Pharmacy Cost Mitigation Strategies Work Group
September 7, 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
10:00 a.m.	I. Welcome
10:05 a.m.	II. Recommendations for PBM strategies (continued)
10:30 a.m.	III. State-contracted production of generic drugs (continued)
10:45 a.m.	IV. Inclusion of pharmacy expense in Total Cost of Care contracts
11:05 a.m.	V. Penalizing excessive price increases
11:25 a.m.	VI. Wrap-up and next steps
11:30 a.m.	VII. 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
	  • International, Medicare, other
	  • Combination of multiple benchmarks

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

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Recommendations for PBM Strategies

Recommended PBM Strategy Proposals

- As a reminder, the Work Group previously recommended further developing PBM legislative and non-legislative strategies that would:
  1) Create transparency regarding rebates
  2) Prohibit spread pricing
  3) Promote fee-based pricing by employers
- During the last Work Group meeting, members conveyed support for advancing legislation aimed at PBM transparency that could complement the new legislatively directed PBM study, which will be completed by January 1, 2025 (see Appendix for details).

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1. Rebate Transparency

- **Summary**: The amount of rebates paid by manufacturers to PBMs, and the amount of rebates retained by the PBM vs. how much is passed on the health plan or employer, are typically kept confidential.
  - While CT state law currently requires rebates reported in the aggregate, CT doesn't have access to drug-specific rebate information.
  - The current definition of rebates may also not capture the full scope of rebates.
- **Proposed solutions**:
  1) Expand the definition of rebates to capture the complexity of rebate relationships and how they are funneled through different entities.
  2) Require PBMs to disclose certain pricing and cost information, such as drug-specific data on rebates, and payments and fees collected from drug manufacturers, insurers, and pharmacies.

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.

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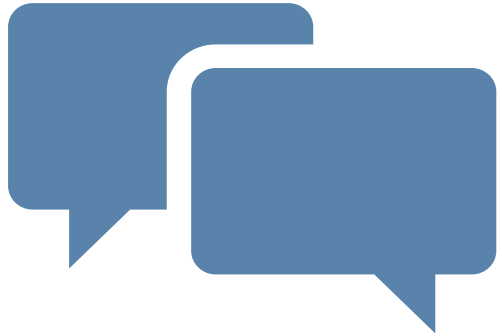
Proposed Amendment to Rebate Definition

In order to capture all rebates, including those funneled through rebate aggregators, the definition of rebates, pursuant to § 38a-479ooo, could be expanded.

- *Current 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.
- *Proposed definition*: **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**.

Discussion



Should Connecticut introduce legislation in the upcoming session that:

1) Expands rebate reporting requirements such that:
   a) the definition of rebates more comprehensively captures all rebate relationships, and
   b) PBMs are required to report rebates according to more detailed funds flow channels?
2) Requires PBMs to report drug-specific rebate information for a limited number of prescription drugs that have the highest total expenditures in the commercial market?

How else should CT expand rebate reporting requirements?

2. PBM Spread Pricing

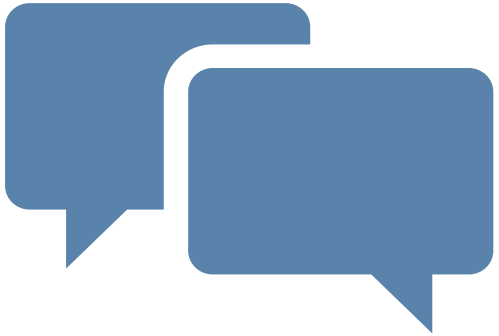
- **Summary**: Spread pricing occurs when a PBM charges a health plan or employer a higher price for a prescription drug than what the PBM actually pays the pharmacy for that prescription, and the PBM retains the difference as profit.
- **Proposed solution**: Prohibit PBMs from engaging in the practice of spread pricing. Instead, PBMs would use a pass-through pricing model, where the PBM passes through the amount charged by the pharmacy to the health insurer.
- **State level action**: 12 states have passed laws to prohibit spread pricing models in PBM and health plan contracts.

3. Fee-Based PBM Pricing

- **Summary**: 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.
- **Proposed solution**: The State could promote fee-based pricing by self-funded employers via educational efforts. Future legislation could also require and/or encourage PBM contracts to include fixed fee-based compensation.
- **State level action**: While states have not legislatively required fee-based pricing, the elimination of spread pricing will likely lead to PBMs charging administrative fees instead in an effort to maintain their profits.

Discussion

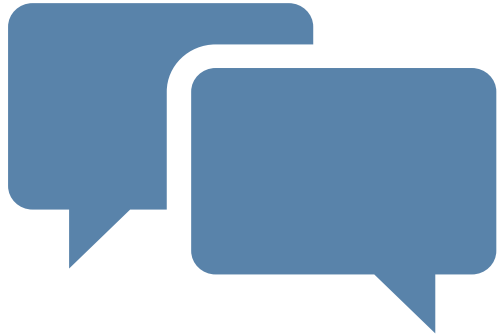
Should Connecticut introduce legislation in the upcoming session that prohibits spread pricing?



