Pharmacy Cost Mitigation Strategies Work Group
September 19, 2023

"We collaborate, out of a shared concern and responsibility for all Connecticut residents, to develop consensus models that advance equity and consumer affordability of healthcare in our state."

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Meeting Agenda

Time	Topic
11:00 a.m.	I. Welcome
11:05 a.m.	II. Review recommended proposals for: • Reference-based payments • Pharmacy benefit manager strategies • State-contracted production of generic drugs
11:50 a.m.	III. Discuss additional proposals • Penalizing excessive price increases • Inclusion of pharmacy expense in Total Cost of Care contracts
12:25 p.m.	III. Wrap-up and next steps
12:30 p.m.	IV. Adjournment

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Workplan

Meeting	Content
Meeting #1: June 15, 2023	• Review workplan • Overview of recommended strategies • Update on Cross-State Pharmacy Workgroup
Meeting #2: July 6, 2023	• Reference-based payments
Meeting #3: July 27, 2023	• Reference-based payments (continued) • State-contracted production of generic drugs
Meeting #4: August 17, 2023	• Pharmacy Benefit Manager (PBM) strategies • Update on Cross-State Pharmacy Workgroup
Meeting #5: September 7, 2023	• PBM strategies (continued) • State-contracted production of generic drugs (continued)

Meeting #6: September 19, 2023	• Recap and review of all pharmacy cost mitigation strategies discussed to date
	• Review additional proposals
	  • Penalizing excessive price increases
	  • Inclusion of pharmacy expense in Total Cost of Care contracts

Recommended Proposal for Reference-Based Payments

Major Components of Reference-Based Payments

- **Benchmarks for determining the state payment limits** would be calculated as an average of the following:
  - To-be-negotiated Medicare maximum fair prices
  - Average international prices from a limited number of OECD countries
  - Direct federal purchaser prices, represented primarily by the VA paid prices
- **Targeted drugs subject to the state payment limit**: Medicare Part B and D drugs as determined by CMS pursuant to the Inflation Reduction Act (IRA) + state-defined list of up to 50 top spend prescription drugs, with physician-administered drugs phased in over time
- **Regulated transactions**: All in-state payer and purchaser transactions

Benchmarks for Determining the State Payment Limit

The state payment limit would be determined based on an average of:

1) Medicare Maximum Fair Prices negotiated under the IRA
2) Average international prices from 4-6 Organization for Economic Cooperation and Development (OECD) countries that have publicly available pricing information
3) Direct federal purchaser payment rates, using the prices paid by the U.S. Department of Veterans Affairs, if available
   - For drugs excluded from the VA formulary, the benchmark would equal the "Big Four" purchaser amount available to the other largest direct federal purchasers (i.e., Department of Defense, Coast Guard, and Public Health Service).

Targeted Drugs Subject to the State Payment Limit (1 of 2)

- The number of pharmaceuticals subject to state payment limits would scale up over time and would include:
  - up to 50 of the highest spend retail and physician-administered drugs for the commercial market the state; and
  - Medicare Part D and B drugs that will be subject to Medicare Maximum Fair Price negotiations under the IRA
- If the eligible Medicare Part B or D drugs include the top commercial market spend drugs, the total number of drugs in the state-defined list would be reduced accordingly.

Targeted Drugs Subject to the State Payment Limit (2 of 2)

- The number of drugs subject to the state payment limits would expand over time based on: 1) the drugs subject to **Medicare maximum fair price (MFP)** negotiations under the IRA, and 2) a **state-defined list** of the highest spend drugs in the commercial market, with phase-in of physician-administered drugs over time
  - 2027: Medicare MFP Part D drugs + state's top 10 commercial market retail drugs
  - 2028: Medicare MFP Part B & D drugs + state's top 20 commercial market retail drugs
  - 2029: Medicare MFP Part B & D drugs + state's top 30 commercial market retail and physician-administered drugs
  - 2030: Medicare MFP Part B & D drugs + state's top 40 commercial market retail and physician-administered drugs
  - 2031 and beyond: Medicare MFP Part B & D drugs + state's top 50 commercial market retail and physician-administered drugs

