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

Friday, October 27, 2017
OHA, 450 Capitol Ave., Hartford

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

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

Others present: Jill Zorn (UHCF), Jennifer-Pharmacist student (CT Pharmacists Assoc.),

Pharmaceutical Guests present: Anita Schepker, Rick Smith, Paul Pescatello, Tamar Thompson, Audra Adele, Jennifer ??, Kathy, Joe Morris

Call meeting to order 2:30pm.

Pharmaceutical industry presentation and Q and A
The meeting opened with a presentation by representatives from the pharmaceutical industry, followed by a question and answer session. The presentation included information on employment and clinical trials in Connecticut, in response to a work group request. (See attachment for the presentation: *Prescription Medicines: Costs in Context*. A second attachment is a letter from Pfizer submitted to the work group).

Work group question: Please explain the relationship between manufacturers and PBMs.

Answer: The PBM typically doesn't take possession of the medicine. Manufacturer sells medicine to wholesaler who sells to pharmacy. PBM may also run a mail order pharmacy.The PBM is the health plan's agent in negotiating negotiates discounts, rebates and other fees with manufacturer. This will often determine formulary placement - is the drug put on preferred tier, not preferred tier, specialty tier, etc. Manufacturer pays rebates and other fees to PBM. Rebates are negotiated, there are several different kinds – base rebate, etc. PBMs talk about price protection so if there are any prices increases above the agreed threshold in the course of a year all of that goes back to the PBM in terms of additional rebates. There may be other fees for other services the PBM provides. PBM and health plan then have their set of relationships and arrangements and that determines how much the health plan is paying the PBM.

Work group question: Is the PBM passing through all of the rebates or only some of them to the health plan?

Answer: What ends up happening in almost all instances is when medicine is sold to patient at pharmacy – if they are in a deductible or if they have a coinsurance benefit rather than a fixed dollar

copay, the practice has been to base what the patient pays on list price. The argument from PBM industry is that most of rebate dollars get passed back to health plan or employer, if it's an employer that they're contracting with. It's the health plan or employer decision how to structure the benefit or price at the point of sale. We often hear then the rebate dollars are used to lower premiums. There isn't a lot of information that allows you to trace how those rebate dollars are being used and how much are being used for one purpose or another.

Conclude by saying I think that viewing rebate dollars as way of lowering premiums is getting insurance a little bit backwards. Basically saying we're going to charge cost sharing to sicker people who are higher utilizers based off an amount that is more than is actually paid to purchase the drug by the health plan. Then we are going to use that extra savings from patients paying higher cost sharing to reduce premiums across the board by some amount. So in this instance, the sick are subsidizing the healthy rather than other way around. There is a case to be made –just like other services - where patients are paying based on what the plan is paying rather than more than what the plan is paying. There is a case for moving in that direction, while maintaining confidentiality of the specific financial transactions, because that ultimately allows for bigger savings in the market.

Work group question: Does manufacturer believe there is an onus on them to make sure that the PBMs that are negotiating these rebates and discounts are actually passing along the full rebate.

Answer: The challenge that we have in healthcare paradigm – our relationship is through contractually either directly with the PBM and/or the health plan. Once we make that negotiation our ability to track next steps of how that is pushed through the system disappears. We feel obligation to patient and try to work around that process and that's where you see patient assistance programs come in. I know there has been a lot of scrutiny around that, but the reality is that, not only the sicker population, but it's the commercial population and the people being discriminated against. There are poor Medicare and Medicaid protections to allow those patients to pay certain capped costs. So it's the commercial population of people and those that are sicker in that population who are being discriminating against. Therefore, we've tried to work around that angle by providing additional assistance for those patients. But we are in a very complex situation because the PBMs are also our customers. So in order for us to make our products successful to the market in the system as it stands, we have no choice but to work with that structure.

Work group question: I'm guessing then that you'll all be supportive of a proposal to require full transparency by manufacturers and PBMs around rebates and costs. Because that would just cut right through the argument you just made to us about what the PBMs are doing. We would probably all agree about what some of the PBMs are doing. But right now the PBMs argue with health plans that they can't allow price transparency because the manufacturers won't allow it.

