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Federal and National Issues

Legislative Issues

State Attorneys General File Motion to Intervene in CSR Lawsuit
On Thursday, the attorneys general of fifteen states (California, New York, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, New Mexico, Pennsylvania, Vermont, and Washington) and of the District of Columbia filed a Motion to Intervene in House v. Price. As we reported previously, this case involves a challenge, by the U.S. House of
Representatives, to the Administration’s payment of cost sharing reduction (CSR) subsidies as lacking a congressional appropriation. The matter is currently before the U.S. Court of Appeals for the DC Circuit, following a decision in U.S. District Court that the CSR subsidies did lack such an appropriation, but staying the impact of that decision pending appeal.

The attorneys general argue that they should be permitted to intervene in the matter “to ensure an effective defense against the claims made in this case and to protect the interests of millions of state residents affected by this appeal.” The motion argues that the current Administration does not represent the states’ interests in the matter, given statements by the Administration that CSR payments have not been authorized by Congress. The motion notes a number of reasons for the states’ interest in intervening, such as higher premiums for state residents, fewer insurance choices for state residents, more uninsured residents, more uncompensated care, the loss of direct federal funding in states with Basic Health Programs, and annual uncertainty and higher administrative costs for states as they regulate insurance markets.

The court previously denied, in January of this year, an attempt by consumers to intervene. The attorneys general note that the Administration argued, in response to that brief, that intervention would be premature and speculative. It adds that more recent Administration statements about CSR payments have made it clear that intervention would no longer be premature or speculative.

The appeal is currently in abeyance based on a request by the parties “to allow time for a resolution that would obviate the need for judicial determination of this appeal, including potential legislative action.” Because of this, the state attorneys general also filed a request today that the Court lift its abeyance order to the extent necessary to permit responses to and a ruling on the states’ motion to intervene. In addition, the parties are required to file status reports every three months while the abeyance is in effect, and the next status report is due on Monday, May 22.

**Senate Committee Approves Chronic Care Reform Bill**

On Thursday, the Senate Finance Committee unanimously approved an amended version of S. 870, the “CHRONIC Care Act.” This bipartisan legislation proposes steps aimed at improving health outcomes for Medicare beneficiaries who have chronic conditions.

America’s Health Insurance Plans (AHIP) has addressed a letter to the sponsors of the “CHRONIC Care Act,” expressing our support for the bill’s efforts to “increase care coordination among plans and providers serving individuals with chronic diseases, develop payment systems to incentivize the delivery of higher quality, more efficient services to this vulnerable population, and improve outcomes while reducing health care costs.”

The bill is based on the deliberations of a Chronic Care Working Group that has collected extensive public comments from hundreds of stakeholders. The bill includes several provisions supported by insurers, including: permanent reauthorization of Medicare Advantage (MA) Special Needs Plans (SNPs); a unified grievances and appeals process for individuals enrolled in dual eligible SNPs (D-SNPs); a nationwide expansion of the current value-based insurance design (VBID) demonstration for the MA program; flexibility for MA plans to offer additional supplemental benefits to better serve individuals with specific health care needs; and authority to broaden the use of telehealth in delivering basic Medicare benefits to enhance value and reduce premiums for their enrollees.

During the markup, the committee approved an amendment by Senators Tom Carper (D-DE) and Pat Roberts (R-KS) that would direct the HHS Secretary to establish a process, beginning in plan year 2020, by which a Medicare Part D plan sponsor may submit a request to HHS for Parts A and B claims data to be used to optimize therapeutic outcomes through improved medication use and to improve care coordination to prevent adverse health outcomes.
House Subcommittee Approves FDA Reauthorization Act
On Thursday, the House Energy and Commerce Subcommittee on Health approved an amended version of H.R. 2430, the “FDA Reauthorization Act.” This bill is likely to be considered by the full House Energy and Commerce Committee next week.

Like a companion bill (S.934) that was approved in the Senate HELP Committee, H.R. 2430 would reauthorize user fee programs that generate funds to support key activities, including the review and approval of new products, at the Food and Drug Administration (FDA). Leaders of both the House Energy and Commerce Committee and the Senate HELP Committee are strongly focused on finalizing this legislation, and sending it to the President’s desk, before the August recess.

The subcommittee approved four amendments that are similar to amendments approved by the Senate HELP Committee. One amendment, offered by Reps. Kurt Schrader (D-OR) and Gus Bilirakis (R-FL), would establish an accelerated review process for certain competitive generic therapies, award a six-month exclusivity incentive for generic manufacturers that receive approval through that pathway, improve program integrity in the priority review voucher program for tropical diseases, and require a study on first-cycle generic approvals. Other amendments focus on authorizing over-the-counter hearing aids, improving the quality and efficiency of medical device establishment inspections, and keeping counterfeit and diverted drugs out of the health care system.

