Healthcare Cost Growth Benchmark Steering Committee Meeting September 28, 2023

"We collaborate, out of a shared concern and responsibility for all Connecticut residents, to develop consensus models that advance equity and consumer affordability of healthcare in our state."

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Welcome and Roll Call

Meeting Agenda

Time	Topic
3:00 p.m.	I. Welcome and Roll Call
3:05 p.m.	II. Public Comment
3:10 p.m.	III. Approval of July Meeting Minutes – Vote
3:15 p.m.	IV. Designee and Attendance Expectations – Dr. Gifford
3:25 p.m.	V. Pharmacy Cost Mitigation Strategies Work Group Recommendations – Josh Wojcik and Kristen Whitney Daniels
4:05 p.m.	VI. Cost Growth Mitigation Strategies and Other Recommendations – Dr. Gifford
4:20 p.m.	VII. Change in Commercial Hospital Payment per Service Unit for High Spend Services, 2016 -21 – Michael Bailit
4:55 p.m.	VIII. Wrap-Up
5:00 p.m.	IX. Adjournment

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Public Comment

Approval of July 24th Meeting Minutes - Vote

Designee and Attendance Expectations

Designee and Attendance Expectations (1 of 2)

- The proper functioning of the Steering Committee depends on the commitment and participation of its members. When members are unable to attend, OHS asks that members send a designee in their stead. To clarify expectations, and in the spirit of ensuring robust participation, OHS would like to propose the following modification to the Steering Committee's bylaws:
  - *"A member and/or their designee must attend at least seventy-five percent of meetings annually to remain in good standing. Members and/or designees should inform the Chair if a member/designee will be absent from a meeting."*

Designee and Attendance Expectations (2 of 2)

- Further, OHS would like to propose the following modification to the bylaws pertaining to designees and voting:
  - *"A member may allow their designee to vote by proxy but must let the Chair know in advance."*

Do members agree with these proposed modifications to the bylaws?

Pharmacy Cost Mitigation Strategies Work Group Recommendations

Pharmacy Work Group: Background (1 of 2)

- As a reminder, OHS initially convened a Pharmacy Cost Mitigation Strategies Work Group in the fall of 2022. The Work Group is co-chaired by Steering Committee members Kristin Whitney Daniels and Josh Wojcik and also includes several other Steering Committee members.
- The Work Group recommended in April that OHS pursue four pharmacy-specific cost mitigation strategies:
  1. reference-based payments
  2. PBM strategies
  3. state-contracted production of generic drugs
  4. inclusion of pharmacy expense in Total Cost of Care contracts

Pharmacy Work Group: Background (2 of 2)

- When presented with these recommendations in April, the Steering Committee recommended that OHS and the Pharmacy Cost Mitigation Strategies Work Group conduct additional work to determine how these strategies could be best implemented in Connecticut.
- Since the April Steering Committee meeting, the Pharmacy Cost Mitigation Strategies Work Group has met six times.
- The following slides contain the Work Group's recommendations.

