Highmark's Weekly Capitol Hill Report

Issues for the week ending May 31, 2019

Federal Issues
Legislative

HELP Leaders Release Bipartisan Discussion Draft on Health Care Costs

On May 23, Senate HELP Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) released a discussion draft of bipartisan legislation aimed at reducing health care costs.

- **Background**: This draft bill is based on a series of committee hearings earlier in the year as well as recommendations provided by hundreds of health care organizations.

The draft bill includes 5 titles with more than 30 legislative provisions aimed at:

- ending **surprise medical bills**
- reducing the price of **prescription drugs**
- improving **transparency** in health care
- improving **public health**
- improving the exchange of **health information**

A section-by-section summary of these provisions can be found here.

In this Issue:

More momentum for surprise billing: This marks the fourth piece of sweeping, bipartisan surprise billing legislation unveiled in the last few weeks. It is one of the **hottest issues on Capitol Hill** right now.

What's next: Alexander and Murray are **accepting comments on their draft through June 5**. The committee is planning to mark up an updated version of the bill before the July 4th recess, with the goal of preparing the bill for **Senate floor action by the end of July**.

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Committee Leaders Release Bipartisan Medicare Part D Discussion Draft

On May 23, bipartisan leaders of the House Ways and Means Committee and the House Energy and Commerce Committee announced a discussion draft of legislation addressing the Medicare Part D prescription drug program.

- The discussion draft focuses on two issues:
    - **Creation of an out-of-pocket maximum** on prescription drugs costs for Medicare beneficiaries in Part D based on the current catastrophic threshold
    - Changing the incentive structure for Part D plans to manage costs by **reducing the government's share of the catastrophic coverage** from 80 percent to 20 percent over four years

Background: These proposals are based on recommendations from the Medicare Payment Advisory Commission.

More: In addition to releasing the draft, the committees are also soliciting comments on

- changes to the Part D coverage gap
- the catastrophic threshold
- liability in the catastrophic tier
- promotion of lower-cost generic alternatives
- improvements to the low-income subsidy program

- how Part D could better address the problem of high cost drugs
- potential improvements for low-to-moderate income Part D beneficiaries
- out-of-pocket costs below the catastrophic level.

The committees are accepting comments through June 6.

House Holds Second Single Payer Hearing

Officials from the Congressional Budget Office (CBO) testified May 22 at a House Budget Committee hearing on establishing a single-payer health care system.

- **The witnesses**: The hearing featured three witnesses from the CBO, who discussed its recent report describing the primary features of single-payer systems and **discussing key design considerations and choices** that policymakers will face as they develop proposals.
- **The message**: CBO Deputy Director Mark Hadley testified that a transition toward a single-payer health care system would be "a major undertaking" and could be **complicated, challenging, and potentially disruptive**. He emphasized that any effort to establish a single-payer system would require Congress to make many decisions and face **complex tradeoffs for individuals, providers, insurers and manufacturers of prescriptions and devices**.
- **The guide**: CBO testimony was based in part on a recent report that discussed major decisions U.S. policymakers would face.

Discussion among committee members was **divided along party lines**, with Democrats speaking in support of universal coverage, although some expressed interest in alternatives to single-payer, including **a public option that would compete against existing private plans**. Republicans, meanwhile, raised serious concerns about the cost of a single-payer system and its **impact on health care quality, innovation, and consumer choices**.

No vote coming: This was the second congressional hearing over the past month to focus on single-payer and "Medicare for All" proposals, with one additional hearing expected in the House Ways and Means Committee. Committee Chairman John Yarmuth (D-KY) said he **does not expect the House to vote on "Medicare for All"** legislation in the current Congress (2019-2020).

Highmark joins AHIP, BCBSA, the AHA and others in supporting the Partnership for America's Health Care Future (PAHCF) to improve the health care system in a way that builds on employer-sponsored coverage and protects Medicare and Medicaid to promote affordability and access for all Americans.

House Panel Examines Surprise Billing

On May 21, the House Ways and Means Committee held a hearing to discuss solutions to protect patients from surprise medical bills.

> **Why it matters**: Momentum on the issue is building because the stories are hitting close to home. **Two members of Congress testified** -- Rep. Katie Porter (D-CA) discussed her **personal experience** in receiving a surprise medical bill last year after being hospitalized with a ruptured

appendix. Rep. Cathy McMorris Rodgers (R-WA) highlighted the story of a constituent in her home state of Washington who **received a surprise bill for $227,000** after being hospitalized following a heart attack.