“FAIR Drug Pricing Act” Introduced in Senate and House
Bipartisan legislation – the “FAIR Drug Pricing Act” (S. 1131 / H.R. 2439) – has been introduced by Senator Tammy Baldwin (D-WI), Senator John McCain (R-AZ), and Rep. Janice Schakowsky (D-IL).

This bill proposes steps aimed at increasing transparency in prescription drug pricing. Specifically, the bill would require drug manufacturers to submit a report to the Department of Health and Human Services (HHS) 30 days before they increase the price of certain drugs by more than 10 percent over one year or 25 percent over three years. Such reports would be required to include a justification for each price increase, along with information on manufacturing, research and development costs, net profits attributable to the drug, and marketing/advertising spending on the drug. HHS would make the information from these reports publicly available within 30 days and would submit an annual report to Congress summarizing the information submitted by drug manufacturers.

The bill’s sponsors issued a joint statement that comments: “American taxpayers and individuals who rely on prescription drugs are paying for price increases, without any explanation of why or what they are getting for their money. Drug price transparency reforms like the FAIR Drug Pricing Act are extremely popular with the public as more than 85 percent of Americans support requiring drug companies to release information on how they set prices. In the same survey from the Kaiser Family Foundation, six in 10 Americans – including a majority of Democrats, Republicans and independents – identified lowering the cost of prescription drugs as a ‘top priority’ for the President and Congress.”

Regulatory Issues
CMS Publishes SHOP Enrollment Numbers and Announces 2018 FF-SHOP Changes
Centers for Medicare and Medicaid Services (CMS), on May 15th published SHOP enrollment numbers by state. As of January 2017 approximately 39,000 individuals employed by 7,600 businesses were enrolled on FF-SHOP coverage in the 36 states that use the FF-SHOP. Nationwide, including both FF-SHOP and state-based SHOPs, as of January 2017 approximately 230,000 individuals employed by 27,000 businesses were enrolled on coverage through a SHOP exchange. This represents a small portion of the approximate 16 million individuals who are
enrolled on small group plans purchased through all purchasing channels nationwide. In Delaware there are 40 active employers with 179 covered lives. In Pennsylvania there are 663 active employers with 3,080 covered lives. And rounding out the Highmark service area is West Virginia with 81 employers and 488 covered lives.

Currently, the FF-SHOP facilitates enrollment and premium collection for employers that purchase FF-SHOP coverage. CMS announced a plan to propose, in future rulemaking, that employers in FF-SHOP states will no longer use HealthCare.gov to enroll for SHOP plans with an effective date on or after January 1, 2018. These employers will instead be able to sign up for SHOP plans directly through an agent or broker, a web-broker, or an issuer of their choice.

The expectation is that the FF-SHOP will continue providing the following functions in 2018:

- Enrollment and premium payment support for 2017 policies, subject to user fees and monthly reporting requirements; and
- Consolidated information on all available 2018 FF-SHOP plans to support the small business shopping experience; and
- SHOP coverage eligibility determinations, which businesses will need if they plan to claim the small business tax credit.

CMS and the Department of Treasury Release a Checklist for Section 1332 Waivers
The checklist is designed to help states that are pursuing Section 1332 Waivers, as they develop and complete the required elements of the application, in particular the 1332 waiver implementing a high-risk pool/state-operated reinsurance program. States that are interested in applying for Section 1332 Waivers are encouraged to reach out to the Centers for Medicare and Medicaid Services (CMS) and Treasury promptly for assistance in formulating an approach that meets the requirements of Section 1332. The checklist is available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-cpdl.pdf

CMS Announces Medical Loss Ratio and Risk Corridors Annual Reporting Procedures for the 2016 MLR Reporting Year
The Centers for Medicare and Medicaid Services (CMS) memorandum outlines the process by which health insurance issuers will submit their medical loss ratio (MLR) data to fulfill reporting obligations under the MLR provisions of the Affordable Care Act. The report for the 2016 MLR reporting year must be filed by July 31, 2017.

CBO Score of AHCA Expected May 24
The Congressional Budget Office (CBO) and the Joint Committee on Taxation, on May 19th, announced that they will release cost and coverage estimates of the House-passed American Health Care Act (AHCA) on Wednesday, May 24.

