Federal Issues
Legislative

Appropriations Deal Reached to Bring 2019 Session to a Close
House and Senate Appropriations Committee Chairs announced an “agreement in principle” last week to keep the federal government funded for the rest of fiscal 2020.

- Why it matters: Government funding is set to expire on December 20. The deal ends months of negotiation centered on border wall funding. The package may also address issues such as health extenders, drug pricing, surprise medical billing, and/or health insurance tax (HIT) and other ACA tax relief, among others.

In this Issue:

Federal Issues
Legislative
- Appropriations Deal Reached to Bring 2019 Session to a Close
- House Prices Drug Pricing Legislation
- House and Senate Agreement on Health Care Costs Legislation
- House Panel Explores Universal Coverage Proposals
- Supreme Court Hears Arguments in Risk Corridors Litigation

Regulatory
- HHS Inspector General Flags Risk Adjustment Overpayments in Medicare Advantage

State Issues
Legislative

Pennsylvania
- Criminal Justice Reform to Dominate Last Voting Week in House

Industry Trends
Policy / Market Trends
• NAIC Doesn’t Want CMS to Proceed with ACA Health Care Choice Compacts
House Passes Drug Pricing Legislation


Why it matters: Passage of the bill fulfills one of the top priorities of the Democrats’ new majority. It comes on the heels of a deal between House Speaker Nancy Pelosi (D-CA) and the progressive wing of her caucus, which had threatened to block the bill.

Highlights of the bill include:

- Allows the federal government to directly negotiate prices for the 250 most expensive drugs with no competition and require negotiation of at least 50 drugs annually under the Medicare prescription drug benefit and Medicare Advantage. Heavy fines would be levied against drug manufacturers that refuse to negotiate.
- Establishes new inflation rebates for drugs covered under Medicare Part B and Part D that would be extended to employer plans under the deal with progressives.
- Redesigns the Medicare Part D benefit by establishing a $2,000 beneficiary maximum out-of-pocket limit and requiring manufacturer discounts in the initial and catastrophic phase of the benefit.

The impact: The Congressional Budget Office estimates that H.R. 3 will lower spending by $456 billion, would cut the federal deficit by $5 billion and would result in approximately eight fewer new drugs by 2029.

GOP alternative fails: House Republicans unveiled their drug cost bill, H.R. 19, “The More Cures, Lower Costs Act,” designed to promote more low-cost options for patients and curb the gaming of the system by drug companies. The legislation failed by a vote of 201-223 on Thursday.

Looking ahead: It is not expected that the GOP-controlled Senate will take up H.R. 3 and President Trump has indicated he would veto it. Meanwhile, Senate Finance Committee leaders have reintroduced their version of drug pricing legislation with changes intended to increase Republican support and make the bill more attractive to Senate leadership.

Highmark joins AHIP, BCBSA and the AHA in working with the Campaign for Sustainable Rx Pricing (CSRxP), to promote bipartisan, market-based solutions to lower drug prices. The CSRxP issued a statement commending the House for taking action to lower drug prices and urging the Senate to act as well.

House and Senate Agreement on Health Care Costs Legislation

Last week, Senate HELP Committee Chairman Lamar Alexander (R-TN), House Energy and Commerce (E&C) Committee Chairman Frank Pallone Jr. (D-NJ) and E&C Committee Ranking Member Greg Walden (R-OR) announced they had reached an agreement on compromise legislation to address surprise medical bills, improve transparency and lower prescription drug costs.

Key highlights in the E&C and HELP agreement include:

- Surprise Billing: The agreement adds new protections that hold patients harmless from surprise medical bills. Payments to providers would be based on the median in-network benchmark and the compromise adds an arbitration provision that would be available for individual claims where the in-
network payment would exceed $750 restricted by a 90-day “cooling off period”. During which, the party that initiated the arbitration may not initiate another dispute with the same party for the same item or service. In related news, the House Ways and Means (W&M) Committee on Wednesday announced it had reached its own bipartisan deal to provide relief to consumers on surprise billing. Their bill does not set a federal benchmark payment rate and would include an outside mediation process to determine payment disputes.

- **All-Payer Claims Database (APCD):** An earlier provision to create a national APCD was dropped in favor of a grant program that would provide funding to create or improve state-based APCDs.

- **Pharmacy Benefit Managers (PBMs):** The bill includes provisions that require reporting to employer health plan sponsors on the costs, fees, and rebates associated with their PBM, prohibit PBMs from engaging in spread pricing and require PBMs to pass along 100 percent of any rebates to plan sponsors.

- **Rx Costs:** The bill contains several prescription drug provisions addressing manufacturer abuses and increased reporting. Other provisions increase transparency on patents and exclusivity periods for brand drugs and reference biologics, require public education efforts for biologic products, and clarify standards for drug approvals under the Orphan Drug Act.

- **Anti-competitive Contracts:** The deal includes a number of recommendations to ban anti-competitive contracts by removing gag clauses on price and quality information and eliminating anti-tiering, anti-steering and most favored nation clauses.

- **Tobacco:** The compromise bill adds a new section that updates tobacco product regulation; increasing the minimum age of sale of tobacco products to 21 and tying block grant funding to states under Section 1921 of the Public Health Service Act to greater enforcement on retailers. The compromise also requires the Secretary to apply certain labeling and advertising restrictions on electronic nicotine delivery systems and includes language to take action on preventing online sales of e-cigarettes to children.

Highmark supports the Coalition Against Surprise Medical Billing, which issued a statement expressing concerns about arbitration. Given the limited number of remaining legislative days, it is unlikely there will be further action on a broader healthcare cost package before year’s end.

