MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Annual Health Care

COST TRENDS HEARING

OCTOBER 17, 2018

Themes from Day One

2018 Health Care Cost Trends Hearing

Morning Presentations:

- Price as a driver of health care cost growth
- Affordability challenges for low to middle income individuals and families
- Market competition vs. government price setting
- Opportunities to unleash the promise of APMs and ACOs

Panel 1: Meeting the Health Care Cost Growth Benchmark – Top Trends in Care Delivery and Payment Reform

- Opportunities to reduce administrative costs
- Expanding alternative payment methods and aligning incentives
- Community-appropriate care
- Challenges facing small businesses and employers
- Product design and engaging consumers

Panel 2: Innovations to Enhance Timely Access to Primary and Behavioral Health Care

- Use of technology: EMRs and telemedicine
- Integration of behavioral health into primary care, and use of mobile integrated health to provide lower-cost care in the community
- Role of alternative care sites – such as urgent care centers – in providing access and supporting cost containment goals

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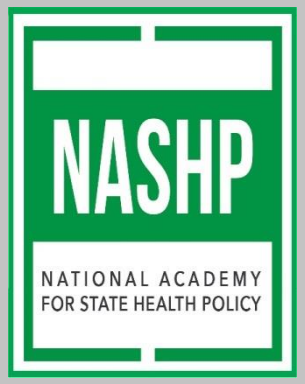
Up Next
Spotlight on State Solutions to Health Care Spending



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MASSACHUSETTS HEALTH POLICY COMMISSION

2018 HEALTH CARE COST TRENDS HEARING

WEDNESDAY, OCTOBER 17, 2018

"SPOTLIGHT ON STATE SOLUTIONS TO HEALTH CARE SPENDING"

PRESENTED BY TRISH RILEY
EXECUTIVE DIRECTOR
NATIONAL ACADEMY FOR STATE HEALTH POLICY
TRILEY@NASHP.ORG

National Academy for State Health Policy

- Private, non-profit, bipartisan forum of and for state leaders
- Serving States for 31 years
- Cross disciplinary- Legislative and executive branches
  - AG's
  - Insurance departments
  - Exchanges
  - Cost Commissions
  - Medicaid
  - Public Health
  - State employee health plans
  - Governor's office
  - Legislators and staff
- Guided by cross disciplinary Steering Committees and work groups

  Louis Gutierrez
  David Seltz
  Daniel Tsai

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

What Motivates States to Act?

- +/- 40% of healthcare in states paid by public dollars
- Balanced budget requirements
- Medicaid
- Market dynamics
  - Individual and small group
  - Increasing out of pocket exposure
- States as "Laboratories of Innovation"
  - ACA
  - Children's health
  - Medical health parity
  - "Gag clauses"
- Public outcry

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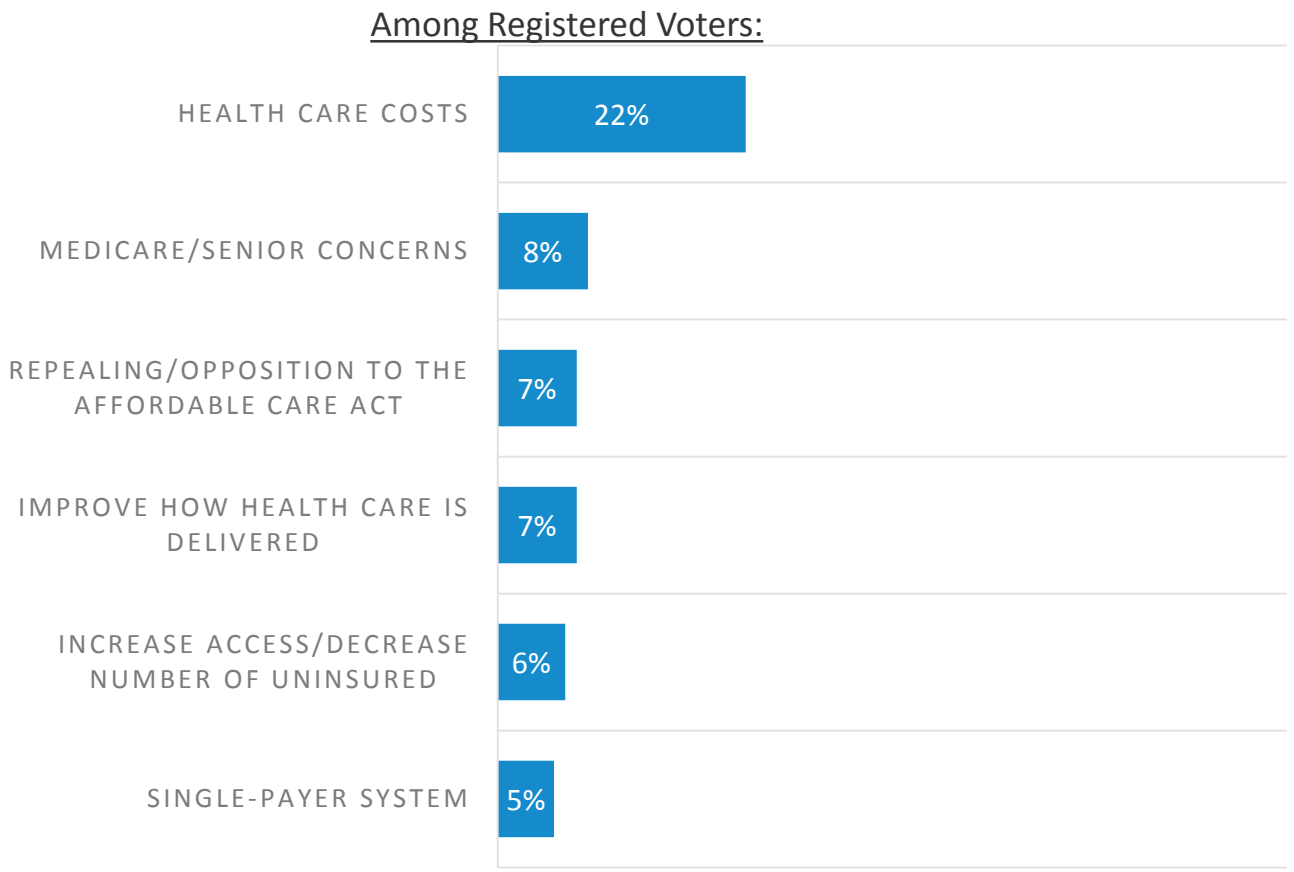
Health care costs is the top health care issue voters want 2018 candidates to talk about

While this year's election is still a long way off, what health care issue do you most want to hear candidates talk about during their upcoming campaigns? (*open-end*)



NOTE: Only top six responses listed.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)

Peterson-Kaiser
Health System Tracker

State of the State – Health Cost Reduction Strategies

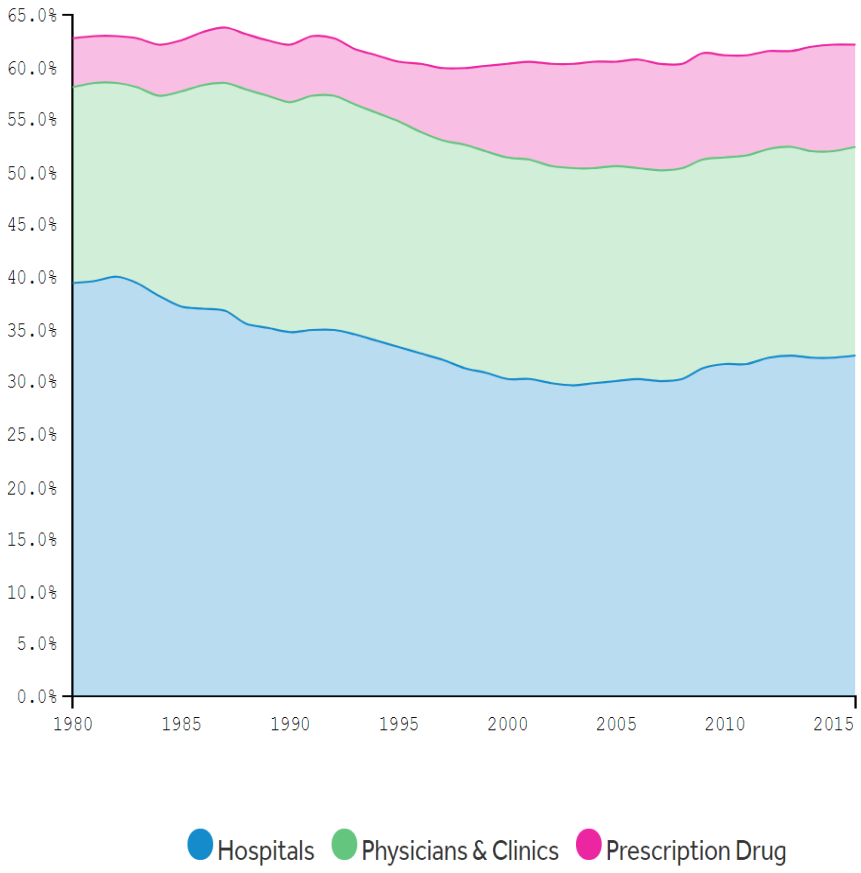
- Payment and delivery system reforms
  - Medicaid
  - ACO's / Integrated Delivery (VT all payer ACO)
  - WA Technology Assessment Program.
- Global budgets/ Sustainable growth rate
  - MA, VT, OR
- Ratesetting
  - MD
- Market oversight
  - DON/CON/COPA– MA, CT, ME, VA, TN
  - Insurance review and oversight e.g. 23 States "Surprise Billing" laws
- Transparency – cost compare websites
  - APCD's WA, NH, ME

