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Federal Health Policy Report for CalPERS
February 2016

I. DELIVERY REFORM DEVELOPMENTS:

A. Nursing Facility Initiative Annual Report: On February 3rd, CMS released their annual report summarizing the impacts of its Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents for 2014. CMS research estimates that 45% of hospitalizations among nursing facility residences could be prevented. All seven sites participating in their initiative showed reductions in Medicare expenditures and statistically significant declines in two sites, as well as hospitalizations. For example, the Indiana site saw a 21.2% reduction in all cause hospitalizations from 2012 compared to 2014.

B. ACA Impact on Rx Drug Spending and Preventive Services: On February 8th, the Administration announced that more than 10 million people with Medicare have saved over $20 billion on prescription drugs since 2010 (primarily because beneficiaries in the so-called coverage "donut hole" – until it is closed in 2020 – are eligible for an approximately 50% discount for their medications) and 39 million Medicare beneficiaries utilized free preventive services in 2015 as a result of the ACA.

C. CMS and AHIP Partner to Improve Quality: CMS and America's Health Insurance Plans (AHIP) as a part of the Core Quality Measures Collaborative, released seven clinical quality measures. These measures support multi-payer alignment on core measures for physician quality programs. This will inform CMS's Medicare Access and Chip Reauthorization Act of 2015 required rulemaking and measure development plan. These ratings are intended to ensure uniform quality ratings to help patients choose doctors. Measures include a wide range of topics from controlling blood pressure, to HIV treatment. Consolidating measures make comparisons easier AND they reduce needless burdens on the health care providers.

D. Value Based Insurance Design: A study in the American Journal of Managed Care examined Geisinger Health System's $0 co-pay drug program for its chronically ill employee population and found that it is associated with positive cost savings and a nearly two year 5-year return-on-investment. The study concludes that value-based insurance designs (VBID) within the context of a wider employee wellness program targeting the appropriate population can potentially lead to positive cost savings.

E. CalPERS Implications: These generally quite encouraging delivery reform outcome findings help underscore the potential for improved quality and greater affordability that continue to be available for thoughtful reform ideas and effective execution. They validate CalPERS ongoing commitment in this area and encourage further system interventions.

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F. **CalPERS Next Steps:** To review the findings above and consider their implications to ongoing work and potential for further application to system contracting with plans and providers.

II. Cadillac Tax Update

A. **2017 Budget Proposes Regional Adjustments to Cadillac Tax:** The 2017 budget includes provisions for raising the Cadillac tax threshold in areas where health care is more expensive. In particular, it increases the threshold for the Cadillac tax if the average cost of a gold exchange plan is higher than the current threshold. The administration said this would cost $1.26 billion over 10 years. The budget calls for changes aimed at making it easier for companies offering flexible spending accounts to figure out how much they'd owe under the tax. It would also have the Government Accountability Office investigate how the tax would affect companies with large numbers of sick employees. This was met with mixed review from stakeholders, some of whom appreciated the acknowledgement of the flaws, but others, such as AFSCME, stated they support nothing less than a full repeal.

B. **Exclusion of Savings Accounts:** On February 4th, Senate Finance Committee Chairman Orrin Hatch and Representative Erik Paulsen, introduced a bill to exclude employee contributions from FSAs, HSAs, and MSAs from consideration toward the Cadillac Tax threshold. It would also exclude employer contributions if it replaced higher salaries.

C. **Employee Benefit Trend Study:** According to a study released by Wells Fargo Insurance, employers expect health care costs to rise in 2016. 58% of employers surveyed expect their medical plan costs to exceed the thresholds for the Cadillac tax. Half of employers said they expect to make changes this year or in 2017 by either adding a high deductible plan, increasing the employee contribution percentage, or increasing co-insurance. Over 50% of companies expect to increase wellness offerings.

D. **CalPERS Implications:** In the wake of the late year two-year delay of the imposition of the so-called "Cadillac tax" to 2020, there continues to be notable and welcome attempts to moderate its impact on CalPERS and all other potentially impacted entities.

E. **CalPERS Next Steps:** Continue to look at reform interventions that would mitigate against any negative impact on CalPERS plans and keep the Board informed of opportunities in this regard.

