HEALTHCARE CABINET

PHARMACEUTICAL STRATEGIES

May 5, 2017

In January 2017, the Healthcare Cabinet released a report, the "Cabinet Report," to the Connecticut General Assembly on recommendations for strategies to contain healthcare costs while ensuring improved health outcomes, improved access to care and a focus on the elimination of health inequities. The Cabinet did not include in its study specific recommendations on strategies to reduce pharmaceutical costs, opting instead to include a set of issue areas the Cabinet could explore in 2017.[1] Over the last few months, experts presented background and options for containing pharmaceutical costs. Several legislative proposals are also pending before the Connecticut General Assembly.

To move our work forward, the Office of the Lieutenant Governor offers this summary of topics presented, pending legislation/regulatory action and some potential discussion items for moving forward.

I. Cabinet Work Guided by Principles

The Cabinet adopted a set of principles that continues to guide its work.

Health Care Cabinet
Operating Principles[2]
(Approved June 14, 2016)

1. Commitment to Impact: Contribute to the improved physical, behavioral, and oral health of all Connecticut residents as seen in the following:
a. The number of individuals and/or constituencies affected
b. The depth and/or intensity of the problem
c. Reduction of barriers and burdens for those most vulnerable
d. The time frame in which change can occur
e. The cost effectiveness of health and health care purchasing that promotes value and optimal health outcomes.
f. A health insurance marketplace that provides consumers a competitive choice of affordable and quality options**.**

[1] *Recommended Health Care Cost Containment Strategies: Health Care Cabinet Report in Response to PA 15-146*, January 5, 2017, available at http://portal.ct.gov/Office-of-the-Lt-Governor/Health-Care-Cabinet/Health-Care-Cabinet-Meetings/Health-Care-Cabinet-Regular-Meetings-2017, access on April 28, 2017.
[2] Cabinet Operating Principles, available at http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/principles-approved-(5).pdf?la=en, accessed on May 1, 2017.

2. Equity in health care delivery and access: Recommendations incorporate the goal of reducing disparities based on race, ethnicity, gender, and sexual orientation.

3. Leverage: Recommendations must:
a. Make the best use of past and current knowledge and expertise.
b. Maximize the opportunities provided through initiatives from the public and private sector.
c. Be informed by data and evidence-based practice and research.
d. Be sustainable.

4. Accountability and Transparency: Be fully accountable to the public in a transparent process that meets the objectives of Public Act 11-58.
a. Identify and measure outcomes that demonstrate meaningful results
b. Maintain consumer-driven goals throughout the process

5. Inclusion: Ensure that there are meaningful opportunities to obtain a broad cross-section of views from all stakeholders, including consumers, communities, small business, payers, providers and government.

6. Action: All recommendations must take into account implementation and position of Connecticut to seize opportunities.

II. Background on Prescription Drug Costs Nationally and in CT

Healthcare expenditures have grown as a percentage of the overall economy, from 17.4% in 2014 to 17.8% in 2015. [3]

In 2015, national health data shows that prescription drugs accounted for 10% of all healthcare spending.[4] According to CMS, "***spending on prescription drugs outpaced all other services in 2015.*** The strong spending growth for prescription drugs is attributed to the increased spending on new medicines, price growth for existing brand name drugs, increased spending on generics, and fewer expensive blockbuster drugs going off-patent."[5]

At the same time, total out of pocket expenditures grew by 2.6%.[6] Eighty-four percent of "specialty drugs" are subject to co-insurance on silver exchange plans in 2017.[7] "Health spending by households grew at a rate of 4.7 percent, which was an acceleration from 2.6 percent in 2014. Household spending accounted for 28 percent of health care spending in 2015, unchanged from the year before. The faster growth in spending by households was driven

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[3] Center for Medicare and Medicaid Services, *National Health Expenditures Highlights*, available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf, accessed on April 26, 2017.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Avalere Health LLC, Slides from Webinar, Drug Pricing: Where's the Future Headed?, April 2017, http://avalere.com/business-intelligence/expert-webinar-series/drug-pricing-wheres-the-future-headed.

largely by households' contributions to employer-sponsored private insurance premiums….Health care spending financed by private businesses accelerated slightly, increasing 5.3 percent in 2015 compared to 4.7 percent growth in 2014."[8]

In CT, employers identified health costs as a top concern, including specialty pharmacy drug spending.[9] According to State Comptroller Kevin Lembo, who administers the state employee and retiree health plan, including pharmacy benefits for over 200,000 people, "even as overall drug utilization was down about 1.3 percent in Fiscal Year 16, and the overall medical cost trend was maintained at single-digit growth, the state pharmacy plan experienced a 15-percent increase in costs over the prior year."[10] And in certain cases, costs for certain classes of drugs grew by significantly higher percentages—antidiabetic drug costs grew by 52% over the previous year.[11] During the same time frame, the Department of Social Services (DSS) was able to lower its pharmaceutical expenditures by $55.8 million.[12]

Nationally, reports indicate that misuse of drugs costs up to $52.2B annually while overuse of antibiotics may cost $1.1B.[13]

III. Cabinet Activity on Drug Spending

The Cabinet began detailed discussions in 2017 centered on potential strategies to address growing pharmaceutical costs across all payers.[14] The Cabinet elected to defer study of potential strategies to contain pharmaceutical spending until 2017 to allow sufficient time to develop meaningful recommendations.

In 2016, several Cabinet members volunteered to develop issues areas for exploration. The issue areas included:

- Better understand drug pricing
- Maximize state purchasing and regulatory powers to reduce pharmaceutical costs
- Optimize safe and effective use of medications

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[8] Center for Medicare and Medicaid Services, *National Health Expenditures Highlights*, available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf, accessed on April 26, 2017.

[9] Cabinet Report at 10, citing Bailit Health's interview with CBIA on April 20, 2016.

[10] Testimony of Kevin Lembo, March 7, 2017, available at https://www.cga.ct.gov/2017/INSdata/Tmy/2017SB-00925-R000306-Lembo,%20Kevin,%20Comptroller-State%20of%20CT%20Office%20of%20the%20Comptroller-TMY.PDF, access on April 27, 2017.

[11] Ibid.

[12] DSS Pharmacy presentation to the Cabinet at 12, http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2017-Meetings/DSS-Pharmacy-Presentation-Health-Care-Cabinet-2-12-17-Read-Only.pdf?la=en.

[13] Cabinet Report at 50, citing O'Connor, 'Heart Stents Still Overused, Expert Says," New York Times, August 15, 2013.

[14] Cabinet Report, Appendix F.

A. Better Understanding Drug Pricing

Cabinet volunteers concluded that a lack of understanding around manufacturing costs and pricing leave purchasers at a disadvantage and should drive the state to promote transparency on industry practices that impact pricing in several ways:

- Giving the Attorney General enhanced authority to investigate the industry, report on findings and hold a hearing to help educate the public
- Strengthening unfair trade practice laws to address effectiveness pricing and deceptive and misleading marketing
- Enacting transparency legislation to increase disclosure by Pharmacy Benefit Managers (PBMs) in their contracts with pharmacists and require disclosure by manufacturers to the Attorney General certain pricing information and making such information available to state purchasers and policymakers.

