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

Thursday, November 9, 2017
OHA, 450 Capitol Ave., Hartford

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

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

Others present: Jill Zorn (UHCF)

Meeting goals
- To continue discussion on the emerging recommendations of each of the sub-groups: pharmacy benefit managers, consumers, and pharmaceutical manufacturers

Frances Padilla called the meeting to order at 2:30pm.

Introductions were made.

Public Comment: No comment.

Recommendations of Subgroups

Pharmaceutical Manufacturer Subgroup (Josh, Bob C., Ted)
Josh handed out copies of some high-level recommendations. The subgroup discussed a variety of options. One potential opportunity needs significantly more review. From a high level this is where we are. They all relate together.

1. Create a Drug Review Board (DRB) of clinicians and health economists including consumer representation. They analyze and determine whether drug price increases are justified.
2. Require insurers to report information to CID on the contribution of drug costs to insurance premiums, including rebate information broken down by drugs. Pulling from the California law. Pulling from the top 25 drugs.
3. Require CID to share that information with the DRB
    - Medicaid and the state employee health plan should also report high increases to the DRB
    - Give DRB access to reports from the all payer claims database (APCD)
4. Give DRB authority to request additional information from manufacturers to inform its review process. Note: some of this information could be proprietary in nature and would likely need to be exempt from FOIA. It would be needed by the DRB to make their decisions, with limited use for individual consumers
5. Look to change CT price gouging statutes to include not just pharmaceutical prices or price increases as determined by the DRB. Give AG authority to pursue price gouging cases against pharmaceutical manufacturers.

If you look at this, somewhat of a combination of the New York, California and Maryland approaches. Doesn't depend on the AG to make the determination of what's unjustified or in the Maryland model what's unconscionable. Instead, as in NY law, sets up a panel, the DRB, that has the expertise to make those judgements. Uses the California law as a model for asking for justification for price increases.

Of note, the price increase data that California will be collecting under their new law will be available to payers. This data could be useful to the DRB as well as to the payers submitting data to the Insurance Department in their rate filings about the contribution of drug price increases to premiums. This is not the proprietary data that may need to be protected when it is submitted to the DRB when it requests information justifying the price increase.

Understood, CID is supportive of that piece with the California law with the data coming into the CID, just so everyone knows, the rate filings are public information. Any data that we add to that unless it specifically states in the law that it is not to be shared publicly, would be public information. Agreed-this is not about the data the carrier submit to the Department for the rate filing.

The above five are all related in terms of creating a process and resources for reviewing drug prices and doing something about them. The next two recommendations are independent of that.

6. Require nonprofit patient advocacy groups to disclose when they get funding from drug manufacturers, PBMs and health insurers and post that information to their website. This provision comes from Nevada's law. We want people to be aware. This is similar the ACA requirement for reporting of payments accepted by physicians from pharmaceutical companies – see Open Payments website. It is important transparency around potential conflicts of interest.
7. Require manufacturers to report to payers an increase in the price of a drug 60 days in advance that exceeds certain thresholds. The purpose of doing this (it's done in the California law) allows payers to proactively make formulary decisions before that price hits so they are not stuck for a whole quarter paying outrageous prices. They could make formulary decisions in advance that would move people to a competitive drug or other potential options.

In terms of threshold – similar to California bill? Yes. 15% for example. That would include launch prices too.

Important piece, the potential pitfall is if we wouldn't want this information to be public – would want to report to the payers and the payers would be required to keep that information confidential even from their business units that may take possession of a drug. Don't want to advantage groups that maybe take possession of a drug could then stock pile that drug at the lower cost and sell it at the higher cost to enormous profit. That is a legitimate concern that the manufacturers have. It needs to be dealt with.

Is that requirement realistic? The California law just passed. Idea of carriers getting certain information then restricting what they can do with it, is it a model that works?

Don't we have to do that regarding SEC rules? There may be some parallels from other sectors.

An example from health care may be, United Health Care is a payer but also has a division of practitioners and providers and maintains walls between the divisions.

The group discussed some of the recommendations in greater detail.

- Creation of Drug Review Board (#1)

Where does it belong? Is it a state agency? It could require staffing and resources. It could have a fiscal note. New York has one for their Medicaid. We had a formulary committee for Medicaid at one time – that still exists. We could say that a) it should exist and b) put it under the new Office of Health Strategy and they should be administrator since it fits under them. What about Department of Consumer Protection, which regulates pharmacies? Options for funding, will be another question that arises.

History shows when you just levy a fee that is earmarked to support a specific purpose, the money, even if earmarked, can end up in the general fund.

