Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

# Healthcare Cabinet Meeting Minutes

January 10, 2017



**Members in Attendance:** Lt .Governor Nancy Wyman, Susan Adams, Ellen Andrews, Pat Baker, Kurt Barwis, Roderick Bremby(DSS), Anne Foley(OPM), Demian Fontanella(OHA), Bonita Grubbs, Marguerite Giuliano, William Handelman, Frances Padilla, Raul Pino(DPH), Hussam Saada, Kristina Stevens(DCF), Katharine Wade(CID), Jim Wadleigh (Access Health CT), Joshua Wojcik(OSC)

**Members Absent**: Miriam Delphin-Rittmon (DMHAS), Jordan Scheff(DDS), Shelly Sweatt, Robert Tessier, Gary Letts, John Orazietti, Lawrence Santilli, Greg Stanton

**Others present:** Victoria Veltri (Lt. Governor's Office), Ameet Sarpatwari, Ph.D. J.D, Assistant Director, Program on Regulation, Therapeutics, And Law (PORTAL), Brigham and Women's Hospital and Harvard Medical School, Thomas Brownlie, Director, U.S. Policy, Global Policy Division, Pfizer and Jennifer Bryant, Senior Vice President, Policy and Research PhRMA

| Agenda Item | Topic | Discussion | Action |
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| 1. | **Call to order & Introductions** | The Lieutenant Governor welcomed everyone to the meeting and noted that the presenters will discuss recommendations on pharmaceutical costs, balancing costs, innovation and accessibility. She reported that the Cost Containment Study went to the Legislature on January 5th and will be discussed with leadership. She also mentioned public comments that were received. | |
| 2. | **Public Comment** | **Gaye Hyre, presenting as a private citizen and as the Citizen Advisor of the CT Board of Pharmaceuticals and Therapeutics.** Ms. Hyre relayed the opinion of Dr. Carl Sherter and the CT Board of Pharmaceuticals and Therapeutics, who expressed concern regarding Medicaid waivers for dismissing use of FDA approved pharmaceuticals even if expensive and medically necessary. If prescribing becomes more time consuming and difficult for Medicaid providers, fewer providers will opt to participate, limiting access for consumers. Limiting access to FDA approved meds for Medicaid members results in lower quality care compared to commercially insured.<br><br>The P&T Committee has done a great job over 13 years balancing the need for quality medication access with cost control initiatives.<br><br>The more difficult access to appropriate and affordable meds for chronic disease, the higher utilization costs will go.<br><br>**Sheldon Toubman, Staff Attorney for New Haven Legal Assistance**, has worked with Medicaid clients for over 26 years, and has seen Dept of Social Service's history of restricting access to medications through prior-auth, step therapy, etc.,, restricting access to more expensive meds. | |

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| | | The proposal at pages 13 & 14 of NASHP's recommendations addressing selected contracting or excluding access to a drug if others in the same class are available means an "absolute denial of access to these prescription drugs". We already have preferred drug lists and pre-auth. Federal law requires any FDA approved med must be available where medically necessary.<br><br>In order to implement this NASHP proposal, the state would need to Medicaid waiver. This would be dangerous because it limits access to medically necessary treatment, leading to higher utilization costs in the long run. Used Hep C as example: Sovaldi is very expensive, but highly effective, which avoids the long term costs associated with active Hep C infections. | |
| 3. | **Review & Approval of minutes** | Motion to approve by Demian Fontanella, Seconded by Pat Baker | Minutes approved |

