Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes

April 18, 2017

Members in Attendance: Lt. Governor Nancy Wyman, Susan Adams, Pat Baker, Theodore Doolittle (OHA), Anne Foley (OPM), Margherita Giuliano, Dr. William Handelman, Michael Michaud (DMHAS), Raul Pino (DPH), Jordan Scheff (DDS), Robert Tessier, Jim Wadleigh (Access Health CT), Joshua Wojcik (OSC), Kate McEvoy (DSS)

Members Absent: Ellen Andrews, Kurt Barwis, Bonita Grubbs, Frances Padilla, Shelly Sweatt, Gary Letts, John Orazietti, Hussam Saada, Lawrence Santilli, Greg Stanton, Kristina Stevens(DCF), Shelly Sweatt, Katherine Wade(CID)

Others present: Victoria Veltri, Chief Health Policy Advisor (Lt. Governor Office), Jonathan Shaw, VP,PBM Product Development, Prod Innov & Mgmt, CVS Health, Mr. DiLoreto Diloreto, Vice President, State Government Affairs, Healthcare Distribution Alliance, Ms. Annik Chamberlin, PharmD, Angelo DeFazio, RPh Rick Carbray, R.Ph., former owner of Apex Pharmacy

Agenda Item	Topic	Discussion	Action
1.	**Call to order & Introductions**	The Lieutenant Governor welcomed everyone to the meeting and noted that the presenters will discuss the pharmaceutical supply chain. She noted that questions should be asked at the end of all three presentations unless it was regarding clarification.	
2.	**Public Comment**	There was no public comment	
3.	**Review & Approval of minutes**	The minutes from the February meeting had not been posted for the requisite period prior to the meeting, and will be voted on at the May meeting	

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4.	**Presenters:**	Victoria Veltri introduced Jonathan Shaw, VP, PBM Product Development, Product Innovation & Management, CVS Health, who discussed the role of the Pharmacy Benefit manager (PBM) Mr. Shaw explained that he works on PBM side, specifically for Caremark, which covers ›80 mill people nationally. Some of a PBM's constituents/clients include public, private sector employers, insurers and Taft-Hartley plans; downstream are the client's members. He noted that more than 253M people have pharmacy benefits through a PBM, and explained that PBM's role is to: - Administer benefits – process claims, manage networks - Work to keep costs down – negotiating power to reduce drug costs, promote lower cost meds (generics), avoid inappropriate med use - Improve patient care – patient support, education and compliance activities PBM's result in a 35% average savings to plan sponsors and consumers Mr. Shaw explained that growth in healthcare costs are expected to exceed GDP, and that this growth is driven by: 1. increasing cost of drugs – brand and new, innovative meds	

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		2. increased utilization – more clinical indicators for medication use, more people needing meds Market forces result in an 11% trend (which Mr. Shaw defined as the year to year growth in expenditures) for medications costs, but PBMs reduce that to 3.2% through the use of: intelligent purchasing, effective med management and versatile cost strategies Dr. William Handelman asked if PBMs have such incredible negotiating power, then why do pharmaceutical cost increases outpace inflation every year? Mr. Shaw noted that he would be discussing that in more detail later, but briefly identified that the key to managing costs is competition. When there's competition, there is more opportunity. He used the example of statins, which has lots of competition, so costs can be kept down. Specialty drugs are a good example of the impact of limited or no competition on pricing, because they are often unique drugs. With no competition there is less opportunity to negotiate lower prices. Dr. Handelman acknowledged that, but countered that even generics see increasing costs. The market has consolidated, fewer "mom and pop" pharmacies, with more and larger chains, but we haven't seen the cost savings Mr. Shaw believes that PBMs are doing a good job, but even a 3.2% increase is an increase. For generics, they do get a lot of headlines.	

