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

Tuesday, August 29, 2017
11:00am – 12:00pm
Online Zoom Meeting

Members present online: *Chair* – Frances Padilla (UHCF), Josh Wojcik (Office of Comptroller), Ted Doolittle (OHA), Marghie Giuliano (CT Pharmacists Assoc.), Bob Clark (Office of Attorney General), Rob Blundo (AHCT), Raul Pino (DPH)

Members excused: Katherine Wade (Insurance Dept.), Bill Handelman (Nephrology Assoc.), Bob Tessier (Taft-Hartley)

Others present: Jill Zorn (UHCF), Carole Dicks (UHCF)

Frances Padilla called the meeting to order 11:01am.

Public Comment: No comment

Meeting Goals:

- To understand the various supply chain transparency issues as they differ from PharmA transparency.
- To begin clarifying where states are intervening to achieve greater transparency.
- To begin identifying possible data needs to inform future recommendations.

Supply Chain Transparency: How does the State Employee Health Plan supply chain work? How are costs added throughout the supply chain by stakeholders such as the Pharmacy Benefit Managers (PBM)? (Josh Wojcik and Marghie Giuliano anchored the discussion.)

Showed a chart entitled "*RX Pricing Along the Supply Chain*". Frances referred to an article in the materials titled "The Prescription Drug Chain 'Black Box'" by Henry C. Eickelberg (2015) noting it was very informative.

Josh Wojcik began the discussion by walking through how the State Employee Health Plan works. He explained that the state is in the 5th year contract with CareMark (usually do 3 year, two single years added on to end).

He gave an overview of how the traditional benefit manager contract sets discounts for generic brand and specialty drugs as well as additional discounts for 90 day supply. State pays dispensing fee along with discounted rate associated with each drug. It does not pay an admin fee or any dollars directly to PBM. The PBMs revenue comes in two forms: one - differential between the reimbursement that Comptroller's is paying to the PBMs and reimbursement they're paying to the network pharmacy; second - percentage reimbursement from manufacturers they negotiate similar to rebate, but not considered a rebate, revenue directly to PBM. State gets 100% of negotiated rebate.

PBM are changing way they are operating – used to direct market share towards preferred drug on tiers. Moved to straight exclusion of nonpreferred brand drugs. Allowed them more leverage negotiating

w/manufacturers. Adoption of SEBAC agreement. Moving to standard formulary includes prior authorization. Access to more significant rebates on brand name drugs. Generate savings of a little bit more than $20m a year to move to formulary.

PBMs are now including price caps in contracts which limits the price increase a PBM will pay.

PBM provides:

- Claims information which shows gross cost of each drug sold thru pharmacy (i.e., what we are paying CVS). Does not show final cost of drug (rebates paid out on quarterly basis); don't know how rebates associate with individual claims. Audits can be done annually to make sure appropriate amount of rebates are given for our claims. Looking at contractor to do audit.
- administer prior authorization and appeals – also, fraud prevention, claim processing, eligibility – primary responsibilities on SEHP behalf.

Issues with PBMs

- no incentive to reduce quantity of preferred drug. Pushing things to 90 day supply that can be inappropriate.
- 5 year contract (3 year plus 2 one year extensions) - over life of contract, discounts negotiating tends to increase over time. Stuck in contract, not getting market rates anymore. Savings flowing to PBM rather than coming back to plan. Have to push for a market check each year (within first 3 year).
- Coordination with medical plan is lacking. Incentives for PBM are only in establishing customer base, reduction in pharmacy spend. Don't care re: impact on medical side. Showing pharmacy trend only. In some instances additional spending on pharmacy side may result in lower cost on medical side.

What is the distinction between employees and retiree? Historically, no distinction, but will be now. Open formulary thru CVS / Silver Script (subsidiary) over last decade. Moving forward – Medicare Advantage (United /PBM Optum) for retirees. Active will now be more restrictive. Retirees not as restrictive. Difference in volume – which one is larger: 40% Medicare retirees / 60% active and Pre-65 retirees.

Points made in article – PBMs have incentive to drive demand. How do you mitigate that?

Right now – ad hoc – reports from employees pushed to 90-day supply inappropriately. Chronic disease, want 90 day supply. Other instances – opioids, not 90 day supply. Drugs for psychological disorders – doctors need to adjust strength, etc. Struggle with PBM on moving away from 90 day. Get prescribing info by hearing from doctors or employees – happenstance as information is given.

Very interested in looking at – when we go out to bid again – looking at more transparent forms of PBM contract and other ways to control activities of PBM. Limited right now.

Marghie Giuliano from the CT Pharmacists Association: not always 90 day supply is way to go – should be bigger part of negotiating.

For example, forced to get 3-4 asthma inhalers at a time and no way to opt out. Good health and healthcare – reduce costs. Renegotiation opportunity. Could go with 90 day supply only when prescriber would order it. Opportunities to address waste that are in the system.

Robert Clarke – 90 day protocol? – collective bargaining plan? Drive down costs? What are constraints?

2009 or 2011 was part of savings state was attempting to achieve. Ability to identify instances were not appropriate is a challenge. But there is no collective bargaining restriction.

Claims data possible to give better information? Challenge with claims data is that it is independent of medical claim (very vanilla). You only get "filled here, at this rate".

Marghie Giuliano gave a summary of Supply Chain issues from the perspective of pharmacy. She used the Altarum/Healthcare Value Hub supply chain graphic as a guide.

Manufacturer sets wholesale acquisition price and the rebates and discounts at that stage of the supply chain is a "big black hole".