B. Maximizing State Purchasing and Regulatory Powers to Reduce Pharmaceutical Costs

Cabinet volunteers suggested that through the state's payers, the state consider strategies addressing:

- Medicaid functioning as a contractor for pharmacy coverage
- Medicaid and the Comptroller's office should consider the feasibility of jointly administering their prescription drug programs
- State agencies acting as contractors for coverage—contractual requirements and in-house expertise
- The state's role as a bulk purchaser for certain drugs that have a public health benefit.
- The state's role as a regulator.
- The state's ability to tie its purchases to the lowest price paid for the same drug by the United States Department of Veterans Affairs, except as may be required by federal law.[15]
- Creation of a public utility model to oversee drug prices.
- Passage of legislation requiring all providers prescribing or administering biologically based drugs to use biosimilar drugs, whenever available.

[15] The requirement would also need to be implemented in a manner that does not jeopardize Medicaid's best-price guarantee.

C. Strategies to optimize safe and effective use of medications

The Cabinet volunteer members made suggestions about areas to explore to ensure safe and effective use of medications, including:

- Expanding the role of community pharmacists in medical homes and primary care payment models.
- Working on standard discharge forms from skilled care that would allow for medication reconciliation with community providers.
- Restricting automatic refills and promoting the use of e-prescribing.
- Ensuring the availability of clinical information across the provider spectrum to ensure proper medication reconciliation.

The Cabinet solicited multiple presentations, beginning in January 2017. The Cabinet heard from experts in academia and the industry on potential strategies Connecticut could pursue to control pharmaceutical costs. The strategies mirror some of those suggested by the Cabinet volunteer members in 2016. Presenters also offered additional strategies.

D. PRESENTERS

1. January 10, 2017

Presenters included:

- Ameet Sarpatwari, Ph.D. J.D., Harvard University
- Thomas Brownlie, Director, U.S. Policy, Global Policy Division, Pfizer
- Jennifer Bryant, Senior Vice President, Policy and Research PhRMA

In January, Ameet Sarpatwari, J.D., Ph.D.[16] from Harvard, presented, "States and Rising Prescription Drug Costs: Origins and Prospects for Reform."[17] Joined in serial presentations by Tom Brownlie of Pfizer and Jennifer Bryant of PhRMA, Dr. Sarpatwari laid out the drivers behind increasing prescription drug costs and the ramifications of those costs upon consumers, employers and state budgets. Noting the rate of increase in drug costs, Dr. Sarpatwari pointed out that while more consumers have coverage for prescription drugs, consumers face higher out of pocket costs for medications than ever before, and some are not filling needed prescriptions because of out of pocket costs. He

[16] Instructor in Medicine, Harvard Medical School, Assistant Director, Program On Regulation, Therapeutics, And Law (PORTAL), Division of Pharmacoepidemiology and Pharmacoeconomics, Department of Medicine, Brigham and Women's Hospital

[17] We acknowledge the support of the Office of the State Comptroller's assistance in requesting Dr. Sarpatwari's appearance.

also noted that consumers adhere better to prescription drug regimens when they are prescribed more affordable, generic alternatives to name-brand drugs.[18]

Dr. Sarpatwari noted that drug prices are higher because we allow companies to charge what the market will bear without allowing for a counterbalance. He stated that the availability of generic alternatives is the only competition that actually drives down prescription drug costs.[19] He cited the restrictions on negotiation of drug prices for major payers in the United States, except for the Veterans Administration, recommending that states should drive reform.

Dr. Sarpatwari described the work of the National Academy of State Health Policy's (NASHP's) work group, a bipartisan work group that included Connecticut's Comptroller. The ten possible state solutions developed by the work group include the following:[20]

1. Leverage transparency laws to create accountability
2. Create a public utility model for in-state drug prices
3. Bulk purchase and distribute high-priced, broadly-indicated, drugs that protect the public's health
4. Utilize state unfair trade and consumer protection laws
5. Seek the ability to re-import drugs from Canada
6. Pursue Medicaid waivers to promote greater purchasing flexibility
7. Create a State Pharmacy Benefits Manager (PBM)
8. Pursue return on investment (ROI) pricing and forward financing
9. Ensure state participation in Medicare Part D as Employer Group Waiver Plans
10. Protect consumers against misleading marketing
11. State pension funds assume active shareholder role to influence pharmaceutical company actions

Dr. Sarpatwari described possible legal issues raised by each possible state solution and concluded by offering additional possible solutions: including re-evaluating the use of free samples and "dispense as written" prescriptions and pursuing value-based prescribing.[21]

Jennifer Bryant from PhRMA presented "Prescription Drug costs in Context." She addressed pharmaceutical spending in the larger context of overall health expenditures. A focus solely on prescription drug costs would not account for the overall increase in healthcare costs.

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[18] http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2017-Meetings/Connecticut-010917.pptx?la=en, accessed on May 1, 2017.

[19] Ibid.

[20] States and the Rising Cost of Pharmaceuticals: A Call to Action, NASHP Pharmacy Costs Work Group, October 18, 2016, available at http://nashp.org/states-rising-cost-pharmaceuticals-call-action/, accessed on May 1, 2017.

[21] See note 11.

Ms. Bryant also shared that PhRMA is open to value-based frameworks for pharmaceuticals if certain barriers to doing so can be addressed, including anti-kickback restrictions, data sharing requirements and price transparency reporting clarity.

Tom Brownlie of Pfizer presented, "Balancing the Tradeoffs Between Cost, Innovation, Accessibility and Affordability." Brownlie noted that innovation leads to generic development and generics now comprise 90% of fills. Brownlie acknowledged that specialty drug costs are increasing faster than non-specialty drug costs, but he noted a Maryland case study that showed in that state that the high rate of increased costs resulted from increased utilization, not price. He also noted that chronic disease management plays a role in increasing drug expenditures.

Mr. Brownlie finished his presentation by noting changes to health plan designs that expose consumers to increasing out of pocket costs for prescription medications. He signaled that the pharmaceutical industry is beginning to embrace the value concept—he cited existing Connecticut law that allows for medication synchronization for fills and the need for ongoing medication management to contain costs and improve patient health.

Following the presentations, Cabinet members engaged in discussion with the presenters. Members learned that there is no clear definition of "specialty drugs." Members noted that in some cases, inexpensive, ineffective drugs may no longer be available for coverage while drugs needed for conditions such as diabetes are still expensive. Members also noted expenditures in marketing often exceed those for research and development (R &D). Still others expressed concerns about increased cost sharing for consumers and cited Vermont's efforts at transparency in comparing gross to net costs and efforts at value-based pricing.

In response to a request for the three most impactful strategies Connecticut could consider, Dr. Sarpatwari suggested: 1) increased transparency on systemic and granular levels, 2) the promotion of generic entry into the market, and 3) Medicaid waivers. Mr. Brownlie suggested improved electronic communication/documentation could improve communication and provider patient management.

At the January meeting, two commenters expressed concerns about one of the NASHP Work Group recommendations to allow states to pursue Medicaid waivers to increase purchasing flexibility. The commenters stated that allowing a Medicaid waiver might limit access to certain FDA approved drugs currently required to be covered under federal law.