Regulated Transactions

Regulated in-state purchaser and payer transactions would include:

- Pharmacy (retail, specialty and mail-order) purchases from:
  - Pharmaceutical manufacturers
  - Wholesale distributors
- Hospital and other provider purchases from:
  - Pharmaceutical manufacturers
  - Wholesale distributors
- Fully insured commercial insurer payments and state employee health plan payments to:
  - Hospitals and other providers
  - Pharmacies (including retail, specialty and mail-order)

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Recommended Proposals for PBM Strategies

Overview of Work Group Recommendations for PBM Strategy Proposals

- Advance legislation for the following strategies:
  1) Strengthen rebate transparency
     a) Expand the definition of rebates
     b) Require drug-specific rebate information
  2) Prohibit spread pricing
- Promote educational efforts focused on:
  1) Promotion of fee-based pricing by employers
- Further explore the following strategies:
  1) Require additional PBM reporting (e.g., conflicts of interest, average PBM PMPM costs, contracting with rebate aggregators)
  2) Require state licensure of PBMs

Strengthen Rebate Transparency (1 of 3)

- **PBM legislative proposal #1(a)**: Expand the current CT state law definition of rebates to capture the complexity of rebate relationships and how they are funneled through various layers within and adjacent to the PBM.
- The revised definition of rebates would apply to
  a) Existing PBM reporting requirements for:
     - the aggregate amount of drug formulary rebates the PBM collected from manufacturers, and
     - the aggregate amount of all rebates that the PBM retains (total rebates excluding the amount paid to health carriers) (CT Gen Stat § 38a-479ppp)
  b) Any future transparency requirements or regulations regarding rebates

Strengthen Rebate Transparency (2 of 3)

Rebate definition § 38a-479ooo	Proposed revised definition
A **discount or concession**, which affects the price of an outpatient prescription drug, that a **pharmaceutical manufacturer directly provides to a (i) health carrier** for an outpatient prescription drug manufactured by the pharmaceutical manufacturer, or (ii) **pharmacy benefits manager** after the manager processes a claim from a pharmacy or a pharmacist for an outpatient prescription drug manufactured by the pharmaceutical manufacturer.	**Price concessions, price discounts, or discounts of *any sort* that reduce payments**, including a partial refund of payments or any reductions to the ultimate amount paid; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, **and all other compensation to carriers, their PBMs, rebate aggregators, or subsidiaries.**

Strengthen Rebate Transparency (3 of 3)

- **PBM legislative proposal #1(b)**: Require drug-specific rebate information for a limited number of prescription drugs that have the highest total expenditures in the state

Prohibit PBM Spread Pricing

- **PBM legislative proposal #2**: Prohibit PBMs from engaging in the practice of spread pricing.
  - Spread pricing occurs when a PBM charges a health plan or employer a higher price for a prescription drug than what the PBM actually pays the pharmacy for that prescription, and the PBM retains the difference as profit.
  - Instead, PBMs would use a pass-through pricing model, where the PBM passes through the amount charged by the pharmacy to the health insurer.
  - Since the PBM does not retain the "spread" amount, the PBM typically charges an administrative fee.

Fee-Based PBM Pricing

- **PBM educational proposal:** Pending the elimination of spread pricing, the State should promote fee-based pricing by self-funded employers via educational efforts.
  - Under current payment structures, PBMs are typically paid as a percentage share of the drug's cost, which creates incentives for PBMs to prefer higher-cost drugs.
  - With pass-through pricing, PBMs are paid administrative fees as their only source of revenue under the contract, charging straightforward administrative fees to the carrier or employer, often structured as a flat fee per prescription.
  - The elimination of spread pricing will likely lead to PBMs charging administrative fees instead in an effort to maintain their profits.