Much of the discussion during the hearing centered on how providers set rates and **how to determine fair payments** for out-of-network providers. Members of the committee also probed New York and California surprising bill laws, which feature **arbitration as a key component**.

America's Health Insurance Plans and the America Hospital Association joined the ERISA Industry Committee and the American Medical Association in offering testimony.

House Subcommittee Holds Hearing on Rx Pricing Transparency

The House Energy and Commerce Subcommittee on Health held a legislative hearing May 21 on drug pricing transparency that focused on several bills that have been introduced.

Who testified: witnesses included representatives from PhRMA, the Pharmaceutical Care Management Association (PCMA), the Coalition of State Rheumatology Organizations, Families USA, Arnold Ventures and American Action Forum.

- PhRMA's witness noted its **commitment to greater transparency** across the health care system, and stated PhRMA's willingness to work with lawmakers.
- PCMA pointed to PBMs' mission to control costs, which is only effective when there is **sufficient competition among drug companies**.
- Families USA told the panel that the drug industry enjoys one of the **highest profit margins**, and said the industry spends less than 25 percent of their funds on innovation.

The bills considered at the hearing touched on:

- **Justification of Price Increases** -- H.R. 2069 and H.R. 2296 would require drug makers to report detailed information to the Department of Health and Human Services (HHS) to justify price increases.
- **Reporting on Product Samples** -- H.R. 2064 would increase scrutiny and disclosure on the number and value of prescription drug samples provided to physicians.
- **Reporting on Prices** -- H.R. 2087 -- would improve the accuracy and timeliness of drug pricing data submitted by drug makers under the Medicare Part B program.
- **Encouraging Generic Utilization** -- H.R. 2757 would encourage the use of generic drugs by eliminating the copayment for generic drugs for Medicare Part D beneficiaries who receive low-income subsidies.
- **Supply Chain Transparency** -- H.R. 2115 and H.R. 2376 would requires PBMs to disclose the aggregate amount of rebates, discounts, and price concessions they negotiate with drug manufacturers and require the Federal Trade Commission to conduct a study on the state of competition in the drug supply chain.

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.

Bipartisan Committee Questions Rising Insulin Prices

Senate Finance Committee Chairman Chuck Grassley (R-IA) and Ranking Member Ron Wyden (D-OR), as members of the Committee charged with oversight of Medicare and Medicaid, sent a letter to the Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma requesting information from CMS regarding the cost of insulin products and their effect on both the federal government's healthcare spending, and the impact on the tens of millions of Americans its programs serve.

Background

Earlier this year, concerned about the impact of rising insulin costs on patients and taxpayers, Grassley and Wyden sent letters to the three primary manufacturers of insulin, and the three largest pharmaceutical benefit managers (PBM), seeking information about how their actions have contributed to rising healthcare costs. For example, one recent analysis found that from 2007 to 2017, Medicare's pre-rebate spending on insulin increased 840%, while aggregate annual out of-pocket spending more than quadrupled.

As part of the committee's investigation into the rising price of insulin, the senators are specifically interested on the impact of costs to taxpayers and patients, with respect to reimbursements paid by the federal government on insulin, average out-of-pocket costs, and total prescription volumes/fees related to insulin rebate programs. Furthermore, a few questions raised in the letter ask for fees or direct and indirect remuneration (DIR) tied to specific manufacturers (Eli Lilly, Sanofi, Novartis) or pharmacy benefit managers (Express Scripts/Cigna, CVS Health, OptumRx).

Why it matters:

- Prescription drugs are a significant driver of healthcare costs
- Rising prescription drug costs may serve as a barrier to care
- Uncontrolled diabetes can lead to other health complications

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Federal Issues

Regulatory

CMS Finalizes Rule Updating Programs of All-Inclusive Care for the Elderly

The Centers for Medicare & Medicaid Services issued a final rule updating Medicare and Medicaid requirements for the more than 100 Programs of All-Inclusive Care for the Elderly in 31 states, the first major update since 2006.

The changes will provide greater operational flexibility, remove redundancies and outdated information, and codify existing practice.

PACE is a unique model of risk-based integrated care for frail elderly individuals. Enrollment in the programs has increased by 120 percent since 2011 to more than 45,000 older adults, most of whom are eligible for both Medicare and Medicaid.

