Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes
January 16, 2018

Members in Attendance: Lt. Governor Nancy Wyman, Ellen Andrews, Pat Baker, Kurt Barwis, Theodore Doolittle (OHA), Anne Foley (OPM), Margherita Giuliano, Dr. William Handelman, Paul Lombardo (CID), Kate McEvoy (DSS), Michael Michaud (DMHAS), Nichelle Mullins, Frances Padilla, Dr. Raul Pino (DPH), Shelly Sweatt, Robert Tessier, James Wadleigh (Access Health CT), David Whitehead

Members via Phone: Susan Adams

Members Absent: Bonita Grubbs, Jordan Scheff (DDS), Joshua Wojcik (OSC), Dr. Ricka Wolman (DCF)

Others present: Victoria Veltri (OTLG)

Meeting Information is located at: http://portal.ct.gov/Office-of-the-Lt-Governor/Healthcare-Cabinet/Healthcare-Cabinet

Agenda Item	Responsible Person
Welcome and Introductions	**Lt. Governor Nancy Wyman**
Call to Order The specially scheduled meeting of the Healthcare Cabinet was held on Tuesday, January 16th at the State Capitol Room 310 in Hartford, CT. The meeting convened at 9:00 a.m. Lt. Governor Nancy Wyman presiding.	
Public Comment	**Lt. Governor Nancy Wyman**
Lesley Bennett from the National Organizations on Rare Disorders reported that she had sent comments however, is adding additional comments. She noted that the time frame allowed for commenting on the recommendations was too short and requested an extension to the end of the month. Ms. Bennett also commented that patient experience needed to remain at the center of all drug discussions. She pointed out that costs for	

rare disease patients are astronomical, running up to $2 million dollars over their lifetime. Ms. Bennett stated that pediatric medicine has improved and children are living into adulthood, running up healthcare costs for the Department of Social Services. She also shared an example of her daughter's about a time when management of her medical condition went out of control due to drug shortages, and pointed out that the Cabinet has not even discussed drug shortages. The medication her daughter needed was a generic medication, and because of the shortage and lack of access, her condition deteriorated, she was hospitalized six times and had a hospital bill for over a million dollars. Ms. Bennett is aware of this because the insurers keep trying to dump her. She suggested that the Cabinet keep focused on long term costs. Sometimes patients will use cost calculators used in organizations like the American Heart Association, the Cancer Society and the Institute for Clinical and Economic Research, which include economic factors, but are not taking into account patient factors which is important factors. Ms. Bennett states that health experts and patients are not looking at costs but at clinical outcomes, ease of use, side effects and things that will keep patient medication adherent. She added that the choosing the cheapest medication is not always the best for outcomes. Ms. Bennett stated that generics work for some people but are problem to about 15-20% of people. She added that generic medications are not the same and that they are biosimilar with variations in additives and composition. There are additives, like gluten or sugar, in generic drugs that some people may not be able to take or have an allergy to. She also stated that are variations in the amount of active ingredient in generics, and that the FDA knows that generics cannot be made exactly the same as the brand name because some go off patent and are made proprietary. She explained what they do is allow some variation in the amount of some active ingredient which can be between 80 and 125%. She added that this may not sound like a lot of people but it is big for some patients that have a neurologic conditions and behavioral health problems and who have a narrow therapeutic range. Ms. Bennett added that the problem is that some patients will be stable on one generic and then switched to another and they become unstable. She stated the issue is there are no test doses or notice of change to which drug is given to the patient. She stated that she would like to see more patient centric recommendations and believes that consideration should be given to allowing trial doses available for drugs, as well as requiring patient notice when a new version of a drug is going to be dispensed. She added that it should be done with the patient's consent and physician approval. She emphasized that the Cabinet talked about making physicians responsible for medication adherence and she didn't see the how physicians could do that.	

