Rhode Island Health Care Cost Trends Steering Committee

May 24, 2023

Welcome

Agenda

1. Welcome
2. Approval of March Meeting Minutes
3. New Cost Trends Compact
4. Review of Pharmacy Strategy Options
5. Status of Hospital Global Budget Design Work
6. Public Comment
7. Next Steps and Wrap-up

Approval of Meeting Minutes

Approval of Meeting Minutes

- Project staff shared minutes from the March 30th Steering Committee meeting in advance.
- **Does the Steering Committee wish to approve the March meeting minutes?**

New Cost Trends Compact

Cost Trends Compact for 2023-2027

- Project staff distributed the signed **Compact to Reduce the Growth in Health Care Costs while Improving Health Care Access, Equity, Patient Experience, and Quality in Rhode Island** ("the Cost Trends Compact") with today's meeting materials. 17 organizations are represented among the signatories. They are listed on the next slide.
- The **Public Health and Health Equity Measures Work Group** held its first meeting earlier this month. Members will meet over the next few months to develop recommended measures and target values for Steering Committee consideration. Work group members are listed on the second slide following.

2023-2027 Cost Trends Compact

- Amica
- Blue Cross Blue Shield of Rhode Island
- Care New England
- CVS Health
- Hope Health
- Hospital Association of Rhode Island
- Lifespan
- Neighborhood Health Plan of Rhode Island
- Point32Health
- Rhode Island Business Group on Health*
- Rhode Island EOHHS
- Rhode Island Foundation
- Rhode Island Medical Society
- Rhode Island OHIC
- Rhode Island Parent Information Network
- Rhode Island Public Expenditure Council
- The Wilson Organization

*RIBGH supports the process but disagrees with the cost growth target percentage chosen for 2023 (6.0%).

The Public Health and Health Equity Measures Work Group Membership

1) Chris Ausura, EOHHS
2) Adama Brown and Larry Warner, United Way
3) Paige Clausius-Parks, KidsCount
4) Joseph Diaz, Care New England
5) Cesarina Elias, NHPRI
6) Pat Flanagan, CTC-RI
7) Andrea Galgay, RIPCPC
8) Peter Hollmann, Brown Medicine
9) Elizabeth Lange, Lifespan
10) Rebecca Labeau, OHHS
11) Kevin Martins, Care New England
12) Weayonnoh Nelson-Davies, Economic Progress Institute
13) Zach Nieder, RI Foundation
14) Gonzalo Paz-Soldan, BCBSRI
15) Kaitlyn Rabb, KidsCount
16) Sam Salganik, RIPIN
17) Larry Warner, United Way
18) Christine West, UnitedHealthcare
19) Christin Zollicoffer, Lifespan

Review of Pharmacy Strategies

Introduction

- During the last meeting, project staff reminded Steering Committee members of the group's previous work pursuing a pharmacy cost mitigation strategy focused on pharmacy prices.
- To augment and revive these previous efforts, staff presented a set of new medical pharmacy analyses performed by the state's analytics vendor, Freedman Healthcare. Unsurprisingly, these analyses highlighted that prices for a small number of brand name drugs contributed significantly to high and increasing commercial spending year over year.
- The co-chairs noted that for a bill to be considered in the 2024 legislative session, the Steering Committee would need to recommend one well in advance of January. To that end, project staff have prepared for today's discussion pharmacy pricing strategies for initial consideration.

Today's Discussion

- We will explore two classes of strategies: 1) reference-based pricing and 2) capping price growth. Note that these strategies can be complementary, with the first focused on price level and the second focused on price growth.
- There are multiple options for both reference-based pricing and price caps:
  1. Reference-based pricing: a) International, b) Medicare, or c) a hybrid of the two
  2. Capping price growth: a) capping annual growth relative to an economic index, or b) capping price growth at levels that can be supported, as determined by ICER
- The Steering Committee previously endorsed the introduction and passage of legislation in both of these areas in its letter to the Governor in 2021.
- We will now examine the options and their associated pros & cons. Recall that a separate work group will consider 340B implications for providers.