Legislation would have to be very specific. For example, Office of Healthcare Advocate has specific funding source. It's possible to do it right.

If you put it on the insurance premium, you're creating problems – you're taxing 35% of the market to pay for something that benefits everybody, which isn't a great idea. You're going to up premium costs for that 35% of the market in order to do it and you're also going to bring opposition from the one party that might actually support this. Should consider that.

Another potential option, PBMs, would also be considered. PBMs would have to be licensed, pay a licensing fee based on the number of members they have in the state. If there was a licensing fee, that would cover the entire population.

Why not the manufacturers? We could. If you're selling a product in state.

PBMs already pay a registration fee into the Insurance Department (strictly just a registration fee – not a licensure process). It's the same for everybody. Add a surcharge?

Options could be discussed when we have public comment. We will need to identify a plan for which recommendations will need a deeper dive to address specific issues, that will be answered when writing legislation down the road.

How is the DRB going to get the data on the drugs? That's part of what will incur costs. What drug price increases are we talking about? We know the price of the drug depends on who's buying it. Run into the same problem with all of the transparency issues – which drug price are we talking about. Every payer is paying a different price for these drugs.

Some of these other laws have figured this out. They typically pick a publicly available price as a standard. The simplest one may be AWP. Although now there will be better price information available through California's law.

One of the questions is, what are some criteria that would be helpful for this board to determine when they should be doing a full investigation into the drug. Is that going to be something akin to in the transparency laws. Is it publicly available, list prices and when they rise above certain thresholds that triggers a certain investigation. That doesn't mean your prices are justified or egregious or you're going to be referred, it just means that will trigger an investigation. An analysis to make a determination.

Another option, maybe criteria to determine the next step, when Massachusetts AG looked at Sovaldi (Hepatitis C drug) the price was so high that it caused consumers and payers to act outside of their best interest, it limited access. Is that a criterion for the next level, for needing a deeper dive? First level would need to be something like what a transparency law does.

New York has criteria, look at different laws that have already been written. New York picked a certain number of drugs. New York set a drug spending cap. We're going to breach that cap, what are the five drugs that are most going to breach and that's how they fell in.

In NY it's limited to Medicaid program. Medicaid was required to report to the DRB (their equivalent) when that happened and which drugs they were. It would require another step, like what MA does by having their Health Policy Commission set up a health cost target - if it's breached what's contributing most to it.

Picking the criteria is really important. If you pick a threshold, there can be abuse-like raising prices that are just barely under the threshold. Other people that have been thinking about this, probably evolving.

Determining the base line price – two inputs – the consumers paying out of pocket and the premiums. If we're already trying to get the figure of what the drugs are contributing to the premiums. Couldn't we do like the APCD and find out what the out of pocket for drugs is and have something that actually be a more real figure that we can figure out ourselves as opposed to relying on the kindness of the PBMs to be straightforward with us. You could do (rather than AWP), the allowed amount in the APCD would be an option and it would be something that's fully available. It is updated quarterly.

The APCD doesn't have Medicaid data and Medicare data is lagging. You could do it just on commercial lines. There is the consumer's payment for premium also, its not just the amount that they pay.

Paul put together a draft table showing the proportion of premium increases attributed to pharmaceutical costs for the largest insurers in the state.

Percent and growth of drug over the last over the last 5-6 years from what we're seeing in the rate filings shows that prescription drugs now account for 22-23% of total spend. CID gets prescription drug claims per member per month. Getting more detailed information through the required reporting in California will enable payers to provide more information to the insurance departments in their rate filings. We would at that point clearly see what is driving that spend of 22-23%. About 40% drug spend right now is from the specialty drugs of 1-2% utilization. That is driving a lot of what is happening right now. Anthem/BCBS Group came out with report on drugs – they site 38% of drug spending is coming from specialty. Also true for consumers. This will continue to grow exponentially.

On high level, we know we need a threshold, we know we need it based off information that is accessible, publicly available list price or allowed amount from APCD, those are options. Whether we want other criteria which could be informed by reporting that would not be required by the CID by manufacturers – that would get rebate information, dual criteria. Don't need to define what that is yet.

Move forward with this recommendation – all in agreement.

- Price gouging (#5)

Not sure, other than #5, where the AG has enforcement mechanism. Are there administratively steps that we need for enforcement?

Is the creation of the DRB purely a function intended to perform the analysis that would ultimately trigger a potential referral of a case to the AG? Or is there something more that the DRB would be doing? Will they have any remedies short of referral that can lead to rolling back price increases?