2. February 14, 2017

Presenters Included:

- Attorney General George Jepsen, Special Counsel Robert Clark and Associate Attorney General & Head of the Antitrust and Government Program Fraud Department, Michael Cole

- Robert Zavoski, MD and Herman Kranc, RPh, Department of Social Services

At February's Cabinet meeting, Attorney General George Jepsen, Special Counsel Bob Clark and Associate Attorney General and Head of the Antitrust and Government Program Fraud Department, Michael Cole presented on *Past and Present Efforts to Address Rising Prescription Drug Costs*. Attorney General Jepsen stated after reading an article about rising prescription drug costs in 2014, his office began to take action.[22] He stated that one of the underlying factors affecting costs of pharmaceutical costs in the United States is the lack of price controls. He noted that patents on high level and very specific components of drugs, including the drug itself, specific actions and delivery systems, limit competition and innovation, especially in the generic market. As previous speakers stated and reports shared with the Cabinet note, he agreed that the barriers to generics entering the market stifle competition for generics.

Attorney General Jepsen's office found systemic price fixing in the generic market through a multistate investigation in cooperation with the United States Department of Justice (USDOJ). He reported that the USDOJ continues to pursue a criminal investigation while he joined with 16 other states to file suit against six drug companies for alleged price fixing. He noted that drug manufacturers may be paying generic manufacturers to delay the launch of their products to maximize profits.

Robert Zavoski, MD and Herman Kranc, RPh of the Department of Social Services (DSS) presented on "Connecticut Medicaid and Pharmacy." Like Attorney General Jepsen, Dr. Zavoski expressed the Department's concern about drug pricing in the United States, however he cautioned the Cabinet to examine these costs viewed through the lens of the total costs of care in the U.S. healthcare system. Pharmaceutical research and the resulting medications very positively impact health in the U.S. Dr. Zavoski noted that many of the childhood cancers he treated as a resident in training had dismal prognoses at that time, but are curable today. Furthermore, other often fatal diseases he saw as a resident, such as epiglottitis, no longer exist thanks to vaccines.

Dr. Zavoski also pointed out that a previous presenter cited new medications to treat Hepatitis C as examples of medications with exorbitant prices, but these costs need to be viewed in comparison to the costs of alternative treatments. The new Hepatitis C medications are curative, whereas the previous treatments used for this disease (which were also quite expensive) merely suppressed the disease and therefore were taken indefinitely over many years, or until the patient suffered serious enough medication side effects or liver failure to require organ transplantation. Lastly, in contrast to the new medications which are pills taken orally, the older treatments were administered via expensive intravenous infusion and required many hospital and physician visits. So in terms of overall cost, although the new medications for

22 Aaron S. Kesselheim, MD, JD, MPH; Jerry Avorn, MD; Ameet Sarpatwari, JD, PhD, The High Cost of Prescription Drugs in the United States Origins and Prospects for Reform *JAMA*, 2016;316(8):858-871, available at http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/High-Cost-of-Prescriptions-Article.pdf?la=en, accessed on May 4, 2017.

Hepatitis C are very expensive today, they are a cure that becomes cost effective in 5 – 7 years. Connecticut Medicaid's self-insured model allows DSS to view these medications in the context of their total cost of care over many years, and thus we cover these medications widely and focus our efforts on ensuring patients are not re-infected once they complete their treatment.

DSS next examined four recommendations from the Cabinet's cost containment study and the NASHP Work Group recommendations:

- Strategies to maximize state purchasing.
- Strategies to address the rapidly rising costs of specialty pharmaceuticals.
- Pricing and incentive design based upon efficacy, performance and comparative effectiveness research.
- Alternative Medicaid pricing strategies.

There were several strategies to maximize state purchasing offered by previous presenters that are not available to Medicaid. The first, joint purchasing arrangements, are not financially viable because of Medicaid's heavy reliance on the federal government's successful ability to negotiate price rebates. Medicaid is a federal/state partnership; the Omnibus Budget Reconciliation Act of 1990 requires that state Medicaid programs cover only those medications whose manufacturers participate in the federal drug rebate program in order to get matching funds.[23] Connecticut Medicaid twice investigated the possibility of joint purchasing with non-Medicaid state agencies and was twice informed by CMS that "the purchasing power of the U.S. Government (federal rebate) is not transferrable" and that Medicaid cannot participate with other purchasing arrangements and continue to receive federal rebates. DSS does participate in a joint purchasing arrangement, however with other state Medicaid programs. This pool generates over $750 million in rebates annually. As a result, DSS lowered its pharmacy annual spend by $55.8 million between 2015 and 2016.[24] DSS therefore cannot foresee participating in other joint purchasing arrangements that would yield comparable savings.

Another strategy previously recommended was that legal action be taken to make pharmaceutical prices more transparent. It must be recognized that joint purchasing agreements like Medicaid's successful rebate negotiations are by their nature best conducted without public scrutiny; no manufacturer would aggressively rebate their prices knowing that their competitors were aware of the actual price.

The last strategy offered by previous experts was for the state and the Medicaid program use a Pharmacy Benefit Manager to support joint purchasing arrangements. One of the strategies used by PBMs to control costs is provider competition, which, under the terms of

[23] DSS Pharmacy presentation to the Cabinet at 10, http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2017-Meetings/DSS-Pharmacy-Presentation-Health-Care-Cabinet-2-12-17-Read-Only.pdf?la=en.
[24] Ibid at 12.

the State Plan with the federal government, is unavailable to Medicaid programs because they must enroll 'any willing provider' .[25]

DSS, like previous presenters, is very concerned about the rapidly rising costs of specialty drugs, but Dr. Zavoski noted the lack of a clear definition of 'specialty drug." DSS is very interested to explore performance-based pricing, however, as previous presenters did, Dr. Zavoski called for the FDA to set national policy on biosimilars. Furthermore, he noted that the FDA:

- Approves most new medications coming on the market as orphan drugs, with less rigorous efficacy and safety standards required for approval.
- Approves a larger number of new drugs that in past years which later go on to be recalled for safety reasons that initial research and review failed to identify.
    - Vioxx
    - Seldane

There were several other strategies offered by previous presenters upon which the Department wished to comment. First, DSS uses comparative effectiveness research in its policymaking to the extent possible, offering the Department's coverage of PCSK9 inhibitors for hypercholesterolemia as an example. Dr. Zavoski cautioned, however, that comparative effectiveness research is still in its "infancy".[26] Further, while commercial carriers and employer plan experience supports medication adherence strategies,, DSS' experience with financially incentivizing Medicaid beneficiaries only attracted modest participation.

Finally, Dr. Zavoski concluded his presentation by noting how much the opioid epidemic contributes to tragic outcomes, rising drug costs and rising healthcare costs, which are "almost entirely" attributable to the healthcare industry because of labeling and marketing efforts. He noted that "No high-quality, long term clinical trials demonstrating the efficacy and safety of opiates for chronic non-cancer pain have ever been conducted."[27] He described the efforts that DSS undertook to stem the epidemic, including implementation of Section 7 of Public Act 16-43, which limits opioid prescriptions to a seven day supply, naloxone, and other strategies.

He summarized his presentation by asking Cabinet members not to focus on costs to the exclusion of overall context in which pharmaceuticals are used. Herman Kranc also commented on the role of the P & T committee and described some of DSS" utilization review programs and programs such as CADAP.