Cont.- State of the State – Health Cost Reduction Strategies

- Reference pricing
  - MT – hospital rates
  - CA -“shoppable services”
- Consolidate state purchasing
  - WA Health Care Authority
  - Oregon Health Authority – Purchases for 1:3; Medicaid, public employees, educators; 3. 4% SGR
  - TN – episode based payment across state employees, retirees, and Medicaid
  - WI Dept. of Employee Trust Funds – allows local government and public universities opt in

Why Focus on Rx?

Drug spending has grown rapidly recently, but most of the health dollar is spent on hospitals and physicians



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group

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Why States Take on Rx?

- Rx price increases rapid and unpredictable
- Specialty drugs, biologics, immunotherapy = costs will continue to rise
- 21st Century Cures -> Fast Tracking
- State Medicaid Spending
    - 25% 2016; 14% in 2015
    - CMS predicts 6% growth 2016-2025
    - PT. D "claw back"
- No federal consensus on action despite President's "Blueprint"
    - States can't wait on Feds
        - E.g. 28 states enacted "gag clauses" before Congress did
- Disrupt business model
- Rx issues cross the partisan divide

NASHP's Center for State Rx Pricing

- Laura and John Arnold Support
- Pharmacy Cost Work Group
- Model legislation, legal resources, track emerging activity, other technical assistance

https://nashp.org/center-for-state-rx-drug-pricing/

- Diverse state engagement

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How Are States Approaching Rx Costs?

- 2018 Session: 171 Bills
- 28 States Passed 45 New Laws:
  - PBMs – 92 Bills (31 laws in 20 states eg: AR, AZ, FL, KS, KY, MO, SC, CA, CT etc
  - Transparency – 26 Bills (7 laws: OR, VT, ME, NH, CT, CA*, NV*)
  - Importation – 9 Bills (1 law: VT; Utah – Proposal due to Legislature Oct 1)
  - Price Gouging – 13 Bills (1 law: MD*)
  - Rate Setting – 3 Bills: MD, NJ, MN
  - Volume Purchasing – 4 Bills

(*= enacted in 2017)

State Transparency Law	Requires reporting from…				
	Health Plans	PBMs	Manufacturer Price Increases	Manufacturer Launch Price	Other
California (SB 17)	X		X	X	
Connecticut (HB 5384)	X	X	X	X	
Maine (LD 1406) *Study only			X		
Nevada (SB 539) *Only relates to diabetes drugs		X	X		Pharmaceutical sales reps. & manufacturer donations to non-profit organizations
New Hampshire (HB 1418) *Study only		X	X		
Oregon (HB 4005)	X		X	X	
Vermont (S 92)	X		X	X	
Maryland's Price Gouging Law (MD 631) *law's main focus is not on transparency			X		
Louisiana's PBM Laws (SB 283 & HB 436) *law's main focus is not on transparency		X			

Vermont: Transparency (S. 92)

- Vermont was the first state to enact transparency laws in 2016. S. 92 adds reporting from health plans and public disclosure of manufacturer reports.
- Requires Reporting from:
  - **Health Plans** on most costly drugs, the impact of drugs costs on premium rates, and information on PBM use
  - **Manufacturers** on price increases and high launch prices.
    - Price Increases: reporting occurs on 15 drugs with WAC increases of 50% or more in past 5 years or 15% or more in previous year (must explain each factor that caused net cost increase)
    - Launch Prices: sponsors of new drugs with a WAC that exceeds the threshold for a specialty drug under Medicare Part D must report expected utilization, FDA approval designation, acquisition cost, and drug pricing plan

California: Transparency
(SB 17 Chapter 603, Statutes of 2017)

Manufacturer Reporting

1) Chap. 603 requires manufacturers to give 60 days advance notice of price increases when certain thresholds are met:

- The wholesale acquisition cost (WAC) for a drug is more than $40 for a course of treatment
- The manufacture will increase the WAC more than 16% (including the proposed and cumulative increases that occurred within the previous two calendar years)

2) If a pending price increase triggers reporting requirements for advance notice, manufacturers must also report specified financial and non-financial factors that contributed to the price increase

3) When launching new drugs that exceed $670, manufacturers must report expected utilization, acquisition cost if applicable, FDA approval designation, pricing plans, and launch price.

Health plans must report 1) the 25 most frequently used drugs; 2) the 25 most costly drugs by total spend; 3) the 25 drugs that contribute the most to year-over-year plan spending

PhRMA Files Suit Against CA SB 17

- In response to SB 17, PhRMA filed suit challenging the law. PhRMA claimed the law would cause market distortions, such as drug stockpiling and reduced competition. PhRMA also argued that SB 17 violates:
  - The Commerce Clause, which prohibits CA from regulating drug pricing beyond the state's borders;
  - The First Amendment, by compelling speech through manufacturers justifying price changes; and
  - The Fourteenth Amendment's due process clause because the law is unconstitutionally vague.

PhRMA Files Suit Against CA SB 17

- U.S. District Judge Morrison England dismissed the case on August 28, 2018. He argued PhRMA failed to show that the court has jurisdiction to hear the case

- The judge gave PhRMA 30 days to amend the complaint after finding its initial claim – that CA's law attempted to "dictate national health policy"- without merit

- On September 28, PhRMA refiled.

Connecticut: Transparency (HB 5384)

- Connecticut's transparency law is one of the most robust—it requires reporting from health plans, PBMs, and manufacturers on both price increases and launch prices.
- Requires Reporting from:
  - **Health Plans** on the most costly drugs and the impact of drugs costs on premium rates
  - **Pharmacy Benefit Managers** on aggregate amount of rebates collected from manufacturers and amount of rebates going to carriers
  - **Manufacturers** on price increases and high launch prices
    - Price Increases: reporting occurs on 10 outpatient drugs where 1)WAC increased by at least 20% during previous year or by 50% over past three years or 2)WAC was more than $60/month or course of treatment
      - Must report each factor that caused net cost increase, company level research & development costs
    - Launch Prices: ALL sponsors of new drugs or biologics must report expected utilization, clinical trial comparators, FDA approval designation, and estimated market entry date

New Hampshire & Maine: Transparency Studies

- New Hampshire and Maine enacted laws mandating further study of transparency
- New Hampshire created a commission to determine if increased transparency would lower drug costs. The commission will study:
  - PBMs' role in cost, administration, and distribution of prescription drugs.
  - Amount of rebates from manufacturers for certain high cost, high utilization drugs
- Maine requires the Maine Health Data Organization to develop a plan to collect data from manufacturers related to cost and pricing of drugs, including:

Maryland's Price Gouging Bill

- In 2017, lawmakers passed SB 631, which prohibited manufacturers and wholesale distributors from engaging in price gouging of generic drugs. This was the first price gouging legislation to become law.

- The Association for Accessible Medicines filed suit, claiming the law could hurt competition and drive up prices.