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		Some single source generics are more expensive, due to reduced competition. Ms. Veltri asked for clarification on trend data. Is it really a trend, since it's only addressing one year? Mr. Shaw explained that the term trend described cost increases for last plan year in that slide Mr. Tessier followed up, asking that Mr. Shaw discuss Dr. William Handelman's question in more detail during the panel discussion, since many Cabinet members have similar concerns. He also has a question about data in slide – are specialty drugs rolled into the brand drug category? Mr. Shaw informed him that they were, and Mr. Tessier inquired why they weren't listed separately? What was the trend for specialty drugs? Mr. Shaw explained that the trend for specialty was in the high teens. Mr. Tessier followed up, asking about the 3.2% overall trend, what percentage of the PBM's clients did better? Did worse? What was the State of CT's trend? Josh Wojcik clarified that the state's pharmacy trend was significantly higher because it doesn't use Caremark's standard formulary, so the costs are more sensitive to price variation.	

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		Ms. Giuliano asked if many PBMs have distinct specialty pharmacies to help manage these drugs. The trend for these is in the teens? Mr. Shaw agreed that there are specialty pharmacies for these drugs, and the trend is typically about 17-18%. He then reviewed the importance of competition on the PBMs ability to drive down costs through negotiation, providing the example of statins, showing a significant decrease is costs as more manufacturers entered the market. 85-90% of medications members take are generics, so there is significant opportunity to leverage PBMs market power to keep costs down. The remaining 10-15% of meds, mostly specialty, are responsible for costs. PBM market power also helps keep costs down. When EpiPen cost increased 150%, Caremark was able to negotiate only a 10% increase for clients through negotiated discounts, rebates and price protection. Mr. Shaw then discussed formulary management, and the guiding principles: maintain clinical integrity, use market power to secure competitive pricing and education of members and providers. PBMs pick and choose preferred and non-preferred brands based on negotiated pricing. Clinical care and efficacy is primary consideration, but when there are multiple meds to treat a condition, they look for lowest cost.	

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		When changing formulary, PBMs work to help members with transition as needed. There is also a medical exception process for those members for who the new medication is contraindicated. Historically, PBMs had assigned different co-pays to non-preferred drugs, but in the last 5 years the trend has been to exclude coverage of these non-preferred, usually higher cost drugs. He then explored the benefit of PBMs on net price vs list price. Noted that when they began excluding non-preferred vs imposing higher cost sharing, the net cost savings increased. Ms. Veltri asked whether the price discounts vary by client or payer? Mr. Shaw explained that they vary by payer and manufacturer, but not usually by client, since the PBM usually negotiates as a block. Finally, he addressed the egregious price increases we've seen in recent years. With more drugs experiencing major increases in cost, 100-200% and more. In response, they have introduced a Hyperinflation Program, which identifies drugs with these massive increases earlier than they historically would. Previously, they might not catch these increases at the system level until planning for the next plan year. Some manufacturers would wait until the new plan year, and then increase costs 200-300%, leaving the PBM stuck with the negotiated pricing schedule until the next year. The Hyperinflation program detects these changes sooner, usually quarterly, and lets the PBM address the increases right away,	

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		typically by dropping the drugs or renegotiating if there are no clinically appropriate alternates. Ms. Giuliano asked how that impacts the patient? Mr. Shaw explained that the PBM may contact the patient to discuss the change and options, as well as provider and pharmacist. Ms. Veltri asked if these contracts include price protections? Mr. Shaw explained that they don't always, and depends on the manufacturer and drug. It is more their client contracts that limit the PBMs ability to respond to these changes, since many will limit formulary exclusions during a plan year. Mr. Shaw then explained how PBMs keep people healthy. This is a cost reduction exercise, but on the medical side. Appropriate and well managed treatment of medical conditions with medications, example of high cholesterol, can reduce the incidence of medical complications, reducing the medical utilization costs. CVS is more than a PBM – it is a connected healthcare company, with retail stores and clinics, mail order and specialty pharmacy, long term care, infusion, etc. This level of holistic engagement allows for better adherence and identification of gaps in care, minimizing problems and improving outcomes. Cost savings of this model – statin example showed increase in member compliance from 43.5% to 52.7% with the addition of	