Strategy #1: Reference-Based Pricing (1 of 2)

- Definition: Reference-based pricing sets a limit on what purchasers pay for some or all prescription drugs based on a reference price. *Purchasers and pharmacies are prohibited from buying drugs above the reference price.* Reference prices could be set to international prices or to other payers, like Medicare. We will explore these options on the following slides.
- This strategy requires state entities, health plans, ERISA plans that choose to opt-in, and in-state retail pharmacies to purchase drugs at or below the reference price.
  - Medicaid is excluded as it is a federal/state partnership subject to different policies.
  - Payers are subject to a fine (e.g., $1,000) for each individual transaction in which payment for a referenced drug exceeds the referenced rate.

Strategy #1: Reference-Based Pricing (2 of 2)

- Strategy in Use: Many countries use reference pricing, often referencing prices in multiple other countries. Employers occasionally use the approach as part of benefit plan design (e.g., the RETA Trust, a national association of 55 Catholic organizations that purchases health insurance for their employees, implemented reference pricing). Potential savings to Rhode Islanders are large.

- Let's now explore three possible approaches to reference-based pricing:
  1. International (Canadian)
  2. Medicare (leveraging the Inflation Reduction Act)
  3. a combination of these two approaches.

Why International Reference Pricing?

- There are a few sound reasons to look to international drug prices as a reference:
  - Foreign countries pay a fraction of what Americans pay for prescription drugs
  - International prices offer a fair, easy-to-implement approach to rate setting.
- Operationalizing such a strategy in Rhode Island would involve using the APCD to identify some count of the costliest drugs in RI in terms of annual spend, crosswalking to international prices, and establishing an upper payment limit for those drugs.
  - NASHP previously suggested identifying the top 250 drugs.
  - There are over 45,000 drugs in the APCD!

*Slide adopted from the Fall 2020 public forum presentation from Trish Riley of NASHP.

Approach 1a: Canadian Reference Pricing

- Canadian prices are particularly attractive for reference-based pricing for the US because:
  - there are publicly available Canadian price data;
  - Canada analyzes data from a basket of countries part of the Organization for Economic Cooperation and Development (OECD) to set prices, and
  - Canada's model uses price data from four provinces (Ontario, Quebec, British Columbia, and Alberta) and, for unavailable prices, Patent Medicines Prices Review Board.
- The next slide provides a comparison of Canadian and US rates for eight top selling drugs as of 2018.
  - This analysis could be updated, expanded and customized to Rhode Island should the Steering Committee have interest in this strategy.

*Slide adopted from the Fall 2020 public forum presentation from Trish Riley of NASHP.

Examples of Canadian Rates

Drug Name & Dosage	US Price	Canadian Reference Rate*	Price Difference	Savings off US Prices
Humira pen injector (40 mg/0.4 ml pen) (arthritis, psoriasis, Crohn's)	$8,109.66	$1,046.08	$7,063.58	87%
Stelara (90 mg/ml syringe) (arthritis, psoriasis, Crohn's)	$13,258.50	$3,158.80	$10,099.70	76%
Enbrel pen injector (50 mg/1 ml pen) (arthritis, psoriasis, Crohn's)	$6,419.24	$1,049.08	$5,370.16	84%
Ozempic (4 mg/3 ml syringe) (diabetes)	$821.01	$142.90	$678.11	83%
Skyrizi pen injector (150 mg/1 ml pen) (arthritis, psoriasis, Crohn's)	$7,087.79	$3,615.42	$3,472.37	49%
Dupixent pen injector (300 mg/2 ml pen) (eczema, asthma)	$3,386.18	$1,374.88	$2,011.30	59%
Humira pen injector (40 mg/0.8 ml pen) (arthritis, psoriasis, Crohn's)	$7,724.08	$1,046.46	$6,677.62	86%
Trulicity pen injector (1.5 mg/0.5 ml pen) (diabetes)	$810.32	$123.28	$687.04	85%
	Average discount based on select, high-cost drugs in 2022			**76%**