Answer: Would amend that statement slightly by saying that we are supportive of transparency in this regard through entire supply chain. So it would be beneficial not only with PBMs and drug manufacturers, but also distributors, hospitals and providers as well.

I've seen cases that are egregious in markup of life saving drugs like chemotherapy and drugs from hospitals' 340B program.

Work group question: Trying to understand, I'm the patient. I'm paying the pharmacist a dollar amount that's higher amount than whatever it costs of the plan to obtain the drug – or whatever it's costing the

plan to reimburse for the drug. So that extra cash goes into a cash register at pharmacy. Who's getting that higher cost?

Answer: It's actually a back-end rebate. Technically a transaction occurs where the patient pays list price and then at the end of day/month it all gets reconciled against the pharmacist. So who's getting that spread – the PBM and/or health plan based on their contractual agreement.

Health plan will then reduce their prescription claims by rebate amount, in some cases. For Medicare Part D that is absolutely true. It is required by statue that they do so. It is not required that they do so for commercial plans. In fact, when we have gone to negotiate pricing in some cases, we wanted to give a discount off the pricing and the plan or PBM said no, they'd rather see the rebate on the back-end side because those dollars are not accounted. They are not premium dollars. They are not counted in the cost calculation of the medical loss ratio.

Work group comment: If you really want to help the consumer, I'm sure there's ways to. Every time a consumer goes into a pharmacy and they run their card through, certainly there's a way to say well let's rebate it all the way to that customer at point of sale. The computer systems are sophisticated enough if they're currently sophisticated to do all the manipulations they do with the 20 million different plans the pharmacies deal with. Pharmacies only purchase what we can purchase from a wholesaler. They never get whatever happens out of that back-end. If you really want to get it to the consumer, I'm sure you can swipe that card and that rebate dollar can come right to the pharmacy counter and the patient can be paying what they need to pay. That's where I think transparency should go.

Answer: I would make a distinction. I think there is a lot of transparency that's beneficial to consumers. I think there's also proprietary information that facilitates against commercial transactions and I think the two are not unreconcilable. There is a role and the FTC has said this time and time again, for maintaining confidentiality of certain commercial terms including specific rebates around specific drugs that doesn't preclude from developing practices or policies that provide for the pass through of the large majority of share of rebates to bring the patient out of pocket costs more in line with the actual acquisition cost.

Work group question: Related to passing through rebate down to consumer. The larger PBMs can do this, they can already process it to bring it down to the consumer level. They're essentially doing an estimate of what they assume it will be in the future based upon volumes and certain other things. Any concerns on your part in terms of protection of rebated price, the fact that that is now being shown at the pharmacy counter. Is that an issue for you?

Answer: There is role for maintaining some level of proprietary information about pricing. I don't think that has to preclude moving to a system where the patient's out of pocket costs is much better aligned with what the actual cost to the plan is. There are a variety of possibilities. Don't have specific answers today. Could work with some averages or other sorts of mechanisms.

We don't want to find ourselves in a price fixing situation where it actually becomes anti-competitive. Then the reverse happens for the patient where we find ourselves in the reverse of what we are trying to accomplish. But things like a point of sale discounted rebate are attractive and we certainly are open to having discussions around that.

Work group question: Help me understand this transparency throughout the system from top to bottom. Help me understand dangers of that. What is the specific scenario that will follow.

Answer: One of the dangers of this and I will tread lightly in talking about a competitor who is not here to defend him/herself. We have a product in the oncology space that came to market _____. One of our competitors came to market with something very similar. We've priced under what our competitor has done. So, it's not necessarily a price fixing environment, but the danger is there. We want to be competitive and one of the things we've talked about is that when you come into market you have to account for all of the research and development that goes into that pricing. When products are in the market longer, there's a ripple effect through the community. For example, cholesterol inhibitors - physicians know more because of the research and development that was put into those drugs. They can treat their patients better.

In addition to a point raised here, a point the FTC has made repeatedly is that proprietary information can actually facilitate negotiations to lead to deeper discounts. If every discount becomes public… For example, when you put bids out in general you don't want competitors knowing what the other one is bidding.