During the Q & A period, Cabinet members asked whether DSS examined price gouging and Herman Kranc responded that DSS does look for price gouging and reviews wholesale drug prices. In response to a question about state/national policies that might make a difference in

[25] Ibid at 11.
[26] Ibid at 22-27.
[27] Ibid at 37.

reducing drug costs, Dr. Zavoski remarked that advances in drug development, including newer cancer and hepatitis drugs, are safer and work well, reducing long-term costs to the healthcare system.

3. April 18, 2017

Presenters included:

- Jonathan Shaw, VP, PBM Product Development, Product Innovation & Management, CVS Health
- Matt DiLoreto, Vice President, State Government Affairs, Healthcare Distribution Alliance
- Annik Chamberlin, PharmD and Angelo DeFazio, RPh

Mr. Shaw presented, "CVS Health: Understanding the Role and Value of Pharmacy Benefit Managers." He explained that he works on PBM side, specifically for Caremark, which covers >80 mill people nationally. Some of a PBM's constituents/clients include public, private sector employers, insurers and Taft-Hartley plans; downstream are the client's members. He noted that more than 253M people have pharmacy benefits through a PBM, and explained that PBM's role is to:

- Administer benefits – process claims, manage networks
- Work to keep costs down – negotiating power to reduce drug costs, promote lower cost meds (generics), avoid inappropriate med use
- Improve patient care – patient support, education and compliance activities

Mr. Shaw stated that PBMs result in a 35% average savings to plan sponsors and consumers. Mr. Shaw explained that growth in healthcare costs are expected to exceed GDP, and that this growth is driven by:

- increasing cost of drugs – brand and new, innovative meds
- increased utilization – more clinical indicators for medication use, more people needing meds

Market forces resulted in an 11% trend (which Mr. Shaw defined as the year to year growth in expenditures) for medications costs, but PBMs reduced that to 3.2% through the use of: intelligent purchasing, effective med management and versatile cost strategies. In response to a question that if PBMs have such negotiating power, then why do pharmaceutical cost increases outpace inflation every year, Mr. Shaw briefly identified that the key to managing costs is competition. When there's competition, there is more opportunity. He used the example of statins, which in a drug type with plenty of competition, so costs can be kept down. He said that specialty drugs are a good example of the impact of limited or no competition on pricing, because they are often unique drugs. With no competition there is less opportunity to negotiate lower prices.

The same Cabinet member countered that even generics see increasing costs and stated that the market has consolidated, there are fewer "mom and pop" pharmacies, with more and larger chains, but we haven't seen cost savings. Mr. Shaw believes that PBMs are doing a good job, but even a 3.2% increase is an increase. For generics, they do get a lot of headlines. Some single source generics are more expensive, due to reduced competition.

Another Cabinet member followed, asking about the 3.2% overall trend, inquiring what percentage of the PBM's clients did better? Did worse? And what was the State of CT's trend? The Comptroller's Office clarified that the state's pharmacy trend was significantly higher because it doesn't use Caremark's standard formulary, so the costs are more sensitive to price variation.

Another Cabinet member asked if many PBMs have distinct specialty pharmacies to help manage these drugs. Mr. Shaw said that there are specialty pharmacies for these drugs, and the trend in expenditures is typically about 17-18%.

Mr. Shaw then reviewed the importance of competition for the PBMs' ability to drive down costs through negotiation, providing the example of statins that showed a significant decrease in costs as more manufacturers entered the market. Mr. Shaw reiterated that 85-90% of members take are generics, so there is significant opportunity to leverage PBMs market power to keep costs down. The remaining 10-15% of meds, mostly specialty, are responsible for the highest costs.

Mr. Shaw stated that PBM market power also helps keep costs down. When EpiPen cost increased 150%, Caremark was able to negotiate a 10% increase for clients through negotiated discounts, rebates and price protection.

Mr. Shaw then discussed formulary management, and Caremark's guiding principles: maintain clinical integrity, use market power to secure competitive pricing and education of members and providers. PBMs pick and choose preferred and non-preferred brands based on negotiated pricing. Clinical care and efficacy is the primary consideration, but when there are multiple medications to treat a condition, Caremark looks for the lowest cost.

When changing a formulary, PBMs work to help members with transitions as needed. There is also a medical exception process for those members for whom the new medication is contraindicated. Historically, PBMs assigned different co-pays to non-preferred drugs, but in the last 5 years the trend has been to exclude coverage of these non-preferred, usually higher cost drugs.

Mr. Shaw then explored the benefit of PBMs on net price versus list price. He noted that when Caremark began excluding non-preferred drugs versus imposing higher cost sharing, the net cost savings increased. When asked whether the price discounts Caremark offers vary by

client or payer, Mr. Shaw explained that they vary by payer and manufacturer, but not usually by client, since the PBM usually negotiates as a block.

Finally, Mr. Shaw addressed what he called the "egregious" price increases we've seen in recent years, with more drugs experiencing major increases in cost, 100-200% and more. In response, Caremark has introduced a Hyperinflation Program, which identifies drugs that experience these price increases earlier than they historically would. Previously, Caremark might not catch these increases at the system level until planning for the next plan year. According to Mr. Shaw, some manufacturers would wait until the new plan year, and then increase costs 200-300%, leaving the PBM restricted by the negotiated pricing schedule until the next year. The Hyperinflation program detects these changes sooner, usually quarterly, and lets the PBM address the increases right away.

A Cabinet member asked how this impacts the patient. Mr. Shaw responded that Caremark contacts the patient, provider and pharmacist to discuss the change and options. Another member asked whether the PBM contracts include price protections. Mr. Shaw said that it depends on the manufacturer and drug. Client contracts limit the PBM's ability to respond to these changes, since many will limit formulary exclusions during a plan year.

Mr. Shaw addressed a question about whether PBMs keep people healthy. He said appropriate and well managed treatment of medical conditions with medications, can reduce the incidence of medical complications, reducing the medical utilization costs. Mr. Shaw said that CVS is more than a PBM – it is a connected healthcare company, with retail stores and clinics, mail order and specialty pharmacy, long term care, infusion, etc. This level of holistic engagement allows for better adherence and identification of gaps in care, minimizing problems and improving outcomes. He remarked that there are cost savings in this model – a statin example showed an increase in member compliance from 43.5% to 52.7% with the addition of pharmacist counseling, resulting in a net savings of $2,710 per patient, including productivity.

A Cabinet member asked if insurers pay the pharmacies or pharmacists for these intervention services? Mr. Shaw said it's a mix. All PBMs have processes in place to require certain activities of the pharmacies, with reimbursement and other incentives associated. In follow-up, the same Cabinet member asked how this works, who is held responsible for these compliance activities and whether there is any impact on reimbursement? Mr. Shaw said this is a relatively new concept, and while it's not being implemented broadly and across all plan or payer types, where it is, Caremark is not modifying payment based on these clinical metrics.

In addition to pharmacy care, CVS Health is also exploring patient care, which complements the pharmacy's function. For example, he said that diabetics can receive more personalized care management of their diabetes through all of the parts of Caremark's holistic model.

