Issues for the week ending January 6, 2017

Federal and National Issues

Legislative
- Congress Begins 2017 Session
- Reps. Noem and Sinema Introduce Bipartisan Bill to Repeal ACA Health Insurance Tax
- Court Delays House v. Burwell CSR Proceedings
- Class Certified In Risk Corridor Litigation
- Trump Transition Team Announces White House Domestic Policy Council Health Staffer

Regulatory
- CSR Reconciliation Manual Released
- States to Boost Behavioral Health Care Under Medicaid Demonstration
- Final Regulations Published Governing Penalties in 340B Drug Discount Program
- Medicare Wants Input on Expanding Program for Frail Elderly
- Medicaid Personal Care Oversight Seen Falling Short

State Issues

Delaware

Regulatory
- Trinidad Navarro Sworn in as Delaware’s 26th Insurance Commissioner
- Governor-Elect Carney Nominates Dr. Walker to run Health and Social Services

Pennsylvania

Legislative
- Pennsylvania General Assembly Holds Swearing-In Ceremonies for Members
- Committee Chairs Named in Pennsylvania Senate and House of Representatives

Regulatory
- PID Announces Student Health Plans Considered Individual Coverage
- Department of Human Services Announces HealthChoices Procurement Decisions

Industry Trends

Provider / Delivery System Trends
- President-elect Trump Gathers Top Hospital CEOs for Health Care Discussion
- New York Study Finds Wide Variations in Hospital Prices
Federal and National Issues

Legislative Issues

Congress Begins 2017 Session
The Senate and the House convened on January 2 to launch the 115th Congress, devoting much of the day to ceremonial and organizational issues. Newly elected and reelected lawmakers were sworn into office in both chambers, and Rep. Paul Ryan (R-WI) was officially reelected as Speaker of the House.

Senate Budget Committee Chairman Mike Enzi (R-WY) began the process of repealing parts of the Affordable Care Act (ACA) by introducing a budget resolution that includes language instructing the Senate Finance Committee, the Senate HELP Committee, the House Ways and Means Committee, and the House Energy and Commerce Committee to submit recommendations – no later than January 27, 2017 – for changing laws within their jurisdiction. These changes will focus on repealing the core components of the ACA. Upon receiving these recommendations, the Senate and House Budget Committees will assemble them into a budget reconciliation bill that will be considered first on the Senate floor and later on the House floor. A final reconciliation bill with ACA repeal provisions will be sent to President Trump’s desk – possibly by late February or early March. The budget resolution includes two “reserve funds” that would allow most of the budget savings resulting from ACA repeal legislation to be set aside to support replacement health reforms at a later date.

Reps. Noem and Sinema Introduce Bipartisan Bill to Repeal ACA Health Insurance Tax
On January 4, Representatives Kristi Noem (R-SD) and Kyrsten Sinema (D-AZ) introduced bipartisan legislation, the “Jobs and Premium Protection Act” (H.R. 246), which would fully repeal the ACA health insurance tax. In a letter addressed to their House colleagues, Representatives Noem and Sinema state: “As you recall, the HIT is a $100 billion tax on health insurers that is passed to consumers who bear the brunt of the tax through higher premiums and out-of-pocket costs... In fact, the nonpartisan Joint Committee on Taxation estimates that by 2018, the HIT will increase the cost of individual premiums by $100-$300 and employer-provided family premiums by more than $450.”

Court Delays House v. Burwell CSR Proceedings
The U.S. Court of Appeals for the District of Columbia ordered a temporary delay until February 21, 2017, in House v. Burwell, a case challenging the Obama Administration’s payment of cost sharing reduction (CSR) subsidies without a congressional appropriation. The House asked for the delay to allow discussion of settlement or other resolution of the case with the new Administration. On December 20, 2016, two CSR-eligible individuals who receive health insurance coverage through exchanges moved to intervene (i.e., become parties) in the case “to defend their interest in continued payment of the cost-sharing reimbursement.” The individuals indicated that their interests had been “aligned with the interests of the Executive Branch,” but believed that may no longer be the case with the new Administration.