Why it matters
The rule finalizes provisions in the 2016 proposed rule that:

- expand the definition of primary care practitioner for the interdisciplinary care team to include non-physician caregivers, such as nurse practitioners or physician assistants;
- allow interdisciplinary team members to fulfill multiple clinical roles;
- enhance screening protocols for hiring employees; and
- require state Medicaid capitation payments to be linked to a general payment standard.

FDA Seeks Input on Requiring Blister Packs for Certain Opioid Pain Medicines

The Food and Drug Administration published a notice seeking comment through July 30 on a potential change to the Opioid Analgesic Risk Evaluation and Mitigation Strategy.

The proposal would require that certain solid oral dosage forms of immediate-release opioid analgesics commonly prescribed to treat acute pain be made available in fixed-quantity blister packaging for outpatient dispensing.

Why it matters:

- The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 allows the FDA to require special packaging for opioids and other drugs that pose a risk of abuse or overdose.
- This proposal could reduce the amount of unused opioid analgesics, thereby reducing opportunities for misuse, abuse, inappropriate access and overdose, and possibly reducing the development of new opioid addiction.

CMS Releases Details on Applying for New Ambulance Service Model

The Centers for Medicare & Medicaid Services has released a request for applications from Medicare-enrolled ambulance suppliers and providers to participate in its new payment model for emergency ambulance services beginning in 2020.

Announced in February, the Emergency Triage, Treat and Transport (ET3) model will enable participating ambulance suppliers and providers to partner with qualified health care practitioners to deliver treatment in place (either on-the-scene or through telehealth) and with alternative destination sites (such as primary care doctors' offices or urgent-care clinics) to provide care for Medicare beneficiaries following a medical emergency for which they have accessed 911 services. The five-year model also will encourage development of medical triage lines for low-acuity 911 calls in regions where participating ambulance suppliers and providers operate. CMS expects to release a notice of funding opportunity for the triage lines after selecting model participants this fall.

Model payments for alternative destination transport and treatment in place interventions will be made available for Medicare Fee-for-Service beneficiaries only. Applicants responding to the RFA will be required to identify whether they plan to implement the Model in Medicare Fee-for-Service only; or plan to align the Model interventions across additional payers, such as Medicare Advantage plans, Medicaid plans, or commercial payers. **The Innovation Center encourages multi-payer alignment as a strategy for success in the ET3 Model, although it is not required to be eligible to respond to the RFA.**

For more on the model, see the agency's answers to Frequently Asked Questions.

Why it matters:

- Emergency Triage, Treat, and Transport (ET3) is a voluntary, five-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service beneficiaries following a 911 call.
- The model will allow beneficiaries to access the most appropriate emergency services at the right time and place.
- The ET3 model aims to improve quality and lower costs by reducing avoidable transports to hospital emergency departments and unnecessary hospitalizations following those transports.
- The ET3 model complements and expands upon Pennsylvania law -- Act 103 of 2018 – that requires insurance companies and Medicaid to reimburse EMS agencies for calls where the EMS provider treated the patient, but did not transport them.

HHS Releases Proposed Rule Regarding Nondiscrimination

Background

- The Obama administration in 2016 issued a rule interpreting section 1557 of the Affordable Care Act (ACA) which prohibited health care providers and insurers from discriminating against a person based on gender identity and "termination of pregnancy."
- A lawsuit was brought by a coalition of states and faith-based providers challenging the rule. They won, but the lawsuit was put on hold in July 2017 when HHS said it was developing a rule fixing the issues addressed in the suit.

Recent Activity

A proposed rule on "Nondiscrimination in Health and Health Education Programs or Activities" would eliminate major parts of the 2016 regulation and make significant changes to the scope of Section 1557.

The proposed rule would entirely eliminate:

- The definitions section of the current rule (thereby eliminating definitions of key terms such as "covered entity" and "on the basis of sex");
- Specific nondiscrimination protections based on sex, gender identity, and association;
- Major language access requirements (such as a requirement that covered entities include translated taglines on notices and significant communications to consumers);
- Notice requirements that require covered entities to post information about Section 1557 and nondiscrimination at its locations and on its website;
- Requirements to have a compliance coordinator and written grievance procedure to handle complaints about alleged violations of Section; and
- Various enforcement-related provisions (such as protections against intimidation and retaliation).

Scope of the Proposed Rule

One of the main concerns of the original proposed rule was its broad application. The rule had stated if any federal money was received by any part of an organization, then the entire organization was effected by the rule. For example, if an insurer received Medicare payments or ACA subsidies, section 1557 would apply to their entire operation and all lines of business. The new proposed rule changes this and restricts the applicability to only those specific operations that (1) receives federal financial assistance provided by HHS

and (2) any program or activity administered under Title I of the ACA.

