

COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

12.14.2015
COPIC, Mile High Room

Meeting Summary

Commissioners present: Bill Lindsay (chair), Cindy Sovine Miller (co-chair), John Bartholomew, Jeff Cain, Rebecca Cordes, Greg D'Argonne, Steve ErkenBrack, Ira Gorman, Linda Gorman, Dorothy Perry, Chris Tholen, Jay Want, Larry Wolk,
Staff: Lorez Meinhold, Michele Patarino

Meeting Summary:

I) Approval of the Minutes

- A) Motion for approval by Steve ErkenBrack, seconded by Dorothy Perry.
- B) The meeting minutes from the November 16th Commission meeting were approved unanimously with no opposition or changes.

II) Presentation on Prescription Drugs – Len Nichols

- A) Len Nichols, PhD from George Mason University, provided a presentation titled, “Spiraling Drug Costs: What Can States Do?” The presentation can be found on the [Commission website](#).
- B) Questions and discussion from Commissioners included:
 - 1) If a hypothetical purchasing pool included the state’s employees and retirees, Medicaid and other public entities and private employers, could we create a “super PBM” with increased expertise and market leverage?
 - (a) Exactly; it would redress the balance in market power by creating power on the purchasing side.
 - 2) The overall price trend on specialty drugs is alarming (see slide 9). Is the rate of increase expected to stay at these levels?
 - (a) From 2007 to 2013 the 18 percent increase was fairly constant. From 2013 to 2014 it jumped to 28 percent due to Sovaldi. Two things drive the trend: average price and the number of people taking the drug. Sovaldi was priced extremely high and targeted millions of people.
 - (b) There is concern that the drug pipeline includes additional biologics that could have a similar cost effect.
 - 3) Does slide 9 capture overall spending or was there an adjustment for the number of people covered?
 - (a) The slide includes the price and the fact that the population expanded.
 - 4) Back to the augmented bargaining power suggestion; are there states that are doing this, and is Colorado the right size? We’re certainly not California.
 - (a) Over half of the states participate in a supplemental rebate program; Colorado does not.
 - (b) Colorado is precisely the right size because it is so much smaller than CA, but it might take more states to make it work.
 - 5) It isn’t just specialty drugs that are showing high prices; common drugs like doxycycline have shown price increases of ten to thirty times.

- 6) Staying with the purchasing pool concept: for specialty drugs, there is not a lot of competition to drive down the price. A lot of employers and others are afraid to say “no” to these drugs. Could a state pass a law to say if a reference price can’t be reached, the insurer can deny the drug until it is achieved? Would that provide some level of protection?
 - (a) The general idea is a good one.
 - (b) Suggest paying attention to oncologists who tried something similar – they are now advocating for condition-specific approval. Once the FDA approves a drug, it can be prescribed for any indication. For some of these, the drug is only effective for a limited time. You could selectively utilize only the indication that is clinically the most effective and say “no” to everything else. This would help you to avoid saying “no” in a blanket way – but you’d only say “yes” where it is clinically appropriate and meaningful.
- 7) Canadians are already doing reference pricing on drugs; the result has been older drugs and a longer time to access new therapies.
- 8) Aren’t there two other Sovaldi-like drugs in the pipeline?
 - (a) There are two that are now on the market, which has allowed purchasers to play one against another. This has led to PBMs getting 40-50 percent discounts. But, even with a 50 percent discount, it costs forty thousand dollars per patient.
- 9) Didn’t it take time to define biologics and biosimilars?
 - (a) It did take a while to define the terms from a regulatory perspective. The ACA incorporated provisions on this point, offering twelve year exclusivity rather than five years for small molecule drugs.

III) Presentation on NCSL Work on Cost Containment – Richard Cauchi

- A) Richard Cauchi offered a presentation titled “NCSL Work on Cost Containment – New Partners, Tools and Resources. The presentation can be found on the [Commission website](#).
- B) Mr. Cauchi reviewed additional NCSL State Health Cost Containment Resources. Links to these are also posted on the [Commission website](#).
- C) Questions and discussion from Commissioners included:
 - 1) Can you provide more information on how states can influence the employer/individual mandate?
 - (a) The ACA includes section 1332 which specifies what the waivers can do, as of 1/1/2017. Now that the deadline isn’t so far away, people are paying attention. State legislatures must file a bill and pass a law to say what they want the waiver to do. It could allow the employer/individual mandate to be eliminated, but see the list of “must do’s” on the last slide. Innovation waivers must provide coverage that is comprehensive and affordable and covers “at least a comparable number of residents.”
 - (b) Research papers and descriptions on 1332 waivers should be released soon.
 - (c) The Exchange Oversight Committee and House Speaker’s office have asked questions about 1332 waivers as well.
 - 2) There is a lot of interest for the Exchange to do something. With regard to waivers, who approves them?
 - (a) The Treasury and Health and Human Services (HHS).
 - 3) Recognizing the 2016 elections – the decision-makers almost definitely will change. How will that impact the 1332 waivers?
 - (a) Can’t begin to speculate.
 - (b) Cindy Mann, who previously worked at CMS recently gave a presentation on “To Waiver or Not?” and offered useful insight on this question.
http://www.ncsl.org/documents/health/C_Mann_NCSL%20Presentation_12-8-2015.pdf