Supriyo Chatterjee provided a general comment following up to a testimony previously from November 15, 2016 and stated that he resides in West Hartford, Connecticut. He suggested that health equity be addressed within the Office of the Health Strategy. Mr. Chatterjee shared that currently there are three offices of health equity within various state agencies thatcould lead into gaps in coordination of services, measurement and reporting across agencies and distribution of funding to address health equity. He stated that the estimated impact and cost of health disparities in the state is approximately $550 million. He stated that a unified plan from the Office of Health Strategy to address health equity will help improve the effectiveness of related programs and manage the economic cost of disparities. He elaborated on several initiatives that contribute to health equity in Connecticut and how the new Office of Health Strategy can help coordinate and align the effort with state strategies. He identified the need for a uniform approach in capturing race, ethnicity, language data by using predefined guidelines and categorization. Consistent data and operations analysis can provide insights into more efficient and effective care management. Another initiative promotes the importance of cultural competence in healthcare. He believes it is one of the most effective ways of providing quality care, while mitigating disparities and lowering costs. Mr. Chatterjee stated that over the past several years there was considerable effort and resources in the implementation of the National Standards for Culturally and Linguistically Appropriate Services in healthcare, and he noted the importance of including social and behavioral data into the clinical data structure. He believes there is ample evidence that addressing social and behavioral determinants of health can bring improvement in health outcomes, and that linkages between these determinants and outcomes are important to identify the conditions and can contribute to the diagnosis and treatments. He concluded by stating that Community Health Workers in the field can provide social data of patients and communities.

Lieutenant Governor Wyman thanked Mr. Chatterjee for his public comment and stated that he is one of the most dedicated persons to come to the meetings.

Attorney Sheldon Toubman commented on behalf of the three Legal Services agencies in the State of Connecticut. He stated that they are very supportive of the report addressing high prescription drug prices. Mr. Toubman emphasized that it's really important because most clients they represent are on Medicaid and do not have co-pays, cost sharing or deductibles, but even for them the cost drivers from the pharmaceuticals are affecting the Medicaid budget. He also stated that he thinks the Department of Social Services deserves a lot of credit for its efforts to control the cost of pharmaceuticals, but acknowledges there remains work to do. He stated that Legal Services also represents non-Medicaid

consumers, noting that prescription costs have a major impact on their costs. Mr. Toubman identified a major concern regarding the Cabinet's recommendations on page 19 through 20, specifically the recommendation that that there be a workgroup to evaluate the potential risks and benefits of adding exclusions or more onerous prior authorization requirements to the Medicaid formulary in order to drive toward value-based pricing. He added that it's a very destructive proposal and he realizes that it's well intended. He stated that the idea is to give more bargaining power against the drug companies, but thinks it's going to take us into the exact wrong direction when the rest of the report is looking at things that are pro consumer. He believes that adding preauthorization requirements would be unduly burdensome, causing the patient to be adversely impacted. He stated that Legal Services routinely deals with patients that are denied access to their pharamceuticals directly because of prior authorization issues. Mr. Toubman acknowledged that some might argue that this is simply an administrative element, and that the patient could use an alternative drug, but stated that the reality is that this doesn't work, supported by hard data at DSS. The data is cited in the Legal Services' comments, and cites an example at DSS from 2016 when about 5,900 people went to the pharmacy for a drug that required prior authorization, but were denied because their prescriber had not requested the prior authorization. He emphasized that these access issues were not the patient's fault, and noted that even though the department approved a one-time, 14-day supply, out of the 5,900 people impacted, 797 remained denied. He added that the system already has problems, and can't understand why the Cabinet would adopt a proposal that would make access even more challenging. He reminded the Cabinet that the focus is the consumer, not the prescriber. In addition he added that the recommendation considers seeking a waiver to permit using stricter pre-authorization or exclusions of coverage certain drugs that under federal law, must be covered under Medicaid, but are high cost, low value. He argued that would be a bad idea because prior authorizations are bad and total exclusions are even worse because some patients need a particular drug and if it's excluded entirely they are going to pay the price. He also shared the second reason is because The Trump administration has made it very clear that they want to use Medicaid waivers for a particular purpose and that is to push an agenda that most of us will disagree with and if you go to CMS seeking a waiver then you will likely be going fine but we want these additional conditions. Lastly Mr. Toubman stated that although Legal Services opposes the idea of a waiver, he also urged the Cabinet to read Kathy Flaherty's comments because it talks about her personal experiences. He emphasized that if the decision is to move forward with the waiver request, the process needs to be inclusive of all stakeholders including consumer representation.. Mr. Toubman stated	

