Connecticut Health Care Cabinet Work Group on Prescription Drug Cost Determination and Cost Containment

Preliminary Recommendations

November 14, 2017

Work Group Charge

Develop recommendations to the Health Care Cabinet on ways to lower prescription drug costs for consumers and health care purchasers (e.g., self-insured employers, insurers and government purchasers). Examine policies in the following broad categories:

- Price Transparency
- Price Regulation
- State agency purchasing (other than value based contracts)
  - Impact on state agency costs
  - State purchasing that can benefit non-state individual or entities in Connecticut

Work Group Members:

- Cabinet members: Bob Tessier, Marghie Giuiliano, Josh Wojcik, Paul Lombardo & Lena Bachar for Comr. Katie Wade, Comr. Dr. Raul Pino, Ted Doolittle

- Bob Clark (AG's office), Mark Zatyrka (Consumer Advisory Board), Rob Blundo (APCD), Jill Zorn (UHCF)

Questions to be Explored

Transparency

- What are the transparency policies we're trying to pursue and what public and commercial data are needed to inform them?
- How can we best obtain current state agency and commercial data on pharmaceutical costs?
- What are the data barriers and how can they be overcome?
- How are specialty drugs defined?
- How is transparency of drug pricing data useful to consumers? To regulators? To purchasers?
- Should there be any categories of data excluded from disclosure requirements?

Regulation

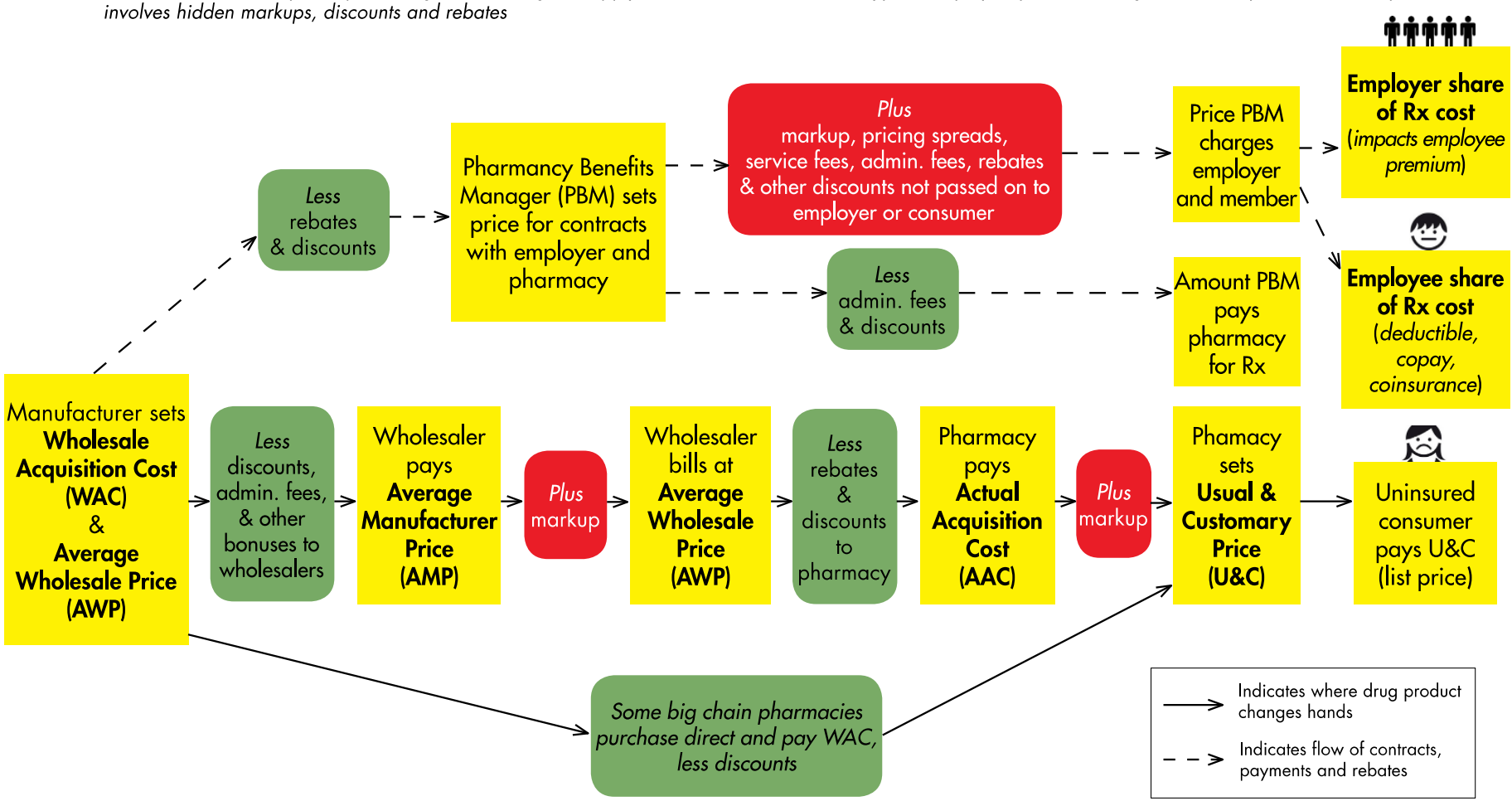
- What are the different price regulation strategies?
- How do we define "unaffordable"? List price above $x? An increase in price greater than x%
- in one or over multiple years?
- What is the role of coupons and rebates in drug pricing?
- Who are the stakeholders and how are they impacted? Possible list includes: pharmaceutical companies, pharmacy benefit managers (PBMs), insurance companies, providers that prescribe and/or administer medications, pharmacists and consumers.
- What are the potential policy pitfalls and/or legal issues associated with any price transparency and/or regulation strategies?
- What kind of infrastructure would be needed to monitor and potentially regulate drug prices? What existing agencies could become involved?