- 4) What is your opinion of Colorado's ranking in the Commonwealth Report?
 - (a) Haven't fully digested the report – it was just released and is a very detailed piece of work.
 - (b) The publication allows you to draw your own judgment.
- 5) What does the federal law say on Exchanges responsibility with respect to Medicaid?
 - (a) They must examine customers' eligibility (there are some details to that) and it is somewhat flexible after that. Some Exchanges just transmit the paperwork and others provide additional assistance such as simplified or single applications. HHS has been willing to negotiate this with states.
- 6) The Commonwealth report is one of the many resources at our disposal; we should use all of them to see where we fit with other states and put our work into context.
- 7) Specific items provided by NCSL pertain to prescription drug cost containment; we should crosswalk these materials.

IV) Public Comment

- A) George Swan, retired hospital administrator: Relative to the drug cost presentation, it is helpful to use clinical criteria. I have sent Lorez a Health Affairs article by Larsen at the Boston Consulting Group on disease registries which may be applicable. The NCSL presentation talked about the Commonwealth Fund scorecard, which is good at a high level. However, the data they cite is typically three to six years old; I prefer the Wisconsin County Health Rankings. Finally, Section 1332 Waivers will be applicable to Amendment 69 (ColoradoCare).
- B) Dan Gibbs, Summit Board of County Commissioners and former state representative: Summit County is at the breaking point with affordable health care. Without the CoHealthOp, 1,600 residents have lost coverage. The next cheapest comparable plans are about 40 percent more. Residents have to make tradeoffs about paying the mortgage vs. child care vs. health care. The county is working on affordable housing; local government would also like to be part of the affordable health care discussion.
 - 1) Locally, what have you done to address health care affordability?
 - (a) After working with the Division of Insurance on geographic rating, we have worked with our new FQHC (county only charges \$1 rent) though it is already exceeding capacity. Kaiser Permanente is expanding to Summit County and the local Centura Hospital hasn't yet agreed to a contract; we are working with them to see what can be achieved.
 - 2) Do local constituents have a direction they want the Commission to go?
 - (a) There is a lack of awareness of the Commission and its work, however, they would tell you that the cost of living overall is unsustainable in Summit County. They feel that we add a lot to the state's economy but are getting hammered on the back end. It is unfair to pay so much more for coverage in Summit County than 60 miles east in Denver or even Clear Creek, which is included in Denver's rating area.
 - 3) What has led to the cost increases in Summit County?
 - (a) Too little competition and the fact that a lot of people are willing to drive to Denver for less expensive care.

V) Discussion on Amplification of Milliman Report – Bill Lindsay, Chair

- A) The Memorandum regarding HB15-1083 Physical Rehabilitation Services – Copayments and Coinsurance Research has not yet been released to the legislature. The legislation asked questions that Milliman couldn't answer using claims data alone. The memo tries to close the gap and provide some education to the legislators.
- B) Bill invited the Commissioners to ask questions and make comments on the memo.

- 1) There were other studies and resources available to look at issues such as whether cost-sharing is an inhibitor to utilization.
- 2) It is particularly troubling for physical, occupational and speech therapists who could serve as a replacement to physician office visits.
- 3) There is an overall sense that the data didn't give the proper context and the Commission didn't offer its opinion; this warrants more conversation from the Commission.
- 4) Public Comment:
 - (a) Senator Larry Crowder, Senate District 35: The purpose of the bill was to reduce and maintain health care costs. The intent was not to replace physician office visits with therapist visits but to use both. Copays were a problem. We are attempting to get therapy copayments down to be similar to a physician office visit fee. That could keep patients out of doctors' office and lower health care costs because individual visits for therapists cost less than visits to the physician. My district is rural Colorado – 16 counties, healthcare is a different world there. There is an overall lack of providers and specialists; therapists play a vital role. The higher copayments are restrictive in that sense, so it creates an additional burden on the medical providers. Using therapists more extensively could extend physician capacity.
 - (b) Marcia Smith PT, PhD: I have been involved in physical therapy licensure actions of the legislature. Only about 25 percent of physical therapists have patients that have direct access to their care. For people who only attend one visit, there will be problems.
 - (c) Cameron McDonald PT, DPT, President, American Physical Therapy Association: Physical therapy as a rehabilitative service is only 2.74 percent of the cost of health care. Research and other data are somewhat available as Mr. Gorman commented. A Centura Health representative who was in an APTA meeting recently said to share the sentiment that PT copays need to come down. The research exists. The insurers should be scrambling to do this. I encourage the Commission to continue looking at the data.
- 5) The Commission contracted with Milliman to do the report and the memo is to clarify the report, not give the Commission's opinion. The memo is factually correct and fairly synthesizes the report.
- 6) Motion for approval by Steven ErkenBrack, seconded by Jeff Cain.
 - (a) The memo was approved unanimously and the Commission will revisit data outside the Milliman report in an upcoming meeting.