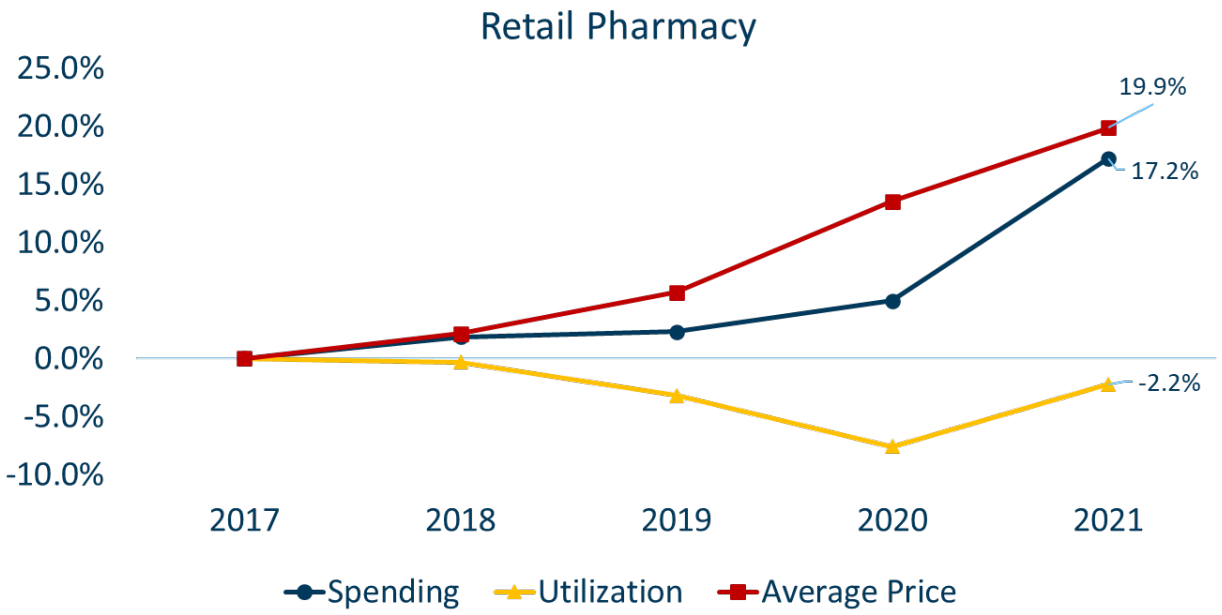
Criteria for Assessing Pharmacy Cost Strategies

As a reminder, the Work Group adopted the following evaluative criteria to help assess the multiple strategy options:

1. Measurable impact on pharmacy spending trend likely
2. Implementation requirements are reasonable
3. Opportunity exists to align efforts with other states
4. Political will is attainable
5. Limited potential for negative consequences for patients and clinical outcomes
6. Balanced benefit across insured and self-insured

Pharmaceutical Spending Growth in Connecticut Threatens Benchmark Attainment

- In 2019, 28% of commercial spending was for pharmacy services, more than inpatient hospital or outpatient hospital.
  - 20.2% was retail pharmacy
  - 7.9% was medical pharmacy (and growing as a share of total pharmacy).
- Since 2017, retail pharmacy has experienced **growing prices and flat utilization.**



Spending = Spending per member per month (PMPM); Average price = Spending per prescription; Utilization = prescriptions per member month

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High Prescription Drug Costs Are a Significant Barrier to Medication Access

- A survey of more than 1,300 Connecticut adults conducted in July and August of 2022 found that:
  - **23%** of overall respondents cut pills in half, skipped doses of medicine or did not fill a prescription.
  - **33%** of Black/African-American respondents and **30%** of Hispanic/Latinx respondents reported rationing their medication due to cost in the previous 12 months.
  - **51%** reported high levels of worry that prescription drugs will become unaffordable.

1. Reference-Based Payments Overview

- **Establishes a limit on what state-licensed payers and purchasers pay for certain prescription drugs based on a state payment limit.**
- **Benchmarks for determining the state payment limits** would be calculated as an average of the following:
  - To-be-negotiated Medicare "Maximum Fair Prices"
  - Average international prices from a limited number of OECD countries
  - Direct federal purchaser prices, represented primarily by the VA paid prices
- **Targeted drugs subject to the state payment limit**: Medicare Part B and D drugs as determined by CMS pursuant to the Inflation Reduction Act (IRA) + state-defined list of up to 50 CT top-spend prescription drugs, with physician-administered drugs phased in over time
- **Regulated transactions**: All in-state payer and purchaser transactions.

1. Reference-Based Payments: Benchmarks for Determining the State Payment Limit

The state payment limit would be determined based on an average of:

1) Medicare Maximum Fair Prices negotiated under the IRA
2) Average international prices from 4-6 Organization for Economic Cooperation and Development (OECD) countries that have publicly available pricing information
3) Direct federal purchaser payment rates, using the prices paid by the U.S. Department of Veterans Affairs, if available
    - For drugs excluded from the VA formulary, the benchmark would equal the "Big Four" purchaser amount available to the other largest direct federal purchasers (i.e., Department of Defense, Coast Guard, and Public Health Service).