The Obama Administration and the House each filed their responses to the motion. The Administration’s response indicated that, in light of the Court’s order delaying the case until
February 21, 2017, the Court should defer, for now, ruling on the intervention motion as it is not timely. The House’s response recommends that the Court should deny the intervention motion.

Class Certified In Risk Corridor Litigation
On January 4, Judge Margaret Sweeney of the United States Court of Federal Claims certified Health Republic Insurance Company v. United States as a putative class action. The Health Republic litigation was the first case filed in this Court to recover unpaid risk corridor shortfalls. Since then, over a dozen other entities have filed separate actions.

The certified class includes: All persons or entities offering Qualified Health Plans under the Patient Protection and Affordable Care Act in the 2014 and 2015 benefit years, and whose allowable costs in either the 2014 or 2015 benefit years, as calculated by the Centers for Medicare and Medicaid Services, were more than 103 percent of their target amounts (as those terms are defined in the Patient Protection and Affordable Care Act).

Under the Court’s procedures, potential class members must be notified and must decide whether to “opt in” to the class. Lead counsel are directed to submit to the court a proposed notice plan and opt-in schedule no later than Monday, January 23, 2017.

Trump Transition Team Announces White House Domestic Policy Council Health Staffer
President-elect Trump’s transition team has announced eight individuals who have been selected to serve on the White House Domestic Policy Council. One of these appointments, Katy Talento, will be responsible for health care policy. Talento is an infectious disease epidemiologist who has nearly 20 years of experience in public health and health policy, including 12 years in high-level Senate staff positions. Other individuals were appointed to handle education policy, urban affairs and revitalization, regulatory reform, immigration policy, and homeland security.

Regulatory Issues
CSR Reconciliation Manual Released
On December 27, 2016 the Centers for Medicare and Medicaid Services (CMS) released, for the first time, a Manual for Reconciliation of the Cost-Sharing Reduction (CSR) Component of Advance Payments for Benefit Year 2016. The manual outlines the process by which QHP insurers receive advance payments reimbursing them for reducing deductibles, coinsurance, copayments, and out-of-pocket limits for essential health benefits (EHBs) for their low-income and Native American enrollees. The manual also sets out how corrections should be made for 2014 and 2015 CSR reconciliations. Each year, these payments must be reconciled with the payments the insurers were actually due. The 2016 reconciliation process will begin on April 3, 2017 and must be completed by June 2, 2017. Claims settled after that date can be submitted in 2018. Claims for 2015 not included in the 2015 reconciliation filings may be submitted as restatements of the 2015 CSR reconciliation data.

States to Boost Behavioral Health Care under Medicaid Demonstration
Eight states are moving to implement efforts that strengthen behavioral health care under Medicaid. Targeting adults and children with serious mental illness, as well as those with severe and chronic substance abuse disorders, the recently approved demonstration project will certify community clinics and cover their behavioral health services and support in Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon and Pennsylvania.

In these states, behavioral health clinics will work to better partner with primary care providers and hospitals and use evidence-based tools and health data such as Medicaid claims and clinic cost reports to monitor patient care and measure its quality. The effort will gather information from interviews with clinics and states.
States have until July 1 to begin their two-year demonstration programs, according to the Department of Health and Human Services. The move is in keeping with a larger push toward more holistic care that has seen pilots for Medicaid-covered residential mental health and substance abuse treatment approved in Maryland and Florida in recent months. And the funds in question are critical to a mental health system that has fallen under increased scrutiny and targeted for reform; Medicaid makes up almost half of public mental health spending, according to National Alliance on Mental Illness figures.

The demonstration project reflects a key priority for state Medicaid directors. This work comes from a recognition that there is a lot of bifurcation between physical health and behavioral health services and thinking about the best way to serve the whole person and create a person-centered model of care. A large part of that in the coming year will focus on how to change payment systems to encourage this more and on looking at socioeconomic factors that affect health outcomes such as housing insecurity. And with a focus on treating substance abuse disorders, the pilots will also provide another chance to chip away at the deadly nationwide opioid crisis.

**Final Regulations Published Governing Penalties in 340B Drug Discount Program**

The Health Resources and Services Administration (HRSA) in the January 5 Federal Register published a final rule, required under the Affordable Care Act, on civil monetary penalties under the 340B drug discount program. Under the program, drug manufacturers participating in Medicaid agree to provide outpatient drugs to covered entities, such as safety-net hospitals, at significantly reduced prices.