- The Fourth Circuit Court of Appeals found that the law regulates trade outside Maryland's borders and thus violates the Dormant Commerce Clause.

Maryland's Rate Setting Bill

- SB 1023/HB 1194, based on NASHP's rate setting model, would have created an all-payer drug rate setting program through a Drug Cost Review Commission.

  - Anticipate re-introduction in 2019

- Minnesota proposed a similar bill which failed to receive consideration, while New Jersey has a rate setting bill in the pipeline.

Wholesale Importation

- Section 804 of FDCA allows the HHS Secretary to approve a *program* of wholesale importation of prescription drugs that will:
  - Pose no additional risk to the public's health and safety; and
  - Result in a significant reduction in the cost of the covered products to the American consumer

- Vermont enacted S.175, which creates a wholesale importation program to purchase high-cost drugs in Canada and make them available to Vermonters through the existing supply chain
  - Vermont's Agency for Human Services is currently working to develop an application to HHS

- Utah's importation bill (HB 163) passed the House, but not the Senate
  - UT's Department of Health recently submitted a report on importation as requested state legislative leadership

Louisiana's Subscription Model

- In August, Louisiana issued an RFI on its plans to use a subscription-based model for Hep C medication.

- Under the subscription model, Louisiana would agree to pay a fixed amount of money over several years, and a manufacturer would provide the state with all the medication the state needs.
  - Payment to the manufacturer would be equal to or less than what the state currently spends to provide the medication.
  - In the first years, the state will get more drugs than they pay for; as fewer people need treatment, the manufacturer would get extra money.
  - Theoretically, a guaranteed fixed purchase price for a contracted period of time would allow the manufacturer to expand its product reach.

Medicaid Initiatives

Challenging – Medicaid law

- Rebates
- Best price
- Cannot limit Rx
- Tools inadequate (PDL, PA. limits etc.)

NEW YORK

- Budget cap on Rx spending
  - Target high cost Rx
  - Review value
  - Seek “supplemental/ supplemental”
  - Most cover all Rx but may:
    - Request more info on costs
    - Move rx to prior approval
    - Case study: Vertex’s Orkambi

Medicaid Alternative Payment Models

OKLAHOMA

- OK Medicaid has entered into three separate APMs directly w/ drug manufacturers (first-in-nation)
- State and manufacturer agree upon outcome(s) to measure
- Additional rebates are based on performance against agreed-upon measure
- Example: As adherence targets are met- which result in greater usage, sales and outcomes- the price the state pays for the drug decreases

COLORADO

- Colorado is surveying physicians to determine their actual acquisition cost (AAC) for physician administered drugs (PADs)
- Results will be used to design a more transparent APM based on average acquisition cost (2019)

Next Steps

- States testing approaches to inform Federal debate
  - 28 Politically diverse states have enacted "gag clauses" before Congress acted
    eg: MS, TX, KY, IN, GA, CO, WVA, VT, NH
  - 23 States have enacted "surprise billing" laws – Sen. Cassidy has proposed bipartisan draft legislation –no Congressional action yet
- New England states actively engaged on Rx issues
- NASHP eager to work with MA to push Rx pricing reforms

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Up Next
Presentation from the Office of the Attorney General: Health Care Division

Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 12C, § 17

October 17, 2018

OFFICE OF ATTORNEY GENERAL
MAURA HEALEY
ONE ASHBURTON PLACE
BOSTON, MA 02108

AGO Cost Trends Examinations

- Authority to conduct examinations:
  - G.L. c. 12, § 11N to monitor trends in the health care market.
  - G.L. c. 12C, § 17 to issue subpoenas for documents, interrogatory responses, and testimony under oath related to health care costs and cost trends.
- Findings and reports issued since 2010.
- This examination focuses on variation in payment methodologies for health care services in the commercial market.

Questions Presented

I. Are payment methods for health care services consistent across insurers and providers in the commercial market?

II. What are the costs associated with administering complex and varied health care payment methods?

III. How is this payment system a barrier to price comparisons for market participants?

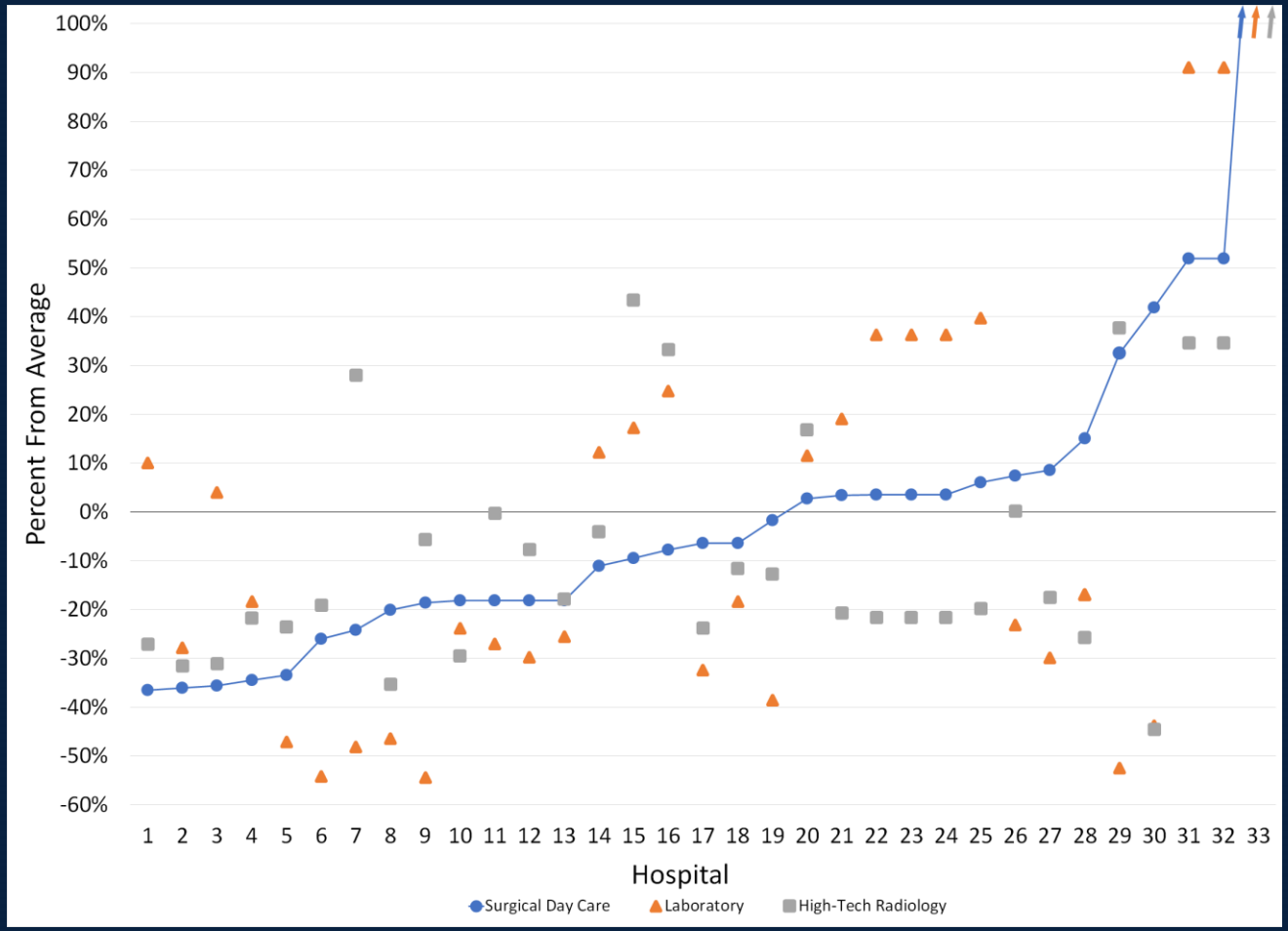
Hospital Outpatient Payment: Significant Complexity and Variation

Hospital Outpatient Fee Schedules Do Not Share A Consistent Structure Across Payers

	Payer 1	Payer 2	Payer 3
Number of outpatient billing service categories	17	12	4
Rate multipliers negotiated by outpatient billing service category?	Yes	Yes	No

Even Where Service Categories Align, Negotiations Over Fee Schedules Result In Significant Differences in Relative Price Across Services at a Single Hospital