Pros & Cons of Canadian Reference Pricing

- Pros:
  - Can greatly lower prescription drug spending in a state without running afoul of patent law through price setting
  - Relatively easy to implement
- Cons:
  - Subject to challenge under the Dormant Commerce Clause (limits to in-state transactions).*

*For more information, see: https://www.nashp.org/wp-content/uploads/2017/11/DCC-White-Paper.pdf

Approach 1b: Medicare reference pricing (1 of 2)

- This strategy is the same as the previous one, except the referenced drugs and prices would be those negotiated by Medicare per the prescription drug provisions of the Inflation Reduction Act of 2022 (IRA).
- The IRA includes several Medicare drug price negotiation parameters:
  - The drugs cannot have any competitors (no generic equivalent, and if it is a biologic drug, cannot be a biosimilar product).
  - The medications must have been on the U.S. Food and Drug Administration's approved list for many years (nine years for "small molecule drugs" and 11 years for biologics).
  - The law takes effect in 2026 and follows this schedule:
    - **2026:** A maximum of 10 drugs will be negotiated.
    - **2027:** Another maximum of 15 drugs will be negotiated.
    - **2028:** Another maximum of 15 drugs will be negotiated.
    - **2029:** Another maximum of 20 drugs will be negotiated this year and every year after that.

Medicare reference pricing (2 of 2)

- The Medicare price negotiation process is as follows:
  1. The HHS Secretary compiles the list of drugs that meet the criteria to be benchmarked.
  2. From this list, the Secretary selects the first ten drugs off the list in order of highest to lowest spending.
  3. The Secretary requests information from manufacturers of the drug on the list.
  4. The Dept. of HHS then reviews information and offers a Maximum Fair Price, or MFP* (range from 40% to 75% of non-federal average manufacturer price [AMP]).
  5. Manufacturers can accept or propose a counteroffer.
  6. **The Secretary publishes final and binding MFP.**
- There are severe penalties for lack of compliance with this process.

*The longer a drug has been on the market, the lower the MFP.

Drug Price Negotiation Program: Possible High-Spend Drugs for CMS Negotiation

Brand Name	Generic Name	Manufacturer	Therapeutic Treatment	Total Spend (2020)
Eliquis	Apixaban	Bristol-Myers Squibb	Blood clots	~$9.9 billion
Xarelto	Rivaroxaban	Janssen Pharmaceuticals	Blood clots	~$4.7 billion
Humira	Adalimumab	AbbVie	Rheumatoid arthritis	~$4.2 billion
Januvia	Sitagliptin Phosphate	Merck	Type 2 diabetes	~$3.8 billion
Trulicity	Dulaglutide	Eli Lilly & Co.	Type 2 diabetes	~$3.3 billion

*Slide adopted from a presentation by NASHP to the Connecticut Cost Growth Benchmark Steering Committee on 9/28/22.

Pros & Cons of Medicare Reference Pricing

- Pros:
  - Can lower prescription drug spending in a state
  - Relatively easy to implement
- Cons:
  - Won’t be implemented until 2026
  - Limited number of high-cost drugs impacted, especially in early years
  - Limited to “old” medications – cannot be used for new drugs entering the market at very high prices, e.g., Trikafta

Approach 1c: Hybrid of Medicare MFPs and Canadian Prices

- A hybrid reference-based pricing option would allow for the selection of either Medicare MFPs or Canadian prices (the lower of the two).
- This approach would have all of the benefits of Canadian reference pricing but would utilize CMS-negotiated Medicare prices if lower.

Note: NASHP has created model reference pricing bills for state use for international reference pricing and for Medicare MFPs.

Discussion

- Does the Steering Committee view reference-based pricing as a possible strategy option to pursue?
  - If so, which of the three strategy options appears most attractive?
- What additional information do you need to fully evaluate reference-based pricing as a strategy?