Under the rule, manufacturers must pay a penalty if they intentionally charge above what is known as the ceiling price. The law says the penalty cannot exceed $5,000 for each instance of overcharging a covered entity.

The provisions of the final rule include:

- the requirement that a manufacturer calculate the 340B ceiling price on a quarterly basis;
- the requirement that a manufacturer charge $0.01 per unit of measure if the 340B ceiling price calculation results in a ceiling price that equals zero (penny pricing);
- the methodology manufacturers must use when estimating the ceiling price for a new covered outpatient drug;
- an explanation of how a civil monetary penalty (CMP) would be imposed on a manufacturer that knowingly and intentionally overcharges a covered entity; and
- an explanation of what would constitute an instance of overcharging to trigger a CMP.

The final rule will be effective March 6, 2017. However, HRSA recognizes that the effective date falls in the middle of a quarter. As such, HRSA will begin enforcing the requirements of this final rule at the start of the next quarter, which begins April 1, 2017.

**Medicare Wants Input on Expanding Program for Frail Elderly**

The federal government is asking for ideas on expanding a Medicare managed care program intended to keep frail beneficiaries out of nursing homes. The Centers for Medicare & Medicaid Services wants feedback by February 10 on a five-year model it developed that would expand eligibility for the Program of All-Inclusive Care for the Elderly (PACE), the agency said December 23 in a request for information. As part of the expansion, younger beneficiaries could join PACE.

The PACE program is currently restricted to individuals at least 55 years old who are designated by their state to require a nursing home level of care. The program provides beneficiaries with a package of medical and social services in order to keep them in the community and out of institutions. There are 121 PACE program organizations serving 38,072 enrollees in 31 states.
The two-part request for information (RFI) is the first step in implementing the Pace Innovation Act of 2015, signed by President Barack Obama in November 2015, which allows testing of similar models for other groups. The first part looks for feedback on a model that would test the program for individuals at least 21 years old who are dually eligible for Medicare and Medicaid, and who need a nursing home level of care. The model is called Person Centered Community Care or P3C. It is aimed at those whose disabilities impair their mobility.

Medicare is looking for comments on such issues as whether there should be a maximum eligibility age for the P3C model and whether the broader population would make it more difficult to make program innovations. The government also wants to know the types of technical assistance states and groups joining the P3C would need to participate.

The second part of the RFI is looking for information on other groups that would benefit from enrollment in PACE-like models. Specifically, these would be individuals with “complex medical needs whose current interactions with the health care delivery system too often result in suboptimal care, poor health outcomes, and high costs,” the RFI said.

Among these populations are older individuals with Medicare who do not require a nursing home level of care but do need support to remain in the community. Other examples could be people with end stage renal disease or mental illness, the RFI said.

**Medicaid Personal Care Oversight Seen Falling Short**

Oversight of Medicaid personal care is uneven and needs more work, according to a report released December 22 by the Government Accountability Office. The reliability and cohesiveness of protections preventing patient abuse and fraud fluctuate greatly across states and programs.

Personal care services are delivered in-home for the elderly and disabled, making patients more vulnerable to attacks but also to theft, neglect, falls and malnutrition. And Medicaid is often billed in this sector for tasks that were never performed, costing the federal government about $2 billion in 2014, according to a Centers for Medicare & Medicaid Services estimate.

The number of patients receiving this care, which covers daily tasks such as dressing and bathing and is conducted under various Medicaid programs, is only expected to increase as Baby Boomers age, making tweaks to the program that much more critical and highlighting congressional calls to improve consistency.

The report’s findings underscore this: CMS’ collection of state reports on these services has been spotty, and efforts to improve consistency “have not addressed the significant differences across federal program requirements.” “A more consistent administration of policies and procedures across programs could help the federal government and states better manage risks to beneficiaries and protect the integrity of the program,” the report from the GAO says.

