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Federal Health Policy Report for CalPERS
April 2016

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

A. Additional Evidence of Increasing Prescription Drug Prices: According to a new (mid-April 2016) report by the IMS Institute for Healthcare Informatics, prescription drug spending growth remained historically high in 2015 for the second year in a row, but it dipped about 2 percentage points from 2014 - the year skyrocketing prices sparked intense scrutiny of drug costs. The report estimates that drug spending nationwide increased by 8.5 percent last year - more than any other year in the past decade except for a double-digit spike in 2014. Pharmaceutical companies are spending more money to offset increasing patient cost-sharing, the report finds. More than half of diabetic patients responsible for more than $50 per prescription paid nothing in 2015 because of coupons or other drug company cost-sharing measures that the industry provides to encourage patients to purchase higher cost medications. (This is to combat the fact that the average co-pay for a brand name drug last year was $44 - up 25 percent since 2010). The patient's share for a generic prescription has remained stable over the same period at $8.

B. Anti-Hepatitis Rx Drugs (Sovaldi and Harvoni) Are Not Lowering Overall Medical Costs: According to a recent analysis of federal data, the number of liver transplants in the United States has gone up, as has the number of people on waiting lists for the procedure. Drugs produced by Gilead Science, Sovaldi and its sister Harvoni, priced at $84,000 and $94,000 per treatment, respectively, are providing lifesaving therapies that have helped some patients avoid liver transplants, which can cost half a million dollars. There's a difference between saving money for an individual's care, however, and lowering the cost to society. To date, seemingly contrary to Gilead's pricing justifications, the pills are not (at least yet) reducing liver transplants or the economic burden they pose to the U.S. health care system, in which Medicare, Medicaid and other federal entities pick up a large chunk of the costs for liver diseases. However, according to a new report from the National Academies of Sciences, Engineering and Medicine, drug prices are hindering efforts to eradicate hepatitis C.

C. CMS Part B Reimbursement Prescription Drug Demonstration Update:

i. **Exclusion of Physician Practices from the Oncology Care Model:** CMS announced a proposed rule in March to test new models to improve how Medicare Part B pays physicians and, indirectly, drug manufacturers for the frequently extremely expensive prescriptions that are administered on an in-patient basis. These costs now exceed $20 billion a year. This policy was developed to address a structural payment flaw that actually effectively punishes physicians (through much lower reimbursement for their services) to prescribe and dispense lower cost alternatives. However, in April it was reported that CMS will modify a portion of its recent Part B demo, seemingly to appease some opponents of this initial proposal.

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CMS now plans to exclude physician practices participating in the Oncology Care Model from the Part B drug demonstration.

ii. **Republicans Attempt to Block the Part B Demo and Hill Democrats Also Voice Concerns:** Republican Congressman Larry Bucshon (R-Ind.) said that he plans to introduce a bill to block the Part B demonstration and that he expects some Democrats to support it. In late April, Senate Finance Committee Republicans wrote a letter to CMS Acting Administrator Andy Slavitt asking him to withdraw the proposal. They and other opponents of this demo argue that the scope of the demonstration goes too far and does not adequately show how CMS will assess impacts to quality of care and access to medicines. Finance Committee and other Hill Democrats have been more muted in their criticism, but they too have wrote and criticized the Administration on April 27th, raising concerns about the potential negative impact the pilot would have on physician payment that may impact consumer access (amongst other issues). They would like to see the program delayed until concerns are addressed. On the stakeholder side, the Public Sector HealthCare Roundtable, AARP and the American Academy of Family Physicians support the demonstration while PhRMA, BIO and a number of patient groups oppose it. The current experience by CMS demonstrates how difficult it is to implement virtually any pharmaceutical cost containment policy in the face of strong PhRMA opposition.

D. **Campaign for Sustainable Prescription Rx Pricing Releases Proposals:** On April 25th, The Campaign for Sustainable Rx Pricing a coalition of payers, providers, unions, and others released 12 proposals to take on high drug costs. Included in these were limits on market exclusivity, additional reporting and transparency as well as policies designed to evaluate and reward value. The Biotechnology Innovation Organization (BIO) said that these proposals would bring intrusive government regulation and leave other industries where "nearly 90 percent of all health care spending" occurs untouched and would drive up costs through additional regulation.