PBM Strategies for Further Exploration (1 of 2)

1) Expand PBM transparency and reporting requirements to include:
   - Average PBM PMPM costs in order to help health plans and self-insured employers better evaluate PBM options
   - Any activity or policy that directly or indirectly presents any conflict of interest with the PBM's relationship with the health plan client, including disclosure of all organizations with which the PBM is affiliated
   - Information that differentiates between payments made to pharmacies owned or controlled by the PBM and those not affiliated with the PBM
   - Terms and conditions of any contract/arrangements between the PBM and any other party relating to PBM services to health plans (e.g., rebate aggregators)

Should any of these reporting requirements be moved to recommended legislative strategies?

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PBM Strategies for Further Exploration (2 of 2)

2) Require PBMs to be licensed with the state in order to operate as a PBM in the state.
   - CT state law currently requires registration of all PBMs operating in the state (CT Gen Stat § 38a-479bbb)
   - While registration enables the state to obtain information from PBMs, state licensure would bring PBMs under the regulatory authority of CID, which would ensure that CT has appropriate enforcement mechanisms for any further state regulation of PBMs.

Recommended Proposals for State-Contracted Production and Distribution of Generic Drugs

Strategies to Promote State-Contracted Production and Distribution of Generic Drugs

- Based on discussion of California's current efforts around state-contracted production and distribution of generics, and a follow-up discussion with Civica Rx, the Work Group recommends *further exploration* of the following strategies:

1) Establish upper payment limits for generic drugs.
    - For generic drugs that have lower-cost alternatives available on the market, the payment limit could be set at the price of the lower-cost option.
    - Alternatively, the payment limits could be set via a formula, such as 120% of the National Average Drug Acquisition Cost (NADAC).
2) Explore opportunities for CT to provide capital investment to fund the development, production, and/or distribution of generics.

Penalizing Excessive Price Increases

Multi-State Rx Pricing Strategy Workgroup

- As a reminder, CT is participating in the Multi-State Pharmaceutical Pricing Strategy Workgroup, with a goal of identifying aligned strategies to bring down pharmaceutical price growth that states can jointly champion in the 2024 legislative session.
- To date, the Multi-State Workgroup participants have conveyed interest in pursuing both reference-based payments *and penalizing excessive price increases.*
- In order to maximize alignment across states, we recommend adding this strategy to the pharmaceutical strategies that this Work Group recommends to the Healthcare Cost Growth Benchmark Steering Committee.

Penalizing Excessive Price Increases Overview (1 of 2)

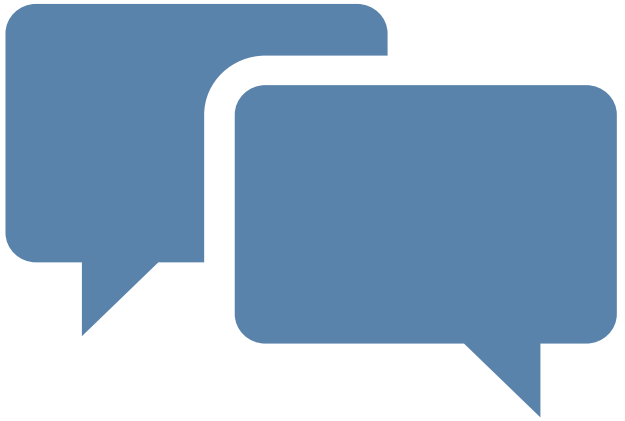
- Under the state's taxing authority, Connecticut would penalize pharmaceutical manufacturers that increase the Wholesale Acquisition Cost of drugs above the benchmark rate increase.
  - All drugs sold in the state would be subject to the benchmark, except for drugs subject to state payment limits, and provided that drug sales exceed a certain dollar threshold.
- The benchmark increase would be defined as the Wholesale Acquisition Cost in the base year, adjusted annually by CPI-U.
  - CPI-U is used to limit price Medicaid increases through the rebate program, and Medicare prices increases through the Inflation Reduction Act.