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		pharmacist counselling, resulting in a net savings of $2,710 per patient, including productivity. Ms. Giuliano asked if the insurers were paying the pharmacies or pharmacists for these intervention services? Mr. Shaw acknowledged that it's a mix. All PBMs have processes in place to require certain activities of the pharmacies, with varying associated reimbursement and other incentives. Ms. Giuliano inquired how that works? Who is held responsible for these compliance activities? Is there any impact on this reimbursement? Mr. Shaw explained that this is a relatively new concept, and while it's not being implemented broadly and across all plan or payer types, where it is, they are not modifying payment based on these clinical metrics. In addition to pharmacy care, he also looked at patient care, which compliments the pharmacy's function. For example, diabetics can receive more personalized care management of their diabetes through all of the parts of Caremark's holistic model. Looking ahead, specialty drug spend is expected to be 55% of drugs costs by 2020, from 36% in 2015, despite this being a small portion of the population. Factors driving this trend include increasing utilization and prices	

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		The cost for many specialty meds is split, with part covered on the medical side, and the drug on the pharma benefit. Mr. Shaw noted that patient adherence is a huge problem nationwide. "If you talk to one patient about why they're not adhering, you've basically talked to one patient. Everyone's got different issues, everyone's got different reasons." Patient adherence activities, while complicated, can have significant cost savings. High cost out of pocket expenses is a challenge as well. Higher cost sharing can impact patient ability to use most appropriate med, or stay on it. Dr. Handelman opined that one thing that wasn't addressed is waste. Lots of consumers don't use of don't finish their prescriptions, which results in costs, but no clinical benefit. An example of industry practice that can drive waste are 90 day fills. Might be lower up front out of pocket costs, but since med or dose could change, the 90 day fill could be inconsistent with changing medical direction. Auto refills are another source, since there's no way to know if a patient is taking these meds, so med adherence is impossible to monitor. Mr. Shaw admitted that the industry has studied this a little, in particular the 90 day and auto refill, and that they haven't seen a big difference. Also, once a patient's medication regimen has been established, 90 day and auto refills can be very beneficial.	

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		Ms. Giuliano noted that the largest criticism they hear about PBMs is their lack of their acting as a fiduciary, specifically Caremark as PBM for the state plan. In some PBM-client contracts, there are provisions requiring that the PBM have fiduciary role. Is this a part of the State plan contract? Mr. Shaw didn't think Caremark was doing that, and wasn't aware of any contracts where they were. Mr. Tessier asked why not? Mr. Shaw explained that was a complicated answer Ms. Veltri followed up, asking how do you reconcile the role as a PBM and also as a pharmacy? How do they work together, since the interests of each seems to be conflicting. Mr. Shaw explained that for the most part, there isn't a problem. There are internal firewalls to prevent conflicts when the pharmacies negotiate with the PBM. Overall, the vision of each are aligned (promoting med adherence, lower cost meds, etc) Kate McEvoy expressed that she would be interested to hear about the link between pharmacists and clinical care, like the example of a pharmacist flagging that A1C as an indicator of diabetes and referring to the Minute Clinic. What is the feedback loop to the PCP?	

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		Mr. Shaw explained that the Minute Clinic is on Epic EMR, which allows for very effective sharing of patient information. If there is no integration, the clinical records are faxed to the PCP. Bob Tessier mentioned a journal article that looked at PBMs as "predatory". He cited the example of Express Scripts' per prescription profit increasing 500% since 2003, so how effectively are PBMs really managing costs? PBMs lack transparency, and you didn't mention it. Why does the industry fight transparency? Mr. Shaw noted that client negotiations are complex and the landscape changes frequently, so these agreements can be difficult to manage. Pricing is competitive with other PBMs, which should result in industry self-management. He continued, noting that transparency is an interesting question since it means different things to different people. Many aspects to transparency. One area people look for transparency in are the agreements between PBMs and manufacturers, discounts, etc. He pondered what the end goal of transparency is? Increasing disclosure could result in less effective negotiations, since manufacturers may be less inclined to negotiate robustly since their competitors could then see their pricing and adjust accordingly. Ted Doolittle commented on the slide on the cost of EpiPens, asking while you show that your client's costs only experienced a modest increase, who do you think is paying the higher price?	