E. **FDA Approves a Second Biosimilar:** On April 6th The FDA approved its second biosimilar, a copy of a costly drug to treat Crohn's disease and rheumatoid arthritis. Celltrion's Inflectra will compete with the Janssen Biotech drug Remicade, which first came to the market in 1998. Celltrion has not yet released pricing information on Inflectra, but most biosimilars are expected to be priced initially with about a 25 percent discount. Purchasers, consumers and many medical groups are hoping that this signals the beginning of an accelerated and increased number of future FDA approvals to enhance competition and choice and, of course, greater affordability.

F. **CalPERS Implications:** The new studies and data continue to justify broad concerns about prescription drug cost trends and its negative impact on premiums and overall costs. However, the effective push back by PhRMA also illustrates the challenges of getting the Administration and, particularly the Congress, to embrace pharmaceutical cost containment initiatives. It does, however, validate CalPERS' efforts to highlight the impact of rising prescription drug costs on premium growth as well as to support work to embrace thoughtful policies to address the problem.

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G. CalPERS Next Steps: Assuming some version of the CMS Part B demo is implemented, CalPERS will evaluate its success over time. Moreover, CalPERS is considering the advisability of providing more explicit support for this demo and other efforts designed to lower overall prescription drug cost growth.

II. CADILLAC TAX UPDATE

A. Ways and Means Chairman Brady Raises Objections to Cadillac Tax and Suggests Need for Alternative Approach: On April 14th, Ways and Means held a hearing on the tax treatment of health care. Watchers of the debate around the Cadillac tax noted that Chairman Brady (R) felt that the Cadillac tax in its current form was "punitive" and indicated that the health care tax exclusion overall needed to be overhauled and replaced. This is significant because it signals that Republicans are determined to repeal not only the Cadillac tax and the entire Affordable Care Act, but also suggests that many leaders in the party would still like to have some policy structure that does not provide 100% tax deduction for health care. This is not surprising because Republican policy experts believe that there needs to be a fundamental restructuring of the health tax exclusion that employers and employees currently enjoy. This suggests that tax benefits for Americans will continue to be scrutinized, but that Republicans will work to ensure that it looks different than the ACA's Cadillac tax. There is, however, no consensus as to how this will be accomplished.

B. Two Economists Cite Concerns with the Cadillac Tax: On April 25th, Jeff Lemieux and Chad Moutray two economists who work for the Interindustry Economic Research Fund and the National Association of Manufacturers, respectively, wrote a post in Health Affairs criticizing the Cadillac tax. In particular, they pointed to the often maligned indexing system that does not keep pace with health inflation as well as their belief that in fact the tax would cause employers to shift more costs to patients. Their thinking is in line with criticisms leveled by the broad coalitions that oppose the tax.

C. CalPERS Implications: If one thing is certain, it does seem that the current policy will be delayed, reformed, or repealed taking into account the Republican and Clinton position. Much discussion and debate will continue on this issue particularly after the 2016 election and as we get closer to 2020.

D. 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. DELIVERY REFORM DEVELOPMENTS:

A. CMS Releases Proposed Changes to Medicare Physician Payment: On April 27th, Centers for Medicare and Medicaid Services (CMS) released their much anticipated 962-page proposed rule outlining the agency's initial approach to implementing provisions of the Medicare Access and Chip Reauthorization Act of 2015 (MACRA.) This law replaces the previous Medicare sustainable growth rate (SGR) payment methodology for physicians with the physician fee schedule (PFS.) The proposed rule would continue the Congressional and Executive Branch's objective to shift Medicare away from paying physicians for volume of services to value of those services. Notable highlights include a requirement for clinicians to comply with numerous health IT requirements to qualify for

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an Advanced Alternative Payment Model including 50 percent using electronic health records by 2017. Additionally providers must assume a certain amount of risk to qualify for the Advanced Alternative Payment Model. Overall, CMS administrator Andy Slavitt asserted that these changes were designed to "put physicians back in control" and lessen the regulatory burden on them. Initial reactions were mixed with the American Medical Association generally positive and the American Hospital Association concerned that the policy did not provide hospitals with sufficient incentives and opportunity to develop their own unique systems that rewarded value. Final comments are due by June 27, 2016.

