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

Thursday, November 2, 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), Ted Doolittle (OHA), *phone*-Raul Pino (DPH)

Members excused: Katharine Wade (Insurance Dept.), Rob Blundo (AHCT)

Others present: Jill Zorn (UHCF)

Meeting goals:
• To discuss the emerging recommendations of each of the sub-groups: pharmacy benefit managers, consumers, and pharmaceutical drug manufacturers

Frances Padilla called the meeting to order at 1:00pm.

Introductions were made.

Public Comment: No comment.

Recommendations of Subgroups

Pharmacy Benefit Managers (PBMs) – (Marghie, Bob Tessier, Paul Lombardo, Lena Bachar)
The bulleted recommendations are categorized by high priority and nice to have.

- PBM should be required to have fiduciary responsibility when contracting in state. (felt strongly)

What does it mean? It means that they're acting in the best interest of their client versus in their own best interest. Currently we determined that the state of CT's contract with CVS health does not contain fiduciary responsibility. It is an important concept and if we can get it into law that would be great and if not at the very least it should be something that we should ask the State to do in their contract.

Have other states enacted or codified that? I know that there are some PBMs that have put it into their contracts at the request of an employer. We discussed if we could make it a legal requirement. We're assuming there are criteria that need to be met to meet the definition of fiduciary responsibility. How would industry react to it if CT became only state to do it. Also, could there be federal pre-emption issues, particularly with regard to self-funded plans' use of PBMs? Will ask AG office.

At least should require state of CT to make sure as an employer that's part of their contract with a PBM if nothing else.

Did you have conversations with counsel at the Insurance Department since PBMs register with the Insurance Department. Does the department have the ability to require that as part of registration? Paul Lombardo explained that CID only requires PBMs to register. CID primary responsibility is to regulate the carriers, who in turn contract with PBMs.

- All negotiated prices between PBM/manufacturer/payer shall pass through to the consumer at point-of-sale and consumer copays and coinsurance will be based on these negotiated prices.

Based on discussion we had with pharma, from what I heard from national organization, this is something they too are interested in. If we frame it right, could get some support and will definitely will help consumers.

Discussion about how there might be a one-time hit to premiums. Right now when the carriers make their rate filings, they have a line item that reduces prescription drug claims by the rebate. They pass the rebate through by a reduction of approximately $10-$15 per member per month in premiums. If the rebate is going to be passed directly to the consumer at the point of sale, the rebate could no longer be subtracted from premiums and there would probably be a 3-4% premium increase. But it would be a one-time premium increase that would be built into the base going forward and not change after that. The way that we're proposing it, the prescription rebates would go directly to the people that are accessing the prescriptions. Their premium would go up, but the people that don't access scripts would have the same premium increase. That's the idea of insurance – to spread costs across everyone, both healthy and less healthy individuals, and not make sick people pay more.

Generally the carriers might not be too pleased with this one, or is it just a trade-off?

The value of the rebate is accounted for one way or the other. The carrier should not feel there is a loss. Unless they weren't passing the full rebate through to reduce premiums, but we think they are passing the full rebate through. If they aren't fully accounting for the rebates in their rate filings, they're out of compliance. Shouldn't be a problem. If this ends up being a Cabinet recommendation, Insurance Department can have discussion with the carriers. Their first response will be, well you know your premium rates are going to go up. Yes, we understand that, but you're putting the rebates where they should be.

Seems to me that although it's a one-time bump, it also affects the consumer because the premium increase is passed along to the consumer. So it's one hand we giveth and the other we taketh. How do people feel about that? Already facing 31% premium increases.

Personal opinion: As a consumer of CT, if I'm paying 20% coinsurance on a drug, I would much rather pay 20% coinsurance on a drug that has a rebate included in that. That rebate is really for the use of the drug, it's not for the potential use of the drug. Right now when they're pricing through the rate filing mechanism, it's for the potential use for anybody to use the script.

Is there any other medical claim that the consumer on the cost sharing piece is paying above and beyond what the negotiated price from the carrier is? Why should this be an exception? When Hartford Hospital contracts with ConnectiCare for a specific fee schedule, their fee is for that particular service and when you pay that cost sharing it goes against that negotiated price.

We know that PBMs also negotiate prices with pharmacies, so they're paying the 20% negotiated price with the pharmacy which is certainly not the same as the rebate. Could be that's why we were specific in saying the negotiated price we're looking at is the negotiation between the PBM and the manufacturer because that is where the big discounts lie.

For instance, if carriers had negotiated deals with hospitals or doctors that included one of these rebate structures, that should be the ultimate price that someone's cost share is based on. Don't understand why drugs should be any different. If you're a network hospital or network doctor, then you're bound to the contractual rate when that service is provided. You can't balance bill. With prescription drugs, right now it's kind of like balance billing, because you're not passing on the rebate to the patient.