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		Mr. Shaw admitted that it's often cash payers. Ted Doolittle clarified that, by paying in cash, you mean the uninsured? Mr. Shaw agreed that yes, that would impact the uninsured, but the coupon programs will help to offset some of these costs. Lt. Governor Wyman introduced Mr. Matt DiLoreto, Vice President, State Government Affairs, Healthcare Distribution Alliance (HDA), to discuss the role of the wholesaler. Mr. DiLoreto explained that represents wholesalers, and went into his background a little. He noted that wholesalers are an important link between manufacturers and the pharmacy, hospitals, long term care, etc., and have a highly efficient and advanced distribution system in the supply chain. The core function of wholesalers is a very simple one – purchase and store medications and other items from manufacturers, the fill client orders and ship to them. However, the pharma supply chain is highly complex and difficult to understand. HDA represents 34 member companies, each with a unique business model. Based on each client's needs, deliveries will ship meds at least once a day. Anti-trust law requires that they cannot discuss pricing. There are 200 wholesale distributor warehouses nationwide that serve as the middleman for 94% of medications, something that	

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		most people don't think about. Only 6% of drugs go directly from the manufacturer to the pharmacy. Top 25% of wholesalers purchase products from over 1,300 manufacturers. Wholesalers provide a "one-stop shop". Creates efficiency and reduces burden of finding, ordering and storing products. Wholesalers ship 15,000,000 products to pharmacies every day across the nation. Wholesalers have no control over or role in drugs pricing, PBMs or plan designs. There are other services that wholesalers also provide, including some health IT and others. He explained that the focus is to ensure that clients get the medicines they need when they need them. By working directly with manufacturers, wholesalers can ensure that the medications in the stream are FDA approved and legitimate drugs. How does this relationship with manufacturers and providers work? They purchase from manufacturers based on wholesale actualization costs (WAC), which are independently created and represent list price, and don't include rebates, etc. Each WAC is specific to each drug and drug dose. The cost to the wholesaler, based on the WAC, is passed onto the pharmacies. He discussed a US Today article, exhibiting a graphic that illustrates the complexity of the pharmaceutical supply chain. One example from this is that a $250 drug would give a wholesaler a	

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		$2.50 profit, supporting the premise that while the wholesaler is a crucial part of the supply chain, it doesn't add to costs. Wholesalers operate on very high volume, but very low profit margins (around 1%). He then explored how the model works. Compensation has shifted from a "buy and hold" model to a fee for service model. Under buy and hold, wholesalers could purchase a lot of a product at lower cost, and hold it until costs went up, then sell to increase profit. Industry shifted to fee for service, which reimburses wholesalers for distribution costs. This model helps to stabilize supply chain and costs, as the model is built on the efficient movement of product. What other services do they provide beyond distribution? Product analysis, supply chain security, health IT, EMRs, suspicious order monitoring, contracting services, and more. Pursuant to federal law, there is a new product tracing capability being implemented across the system, allowing an individual drug to be tracked through the supply chain. Dr. William Handelman noted that there is an ongoing scandal within the distribution network, where essential drug shortages that are "suddenly" unavailable and then marked up dramatically. What is the industry's plan for dealing with this? Mr. DiLoreto stated that he was not familiar with the specifics of the issue raised, but would research and follow up on this "price	

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		gouging" issue. He noted that HDA has testified against this practice. Ms. Veltri asked who has oversight over distributors? Mr. DiLoreto explained that there are multiple levels – state licensing, DEA and FDA rules all apply. Ms. Giuliano made a point of clarification – the CT Dept of Consumer Protection manages all drug distribution.	
		Ms. Giuliano introduced Ms. Annik Chamberlin, PharmD, Owner of Beacon Prescription Center and Mr. DeFazio, who owns five pharmacies and two medical marijuana dispensaries, to address role of pharmacies	