The GAO recommended that CMS examine states’ data on health effects and quality for personal care and move to better align federal requirements on safety and payments. CMS has bolstered its oversight over the past four years, reviewing three state primary care programs, issuing guidelines for systems to better handle responses to potential safety violations and offering webinars on curbing inaccurate Medicaid charges. The agency’s examination looked specifically at personal care in California, Maryland, Oregon and Texas from July 2015 to November 2016.

CMS found all had implemented systems to monitor the health and wellness of patients using personal care services, but some checked in with personal visits and others by phone. The time frames and data systems used for tracking problem reports also varied. Billing oversight did not match up across states and programs either, with some tracking care through paper timesheets and others via an electronic system. Finally, the GAO wants the agency to make its Medicaid rules
and regulations on personal care more seamless with no contradictions. The GAO said that would make training, monitoring and other processes more consistent.

State Issues

Delaware

Regulatory

Trinidad Navarro Sworn in as Delaware’s 26th Insurance Commissioner
Former New Castle County Sheriff Trinidad Navarro was sworn in as Delaware’s 26th Insurance Commissioner on Tuesday, January 3, 2017. Following Navarro’s swearing in, the Commissioner swore in Mitch Crane, Esquire, of Lewes, as the Deputy Insurance Commissioner. While addressing the department’s employees, Navarro stated “I am honored to serve as Delaware’s Insurance Commissioner. There is much we need to accomplish for the consumer. I look forward to working with the staff, legislature, governor and industry to refocus the Department of Insurance’s priorities on the insurance consumer. We will work hard in the coming months and years to ensure a fair and affordable marketplace by ending discriminatory practices used in setting rates and holding the line on excessive costs that affect consumers and businesses.”

Governor-Elect Carney Nominates Dr. Walker to run Health and Social Services
Gov.-Elect Carney has chosen Kara Odom Walker, MD, MPH, MSHS to run the Department of Health and Social Services. Dr. Walker is currently the Deputy Chief Science Officer at the Patient-Centered Outcomes Research Institute (PCORI). As part of the leadership team, Walker has responsibility for overseeing PCORI’s long-term research investments, working on operational efficiencies for the Science department, managing external relationships with stakeholders and Board members, and managing the front office of the Chief Science Officer. A family physician with health services and community-based participatory research training, Walker previously was assistant clinical professor in family and community medicine at the University of California, San Francisco, where she created measurement instruments to better understand integrated care in health systems for diverse populations.

An honors graduate of University of Delaware with a BS in chemical engineering, Walker received her MD from Jefferson Medical College and her MPH from Johns Hopkins University. She completed postgraduate training at University of California, San Francisco, and served as a Robert Wood Johnson Clinical Scholar at the University of California, Los Angeles, where she conducted research on the impact of hospital closure on underserved, minority populations. As an advocate for health equity and minority and underserved populations, Walker has been recognized for leadership by the Harvard Business School’s program for leadership development, the American Medical Association, and the National Medical Association. She is a past national president of the Student National Medical Association and past postgraduate physician trustee of the National Medical Association. She continues to see primary care patients in a local clinic for the uninsured.

Pennsylvania

Legislative

Pennsylvania General Assembly Holds Swearing-In Ceremonies for Members
January 3 marked the opening of the 201st session of the Pennsylvania General Assembly. The Senate swore in 34 Republicans and 16 Democrats, while 121 Republicans and 81 Democrats took the oath in the House of Representatives. The House currently has one vacancy due to the resignation of Representative Leslie Acosta (D-Philadelphia).
Committee Chairs Named in Pennsylvania Senate and House of Representatives

The following members were named committee chairs in the Senate and House of Representatives. Highlighted are the panels where the majority of bills impacting Highmark’s business interests are referred. The remaining members of the committees will be assigned over the next few weeks.