III. PRESCRIPTION DRUG PRICE/COST DEVELOPMENTS OF RELEVANCE TO CalPERS:

A. **Prescription Drug Pricing:**

i. **Drug Spending Cuts in the President's Proposed 2017 Budget:** Included are proposals which have often been included in other budgets such as lowering market exclusivity to 7 years from 12 years and allowing HHS to directly negotiate drug prices for part D. Additional proposals include:

1. **Align Medicare Payment for Low Income Beneficiaries with Medicare Rates:** About $121.3 billion would be saved by lowering the payments for

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drugs purchased for people on Medicare who are living in or near poverty, to match Medicaid payments.

2. **Encouraging Generic Drug Use:** Another $9.6 billion would be saved over a decade by encouraging people on Medicare who qualify for low-income assistance to use more generic drugs.
3. **Part B:** The President's budget proposal also calls for modifying the reimbursement of Part B drugs. The proposal lowers payment from 106% of the average sales price to 103% of the average sales price. If a physician's cost for purchasing the drug exceeds this, the drug manufacturer would have to provide a rebate to the provider. It would save $7.8 billion over a decade.
4. **Increasing Transparency:** A transparency measure would let HHS mandate that drug companies publicly disclose information including research and development costs, discounts on their products and other data. It is generally assumed that more transparency -- including around the discounts to particular payers --might help all payers negotiate lower drug prices.

ii. **Notorious Drug CEO Testifies:** On February 4th the former CEO of Turing Pharmaceuticals, Martin Shkreli was brought in to testify before the House Government Reform and Oversight Committee along with another executive from the company an FDA expert on generic drugs. While Shkreli asserted his Fifth Amendment rights, lawmakers questioned whether the slow process of approval for generic drugs at FDA enables openings for price gougers to take advantage of monopolies.

iii. **Value Based Drug Contracts:** on February 1st, Eli Lilly and Anthem released a memo asking Congress and the Administration to alleviate legislative and regulatory burdens -- including those posed by anti-kickback laws and Medicaid best price policy -- to make it easier for drug makers and health insurers to negotiate value-based payment contracts for drugs. The companies suggest the parameters of such contracts be defined through federal regulation, and say regulators could develop a template memorandum of understanding for payers and manufacturers or a sample agreement between a manufacturer and the government to exclude value-based pricing from certain reporting requirements. The companies also say CMS should be authorized to create a pilot program to test how value-based contracts and alternative approaches to best price impact government spending, Medicaid rebate amounts and the ceiling prices in the 340B drug discount program.

iv. **Funding for Drug Cost Research:** On February 17th the Laura and John Arnold Foundation announced they will provide $7.2 million to organizations to research and pilot projects aimed at lowering drug costs and financial barriers for patients. The money will fund efforts to expand payment arrangements in which health insurers and government health programs pay drug companies based on how well

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a treatment works on patients rather than payments based solely on volume of medicine sold.

v. **Health Transformation Alliance:** Twenty major companies including American Express, Macy's and Verizon have agreed to share data and use their market power to attempt to lower the cost of providing workers with health care benefits. The new alliance covers approximately 4 million people. They will share information about employee health spending and outcomes and look to change how they contract for care. They say that eventually they may form a purchasing cooperative to negotiate lower prices. Additionally, a pilot project specifically aimed at curbing prescription drug prices is in the works and the alliance expects to announce its development in 2017.

vi. **Diverse Stakeholders Outline Improvements for the Health System:** A list of health system policy recommendations from the Healthcare Leadership Council, an unusually diverse group of health care industry players including drug and medical device companies, payers, providers and patient groups, in conjunction with public policy researchers at the University of Chicago, calls for FDA reform, changes to federal anti-kickback and physician self-referral laws, as well as harmonization of state and national patient privacy laws and regulations. It seeks comprehensive and coordinated care for the chronically ill, as well as changes to Medicare's Medication Therapy Management program. And it wants the long-sought nationwide health information interchangeability achieved by the end of 2018.

vii. **FDA Commissioner Confirmed:** On February 24th, new FDA Commissioner, Robert Califf was confirmed by the Senate by a vote of 89-4. Early on, Senators Sanders and Murkowski placed holds in his nomination, but eventually lifted them. Some Senators, including Sanders criticized him for ties to drug companies, which funded many of his studies while he was a researcher at Duke. Others used the vote as an opportunity to raise objections to FDA's handling of opioids.

B. **CalPERS Implications:** The scrutiny on the pharmaceutical industry's pricing practices and costs continues relatively unabated. This is encouraging as new innovations in purchasing/acquiring these medically necessary and valuable products more affordably are being developed to the benefit of all purchasers (including CalPERS). This scrutiny seems to be moderating (modestly) drug prices and the trend rate for this year may be lower than last year.