Looking ahead, Mr. Shaw said that specialty drug spend is expected to be 55% of drugs costs by 2020, up from 36% in 2015, despite it reflecting services for a small portion of the population. Factors driving this trend include increasing utilization and prices. The cost for many specialty medications is split, with part of the expenses covered on the medical side, and the drug itself covered as a drug benefit.

Mr. Shaw said that patient adherence is a major problem nationwide. "If you talk to one patient about why they're not adhering, you've basically talked to one patient. Everyone's got different issues, everyone's got different reasons." He said that patient adherence activities, while complicated, can have significant cost savings.

Mr. Shaw also commented that the cost out of pocket expenses is a challenge. Higher cost sharing can impact patient ability to use most appropriate med, or stay on it.

A Cabinet member noted that one thing the Cabinet did not talk about is waste. Many consumers don't use or don't finish their prescriptions, resulting in costs with no clinical benefit. This Cabinet member noted that an example of industry practice that can drive waste are 90-day fills. There may be lower up front out of pocket costs, but since a medication or dose could change, a 90-day fill could be inconsistent with changing medical direction. Auto refills are another potential source of waste, since there's no way to know if a patient is taking the medications, so medication adherence is impossible to monitor.

Mr. Shaw said that CVS Health has studied this, in particular the 90-day and auto refill and hasn't seen a big difference in costs. He said that once a patient's medication regimen has been established, 90 day and auto refills can be very beneficial.

A Cabinet member commented that the major criticism we hear about PBMs is their lack of their acting as a fiduciary, specifically Caremark, as the PBM for the state plan. In some PBM-client contracts, the Cabinet member noted that there are provisions requiring that the PBM have fiduciary role. She asked if this was part of the State plan contract. Mr. Shaw indicated that he did not think Caremark was a fiduciary under the state contract, and was not aware of any contracts where Caremark acts as fiduciary.

Another member asked how CVS Health reconciles its role as both a PBM and a pharmacy, since the interests of each seems to be conflicting. Mr. Shaw responded that for the most part, there is no problem. There are internal firewalls to prevent conflicts when the pharmacies negotiate with the PBM. Overall, the vision of each are aligned (promoting med adherence, lower cost medications, etc.)

A cabinet member expressed interest in hearing about the link between pharmacists and clinical care, like the example of a pharmacist flagging that A1C as an indicator of diabetes and referring to the Minute Clinic. She asked about the feedback loop to the primary care provider. Mr. Shaw said that Minute Clinic is on Epic EMR, which allows for very effective

sharing of patient information. If there is no electronic integration, the clinical records are faxed to the PCP.

Another Cabinet member discussed a journal article looking at PBMs as "predatory". He gave an example of Express Scripts per prescription profit increasing 500% since 2003, and asked how effective PBMs are at really managing costs, remarked that PBMs lack transparency and asked why the industry fights transparency. Mr. Shaw responded that negotiations are complex and the landscape changes frequently, so these agreements can be difficult to manage. Pricing is competitive with other PBMs, which should result in industry self-management.

Mr. Shaw continued. He said that transparency is an interesting question since it means different things to different people and there are many aspects to transparency. One area people where people look for transparency are the agreements between PBMs and manufacturers, discounts, etc. He pondered what the end goal of transparency is? Increasing disclosure could result in less effective negotiations, since manufacturers may be less inclined to negotiate robustly since their competitors could then see their pricing and adjust accordingly.

Another member asked about EpiPen, asking that while Caremark shows that its clients' costs only experienced a modest increase, who might be paying the higher price? Mr. Shaw – said that cash payers, including the uninsured, pay a higher price, but the coupon programs would help to offset some of these costs.

Matt DiLoreto from Healthcare Distribution Alliance (HDA) presented next. He represents wholesalers. Wholesalers are an important link between manufacturers and the pharmacy, hospitals, long term care, etc.

Mr. DiLoreto said that wholesalers are a highly efficient and advanced distribution system in the supply chain. The core function of wholesalers is a very simple one – purchase and store medications and other items from manufacturers, fill client orders and ship to them. He stated that the pharmaceutical supply chain is highly complex and difficult to understand.

HDA represents 34 member companies, each with a unique business model. Based on each client's needs, his firm will ship medications at least once a day. Anti-trust law requires that they cannot discuss pricing.

He said there are 200 wholesale distributor warehouses nationwide that serve as the middleman for 94% of medications, something that most people don't think about. Only 6% of drugs go directly from the manufacturer to the pharmacy. The top 25% of wholesalers purchase products from over 1,300 manufacturers. Wholesalers provide a "one-stop shop". This creates efficiency and reduces burden of finding, ordering and storing products. Wholesalers ship 15,000,000 products to pharmacies every day across the nation. Wholesalers have no control over or role in drug pricing, PBMs or plan designs.

The wholesaler's focus is to ensure that clients get the medicines they need when they need them. By working directly with manufacturers, wholesalers can ensure that the medications in the stream are FDA approved and legitimate drugs.

Wholesalers purchase from manufacturers based on wholesale acquisition costs (WAC), which are independently created and represent list price, and don't include rebates, etc. Each WAC is specific to each drug and drug dose. The cost to the wholesaler, based on the WAC, is passed onto the pharmacies.

Mr. DiLoreto referenced the US Today graphic showing the complexity of the pharmaceutical supply chain. Using an example from the graphic, a $250 drug would give a wholesaler a $2.50 profit, supporting the premise that while the wholesaler is a crucial part of the supply chain, it doesn't add to costs. Wholesalers operate on very high volume, but very low profit margins (around 1%).

Mr. DiLoreto said that the payment model has shifted from a "buy and hold" model to a fee for service model. Under buy and hold, wholesalers could purchase a lot of a product at lower cost, and hold it until costs went up, then sell to increase profit. The industry shifted to fee for service, which reimburses wholesalers for distribution costs. This model helps to stabilize supply chain and costs, as the model is built on the efficient movement of product.

Wholesalers also provide analysis, supply chain security, health IT, EMRs, suspicious order monitoring, contracting services, and more. Pursuant to federal law, there is a new product tracing capability being implemented across the system, allowing an individual drug to be tracked through the supply chain.

A Cabinet member noted that there is an ongoing scandal within the distribution network, where essential drugs are "suddenly" unavailable and then marked up dramatically. The member asked what the industry's plan is for dealing with this. Mr. DiLoreto was not familiar with the specifics of the issue raised, but said he would research and follow up on this "price gouging" issue. He noted that HDA has testified against this practice.

Mr. DiLoreto noted that many entities have oversight over wholesalers, including the CT Department of Consumer Protection. Drug Enforcement Agency (DEA) and FDA rules also apply.

Annik Chamberlin, PharmD owner of Beacon Pharmacy and Angelo DeFazio, RPh, who owns five pharmacies and two medical marijuana dispensaries, were the next presenters. Their presentation was titled, "Pharmacy's Limited Influence on the Cost of Medications."

Ms. Chamberlin began by describing the players involved in medication pricing, including the patient, manufacturers, wholesalers, pharmacies, PBMs and government. When consumers present prescriptions, the pharmacist knows what they owe, and what their reimbursement is, subject to additional factors. Mr. DeFazio discussed how the lack of U.S. regulation over pricing makes it very complicated to navigate. Each participant/purchaser has different reimbursement.