**Senate Standing Committee Chairs**
- Aging & Youth: Michele Brooks (R-Mercer) and Art Haywood (D-Montgomery)
- Agriculture & Rural Affairs: Elder Vogel (R-Beaver) and Judy Schwank (D-Berks)
- Appropriations: Pat Browne (R-Lehigh) and Vincent Hughes (D-Philadelphia)
- Banking & Insurance: Donald White (R-Indiana) and Sharif Street (D-Philadelphia)
- Communications & Technology: Ryan Aument (R-Lancaster) and Art Haywood (D-Montgomery)
- Community, Economic & Recreational Development: Mario Scavello (R-Monroe) and Larry Farnese (D-Philadelphia)
- Consumer Protection & Professional Licensure: Robert Tomlinson (R-Bucks) and Lisa Boscola (D-Northampton)
- Education: John Eichelberger (R-Blair) and Andrew Dinniman (D-Chester)
- Environmental Resources & Energy: Gene Yaw (R-Lycoming) and John Yudichak (D-Luzerne)
- Finance: Scott Hutchinson (R-Venango) and John Blake (D-Lackawanna)
- Game & Fisheries: Pat Stefano (R-Fayette) and Jim Brewster (D-Allegheny)
- Intergovernmental Operations: Camera Bartolotta (R-Washington) and Anthony Williams (D-Philadelphia)
- Judiciary: Stewart Greenleaf (R-Montgomery) and Daylin Leach (D-Montgomery)
- Labor & Industry: Kim Ward (R-Westmoreland) and Tina Tartaglione (D-Philadelphia)
- Law & Justice: Charles McIlhinney (R-Bucks) and Jim Brewster (D-Allegheny)
- Local Government: Scott Wagner (R-Westmoreland) and John Blake (D-Lackawanna)
- Public Health & Welfare: Lisa Baker (R-Luzerne) and Judy Schwank (D-Berks)
- Rules & Executive Nominations: Jake Corman (R-Centre) and Jay Costa (D-Allegheny)
- State Government: Mike Folmer (R-Lebanon) and Anthony Williams (D-Philadelphia)
- Transportation: John Rafferty (R-Montgomery) and John Sabatina (D-Philadelphia)
- Urban Affairs & Housing: Tom McGarrigle (R-Delaware) and Wayne Fontana (D-Allegheny)
- Veterans Affairs & Emergency Preparedness: Randy Vulakovich (R-Allegheny) and Jay Costa (D-Allegheny)

**House Standing Committee Chairs**
- Aging and Older Adult Services: Tim Hennessey (R-Chester) and Steve Samuelson (D-Northampton)
- Agriculture and Rural Affairs: Martin Causer (R-McKean) and Eddie Day Pashinski (D-Luzerne)
- Appropriations: Stanley Saylor (R-York) and Joseph Markosek (D-Allegheny)
- Children and Youth: Katharine Watson (R-Bucks) and Scott Conklin (D-Centre)
- Commerce: Brian Ellis (R-Butler) and Curtis Thomas (D-Philadelphia)
- Consumer Affairs: Bob Godshall (R-Montgomery) and Thomas Caltagirone (D-Berks)
- Education: Dave Hickernell (R-Lancaster) and James Roebuck (D-Philadelphia)
- Environmental Resources and Energy: John Maher (R-Allegheny) and Mike Carroll (D-Luzerne)
- Finance: Bernie O'Neill (R-Bucks) and Jake Wheatley (D-Allegheny)
- Game and Fisheries: Keith Gillespie (R-York) and Bryan Barbin (D-Cambria)
- Gaming Oversight: Scott Petri (R-Bucks) and Patrick Harkins (D-Erie)
- Health: Matt Baker (R-Tioga) and Flo Fabrizio (D-Erie)
- Human Services: Gene DiGirolamo (R-Bucks) and Angel Cruz (D-Philadelphia)
- Insurance: Tina Pickett (R-Bradford) and Tony DeLuca (D-Allegheny)
- Judiciary: Ron Marsico (R-York) and Joe Petrarca (D-Westmoreland)
- Labor and Industry: Rob Kauffman (R-Franklin) and John Galloway (D-Bucks)
- Liquor Control: Adam Harris (R-Juniata) and Paul Costa (D-Allegheny)
- Local Government: Kate Harper (R-Montgomery) and Bob Freeman (D-Northampton)
- Professional Licensure: Mark Mustio (R-Allegheny) and Harry Readshaw (D-Allegheny)
- State Government: Daryl Metcalfe (R-Butler) and Greg Vitali (D-Delaware)
- Tourism and Recreational Development: David Millard (R-Columbia) and Mark Longietti (D-Mercer)
- Transportation: John Taylor (R-Philadelphia) and William Keller (D-Philadelphia)
- Urban Affairs: Mark Keller (R-Perry) and Michael O'Brien (D-Philadelphia)
- Veterans and Emergency Preparedness: Stephen Barrar (R-Delaware) and Chris Sainato (D-Lawrence)