**House Panel Explores Universal Coverage Proposals**
The House Energy and Commerce Committees Health Subcommittee on Tuesday held a hearing to explore nine separate proposals aimed at achieving universal healthcare coverage for all Americans:

- During the first panel, members of the Subcommittee heard from five of their own colleagues who each presented their own bills featuring a different approach to expanding coverage. They included: a limited proposal that would cover first responders and early retirees under the Medicare program; a Medicare buy-in proposal for individuals aged 50-65; a public option which would cover all Americans within three years; and two “Medicare for All” proposals aimed at covering all Americans.

- Members also heard from a panel of health experts and economists, a patient advocate and a representative from the nurses’ union. They explored ways to achieve universal coverage by expanding Medicaid in non-expansion states, covering undocumented immigrants, establishing an auto-enrollment system, restoring the Affordable Care Act’s individual mandate and strengthening subsidies.
The debate: Democrats on the Committee discussed a wide variety of health care issues including the progress made since the Affordable Care Act, the benefits of a public option and the feasibility of Medicare for All. Republicans primarily discussed the consequences of shifting to a government-run system, pointing out that most Americans are already satisfied with their health insurance and the impact it would have on providers and rural hospitals.

Supreme Court Hears Arguments in Risk Corridors Litigation
On Tuesday, the U.S. Supreme Court heard oral arguments in several lawsuits brought by various health plans seeking recovery of unpaid Affordable Care Act risk corridor amounts.

- Why it matters: The case involves a statutory obligation to make payments to insurers under the Affordable Care Act being subsequently nullified by an appropriations rider. It raises significant questions regarding the ability of private parties to depend on the government as a fair and reliable business partner. AHIP and BCBSA filed amicus briefs earlier this year in the case.

Plan arguments: Paul Clement, counsel for Moda Health Plan and Blue Cross Blue Shield of North Carolina faced questions from Justice Alito regarding Congress’ intent surrounding the “shall pay” statutory language associated with the risk corridors program, the impact of the subsequent appropriations riders and the availability of a remedy for plans. Other Justices posed questions focusing on plans’ expectations when the statute was drafted, prior decisions by the Court involving issues regarding retroactivity and the government’s statutory payment obligations.

Government’s defense: Deputy Solicitor General Edwin Kneedler presented arguments for the Federal Government and received a majority of questions from the bench. These included several pointed questions from Justice Breyer focused on contracting principles and underlying policy questions, as well as questions from Justice Kagan regarding the Government’s obligations following health plans’ participation in the ACA exchanges and subsequent “payments in” to the risk corridors program. Other Justices, including Chief Justice Roberts and Justice Kavanaugh posed questions to both sides focusing on the potential impact in the event the Court were to rule in favor of either side’s position.

The case is now fully submitted to the Court and a decision is expected by June of next year.

Federal Issues
Regulatory

HHS Inspector General Flags Risk Adjustment Overpayments in Medicare Advantage
On Thursday, the HHS Office of Inspector General issued a report offering new concerns about the Medicare Advantage (MA) risk adjustment program. The report focused on MA insurer use of medical chart reviews to raise payment codes in order to obtain higher risk adjustment payments from the federal government. Using 2016 Medicare Advantage claims, the OIG found that insurers that reported additional diagnoses based on medical charts increased their payments $6.7 billion in 2017.

The OIG recommended a number of ways that CMS should conduct additional oversight of MA plan risk adjustment practices and CMS concurred those recommendations. The report arrives at an important
time -- CMS will soon issue a MA-focused regulation that is expected to clarify whether it will begin extrapolating coding errors discovered during risk adjustment audits. This could dramatically increase the negative consequences of risk adjustment coding errors.

**State Issues**

**Pennsylvania**

**Legislative**

**Criminal Justice Reform to Dominate Last Voting Week in House of Representatives**

The House of Representatives' final voting week of 2019 will have the chamber consumed with criminal justice reform initiatives. Members will be casting votes on bills that were vetted via extensive multi-year reviews of the state's criminal justice system. Probation reforms and post incarceration employment opportunities are among the measures set to receive consideration. **While health care legislation is currently not on the voting schedule, this is subject to change.**

The Senate is scheduled to be in session one day this week – Wednesday, December 18.

Both chambers are scheduled to begin their Christmas and Hanukkah recesses later this week.

**Industry Trends**

**Policy / Market Trends**

**NAIC Doesn’t Want CMS to Proceed with ACA Health Care Choice Compacts**

The National Association of Insurance Commissioners (NAIC) sent a letter to CMS stating there is no need for federal guidelines facilitating the sale of insurance across state lines. NAIC argued states already have the authority and no insurers have expressed interest in participating in existing interstate compacts.

Section 1333 of the Affordable Care Act directs HHS, in consultation with NAIC, to develop guidance on establishing Health Care Choice Compacts (HCCC) in order to sell insurance across state lines. Last March, CMS issued a request for information seeking stakeholder input on what guidance should look like for these HCCCs. On November 15, CMS invited NAIC to work with the agency on drafting regulations.

**Why it matters**

There is considerable concern regarding HCCC and how insurance sold across state lines would be regulated and how to enforce oversight. Network adequacy concerns, state mandated benefits, consumer protections, among other issues, are viewed as potential complications.

The Pennsylvania House of Representatives is in session December 16-18. The Pennsylvania Senate is scheduled to be in session Wednesday, December 18.

The Delaware Legislature has adjourned for the year.
The West Virginia Legislature has adjourned for the year.

Congress
The U.S. Congress is in session this week.

Interested in reviewing a copy of a bill(s)? Access the following web sites:

Pennsylvania Legislation: [www.legis.state.pa.us](http://www.legis.state.pa.us).
West Virginia Legislation: [http://www.legis.state.wv.us/](http://www.legis.state.wv.us/).
For copies of congressional bills, access the Thomas website – [http://thomas.loc.gov/](http://thomas.loc.gov/).