Ms. Chamberlin said that drug coupons were intended to help offset costs to un- or under-insured consumers, but they actually add cost to the system. Coupons reduce manufacturers' incentive to lower costs. She provided the example of EpiPen. Coupons to consumers to lower net cost to people, but the list price is the same, which impacts pricing negotiations. This increases overall costs to consumers. Coupons are also usually limited to a short duration or quantity, which leaves the consumer paying full price after the coupon expires.

Ms. Chamberlin said that pharmacies touch every piece of the supply chain – purchasing from manufacturer and wholesaler, dispensing to patient, working with insurance and collecting cost sharing, and providing counseling to patients and providers, but with little or no reimbursement for this counseling.

She commented that pharmacies have no say in reimbursement rates, which have been dropping, as have dispensing fees, which dropped from $2.31 to $1.62 between 2000 and 2010. Mr. DeFazio said that a cliché in the industry is that pharmacies negotiate reimbursement and prices with PBMs, and that is absolutely not true. It is a take it or leave it contract, with small room for negotiation. He has some plans that do not pay a dispensing fee for the pharmacist. Ms. Chamberlin said that much of the reimbursement for medications is less than the cost of the drug, so the pharmacies lose money. Pharmacies can't easily drop these plans, because they would lose all of those members of those plans. Between 2005-2010 more than 50% of independent community pharmacies operate at revenue margin of 2% or less. Pharmacies have very little to do with overall costs.

She said that large companies hire PBMs to manage pharmacy benefits. Pharmacies are reimbursed at a contracted rate determined by the PBM. There is no chance to negotiate.

Mr. DeFazio said that another issue in industry is narrow network for PBMs, limiting the ability of pharmacies to enroll in network. There are changes from year to year and PBMs can impact pharmacies, since they may end up out of network.

Ms. Chamberlin said that the three largest PBMs control over 78% of the prescription transactions in U.S. Mr. DeFazio admitted that PBMs do a great job administratively, but PBMs morphed into entities that have no direct connection with the patient and drug dispensation. This disconnect complicates the system.

Ms. Chamberlin remarked that the system that evolved can incentivize consumers to use fewer pharmacy services, e.g. mail order, limiting the important face to face needed for effective education and medication management. She said that drug rebates, claw backs, kickbacks, and performance based direct and indirect remuneration fees (DIRs) complicate the fiscal picture more, and it's difficult to know where the money goes. Transparency is needed to understand this.

She commented that drug manufacturers provide incentives for PBMs to keep drugs on formulary – rebates, etc. – despite no way of knowing if these savings are passed on to a health plan and members—which can lead to increased costs for the retained drugs. For example, the U.S. Department of Justice fined Medco and Express Scripts for accepting kickbacks. Claw backs are complicated. The pharmacy fills the prescription, gets contracted reimbursement, and the additional amount paid by the member stays with PBM.

She said that DIR fees are "backdoor" fees that are imposed on pharmacies by PBMs after the prescription and reimbursement has been processed. For example, a pharmacy processes a claim, ends up with $10 for dispensing. Three to four months later the PBM sends a report noting that some patients had poor medication adherence, and the PBM will take back $5,000 over next 3 months.[28]

A Cabinet member asked for clarification on the process. Ms. Chamberlin gave an example of the process: A pharmacy buys drugs from wholesaler for $85. The member brings in prescription for the drug, which the pharmacy fills, then submits the claim to PBM for $100 based on the benchmark. The PBM processes the claim and pays it, leaving the pharmacy with $15 gross profit. Months later, the PBM claws back a $7 DIR fee, cutting gross profit by over 50%, from $15 to $7.

Mr. DeFazio said that under the ACA, the intent was to get away from a fee for service model and to focus on quality. Pharmacies have limited ability to impact this quality, but are penalized. He asked the Cabinet to imagine an industry where you don't know what your end payment for a service will be for several months.

A Cabinet member asked if there is transparency in how the claw back is determined and Mr. DeFazio responded that there isn't. If he were 100% compliant with adherence, he could still be faced with a 3% claw back from the PBM. The Cabinet member stated that this is asking pharmacists to exceed the scope of their practice, that the pharmacist is being asked to manage a patient's medical care without a license.

Ms. Chamberlin stated that as an example, she received a report from a PBM for the last trimester which showed overall adherence for statins, diabetes, gap therapy, medication therapy management reviews, and requires her to ensure that none of the elderly patients are on high risk medications, which requires calls to the provider. Mr. DeFazio said that if the physician refuses to change the medication, despite a call from the pharmacist, the pharmacist is still penalized.

Another Cabinet member asked what tools the pharmacist gets from a PBM for the pharmacists to meet these expectations. Mr. DeFazio remarked that tools are what he's been

[28] See Presentation at 19-20.

asking for, to take the guesswork out of this, so the pharmacists know what their expectations are and how to comply fairly. He said that there really are no support tools.

Ms. Chamberlin said that these contracts have gag clauses barring them from discussing specifics of the plan, reimbursement, etc. For example, if a patient's co-pay would exceed the out of pocket cost for a medication, they're barred from telling the patient. She believes that the extra payment goes to the PBM, not the client.

Mr. DeFazio remarked that there have been examples of employers dropping their PBM and managing this themselves, like Caterpillar, which reduced their costs. There is no transparency, and these efforts have not reduced the cost of healthcare. He asked how is it transparent or reducing costs if a patient has to go to one specific pharmacy for a medication, who then refers to a specific pharmacy to fill that type of drug, but that pharmacy is owned by the PBM.

A Cabinet member said that pharmacists are uniquely positioned to help monitor patients' adherence, and have a different perspective in patient management. Because this is still evolving, we are not there yet to equitably incorporate all pharmacists, in particular small pharmacies, into the care management team. Pharmacists are the experts on medications, and a part of the care team that is often overlooked.

Ms. Chamberlin said that the system is extremely complicated. Mr. DeFazio agreed and used the example of specialty drugs. How are they classified? He thinks it's by of cost. He asked why we can't have complete transparency on where all the money goes. He commented that the U.S. has the best distribution system in the world, but there's an invisible man behind the curtain, which is the PBM. In order to address this, we really need to know who is getting paid what, when and why, and what the impact on the system is.

A Cabinet member asked, if PBMs truly believe that pharmacists are an important part of the process for monitoring patient adherence, then why do PBMs push patients to use the 90-day refill and mail order?

Ms. Chamberlin cited an example of recent patient, who needed one box of two meds. The PBM required a 90-day fill, but the provider only wrote the prescription for 1, which is not a 90-day quantity. The claim would not go through unless she classified the box as a 90-day fill, but she was able to call the PBM and get a one-time override, instead of sending the patient home with 24 boxes that would have been wasted.

A Cabinet member thanked the presenters and summarized some of the CMS proposals to change pharmacy management for Medicaid, and discussed some of the challenges.

Another member asked for some ways in each area of the pharmaceutical chain where we could reduce costs.

Mr. Shaw said that his personal perspective is that enabling competition between manufacturers can drive costs down, as can the use of generics. He recommended review and simplification of the regulatory pathways to new drug development. He said that excluding drugs will also drive costs down through increased competition by manufacturers to participate, but it has an adverse impact on the member experience.