Trying to figure out who's making the spread. Both the carrier and the PBM. Carriers have to build it into their premiums and if they don't put their full rebate in their, rates are excessive.

Rebates are built into the insurance rates that are filed with the Department today. That's the rebate dollars that they have received or that they project will receive within the next year. That's not the total rebate as a result of PBM and manufacturer contracts. PBMs are withholding as much as they can from the carriers. If we define this as the price negotiated between the manufacturer that's a lower price or a large rebate dollar than the carriers are getting. There probably are some carriers who have contracts where they feel comfortable that they're getting it all, but I'm sure that most aren't.

If I'm a carrier and I'm allowed to increase my premiums to account for the fact that at least their portion of the rebate is going to float through to the consumer then there's no harm nor fowl in my book.

The PBMs will probably have more of an issue than the carriers.

Explore – can the state mandate that any PBM doing business in the state must pass through manufacturers' rebates that are earned as a result of drug utilization to whoever is purchasing those drugs, whether it's carrier or self-insured plan? It would be nice to figure out what the state's authority on that could be.

Go back to the basics that any provider that contracts with a carrier, there is a law out there that does not allow a network provider (hospital or doctor) to balance bill a patient. They have to abide by the contractual amount. As far as ability to write law, whether it gets through and whether they like it or not, it may not be exactly like that, very similar to that arrangement and we have a law out there now. I think rather than say rebate, we say negotiated amount that, whoever negotiates that whether it's the carrier or PBM, needs to pass that along to the consumer. Whether you get it into law or not, that's totally different. No different than balance billing.

But we may have a problem with self-funded plans. More and more insurers are going self-funded. Probably 60-65% of employer market is self-funded and the small employers are starting to go into stop loss which is not fully insured either. It's the age old thing that we can't sit there and say we found the silver bullet, because 65% of the people out there may not have access to the silver bullet.

This is the type of activity that obviously if the state of CT takes the lead on passing something like this, it ripples across other states. This also gives the federal government an opportunity to say maybe this is a good law to pass federally as well. Why not try to be a leader on this and try to get out in front of it.

Agree that it could ripple into the self-insured market as well. We know that plan design matters and the self-funded plans sometimes are best at instituting value-based benefit design. The other reason why it makes sense to have it pass through at point of sale instead of through premium, is that when folks are at the pharmacy counter and attempting to access their drugs, you're looking at an issue of compliance with their medication regime. If they can't afford the drug at that moment, they become noncompliant. Other things can happen, medical costs rise. When you're thinking about an overall cost to the system, putting it there is going to reduce costs better than putting it in the premium.

- The Maximum Allowable Cost (MAC) should be defined and criteria should be managed.
- The PBM MAC to the employer must be the same as the Pharmacy/retail MAC.

This is focused on the generic industry. Important that the state takes the time to define what maximum allowable cost should be. Other states have done this. We've heard from previous speakers that there are many MAC lists. So one generic drug can be reimbursed at one price for Silver Scripts which is run by Caremark and at the State Employee Plan we have a totally different MAC price list for the same drugs. Basically saying let's define it, let's provide what the methodology is as to how generic drugs are reimbursed. In what other industry are you asked to sign up for a contract when you have no idea what the reimbursement is for a drug/product that is being purchased?

This comes to surface time and time again. Just had something from our list serv that says pharmacies in New York are experiencing dramatic cuts in reimbursement that are jeopardizing the viability of their independents as well as chains. On 10/26 a particular PBM drastically changed the MAC list without the knowledge of health plans, pharmacists or their buying groups. It started in the Medicaid managed care program and has rippled into the commercial plans. There's another state saying we learned that, the largest PBM made a *mistake*. For seven days they changed this list and the mistake resulted in multi-millions of dollars and impacted the pharmacies, not just the independents but the chains as well. Is it going to be corrected, is it going to be retroactive? These are issues that we care about from a business perspective. But at the end of the day, it impacts consumers as well.

What is maximum allowable cost exactly? Don't know. It's whatever a PBM will pay for a particular drug. There's no formula or definition for it. The only one I know that really defines it is the state of CT defines how they reimburse for Medicaid generic drugs.

The commercial plans don't define? No. We know what the list is and we know what they're going to pay on this particular list, but there's no methodology. When the pharmacy signs a contract with a PBM, they know that every time they dispense a brand name product to somebody is who is out of the state of CT, the pharmacy is going to be reimbursed AWP minus 20-26% (depends on 90 day supplier). There is a benchmark number and know that benchmark number is going to be reduced by a particular percentage. It's defined in contracts. When you get to generics, it says you will be reimbursed MAC plus a $1 or nothing. But don't know what MAC is.

Who are you entering into contracts with? With PBMs or payers. Whoever is paying the prescription drug bill. Nobody tells pharmacies what MAC is. They provide with a list, that list can change. And as you can see they don't always inform of change. All of a sudden when they need to meet a contract

agreement with the payer and they're not able to they can adjust their MAC prices and take money out of the pharmacies.