Penalizing Excessive Price Increases Overview (2 of 2)

- The penalty would be set to 80 percent of the excessive price increase.
  - Set at 80 percent based on NASHP model law to avoid legal challenge
  - Calculated as the difference between revenue generated under the manufacturer's actual price increase and the revenue that would have been generated using the benchmark rate increase
  - In order to calculate the amount of the penalty, any manufacturer subject to a penalty would be required to report information on the total unit of sales from the manufacturer to an in-state wholesaler, provider, or pharmacy
- Penalties paid by manufacturers would be earmarked towards programs to offset prescription drug costs for consumers.
  - *Are there ways to tie the excessive price threshold to actual costs incurred by consumers?*

Discussion

- Do you support adding this strategy to the pharmaceutical strategies that the Work Group recommends to the Healthcare Cost Growth Benchmark Steering Committee?



Inclusion of Pharmacy Expense in Total Cost of Care Contracts

Include Pharmacy Expense in TCOC Contracts

- **Strategy**: Public and private payers include pharmacy spending when setting Total Cost of Care (TCOC) budgets for shared savings and shared risk provider contracts.
  - By including pharmacy expense, provider organizations will have an incentive to prescribe the most cost-effective drugs.
- **Strategy in Use**: Provider risk contracts across the country frequently include pharmacy spending in the TCOC budget.

Including Pharmacy Expense in TCOC Contracts: Ideas for Discussion

- The Work Group could recommend a broad mandate on the fully-insured market requiring that, to the extent that payers have TCOC contracts of any sort, such contracts must be inclusive of pharmacy spending.
- Alternatively, the Work Group could recommend the development of a series of statewide targets that guide payers to use more and increasingly advanced payment models each year, with a requirement that contracts must include pharmacy spending to qualify for meeting the target.

Wrap-up and Next Steps

- The Work Group's recommendations will be presented to Healthcare Benchmark Initiative Steering Committee Meeting on Thursday, September 28th.

Appendix

Connecticut PBM Study (PA 23-171 §7)

- **The Office of Health Strategy, in consultation with the Insurance Department, shall conduct an analysis of PBM prescription drug distribution practices**, including, but not limited to:
  - spread pricing arrangements,
  - manufacturing rebates and transparency,
  - fees charged,
  - financial incentives for adding drugs to health plan formularies, and
  - an evaluation of prescription drug distribution practices conducted by pharmacy benefits managers in other states.
- Such report shall provide recommendations (1) to reduce prescription drug costs for consumers, and (2) for the regulation of pharmacy benefits managers in the state.
- Analysis and report to be completed no later than January 1, 2025.

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PBM Study: Scope of Recommendations

The RFP contains further details on the PBM practices to be analyzed, and further specifies the recommendations the study shall consider:

- Restricting rebate contracting and the impact on the overall cost of the prescription drugs to consumers, if any
- Requiring formulary tier placement of generics to reflect total cost to the health system
- Requiring transparent PBM reporting
- Requiring PBM contracts to use fixed fees per transaction
- Examining the PBM market from an antitrust perspective
- Imposing fiduciary requirements on PBMs and insurers
- Providing audit rights for employer and government purchasers
- PBM transparent pass-through models with cost transparency
- A transparent, competitive cash market model for low-cost generics

Connecticut PBM Reporting Requirements

PBM Reporting (CT Gen Stat § 38a-479ppp)

- PBMs are required to report to the insurance commissioner:
  - the *aggregate amount* of drug formulary rebates the PBM collected from manufacturers, and
  - the *aggregate amount* of all rebates that the PBM retains (total rebates excluding the amount paid to health carriers)
- The CID publishes this information on an annual basis.

Carrier Rebate Reporting Requirements

Carrier Reporting (CT Gen Stat § 38a-479rrr)

- Health carriers are required to certify to the commissioner that they account for all rebates when calculating plan premiums.

CID Annual Report on prescription drug rebates (CT Gen Stat §38a-479ttt)

- CID publicly reports health carrier rebate practices, including:
  1) The manner-in-which the health carrier accounted for rebates in calculating premium for health care plans during such year.
  2) A statement disclosing whether, and describing the manner in-which, the health carrier made rebates available to insureds at the point of purchase during such year.
  3) Any other manner-in-which the health carrier applied rebates during such year.