State Purchasing Policies

- What opportunities exist for leveraging the state's purchasing power to reduce pharmaceutical costs to the state, other than value-based contracting? To non-state entities?

Rx Pricing Along the Supply Chain

This chart shows how prescription drugs move along the supply chain to consumers. For a typical employer-sponsored drug benefit, the price at each step involves hidden markups, discounts and rebates

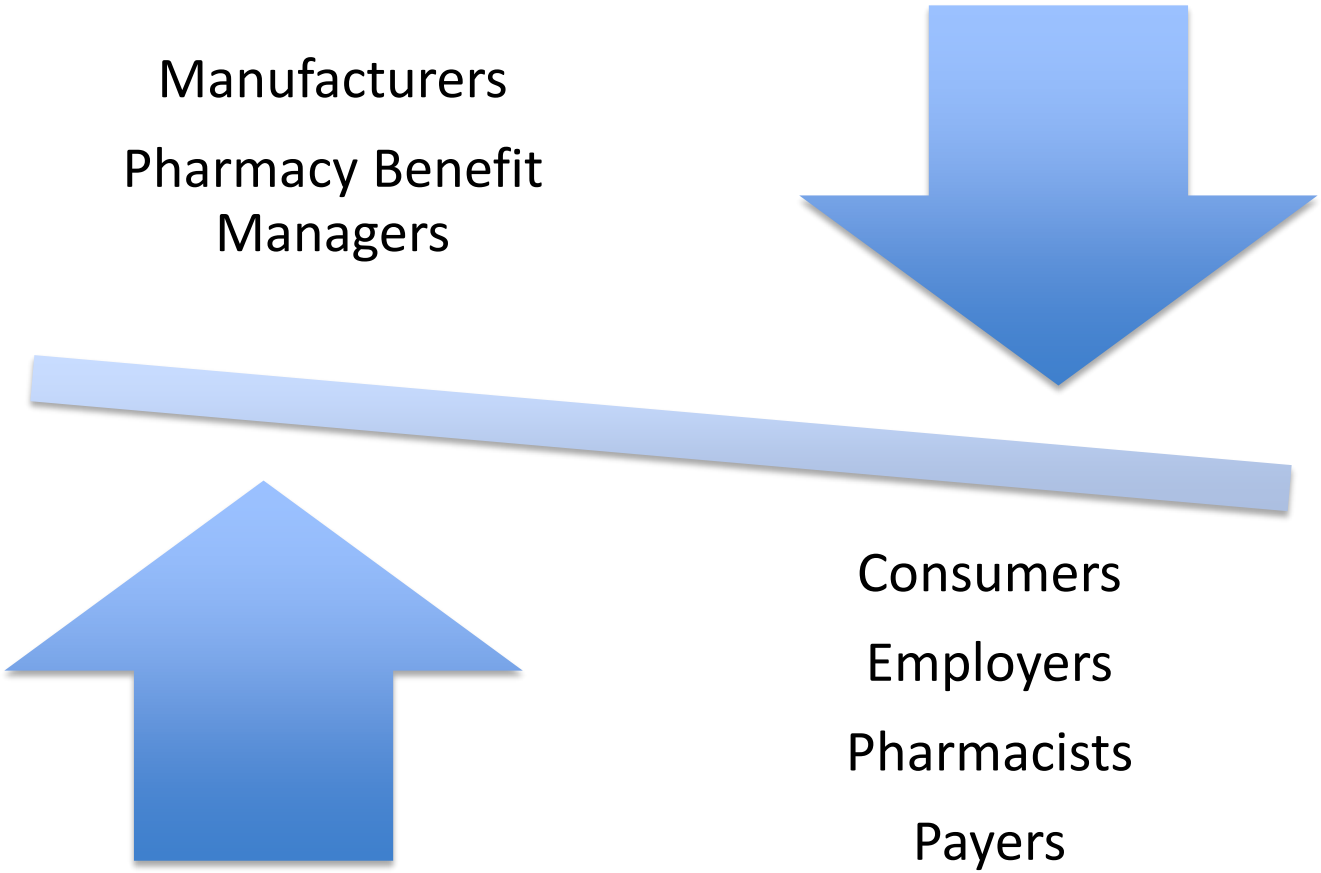


Note: This graphic is a simplified overview of the drug pricing supply chain, showing how important pricing concepts fit together. As such, it does not reflect myriad other connections between parts of the system. Source: Adapted from The Prescription Drug Supply Chain Black Box: How it Works and Why You Should Care, *Eickelberg, H.C., American Health Policy Institute (2015). For more resources on healthcare costs see www.HealthcareValueHub.org.*

Many different kinds of information may be relevant in manufacturer price determinations.

- Prices offered to other payers
- Research and development costs including clinical trial costs
- Manufacturing costs
- Marketing and advertising costs
- Patient financial assistance and rebates
- Intellectual property status
- Acquisition costs (if relevant)
- Pay-for-delay settlements
- Regulatory approval costs
- State and federal tax benefits
- Off-shored profits and jobs
- Donations to patient disease advocacy groups
- Grants, subsidies, and costs paid with public funds or by third parties.

Two major actors affect employers, payers, pharmacists and consumers most



Recommendations are informed by various states' experience

Preliminary Recommendations:
Create a transparency infrastructure for manufacturer prices

- Create a **Drug Review Board (DRB)** of clinicians, health economists & consumers to **analyze & determine whether drug prices & price increases are justified**, & result in putting at risk the health of CT patients.
- Require insurers to report information to the CID on the **impact of prescription drug price increases on premiums**.
- Require **CID** to share information with the DRB. Allow the state **Medicaid** program and the **State Employee Health Plan** to **refer drugs to the DRB for review**. Allow the DRB access to de-identified claims data through the **APCD** to perform their analysis.
- Give the **DRB authority to request additional information** from manufacturers to inform its review process. **Exempt information from FOIA**, or clarify that existing exemptions apply.
- **Change CT price gouging statutes** to include unjustified pharmaceutical prices or price increases as determined by the DRB. Give the **AG authority** to pursue price gouging cases against manufacturers of both generic and brand name drugs, as referred by the DRB.
