



News from:
COMPTROLLER KEVIN LEMBO

FOR IMMEDIATE RELEASE

THURSDAY, DECEMBER 6, 2018

Contact: Tara Downes
860-702-3308
Tara.Downes@ct.gov

**LEMBO ANNOUNCES PHARMACY RFP, PLAN TO ESTABLISH
NEW ERA OF DRUG PRICING AND TRANSPARENCY**

State Comptroller Kevin Lembo today announced a request for proposals for a new state pharmacy benefits agreement that seeks to change the paradigm of how pharmacy benefits are managed and to establish the most innovative and transparent pharmacy benefits contract in the nation.

Lembo administers health care and prescription benefits on behalf of more than 200,000 public employees, retirees and their dependents, including employees from over 100 municipal groups that should benefit from the savings of this new contract.

“We are putting every bidder on notice that the State of Connecticut is calling the shots on prescription drug costs and quality,” Lembo said. “Taxpayers and patients are ready for a new way of doing business. The State of Connecticut will exert its force in the market, setting an example for other large employers across the nation, to demand what is right, beginning with details about who is paying who – and requiring that pharmacy benefit managers and drug corporations pass on all cost savings to taxpayers and consumers.”

A broken national model for pharmaceutical pricing has allowed pharmacy benefit managers (PBMs) to operate in the shadows, with employers and patients knowing little to nothing about where their money is going, including how much the PBM is paying the pharmacies in its networks and how much it receives in rebates and other compensation from drug manufacturers, Lembo said.

The state is preparing to simplify and streamline how it pays PBMs with a more transparent system of administrative fees per drug. This will replace a system that allows the state’s PBMs to arrange for hidden wealth exchanges with drug manufacturers that only benefit the PBM. Those once-hidden manufacturer payments and price spreads must now be disclosed and entirely passed on to the state.

“The State of Connecticut is seeking a new paradigm in pharmacy benefit management contracting by requiring true transparency and the alignment of incentives between the state employee health plan, patients and the PBM,” Lembo said. “We are putting an end to hidden incentives that put drug profitability above the state plan and patients.”

Lembo said the pending RFP demands that bidders prepare for a new era of transparency, pricing and scrutiny, including the following:

Transparency: The entirety of all drug manufacturer payments to the PBM related to the state will be passed on to the state, and the state will fully know and only pay the amount that the PBM paid each pharmacy for the cost of filling prescriptions with no added so-called “spread pricing,” the practice by PBMs of charging plans more than what they paid. And the amount paid for drugs will be based on the lowest price list, or “Maximum Allowable Cost,” preventing PBMs from subsidizing their spread pricing contracts by making the state plan pay more to network pharmacies than the PBM pays to those same pharmacies when it is allowed to pocket the difference. Bidders will also provide frequent data feeds to disclose all net costs, post manufacturer rebate, so that the state has full information as to actual costs of medication, and these requirements will be subject to audits to verify compliance.

New Pricing Models: Drug costs guaranteed by the PBM should now be based on a per-patient, or per-unit, basis, rather than a discount off of the average wholesale price (AWP). Currently, PBMs benefit from ever increasing AWP as it makes it easier for them to meet their pricing guarantees while maximizing the amount of revenue they retain. Worse still the guaranteed discount off of AWP model doesn’t always favor the lowest cost therapeutically equivalent drugs; rather, it favors the drugs that the PBM can achieve the greatest discount off of AWP. Moving to pricing guarantees on a per-patient or per-unit basis better aligns the PBM’s incentives with that of the plan and patients by incenting the PBM to prefer the highest value drugs, rather than those that help the PBM maximize revenue. Bidders must also commit to annual “market checks” to ensure that the state plan is getting the best market pricing.

In other words, Lembo said, PBMs may prefer certain generic manufacturers over others – not because the cost of the generic is less, but because the PBM will receive a greater percentage of the cost. For example:

“Generic Drug A” has an AWP of \$50 and an actual acquisition cost of \$10 (80% less than the AWP, according to contract with the plan), whereas a generic competitor, “Generic Drug B” has an AWP of \$40 and an acquisition cost of \$9 (78% less than AWP). The assumption would be that the pharmacy and the PBM would prefer Generic Drug B due to lower cost, but the reimbursement structures actually incent the PBM and pharmacy to prefer Generic Drug A. This is because Generic A will result in more revenue to the PBM

because the PBM is not reimbursed from the health plan on actual cost, but on a percentage below AWP. For this example, if the contracted rate is 75 % below AWP, the PBM would receive \$12.50 for Generic Drug A, while reimbursing the pharmacy \$10 (a \$2.50 margin), while for Generic Drug B the PBM would only receive \$10 from the health plan and pay the pharmacy \$9 (a \$1 margin). Lembo's proposal will eliminate the incentive for PBMs to prefer the more expensive manufacturer.

New Auditing Authority: The state will require expanded audit authority to ensure PBMs are complying with new transparency and price guarantee models.

New Rebate Policy, Prescription Amounts and Incentives for Low-Cost Generics:

Drug rebates, where applicable, will be immediately provided to consumers at the pharmacy counter. The state will also require the PBM to offer a reduced generic copay to participants if a lower-cost therapeutically equivalent alternative is available. Lembo said this new requirement will block PBMs from the troubling practice of offering lower copays for more expensive drugs over generics, a practice explained in [this article](#).

The state will also put an end to prescription drug waste by limiting first-time prescriptions to 30-day fills, because analysis has found that 30 percent of 90-day first-time fills were never refilled, indicating medication waste.

New Data Sharing with Doctors, Nurses and Other Prescribers: The state will require its new PBM to provide new tools embedded into prescribers' electronic medical records systems that allows prescribers to see the actual cost of the medications they are prescribing alongside therapeutically equivalent alternatives so the prescriber will have the information they need to make an informed choice when otherwise interchangeable drugs are available, thus reducing the cost of care. Once established the comptroller's office will advocate expansion to other health plans including Medicaid and other private payers, creating a powerful new tool to drive down net pharmacy drug costs.

“Traditional pharmacy benefit management contracts across the nation have allowed wealth exchange to occur under a veil of secrecy while patients and taxpayers suffer,” Lembo said. “The State of Connecticut will disrupt these practices and replace them with an arrangement based upon transparency, partnership and collaboration in which the incentives of the PBM align with the interests of the health plan and patients.”

Interested bidders were required to submit their intention to bid by Friday Nov. 30. The Comptroller's Office received strong interest from the proposals. Lembo and his staff will review the proposals, together with members of the state's Health Care Cost Containment Committee. A contractor will be selected at the end of February 2019.

*****END*****