Connecticut Health Care Cabinet
Pharmaceutical Drug Cost Determination & Cost Containment Work Group
Meeting Summary
DRAFT

Friday, September 29, 2017
OHA, 450 Capitol Ave., Hartford

M**embers Present:** *Chair*–Frances Padilla (UHCF), Rob Blundo (AHCT), Josh Wojcik (Office of Comptroller), Ted Doolittle (OHA), Bob Clark (Office of Attorney General), Kristin Campanelli (Insurance Dept.), Marghie Giuliano (CT Pharmacists Assoc.), Mark Zatyrka (Consumer)

Members excused: Katharine Wade (Insurance Dept.), Raul Pino (DPH), Bill Handelman, Bob Tessier (Taft-Hartley)

Others present: Jill Zorn (UHCF)

Meeting goals:
- To debrief the presentation and discussion of the Yale GHJP presentation held at the September 12 Healthcare Cabinet meeting
- To discuss key learnings from the transparency discussions held during the previous two work group meetings as well as Cabinet meetings
- To identify what we need to learn and decide in the next 2-3 meetings

Frances Padilla called the meeting to order at 3:15pm.

Introductions were made.

Public Comment: No comment.

Acceptance of August 29, 2017 and September 11, 2017 Meeting Summaries
Ted Doolittle moved, Bob Clark seconded. Meeting summaries accepted by consensus.

Yale GHJP Cabinet presentation Curbing Unfair Drug Prices in Connecticut
Frances began with one takeaway from Yale was that transparency in terms of solutions that states can pursue should be designed to provide information needed to understand how drug prices are set – how manufacturers set prices. Looking at the infographic first discussed in the 8/29 meeting, "RX Pricing Along the Supply Chain", this is about drug prices set by the manufacturers on the far left side of the chart, at the beginning of the supply chain. The Yale team recommends that states require detailed disclosure about costs at the manufacturer level: R&D, production costs, marketing on drug by drug basis. They also emphasized that there should be a presumption of public release of this information, not just release to policymakers.

Marghie pointed out this would be a big task and that there would likely be lots of pushback from manufacturers. Since this would not be easy, perhaps it is not something to look at as a first step. Frances referred to other states that are blazing trails in this area with their focus on transparency around drug pricing by the manufacturer.

APCD Cabinet presentation
Frances asked Rob Blundo to further explain what is available within the All Payer Claims Data Base (APCD) per his September 12 Cabinet presentation. She specifically asked about the list of financial values on slide 4 of his presentation Prescription Drug Data: What's in CT's APCD?.

Rob went through the slide and then talked about another term: allowable amount, which is the price amount captured in the APCD. In general, the negotiated price (negotiated with the manufacturer by the PBM or payer) plus the dispensing fee is equal to the allowable amount. Another way of thinking about allowable amount is to look at the right side of the Rx Pricing Along the Supply Chain chart. It consists of the employer/insurer share plus the out of pocket amount paid by the consumer. If the consumer pays the entire amount (usual and customary on the chart) that correlates with "charge amount" on page 4 of the APCD slide handout.

There was a long discussion about the terms used to describe prices and how each stage of the supply chain views price. At the end of that discussion, it was clear that the manufacturer, payer (either insurer or employer), PBM, pharmacy and consumer each experiences price differently and there are multiple prices for a drug, depending on who is paying or where they are in the supply chain. Each participant in the supply chain has a different perspective and different knowledge of cost and price. What is the cost of a drug to whom?

Consumers

- If a consumer has a high deductible plan they don't get the rebate. The consumer almost never gets the rebate. The exception is that there are certain plans where the deductible insurance amount is based off the net purchase price. But with the absence of that consumers will only see benefit of rebates in their premiums.

PBMs and Manufacturers

- Manufacturers set price. There is no transparency right now about how the price relates to actual costs of developing and manufacturing and marketing the drug, overhead, etc.

Insurers and PBMS

- The "allowable amount" is the price captured in the APCD. There was some discussion about whether the APCD's "allowable amount" captures rebates that may have been negotiated upstream. Rob explained that "allowable amount" reflects the contractual amount that has been negotiated by the PBM. Josh said that reimbursement from the carrier to pharmacy, the "allowable amount" for that particular claim, doesn't account for activities that occurred upstream, like rebates.
- Pharmacy claims differ from medical claims in that they are not negotiated with each facility (like a hospital or physician contract). Instead, they are not pharmacy-specific and generally all pharmacies are reimbursed the same for a given insurance plan.

Pharmacy

- Marghie explained that the insurer or PBM hands a contract to the pharmacy saying this is what we will pay you for this group of insured people. There are hundreds and hundreds of insurance plans. The pharmacy doesn't know anything about the rebate amount that may have been negotiated between the PBM and the manufacturer. The computer just spits out to the pharmacy what to charge the customer.