Strategy #2: Capping price growth

- Definition: A price growth cap penalizes manufacturers for the sales of drugs with excessive price increases. The definition of 'excessive' differs between our two proposed approaches.

- Strategy in use: The Steering Committee previously endorsed adoption of Connecticut's and Massachusetts' price increase legislation. Neither bill passed during the 2022 legislative session.

Approach 2a: Capping annual price growth relative to an economic index

- This strategy penalizes manufacturers for the sale of drugs with excessive price increases.
- In prior proposed legislation introduced by the Governors Baker and Lamont of MA and CT, "excessive price increase" was defined as a price increase that is 2% or more over the inflation rate (i.e., CPI + 2%) when compared to the price as of January 1st of the prior calendar year, or as of first marketing for drugs introduced after legislation passes.
- Manufacturers of drugs with an excessive increase would be subject to a tax penalty of 80 percent of the "excessive" amount of the price increase for each unit sold.

Pros & cons of capping annual price growth relative to an economic index

- Pros
  - Easy to implement
- Cons
  - Low impact relative to reference pricing
  - Can capture drugs with high inflationary increases but with low prices in absolute terms (do not necessarily represent the drugs with the highest total spending)
  - Does not discriminate against price increases that could be justified

Approach 2a: Capping price growth at levels that can be supported as determined by ICER

- This strategy penalizes manufacturers for the sale of drugs with unsupported price increases (UPIs) as determined by Institute for Clinical Effectiveness Research (ICER). ICER annually evaluates 10-13 drugs for such increases and documents its determinations in a report each year (their most recent report is on UPIs in 2021).
- A NASHP model bill defines the penalty as "80 percent of the difference between the revenue generated by sales within the state of the Identified Drugs and the revenue that would have been generated if the manufacturer had maintained the Wholesale Acquisition Cost from the previous calendar year, adjusted for inflation utilizing the Consumer Price Index."
  - The penalty is only applicable to manufacturers with "at least $250,000 in total annual sales within the state in the calendar year for which the tax is assessed."
- Manufacturers are "prohibited from withdrawing the Identified Drug from sale or distribution within the state" and are subject to a penalty if they do so.

Pros & cons of capping price growth at levels that can be supported as determined by ICER

- Pros
  - Administratively simple, uses ICER's data
  - Model legislation exists and relies on ICER for calculations
  - Both consumers and manufacturers have input on what is unjustified
- Cons
  - Limited number of drugs
  - Low impact (and much smaller than capping price growth across all drugs)

Discussion

- Does the Steering Committee view capping price growth as a possible strategy option to pursue?
  - If so, which of the two strategy options appears most attractive?
- What additional information do you need to fully evaluate capping price growth as a strategy?

Summary

Strategy	Pros	Cons
Canadian Reference Pricing	▪ Can lower Rx spending in a state without violating patent law ▪ Relatively easy to implement	▪ Subject to challenges under DCC
Medicare Reference Pricing	▪ Can lower Rx spending in a state ▪ Relatively easy to implement	▪ Won't be implemented until 2026 ▪ Limited to # of high-cost drugs impacted (especially in early years) ▪ Limited to 'old' medications
Reference Pricing Hybrid	See above	See above
Capping annual price growth re: economic index	▪ Easy to implement	▪ Lower impact than reference pricing ▪ Can capture drugs with high inflationary increases but with low prices in absolute terms ▪ Does not discriminate against justified price increases
Capping annual price growth re: ICER	▪ Administratively simple, uses ICER's data ▪ Model legislation exists and relies on ICER for calculations ▪ Both consumers and manufacturers have input on what is unjustified	▪ Low impact than reference pricing, and lower than capping growth for all drugs ▪ Limited number of drugs

Status of Hospital Global Budget Work

Hospital Global Budget Working Group Timeline

The VBP compact outlined the following timeline for the Hospital Global Budget Working Group:

July 1, 2023	Identification of the key parameters of the hospital global budget model
July 1, 2024	Completion of an independent study of hospital costs and cost-shifting
July 1, 2025	Establishment of sufficient state government administrative capacity to oversee the successful implementation of the model
January 1, 2026	Implementation of the hospital global budget model

Hospital Global Budget Working Group Structure

The Working Group consists of hospitals, payers, providers, business representatives, consumer representatives and more.