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		Ms. Chamberlin thanked the Cabinet for the invitation to participate in this discussion about this complex topic with many players. She started by identifying some of the key players in medication pricing – patient, manufacturers, wholesalers, pharmacies, PBMs, government. When consumers present a prescription, the pharmacist knows what they owe, and what their reimbursement is, subject to additional factors that will be discussed later. Mr. DeFazio discussed how the lack of US regulation over pricing makes it very complicated to navigate. Each participant/purchaser will have a different reimbursement Ms. Chamberlin addressed the impact of drug coupons, which are intended to help offset costs to un- or under-insured consumers, but may result in a higher overall cost to the system. Coupons reduce manufacturer incentive to lower costs. She cited the example of EpiPen, which has coupons for consumers to lower net cost to people, but the huge list price remains the same, which impacts pricing negotiations, and increases overall costs to consumers. Coupons are also usually limited to a short duration or quantity, which leaves the consumer paying full price after the coupon expires. Pharmacies touch every piece of the supply chain – purchase from manufacturer and wholesaler, dispense to patient, working with	

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		insurance and collecting cost sharing, and lots of counselling to patients and providers, but with little or no reimbursement for this counselling. Pharmacies have no say in reimbursement rates, which have been dropping, as have dispensing fees, which dropped from $2.31 to $1.62 between 2000 and 2010. Mr. DeFazio noted that a cliché in the industry is that pharmacies negotiate reimbursement and prices with PBMs, and that is absolutely not true. It is a take it or leave it contract, with small room for negotiation. He has some plans with a $0 dispensing fee for the pharmacist Ms. Chamberlin added that the reimbursement for meds can be less than the cost of the drug, so they lose money. But, these pharmacies can't easily drop these plans, because they would lose all of those members. Between 2005-2010 more than 50% of independent community pharmacies operated at revenue margin of 2% or less. Pharmacies have very little to do with overall costs. She then explored who is paying for this. Large companies hire PBMs to manage the pharma benefits. They process claims, reimburse at contracted rate determined by the PBM. No chance to negotiate. Mr. DeFazio identified that another issue in industry is a narrow market for PBMs, limiting the ability of pharmacies to enroll in	

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		network. These may change from year to year and PBMs could impact pharmacies, since they may end up out of network. Ms. Chamberlin explained that the three largest players control over 78% of the prescription transactions in U.S. Mr. DeFazio acknowledged that PBMs do a great job administratively, but have morphed into an entity that has no direct connection with the patient and drug dispensation. This disconnect complicates the system. Ms. Chamberlin expanded, noting that the system as it evolved can incentivize consumers to use fewer pharmacy services, ex. Mail order, limiting the important face to face needed for effective education and med management Concerning drug rebates, clawbacks, kickbacks, and performance based direct and indirect remuneration fees (DIRs), these complicates the fiscal picture more, and it's difficult to know where the money goes. Transparency is needed to understand this. Drug manufacturers provide incentives for PBMs to keep drugs on formulary – rebates, etc – despite no way of knowing if these savings are passed on to plan and members, as well as increased costs for the retained drugs. An example of this is when the U.S. Dept. of Justice fined Medco and Express Scripts for accepting kickbacks.	

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		Clawbacks are complicated. Pharmacy fills prescription, gets contracted reimbursement, and additional amount paid by member stays with PBM. DIR fees are "backdoor" fees that are imposed on pharmacies by PBMs after the prescription and reimbursement has been processed. For example, pharmacy processes a claim, ends up with $10 for dispensing. 3-4 months later the PBM sends a report noting that some patients had poor med adherence, and the PBM will take back $5,000 over next 3 months out of Ms. Giuliano asked for clarification: PBMs can penalize pharmacists for poor medication compliance, but no incentive for them to do it other than a loss for not doing it. Ms. Chamberlin provided an example of the process: Pharmacy buys drugs from wholesaler for $85. Member brings in prescription for the drug, which pharmacy fills, then submits claim to OBM for $100 based on benchmark. PBM processes and pays, leaving pharmacy with $15 gross profit. Months later, PBM claws back a $7 DIR fee, cutting gross profit by 50%, from $15 to $7, months later. Mr. DeFazio added that under the ACA, the intent was to get away from a fee for service model, but focus on quality. However, pharmacies have limited ability to impact this quality, but are penalized. Imagine an industry where you don't know what you're end payment for a service will be for several months.	