that looking only to the CAB is not going to ensure adequate consumer representation. He mentioned that the CAB members are appointed directly or indirectly by the Executive branch, unlike most official bodies which have more legislators or appointments. Mr. Toubman concluded by stating if we want to have genuine independent consumer representation, the Cabinet would have to look beyond the CAB.	
Review and Approval of the December 12th, 2017 Minutes	**Lt. Governor Nancy Wyman**
The motion was made by Pat Baker and seconded by Frances Padilla to approve the minutes of the December 12, 2017 meeting @ 9:05 a.m. as amended by the correction of Paul Lombardo. **Motion carried.**	
Access Health CT Open Enrollment Update	**James Wadleigh (Access Health CT)**
Lt. Governor Wyman introduced Jim Wadleigh to provide an update on Access Health CT. Jim Wadleigh reminded the Cabinet that open enrollment ended on December 21st. He stated that this year AHCT only had seven weeks to enroll individuals whereas in previous years they had 3 to 6 months, and that this has been a challenging year. Mr. Wadleigh reminded everyone that Access Health CT enrolled about 114,000 individuals, 55,000 of whom utilized the Department of Social Services' integrated eligibility. He stated that there is a 2.3% increase in enrollment in QHPs over last year, much higher than was anticipated. Of the QHP enrollees, 83,000 individuals enrolled with ConnectiCare and 31,000 individuals chose Anthem. He added that more individuals were buying down from Silver to Bronze, and that these tended to be the individuals that did not receive financial help. He stated that of the eight counties, six saw an increase in enrollment, with Hartford and Windham Counties seeing a decrease. He noted that 74% of the population qualified for financial help. He stated that AHCT saw significant increase and will continue the partnership for next year with the support of the community health centers adding that Danbury was the highest performer. He stated that even though open enrollment has ended, individuals still need to send income verification documents if requested, and noted that AHCT has been communicating by email and social media to remind customers that open enrollment has finished and customers need to make the first payment because they only have 30 days to make the first payment. He did note that over the weekend about 2000 customers were already disenrolled for not making the first payment and requested that everyone to spread the word and have individuals complete their enrollment. He thanked Lt. Governor Wyman, the Governor and the congressional delegation and everyone that helped Access health CT.	

Lt. Governor Wyman thanked Mr. Wadleigh and reminded everyone that it was not an easy open enrollment, but that she is glad it continued to be successful Vicki requested that Kate McEvoy provide an update to the CHIP program. Ms. McEvoy announced that Congress has not permanently appropriated extension funding for the CHIP program that ended on September 30th. She stated that with the redistribution of unspent funds and distribution of the continued funds Connecticut was able to extend the program until February. She added that they are heavily reliant on an infusion of additional funds. She noted that there is debate on the offset in terms of Medicare eligibility and in terms of higher tier with folks on Medicare and causing challenges. She stated that they are required to observe due process protections for people that are served by Husky B. Ms. McEvoy wants to reinforce what Mr. Wadleigh stated regarding the delegation being great advocates. Pat Baker requested that Nichelle Mullins provide on update on Community Health Center funding by Congress. Ms. Mullins stated that Legislation is similar and they were granted an extension of funding until February 28th and unsure what will happen after the 28th.	
Discussion of Draft Report: Recommendations on Pharmaceutical Costs	**Vicki Veltri (OTLG)**
LT. Governor Wyman thanked all the Working Groups for their hard work. Ms.Veltri escribed what the work groups were discussing, and summarized the public comments received to date. She also mentioned that the public was invited to make comments that will be posted on the website. Stephanie Burnham from the State Innovation Model's Program Management Office was asked to comment, and stated the Quality Council agrees with the intent of the specific quality measures recommendation. Ms. Burnham stated that there are things to consider such as what is being measured, how it is being captured, what are we asking from providers to be meaningful measures. There are no NQF endorsed measures that mirror the recommendations. She agreed to talk to the SIM team about bringing the recommendation to the SIM Practice Transformation Task Force instead of the Quality Council. Ellen Andrews stated and clarified a conflict from the written public comments between the Education work group and the Value Based Pricing work group about drug coupons. She stated that contrary to the written public comments, in both work groups there was strong support for limiting the use of coupons, and making sure they aren't false savings to the consumer or the system. She stated that the Education committee did not mean to endorse coupons in form or any level. Ms. Andrews also added that	

