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

Thursday, October 12, 2017
OHA, 450 Capitol Ave., Hartford

M**embers Present:** *Chair*–Frances Padilla (UHCF), Josh Wojcik (Office of Comptroller), Bob Clark (Office of Attorney General), Paul Lombardo (Insurance Dept.), Lena Bachar (Insurance Dept.), Marghie Giuliano (CT Pharmacists Assoc.), Mark Zatyrka (Consumer), Bob Tessier (Taft-Hartley Coalition)

Members excused: Katharine Wade (Insurance Dept.), Raul Pino (DPH), Bill Handelman, Rob Blundo (AHCT), Ted Doolittle (OHA)

Others present: Jill Zorn (UHCF), Sandra Murphy (Taft-Hartley Coalition), Anita Schepker

Meeting goals:
• Provide status updates on the progress of the three sub-groups formed on Sept. 29th
• Check in on progress addressing the questions outlined in the work group's charter
• Set the agenda for the next 2 meetings

Frances Padilla called the meeting to order at 10:00am.

Introductions were made.

Public Comment: No comment.

Acceptance of September 29, 2017 Meeting Summary
Josh Wojcik moved, Marghie Giuliano seconded. Meeting summary accepted by consensus.

Status of Subgroups

Manufacturing price and cost subgroup (Josh, Ted, Bob)
Josh reported that the subgroup has been meeting and plans to bring back a series of options to talk through with the full work group. An important event in the changing landscape is the passage of a transparency law in California – a large state with significant resources. The subgroup is studying the new law and advances made in other states, thinking about their applicability to Connecticut, and identifying other issues to be considered.

Questions were asked about the specifics of the California law. The law has reporting requirements when prices are raised above a certain threshold and also requires price increase justifications. Bob Clark said the AG's office is reviewing the bill right now. The subgroup said they would prepare a one–page summary of the bill, SB 17, for the workgroup for the next meeting.

The group agreed it would also be helpful to know more about what different stakeholders thought about the bill and which groups supported it. It was observed that the insurance industry in California was generally supportive of the new law.

Consumer Subgroup (Mark, Jill, Raul, Rob)
Mark reported on some of the things the group is looking at. One area is patient assistance programs, including a variety of coupon programs such as manufacturer copay assistance programs, coupons used at the pharmacy. A coupon company, FamilyWize, has reached out to the cabinet and Jill and Mark plan to meet with them by phone.

In addition to passing a transparency law, California also passed a coupon law, AB 265, that generally prohibits manufacturers from offering a coupon for a medication if there is a generic equivalent. Massachusetts already has a similar law and previously banned all coupons. While coupons are one more element that obscures costs to the system, they do help consumers afford their prescriptions. It's not clear that banning coupons is in consumers' best interests, especially at a time when more and more of the cost of prescriptions is being shifted to them.

Another area the subgroup is exploring is specialty tier laws that other states have considered to protect consumers from high co-insurance costs.

Paul Lombardo explained that the Connecticut Insurance Department (CID) has issued a bulletin (2/5/2016) that sets maximum cost sharing for a number of services, including a generic drug maximum copay of $5 and brand drug maximum of $60. The bulletin also sets a maximum coinsurance of 50% for any service, including drugs.

He also shared that CID gets trend information, overall unit cost and utilization for prescriptions from annual insurance rate filings. They are seeing that 40% of a carrier's prescription drug spend right now is coming from 1% of utilization, mainly of specialty drugs. Pharmacy cost trends are increasing much more rapidly than overall medical trend. The trend for 2018 is in the low double digits, between 11-13% for pharmacy while medical trend is much lower. Pharmacy costs are becoming a larger percentage of the whole premium. Was 8-9%, now 22 – 25% of total health care spending.

It was asked if it would be possible for CID to make a chart showing pharmacy and medical trend increases over time. Paul said they would make the chart and would likely be able to go back 8 or 9 years.

Jill explained that she has spoken with Rob Blundo about whether reports can be generated by the APCD, including trend reporting about what has happened to consumer out-of-pocket costs over time. Rob is looking into what types of reports have been generated in other states, including Oregon, Minnesota and Massachusetts.

Bob Tessier said that the Taft Hartley Coalition has seen numbers more like 30% of pharmacy costs are coming from 1% of patients. He has seen similar trend numbers and expects it to get worse. He noted that coalition members get inundated with vendors and consultants offering to help manage what they are describing as the "tsunami" of expensive specialty drugs that are coming soon. He also said that some specialty pharmaceuticals are reflected in medical trend. For example, in the self-funded plans in the coalition, some pharmaceutical costs are counted as medical claims, when a specialty drug is administered in a hospital or outpatient setting.