Hospital Rate Multipliers for Three Outpatient Services for One Massachusetts Payer (2018)

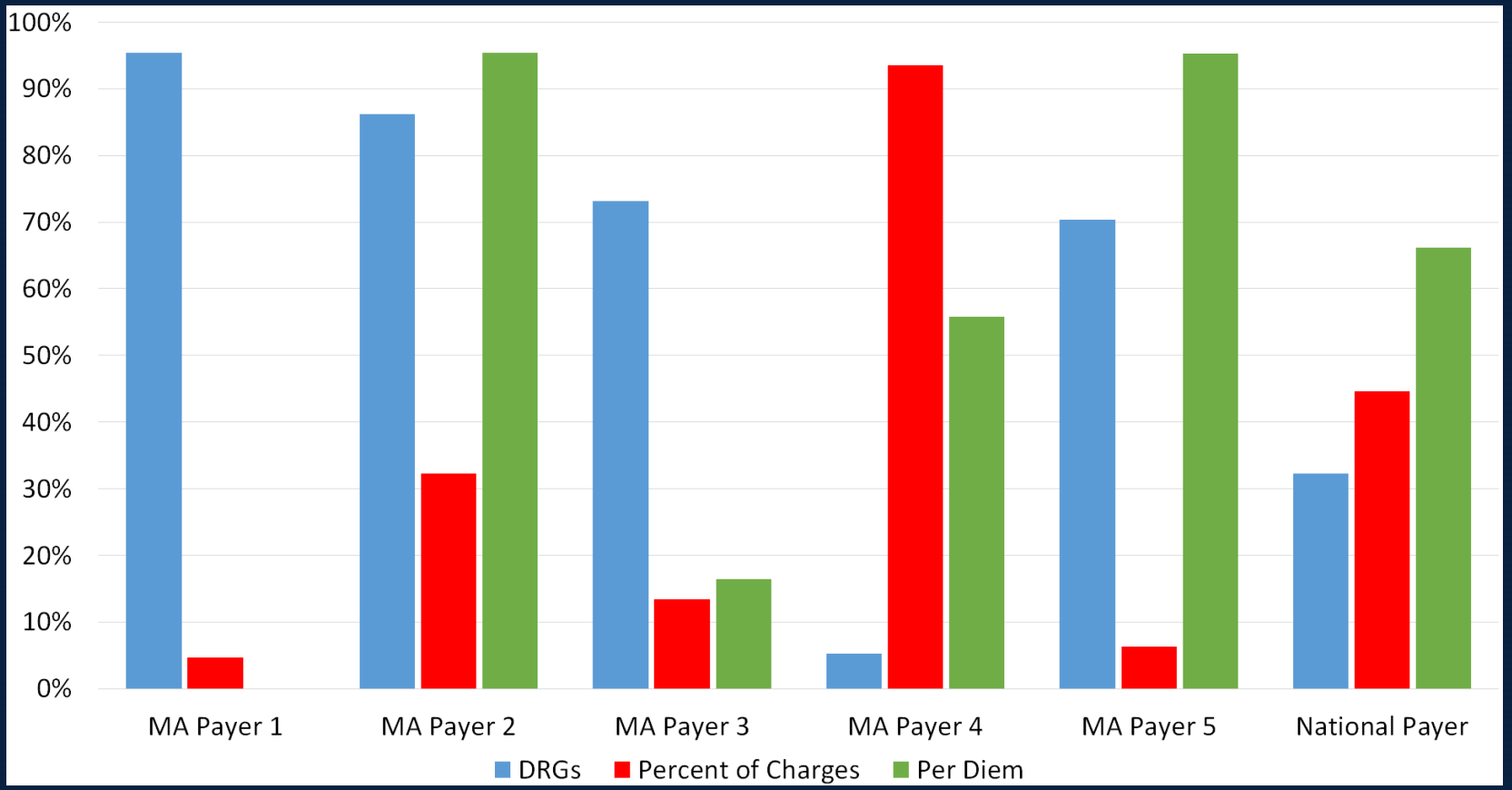


Outpatient Payment Variation: Observation Services Case Study

Payer 1	Payer 2	Payer 3
Six different time-based payment structures (each for different time ranges)	Negotiated base rate multiplied by hours of observation and a negotiated multiplier	24-hour all-inclusive rate

Hospital Inpatient Payment Is Somewhat More Standardized Across Big Three Payers, But Variation Exists Across State

Percent of Payers' Massachusetts Hospital Contracts that Use DRG, Percent of Charges, and Per Diem for Inpatient Payment



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III. How is this payment system a barrier to price comparisons for market participants?

Administrative Costs

- Recent national studies have documented the high costs of administrative complexity in health care.
  - 25% of hospital costs are administrative.
  - For every 10 MDs, there are 7 FTEs engaged in billing activities.
  - Growth of billing costs from 14% in 2009 to 17% in 2014.
  - Administrative costs are a major driver in the difference in overall cost between the US and other countries.
  - Reducing US spending for hospital administration to that of Canada or Scotland would have saved ~$158 billion in 2011 dollars.
  - Higher administrative costs do not appear to be connected to higher quality care.

Questions Presented

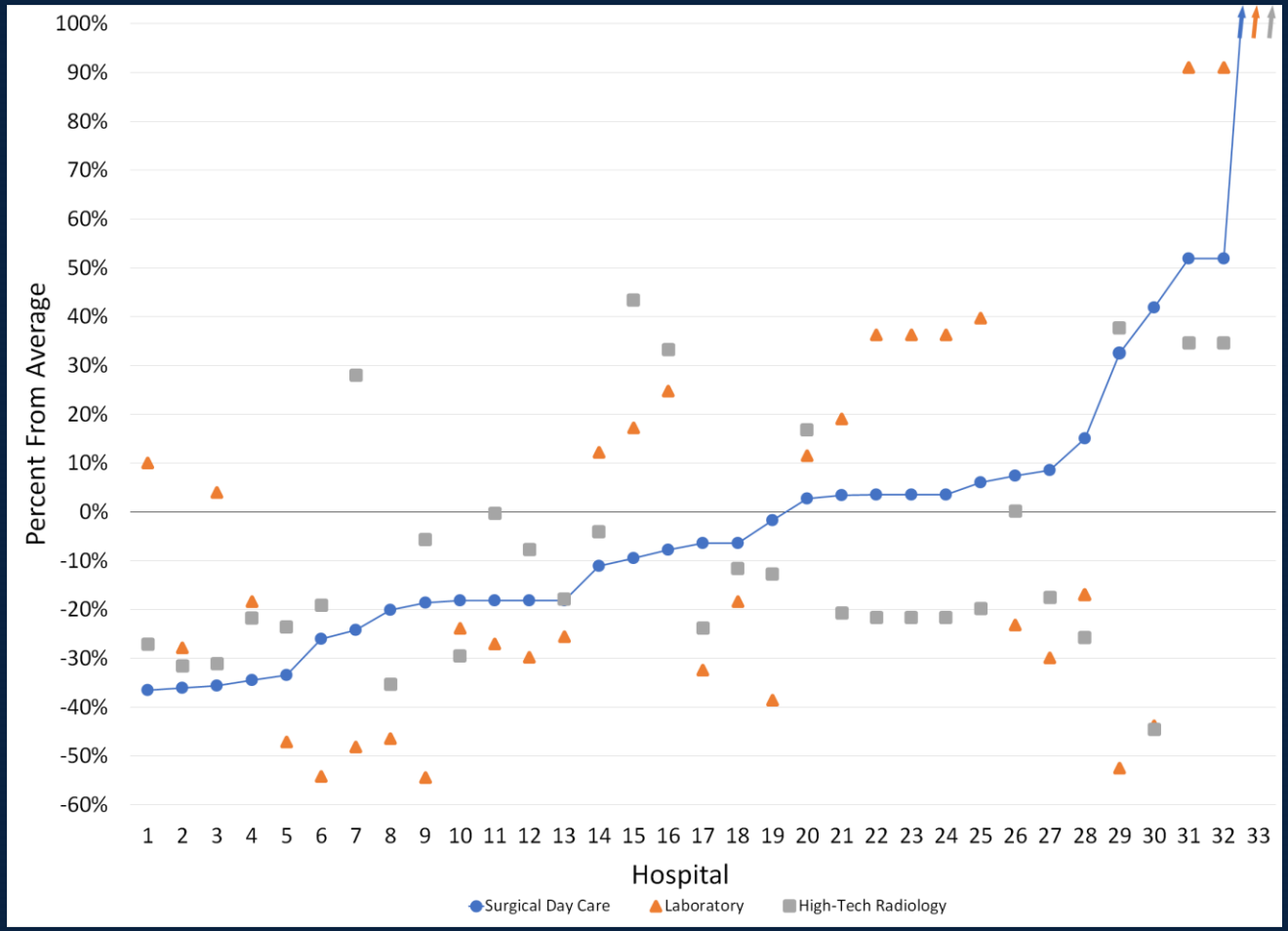
I. Are payment methods for health care services consistent across insurers and providers in the commercial market?