Based on Josh's statement of getting 100% of rebates negotiated, unless you are shown what the manufacturer has negotiated with the state for rebates, she suggested challenging that SEHP is getting 100% (you are not being shown what the rebate negotiated with the manufacturer is). Those are areas where there should be more transparency.

Look at how drugs are billed – PBMs will charge employers based on the package size of 100 pills, when in fact the package size purchased is typically larger (1000's and up which gives a cost savings or spread to the PBM) When using their mail order facilities – probably purchasing in larger supply (like 50,000) which gives them better price, and savings are not passed on to plan sponsor. More transparency needed there as well.

Administrative fees – don't know what those actually are.

Manufacturer to wholesaler – black hole where those discounts are too. No idea – In some instances where there is vertical integration of PBM, Retail pharmacy and mail order it gets even more complicated. In the instance of CVS health, CVS also acts as wholesaler as well as retail (CVS is both PBM and pharmacy).

Medicaid is paying pharmacy on actual acquisition cost. Because of this new reimbursement methodology, dispensing fees more accurately reflect cost of dispensing….so the DSS now reimbursed at AAC plus $10.75.

When looking at savings for 90-day supply, the thought behind it is to save on dispensing fees. In the SEHP when dispensing at 90 days, dispensing fees are zero, no real savings. However, it does benefit employees if they don't have to pay copays 3 times for 90 day supply. Incentives for Mail order – benefit of no co-pay or reduced copay.

Having prescription data siloed from medical data is a problem; healthcare professionals should ensure patient is on right drug. Pharmacists don't know diagnosis – know what meds are for, but don't have access to lab data, etc. Info needs to be more integrated.

Many ways to price a drug. Pharmacies typically don't have access to those types of rebates. Volume discounts, etc. Medicare part D instituted Direct and Indirect Remuneration (DIR) clawback – This occurs 90 days after pills dispensed – claiming much broader claims. Fed Gov't looking at that. These DIR fees have mushroomed much more than intended when med part D came out. It's becomes more complicated than buying the drug, selling the drug, when all of the sudden, you get PBM saying that they'll start deducting these DIR fees from your reimbursements. It is very disruptive in a small business, because there's no formula of what it's based on. No formula – big black hole in Medicare part D world. And we don't know who gets all that $$.

Make sure customer is benefiting. Important that we look for transparency in every step of the way, pharmacies really have nothing to hide. We're just trying to make sure consumers can access drugs and afford it. You see where towns come up with drug discount cards, those cards are already negotiated with the PBMs and pharmacies are taking the hit on the discounts, we subsidize those discounts. We would like to make sure the reflection of these price savings end up with the consumer.

Frances: Medicaid is paying pharmacy more than acquisition cost? Marghie: Part of Obamacare – Medicaid being restructured – to be able to pay pharmacy average actual acquisition cost. Price published. Federal survey found PBMs were making money on the drug and then on the dispensing fee. Federal gov't recognized that pharmacy is a for-profit business so if it's not make money on the drug, it should make money on the dispensing fee. So Medicaid pays pharmacy $10.75 dispensing fee over and above average actual acquisition price.

Frances summarized the discussion so far. There are clearly supply chain transparency issues, like PBMs having more information than the payers. Need further discussion about where along the set of challenges ("black holes") on the supply chain there could be some interventions. We need to keep drilling down on. She invited thoughts from the group, noting that the article on the prescription supply chain "black box "written from the payer perspective, offers some strategies.

Marghie suggested there should be some push-back to the role of PBMs. PBMs started to assist in the administrative function – who is eligible, paying claim. Payer plays a bigger role. PBMs are not fiduciaries. Only responsible for themselves. She suggested that the State Employee Health Plan should ask them to take on the fiduciary role and question why if they say no.

Take step back, not bundling all of our things in PBM benefit. Give you opportunity to really affect overall healthcare costs instead of bundling in with drug payments. Establish other partnerships to reduce costs.

Josh noted there are challenges in moving to a more transparent PBM model. Have to consider the immediate cost of doing so – what do you lose – significant rebates that large PBMs negotiate with large manufacturers would be lost. If you go out to bid – price transparent PBM, end up with lower level rebate structure. Challenge is to be competitive in terms of rebates.

Models out there – initial hit will happen – we're always looking to save a dollar now, and don't look down the road. We get blindsided in long run. Certain opportunities in place, see longer term savings. Pharmacy is volume focused – driving price, driving healthcare.

Frances mentioned one strategy from the Eickelberg article, unbundling the mail order contract from the administrative services contract, and asked what the advantages and disadvantages of this approach would be.

CVS allows people to get same price in mail order and in stores. Push to mail order – the payer could end up paying more, re-packagers – smaller bottles – they determine price. PBM in mail order could inflate price.

Bob Clark – if there is a rule in place that Medicaid is supposed to get best price, then how much leverage couldn't the State plan have since it's big enough to go out to bid the PBM contract, if it says the state won't pay more than x% of Medicaid price? Simplified way of thinking about it. PBMs wouldn't get prices below Medicaid. Medicaid as a baseline from which to start.

PBMS can't or won't do it.

California had ballot to reference prices to the Veterans Administration.

Purely market based system – like we are operating in now.

State cannot get 340B price. Have to be a certain entity to get 340B pricing.

Interesting concept – PBM would be taking on the risk. Would that be of value to them.

Frances suggested the group take up the discussion again and find out if any other states have entertained this possibility.

The next meeting is scheduled for Monday, September 11, 2017 from 3:00pm – 4:00pm. Would like to extend to 5pm and have in-person. Carole will send out Doodle Poll to members.

Meeting adjourned at 12:03pm.