Pharmacy Benefit Managers (PBMs) – (Marghie, Bob Tessier, Paul Lombardo, Lena Bachar)
Marghie reported that this group is looking at several states that have considered legislation on PBM transparency, to see what's out there to leverage for our state. Another possible approach they are discussing is whether PBMs should be required to have fiduciary responsibility when they contract and what that might look like. They are also looking at audits and how to have a more standardized process. They are gathering information on different state laws and plan to talk to an audit expert.

Review of Progress on Work Group Charter Questions

1. *What are the transparency policies we're trying to pursue and what public and commercial data are needed to inform them?* This work is ongoing.

2. *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?* Starting to address this. Discussions underway about how APCD could be used. Paul Lombardo has agreed to pull trend data together from insurance rate filings.

   The group also discussed what data could be pulled together from Medicaid and the State Employee Health Plan (SEP). Comptroller's Office has claims data for SEP. They know what aggregate rebates are, don't have rebates for each specific claim. Josh was asked if he could make a trend chart on prescription drug spend vs. total medical spend for the last 3 years, breaking out a number for rebates, also, to see what the trend looks like for rebates over time, too. Frances said she would ask Kate McAvoy if we could get something similar from Medicaid.

   The group agreed that it would be valuable to have data on the landscape of the pharmaceutical industry in Connecticut. Information could include the number of companies, the number of employees, annual revenues and trends. It was noted that some of this information is reported by the federal government. Anita Schepker, a PhRMA representative who attended the meeting by phone, was asked and she said she would facilitate getting that information to the group.

3. *How are specialty drugs defined?* There is a lot of talk at the national level about trying to come up with an accepted definition. Some of this discussion also includes defining biosimilars. This is an appropriate discussion to take place at the national level, so our group may not be able to answer it.

   A subjective definition that exists right now is that specialty drugs are expensive medications that are put into the highest formulary tier for insurance purposes. But formularies vary, so this is not a uniform standard. Possible or previous definitions were also discussed by the group, but clearly there is no one accepted legal definition in the marketplace right now:
   - Specialty drugs used to be identified as those that have an organic/living base rather than a synthetic base. This isn't a relevant definition any longer.
   - Specialty drugs are often those that are funneled through PBM-owned pharmacies for special handling, like refrigeration. (Of course, retail pharmacies have refrigerators, too.) Or they are handled differently because the population requiring them is very small.
   - Specialty drugs can be self-administered; they are not solely drugs that must be administered in a clinical setting

4. *How is transparency of drug pricing data useful to consumers? To regulators? To purchasers?* This is an ongoing question the group is working to clarify. One indication that achieving transparency is important is that these efforts are fought so hard. But is it worth the effort and why? What is the

relative value of transparency for each of the stakeholder groups? Each subgroup should include an answer to this question as context for their recommendations.

Pricing transparency in health care is generally difficult if not impossible and pharmacy transparency is the worst. When we're spending as a country, state, employers, workers and families so much for what is really an essential service, care that may be life-saving, it is unconscionable to not know the price. It is crazy that employers or government agencies buying health care can't verify prices. At every level of the supply chain, more money is being spent: manufacturers, PBMs, even pharmacies, we don't know what they're making. But even with that knowledge, you have very limited choice, if any.

Purchaser perspective: Government purchasers, employers and self-funded arrangements and the carriers who are contracting with PBMs seek transparency about them. Audits could be an important first step to help with transparency for purchasers, giving them more information to help them with their decisions.

Consumers: How would a consumer benefit knowing what the "true" cost of a drug is, unless they have a choice? In the state employee health plan, consumers are represented in the PBM selection by the State of Connecticut Labor-Management group and have input on some other major decisions about how the drug benefit is structured. Outside of this type of arrangement, consumers are generally not involved in employer decisions about prescription drug coverage, PBM selection, pricing decisions, tiering, formularies, etc. They have the least amount of power over what they must pay. Transparency alone is not enough to actually save money for the consumer.

The cost of the drug is different to each player in the chain. In the past, if I'm a consumer and I'm paying a co-pay – what do I care what the price of the drug is, my out-of-pocket is what it is, unless the price of the drug is less than my co-pay. I'm insulated from the full price of an expensive drug.

But now, with the advent of high-deductible health plans and tiering, awareness has definitely grown. Because consumers are bearing more and more of the burden, demand is rising to do something about prescription drug prices. Polls show that consumers are quite concerned about drug costs. Now they are more interested in knowing the price and if there are alternatives that are less expensive. But what good is that knowledge if there are no alternatives and no mechanism for making the price more affordable or fair? Transparency to consumers is important, but if I have to take a drug that I need, health care isn't shoppable in that way. In the end, it all rolls downward to the consumer, and consumers have the least power to protect themselves from high prices.

