DRAFT for Discussion Purposes
Connecticut Health Care Cabinet
Work Group on Prescription Drug Costs Determination and Cost Containment
Prioritized Recommendations
December 2017

Work Group Charge

This work group was charged to develop recommendations to the Health Care Cabinet on ways to lower prescription drug costs for consumers and health care purchasers (self-insured employers, insurers, government purchasers). The group examined policies in three broad categories:

- Price Transparency
- Price regulation
- State agency purchasing policies (other than value-based contracts)
    - Impact on state agency costs
    - State purchasing that can benefit non-state individuals or entities in Connecticut

The third category proved to be more relevant to the charge of the Value Based Pricing Work Group and was referred to it.

Recommendations

I. Increase transparency of pharmaceutical manufacturer prices

a) **ADMINISTRATIVE:** Require insurers to report information to the CT Insurance Department (CID) on the impact of prescription drug price increases on premiums.

i) The CID is currently seeing rate filings with a 22-23% impact of drugs on premiums. About 40% of the drug spend now is from 1-2% of specialty drugs. One carrier reports 38% of the drug spending is coming from specialty drugs. Obtaining more detailed information would identify more clearly which drugs are driving that spend. The CID has the administrative authority and is willing to ask carriers for more detailed reporting on how much prescription drug price increases account for requested premium rate increases. Any information that goes into the rate filing will be available publicly.

ii) California's recently enacted statute requires all manufacturers to report to payers 60 days in advance of launch prices and to report on an increase in the price of a drug that exceeds certain thresholds. The CID will have access to this information from all the national carriers through the bulletin requiring it as part of the rate

filing. CID believes that collecting the same or similar prescription drug data that the California Insurance Department will begin to collect in their rate filings, can be done without a new statute. It can be done as part of the annual rate filing bulletin issued by the CID. The only unknown would be the exact set of prescription drug data that each carrier would have to submit as part of their annual rate filing, and when this information could be provided. It may have to wait until the 2019 rate filing period, when California will begin collecting information.

b) **ADMINISTRATIVE:** Explore the option of creating a Drug Review Board (DRB) of clinicians, health economists and consumers to analyze and determine whether drug prices and price increases are justified, and result in putting at risk the health of CT patients. The new Office of Health Strategy should further research and refine this recommendation, including identify where in state government the DRB could be located, its budgetary needs, potential revenue sources and any needed legislative changes.
   i) Conflict-of-interest rules should be developed for the membership of the drug review board (such as those employed by the Federal Drug Administration).
   ii) Require CID to share information with the DRB. Allow the state Medicaid program and the State Employee Health Plan to refer drugs to the DRB for review. Allow the DRB access to de-identified claims data through the APCD to perform their analysis.
   iii) Give the DRB authority to request additional information from manufacturers to inform its review process. Exempt information from FOIA, or clarify that existing exemptions apply.
   iv) Change CT price gouging statutes to include unjustified pharmaceutical prices or price increases as determined by the DRB. Give the AG authority to pursue price gouging cases against manufacturers of both generic and brand name drugs, as referred by the DRB.

c) **LEGISLATIVE:** Require manufacturers, PBMs & health insurers to disclose to OSE the funding they provide to nonprofit patient advocacy groups, and post such information on a publicly available website. (Related to Recommendation 4b of Value Based Pricing Work Group)

II. Increase transparency and accountability of Pharmacy Benefit Managers

a) <u>Consumer Out-of-Pocket Payments Based on Negotiated Price</u>

i) **LEGISLATIVE:** Require that all prices negotiated between PBMs, manufacturers and payers pass through to the consumer at point-of-sale, and that consumer co-pays/coinsurance will be based on these negotiated prices. (Note: There may be a one-time premium increase as a result).

(1) Prohibit retroactive pharmacy fees to ensure transparency and that all fees are reflected at point of sale:
   (a) Prevent insurance companies and PBMs from applying Direct and Immediate Remuneration (DIR) practices (typically found in Part D plans) to commercial plans
   (b) Example from Louisiana: A health insurance issuer or a pharmacy benefit manager may not directly or indirectly charge or hold a pharmacist or pharmacy responsible for any fee related to a claim:
      (i) That is not apparent at the time of claim processing;
      (ii) That is not reported on the remittance advice of an adjudicated claim;
      (iii) After the initial claim is adjudicated.
   (c) Example from pending federal legislation: Each contract entered into with a plan sponsor shall provide that after the date of receipt of a clean claim submitted by a pharmacy, the plan sponsor may not retroactively reduce payment on such claims directly or indirectly through aggregated effective rate or otherwise except in the case such claims found to not be a clean claim during the course of a routine audit as permitted pursuant to a written agreement between the plan sponsor and such pharmacy.
      (i) Define what a "clean claim" is (those without any defect, impropriety or fraud).

