Rhode Island Health Care Cost Trends Project
Steering Committee Meeting Minutes
EOHHS – Virks Building – 3 West Road, Cranston
September 21, 2023
2:30-4:00pm

Steering Committee Attendees:
Cory King, Office of the Health Insurance Commissioner
Michele Lederberg, Blue Cross Blue Shield Rhode Island
Ed McGookin, Coastal Medical
Stephanie de Abreu (on behalf of Tim Archer), UnitedHealthcare
Erin Boles Welsh (on behalf of Kate Skouteris), Point32Health
Al Charbonneau, Rhode Island Business Group on Health
Patrick Crowley, RI AFL-CIO
Mark Jacobs
Beth Marootian (on behalf of Peter Marino), Neighborhood Health Plan of Rhode Island
Daniel Moynihan (on behalf of John Fernandez), Lifespan
Teresa Paiva Weed, Hospital Association of Rhode Island
Betty Rambur, University of Rhode Island College of Nursing
Sam Salganik, Rhode Island Parent Information Network

Unable to Attend:
David Cicilline, RI Foundation
Tony Clapsis, CVS Health
Michael DiBiase, Rhode Island Public Expenditure Council
Pat Flanagan, CTC-RI
Diana Franchitto, Hope Health
Peter Hollmann, Rhode Island Medical Society
Jim Loring, Amica Mutual Insurance Company
Michael Wagner, Care New England
Larry Warner, United Way
Larry Wilson, The Wilson Organization

I. Welcome
Cory King welcomed Steering Committee members to the September meeting and reviewed the agenda.

II. Approve Meeting Minutes
Cory asked if Steering Committee members had any comments on the June 27th meeting minutes. The Steering Committee voted to approve the June meeting minutes with no opposition or abstentions.

III. Co-Chair Update
Cory King introduced Dr. Ed McGookin, President of Coastal Medical, as the Committee's new co-chair. He noted that Ed's background in primary care allowed him to approach discussions with the Steering Committee with a necessary thoughtfulness and perspective and could help push initiatives forward. Ed expressed his enthusiasm to serve as a co-chair for this advisory body.

Cory King reminded members that they committed to a few priorities in the spring, a few of which were the main topics for discussion for the present meeting.

IV. Draft Pharmacy Legislation
Michael Bailit noted that the fact that prescription drug prices have grown at a rate far above the cost growth target made a compelling case to address them. He added that high drug prices created access and quality issues. He shared an anecdote where a patient taking Humira had to delay her retirement to pay for her medication. He chronicled the Committee's prioritized work on pharmacy in 2021 and its prioritization of a pharmacy cost mitigation strategy for 2023.

Cory King provided details on a cross-state pharmacy workgroup organized at OHIC's initiative, noting that the purpose was to establish whether the group agreed on a strategy to advance a uniform proposal across two or more states for 2024. He shared that he was in discussions with Connecticut on joint efforts.

Michael Bailit then summarized the conversations of the Steering Committee's 340B Workgroup over the summer, during which interested parties shared their feedback on the proposals under OHIC's consideration. He shared the Workgroup's input and invited Teresa Paiva Weed to add her observations. In response, Teresa commented that the 340B program helped hospitals provide drugs to those patients who could not afford them.

Michael Bailit reminded everyone of the theory of action for the pharmacy work and then described the components of OHIC's draft pharmacy price legislation proposal. He noted that the two major elements were severable, and could be advanced separately.

Michael walked through the components of the first proposal: imposing penalties on manufacturers for excessive price increases. He stated that this was essentially the same concept the Steering Committee endorsed in 2021.