II. What are the costs associated with administering complex and varied health care payment methods?

III. How is this payment system a barrier to price comparisons for market participants?

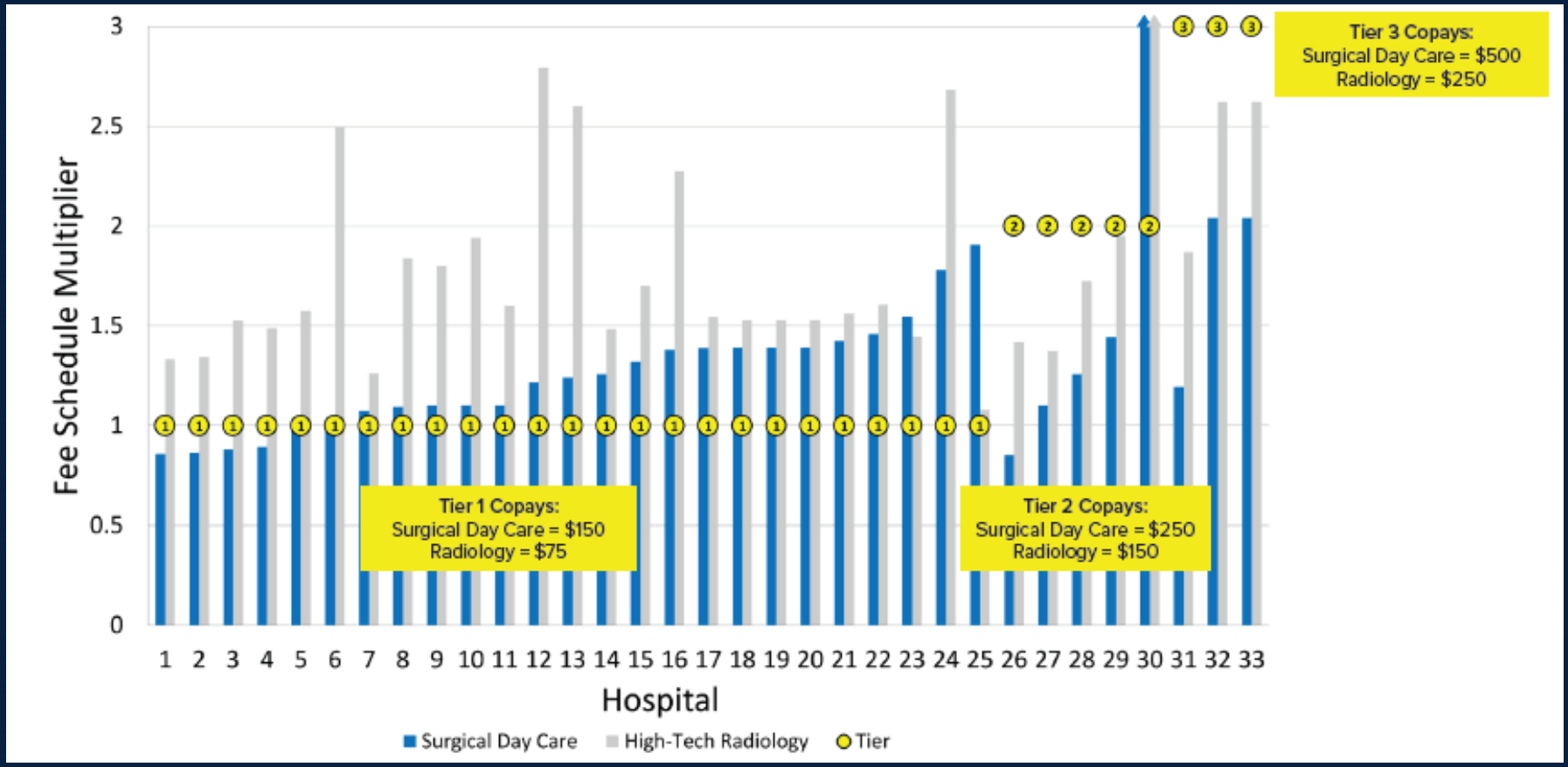
Comparing Prices Across Providers Is Challenging

Hospital Rate Multipliers for Three Outpatient Services for One Massachusetts Payer (2018)



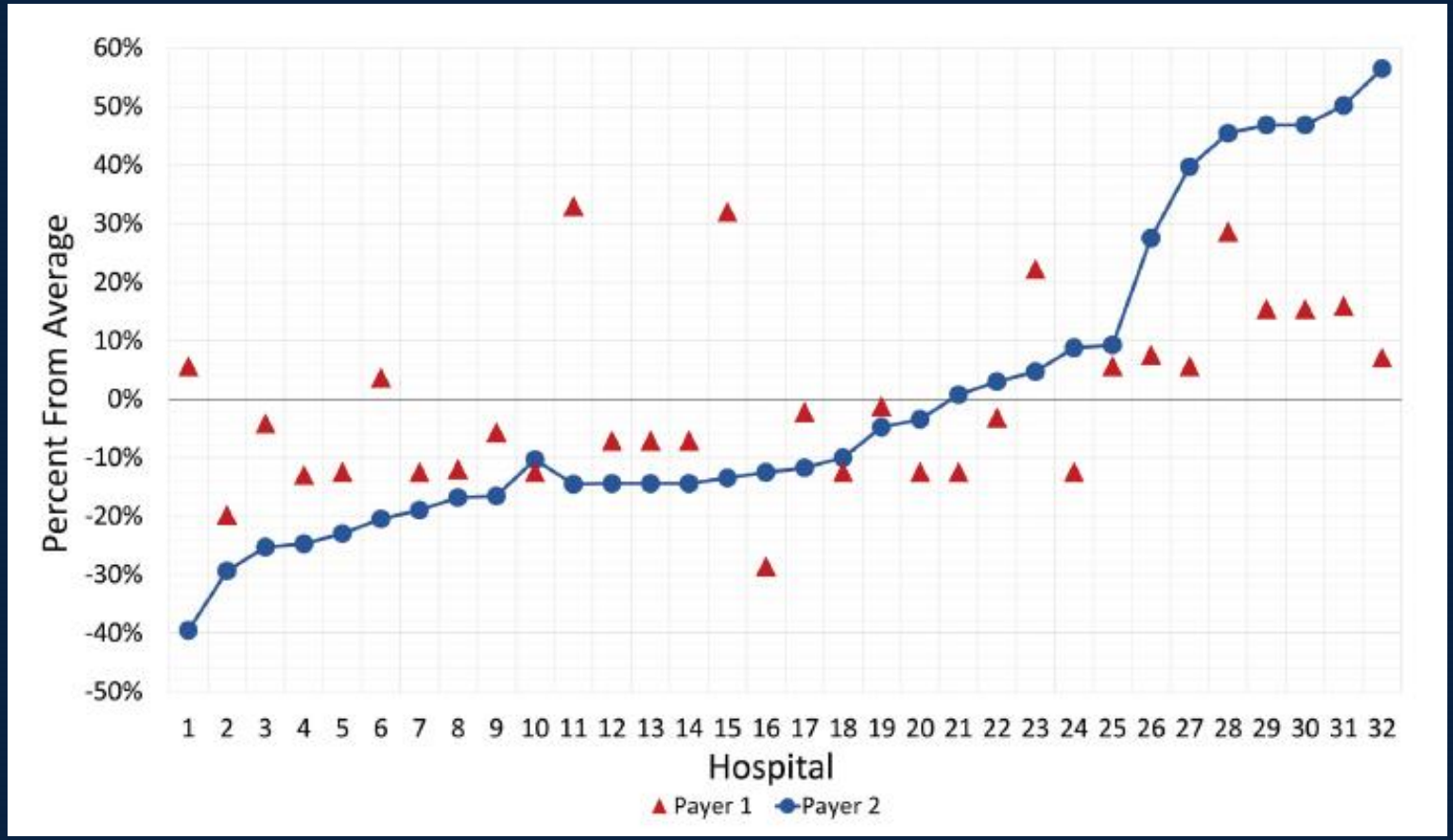
Comparing Prices Across Providers Is Challenging for Consumers