B. **CMS Announces New Primary Care Initiative:** CMS released details about an experimental program called Comprehensive Primary Care Plus. This program is intended to shake up the way 20,000 doctors and clinicians treat more than 25 million patients when it goes into effect in January 2017. In a departure from the current "fee-for-service" system, which offers reimbursements per visit or procedure, providers who volunteer to participate will received fixed monthly fees for every patient and bonuses for meeting various quality goals. When their patients stay healthier and require less expensive care, many primary care doctors will also share in the savings to Medicare, Medicaid or private insurers. The new program expands on a more modest Comprehensive Primary Care experiment already in progress, which offers practices a $20-per-patient-per-month care management fee as well as some bonuses for improving the health outcomes of their patients. Officials say it has produced significant quality improvements, including reduced hospitalizations, though its first two years of data suggest that it has not reduced overall costs. This announcement is receiving a great deal of attention and interest by providers, health systems and plans.

C. **Covered California to Exclude Certain Hospitals with High C-section Rates:** Covered California, the state's insurance exchange, will exclude hospitals with high rates of C-sections in an effort to reduce the number of medically unnecessary cesarean births, which can be costly and carry higher risks for mother and baby. Under terms of its newest contract, Covered California will require insurers on its exchange to exclude hospitals with a C-section rate above 23.9 percent. Insurers will have to document rationale for doing business with hospitals that carry a C-section rate above 23.9 percent. The policy will begin in 2019. The average vaginal birth was $5,809 compared with $11,193 for C-sections, according to the Center for Healthcare Quality and Payment Reform. California's C-section rate varies widely. In 2014, C-section rates in hospitals across the state ranged from 12-70 percent. A spokesperson for the California Hospital Association said that they support the goal of paying for value instead of volume. Kaiser Permanente, California Health Care Foundation, and the California Association of Health plans indicated support.

D. **CalPERS Implications:** These continued delivery reform efforts and encouraging outcomes help underscore the potential for improved quality and greater affordability that can be secured from a still flawed (but improving) U.S. health care delivery and payment system. They validate CalPERS' ongoing commitment in this area and encourage further system interventions. However, they also illustrate the difficulty of

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developing, executing, replicating and measuring success of these and a wide range of delivery and payment reform initiatives.

E. **CalPERS Next Steps:** To review the findings a substantially increasing number of delivery demos and consider their implications to ongoing work and potential for further application to system contracting with plans and providers participating in CalPERS. If CalPERS (as a free-standing system) concludes there are areas we can/should replicate and, if possible, improve upon, we can use these Administration actions as rationale for proceeding. In addition, CalPERS staff and consultants will review the MACRA regulation and contemplate submitting comments to the agency.

IV. MISCELLANEOUS UPDATES

A. **UnitedHealth Group to Exit Most of the Exchange Marketplaces:** On April 18, 2016 UnitedHealth Group announced they would exit the insurance exchange marketplaces all but a "handful of states" of their current total of 34 states. Confirmed states they are leaving include Arkansas, and Michigan as well as much of Georgia. While United is the nation's largest insurer, its marketplace presence is relatively small at approximately a half million. The Kaiser Family Foundation found that if United exited completely, premium increases nation-wide would likely go up by a minor amount, approximately one percent for a 40 year old with a silver level plan. However, under this scenario, certain states would feel a more significant impact such as Kansas and Oklahoma would only have only one insurer competing statewide if no other competitors emerge.

B. **Blue Cross Blue Shield Association Study of Marketplace Enrollees:** The Blue Cross Blue Shield Association (BCBSA) released a study showing that those signing up for Blues plans were 19 percent more expensive than their counterparts in employer-based plans and 22 percent costlier last year. BCBSA has pointed out concerns based on this study about their losses in the exchanges. However, HHS points out that higher cost beneficiaries were always expected given that many newly insured were previously excluded from obtaining health insurance due to preexisting conditions.

C. **Average ACA Premiums Increased Slowly Last Year, Potential for Larger Increases This Year:** According to an HHS report released on April 12, 2016 the average premium cost of ACA coverage for enrollees receiving subsidies increased from $102 per month in 2015 to $106 per month this year, a 4 percent increase. HHS said the data shows that outside reports of average proposed rate increases don't reliably depict what consumers actually pay. Today's report "debunks the myth - based on last year's rate filings - that average consumers experienced double digit percentage premium increases" on the exchanges last year, HHS wrote in a blog post. Despite last year's slow growth, many have speculated that this year may be the year that premiums in fact increase by double digits due to adjustments made by insurance companies that have found they are setting premiums too low.