The proposed rule has not yet been published in the Federal Register. The public will have 60 days after it is published in the Federal Register to submit comments. The proposed rule is accompanied by a press release and fact sheet.

State Issues

Pennsylvania

Legislative

Budget to Dominate June Legislative Session

The Pennsylvania General Assembly returns to Harrisburg June 3 to begin the annual ritual of debating the budget. A nearly $900 million surplus raises speculation on how well talks between the Wolf Administration and Senate and House leaders will go.

Also on tap is the consideration of several health care measures, including legislation that would create a state-based health insurance exchange and reinsurance program, reauthorization of the Pennsylvania Health Care Cost Containment Council (PHC4), and the Lyme disease long-term antibiotic therapy mandate.

House Health Committee to Consider PHC4 Reauthorization

On Tuesday, June 4, the House Health Committee plans to consider House Bill 967. Sponsored by House Majority Leader Bryan Cutler (R-Lancaster), the proposal would reauthorize the Pennsylvania Health Care Cost Containment Council (PHC4) as an independent government entity, versus the current gubernatorial executive order.

Background

The PHC4 was created in 1986 by the Pennsylvania General Assembly and has become a nationally recognized organization that has been copied in many states. In addition to its hospital and payor reports, PHC4 has reviewed many proposals that would mandate new health insurance benefits. Many of these bills would have added millions in new health care expenses; however, this was averted due to PHC4's mandated benefit review responsibilities.

Why it matters: Highmark has supported PHC4 from its inception. Highmark staff have served on its board and contributed expertise toward its payor/data collection processes. Today both Highmark and AHN submit data for a number of reports.

Highmark and AHN support House Bill 967, with amendments that would clarify the use of data, confidentiality, and the potential creation of an all payor claims database (APCD).

Special Election Set for House 85th Legislative District

Speaker of the House Mike Turzai (R-Allegheny) has announced the date for the special election to replace former state Representative Fred Keller (R-Snyder) – Tuesday, August 20. Keller was successful in his

special election bid to capture the 12th congressional district seat. He has already resigned his 85th district House seat, which covers parts of Snyder and Union counties.

West Virginia

Regulatory

Governor Justice Appoints New CHIP Administrator

Gov. Jim Justice this week appointed Jean Kranz as the director of the West Virginia Children's Health Insurance Program (CHIP).

Background

Kranz, who has worked in the health care industry for more than 25 years, was most recently the director of Medicaid Operations at West Virginia Family Health Plan. Prior to that, Kranz served as a senior consultant for The Lewin Group and project manager of the West Virginia Health Improvement Institute. She also held positions with Highmark Health Services, the West Virginia Primary Care Association, and the West Virginia Hospital Association.

Why it matters: West Virginia CHIP is a partnership between the federal government and West Virginia to provide low-cost health care coverage to children in families that earn too much money to qualify for Medicaid and have no other source for health care coverage. The program, which serves 32,000 children annually, should have an experienced administrator to ensure that the children are receiving appropriate care and the program is running efficiently.

Kranz will begin her new role on July 1, 2019.

Industry Trends

Provider / Delivery System Trends

Measles Case Count Threatens Elimination Status

The Centers for Disease Control and Prevention last week reported 971 cases of measles so far this year, the most since 1992. If these outbreaks continue through summer and fall, the United States may lose its measles elimination status, the CDC said.

The virus was declared eliminated in the U.S. in 2000.

Why it matters:

- The CDC recommends vaccination for all eligible children and high-risk adults, including travelers and health care workers. Most of this year's cases involve children who have not been vaccinated.
- Before widespread use of the measles vaccine, an estimated 3 to 4 million Americans got measles each year, resulting in an estimated 400 to 500 deaths and 48,000 hospitalizations.

Policy / Market Trends

Health Insurance Inflation Increases

Health insurance CPI increased 10.7% from April 2018 to April 2019. This is the largest annual increase since April 2014.

Why it matters: It is the highest inflation in five years and was higher than medical care services, professional services, and hospital and related services. This will be a challenging talking point to defuse as we prepare for an upcoming presidential election where health care costs and single payer options will be top campaign issues.

State

The Pennsylvania General Assembly are in session June 3-5.

The Delaware Legislature is in session June 4-6.

The West Virginia Legislature has adjourned for the year.

Congress

The U.S. Congress is in session June 4-7. The U.S. Senate is in session June 3.

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/.**