The Working Group has met 11 times – monthly from July to September 2022, and then roughly two times a month since January 2023.

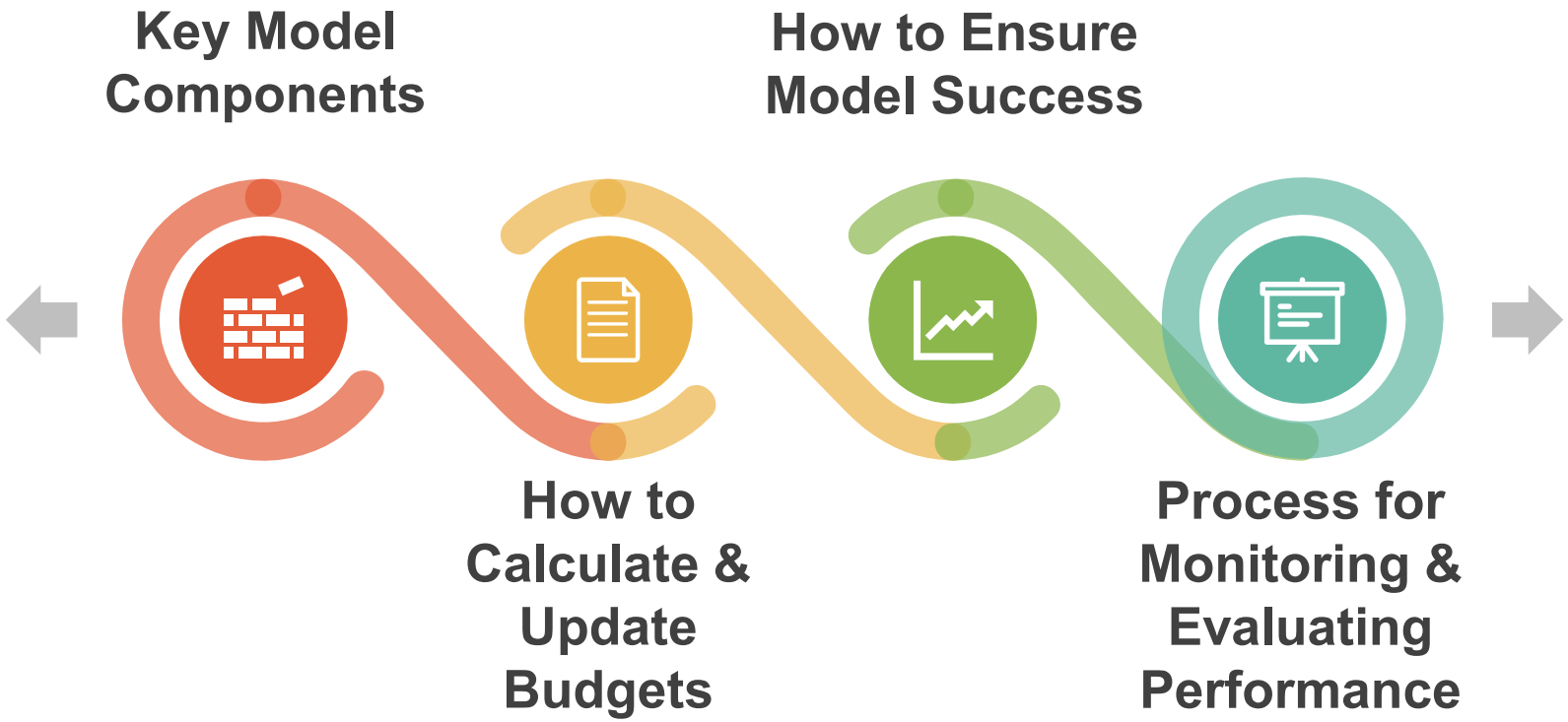
Adopted Hospital Global Budget Model Goals

