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Federal Health Policy Report for CalPERS
May 2016

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

A. Additional Evidence of Increasing Prescription Drug Prices: According to a new report from the Blue Cross Blue Shield Association (BCBSA), hepatitis drug spending grew by more than 600 percent between 2013 and 2014. Overall, the plans associated with the group experienced a 26 percent jump in spending on specialty drugs over those two years. Additionally, BCBSA found that annual spending on specialty pharmaceutical drugs rose by $87 per member, in a survey of claims data from 70.5 million members. The association said the increasing prices of those drugs was the main driver in the growth of that spending; increasing utilization had a smaller effect. The group, which spent $14.6 billion on specialty drugs overall, saw hepatitis spending skyrocket from $150 million to $1.09 billion. But that 612 percent rise was unusual -- spending on inflammatory drugs, which saw the next biggest increase, grew by 29 percent between 2013 and 2014. Other drug categories had smaller increases. The BCBSA report also found that in 2014, specialty drug spending was 17 percent higher for members in the individual market than those in the employer market -- largely because individual market consumers were utilizing more drugs, especially for cancer, viral infections and hepatitis. They attributed the difference in part to increasing use of new oral and self-injectable specialty medications that are typically covered under the pharmacy benefit. They also attributed the difference to a "pharmatization" of drugs -- a tendency of health plans to move existing medications billed through medical benefit to pharmacy benefit in order to improve management of these medications.

The Pharmaceutical Researchers and Manufacturers of America called the BCBSA report "misleading" in a statement. They blasted the insurance industry for an effort to discourage patients with costly conditions from enrolling in their plans, pointing to research from Avalere Health that they say shows health plans put medicines for conditions like cancer and multiple sclerosis on the highest cost-sharing tier of their formularies, "even when generics are available."

B. Savings Associated With Generics: A recent JAMA Internal Medicine study found that the nation could have saved an estimated $73 billion from 2010 to 2012 if clinicians had more frequently prescribed alternatives to brand-name drugs. The total out-of pocket savings for patients would have been about $25 billion. The new JAMA Internal Medicine study is among the latest to focus on reducing costs by curbing the over-prescription of brand-name drugs. Many clinicians have been reluctant to engage in the practice, especially when it comes to prescribing therapeutic substitutes, over fears the drugs could result in worse clinical outcomes for patients.

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However, recent research published in Health Affairs highlights a possible exception to the common argument that competition reduces prices. According to the research, increased competition may not help rein in the increasing costs of cancer drugs in the United States. The findings were released concurrently with another Health Affairs study that showed the U.S gets low value for its spending on cancer drugs. We consistently outspent other developed nations on cancer drugs between 2004 and 2014, but had one of the smallest improvements in cancer-related outcomes. The first study, which looked at 24 orally administered cancer medications approved by FDA between 2000 and 2012, calculated average patient payments for a 30-day supply of the drugs each quarter from 2007-13. Overall, the prices jumped an average 5 percent per year, despite competition from other products. Although prices dropped about 2.4 percent monthly on average when a competitor drug was introduced, other factors led to overall yearly increases.

i. **Centers for Medicare and Medicaid Services (CMS) Part B Reimbursement Prescription Drug Demonstration Update: Republicans Attempt to Block the Part B Demo and Hill Democrats Also Voice Concerns:** A group of moderate Democratic Senators sent a letter to Acting Administrator Slavitt asking CMS to change the size and scope of the demo and make alterations to ensure that seniors' care is protected. The Democrats also raised concerns about patient access and rural doctors. On May 17th, during an Energy and Commerce Health Subcommittee hearing, Republicans on the Committee asked the Administration to withdraw the proposal while Democrats argued in favor of allowing the Obama administration to proceed with its plan to alter Medicare's more than $20 billion in reimbursements to doctors for drugs administered in their offices each year. Much of the debate at the hearing centered on how patients could be affected by the Medicare proposal. On May 18, about a third of the House's Democrats asked the Obama administration to scale back its proposed Medicare experiment to address rising drug costs in a letter that suggested that CMS reconsider the "scale and scope" of the test.

ii. **CMS Willing to Work to Address Concerns:** Dr. Patrick Conway, the No. 2 official at CMS, announced that the Administration is willing to work to address congressional concerns with a proposal aimed at fighting high drug prices. The administration's proposal to change how Medicare pays for certain drugs has drawn objections from both sides of the aisle. Dr. Conway specifically mentioned openness to changes on two fronts that have been raised by lawmakers in both parties: making the proposal apply only to a smaller geographic area and making sure the proposal does not have a harmful effect on rural or smaller providers. Conway noted that "certainly [there are] concerns about smaller practices or rural practices, so we'll have to look at that and consider: Do we need to make adjustments?" He also said the timeline for implementing the changes could be slowed.

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C. **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.

D. **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 Health Subcommittee Holds Hearing on Ways to Improve Health Care Through the Tax Code:** On May 17th, Ways and Means Health Subcommittee held the committee's second Member Day hearing which presents an opportunity for Members of the House to present legislative solutions to challenges facing their constituents. At this hearing, a group of bipartisan Members discussed their ideas for modernizing the tax code to improve the health care system and deliver high-quality, affordable, consumer–driven options to all Americans. These discussions included references to the need to reform the Cadillac tax, though it is clear there is nothing imminent or substantive being offered.

B. **CalPERS Implications:** If one thing is certain, it does seem that the current Cadillac tax policy will be delayed, reformed, or repealed taking into account the Republican and Democratic campaigns and congressional leadership positions. Much discussion and debate will continue on this issue particularly after the 2016 election and as we get closer to 2020.