There is a nuance to how out-of-pocket costs are structured. Co-insurance is tied directly to the price. A co-pay is not. But drug costs are in premiums, too. The higher the cost of the drug, the higher the premium. Consumers have different experiences with regard to how much they must pay for insurance premiums. Some are insulated almost completely by their employer, some are paying a larger and larger share of premiums from their pay checks, or if they are in the individual insurance market without subsidies.

There was discussion about what price and cost information consumers have now and what they should have. There used to be an Explanation of Benefits (EOB) which showed the actual cost of services and what the carrier was paying and what you had to pay. But that is rare now. When I go to pick up a prescription I don't get an EOB for the prescription, so I don't know the actual cost.

Even if price information is available, it might reflect what the pharmacy is being paid, but not the true price to the employer/insurer. Showing the true price at the point of sale would be a challenge, but it could be important information for the consumer.

Overall, more people can see that cost in health care is a problem. Almost every year something changes and you're paying more for it. The consumer education group is thinking about this issue. Informed consumers will ask different questions of their policy makers and their physicians, and will be in a better position to demand change.

This is an issue the full cabinet will have to grapple with, but we can help frame the issue. What are the mechanisms; where do you get the data; what are the true costs; what is the Return on Investment (ROI) of transparency; what are the points on the purchasing continuum where the state could ensure greater transparency and a greater return on behalf of consumers?

5. *Should there be any categories of data excluded from disclosure requirements?* Some states have excluded some data from public release that the industry has said is proprietary – still an open question. Josh's work group can look into this question.

6. *What are the different price regulation strategies?* This work is ongoing. Transparency goes hand-in-hand with regulation. Looking at policy recommendations and at what other states are doing.

7. *How do we define "unaffordable"?* List price above $x? An increase in price greater than x% in one or multiple years? Why do we want to define unaffordable? It's a relative term to everybody. We are in an environment where the general public feels that their prices are through the roof and see examples of that every day.

   This question is more about what criteria for regulation we want to consider. Other states have grappled with this. Do you focus on all manufacturers, on every drug, or focus significant price increases or significantly high launch prices? What are the right thresholds to use to discourage that kind of abusive behavior?

8. *What is the role of coupons and rebates in drug pricing?* These issues are ongoing in our work. The complexity surrounding both coupons and rebates makes transparency and regulation very challenging.

9. *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.* Discussed the list – pharmaceutical companies, PBMs, pharmacists, insurance companies, providers that prescribe and administer, consumers, employers. Within our groups should be thinking about stakeholders and impact.

10. *What are the potential policy pitfalls and/or legal issues associated with any price transparency and/or regulation strategy?* Almost every state that has passed significant legislation has been taken to court. Should really be clear about what is possible under the law, then balance that with what needs to happen. Maybe some things are not possible under existing law and we should at least know that.

11. *What kind of infrastructure would be needed to monitor and potentially regulate drug prices? What existing agencies could become involved?* Practical implementation, what are the roles that need to be played, who's in the best position to play them, are they willing, who needs to have additional authority under legislation – think about all that. Identify that need, but might be phase 2 to figure out how to make it work.

    One important entity of state government that was recommended by the Cabinet last year and is pending approval in the state budget is the Office of Health Strategy. That office could definitely play a role – in coordination with CID, APCD and AG and perhaps others, too.

    Paul pointed out that the Insurance Commissioner doesn't view the department specifically as a regulator of drug prices. CID's role is to make sure that whatever the cost of services that carriers are providing is appropriately reflected in the premiums that they are charging. They can provide technical support, as well as trend information but don't have the authority or expertise to regulate drug prices.

    The issue of "authority" will look different depending on the regulation under consideration. For example, with value based purchasing, if it were to be regulated, it has to come explicitly under some agency's authority. Other states have grappled with this. Some states have robust cost-studying entities, like the health authorities in Washington and Oregon. Maryland has and all-payer rate setting agency for hospitals; they already have a big infrastructure in place that can be given additional authority as needed.

    The Office of Health Care Access in Connecticut, which is proposed to become part of the Office of Health Strategy, used to do rate setting for hospitals, but doesn't anymore.

    PBM legislation in other states has identified insurance departments as the regulator. The PBM work group will reach out to see what they are doing and success rates.

12. *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?* SEP and Medicaid are the two biggest entities. The Healthcare Pricing Work Group that Josh chairs is working on this issue, looking at different possible purchasing models, so it was agreed that our work group will not. They are looking at different purchasing models.

Next Meetings

Next two meetings have been scheduled:

- October 27, 2:30-4:30 pm. Going to have presentation with Pharma industry. Develop agenda based on work group reports.

- November 2, 1:00-3:00 pm

Meeting adjourned 11:15am.