- Michele Lederberg noted that Blue Cross's efforts with legislative sponsors last year to produce a similar bill to penalize excessive price increases were met with both support and pushback. In response to a Steering Committee member's question, she reported that she did not recall pharmaceutical representatives mentioning withdrawing their drugs from the Rhode Island market if such legislation passed, although she agreed it was at least possible it could happen.
- Teresa Paiva Weed suggested that the legislative proposal include something to address the impact of pharmacy benefit managers (PBMs) on prescription drug costs. Teresa suggested that OHIC could use its regulatory authority to expand oversight and regulation of PBMs.
    - Cory King replied that the current law on Third-Party Administrations (TPAs), which included PBMs, required an annual report from the PBMs to the

Department of Business Regulation (DBR). He said that until the regulatory structure on PBMs was more defined, there was not much more that could be done to review market practices. Ultimately, though, his focus was on prescription drug prices.
    - Michael Bailit added that the Steering Committee could move forward with a recommendation on PBMs, independent of OHIC's authority.
- Patrick Crowley asked for 1) an example of how a manufacturer might violate the cap on price increases, and 2) more detail on how the revenue generated from collecting penalties would be used to reduce costs to consumers.
    - Michele Lederberg responded that an example of triggering the penalty would be if Humira came off patent in January and increased its price by 15% without any changes to its indication.
    - Patrick inquired what a drug manufacturer's incentive to increase their price would be if they knew this statute was in place. In other words, how would we ensure that the penalty was significant enough to make a difference in their bottom line.
    - Cory King responded that manufacturers would be required to report on their volume of sales and total revenue generated for those drugs to OHIC. He recognized that a potential pitfall was that manufacturers might decide to pay the 80% penalty and increase their prices. On the question of helping consumers, he answered that there were many ways to use the penalty funds, such as subsidizing medications, or, under Blue Cross' proposal, funding an immunization fund or vaccine program.
    - Dan Moynihan noted that from a point-of-sale perspective, consumers would not see that advantage.
    - Michael Bailit responded to Dan, stating that if manufacturers did comply with such a proposal, consumers would see savings upfront; if they did not, the state would have to work out distribution of the collected penalty funds on the backend.
- Sam Salganik noted that the language in the proposals on benefiting consumers was vague, and expressed a desire to modify the proposal so that it was more mindful to the point-of-sale cost to the consumer. The fact that consumers skipped filling their prescriptions because of high copays should be addressed as part of the proposal.
    - Cory King noted that legislature had recently passed legislation to cap out-of-pocket costs on specialty drugs.
    - Sam suggested potentially building on that list of drugs within the draft bill.
- Patrick Crowley advised giving serious thought about who the "unforeseen opponents" of this legislation would be (e.g., "mom-and-pop" pharmacies), as it was important to address that opposition when the bill was up for discussion by the General Assembly.
    - Michele Lederberg agreed, adding that having protections in place for consumers was one way to get broader support across the board.

Michael Bailit provided an overview of the second legislative proposal concept: setting state payment limits for prescription drugs. He explained that the policy as written in the draft bill was a result of revising the National Academy for State Health Policy's (NASHP's) model legislation based on feedback from the cross-state pharmacy workgroup. The policy set

payment limits based on both domestic and international benchmarks from countries, including but not limited to, Canada.

- Michele Lederberg observed that implementing this strategy would require significant infrastructure, which would make it a hard sell for states.
- Erin Boles Welsh asked how the state would prevent a manufacturer from shifting the costs of drugs subject to the state payment limit to other drugs in their portfolio.
    - Michael Bailit acknowledged this potential shortcoming of the strategy, and added that combining reference payment limits with penalties on excessive price increases would afford protection from such behavior.
- Dan Moynihan asked whether any of the benchmarks included a protective factor against price inflation (e.g., if another country decided to increase their prices significantly).
    - Michael Bailit replied that there was virtually no incentive for countries to do so, and even if they did, he was confident that there would remain large differences between prices in the US and in those other countries.
- Chris Ausura asked whether having the provision establishing an upper limit ("the Maximum Fair Price") under the Inflation Reduction Act on the national level might help make the case to do something locally in Rhode Island.
    - Cory King noted that this idea arose during the cross-state meetings as well.
    - Patrick Crowley thought it would strengthen the argument to do something locally in tandem to prevent manufacturers from passing losses at the federal level onto the state level.
- Erin Boles Welsh asked about how the state could ensure that other states involved in the multi-state conversations would pursue this strategy alongside Rhode Island.
    - Cory King explained that while he initially theorized that more states moving in tandem would increase the chances of the legislature passing a proposal, it was not a necessary condition for OHIC, or any party, to move forward with the concept. Additionally, even if the Committee did not support the proposal, individual parties, including OHIC, could move forward independently.