the group discussed many good concepts that didn't fit into the legislative or administrative categories of the Cabinet's recommendations. Susan Adams and Ms. Andrews would like to continue to work and bring forward recommendations to the Cabinet. Lastly she shared a personal perception that she was pleased to see the work from all the groups and felt like the Cabinet was in a good place. Ms. Veltri mentioned that the National Institute of Social Workers recommended that Connecticut institute a regulation regarding a threshold as to the percentage of increase in medication costs that would be allowed, and that increases above the threshold should go to a public review process where the manufacture must justify the requested increase. This would give the public an opportunity to comment and inform the Drug Review Board's deliberations as it would consider a requested increase. She stated that the NASW-CT recommended strong consumer representation on the Drug Review Board and there should be one. Ms. Veltri stated that PhRMA for Connecticut recommended that there should be up to date and accurate drug formulary information from health plans available to the residents to help residents choose a plan that best fits their needs. She shared the recommendation from the Association for Accessible Medicines that the Drug Review Board fully exempt generics and biosimilars from the process. She noted that there was an equal recommendation on the other side from the advocacy community that we not exempt them. CT Rare Action Network recommended DRB have at least 1/3 of the board of Consumers that are patients with actual experience managing prescription medication for complex and chronic health conditions. Anne Foley asked how the new DRB would be funded. And due to the deficit was there an expectation of increased revenues or reallocations? Frances Padilla responded that her work group discussed the need to identify not only fiscal impact but where it would make sense to house the Drug Review Board. She acknowledged that they recognized that as a group, they did not have the resources to work out the details. She stated that her group considered it critical and went on with its recommendations. She also suggested consumer participation and conflict of interest protections and following FDA conflict of interest. Ms. Padilla shared the PhRMA comment regarding drug formulary information availability to residents and she was under the impression that it was already required. Paul Lombardo noted that carriers do currently have formulary information available for existing plan members.	

Ms. Veltri shared one of the comments in regards to generic manufacturers and biosimilars request to be exempt from the DRB Ms. Padilla stated Maryland did exempt generic drugs and that California did not. Dr. William Handelman stated that the biggest abuses in pricing are for generics, even though they have been around for a long time and have limited use particularly the ones used in the hospitals. Ted Doolittle clarified that the Maryland law is limited to only generics. Mr. Wadleigh stated that even when consumers figure out their formulary it doesn't preclude the carriers from changing which tier their drugs are in. Ms. Baker thanked all the groups and to consider the priorities. She also suggested that the principles of the Cabinet appear on the front of the final recommendations. Robert Tessier stated he thought some of the comments received indicated they thought the DRB was the highest priority, similar to the board's proposal recommendation last year to create an Office of Health Strategy for the purpose of overall cost and payment. His only question about the recommendation to create a DRB concerned whether it will be under the direction of the Office of Health Strategy, since his understanding of OHS as pursuing cost containment in healthcare, which is a primary purpose of the DRB. Ms. Veltri shared the next recommendation about disclosing relationships. She stated it is to require manufacturers, PBM's and health insurers to report the Office of State Ethics the funding they provide to nonprofit patient advocacy groups and to post such information on a publicly available website. She added most people favored it but there are concerns from the Cabinet and Lesley Bennett regarding the narrowness of the recommendation. Mr. Tessier commented that the summary requires any organization that wants to exercise its first amendment rights to advocate on behalf of any healthcare policy issue to disclose funding. Ms. Veltri responded that could have happened because some of the Cabinet members may have affiliations to organizations that were experts in the working groups.	