Outright regulating drug prices is going to be an enormous lift. Going at it from looking for bad actors, may want to include having them do some reporting if this board is going to be doing in-depth reviews. Public reports would be helpful, can still protect proprietary information while publicly reporting valuable information that would help inform policymakers moving forward.

Using a DRB to make judgements is preferable to having lawyers who aren't health care experts making judgements about what appropriate prices are.

- CID reporting (#2)

Already discussed in the long discussion of #1, above. Clarify how Paul views from authority of CID.

Data submitted within the rate filing would be comparable to what CA has in law. CID supportive of receiving data – all public information – putting together summary of data that came in during rate filings. Having better data on rebates within rate filing would help to get to the root of the issue. Right now insurers report $10-$15 per member per month reduction in total premiums due to drug rebates. If that reduction to premiums goes away due to the fact that we have another recommendation that patients should pay out-of-pocket based on the price that includes the rebate, then that reduction in premiums goes away. The premiums would have a one-time increase between 3-4%.

All are in favor of the recommendation.

- Information to DRB (#3)

Have to talk to Kate McEvoy about Medicaid sharing pricing increase information with DRB. Concerns about confidentiality and proprietary information would have to be addressed. The same concerns apply to sharing of data by State Employee Health Plan.

We know they are both significant payers that make large drug purchases that have an impact on the state budget.

All are in favor of the recommendation.

- DRB to require additional information from manufacturers that meet criteria for extended review, with appropriate protections for proprietary information (#4)

All are in favor of the recommendation.

- Patient advocacy group reporting (#6)

Taken from Nevada law. Curious how nonprofit advocacy groups reacted. Could require that the drug companies, PBMs – provide the information rather than the groups doing their own reporting. Better this way. Administratively they are more capable of reporting this information. Will have to identify who they are

Have to be clear – what are they required to report – $$ amount of contributions to the organizations. Report to Office of State Ethics. Should discuss with Office of State Ethics.

All are in favor of the recommendation.

- Advance reporting (60 days) by manufacturers to payers of price increases (#7)

This allows payers to make decisions and update formularies.

We discussed at the last meeting– it was explained that under current rules they can't change their formularies more than twice a year. We are not proposing to change that. Idea is they will have more information to make a judgement as to whether or not to change their formulary after twice a year. It will slow down the price increase they have will have to wait two months for it to kick in and it will keep premiums down as well.

All are in favor of this recommendation.

<u>Consumer subgroup update (Mark and Jill)</u>

Made a few adjustments to recommendations presented at the last meeting. Looking at two aspects of barriers – financial, logistical convenience and consumer information

Financial:

1. As we already discussed, states have passed monthly limits on copays and co-insurance. Help people to spread the cost over the entire year instead of coming up with thousands of dollars in January and February until they meet their deductible. Idea is based on California law passed in 2015. That bill set maximum out-of-pocket limits that did not increase premiums.

2. Have lower deductibles for prescription drug vs medical deductible. This would lower barriers to medication adherence.

3. Maximum out of pocket for pharmacy, like there is for medical. Are there any benefit designs for separate maximums for pharma and medical?

4. Another approach would be to focus on medications that treat the chronic diseases that State health plan is focused on - value based insurance design. Eliminate copays for asthma, high blood pressure, diabetes, high cholesterol medications.

This would have impact on premium, the hope is that it'll save money in the long run with adherence to the medication. State Employee Health Plan allows this for generic drugs only, which

might be an option to consider. Then premium implication of doing it is dramatically reduced if it's just generics that it applies to. Those are the lower cost drug, in general. Another option would be to have lower cost copays even if not $0 copays. The State Employee Health Plan found significant increases in medication adherence when they dropped copays.

Logistical:

5. Medication synchronization – when a new medication is added, adjust the fill date to synchronize pickups. This would apply to chronic disease meds.

Note that this is not cost free. Who's going to pay the pharmacists for synchronizing those meds? When you're synchronizing meds appropriately, its more than just dispensing, you're doing a little bit of care management, nobody pays for that. Needs to be more payment, than dispensing fee. Are some of the corporations doing this? Yes.

6. Not being forced into mail order.

Talked about life and death meds, chronic disease meds. Most meds can be 90 day supply. Patients are pushed to get 90 day supply, when they shouldn't be. PBMs push hard on 90 day. Chronic disease needs to be defined.

Makes sense for both of these recommendations to be for chronic diseases with broader list.