Michael Bailit invited Steering Committee members to share their written comments, questions, or suggested modifications with Jessica Mar via email, and adding that any changes would be reflected in a revised draft. Jessica subsequently reshared the draft with members via e-mail and requested comments by October 6th.

V. **VBP Subgroup Review of Compact Targets**

Cory King shared that based on the two meetings with the Steering Committee's VBP Subgroup and previous discussions with hospital leadership, he did not see a path forward in implementing the April 2022 VBP Compact as written. He added that there did not exist agreement amongst principal parties to move forward in developing a state-driven all-payer hospital global budget, and it was evident that such a model could not be implemented on a voluntary basis. He credited the Hospital Global Budget Working Group with undertaking the unprecedented work of discussing design parameters for an operational hospital global budget model in Rhode Island. However, it was clear that members of the Steering Committee needed to affirm their commitment to VBP and whether they still believed it was a vital means to achieve the cost growth target. He offered the possibility of scrapping, revising, or entirely rewriting the Compact and recognized there were still many TCOC arrangements in the state.

- Betty Rambur applauded the Hospital Global Budget Working Group for its efforts.
- Beth Marootian suggested pursuing a more incremental approach that did not require the same "all-in" attitude as considered by the Hospital Global Budget Working Group.
- Cory King responded that he was aware there were parties interested in global capitation, but he ultimately left it up to the Steering Committee to decide the path forward. That might involve introducing greater downside risk in TCOC arrangements or enhancing incentives currently in place.

VI. CMS' AHEAD Model Announcement

Michael Bailit summarized some of the main details of CMS' States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model. He noted that Rhode Island, through its Hospital Global Budget Working Group, developed the framework, but not design, for a hospital global budget, a core element of CMMI's AHEAD model. CMS will permit states to adopt their own hospital global budget model, or follow the model developed for Medicare. Cory shared that Rhode Island OHIC and EOHHS were part of initial discussions about this model with CMMI. He believed Rhode Island was well-positioned to apply for the model, but he wanted to understand whether there was an appetite among at least a handful of hospitals to take on a Medicare hospital global budget, and align that activity for their Medicaid business.

- Beth Lange (as a public comment) asked whether the enhanced Medicare payments (ranging from $17 to $21 PMPM) were part of the $12M the state would receive from CMMI, and if so, noted that it seemed like a lot of work for states to get $1M a year over the AHEAD model's ten-year period. Additionally, she asked whether Medicaid would also benefit from enhanced payments.
    - Cory King replied that the cooperative agreement funding of $12M, which was for the first five or six years, was to develop a hospital global budget and advance health equity. The primary care PMPM was separate. With respect to Beth's Medicaid question, EOHHS would need to go to the legislature and get a state appropriation if it which to make enhanced payments.
- Betty Rambur asked how Rhode Island's Medicare Advantage-oriented market would work with the hospital global budget, seeing as how the AHEAD model required participation of Medicare fee-for-service.
    - Cory King responded that CMMI expected states to recruit a significant payer, meaning at least one major Medicare Advantage and commercial payer, for the model. He noted that while hospitals were not required to commit to a budget prior to the state's application to the model, they had to do so before the performance period decided upon by CMS and the state.
- Elena Nicollela (as a public comment) noted that there were at least two health centers in the Medicaid Accountable Entities program taking on downside risk.
- Cory King reported that he would reach out to hospitals and commercial payers in the coming weeks, and that he already had a few internal state conversations.

VII. Public Comment

There were no public comments.

VIII. Next Steps and Wrap-Up

The next Steering Committee meeting will be on October 20th from 3:00pm-4:30pm. Beginning in 2024, the Steering Committee will shift to meeting on a quarterly basis.