Hospital Surgical Day Care and High-Tech Radiology Prices by Tier for One Massachusetts Payer (2018)



Comparing Prices Across Payers Is Challenging for Employers and Referring Providers

Hospital High-Tech Radiology Prices for Two Massachusetts Payers (2018)



Recommendations

1. Study further the administrative costs associated with current complex and varied approaches to payment for health care services with the goal of developing strategies to reduce these costs.
2. Reduce complexity and explore increasing standardization where appropriate in the methods for determining health care payment rates to reduce the cost of claims and contract administration and facilitate “apples-to-apples” price comparisons.
3. Establish real-time, service-level price transparency for employers, consumers, policymakers, and providers.

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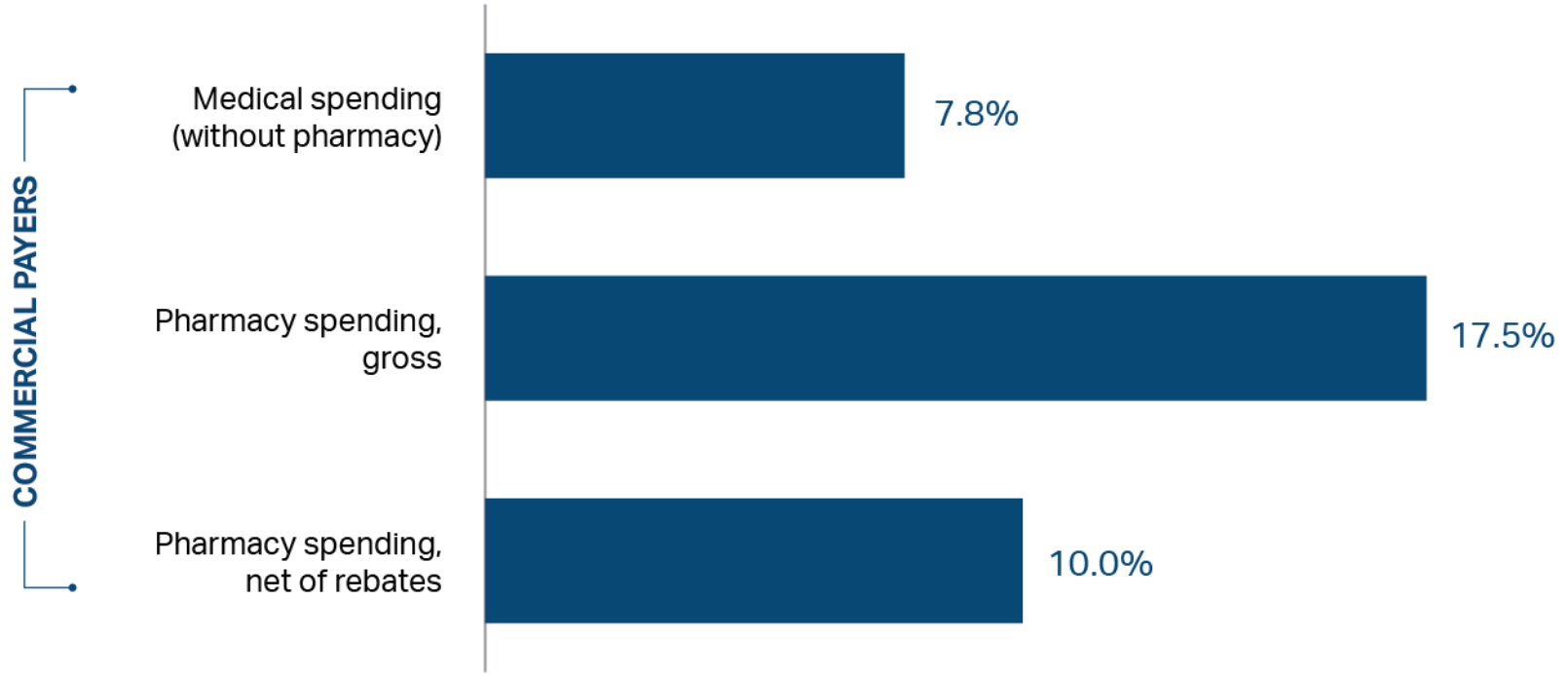
Up Next
Reaction Panel 3: Strategies to Address Pharmaceutical Spending Growth

For commercial payers, pharmacy spending growth exceeds medical growth over recent years

3 year cumulative spending growth per member per month for commercial payers (full claims), 2015 – 2017

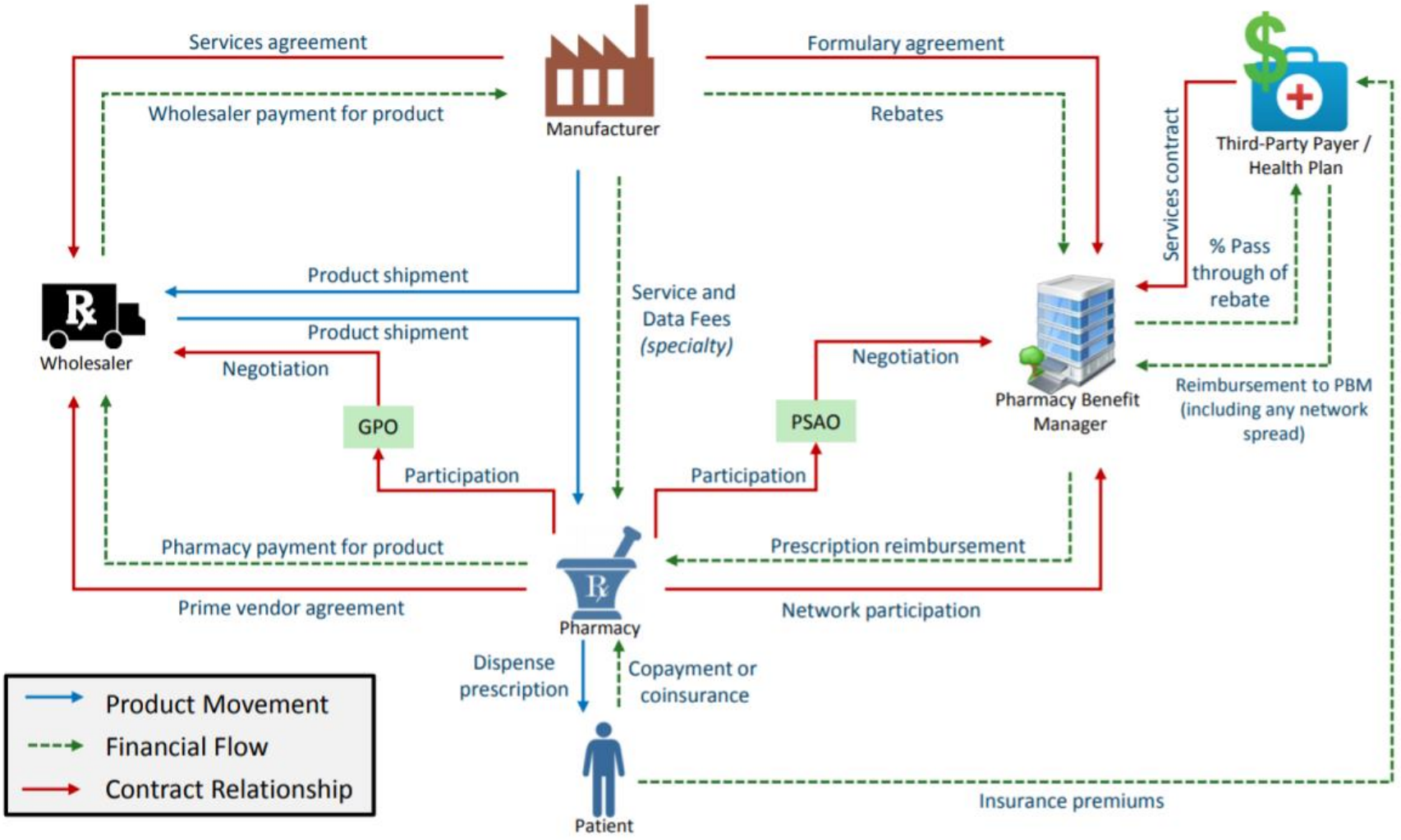


Net of rebates, prescription drug spending (pharmacy only) represented 17% of health care spending for commercial payers in 2017