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| 4. | **Presenters:** | Joshua Wojcik introduced the first speaker, Dr. Ameet Sarpatwari Ph.D, J.D and shared his background. The National Academy of State Health Policy (NASHP) convened a workgroup to look at ways to control healthcare costs in the Fall of 2016. The Comptroller participated, and Dr. Sarpatwari consulted and helped to draft the report.<br><br>Dr. Sarpatwari discussed the system, and the NASHP report, noting that Rx spending for employer-based insurance increased 20% from 2013 -15 compared to 6% in overall healthcare costs. He shared Kaiser Family Foundation data noting that 25% of patients didn't fill a prescription due to costs. This cost factor was also evident in the fact that patients prescribed costlier brand name meds did less well than those who received generic meds, and had worse outcomes. He addressed the notion that high medication prices drive innovation. More than 50% of medication innovations occur in academic settings with NIH funding.<br><br>Reported that 10-15% of pharma revenues goes to R&D, and double that goes to marketing.<br><br>He acknowledged that drug development is extraordinarily difficult, and reviewed the legal and regulatory processes involved. However, he noted that the FDA's requirements to get a drug to market are less burdensome than the rhetoric would indicate.<br><br>He proposed that drug costs are set based on what the market can bear, not actual cost, as well as minimal competition. | |

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| | | He supported this premise by exploring the reduction in costs through early introduction of generics. He also looked at barriers to boosting the availability of generic alternatives, citing patent law and minimal regulation. States also have limited ability to negotiate cost reductions.<br><br>He then reviewed the NASHP Work Group recommendations, available in the report.<br><br>Victoria Veltri introduced Jennifer Bryant.<br><br>**Jennifer Bryant, Senior Vice President of Policy and Research for PhRMA** addressed the potential adverse impact on consumer health and outcomes is we try to limit prescription spending.<br><br>She noted that there are a lot of changes, past and future, within the healthcare and pharma system. She suggested that a narrow focus on prescriptions alone could be bad, since growth in other healthcare costs is projected to be 500% greater than growth in prescription pricing.<br><br>She noted that it is important to remember the benefits of medication in disease management. Increased competition in pharma has sped the process of getting a new drug to market, as quickly as 2.3 years.<br><br>She said that the pharmaceutical industry also must deal with risks to the return on investment of their R&D due to increased competition from other medications and generics. She stated that net drug cost increases have slowed, after accounting for rebates, discounts, etc. | |

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| | | She then explored the role of the provider and payer in effective clinical management and resulting reductions in pharma costs.<br><br>Victoria Veltri introduced Thomas Brownlie<br><br>**Thomas Brownlie, Director of U.S. Policy for Pfizer**, acknowledged that the news can make it look like Pharma is the problem. However, he noted that the industry wants to be a partner with all stakeholders.<br><br>He then reviewed the process for getting to final consumer cost for a medication, and contrasted prescription costs with the growth in other elements of the healthcare system.<br><br>He said that innovation can lead to generics, which are typically lower cost alternatives. He noted that 90% of medications filled are generic, and lower cost, which is how the system is supposed to work. He said that continued promotion of generics is a federal policy/regulatory issue.<br><br>He addressed concerns about specialty drugs, noting the 15-20% growth is expenditures per year, compared to 6% for non-specialty. He summarized a Maryland study that showed a 62% PMPM increase in medication costs between 2013-14, but on deeper exploration, identified that 51% of that increase was due to utilization, and 7% was due to cost increases. He suggested this demonstrates that costs are increasing in large part due to increasing consumer use, with chronic disease management as a significant factor.<br><br>He then discussed insurance benefit design, stating that member cost sharing has increased. | |

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| | | He also discussed the possible benefits in medical management and cost savings of medication synchronization, citing CT's law.<br><br>**Dr. William Handelman** noted that his average patient takes 14 medications, at an annual cost of $15-20,000. He agreed that innovation is important, but that it's not well balanced. He gave the example of Digoxin and the unavailability of this inexpensive and effective medicine. He also talked about insulin, where no generic is available, but costs can be $200/month for consumers.<br><br>Finally, he mentioned that medication compliance, including auto-refill programs, which are easy to administer, result in much waste.<br><br>Dr. Sarpatwari responded to Dr. Handelman's comments, agreeing that the increase in the costs of some generics is outrageous, but noted that most generics are cheaper now. H also noted that the federal government should be more active and incentivize greater manufacturing competition. He agreed that the costs of insulin are a problem.<br><br>Ms. Bryant clarified the distinction between medication management and medication synchronization.<br><br>Mr. Brownlie also discussed medication synchronization, and how pharmacists could adjust refills to accomplish this alignment.<br><br>**Commissioner Pino of the CT Department of Public Health** noted that society is addicted to medication. We have to change our behaviors in order to bring these costs under control. | |