David Whitehead stated that the Cabinet went from a recommendation around funding to discussions and that seems like a wide variation and he would not support it. Ms. Padilla asked for clarification on the recommendation and groups that would be added. Ms. Baker emphasized that the importance is not only about relationships but about funding. Ms. Mullins asked if the Cabinet is requiring manufacturers to report any amount or a threshold and should we consider a threshold amount because even if $1.00 it would have to be reported and it would cause a lot of work for the OSE. Ms. Padilla stated she didn't think there's a way to set the threshold. Lt. Governor Wyman suggested that it could be reported in percentage rather than a dollar figure. Dr. Handelman added that the requirements for payments from pharmaceuticals to physicians gets reported when it's at $50.00 or more. He also suggested that the Cabinet pick a higher threshold. Ms. Veltri also reiterated that the recommendation is limited to advocacy groups that are registered lobbyists with of the Office of State Ethics. She also requested for Ms. Bennett to comment for clarification. Lesley Bennett was asked to clarify. She stated that she believes that the Cabinet is singling out one group and then discriminating against others. She recommended that the Cabinet include the health organizations that are accepting money from PBMs. She stated that everyone should be included and not to single out just one group. Susan Adams stated that the Education Committee recommended that any recommendations had to have a transparency component. Mr. Doolittle supports the recommendation, and stated that he understands its intent not to single out any category of stakeholders, but as a reasonable limitation. He expressed concerns that if the recommendation goes beyond the initial proposal, what would be the boundaries if the Cabinet goes beyond that and risks becoming overbroad? He further noted the recommendation is limited to nonprofit because with for-profit groups, there already is transparency and know where the funding is coming from. Ms. Veltri shared Yale's comment being in favor of the audit and PBM recommendation, but has concerns about compliance.	

The Association of Health Plan's public comments stated that it should be determined by contract, and in some cases, and audit may not make sense, since individual plan experience is used to inform this process and may not be relevant. Mr. Lombardo stated that the carrier sets the community rate based on a health plan's experience and future expectations of cost. He added that health plans already have audit rights. If an audit is performed and the health plan finds extra money, it would not impact consumer premiums, but that it could be used for future premiums. He needed to better look at the comment. He stated that future rates would be determined by the findings. Shelly Sweatt asked who is defined as the client. She suggested clarification on the language. Mr. Tessier addressed this concern, noting that audits occur on a regular basis as a compliance tool. PBMs in general discourage audits, and engages in conduct that can make effective audits difficult to conduct. These audit rights are established in each contract. He noted that this recommendation would be the state setting minimum standards concerning audit provisions, and is not intended to be intrusive. Ms. Veltri shared the recommendation requiring that all prices negotiated between PBMs, manufacturers and payers pass through to the consumer at point-of-sale by requiring consumer coinsurance and deductibles be based on f the negotiated price (net price after rebate) of the drug rather than the list price or price prior to rebate. Ms. Veltri stated that this recommendation is aimed at giving the consumer the benefit of the negotiated rebate at the counter instead of paying the list price. She shared the comments on the recommendation from the Yale School of Management that transaction should be at the negotiated price or below because this would permit a PBM to hide a confidential negotiated price by charging a consumer less. She also shared comments from the Association of Health Plans, that noted that many of the new and non-preferred drugs are not required to offer rebates. Generics do not have rebates and only 6% only of drugs have a rebate and are not subject to the recommendation because of the association with a copay. Mr. Lombardo stated that rebates come through the pricing and through rate filings and there is a reduction to pharmacy claims per member per month. He stated that in rate filings they estimated that this would increase premiums by 3 to 4 percent if savings due to rebates were passed on to the member receiving the medication, instead of being spread across all members. He added that this would be a one-time increase of 3-4 percent..	