My team works on the contracts with PBMs directly and I can tell you that it's complicated. To your point about health plans and price transparency, I think that, I tell my team to think about it from a patient's perspective. We have CVS Caremark as a pharmacy benefit manager. It's a 3-year deal. We are locked in at a rate. CVS will pay you for these pharmacy benefits for 3 years for the 3% increase. They are locked into that deal for 3 years. My bids with PBMs are every year. So every year, everyone in the marketplace is turning to bid. The pricing and the formularies that is gained by that pricing because CVS is beholden to meeting the pricing that they gave the employer. The market sets itself in terms of the pricing and the lowest prices that are out there. One of the problems is that the PBM can't make that cost structure work, so what they do is raise the deductible. That's the easy way to do it. The patient pays more and the employer pays less. But if you narrow those deductible phases, I believe, the employer and ultimately the patient is going to pay more just through the other end (premiums).

Work group comment: My argument would be I'm OK if the deductibles change, because as a patient, and I understand that my deductible is $500 then raises to $750. What I'm not ok with is going to pharmacy to pick up a drug at coinsurance of 20% having to pay $150, when the cost of the drug from the manufacturer to the PBM is $90. We're all in the same boat. There is something wrong there. What we're trying to figure out is where does it go wrong. Unfortunately, not understanding the full story, the first finger that gets pointed is at you guys – the manufacturers. Where is the money going? What I'm understanding is that it's both the carrier and PBM. It would behoove the manufacturers to do whatever you can to help with this process from what you charge after rebates to the PBMs (people who purchase your drug) and what happens or how they negotiate. And what the patient finally pays out as a percentage of that. The rebates and all the discounts are not being relayed down to consumer. What I'm hearing is that after the drug leaves you, you lose control. But everybody blames you. We're seeing you have incentive to ensure that something gets fixed in this process. We have a directive to try to figure out how to fix this. We want to make sure that what we try to put in place for policy is actually going to work.

Answer: With regard to PBMs will offer to come back and give as much as we can by way of reference documents. Pharma has huge campaign of information that talks through this much more succinctly in more lay terms. Will provide more additional resources as we can. The challenge is that we have we are

also talking about an entity that are our customers. The contractual relationships there that we have a individual manufacturers matter. Right now to provide succinct information in today's environment puts us in violation of other legal agreements. We need to work through the trade associations to help you on a collective level. We put a lot into making sure the trade association can tap those resources and will happy to pass those along to help you to get to that point and offer anything else that we can.

Work group comments: What would be helpful is a diagram of the money flow and all different possible things that occur from the top to the bottom.

What also plays into it is often times there are discrepancies in prices between hospitals and the commercial plans. If they get an infusion of the drug or an injectable. Same drug different copay, different price.

Shouldn't the net rebates from manufacturers all flow 100% down to patient? I've heard from the PBMs and some carriers, actually some carriers would prefer 90%. Because then the PBM is still incentivized to go get the steepest discount as opposed to what do I care if the discounts are all going to flow to the third party.

Even when they are get 100% pass through, they are still incented to as deep of a discount as possible.

One of the recommendations that comes out of this process is some form of point of sale rebate for consumer so that the consumer is receiving the benefits and discounts that you are providing.
The PBMs are not going to go for that, and some heath plans may object, too. It would be helpful that where we do agree to have support.

One qualification to complete transparency on rebates and pricing – all the way down supply chain – but is that different than what you were suggesting – what's the damage. You seem to think there is potential damage for transparency.

That's the reason that to all of the us transparency is such a big deal. It's about cost and until you get to full transparency, I'm not sure anybody trusts anybody, nor should they.

Answer: Transparency is a term that covers a lot of different things. I would stick with my principle that I think there are ways to get discounts that the plans receive passed through to the patient at the pharmacy counter or at least to pass through a sizeable share of it, while maintaining the confidentiality of the individual pricing of the drug. Maintaining that confidentiality is ultimately pro-competitive.

Glad to follow up on health plan numbers. Health Care Cost Institute an insurer supported organization that uses data from four big national insurers to run analyses found that – brand retail drugs in 2015 were 12.6% of medical claims before backed out rebate and before they added in to their denominator the 20% that goes to administrative costs. I've heard a lot of statements about drug costs in health plans, but I think even some of the insurer's own data contradicts that.