- Require manufacturers, PBMs & health insurers to **disclose to OSE** the **funding** they provide **to nonprofit patient advocacy groups**, & post such information on a publicly available website.
- Require manufacturers to report to payers **60 days in advance of launch prices and an increase in the price** of a drug that exceeds certain thresholds. Require payers to keep such information **confidentia**l and that they **not share such information with any portion of their company which may take possession of drugs** (e.g., pharmacies, including specialty & mail order; or wholesalers).

Preliminary Recommendations:
Increase transparency & accountability of PBMs

- Require that all **prices negotiated between PBMs, manufacturers and payers pass through to the consumer** at point-of-sale, and that consumer co-pays will be based on these negotiated prices.
- **Define and manage criteria** for the "Maximum Allowable Cost" (MAC), which is what pharmacies can charge for generics and for which there is no transparent formula, only directives from the PBMs. The PBM's MAC to the employer **must be the same** as the PBM's pharmacy/retail MAC.
- Require that **PBMs must provide audit information required** within the contractual agreement between the PBM and its insurer or employer client.
- Require PBMs to exercise **"fiduciary responsibility"** (i.e., they must act in their client's best interest) when contracting in the state of Connecticut.

Preliminary Recommendations:

Promote medication adherence, increase transparency and educate consumers

- Set co-pay/deductible/co-insurance **maximums** per month of $250 for most plans ($500 for bronze ACA plans), per 30-day supply.
- Require benefit designs that separate & have **much lower deductibles for prescription drugs than medical** deductibles.
- Require benefit designs that separate & have a **lower OOP maximum for prescription drugs** vs. medical OOP max.
- **Eliminate co-pays** for asthma, high blood pressure, diabetes & high cholesterol medications.
- Adjust fill-dates for newly added meds to **synchronize pick-up of all meds** at the same time each month

- Allow **90-day supplies for chronic disease meds** to be filled at local pharmacies not only by mail order
- Require **on-line availability of price data for drugs covered by co-insurance**. This information should be available on the insurer's website during open enrollment so consumers can make informed choices.
- Educate consumers about **price variation across pharmacies.**
- Educate consumers about the different types of **patient assistance and coupon programs** that may help them afford their meds.
- Compile reports from the APCD to **illustrate trends in out-of-pocket costs.**

Questions?