b) <u>Audits</u>

i) **LEGISLATIVE**: Require that PBMs doing business with clients in CT allow and cooperate with audits when requested by such clients and establish minimum standards regarding the conduct of such audits.
   (1) <u>Requirement</u>
      (a) That PBMs which have any contractual agreement(s) with any clients in Connecticut must allow and cooperate with audits, no more frequently than annually, when requested by its insurer, employer or multiemployer, or other client.
   (2) <u>Minimum Standards</u>
      (a) For such audits, the PBM clients shall have sole authority to select and hire the qualified auditor of their choosing and shall be solely responsible for such auditor's costs.
      (b) Compliance with such audits shall include electronic transmittal of required data, contracts and other information, as appropriate and requested by such auditor. Any such transmittal of data and/or other information shall, at all times, be protected using encryption and other standard security measures, by all parties. Such transmittal of data and other information should be subject to and covered by appropriate non-disclosure agreements
      (c) PBM shall provide all requested data and other information within 30 calendar days of receipt of auditor's request.
      (d) Upon receipt of the audit findings, PBM has 30 calendar days to contest any such findings and another 30 calendar days to reconcile and resolve any outstanding issues regarding such audit findings with PBM client.

c) <u>Fiduciary Responsibility</u>

i) **LEGISLATIVE:** Require PBMs to exercise "fiduciary responsibility" (i.e., they must act in their client's best interest) when contracting in the state of Connecticut. The CT Department of Consumer Protection should be considered as the potential agency with enforcement authority.

d) <u>LEGISLATIVE: Transparency in Maximum Allowable Cost (MAC) Price</u>

i) The contracts that PBMs have with pharmacies in the state of Connecticut shall not reimburse the pharmacy less than the reasonable cost at which the pharmacy purchases the drug.
   (1) MAC updates and disclosure
   (2) Require PBMs to update MAC lists every 7 days and make the lists available in a searchable spreadsheet format.
   (3) Maintain a procedure to eliminate products from MAC lists if they don't satisfy requirements for inclusion.

ii) Inclusion on MAC list
   (1) Drug must have at least three nationally available, therapeutically equivalent multiple source generic drugs.
   (2) The products must be listed as therapeutically and pharmaceutically equivalent or "A" or "AB" rated in the "Orange Book."
   (3) Must be available for purchase by all pharmacies in the state from a national or regional wholesaler

iii) Right to appeal
   (1) PBM must establish an appeal process
   (2) If the appeal is denied, the PBM must provide the reason for the denial and identify where the drug can be purchased at a price at or below the MAC price.
   (3) If the appeal is upheld, the PBM must adjust the MAC list and make the adjustment retroactive to the date of initial adjudication. The adjustment must be made for all pharmacies.

iv) Enforcement
   (1) Specify which agency will have enforcement authority.
   (2) Establish a private right of action permitting pharmacies to sue a PBM that violates these provisions.

III. Increase likelihood of consistent medication use, increase transparency to and education of consumers

a) **LEGISLATIVE:** Set co-payment and co-insurance maximums per month of $250 for most plans ($500 for bronze ACA plans), per 30 supply.
   i) Consider modeling legislation on a California law that set these limits. California conducted an actuarial analysis finding that there would not be an increase in premiums if monthly copay or co-insurance caps were set at these levels. The California law applied differently to high deductible health plans, but limited annual deductibles for outpatient prescriptions to twice the copay/ co-insurance limits. CID believes there may initially be an increase to premiums. The cost savings may come over time as individuals might be more apt to adhere to their medication regiment if there was a monthly deductible versus annual. See OLR Research Report, State Laws Limiting Prescription Drug Cost Sharing.

b) **ADMINISTRATIVE**: The Office of Health Strategy should further research and refine the following recommendations
   i) Require benefit designs that separate and have much lower deductibles for prescription drugs than medical deductibles.
   ii) Require benefit designs that separate & have a lower OOP maximum for prescription drugs vs. medical OOP max.
   iii) Eliminate co-pays for asthma, high blood pressure, diabetes & high cholesterol medications, and consider also congestive heart failure and COPD.

c) **LEGISLATIVE**: Adjust fill-dates for newly added medications to synchronize pick-up of all meds at the same time each month. CT already has a medication synchronization law that can perhaps be amended.

d) **ADMINISTRATIVE:** Require on-line availability of price data for drugs covered by co-insurance. This information should be available on the insurer's website during open enrollment so consumers can make informed choices.
   i) CID does not believe they have the authority to require on-line availability of price data for drugs covered by co-insurance. They believe that many carriers already have prescription drug cost estimation tools available to their members, but CID will research this. There are requirements concerning medical procedures. It may be a matter of expanding that authority.
   ii) Making information available to consumers about price variation across pharmacies, which would most benefit uninsured consumers should be considered as part of this administrative measure.

e) **ADMINISTRATIVE**: Compile reports from the APCD to illustrate trends in out-of-pocket costs, for use by the Office of Health Strategy, the APCD will be housed starting in 2018.

f) **LEGISLATIVE:** Educate consumers about the different types of patient assistance and coupon programs that may help them afford their meds.
   i) Incorporated into Recommendation 4a of the Value Based Pricing Work Group.

g) **ADMINISTRATIVE:** Referred to Education Work Group:
   i) Educate consumers that it is possible to have 90-day supplies of chronic disease medications filled at local pharmacies, not only by mail order.
      (1) Consumers can do this currently but may not be aware. Need confirmation.