Consumer information:

7. Require on-line availability of price data for drugs, particularly high priced drugs in the tier where co-insurance is charged

Now when a patient picks up their prescription, there is no EOB anymore, so they don't know what their health plan paid. Just like with medical costs, consumers should be able to look up how much it is going to cost you for your drug, just like you can look up how much the cost is for appendectomy, for example.

Good RX has an app that you can plug in a drug and find out what it is going to cost – doesn't include copay or coinsurance. It is what the pharmacy accepts for that drug, the cash price. This would only apply to those commercially insured. Some is anticipated their deductible, etc. Trying to make a decision about their plan and would like to know their out-of-pocket pharmacy costs. You want people to pay negotiated price when they go to the pharmacy.

8. Recommendation to Education workgroup to educate consumers about price variation across pharmacy. Consumer Reports publishes something about drugs every year. People aren't aware that prices vary across pharmacies.

9. Recommendation to Education work group to educate consumers about different types of patient assistance and coupon programs that may help them afford their meds.

10. Compile reports from APCD about out of pocket cost trends.

Group supports these recommendations.

PBM subgroup (Marghie, Josh, Bob T.)
Update since last meeting.

Had conversation with Auditor/Consultant that works with Bob T. regarding recommendations.

PBMs aren't held to ERISA, they're not in insurance.

1. Require all prices negotiated between PBMs, manufactures and payers pass through to the consumer at the point-of-sale, and that consumer's out of pocket costs will be based on the negotiated price.

No further discussion of this recommendation.

2. Require PBMs to exercise "fiduciary responsibility" when contracting in CT

Asked Coalition counsel – ERISA attorney - about a state could pass a law to require PMBs to be fiduciaries to any client they contract with in CT. It would be hard to do, could get challenged. The fiduciary responsibility is with the plan sponsor. Because of ERISA if the plan sponsor has the fiduciary responsibility, would also be problematic to require ERISA plan sponsors to exercise their fiduciary responsibility. Further research needed to make sure it's a legally supportable approach.

If Feds are good at enforcing it, why is it a problem? Because nobody regulates PBMs. They engage in behaviors with authority that they don't have. They've been sued by plan sponsors repeatedly for breach of fiduciary duty and federal courts have found them not to be fiduciaries.

At a minimum, should look into this for the State Employee Plan.

Consultant recommended CT should pass a law similar to what was passed in Arkansas, although this law is currently being challenged in court. North Dakota law also being challenged. Lessons are being learned about how the law is written, that it should focus on consumers. PBMs are not regulated by ERISA yet they're claiming an ERISA pre-emption for not only ERISA plans but also Medicare Part D. Tennessee and North Carolina have also passed laws.

Would have to look at each case and see what laws did or didn't do. Where you get into trouble is when you try to regulate the relationship between PBM and ERISA plans.

Once you go down the road of regulating the relationship between the plan and third parties you're arguable affecting the benefit design and what you seek is uniformity because a lot of these plans cover members from various states.

Clarify that it would be pre-empted for ERISA plans, self-funded plans, but before a formal recommendation is made, more legal research would need to be done, but the group is interested in the possibility of including this in the recommendations.

3. Define Maximum Allowable Cost (MAC), which is what pharmacies can charge for generics. Also require PBM's MAC to the employer equals the PBM's pharmacy/retail MAC

Consultant suggested this may not be a realistic recommendation. Consultant suggested just prohibit spread pricing. This means PBMs can't reimburse pharmacies differently from what they charge the plan sponsors or the insurers. Or, another way to describe it is you can't charge plan sponsors more than you're reimbursing pharmacists. This suggestion has merit.

4. Audits – should be a required part of contract, including what information must be supplied by the PBM for audit purposes.

Agree that the audit recommendation should stay in. Need more definition, but this should be included in recommendations. Keep everything high level for now, then go into detail later.

How do we want to present recommendations to the Cabinet
Expectation for the Cabinet meeting is that each group will make presentation on recommendations. Start with charge and what we were trying to learn and get to. Narrowed down to 3 focal points – PBMs, manufacturers and consumers. Have a set of recommendations for each. Then lay those recommendations out.

Powerpoint with a slide or two about the charge and the questions that we were seeking to focus on. Then right into each area and the high level recommendations for each area. Useful to say we drew from New York, Nevada, California, Maryland, etc. Frances will start the presentation and then each subgroup to speak – Josh and Marghie. Frances to speak for Consumer subgroup. Emphasize that we are open to discussion and questions.

Frances will start the powerpoint and asks each subgroup to send slides to her. She will also include the supply chain chart and a graphic representation of bills that have passed in different states.

Meeting adjourned at 4:20pm.