formulary would cause harm to people living with chronic and complex conditions by restricting their access to necessary drugs. For these people, effective treatment often depends on the ability of a physician to exercise discretion in striking a personalized, delicate balance among many medications. Blocking access to the range of drugs in a therapeutic class would upset that balance and directly harm these vulnerable individuals.

For the reasons described above, HHS should reject MassHealth's request to use a closed formulary for the selection of preferred and covered drugs**.**

III. HHS should reject MassHealth's request to establish narrower networks in the Primary Care Clinician (PCC) plan.

MassHealth proposes to implement narrower networks in the PCC plan to encourage members to enroll in ACOs and MCOs rather than the PCC plan. As noted in the MassHealth Request, the PCC plan currently uses open provider networks. As a result, the PCC plan is an important option for individuals living with chronic illnesses who require consistent access to a variety of health care providers that may not all participate in an a particular MCO or ACO network. By instituting narrow networks, MassHealth would introduce this same problem into the PCC plan, separating patients with complex conditions from providers that they know and trust, and creating potential gaps in care as patients work to identify and access new in-network providers. We therefore request that HHS reject MassHealth's request to establish narrower networks in the PCC plan.

The Chronic Illness and Disability Partnership thanks you for the opportunity to provide input on this MassHealth 1115 Demonstration Amendment Request. For all of the reasons discussed above, we urge you to reject the MassHealth Request, as it would negatively impact access to affordable

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restrictions and health outcomes, and observing that the majority of "studies that included total or medical costs (in addition to pharmacy costs) . . . showed either negative effect on total, medical, or pharmacy costs or no effect on pharmacy costs"); Laura E. Happe et al., *A Systematic Literature Review Assessing the Directional Impact of Managed Care Formulary Restrictions on Medication Adherence, Clinical outcomes, Economic outcomes, and Health Care Resource Utilization* 20 J. MANAGED CARE & SPECIALTY PHARM. 677, 681 (2014) (reviewing 93 studies and concluding "that formulary restrictions are negatively associated with medication adherence" and "there was no distinct trend in the direction of association of economic outcomes with formulary restrictions").

[30] Seth A. Seabury et al., *Formulary Restrictions on Atypical Antipsychotics: Impact on Costs for Patients with Schizophrenia and Bipolar Disorder in Medicaid* 20 AM. J. MANAGED CARE e52, e58 (2014) ("Any cost savings from pharmaceuticals among atypical antipsychotic users appears to be more than offset by the higher medical costs associated with worth adherence and poorer health outcomes.").

care and treatment for individuals living with chronic illnesses and disabilities. Please contact Robert Greenwald, with the Treatment Access Expansion Project at rgreenwa@law.harvard.edu, Amy Killelea with the National Alliance of State and Territorial AIDS Directors at akillelea@NASTAD.org, or Jean McGuire at Northeastern University at j.mcguire@neu.edu with any questions. Thank you for your time and consideration.

Respectfully submitted by the co-chairs of the Chronic Illness and Disability Partnership,

Robert Greenwald
Treatment Access Expansion Project

Amy Killelea
National Alliance of Stat & Territorial AIDS Directors

Jean McGuire
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cc: Seema Verma, Administrator for the Centers for Medicare and Medicaid Services (CMS)