1. Reference-Based Payments: Targeted Drugs Subject to the State Payment Limit (1 of 2)

- The number of pharmaceuticals subject to state payment limits would scale up over time and would include:
  - a state-defined list of up to 50 of the highest spend retail and physician-administered drugs for the CT commercial market*; and
  - Medicare Part D and B drugs that will be subject to Medicare Maximum Fair Price negotiations under the IRA.
- If the eligible Medicare Part B or D drugs include the top commercial market spend drugs, the total number of drugs in the state-defined list would be reduced accordingly.

*Note that some Work Group members recommended that a drug's price and value also be considered in determining selection for the state-defined list.

1. Reference-Based Payments: Targeted Drugs Subject to the State Payment Limit (2 of 2)

- The number of drugs subject to the state payment limits would expand over time based on: 1) the drugs subject to **Medicare maximum fair price (MFP)** negotiations under the IRA, and 2) a **state-defined list** of the highest spend drugs in the commercial market, with phase-in of physician-administered drugs over time
  - 2027: Medicare MFP Part D drugs + state's top 10 commercial market retail drugs
  - 2028: Medicare MFP Part B & D drugs + state's top 20 commercial market retail drugs
  - 2029: Medicare MFP Part B & D drugs + state's top 30 commercial market retail and physician-administered drugs
  - 2030: Medicare MFP Part B & D drugs + state's top 40 commercial market retail and physician-administered drugs
  - 2031 and beyond: Medicare MFP Part B & D drugs + state's top 50 commercial market retail and physician-administered drugs

1. Reference-Based Payments: Regulated Transactions

Regulated in-state purchaser and payer transactions would include:

- Pharmacy (retail, specialty and mail-order) purchases from:
  - Pharmaceutical manufacturers
  - Wholesale distributors
- Hospital and other provider purchases from:
  - Pharmaceutical manufacturers
  - Wholesale distributors
- Fully insured commercial insurer payments and state employee health plan payments to:
  - Hospitals and other providers
  - Pharmacies (including retail, specialty and mail-order)

2. PBM Strategy Recommendations Overview

- Advance legislation for the following strategies:
  1) Strengthen rebate transparency
  2) Prohibit spread pricing
- Promote educational efforts focused on:
  1) Promotion of fee-based pricing by employers
- Further explore the following strategies:
  1) Require additional PBM reporting (e.g., conflicts of interest, average PBM PMPM costs, contracting with rebate aggregators)
  2) Require state licensure of PBMs

2. PBM Strategy Recommendations: Strengthen Rebate Transparency (1 of 2)

- **PBM legislative proposal #1**: Expand the current CT state law definition of rebates to capture the complexity of rebate relationships and how they are funneled through various layers within and adjacent to the PBM.
- The revised definition of rebates would apply to
  a) Existing PBM reporting requirements for:
     - the aggregate amount of drug formulary rebates the PBM collected from manufacturers, and
     - the aggregate amount of all rebates that the PBM retains (total rebates excluding the amount paid to health carriers) (CT Gen Stat § 38a-479ppp)
  b) Any future transparency requirements or regulations regarding rebates.

2. PBM Strategy Recommendations: Strengthen Rebate Transparency (2 of 2)

Rebate definition § 38a-479ooo	Proposed revised definition
A **discount or concession**, which affects the price of an outpatient prescription drug, that a **pharmaceutical manufacturer directly provides to a (i) health carrier** for an outpatient prescription drug manufactured by the pharmaceutical manufacturer, or (ii) **pharmacy benefits manager** after the manager processes a claim from a pharmacy or a pharmacist for an outpatient prescription drug manufactured by the pharmaceutical manufacturer.	**Price concessions, price discounts, or discounts of *any sort* that reduce payments**, including a partial refund of payments or any reductions to the ultimate amount paid; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, **and all other compensation to carriers, their PBMs, rebate aggregators, or subsidiaries.**

2. PBM Strategy Recommendations: Prohibit PBM Spread Pricing

- **PBM legislative proposal #2**: Prohibit PBMs from engaging in the practice of spread pricing.
  - "Spread pricing" occurs when a PBM charges a health plan or employer a higher price for a prescription drug than what the PBM actually pays the pharmacy for that prescription, and the PBM retains the difference as profit.
  - Instead, PBMs would use a pass-through pricing model, where the PBM passes through the amount charged by the pharmacy to the health insurer.
  - Since the PBM does not retain the "spread" amount, the PBM typically charges an administrative fee.