**Regulatory**

**PID Announces Student Health Plans Considered Individual Coverage**
The Pennsylvania Insurance Department has determined that Student Health Plans are to be considered and regulated as individual plans. To this end, the week of January 2, the Department issued student health plan rate and form filing guidelines. The Department now requires annual rate filings for all student health plans, including those with rate decreases or unchanged rates. The first rate filing is due by January 30, 2016. The Department, however, does acknowledge that insurers may engage in negotiation processes with institutions of higher learning and therefore may not be able to submit final rates until after the negotiation process is complete. The filings are, however, file and use.

**Department of Human Services Announces HealthChoices Procurement Decisions**
The Department of Human Services (DHS) intends to negotiate contracts with six managed care organizations (MCO) to deliver physical health care services to 2.2 million Medicaid consumers across the commonwealth through HealthChoices, Pennsylvania’s mandatory Medicaid managed care program. The $12 billion, three-year contracts include a 30 percent target for payments based on value received or outcomes, rather than on the quantity of services provided. Specifically, the new agreements set value-based payment targets of: 7.5 percent in 2017, 15 percent in 2018 and 30 percent in 2018.

The announcement represents several significant changes for the eight current HealthChoices contract holders. Two MCOs (Aetna and United Healthcare of PA) were not selected in any zones; Centene (Pennsylvania Health and Wellness), a national plan that currently contracts with eighteen states to provide coverage to Medicaid consumers, is coming into Pennsylvania; and Gateway will be the only statewide plan.

As a reminder, the original HealthChoices procurement was scheduled to have new MCOs in place statewide as of January 1, 2017. A successful challenge resulted in a reissued procurement, and pushed the new contract start date back to April 1, 2017. With this announcement of the awards for the reissued procurement, the new contract effective date now is June 1, 2017, and it could change again if non-selected bidders file valid protests. All MCOs also must successfully pass DHS readiness reviews, which consider a broad range of program requirements (such as network adequacy, financial stability, staffing, etc.) before they can begin operations.

The chart below lists the existing MCOs currently delivering care, and the selected MCOs that likely will begin providing services in 2017:
<table>
<thead>
<tr>
<th>Zone</th>
<th>Existing MCOs</th>
<th>MCOs as of June 1, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Southeast Region</strong></td>
<td>1. Aetna Better Health</td>
<td>1. Gateway Health</td>
</tr>
<tr>
<td></td>
<td>2. Health Partners Plans</td>
<td>2. Health Partners Plans</td>
</tr>
<tr>
<td></td>
<td>4. United Healthcare of PA</td>
<td>4. UPMC for You</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Vista—Keystone First Health Plan</td>
</tr>
<tr>
<td><strong>Southwest Region</strong></td>
<td>1. Aetna Better Health</td>
<td>1. Gateway Health</td>
</tr>
<tr>
<td></td>
<td>2. Gateway Health</td>
<td>2. PA Health and Wellness</td>
</tr>
<tr>
<td></td>
<td>3. United Healthcare of PA</td>
<td>3. UPMC for You</td>
</tr>
<tr>
<td></td>
<td>4. UPMC for You</td>
<td>4. Vista—AmeriHealth Caritas Health Plan</td>
</tr>
<tr>
<td><strong>Lehigh/Capital Region</strong></td>
<td>1. Aetna Better Health</td>
<td>1. Gateway Health</td>
</tr>
<tr>
<td></td>
<td>2. AmeriHealth Caritas</td>
<td>2. Geisinger Health Plan</td>
</tr>
<tr>
<td></td>
<td>3. Gateway Health</td>
<td>3. Health Partners Plans</td>
</tr>
<tr>
<td></td>
<td>4. United Healthcare of PA</td>
<td>4. PA Health and Wellness</td>
</tr>
<tr>
<td></td>
<td>5. UPMC for You</td>
<td></td>
</tr>
<tr>
<td><strong>Northeast Region</strong></td>
<td>1. Aetna Better Health</td>
<td>1. Gateway Health</td>
</tr>
<tr>
<td></td>
<td>2. AmeriHealth Caritas</td>
<td>2. Geisinger Health Plan</td>
</tr>
<tr>
<td></td>
<td>3. Geisinger Health Plan</td>
<td>3. UPMC for You</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Northwest Region</strong></td>
<td>1. Aetna Better Health</td>
<td>1. Gateway Health</td>
</tr>
<tr>
<td></td>
<td>2. AmeriHealth Caritas</td>
<td>2. UPMC for You</td>
</tr>
<tr>
<td></td>
<td>4. UPMC for You</td>
<td></td>
</tr>
</tbody>
</table>