CMS Announces Streamlined Enrollment Process for Federal Health Insurance Marketplace—Hospitals Urged to Review New Guidance
The Centers for Medicare & Medicaid Services (CMS) announced that it has streamlined the enrollment process for individuals signing up for individual health insurance coverage through the federal health insurance marketplace. Since hospitals and health systems employ individuals to assist in enrollment or contract with outreach staff, it is important for them to make sure staff are familiar with the new guidance.

The new process allows the individual, the insurance company or issuer, or an agent or broker assisting the individual to complete the application, to use one website, rather than having the
individual be redirected to healthcare.gov to complete an application. This process is part of larger efforts by CMS to stabilize the health insurance market.

Open enrollment for 2018 health insurance coverage through the federal marketplace will be shorter this year—November 1 through December 15, 2017. It will be important for hospital and health system staff to be aware of the shorter time period, available insurance options, and the new streamlined enrollment process.

**HRSA Delays Until Oct. 1 the Effective Date of Final Rule on 340B Drug Ceiling Prices**
The Health Resources and Services Administration has delayed to Oct. 1 the effective date of its final rule on 340B drug ceiling prices and civil monetary penalties for manufacturers. The final rule was subject to multiple delays since January.

“The additional time provided to the public before the rule takes effect constitutes an extra quarter and will assist stakeholders in preparing to comply with these new program requirements,” the notice states.

**CMS Delays Start of Comprehensive Care for Joint Replacement Expansion and Bundled Payment Model to Jan. 1**
The Centers for Medicare & Medicaid Services has further delayed from Oct. 1 to Jan. 1 the start date for the expansion of the Comprehensive Care for Joint Replacement model; new bundled payment program for heart attack and cardiac bypass surgery services; and new cardiac rehabilitation incentive program. The hospital industry called for the additional delay in comments submitted last month, but cautioned against additional delays that “would effectively turn the start date for these programs into a moving target.”

The programs were all part of a final rule issued in December.

**HHS Updates Ransomware Guidance for Health Care Organizations**
The Department of Health and Human Services has issued updated ransomware and cyber threat guidance for health care organizations. Ransomware attacks, a type of cyberattack in which the actors demand the payment of ransom to regain access to a victim’s data, were reported Friday by companies and organizations in more than 150 countries, including hospitals and other clinical services in England’s National Health Service.

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**State Issues**

**Pennsylvania**

**Legislative**

**Physician Credentialing Bill Scheduled for House Floor Consideration**
On Tuesday, May 23, the House of Representatives is tentatively scheduled to consider House Bill 125, which establishes physician credentialing requirements, and a related amendment. The legislation currently mandates insurers accept the Council for Affordable Quality Healthcare (CAQH) application and process such applications within 30 days. While the proposed amendment addresses some of Highmark’s concerns, including the removal of provisional credentialing status if an insurer fails to review an application within the specified timeframe and the extension of application review timeframe from 30 to 45 days, we continue to have concerns with House Bill 125. Current Pennsylvania state law, Act 68 of 1998, requires insurers to develop and implement a thorough credentialing process, which is also necessary for Highmark to meet accreditation standards of the National Council on Quality Assurance (NCQA). Highmark also completes 82% of credentialing applications within 45 days.
House Insurance Committee to Vote on CHIP Extension Measure
The House Insurance Committee plans to take up a proposal that would reauthorize the Children’s Health Insurance Program (CHIP). House Bill 1388 would extend CHIP’s sunset date from December 31, 2017 to December 31, 2019 or ninety days after the point in which federal funding for the program expires. Highmark supports reauthorization.

Industry Trends

Provider / Delivery System Trends

Dignity Health Releases Human Trafficking Response Resource for Hospitals
San Francisco-based Dignity Health has published information on its Human Trafficking Response Program to help other hospitals and health systems implement similar programs. “Trafficked persons are often overlooked even though most survivors report that they have visited a health care setting at least once while being trafficked,” said Holly Gibbs, director of the Dignity Health program and a survivor of human trafficking. “Dignity Health has developed a victim-centered, trauma-informed program based on actual cases because we believe that health care providers can provide a critical step in identifying and supporting trafficked persons.”

The health system launched the program in 2014 across its system to educate staff, implement protocols and strengthen communities against human trafficking.

State
The Pennsylvania General Assembly is in session the week of May 22.

The Delaware General Assembly is on break until June 6, due to the budget.

The West Virginia Legislature has adjourned for the year.

Congress
The U.S. Congress is in session the week of May 22.

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

Delaware State Legislation: http://legis.delaware.gov/

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/.