Source: HPC analysis of the Center for Health Information and Analysis THCE and TME Databooks (MA 2014-2017)

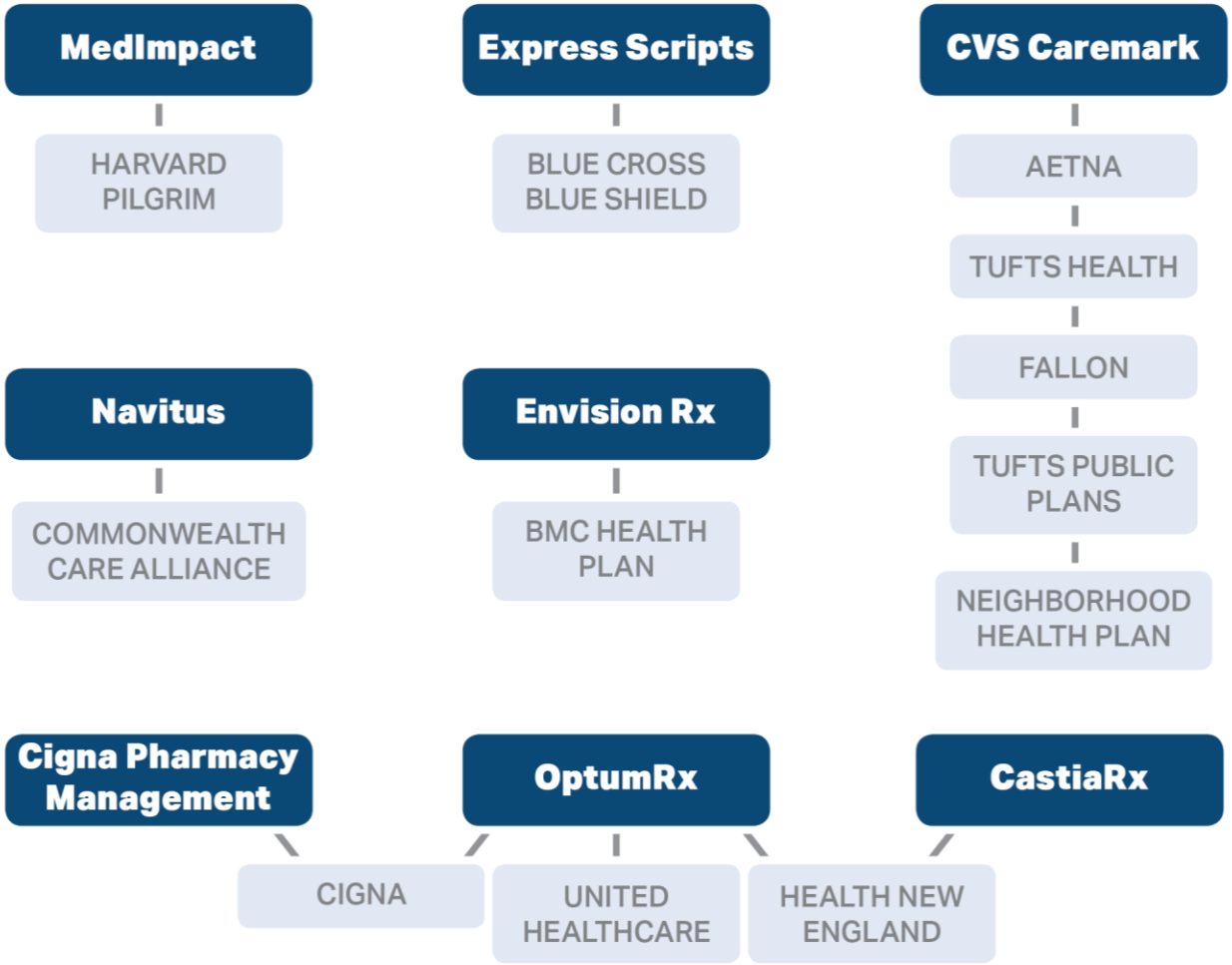
The complexity of the drug distribution and sales chain illustrates the need for transparency and action at many levels

*Flow of drug products, services, and funds for drugs purchased in a retail setting**



* Notes and Source: Fein, Adam J., The 2018 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Drug Channels Institute, 2018. Chart illustrates flows for patient-administered, outpatient drugs. GPO = Group Purchasing Organization; PSAO = Pharmacy Services Administrative Organization

Multiple pharmacy benefit managers (PBMs) contracting with different health plans for a variety of functions adds to the complexity in MA



PBMS PERFORM A VARIETY OF FUNCTIONS FOR THE 12 PAYERS SURVEYED

12 pharmacy contracting

12 pharmacy claims processing

11 negotiate prices and discounts with drug manufacturers

11 negotiate rebates with drug manufacturers

7 provide clinical management care programs to clients

5 develop and maintain the drug formulary

Source: HPC analysis of pre-filed testimony pursuant to the 2018 Annual Cost Trends Hearing

Drug spending a top concern for payers and providers

In pre-filed testimony (PFT), most payers (12 of 14) and half of providers (17 of 35) listed **rising pharmaceutical costs as a top area of concern** for the state's ability to meet the cost growth benchmark, with an emphasis on prices including:

- High prices for new, specialty drugs
- Price increases for existing drugs

Payers and providers recommended numerous strategies to contain cost growth, such as:

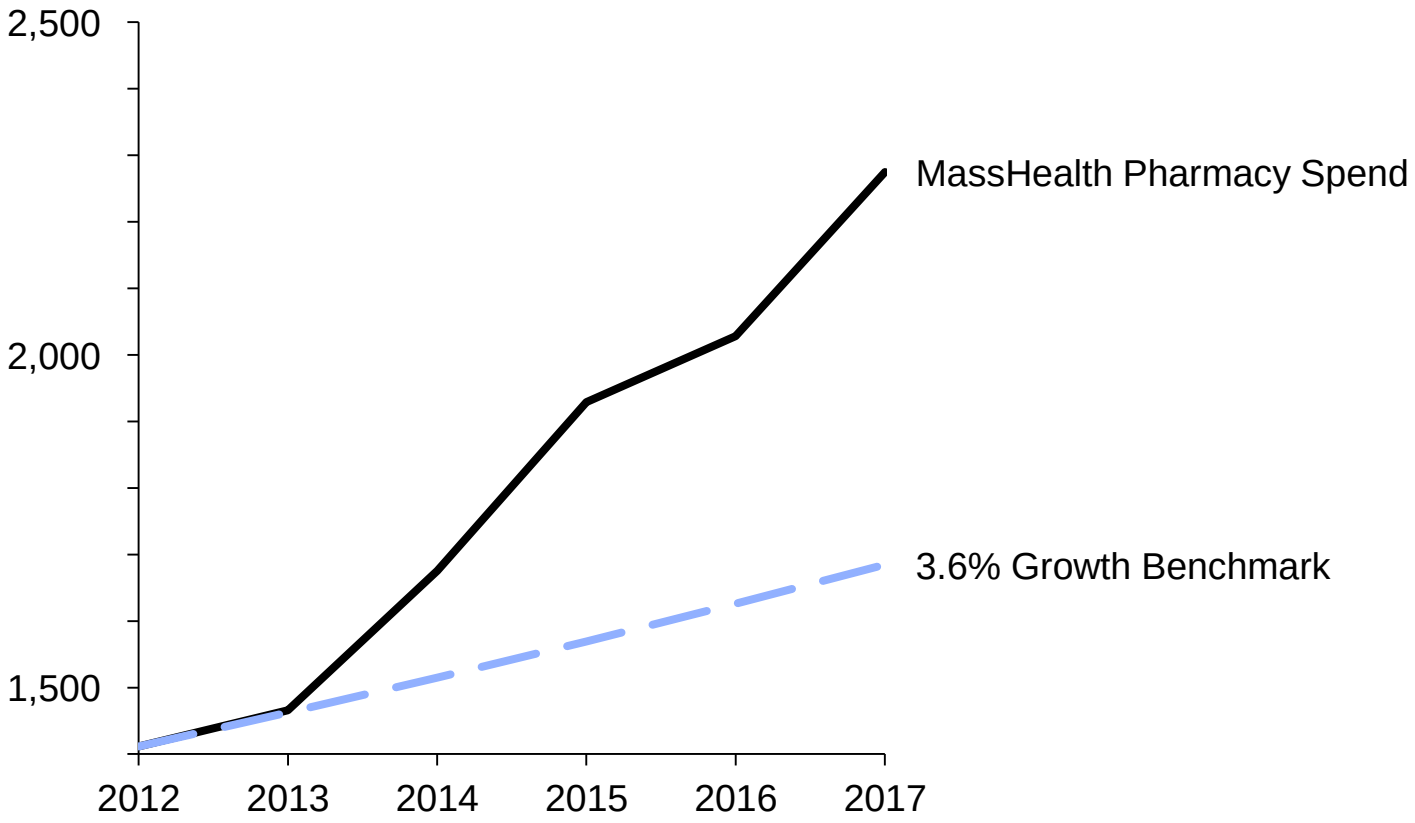
- Maximize high-value, low cost drugs through **formulary design**, prior authorization requirement for certain high-cost drugs
- Greater availability of biosimilars and generic specialty drugs
- Increasing **competition and transparency from manufacturers and pharmacy benefit mangers**, e.g., notice and rationale for price increases
- Enhancing government oversight and monitoring of market tactics: "evergreening", "pay-for-delay", "product hopping"
- Promote clinical guidance on appropriate prescribing and **best practices for medication adherence** and medication reconciliation for complex patients