**Industry Trends**

**Provider / Delivery System Trends**

**President-elect Trump Gathers Top Hospital CEOs for Health Care Discussion**

President-elect Donald Trump met December 28 with leaders of top U.S. nonprofit hospital systems to discuss medical research and patient care. John Noseworthy, chief executive officer of the Mayo Clinic; Paul Rothman, CEO of Johns Hopkins Medicine; David Torchiana, CEO of Partners HealthCare; and Toby Cosgrove, CEO of the Cleveland Clinic participated in the meeting.

Rothman, in a message to Johns Hopkins staff, said the meeting with Trump “reflects his recognition of the critical importance of health care and biomedical research to the country.”

The Mayo Clinic said in a statement that Noseworthy was invited to discuss “his perspective on the future of health care delivery, research and excellence,” including applying principles developed at...
the Mayo Clinic to improve U.S. health care. Noseworthy planned to discuss “Mayo Clinic's views on critical success factors needed to solve our nation's most pressing and complex health challenges,” the Rochester, Minn.-based health system said.

A Partners spokesman, Rich Copp, said the conversation “touched on a wide range of health care issues including affordability, quality and biomedical research.” The organization's hospitals include the Harvard Medical School-affiliated Massachusetts General Hospital and Brigham and Women’s Hospital in Boston.

A Cleveland Clinic spokeswoman, Eileen Sheil, said the group discussed “a broad range of health care topics.” Cleveland Clinic’s Cosgrove has called the Affordable Care Act a success for helping to improve the quality of care and for providing millions of Americans with insurance coverage. He said the country needs to do more to prevent diseases, like reducing smoking and sugar consumption, and to slow rising costs, particularly by controlling skyrocketing drug prices. He has also said that he believed the Obama administration was not as open to input from health care executives as he would have liked.

New York Study Finds Wide Variations in Hospital Prices

Prices for services at some hospitals in New York can range from 1.5 to 2.7 times higher depending more on market leverage than quality, according to a study of privately held data from rate negotiations with insurers. “Why Are Hospital Prices Different: An Examination of New York Hospital Reimbursement,” issued December 19 by the nonprofit New York State Health Foundation (NYSHealth), offered a rare look at the dynamics of rate talks between 107 hospitals and nine insurance plans in the state. It sought to identify the drivers of higher costs as consumers face paying a greater share through high-deductible plans and rising premiums. The NYSHealth study was conducted by analysts at Gorman Actuarial LLC in Marlborough, Mass., with input from the state health insurance regulators.

The study identified complicating factors including contract provisions that can reinforce market advantage, such as terms that keep hospital prices from being included in cost-estimator tools for consumers or anti-steering language that limits information available on high-quality, lower-priced providers.

The study, which covered 2014, also found hospitals in New York City and its suburbs that serve large numbers of Medicaid and Medicare patients have less leverage in rate negotiations in the private commercial market and end up with lower payments. That finding, the authors said, counters a widely held belief that a hospital negotiates higher commercial prices to offset lower reimbursements received for its publicly insured patients.

Health insurers, in a statement by New York Health Plan Association President Paul Macielak, said the report provided “concrete data” backing up their argument that affordability “is directly related to the underlying health care costs, with hospital costs being one of the biggest pieces of the pie.” The group endorsed the study’s findings that market share provides leverage for higher reimbursements and said it supports giving consumers information on prices and costs to help guide coverage decisions. It also backed the report's recommendation to bar anticompetitive contracting clauses, but maintained that the state should also add measures “to protect consumers when hospital mergers considerably increase market share and provider bargaining power.”