The following goals borrow from the Compact to Accelerate Advanced VBP Model Adoption in Rhode Island and OHIC's goals for Rhode Island hospitals:

1. Reduce the growth rate of health care spending to an affordable and foreseeable level.
2. Provide hospitals with predictable revenue to promote financial sustainability.
3. Promote access to appropriate care in Rhode Island across all populations, including those who have been historically underserved.
4. Enhance coordination and efficiency across delivery systems.
5. Support investment in a high-quality clinical workforce and technical innovation in care delivery to support population health management and quality excellence.
6. Improve patient experience of care, quality of care, patient outcomes and health equity.

Issues Discussed by the Working Group

There are four general categories of issues that the Working Group will address.



Summary of Consensus Points to Date (1 of 5)

Over the last nine meetings, the Working Group has come to consensus on the model parameters outlined in the next few slides.

Of note, the Working Group continues to refine these model parameters as it considers additional questions around model design.

Working Group members have recommended establishing a future technical group to advise on the feasibility of implementing the model parameters.

Summary of Consensus Points to Date (2 of 5)

Hospitals and Populations Covered by the Budgets:

1. Consider budgets for all hospitals, including specialty hospitals.
2. Include revenue generated by participating hospitals from claims paid for members covered by participating commercial, Medicaid and Medicare payers.

Levels at Which Budgets are Established:

3. Adopt hospital-level budgets in lieu of system-level budgets.
4. Adopt market-specific budgets for each participating hospital-payer dyad.

Summary of Consensus Points to Date (3 of 5)

Services Included in the Budget:

5. Include all services billed under the hospital TIN, including:
   a. hospital inpatient and outpatient services;
   b. services delivered in hospital-owned entities that are billed under a hospital TIN; and
   c. services delivered by all professionals who bill under the hospital TIN (including employed and contracted, non-employed professionals), regardless of place of service.

The Working Group recommended developing a strategy for monitoring for and mitigating against hospitals shifting services (in an undesired manner) out of the budget.

Summary of Consensus Points to Date (4 of 5)

How to Establish the Baseline Budget:

6. Use hospital revenue from participating commercial, Medicaid and Medicare payers as the basis for developing base budgets. Conduct an analysis of hospital finances that includes hospital costs and hospital operating margins to determine if adjustments to the base budgets will be needed.

7. Use 2017-2019 data to model the impact of moving to a hospital global budget. Use more recent data from 2023 onwards when setting budgets for 2026 and evaluate the need for adjustments to account for COVID-19's impact at that time.

Summary of Consensus Points to Date (5 of 5)

How to Update Budgets Annually:

8. Adopt a flexible budget to account for volume changes during the year.
9. Develop routine budget adjustments to account for changes in:
    a. age, sex and case mix and
    b. inflation (i.e., projected Medicare Market Basket index without productivity adjustments).
10. Develop a process for adjudicating special budget adjustments.

Of note, the Working Group is currently considering potential ad hoc budget adjustments, including for new service offerings/closures, capital investments, new medical technology and social risk.

Additional Topics to Discuss

The Working Group will explore the following questions between now and July:

1. Should the model include supplemental arrangements to improve population health, access and quality (e.g., TCOC or P4P arrangements)?
2. How should the model co-exist with other VBP initiatives in the state (e.g., ACO shared savings agreements)?
3. Should hospitals and payers be allowed to customize the model and diverge from the recommended model parameters?

Public Comment

Next Steps and Wrap-up

Upcoming Meetings

- June 27th, 2:00pm – 3:30pm
- July 24th, 11:30am – 1:00pm