Innovation happens here. Without that ability to have security in our investments, we pay significant amounts of money up front. We want the ability to have some assurances on the back-end side of that, that we will be able to recover some of those investments. So, having full transparency in some ways prohibits us from being able to do that. Full price transparency? Not talking about what your R&D costs are. We're talking about price from you to those who you sell and to the groups to whom they sell.

Keep in mind though that the price that we are negotiating, if we make that public, it becomes a race to the bottom, which happens in the generic space over time. For generics that doesn't matter. The innovation has already occurred up front and you find yourself at Walmart paying $2. So when you have that transparency competitors even though you are under patent for a similar drug, they're just going to beat you at market with their price.

There are policies that could actually address the tension between the two goals and preserve proprietary pricing information while getting savings passed down to the consumers.

Please note, this group represents brand name pharmaceutical companies, not generic companies.

The work group thanked the pharmaceutical industry guests.

After the industry representatives left, there was further discussion.

Why do the numbers differ on cost trends and the percent of health care costs represented by pharma? Josh pointed out that the group has been looking at prescription drugs as a percentage of health plan costs, while the presentation looked at total health care spend, which includes nursing homes, home care and dental.

Marghie voiced concern that it would be great if we can get at point of sale for rebate, but want everybody to think about this. I'm the pharmacist, I pay $100 for that drug, I'm going to get at point of sale $20 because that's what the rebate price is. Worried that the pharmacies are going to end up subsidizing, because the pharmacy – unless the dollars really decrease the cost of the drug, I'm still paying $100. Having hard time following the dollar down from the manufacturer to the PBM to the health plan down to the employer down to the pharmacist to the wholesaler and to the customer and then how the money goes back up the chute. Can't figure out how to make it work without putting pharmacies at risk of holding the bag. Pharmacies are actually the one paying for the drug and we need to pay our bills every 10-15 days. Not able to have that cash flow.

Can PBMs estimate rebates at point of sale. Are any of them doing it? What are you getting at reconciliation at the end. Can only be an estimate. Auditor found to be totally uncooperative.

Josh has PowerPoint he will share that CVS has presented that shows how it goes down to patient. Shows the reconciliation at the end of the quarter.

Public Comment: No Public Comment.

Acceptance of October 12, 2017 Meeting Summary
Josh Wojcik moved, Bob Tessier seconded. Meeting summary accepted by consensus.

SubGroup Updates

<u>PBM Subgroup (Marghie, Bob T., Paul, Lena)</u>
Discussion focused on making assumptions that we can potentially look at audit opportunities for employers and payers. Came up with a list of things. Discussed in detail about them and are going to flesh out a little more to come up with recommendations. Will be getting suggestions for standards

around audits for consideration to create some requirements that any PBM contract in the state would need to allow for full audit rights and then set reasonable minimal standards for those audit rights. Have gotten some starting points and spent fair amount of time discussing that. Will try to come into next meeting with that simplified and clarified. This discussion helped allow us to get there. Prepare something around similar kinds of standards for PBM pharmacy contracts. That might be the possibility of companion standards for dealing with PBMs in the state that maybe aren't onerous or difficult but in fact helpful.

Might be a starting point on transparency for the supply chain.

The audit function comes down to making sure the employer or the health carrier can audit something that's within the contract. For example, the contract with the PBM says that the price has to be identical to the pharmacy as it is to the employer. That is an auditable feature of a contract. But if you don't have that in your contract, then it can't be forced by an audit. Trying to make sure that any feature within the contract that both parties agree to is an auditable function and we can put in the language such as direct or indirect rebates. Not writing or forcing contract terms, instead providing a set of standards.

If customer finds out they are getting bamboozled, it's not the purpose of the legislation to levy a penalty or suggested remedy. It will be a contractual situation for the employer or health plan. It could become a competitive feature among PBMs. The PBMs can say we'll agree to these features in the contact which are auditable by state law and here are some of the findings of the previous audits, we do what we say in our contract. It help players act a little better in the field with competition.

Other states are passing some laws related to transparency, didn't get a lot into that but will focus on next meeting. The auditing piece is separate, but important.

