RAND Update on State Savings Approaches

Chrissy Eibner

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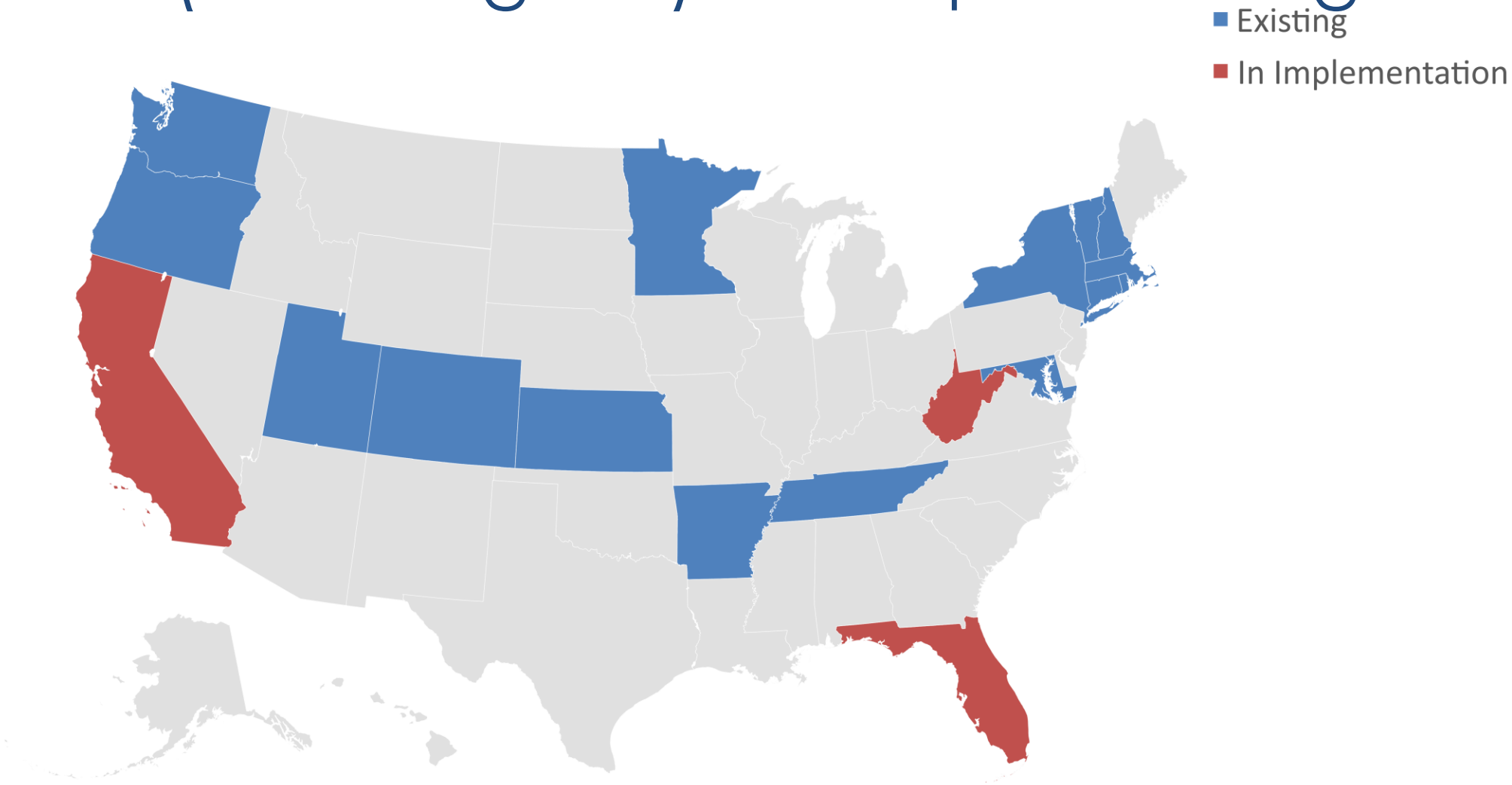
RAND is working with CHCF to describe health care savings options for CA

- Goal is to describe possible savings approaches and discuss their potential for the state of CA
- Work is ongoing
  - Conducted environmental scan
  - Held discussions with stakeholders
  - Identified 17 options to consider
  - Literature review is underway
- What have we learned do far regarding—
  - State-based drug cost reforms?
  - State all-payer claims databases?

Our work has identified several novel approaches to reduce pharmaceutical costs

- OK recently implemented value-based contracting for select high-cost drugs (Aristada for schizophrenia, Melinta for skin infections)
  - Contract guarantees that the drug will, on average, save money
  - If savings do not materialize, manufacturer state gets a rebate
- Louisiana "Netflix" model to pay for Hep-C drugs
  - State pays monthly fee
  - Unlimited access to Hep-C drugs
  - Currently soliciting drug companies to participate
- Numerous states (including CA) have implemented or considered laws to improve pharma price transparency—a couple of states (OH, CT) have gone further in requiring transparency for PBMs
- Price transparency for pharmaceuticals could be facilitated with

Sixteen states currently have APCDs, three (including CA) are implementing



Source: APCD Council

A recent study found that NH APCD reduced imaging costs by 4-5 percent

- New Hampshire APCD implemented in 2005
- Brown (2018) found that APCD implementation reduce consumer OOP spending on imaging by 5 percent ($7.9 million total savings), and payer spending by 4 percent ($36 million total savings)
- Key caveats
  - Mehotra et al. (2014) found that only 1 percent of consumers use price transparency tools
  - Imaging is one of the most "shoppable" services
  - Unlike some price transparency tools, NH's website took into account patient cost sharing