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		Dr. William Handelman asked if there is transparency in how the claw back is determined? Is it in contract? Mr. DeFazio explained that it wasn't, and even worse, if he was 100% compliant with adherence, he could still be faced with a 3% clawback from the PBM. Dr. William Handelman responded that this is clearly asking pharmacists to exceed the scope of their practice, since they're being asked to manage a patient's medical care without a license. Ms. Chamberlin provided an example of these clawbacks, discussing a report she had received from a PBM for the last trimester that shows overall adherence for statins, diabetes, gap therapy, medication therapy management reviews, and ensure that none of the elderly patients are on high risk medications, which requires calls to the provider. Also are paid ingredient costs times an unknown variable rate. Mr. DeFazio added that if the physician refuses to change the medication, despite a call from the pharmacist, the pharmacist is still penalized. Pat Baker asked what tools do you get from a PBM for them to meet these expectations? Mr. DeFazio noted that is what they've been asking for, that they take the guesswork out so they know what their expectations are and how to comply fairly. There really are no support tools.	

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		Who would get into a contract where you have to guess what you'll make? Ms. Chamberlin explained that these contracts have gag clauses barring them from discussing specifics of the plan, reimbursement, etc. For example, if a patient's co-pay would exceed the out of pocket cost for a medication, they're barred from telling the patient. She believes that the extra payment goes to the PBM, not the client. Mr. DeFazio stated that there have been examples of employers dropping their PBM and managing this themselves, like Caterpillar, which reduced their costs. There is no transparency in PBMs, and these efforts have not reduced the cost of healthcare. He further asked that if a patient has to go to one specific pharmacy for a medication, who then refers to a specific pharmacy to fill that type of drug, but that pharmacy is owned by the PBM, how is that transparent or reducing costs? Josh Wojcik asked if there is a minimum number of clients that the clawback would apply to. Mr. DeFazio explained that yes, very small numbers don't have this, but this is not a common situation Ms. Giuliano commented that pharmacists are uniquely positioned to help monitor patients' adherence, and have a different perspective in patient management. Because this is still evolving,	

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		we are not there yet to equitably incorporate all pharmacists, in particular small pharmacies, into the care management team. Pharmacists are the experts on medications, and a part of the care teams that is often overlooked. Ms. Chamberlin agreed that the system is extremely complicated Mr. DeFazio also agreed and used example of specialty drugs. How are they classified? He thinks it's because of cost. Why can't we have complete transparency in where all the money goes? The U.S. has the best distribution system in the world, but there's an invisible man behind the curtain, which is the PBM. In order to address this, we really need to know who is getting paid what, when and why, and what the impact on the system is. Dr. Handelman asked if PBMs truly believe that pharmacists are important parts of the process for monitoring patient adherence, then why do they push patients to use the 90 day refill and mail order, which keeps the patient away from the pharmacist? Ms. Chamberlin cited an example of recent patient, who needed one box of two meds. PBM required a 90 day fill, but provider only wrote the prescription for 1, which is not a 90 day quantity. Claim wouldn't go through unless she classified the box as a 90 day fill, but she was able to call the PBM and get a one-time override, instead of sending them home with 24 boxes that would have been wasted.	

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		Kate McEvoy thanked them for this, and summarized some of the CMS proposals to change pharmacy management for Medicaid, and discussed some of the challenges.	
		Ms. Veltri explained that all of the presentations will be posted on the Cabinet website by the end of the day, and began the open panel portion of the meeting. Lt. Gov. Wyman asked what are some ways in each area of the pharmaceutical chain where we could reduce costs? Mr. Shaw explained that his personal perspective is that enabling competition between manufacturers can drive costs down; as well as encouraging generics. Review and simplify the regulatory pathways to new drugs development. Excluding drugs will also drive costs down through increased competition by manufacturers to participate, but it has an adverse impact on the member experience. Ms. Giuliano emphasized the importance of transparency. Drug pricing is complex, so how can we understand how to fix it? Example of specialty drugs, and lack of clear definition of what it is. Need to know where the money is going. It's not a crime to make a profit, but it needs to be done in a manner that's consistent with the goals. Mr. DeFazio promoted the concept of PBMs being considered fiduciary, and argued that the limited formulary which impacts	