Can you include some of the auditing results in the transparency so that you create "honest broker"?

We talked about the confidentiality of the audits. Usually that's between the employer/health plan and PBM. What's the real purpose of the audit. The purpose is to help the entity that is paying which is the employer or the health plan, to make sure they are not getting hurt in the process. Thought there would be too many problems with making it transparent. Trying to get transparency through the pharmacists. Some states have passed laws around that. Seems to be a precedent getting established.

From consumer work group point of view, it seems that the consumer is paying more money. When they're in the deductible period is when there is a real problem. Two different streams of money.

I have no worry about anybody figuring out what the proprietary contract between the manufacturer and PBM is when I'm at the pharmacy counter. Trust me the pharmacists just collecting what they're told. They have no idea what happens behind the scene, there'll be no discovery there.

Don't you think the health plans are pocketing some of it? Hate to see consumer paying for it.

The health plans right now within the rate filings, there is a section that each carrier has the average is about $10-$15 of a rebate per member per month. The pharmacy claims are lowered by the rebates that the carriers are receiving and that affects insurance rates. It's a question we ask. Does the Department audit that rebate process – No. We have a market conduct area that we will go onsite to

make sure that everything they include in their rate filings is appropriate and can support this. Prescription rebates is a small piece of this. But we can talk to our market conduct people about, when you go into the next health care review, please talk to them about their rebates. Get information on rebates, how they're coming up with this calculation they're providing. That's something Commissioner Wade wants to make a priority for future market conduct exams. We have some leverage to go in and evaluate and will continue to look at it. Anything they file with us at a rate filing or a policy form and how it pertains to the law, is available for market conduct review. The department will continue to work on this and will have conversations with health plans.

Anthem ended relationship with Xpress Scripts. For a health plan of that size, they can create their own PBM. Anthem sold their own inhouse PBM to Xpress Scripts and had a 10 year engagement with them. Now they're sorry they did it. Reality is now you're on the other end of the rebate dollars. As a health plan becomes a PBM, now there's certain agencies that will have access to more information.

What is the purpose of coinsurance? Coinsurance is to dump more money on the consumer. Coinsurance is not working well for consumers. Working well for employers who provide health insurance for corporate plans. A way to shift costs. If you have to buy the drug no matter what. It is being put on the backs of people with chronic illness. Insurance is supposed to help people. It's something that isn't working well for sick people

Some health plans have said we're not going to put chronic drugs into an environment where there is coinsurance or a higher tier. That's an obstacle for that person. They need access to drug. They decided to take certain drugs and put them into lowest tier with the lowest type of cost sharing arrangement. Lo and behold these people are maintaining their regime, and complications from not taking drug are going away, which saves the health plan on the back-end. Insurance Department is working on formularies with the carriers and seeing that. It's in our rate filing. They are creating different tier structures and moving those chronic drugs to a situation where the patient has better access and money isn't an obstacle to receiving the chronic drug. On the other hand, people who are healthier may prefer coinsurance – if I don't have a lot of drugs, I'll pay lower premium and pay higher cost sharing.

Someone who has drugs in Tier 4 or 5, that's still a chronic illness. You just built a barrier.

Some carriers are starting to change their formularies. They've learned from self-funded who have gone out and done some of these. Pitney Bowes came out and did the opposite of what health plans were doing. A value based insurance system. Were able to monitor employees, determine who had chronic disease, who was staying with regime. If you put a $5 copay on the drug instead of coinsurance, the individual takes the drug.

<u>Consumer Subgroup (Mark, Jill, Raul, Rob)</u>
Mark and Jill had a phone conversation with FamilyWise – one of the companies that provides discount cards to patients. Mark researched different categories of discount and copayment cards. The programs help patients afford their medications. They negotiate with the PBMs and use volume discounts to get prices closer to what the payers are paying. Marghie pointed out that the coupon companies basically hook their train to a PBM who has negotiated all their prices. Pharmacy doesn't know whether it's an insurance card or discount card. Never in that loop. Just end up selling medications at a discount.