Hospitals in health care systems with large market share generally have higher prices, regardless of a single member hospital's own size or market share, the study found. Moreover, it said, some insurers do not have the internal capacity to compare the prices of one hospital to another within a network because of variations in reimbursement methods. Meanwhile, the study found, rural hospitals face little competition and generally charge higher prices than urban hospitals.
Policy recommendations in the report included simplifying reimbursement methods, barring certain language from hospital-insurer contracts, and monitoring and reporting provider price information to uncover potential market dysfunctions.

**Insurance / Market Trends**

**Court Hears Final Arguments in Anthem-Cigna Merger**

Anthem Inc., Cigna Corp. and Justice Department lawyers presented final arguments to a federal judge who will decide whether a $48 billion merger of the rival health insurers harms those who buy coverage or provide care. U.S. District Judge Amy Berman Jackson ended a seven-week Washington trial on January 4 with more than two hours of back-and-forth discussion with company and government lawyers.

The Anthem-Cigna case is now the second major health insurer case challenged by U.S. antitrust officials awaiting a judge's decision. The trial in the government's lawsuit seeking to block Aetna Inc.'s proposed merger with Humana Inc. ended December 30 and is now with U.S. District Judge John D. Bates.

The companies have previously said the failure to close the deal by April 30 would trigger an obligation for Anthem to pay Cigna a $1.85 billion breakup fee.

**Study Shows Mylan and Teva Led Pharmaceutical Industry in ‘Anomalous’ Price Moves**

About one in 19 generic drugs sold in the U.S. during the past three years have undergone major price hikes that may be consistent with collusion, according to a wide-ranging study that comes in the middle of a Justice Department investigation into pharmaceutical price-fixing. Fideres Partners LLP, a London-based consultancy analyzed price moves in 1,670 generic drugs sold in the U.S. from 2013 to 2016. It identified 90 medicines whose prices were raised steeply and almost simultaneously by at least two manufacturers, even though there was no obvious reason for the increase, such as greater manufacturing costs. The average price jump among the 90 drugs was 1,350 percent, Fideres found. “I don't think the public or even the politicians in the U.S. have any idea just how widespread and extreme the phenomenon is,” said Alberto Thomas, one of Fideres's founders.

The manufacturers behind the highest number of potentially suspicious increases were Mylan NV with 30, Teva Pharmaceutical Industries Ltd. with 27 and Actavis Inc. with 22, Fideres said. Actavis, now known as Allergan Plc, sold its generic portfolio to Teva in August.

The increases alone are not proof of collusive practices, Fideres said. There are many reasons prices can rise: competing suppliers dropping out, manufacturing problems or market fluctuations that are common in the industry. Still, the analysis provides hard data on the scale of a problem that has provoked outrage among Americans and exercised politicians. On December 22, a U.S. Senate committee released a report calling for pricing legislation, including importation and faster approval of competing drugs.

The antitrust division of the Justice Department has been looking for the past two years into allegations of collusion among manufacturers. So far, a dozen firms have been subpoenaed and 24 specific drugs examined. Fideres acts as an expert witness in cases against companies in industries including pharmaceuticals.

Recently, 20 states, led by Connecticut Attorney General George Jepsen, filed a civil complaint alleging executives at companies agreed at trade shows, golf games and private dinners to pump up the cost of antibiotics and medication used to treat diabetes. Jeffrey Glazer, a former chief executive officer of Heritage Pharmaceuticals Inc., and Jason Malek, an ex-president at the company, were charged in Philadelphia with two counts related to the price-fixing allegations.
State
The Pennsylvania General Assembly will begin session the week of January 23.

The Delaware General Assembly is in session January 10-12.

The West Virginia Legislature will begin session February 8.

Congress
The U.S. Congress is in session the week of January 9.

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


Pennsylvania Legislation: www.legis.state.pa.us.

West Virginia Legislation: http://www.legis.state.wv.us/

For copies of congressional bills, access the Thomas website – http://thomas.loc.gov/.