Does each counterpart for these contracts have different MACs for different drugs? Yes. If you look across Xpress Scripts or CVS Health, depending on who they're contracting with, there's a different list. There are many lists.

Different PBMs using many lists. What they do is manipulate what they will pay and they manipulate what they charge their customers. They will charge a customer off a given MAC list and they reimburse the pharmacy off a MAC list with lower prices. But they have multiple MAC lists.

There's a lot that has to go into just a simple definition, hence the next bullet:

● The PBM MAC to the employer must be the same as the Pharmacy/retail MAC

The pharmacy may be getting reimbursed by the state at one price or the payer or the insurer at one price and the PBM at another price. Example, they're reimburse the state of CT for a MAC, will reimburse you at one price and reimburse the pharmacy at a lower price. They create a spread that they pocket. And you don't know, unless you have audit ability. The state does not because it's not part of the contract.

MAC legislation has been passed in several states. The state that we are probably going to model would be Tennessee – has a very good friendly definition that we would look at. It's not like we have to reinvent the wheel. It was introduced last year in Connecticut, there's been legislation that's been introduced previously with the insurance committee and it's actually gotten out of insurance a couple of times and somebody kills it. We are not the leader on this, we're actually a follower. People have understood that MAC pricing is just not defined. At the end of the day does it impact pharmacy – Yes. But it also impacts consumers.

Do you have any collected data on what occurred in Tennessee as compared to states that have not passed it? I can gather data to see how they got things through and see what some of the potential issues were.

Looking for results. Did their pharmacy costs go down? What was the actual impact to the consumer and/or to the system?

There was a discussion about where the authority would lie to implement. Insurance Department? No. But you register PBMs. Registration is minimal. We regulate through the insurance companies. Where else would it go? Some states have gone through Pharmacy Board or another department. Really would push back that it doesn't belong in insurance.

● PBMs must allow an audit which shall pertain to any auditable feature within the contractual agreement between the PBM and Client.

What might be required? Bob read off requirements.

- Must agree to an audit at the client's request and at the expense of the client
- Qualified audit firm of the client's choosing, the PBM cannot chose the auditor

- Audit may pertain to any auditable features within the contractual agreement between the PBM and the client
- The PBM may require that the audit take place onsite and must allow for a data format request and copies of all documents per the auditor's request
- Information necessary to complete the audit in a timely manner such as 45 days
- The PBM may require the execution of non-compete or confidentiality agreements as necessary because they don't want the data the auditor obtains to become public. But we don't want to create confidentiality agreements that hinder the auditor from conducting the audit.
- The PBMs have an opportunity to refute the audit results with their client

The first step will be that the carrier/employer must negotiate an audit. If they can't negotiate an audit then they won't be able to negotiate the above list.

If the law requires that the PBM has to allow an audit that would at least give the client (a carrier or self-fund employer) the ability to call for an audit. This would dictate that if a client wants an audit they have the ability to audit any feature of the contract.

This would at least set a minimum standard for PBMs doing business in the state. It says that with any contract they sign with whoever to provide services, that they are willing to participate in an audit and what some minimum audit standards would be. PBM has to make themselves available to an audit at the request of the client. Client doesn't necessarily have to call for one, but if they want an audit, they can get it.

Could this have unintended consequences? Could it backfire and lead to contracts that look different than they look like today? That's a potential negative/downside. Something we have to think about. Don't want to put reverse pressure on contracts between PBMs and clients.

Has this be done anywhere else? Not that we are aware of. Some additional research needs to be done on this.

A useful example may be the Insurance Department's market conduct exams for carriers. The carriers are given six weeks to put all data together, in the required format, and are given the option to refute the findings of the market conduct exam. Paul talked to head of market conduct area to fill in some of these bullet points that we hadn't talked about before. Bob's auditor had provided us with some bullet points as well.

Process wise – how would group like to proceed. Focus on high priority?

Marghie - My opinion is that it's hard to separate out any of these. Truthfully it is a big issue, We're going to have a lot of pushback from PBM industry. Might have some support from pharma industry if its presented properly. Certainly a lot of support from consumers. Hard to really recommend one piece without the others. You could put in place the first four, but if you don't have the audit piece, how do you know. They all blend together.

Should we also recommend investigating the possibility of having a state-run PBM?

Medicaid essentially operates its own PBM. HP processes their claims, but they do all of the other things. They set the contracted rate through statute of what they'll pay pharmacies. Then they do the

negotiations with the manufacturers. Technically we already have a state run PBM, but it's not one that you can necessarily go out and put on the market and compete with the other large PBMs that are out there. What about the State Employee Plan?

The other work groups will report at the next meeting:

Manufacturing price and cost subgroup (Josh, Ted, Bob)

Consumer Subgroup (Mark, Jill, Raul, Rob)

The meeting adjourned at 3:00 pm