PBM Reporting Requirements in Other States

- In addition to rebate information, other states have passed laws requiring PBMs to report information aimed at understanding PBM conflicts of interest and deceptive business practices.
  - **Minnesota** requires PBMs give information to plan sponsors that differentiates between payments made to pharmacies owned or controlled by the PBMs and those not affiliated with the PBM (Minn. Stat. § 62W)
  - **New York** requires PBMs to disclose financial information and the terms and conditions of any contract they have with any party in writing, including dispensing fees paid to the pharmacies; and any activity or policy that directly or indirectly presents any conflict of interest with the PBM's relationship with the health plan. (N.Y. Pub. Health Law § 280-a)
  - **Florida** requires PBMs to disclose all organizations with which they are affiliated, including any affiliated pharmacies or companies within their corporate umbrella (Ch. 2023-30)

Discussion



Should Connecticut expand PBM reporting requirements to capture information on:

1) The terms and conditions of any contract or arrangements between the PBM and any other party relating to PBM services provided to a health plan or provider?
2) How PBMs differentiate between payments made to pharmacies owned or controlled by the PBMs and those not affiliated with the PBM?

How else should Connecticut expand PBM reporting requirements?

Requiring PBM State Licensure

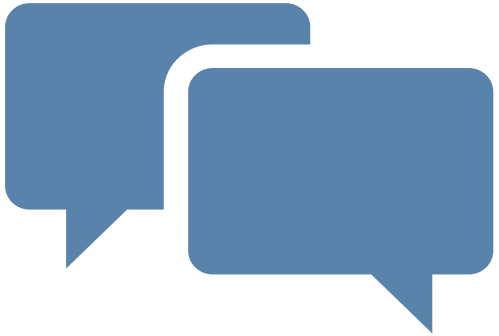
- CT state law currently requires registration of all PBMs operating in the state (CT Gen Stat § 38a-479bbb)
- This law could be expanded to require *state licensure* of PBMs in order to facilitate further state regulation pending the recommendations in the PBM Practices Report.
- At least 25 states require state licensure of PBMs.
- *Why should PBMs be state-licensed*?
  - States have a long history of licensing other parts of the drug supply chain, such as pharmacies, wholesalers, and similar entities, which allows greater state oversight and accountability.
  - 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. .

Major Components of PBM Licensure

- Requires a PBM to be licensed with the state in order to operate as a PBM in the state.
- A state agency, such as CID, would have authority to promulgate rules and regulations pertaining to licensure, including authority to establish and assess fines, impose civil penalties, and suspend or revoke a license of a PBM that is found to be noncompliant or engaging in fraudulent activity.
- Other states typically require renewal of licensing every one to three years.

Discussion

- Should Connecticut introduce legislation in the upcoming session that requires all PBMs operating in the state to be required to be licensed by the state?



State-Contracted Production of Generic Drugs

Recap of Prior Work Group Discussion

- During a prior Work Group meeting, we discussed how California has engaged in efforts around state-contracted production and distribution of generics through its partnership with Civica Rx.
- Members conveyed support for further exploring:
  1) potential opportunities for CT to assist in distribution efforts of Civica-branded products, including the three biosimilar insulin products, and
  2) opportunities for CT to contribute to the development, production, and distribution of other low-cost generics using a similar approach to California.

Takeaways from Conversation with Civica Rx

- On August 22nd, Work Group staff and one of the co-chairs spoke with a representative from Civica to discuss what opportunities Connecticut may want to consider related to generic drug production and distribution. Potential options include:
  1. Setting upper payment limits for generic drugs.
     - This could be specifically focused on generic drugs for which there is a low-cost option available on the market, with the upper payment limit set at the price of the low-cost option.
     - Alternatively, this could be done more broadly using a relatively simple formula such as setting the upper payment limits at 120% of the National Average Drug Acquisition Cost (NADAC), for example.
  2. Seek out opportunities to provide capital investment to address other pharmaceutical market failures.

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.

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)

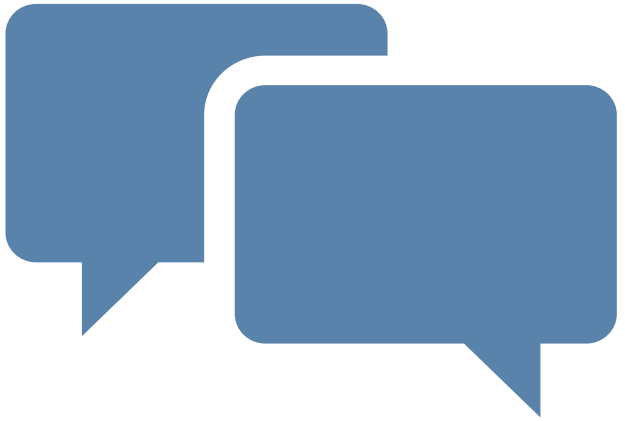
- All pharmaceutical manufacturers would be subject to the price increase benchmark, provided that the manufacturer had at least $250,000 in total annual sales in the state for the calendar year for which the penalty would otherwise be imposed.
- The annual price growth benchmark would be set at inflation.
- Under the state's taxing authority, Connecticut would penalize drug manufacturers that increase the Wholesale Acquisition Cost of the drugs above the benchmark rate increase.

Penalizing Excessive Price Increases Overview (2 of 2)

- The tax would be set at 80% of the difference between revenue generated under the manufacturer's price increase and the revenue that would have been generated using the benchmark rate increase.
- In order to calculate the amount of the financial 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.

Discussion

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



Wrap-up and Next Steps

- The next Pharmacy Cost Mitigation Strategies Work Group meeting is scheduled for Tuesday, **September 19th** from 11 a.m. – 12 p.m.

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