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| | | He suggested looking at Johnson and Johnson as an example of industry spending, citing 2013 data showing that J&J spent $17 billion on marketing and only $8 billion on R&D.<br><br>Finally, he noted that 20% of Medicare costs are spent on end of life care, and that this area also needs to be addressed.<br><br>**Marguerite Giuliano, Executive Vice President of the CT Pharmacist's Association**, asked the presenters how and who defines specialty drugs?<br><br>Ms. Bryant responded that everyone defines specialty drugs differently, stating that insurers may be categorizing those medications they want to charge more for as a specialty drug. She said there is very little transparency in this area.<br><br>**Ellen Andrews, Executive Director of the CT Health Policy Project**, stated that the increase in cost sharing as the largest area of concern for consumers. She acknowledged that there are cost outliers that have significant impacts on care, costs, etc. She gave the example of the Epipen, which is critical if you're having an acute allergic reaction, and the dramatic increases in its costs.<br><br>She cited Vermont as a positive example of options to reduce costs, noting their negotiations with pharma, value based pricing, compared to gross v. net costs.<br><br>Ms. Bryant noted that we need to look at the system as a whole for effective policy, but agreed that certain outliers | |

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| | | must be considered. Ms. Bryant reiterated the concern about cost sharing.<br><br>**Pat Baker, President of the Connecticut Health Foundation**, asked for the three most impactful policy recommendations that states could implement.<br><br>Dr. Sarpatwari proposed 1) increased transparency, systemic, as well as granular, 2) the promotion of generic entry and 3) that states seek Medicaid waivers.<br><br>Mr. Brownlie suggested that improved electronic communication/documentation could improve communication and provider patient management. He also noted that current systems are antiquated and inefficient, and that shifting to electronic administration, like with pre-auth requests, would save time.<br><br>**Kurt Barwis, President of Bristol Hospital,** asked how we can promote the use of the right med for the right patient. He gave an example of the use of a simple genetic test to determine which cholesterol med would work.<br><br>Ms. Bryant responded that providers are best situated to identify the appropriate medication.<br><br>Mr. Brownlie stated that opportunities for testing to identify appropriate medications is limited, and represents a big inefficiency.<br><br>**Commissioner Bremby of Connecticut's Department of Social Services** asked how we can control the likely drastic increase in costs associated with biologicals. | |

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| | | Ms. Bryant noted that it is difficult to know how to formulate policy concerning biologics. Medicaid has the opportunity to be a leader in delivery system reform.<br><br>Dr. Sarpatwari responded that he respectfully disagrees, noting that the FDA has been overly cautious. In Europe, biosimilars have be used for over a decade and produced cost savings. He reminds us that these drugs have been FDA approved. States need to be actively engaged.<br><br>Mr. Brownlie stated Pfizer has been committed to biosimilars and is in the process of developing more.<br><br>**Rev. Bonita Grubbs** suggested next steps should be a round table for recommendations not from Pfizer alone but from providers/consumers input as well. | |
| 5. | **Next Steps** | The Lieutenant Governor announced the next meeting will include presentations from the Attorney General and the Medicaid program. | |
| 6. | **Next Meeting** | The next meeting of the Healthcare Cabinet will be held on Tuesday, February 14, 2017 at the State Capitol Room 310. The meeting time is **9:00AM-12:00PM** | |
| 7. | **Adjourn** | Motion to adjourn | Pat Baker motioned and Demian Fontanella seconded. |

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