- Generally there is a somewhat known formula for the allowable amount for branded products. The pricing for generics is a black hole – there is no formula so there is no way to know how the price was determined. For generics, the pharmacy is told the price - take it or leave it. Sometimes there's a dispensing fee, sometimes there is no dispensing fee. It is very difficult to pin down.
- What the pharmacy is paid bears no relationship to what it costs the pharmacy when they receive the drug into their inventory. Later, the pharmacy attempts to do a reconciliation to see if the reimbursement they received is sufficient to cover the cost they paid for the drug.

Audits

The importance of audits was discussed. Pharmacies conduct them to look at whether what they are reimbursed matches up with what they paid for the drug. Self-insured employers, like the state employee health plan, do audits to see if the rebates they are receiving from the PBM match what they contracted for. There was agreement that given the lack of transparency at multiple points in the supply chain, audits are crucial and should be done more often.

Data

Rob identified other states that have used their APCDs to analyze drug costs and to look at trends: Oregon and Minnesota. Oregon also investigated whether they could use APCD claims data to help set reference prices. Jill and Rob mentioned that Massachusetts has conducted some studies on prescription drug cost trends. They have annual cost trend hearings and the one held in 2016 included some analyses of prescription drug costs. The next annual cost trend hearings will be happening soon. (Note: the hearings occurred on October 2 and 3, 2017).

Rob said he would reach out to these states to find out what they have learned and reported and get that information back to the work group. What studies have they run and what have they learned? Can we get some ideas from them about what studies we should run in our own APCD?

Frances closed the discussion saying that we may need to make recommendations that are short term, medium term and long term. We will have to be clear about what types of transparency are needed, and at what points in the supply chain. The goal of making information more transparent is to give us a better understanding about the underlying drivers of cost. We also need more information about cost trends. One important place to start is with identifying the impact of price increases on consumers.

Takeaways from what we have learned about transparency so far

Jill went through a draft summary of high-level takeaways so far from the work group's focus on transparency. The draft included a chart of different benchmarks used for pricing in the supply chain.

Benchmark list (draft):

Acronym	Meaning
WAC	Wholesale Acquisition Cost
AWP	Average Wholesale Price
AMP	Average Manufacturer Price
AAC	Actual acquisition cost
U&C	Usual and Customary
Other?	

Marghie pointed out that it is useful to have this glossary to know what the acronyms are and it would be helpful to define them. But there is no "real" number on this list. They are just numbers that are published but negotiations either way change them. What used to be the benchmark for pharmacy reimbursement was AWP (average wholesale price) – typically set by manufacturer. From there it goes up and down, as it moves through the supply chain - never up anymore. Most negotiations are built off of AWP – that's why they use this as a benchmark because it is a published number. Anything other than that you won't know about because they're negotiated or handed to pharmacies by PBMs or insurers as to what they will pay.

She also made a correction to the chart to say that AAC should be changed to NADAC - National Average Drug Acquisition Cost. This benchmark is created by doing a survey and pulling invoices periodically to see whether the benchmark still in line. She also said that another term, MAC (maximum allowable cost) should be added; it is what can be charged for generics. This is a particularly troubling benchmark because it is not known how it is derived. For generics, the federal government makes a Federal Upper Limit list (FUL) for use by Medicaid, which has only recently been updated. That's different than the NADAC because it's for generics; NADAC is primarily about branded products.

Frances asked whether the pricing constructs listed on the table are useful for price regulation or for price transparency? Where are places in the supply chain that states could intervene to require transparency?

Marghie discussed how the MAC is a particularly problematic benchmark. There is no formula that a pharmacy can look at and say, "OK this is what I'm going to get reimbursed so let me go to see where I can purchase it so that I can at least potentially get my cost back." The Connecticut Pharmacists Association has sought legislation to base MAC on a formula, to make it more transparent, but so far has not been successful.

Jill remarked that we know that there are a lot of black holes in the supply chain, but it's important to remember that the high cost of the drug starts at what the manufacturer charges.

The group went through the takeaways draft and made several suggestions for corrections.

Next Steps

Josh proposed breaking the group's work into subgroups that represent three key areas in the supply chain. Each subgroup could focus at a high level on what goes into setting prices, what information we need to set policy; what are potential policies and which ones do we want to recommend. The subgroups should consider recommendations about both cost determination and cost control.

Three subgroups were proposed and members signed up to work on one of them:

- Manufacturers
- Consumers
- PBMs, Employer/Insurers, Pharmacies

We need to keep in mind some of these questions:

- Manufacturers: What factors determine how they set their prices? The initial price that is set has an impact because everything that follows is negotiated off that price.

- Consumers: What is impacting consumers' costs and how can consumers get relief from high costs and high increases in what they have to pay?
- PBMs, insurers/employers, pharmacies: how these groups interact with each other and the impact they have on both consumers and manufacturers

All subgroups should also keep in mind the overall impact on total cost to the health care system.

The group agreed this would be a good approach. The next few meetings will consist of report-backs by the subgroups and with building a list of things that we are going to consider recommending.

The meeting adjourned at 4:15 PM.