2. PBM Strategy Recommendations: Fee-Based PBM Pricing

- **PBM educational proposal:** Pending the elimination of spread pricing, the State should promote fee-based pricing by self-funded employers via educational efforts.
  - Under current payment structures, PBMs are typically paid a percentage share of the drug's cost, which creates incentives for PBMs to prefer higher-cost drugs.
  - With pass-through pricing, PBMs are paid administrative fees as their only source of revenue under the contract, charging straightforward administrative fees to the carrier or employer, often structured as a flat fee per prescription.
  - The elimination of spread pricing will likely lead to PBMs charging administrative fees instead in an effort to maintain their profits.

PBM Strategies for Further Exploration (1 of 2)

1) Expand PBM transparency and reporting requirements to include:
   - Drug-specific rebate information for a limited number of prescription drugs that have the highest total expenditures in the state
   - Average PBM PMPM costs in order to help health plans and self-insured employers better evaluate PBM options
   - Any activity or policy that directly or indirectly presents any conflict of interest with the PBM's relationship with the health plan client, including disclosure of all organizations with which the PBM is affiliated
   - Information that differentiates between payments made to pharmacies owned or controlled by the PBM and those not affiliated with the PBM
   - Terms and conditions of any contract/arrangements between the PBM and any other party relating to PBM services to health plans (e.g., rebate aggregators)

PBM Strategies for Further Exploration (2 of 2)

2) Require PBMs to be licensed with the state in order to operate as a PBM in the state.
   - CT state law currently requires registration of all PBMs operating in the state (CT Gen Stat § 38a-479bbb)
   - While registration enables the state to obtain information from PBMs, state licensure would bring PBMs under the regulatory authority of CID, which would ensure that CT has appropriate enforcement mechanisms for any further state regulation of PBMs.

3. Strategies to Promote State-Contracted Production and Distribution of Generic Drugs

- Following discussion of California's current efforts to support state-contracted production and distribution of generics, and a follow-up discussion with CA's contractor, Civica Rx, the Work Group recommends *further exploration* of the following strategies:

1) Establish upper payment limits for generic drugs.
    - For generic drugs that have lower-cost alternatives available on the market, the payment limit could be set at the price of the lower-cost option.
    - Alternatively, the payment limits could be set via a formula, such as 120% of the National Average Drug Acquisition Cost (NADAC).
2) Explore opportunities for CT to provide capital investment to fund the development, production, and/or distribution of generics.

4. Inclusion of Pharmacy Expense in Total Cost of Care Contracts (1 of 2)

- Public and private payers can include pharmacy spending when setting Total Cost of Care (TCOC) budgets for shared savings and shared risk provider contracts, which will give provider organizations an incentive to prescribe the most cost-effective drugs.
- While we were not able to fully vet this strategy with all Work Group members due to timing constraints, multiple Work Group members provided feedback recommending further exploration of this strategy.

4. Inclusion of Pharmacy Expense in Total Cost of Care Contracts (2 of 2)

- The Work Group recommends further exploration of the following two strategies:

  1) A legislative mandate on the fully-insured market requiring that, to the extent that payers have TCOC contracts of any sort, such contracts must be inclusive of pharmacy spending.
  2) Development of a series of statewide targets that guide payers to use more and increasingly advanced payment models each year, with a requirement that contracts must include pharmacy spending to qualify for meeting the target.