Another Cabinet member expressed the importance of transparency. Drug pricing is complex, so how can we understand how to fix it? She gave the example of specialty drugs, and the lack of clear definition. She said that we need to know where the money is going, commenting that it is not a crime to make a profit, but it needs to be done in a manner that is consistent with our overall goals.

Mr. DeFazio promoted the concept of PBMs being considered fiduciary, and argued that the limited formulary which impacts member's ability to use the most clinically appropriate drug in favor of the most affordable is a fiduciary act. Mr. Shaw disagreed, saying that the PBMs are not making the decisions to narrow the networks; that it is the client's decision. PBMs do not want to be in the position to make those decisions. Mr. Shaw also addressed the premise that the PBMs have a fiduciary role, arguing that they don't, but instead noted that their role is specified by the clients.

A Cabinet member asked Mr. Shaw how long ago Caremark adopt exclusionary formularies, and noted that clients were told at the time that about 75 drugs would not be available, disproving the premise that PBMs don't take unilateral actions of this type. He noted that this practice has changed, but that it did begin that way. Mr. Shaw responded that they had taken such action in the past.

The same Cabinet member addressed the issue of fiduciary responsibility, and noted that his membership includes about 60,000 covered lives, and has a PBM that does accept fiduciary responsibility. That PBM has been willing to do it, and it hasn't cost the PBM anything. This simply results in a legal obligation for the PBM to act in the best interest of the client.

Another member stated that there are too many middlemen and providers have less power in this relationship. He noted that the wholesalers may only make 1.4% profit, but that results in billions in profits. He suggested that all players should have to report their data to an HIE to help capture the complete picture of the healthcare system costs.

A member asked if any of the panelists could talk about the role of efficacy. She noted that the effectiveness of a given medication should be a factor in determining coverage and pricing. Mr. DeFazio said that the relationship a patient has with the pharmacist and provider promotes efficacy, since pharmacists can help coordinate care that has the best outcome for the patient. If you analyze the costs of Hep C treatment today compare to the costs of managing untreated Hep C prior to medication being available, you would see benefit. Mr. DiLoreto added that the pharmacists are in a better position to know the overall medication regimen a patient is on than the provider. They can identify possible savings or efficiencies.

The Cabinet member clarified that she was looking at this issue from a larger policy perspective, and how these players could work together to optimize the care and reduce costs. Mr. Shaw provided examples of PBMs negotiating with a manufacturer and looking at shifting from rebates to quality incentives. He also talked about indication based rebates – Humira is used for psoriasis and rheumatoid arthritis but may have better efficacy for one than the other, and he suggested that payment could be based on this instead.

Another member offered her shared perspective as someone in the home care environment, where patients often have multiple, conflicting, changing prescriptions that are complicated to manage. Pharmacists are crucial partners for them and should be properly rewarded. Mr. DeFazio reminded everyone that the focus should be quality, and there should be a reward for that services that pharmacists provide.

Ms. Chamberlin emphasized that the increasing prevalence of Health Savings Accounts are making people more aware of the costs than ever before, and that pharmacists are getting more requests for alternate options. Another member emphasized the importance of an HIE for clearly understanding our healthcare system and costs to which the Chair responded that our new state Health Information Technology Officer was in the audience and was working on health information exchange services.

The presentations concluded with an acknowledgment that many of the issues that were raised in the discussion were being actively explored at the state level, and that all of the elements in care coordination, consumer education, need an importance of transparency, flexibility to respond to consumer clinical needs, and fiscal concerns are critical to improving outcomes.

IV. 2017 Connecticut Legislative/Regulatory/Administrative Efforts Related to Prescription Drug Costs/Oversight of Prescription Drugs

A. The following bills received at least one joint favorable report[29] from a committee—summaries and latest status, including currently filed amendments, are available by clicking on the bill number. (Bills that did not have a public hearing are not included here.)

1. SB 21 -- An Act Concerning Health Insurance Coverage of Orally and Intravenously Administered Medications
2. SB 442 – An Act Clarifying the Right to Enforce Antitrust Laws

[29] A Joint favorable report is a report compiled by the committee clerk on a standard form for each favorably reported bill. Among other things, the JF report summarizes public hearing testimony and lists organizations that support and oppose the bill. Definition from the Connecticut General Assembly Glossary of Legislative Terms and Definitions , available at https://www.cga.ct.gov/asp/content/Terms.asp#J.

3. SB 444 – An Act Authorizing the Health Care Cabinet to Recommend Methods to Study and Report on Total State-Wide Health Care Spending[30]
4. SB 445 -- An Act Concerning Fairness in Pharmacy and Pharmacy Benefits Managers Contracts
5. SB 586 -- An Act Expanding Mandated Health Benefits for Women, Children And Adolescents
6. SB 795 -- An Act Establishing the Office Of Health Strategy and Improving the Certificate of Need Program
7. HB 5077 -- An Act Concerning the Return of Prescription Drugs to Pharmacies
8. HB 7010 -- An Act Concerning Opioids and Substance Use Disorders
9. HB 7042 --An Act Controlling Consumer Health Care Costs
10. HB 7052 – Governor's Bill –An Act Preventing Prescription Opioid Diversion and Abuse
11. HB 7118 – An Act Concerning Biological Products
12. HB 7123 -- An Act Limiting Changes to Health Insurers' Prescription Drug Formularies
13. HB 7124 -- An Act Concerning Maximum Allowable Cost Lists and Disclosures by Pharmacy Benefits Managers, Limiting Cost-Sharing for Prescription Drugs and Shielding Pharmacists and Pharmacies from Certain Penalties

B. The following bills did not receive a joint favorable report:

1. SB 22 -- An Act Limiting Cost-Sharing for Prescription Drugs
2. SB 443 -- An Act Concerning the Monitoring of Health Care Trends by the Attorney General
3. SB 925 – An Act Concerning the Cost of Prescription Drugs and Value-Based Insurance Design[31]

C. Regulatory/Administrative efforts

1. Insurance Department's proposed regulations to review prescription drug formularies as part of plan filings
2. Insurance Department Bulletin HC-113-17 and survey form -- Annual Filing of Formularies
3. DSS – See presentation
4. Comptroller's office -- The Health Care Cost Containment Committee is looking at ways to better control and manage opioid prescriptions, but no actions have yet been agreed upon. Opportunities to lower total medical and pharmacy costs

[30] This bill passed the Senate on May 3, 2017.
[31] This bill received a favorable House report and an unfavorable Senate report.

are a part of ongoing discussions between labor and management. The details of such discussions are confidential.

5. All-Payer Claims Database (APCD) –The APCD is capable of generating reports on pharmacy claims for further research and analysis.