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		member's ability to use the most clinically appropriate drug in favor of the most affordable is a fiduciary act. Mr. Shaw disagreed that the PBMs aren't making the decisions to narrow the networks, but that it is the client's decision. PBMs don't want to be in the position to make those decisions. He also addressed the premise that the PBMs have a fiduciary role, arguing that they don't, but instead noted that their role is specified by the clients. Bob Tessier asked how long ago Caremark adopt exclusionary formularies, and noted that clients were told at the time that about 75 drugs would not be available, disproving the premise that PBMs don't take unilateral actions of this type. He noted that this practice has changed, but that it did begin that way. Mr. Shaw responded that they had. Bob Tessier then addressed the issue of fiduciary responsibility, and noted that his membership includes about 60,000 covered lives, and has a PBM that does accept fiduciary responsibility. They have been willing to do it, and it hasn't cost them anything. This simply results in a legal obligation for the PBM to act in the best interest of the client. Dr. Handelman stated that there are too many middlemen and providers have less power in this relationship. Noted that the wholesalers may only make 1.4% profit, but that results in billions in profits. Suggested that all players should have to report their	

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		data to an HIE to help capture the complete picture of the healthcare system costs. Pat Baker asked if any of the panelists could talk about the role of efficacy. Noted that the effectiveness of a given medication should be a factor in determining coverage and pricing, who would act and in what way? Mr. DeFazio stated that the relationship a patient has with the pharmacist and provider promotes efficacy, since they can help coordinate care that has the best outcome for the patient. If you analyze the costs of Hep C treatment today compare to the costs of managing untreated Hep C prior to medication being available, you would see benefit. Pat Baker opined that we don't need to explore how manufacturers push the use of certain drugs that might not be the most effective, as there's been plenty of discussion about that. Mr. DeFazio noted that it is important to recognize that the pharmacists aren't prescribing these drugs, the providers are. Mr. DiLoreto added that the pharmacists are in a better position to know the overall medication regimen a patient is on than the provider. They can identify possible savings or efficiencies. Pat Baker clarified that she was looking at this issue from a larger policy perspective, and how these players could work together to optimize the care and reduce costs	

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		Mr. Shaw provided examples – PBM negotiating with manufacturer and looking at shifting from rebates to quality incentives. Indication based rebates – Humira is used for psoriasis and rheumatoid arthritis but may have better efficacy for one than the other, and he suggested that payment could be based on this instead. Susan Adams shared her perspective as someone in the home care environment, where patients often have multiple, conflicting, changing prescriptions that are complicated to manage. Pharmacists are crucial partners for them, and should be properly rewarded. Mr. DeFazio thanked her for those comments, and reminded everyone that the focus should be quality, and there should be a reward for that services that pharmacists provide. Ms. Chamberlin emphasized that the increasing prevalence of Health Savings Accounts are making people more aware of the costs than ever before, and that pharmacists are getting more requests for alternate options. Ms. Giuliano emphasized the importance of an HIE for clearly understanding our healthcare system and costs Lt. Gov. Wyman pointed out that Allan Hackney, the state Health Information Technology officer, was in the audience and was working on that	

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		Ms. Veltri acknowledged that a lot of the issues that were raised in the discussion were being actively explored at the state level, and that all of the elements in care coordination, consumer education, flexibility to respond to consumer clinical needs and fiscal concerns is critical to improving outcomes. Mr. Tessier reinforced the need for and importance of transparency	
5.	**Next Steps**		
6.	**Next Meeting**	The next meeting of the Healthcare Cabinet will be held on Tuesday, May, 9, 2017 at the State Capitol Room 310. The meeting time is **9:00AM-12:00PM**	
7.	**Adjourn**	Motion to adjourn	Victoria Veltri motioned and Pat Baker seconded.