VI) Recommendations Document – Bill Lindsay, Chair

- A) Bill commented that the recommendations are an iterative process; we may revisit them and incorporate additional topics as we move forward. He invited the Commissioners to make comments or ask questions about the recommendations as presented. An updated version will be provided at the December 21st meeting.
- B) Comments to date have included broadening beyond state employee strategies and to look at enhancing primary care reimbursement through primary care medical home initiatives. This was echoed by the Colorado Medical Society and the Colorado Academy for Family Practice. In addition, two additional payment reforms that should be reviewed include Direct Primary Care and the Rhode Island Model.
 - 1) Significant growth of coverage in the state's Medicaid population has led to a lack of access to primary care and increased use of emergency room and other services. We need to discuss whether primary care reimbursement should be increased; given the state's fiscal condition, this is a zero sum game.
 - 2) There is conflicting literature about whether increasing access to primary care reduces costs overall. Articles supporting this will be distributed.

- (a) Does increasing reimbursement for primary care increase access to primary care?
 - (b) What form should that payment take? Capitation might not be the best answer.
- C) A recent presentation from the federal trade commission and the Massachusetts Attorney General's Office talked about anti-trust actions; these have relatively limited applicability.
 - 1) A brief from Bob Berenson at the Urban Institute gave other options that could be applicable at a state level, ranging from increased transparency to rate regulation. He proposed rate limitation – which would be a tool in situations we see in Colorado, like a mountain county provider who charges 1500 percent of RBRVS. We've asked CHI to research this option. Lorez will share the presentation.
 - 2) Everything fits under this umbrella – market vs. regulation.
- D) Additional reading materials for today included Health Affairs articles by Sage, Vladeck and Gaynor.
 - 1) The Gaynor article is interesting. It shows a different approach to health care reform. If we set up a flexible system, we can discover options as we go since we don't know what the system should ultimately look like. The other articles were fairly mainstream, talking about redefining products or utilizing the power of the government.
 - 2) How do we sort through regulation vs. market?
 - (a) If we start from where we are now, the ACA has provided a great deal of regulation.
 - (b) Whatever the policy is, we need to apply it uniformly. This was illustrated in Len Nichols' presentation.
 - (c) Maryland is trying to make things uniform; but in our state, things aren't uniform.
 - (d) We can't rely on the market to address it; it already isn't addressing it.
 - (e) Market failure is a very carefully defined term in economics. What we're seeing in rural areas isn't necessarily market failure – the services are just very, very expensive.
 - (f) If our societal values say we should protect rural Coloradoans from high costs, we have options including subsidies; though this may be more challenging to carry out in practice than in theory.
 - 3) The Planning Committee will work with Lorez on recommendations on competition and regulation; this is a central issue. Our strategy and recommendations need to be flexible and recognize that the state isn't uniform. Even the rural areas aren't uniform (Summit County vs. eastern plains).

VII) Updates

- A) Cindy Sovine-Miller's work with the JBC and legislators was commended.
- B) New challenges are likely to be presented to the Commission; potentially without financial support. This is a double-edged sword and needs a carefully considered position.
- C) The Commission won't know until February if there is any funding; this could be the last legislative session so it is an opportunity.
- D) By December 21st there should be a budget update for the Commission. Thank you to Chris Tholen for taking on CFO/controller duties; it has been a big job.
- E) There seems to be a sense of fatigue with the current schedule (meeting twice monthly); moving back to one meeting on the second Monday has been suggested (after January). Let Lorez know if there are conflicts.
 - 1) Meeting once a month might be preferable but it depends on the task and the timeline.
 - 2) Since we won't know until February about continued funding/support from the legislature, this will be revisited.
- F) The Commission's operating procedures limited the chair and vice-chair positions to one year. Bill suggested an election on 12/21 and called for nominees.

- 1) Given our upcoming challenges, there is value in keeping the same leadership team which has worked well.
 - 2) Bill and Cindy are willing to continue in their current roles.
 - 3) A formal vote will be scheduled for 12/21.
- B) January 8th is the date for the Commission to testify with the joint health care committees of the state legislature, but given the time (15 minutes) and the size of the room, the legislative chair indicated that the entire Commission should not attend.
- C) In the absence of additional public comment, the meeting was adjourned.