Ms. Veltri asked if anyone had heard of concerns of premiums and if the consumers be willing to pay the one-time adjustment to get the ongoing benefits. Ms. Padilla stated she didn't hear any concerns. Mr. Lombardo commented that the consumer that doesn't take a lot of prescription drugs would be paying 3 to 4 percent more for something that they may or may not be using. He added people that have medication copays would not be impacted at the counter. Instead it would be the people with coinsurance and high deductibles would be most impacted. He added we would have a percentage of the population that would benefit and a population that would be paying for the benefit. Mr. Wadleigh added that this is the only place where he's seen a potential increase, if the net were not seeing a decrease through the recommendations. He also stated he would be disappointed in the value of a lot of what they're doing if there isn't a reduction in costs. He is hoping for something more, like double digit improvement at the end and it will be better for consumers. Ms. Veltri reviewed comments submitted about the Administrative recommendations, the first of which would require insurers to report more granular information to the Connecticut Insurance Department (CID) on the impact of prescription drug price increases on premiums in their annual rate filing and for CID to compile such information into a public report. Mr. Lombardo discussed the genesis of the recommendation to mirror the California law that requiring carriers to do similar things in their rate filings, noting that it could be done by bulletin or legislation. He stated that the commissioner has the authority to request the additional information. Mr. Lombardo stated that all rate filings are not reviewed adding that the indemnity carriers and self-funded do not submit rate filings. The data they receive will be from the fully insured market. He added that the data is public information and we will ask for a format that separates the piece out from the rate filings. Ms. Veltri stated that the comments were not rejecting this recommendation and that it could be helpful in educating consumers. Mr. Lombardo stated that the health plans thought that it was a good idea because it will provide additional information and education that everyone needs to understand. Ms. Veltri shared the recommendations from a commenter that the Cabinet should consider adopting the Choosing Wisely recommendations to make sure the Cabinet is addressing consumers' challenges in health literacy and CLAS standards. She also shared another comment similar to Lesley	

Bennett's recommendation suggesting that cheaper, smaller quantity, trial medication packs could be covered. This recommendation is to avoid full doses prescribed that a patient cannot tolerate. She also stated that the commenter recommended that pharmacists should have access to the patient's prescription plan to help patient navigate. She also stated that the Yale commenter suggested that unless the Cabinet combines limiting manufacturer coupons along with the copay and coinsurance limits either of recommendations would not be sufficient. Ms. Veltri also shared the recommendation from a commenter that the Work Groups have sufficient consumer representation. She then reviewed some of the general comments the Cabinet received. One public comment stated that we should be paying for alternative providers as well as prescribed vitamins, since these treatments can promote a healthier individual with less need for high cost medications. Another comment proposed prohibiting lobbyists from drug companies and would ban contributions to campaign accounts and funds from drug companies and subsidiaries. Planned Parenthood reminded the Cabinet of the importance of covering contraceptives at zerocopay needing to be preserved. The National Association of Social Workers specifically recommended that Connecticut should pursue action with other states against opioid manufacturers for misleading public and prescribers about the safety of opioids. NASW-CT also recommend that any penalty or settlement should go towards treatment and prevention of opioid addiction. This recommendation is similar to past efforts against the tobacco industry . Dr. Stephen Smith specifically recommended generic drug substitution and recommends therapeutic substitution. This will allow the pharmacist to substitute lower cost equally effective medication to brand name drug for which no generic is available, as long as there is an exception process whereby the MD that can check off that there cannot be therapeutic substitution. and he He recommended learning from other states and it can be done with evidence and supportive protocols. Lt. Governor Wyman stated that the Legislature will look for proposals to act on in a short legislative session. Margherita Giuliano reminded the Cabinet that one of the primary recommendations being made will impact patient out of pocket costs. She also stated last year we passed Legislation that would impact copays. Kurt Barwis stated from a consumer perspective, the consumer hasto use health plan to purchase plan or go to pharmacy and get a discount card and potentially pay less money for the drug but this causes a problem because	

paying for the drug will not go towards copay or deductible. To simplify this the consumer should be allowed to submit their receipts and that the health plans count towards the deductible. Ted Doolittle responded to Mr. Barwis' concern, noting that the Office of the Healthcare Advocate may be promoting this approach in the next Legislative session. He also stated that the consumer can use their HSA card for noncontract services such as over the counter drugs. Dr. Raul Pino took the opportunity to urge the public to get their Flu Vaccine because the rising epidemic has been devastating and led to 15 deaths in Connecticut, including a ten year old boy. Ms. Padilla thanks Ms. Veltri for putting all the work together. Ms. Veltri announced that the Cabinet welcomes all comments from the public until February 6th.		
Wrap Up and Next Steps		**Lt. Governor Nancy Wyman**
The next meeting will take place on Tuesday, February 13th, 2018 at the State Capitol Room 310.		
Adjourn	Lt. Governor called for a motion to adjourn. Mr. Doolittle made the motion and Ms. Andrews seconded	