FamilyWise says they get a percentage of the processing fee that they negotiate with the processing companies or PBMs. Good for people with no insurance or under insured, helping people to fill prescriptions they wouldn't have been able to afford otherwise. Sometimes these prices are lower than what their copays would be. Or if they don't want to pay towards their deductible, or if the drug isn't on formulary or off label. In CT, FamilyWise says they have helped with 150,000 prescriptions in Connecticut, approximately 25,000 people annually. 87% of claims are generic. Pharmacy usually makes about $17-$15 per rx. There is another company that offers video doctor conferences, urgent care, behavioral health, etc. Another company is a non-profit, PSI out of Virginia – they don't take money from pharma. CMS rule that allow payers in marketplace to deny 3rd party payments – 41 different payers that don't accept 3rd party payments, so often if coupons are used, what the patients pay doesn't count toward their deductible.

Another type of patient assistance program is run directly by manufacturers. These programs are not offered to people on government insurance plans and are administered through 3rd party. Manufacturers also offer copay coupons, to cover the cost of copays for some of their drugs.

Given complexity – these programs are band aids and provide relief in short term. Some states- Massachusetts and California have outlawed co-pay assistance coupons from manufacturers if there is a generic drug available.

We are all overpaying. if coupons are so readily available, why aren't we just dropping the price. The coupon allows manufacturer to collect the full price of the drug. That's why it's inflationary to the system as a whole.

We heard from manufacturers they need to be assured if they do all this R&D, then they need to get the cost of R&D back. If we are going to get full transparency top to bottom they are concerned they won't get R&D investments back because someone will undercut them. That's the #1 sticking point. They were all supportive of transparency except the ultimate transparency of knowing what the manufacturer pays to develop, manufacture and market the drug. Don't want to stop R&D because it's saving people's lives. Don't know how we get there to full transparency without putting a big wrench in what they're talking about.

Besides worrying about prices being too low, they were also worried about being accused of price fixing.

There is actually FTC support behind transparency that avoids price fixing. But manufacturers actually not thinking about that. They're worried about race to bottom on prices.

Open Society Foundations say we're paying over and over for R&D. Tax payers have paid for an a big part of R&D through funding NIH.

<u>Manufacturers Subgroup (Josh, Ted, Bob C.)</u>
The group is still meeting. California law presents a lot of interesting questions. Once you dive into it, might be a little less strong than what I thought it was. Actually not full transparency. Only fall into transparency if you are over the 16% and $40, and over 16% increase over 2 years and then if you are specialty drug tier as defined by "Medicare definition". One of those two is going to get you into reporting structure. But then reporting structure asks you for justification and some other key components, but last line in it says that manufacturer only required to report what is publicly available.

Nothing proprietary in that report. In another section it says we will protect any proprietary information.

NY is requiring proprietary – but will hold information. Same with Maryland.

It's reporting versus public transparency. What are you trying to get at. California doesn't have a regulatory process in place to respond if the justification isn't strong, unless it's that you just don't want to be on the list – shaming.

In Maryland and NY there's an actual outcome at the end. You report this because the AG will come to investigate you. You report this because we are going to utilize this information to go after you for additional rebates. There is a means to an end in both of those. Key question to answer in terms of manufacturer transparency – what's our goal? For shaming or means to an end, punish bad actors. Only targeting what could potentially bad actors. No one is saying we want everything from everybody and we are going to put it all online. Potential risks to doing that, putting non-bad actors up there and for most part, nobody can use that data.

Is there a transparency piece around the top 25 - drug cost structure change year over year?

Could be helpful in understanding the marketplace, what's driving. Didn't see anything in there. Asked for generic and brand. Not sure if that helps. Could see where the top 25 cost structure change year over year is significant, see a trend.

Yale said identify top 25. Consistent list top 15-20 top utilized drug for every health plan.

Transparency to regulate in some way – NASHP has model bill. We don't have setup that Maryland has.

Now have budget, with Office of Health Strategy, where they will have a Director with authority – vest authority in that office?

Subgroup needs to develop its recommendations. Which parts of these models can we utilize, etc.

Next meeting is November 2nd to come up with recommendations. At workgroup level come with 3-5 recommendations. Can be high level right now-all of the operational details don't have to be figured out yet.

Meeting adjourned 4:14pm.