HPC

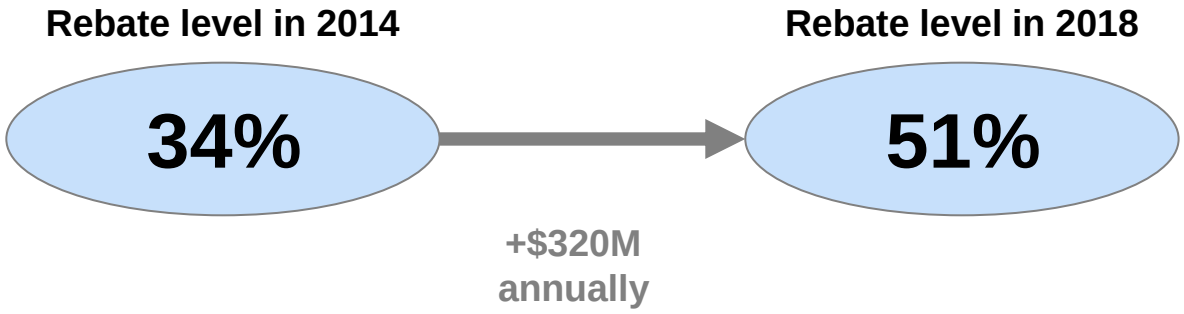
Source: HPC analysis of pre-filed testimony pursuant to the 2018 Annual Cost Trends Hearing

MassHealth Rx spending has grown $900M over 5 years

MassHealth pharmacy spend
$ Millions



MassHealth has emerged as a national leader in pharmacy cost management



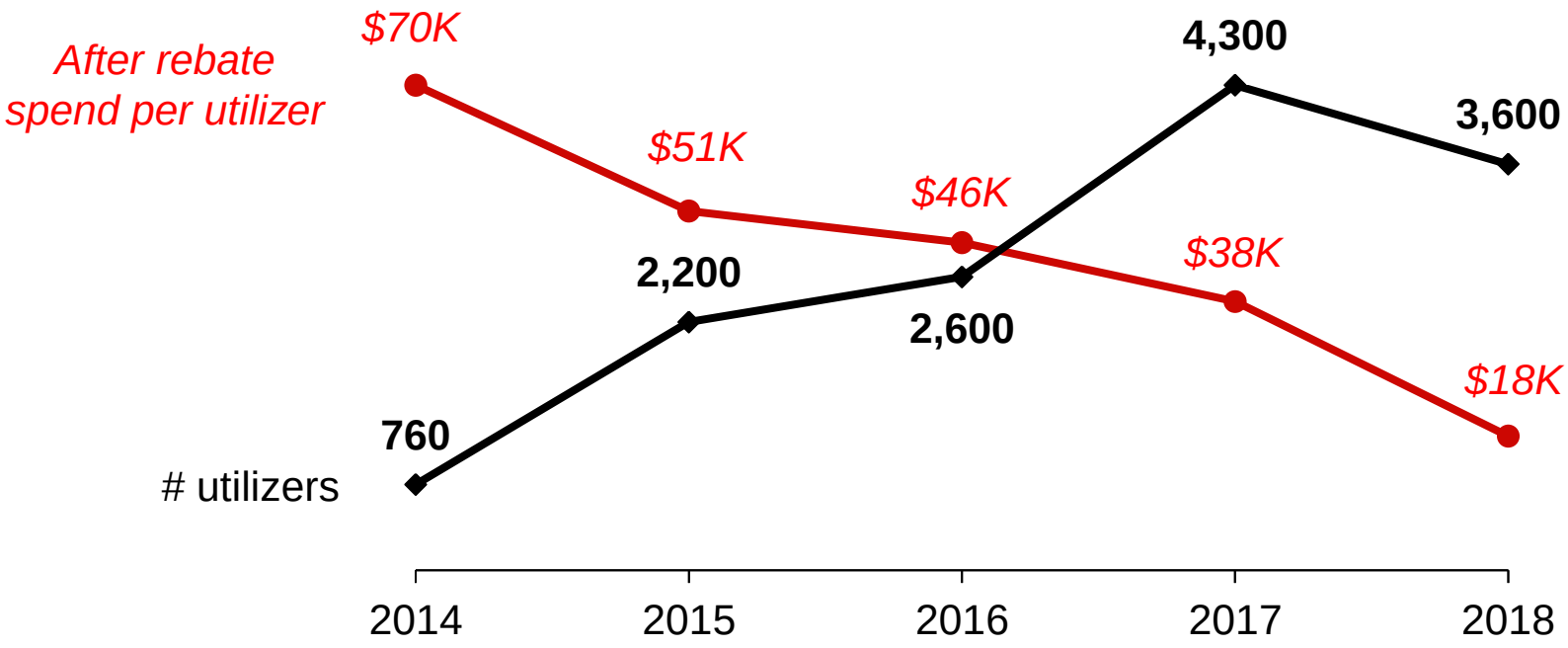
Initiatives

- Aggressive rebate negotiations has led to +$320M annually
- Established preferred drug list
- Leveraged purchasing power to expand rebates

The Positive Effect of Competition: Hepatitis C drug example

MassHealth Hep C net spend per utilizer & utilizers

$ spend, # utilizers



Drug Launches

No competition	Some competition	High competition
GILEAD (1)	GILEAD (2) abbvie (1) MERCK (1)	GILEAD (3) abbvie (2) MERCK (1)

Reaction Panel 3: Strategies to Address Pharmaceutical Spending Growth

Panelists

Ms. Sarah Emond, Executive VP and COO	Institute for Clinical and Economic Review
Dr. Rochelle Henderson, VP of Research	Express Scripts, Inc.
Ms. Amy Rosenthal, Executive Director	Health Care For All
Mr. Daniel Tsai, Assistant Secretary for MassHealth	Executive Office of Health and Human Services
Ms. Leslie Wood, Deputy VP for State Policy	PhRMA

Goals

Building off the preceding expert presentation, the goal of this panel is to discuss emerging policies and strategies that can be implemented at the state level to promote greater affordability and value in pharmaceutical spending. Focus areas will include: enhancing the transparency of pharmaceutical prices, promoting value-based contracting and pricing, establishing high-value formularies, improving consumer affordability, supporting innovation, and understanding the role of pharmacy benefit managers.

Thank You!

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