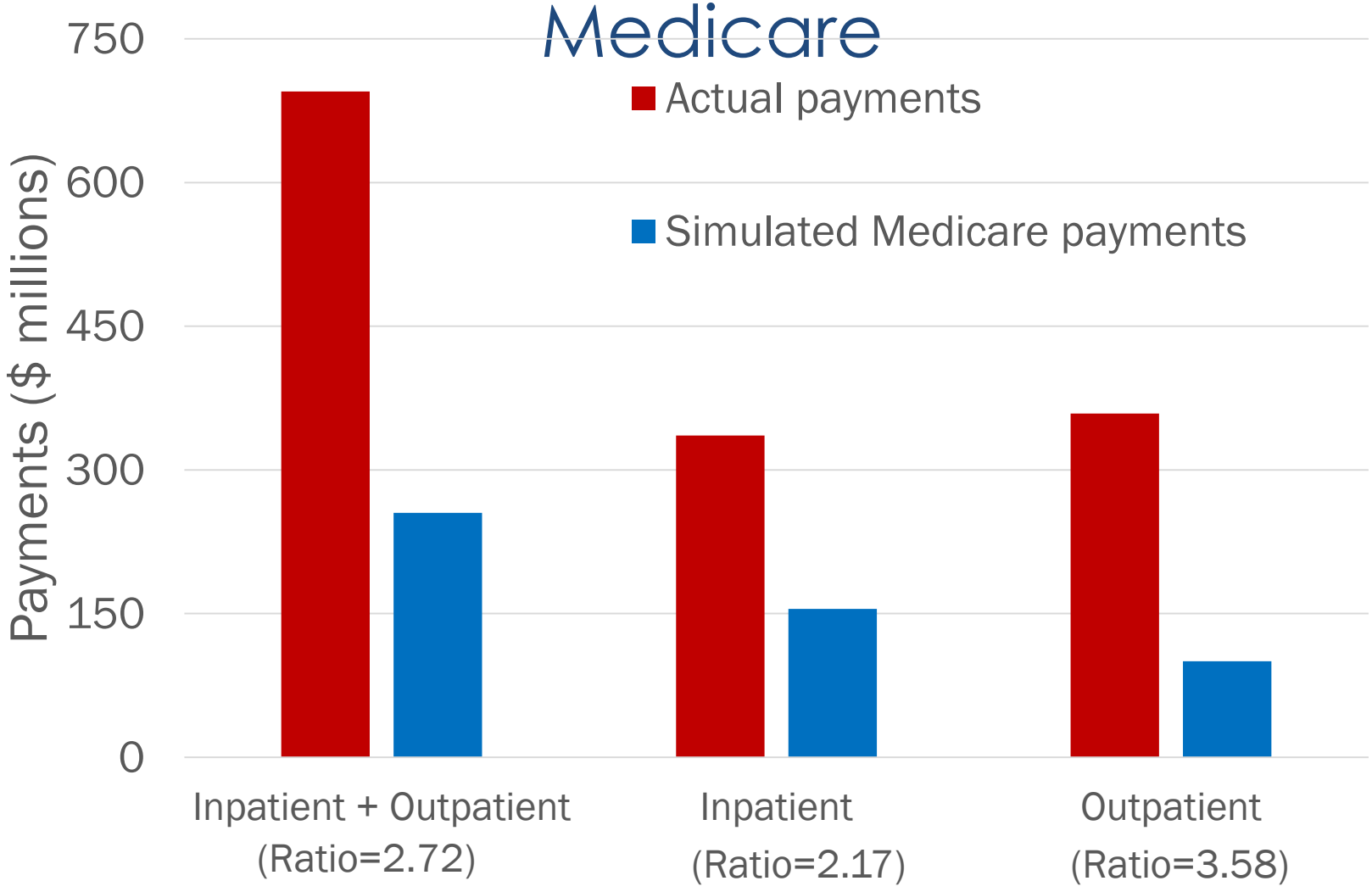
Challenges for APCDs

- Packaging information so that is it meaningful
  - Building user-friendly tools--CA is currently working on this
  - Bundling services
  - Developing labeling and searching conventions
- Tailoring information for stakeholders with different needs
  - Consumers
  - Payers and employers
  - Providers
  - Policymakers
- Addressing missing data
  - Self-insured employers
  - Other exemptions and exceptions (e.g. small insurers)
- Ensuring reliability and completeness
  - Missing data, erroneous submissions, duplicate submissions, etc.

APCDs have many uses beyond consumer price transparency

- Identifying use of low-value care
  - MN report (2017) found that payers spent almost $55 million on low-value services in one year
- Estimating how policy changes affect spending
  - Saloner and Barry (2017) used KS APCD data to analyze the effect of state autism insurance mandate on spending
- Looking for utilization or coverage patterns that predict higher spending
  - Figueroa et al. (2017) used MA 2017 to identify characteristics of high spenders
  - RAND has ongoing work to estimate the relationship between transitions in coverage and spending changes
- Allowing payers and employers to compare their negotiated rates to average payment

APCD-related initiative at RAND found that self-insured employers in Indiana pay 2 to 3 times as much as Medicare



White, Chapin. 2017. *Hospital Prices in Indiana: Findings from an Employer-Led Transparency Initiative*. RAND, RR-2106-RWJ.

Next steps for RAND-CHCF project

- Conduct more rigorous literature for each of the options identified, including Rx reforms and options to increase price transparency

- Contextualize for California
  - Is this likely to be a big saver for CA? Why or why not?
  - Are there potential unintended consequences?

- Report will likely be released sometime this coming summer