5. Penalizing Excessive Price Increases (1 of 3)

- The strategy to penalize excessive pharmaceutical prices increases was not among the pharmacy cost mitigation strategies initially recommended by the Work Group. However, based on serious interest in this strategy by other states in the Multi-State Pharmaceutical Pricing Strategy Workgroup, in which Connecticut participates, the Work Group considered this strategy in an effort to maximize alignment across states.
- While we were not able to fully vet this strategy with all Work Group members due to timing constraints, half of the Work Group members provided feedback recommending that OHS pursue this strategy.
- The following slides summarize this strategy.

5. Penalizing Excessive Price Increases (2 of 3)

- Under the state's taxing authority, Connecticut would penalize pharmaceutical manufacturers that increase the Wholesale Acquisition Cost of drugs above the benchmark rate increase.
  - All drugs sold in the state would be subject to the benchmark, except for drugs subject to state payment limits, and provided that drug sales exceed a certain dollar threshold.
- The benchmark increase would be defined as the Wholesale Acquisition Cost in the base year, adjusted annually by CPI-U.
  - CPI-U is used to limit price Medicaid increases through the rebate program, and Medicare prices increases through the Inflation Reduction Act.

5. Penalizing Excessive Price Increases (3 of 3)

- The penalty would be set to 80 percent of the excessive price increase.
  - Set at 80 percent based on NASHP model law to avoid legal challenge
  - Calculated as the difference between revenue generated under the manufacturer's actual price increase and the revenue that would have been generated using the benchmark rate increase
  - In order to calculate the amount of the penalty, any manufacturer subject to a penalty would be required to report information on the total unit of sales from the manufacturer to an in-state wholesaler, provider, or pharmacy
- Penalties paid by manufacturers would be earmarked towards programs to offset prescription drug costs for consumers.
  - Work Group members supported ensuring financial relief specifically for consumers who purchase drugs with prices increases that exceed the threshold.

Pharmacy Cost Mitigation Strategies Work Group Recommendations Summary

1) Pharmaceutical pricing strategies
   a) Advance legislation to implement reference-based payments
   b) Advance legislation to implement penalizing excessive price increases
2) PBM strategies
   a) Advance legislation to: (i) strengthen rebate transparency, and (ii) prohibit spread pricing
   b) Promote educational efforts of fee-based pricing by employers
   c) Further explore: (i) requiring additional PBM reporting; and (ii) requiring state licensure of PBMs
3) Further explore strategies to promote state-contracted production and distribution of generic drugs
4) Further explore inclusion of pharmacy spending in TCOC contracts

- **Which strategies do you recommend that OHS seek to advance next legislative session?**
- **Which strategies do you recommend that OHS further explore before advancing?**

Cost Growth Mitigation Strategies and Other Recommendations

Cost Growth Mitigation Strategies

- In advance of July's meeting, OHS distributed a survey providing the Steering Committee with an opportunity to advise OHS on policy areas to focus on to slow healthcare spending growth in Connecticut.
  - While reviewed the results at the July meeting, only seven members had completed the survey at that time.
  - As a result, OHS reopened the survey. We will now review updated results based on responses from 17 members.

Cost Growth Mitigation Strategies Survey Results

Cost Growth Mitigation Strategy	Average Priority Ranking (On 1-5 scale)
Contain growth in prescription drug prices	4.2
Improve oversight of provider consolidation	3.9
Improve behavioral health crisis systems	3.7
Promote adoption of population-based provider payment	3.4
Adapt advanced benefit designs	3.2
Reduce administrative waste	3.2
Develop enforcement policies for entities who do not meet the benchmark	3.0
Promote use of community paramedicine	3.0
Strengthen health insurance rate review	3.0
Cap provider payment rates or rate increases	2.4

Recommendations to Include in the Report to the Legislature

- By October 15, 2023, OHS must "submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health."
- The report must include, among other things, OHS' recommendations "concerning strategies to increase the efficiency of the state's health care system, including, but limited to, any recommended legislation concerning the state's health care system."

- ***What strategies, legislative or otherwise, do you recommend that OHS include in this report?***

Change in Commercial Hospital Payment per Service Unit ("Price") for High Spend Services, 2016-2021

Why Have Hospital Prices Been Rising So Quickly in CT?