C. **CalPERS Next Steps:** Continue to actively participate with private and public purchasers in pressing the pharmaceutical industry to be more sensitive to pricing practices and to develop further innovations in purchasing pharmaceuticals in a fashion that also secures more than adequate incentives for R&D and breakthrough pharmaceutical therapy.

IV. MEDICARE ADVANTAGE:

A. **Proposed Call Letter Issue:** In the annual proposed Medicare Advantage (MA) Call Letter, CMS proposed a change to the Group MA bidding process that aims to address

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the fact that bid/benchmark ratios are much higher for Group MA plans than for Individual MA. As opposed to the individual MA market, where plans are trying to get as much membership as possible by bidding below the benchmark level of fee-for-service and providing the difference in additional benefits, CMS believes there is an incentive for Group MA plans to bid as close to the benchmark as possible to maximize the amount of the premium that the government pays (bidding at 100% of the benchmark means that the government is paying 100% of the FFS costs). They can do this because Group MA plans do not need rebate money in order to attract members given that Group MA plans are directly sold by MCOs to employers in private negotiations. Meanwhile, employers will pay a premium to the extent that they want to provide additional benefits (as a retiree benefit), whereas individuals are averse to paying any amount of additional premiums. These group bids are not competitive in other words. MedPAC has documented the differential for several years.

To address this discrepancy, CMS has proposed that group MA plans would no longer have to bid against benchmarks and rather, will be paid the average bids and the average rebates. In essence, their rationale for doing this is it will lower the federal subsidy that taxpayers and fee-for-service Medicare beneficiaries effectively pay for the Medicare benchmark payment to group plans and will concurrently strengthen the Medicare Trust Fund. Although employers are still able to viably use the MA EGWP payment and rebates for their retirees, most estimates are that this change could lower funding for these plans by 2-4%. This will likely mean group plan sponsors would need to pay more in 2017 or reduce member benefits in benefit-rich plans.

B. CalPERS Implications: Since this proposal will likely reduce revenues to employers for their MA offerings as of contract year 2017, CalPERS staff is conducting an analysis to determine the overall impact on CalPERS and its employers.

C. CalPERS Next Steps: CalPERS staff and consultants are considering outreach to outline concerns to key Members of Congress and the Administration. Advocacy on this issue to the Hill and the Administration will be aggressively supplemented by the issuers, particularly those that are large group MA providers. Finally, if the impact of this policy truly is felt to be problematic, CalPERS staff and consultants may wish to seek coalition opportunities with other employers with retiree plans and labor.

V. UPDATES FROM THE CAMPAIGN:

A. Updates from the Campaign Trail

i. Donald Trump Continues to Be the Frontrunner: As of this writing, Donald Trump is the front-runner for the Republican Presidential nomination. Historically, no Republican candidate has ever won South Carolina and New Hampshire and lost the nomination. This added to his dominant win in Nevada seems to suggest that it will be very difficult for any other candidate to be the nominee. As it relates to health care, and consistent with much of his agenda,

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there is not a significant amount known about how he would accomplish his health reform goals. He has said he would repeal the ACA, but ensure coverage for all Americans. He has decried Rx drug costs and would advocate for Medicare direct negotiation authority. He is not interested in entitlement reform, but would seek to make the systems more efficient in removing "fraud and waste." The runner up appears to be Senator Marco Rubio. He does have more details on his "repeal and replace" model and we will provide more information if it becomes clear he is a serious challenger after the March primary season.

ii. **Hillary Clinton and Bernie Sanders Locked in a Tight Race:** Secretary Clinton appears to have the upper hand as of this writing in the election. However, it is likely that the race will continue on at least through the month of March, during which over 50 percent of the delegates will be awarded. Clinton has a detailed array of health policies for everything from autism to prescription drug prices and the Cadillac tax. This month she supplemented her policies with a plan to make exchange premiums more affordable, incentivize expanding Medicaid, an aggressive enrollment plan and provide a state based public option to provide more competition and plan choices on the exchanges.

iii. **CalPERS Implications:** Significant when the likely winner of the Presidency becomes clear and more detailed policy is unveiled

iv. **CalPERS Next Steps:** Closely follow campaigns' policy pronouncements and implications on CalPERS' interests.