V. Additional Items/Articles Relevant for Further Cabinet Discussion

1. National Academy of State Health Policy – Update: What's New in State Drug Pricing Legislation? http://www.nashp.org/update-whats-new-in-state-drug-pricing-legislation/
2. NAAG *2017 Presidential Initiative Summit: Evolving Changes in the American Healthcare Marketplace*– http://www.naag.org/meetings-trainings/video-and-other-av-archive/2017-presidential-initiative-summit-new-york-city.php
3. Berkeley Research Group - http://www.thinkbrg.com/media/publication/863_Vandervelde_PhRMA-January-2017_WEB-FINAL.pdf
4. Network for Excellence in Health Innovation - Rewarding Results: Moving Forward on Value-Based Contracting for Biopharmaceuticals, http://www.nehi.net/publications/76-rewarding-results-moving-forward-on-value-based-contracting-for-biopharmaceuticals/view
5. Avalere Health – *Drug Pricing: Where's the Future Headed?* – webinar - http://avalere.com/business-intelligence/expert-webinar-series/drug-pricing-wheres-the-future-headed
6. Health Strategies Consultancy LLC for the Henry J. Kaiser Family Foundation – Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain, http://kff.org/other/report/follow-the-pill-understanding-the-u-s/
1. Modern Medicine Network, "Pharmacists Pushing for DIR Relief," http://drugtopics.modernmedicine.com/drug-topics/news/pharmacists-pushing-dir-relief

VI. Identifying Themes and Possible Areas for Further Action

A. Possible concepts for state interaction

1. Transparency in pricing, component costs, rebate mechanism, PBM arrangements
2. Value-based pricing[32]
3. Medication reconciliation

[32] A value-based pricing task force was created in legislation in 2016. The task force never convened.

4. Medication adherence
5. Community pharmacists' role in payment reform models
6. Cost-sharing exposure
7. Cost-effectiveness

B. What are the Cabinet's next steps?
    1. Possible solutions within existing authority of Cabinet
    2. Administrative Solutions
    3. Potential Legislative Solutions
    4. Revisit earlier issue areas from Cabinet Report factoring in additional information from 2017
    5. Review other states' legislative efforts in 2017[33]
    6. Analysis against principles of potential options for recommendation
    7. Recommendations

[33] See NASHP's Prescription Drug Work Group 2017 legislative tracker, available at http://nashp.org/wp-content/uploads/2016/09/2017-Rx-Legislation-Tracker-4.11.pdf, access on May 2, 2017.

Appendix A

Cabinet's Enabling legislation

Connecticut General Statutes § 19a-725

[Subsections (a) and (b) address membership]

(c) The Health Care Cabinet shall advise the Governor regarding the development of an integrated health care system for Connecticut and shall:

(1) Evaluate the means of ensuring an adequate health care workforce in the state;

(2) Jointly evaluate, with the chief executive officer of the Connecticut Health Insurance Exchange, the feasibility of implementing a basic health program option as set forth in Section 1331 of the Affordable Care Act;

(3) Identify short and long-range opportunities, issues and gaps created by the enactment of federal health care reform;

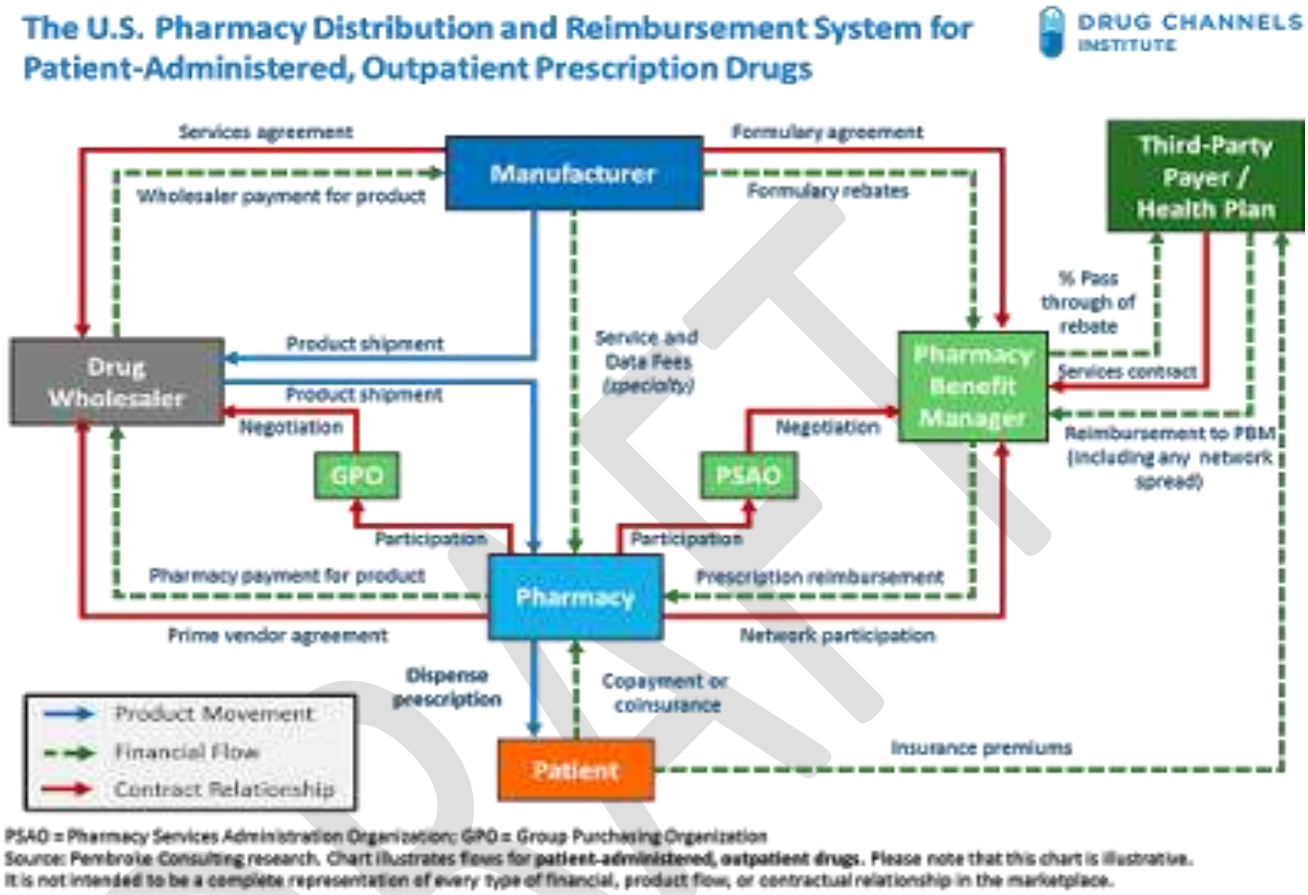
(4) Review the effectiveness of delivery system reforms and other efforts to control health care costs, including, but not limited to, reforms and efforts implemented by state agencies; and

(5) Advise the Governor on matters relating to: (A) The design, implementation, actionable objectives and evaluation of state and federal health care policies, priorities and objectives relating to the state's efforts to improve access to health care, and (B) the quality of such care and the affordability and sustainability of the state's health care system.

(d) The Health Care Cabinet may convene working groups, which include volunteer health care experts, to make recommendations concerning the development and implementation of service delivery and health care provider payment reforms, including multipayer initiatives, medical homes, electronic health records and evidenced-based health care quality improvement.

(e) The office of the Lieutenant Governor and the Office of the Healthcare Advocate shall provide support staff to the Health Care Cabinet.

Appendix B



PSAO = Pharmacy Services Administration Organization; GPO = Group Purchasing Organization
Source: Pembroke Consulting research. Chart illustrates flows for **patient-administered, outpatient drugs.** Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.