- **During the June 2023 public hearing, hospital representatives reported delivering a *different mix of services* to sicker patients, which gave the impression of higher prices.**
- We can assess whether this occurred by looking at changes for a group of high spending services over time to control for any change in service mix.
- The following slides track statewide trend in payment per service unit for the inpatient and outpatient services associated with the most 2021 commercial market spending.

What Happens with **Inpatient** Commercial Hospital Prices When We Control for Change in Service Mix? (1 of 2)

DRG	Inpatient Service	2016 Price	2021 Price	Avg Annual Increase
885	Psychoses	$16,192	$20,299	5.1%
871	Septicemia or Severe Sepsis (infection)	$28,119	$37,631	6.8%
621	Operating Room Procedures for Obesity	$22,091	$29,390	6.6%
455	Spinal Fusion without Complication	$68,336	$87,775	5.7%
454	Spinal Fusion with Complication	$101,015	$114,349	2.6%
25	Craniotomy and Endovascular Intracranial Procedures with Complication	$67,948	$96,558	8.4%
219	Cardiac Valve & Other Major Cardiothoracic Procedures w/o Cardiac Catheterization	$102,337	$148,222	9.0%
460	Spinal Fusion Except Cervical w/o Major Comp.	$54,507	$69,790	5.6%
330	Major Small and Large Bowel Procedures w Comp.	$37,584	$48,093	5.6%
247	Percutaneous Cardiovascular Procedures w/Stent	$32,959	$40,983	4.9%

What Happens with **Inpatient** Commercial Hospital Prices When We Control for Change in Service Mix? (2 of 2)

- The average annual price increase for these 10 highest spend hospital inpatient services between 2016 and 2021 was **6.0%.**
- This increase compares to the average annual price increase for all inpatient hospital services between 2016 and 2021 of **7.8%.**
- The somewhat slower price growth among the 10 highest spend inpatient services compared to all inpatient services does suggest *some* shifting to more expensive services, but also demonstrates price increases that far exceeded average annual CT median household income growth over this period (1.3%).

What Happens with **Outpatient** Commercial Hospital Prices When We Control for Change in Service Mix? (1 of 2)

CPT	Outpatient Service	2016 Price	2021 Price	Avg Annual Increase
99283	Emergency Room Visit – Moderate Severity	$497	$991	19.9%
99284	Emergency Room Visit – High/Urgent Severity	$666	$1447	23.5%
99285	Emergency Room Visit – High Severity & Threat	$874	$1698	18.9%
74177	CT Scan Abdomen & Pelvis with Contrast Material	$1113	$1031	-1.5%
93306	Echocardiography, Transthoracic, Real-Time with Image Documentation	$972	$1153	3.7%
45380	Colonoscopy with Biopsy Single/Multiple	$1578	$1995	5.3%
96413	Chemotherapy Administration w/ IV Administration	$614	$760	4.8%
43239	Endoscopy with Biopsy Single/Multiple	$1570	$1960	5.0%
97110	Physical Therapy Using Exercise, Each 15 Minutes	$120	$141	3.5%

What Happens with **Outpatient** Commercial Hospital Prices When We Control for Change in Service Mix? (2 of 2)

- The average annual price increase for these nine highest-spend hospital outpatient services between 2016 and 2021 was **9.2%**. If we remove the three ED codes, the average annual rate for the remaining six high-spend services drops to **3.5%**.
- This compares to the average annual price increase for all outpatient hospital services between 2016 and 2021 of **4.9%**.
- This analysis is less definitive because of an odd 2021 outpatient price trend for the large systems (high volumes of low-cost, unidentified outpatient claims), but it does not validate the argument that observed price increases were wholly due to a change in service mix.

Discussion

- What should we make of the information presented today?
- What are appropriate next steps?
  - Analytic next steps?
  - Policy next steps?

Wrap-Up

Wrap-Up

- The next Steering Committee meeting will be held on Monday, **October 23rd** from 3–5:00 pm.