C. **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 the Physician Quality Reporting System (PQRS) Experience Report:** On May 12th, CMS released the 2014 Reporting Experience Including Trends (2007-2015), referred to as the 2014 PQRS Experience Report. Report highlights include: 1) 1.32 million medical professionals were eligible to participate in PQRS in 2014. In 2013, there were 1.25 million professionals eligible to participate in PQRS; 2) Participation increased by 11 percent in 2014 from 2013. In 2014, a total of 822,810 (63 percent) eligible professionals (EPs) successfully participated through at least one reporting mechanism compared to 642,114 (51 percent) EPs who successfully participated in 2013; 3) Participation via Electronic Health Record (EHR) more than doubled in number since

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2013. EHR reporting by EPs demonstrated strong growth in 2014, with over 50,000 participant reports received.

B. **Centers for Medicare and Medicaid Services (CMS): Physician and Other Supplier Utilization and Payment data:** CMS posted the third annual release of the Physician and Other Supplier Utilization and Payment public use data aimed to increase transparency in the Medicare program. In addition, CMS is announcing the availability of more timely data for researchers. The Physician and Other Supplier Utilization and Payment data contains summarized information on Part B services and procedures provided to Medicare beneficiaries by physicians and other healthcare professionals. The data includes payment and submitted charges, or bills, for services and procedures provided by each physician or supplier. It allows for comparisons by physician, specialty, location, types of medical services and procedures delivered, Medicare payment, and submitted charges. The release of timely, privacy-protected data is especially important as the Medicare increasingly pays providers based on the quality, rather than the quantity, of care they give patients. Data serves as a rich resource on Part B costs, services, and trends. These initiatives contribute to a wide set of CMS activities focused on achieving better care, smarter spending, and healthier people throughout the health care system.

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

D. **CalPERS Next Steps:** To review the findings of 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. **Presidential Candidates:**

i. **Bipartisan, Center for a Responsible Federal Budget (CRFB) Review of Hillary Clinton's Economic Proposals**: The review found that the economic proposals nearly pay for themselves. Overall, the Democratic front-runner would offset much of her new economic spending by hiking taxes on high earners. Here's CRFB's specific math on Clinton's health care proposals over the next decade: 1) Expand the Affordable Care Act: $300 billion in spending by expanding Medicaid funding, spending more on outreach to the uninsured and establishing a new

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refundable tax credit to cover out-of-pocket health costs; 2) Repeal the Cadillac tax on high-cost health plans: $100 billion in spending; 3) Reduce prescription drug costs and allow for a state-based "public option": $250 billion in savings. Clinton plans to increase bargaining power for Medicare Part D and encourage states to offer a "public option" in health insurance exchanges.

ii. **Bernie Sanders' Single-Payer Proposal:** According to an Urban Institute analysis Bernie Sanders' single-payer health care plan would boost federal spending by $32 trillion over a decade and wouldn't be fully funded by his tax plan. The projected increase in the federal government's spending is considerably higher than figures from the presidential candidate's campaign, which has said a "Medicare for all" system would boost federal spending by $13.8 trillion between 2017 and 2026. Sanders relies on a number of new taxes, predominately on the wealthiest Americans, to pay for his single-payer plan, but Urban Institute researchers suggest they would be much too low. A separate new analysis from the Urban-Brookings Tax Policy Center found that Sanders' tax proposals would raise $15.3 trillion over a decade, less than half of the projected federal cost of his health care plan.

B. **Federal Court Rules in House V. Burwell:** In House v. Burwell, the U.S. House of Representatives claims that the cost-sharing reductions (CSRs) the Administration paid on behalf of low-income enrollees (those with incomes below 250 percent of the federal poverty level [FPL]) in Marketplace coverage were inappropriate because Congress had not made a specific line-item appropriation to do so. On May 12th, U.S. District Court Judge Rosemary M. Collyer, a George W. Bush appointee, ruled in support of the House position. The judge said that the program can continue, pending appeal.

If the ruling stands, it would be a significant financial blow for the millions of low-income Americans who benefit from cost-sharing subsidies, which help people pay for health care services. The Urban Institute recently modeled the ramifications of eliminating federal reimbursement of CSRs. Given that the ACA requires insurers to provide low-income Marketplace enrollees with the reductions regardless of explicit funding, they assume that insurers would build the costs associated with them into the premiums for Marketplace silver plans (those with 70 percent actuarial value). They found that premiums for silver Marketplace plans would increase $1,040 per person on average. This premium increase would, on average, make silver plan premiums higher than those of gold plans (plans with 80 percent actuarial value). The higher premiums would in turn lead to higher federal payments for Marketplace tax credits because such payments are tied to the second-lowest-cost silver plan premium. All tax credit–eligible Marketplace enrollees with incomes up to 400 percent of FPL would receive larger tax credits, not just those eligible for CSRs. On net, Marketplace enrollment would decrease by 1.0 million people because enrollees ineligible for tax credits could find less expensive coverage elsewhere, and federal government costs would increase $3.6 billion in 2016 ($47 billion

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over 10 years). They estimate that the change would also reduce the number of people uninsured by approximately 400,000.

The ultimate judicial decision could be much less important than the impact of the uncertainty on plans. The plans may resort to increasing premiums to offset the uncertainty of whether or when they will get reimbursed on CSR subsidies and may discontinue offering Marketplace coverage in the event of a finding for the plaintiff. Even if insurers are allowed sufficient time to modify premiums, they may leave the Marketplaces in response to the continued litigation and associated policy changes, the lack of predictability such changes create, and the costs such changes impose. On May 13th, the Department of Justice (DOJ) announced that it will appeal the District Court ruling in U.S. House of Representatives v. Burwell. Last week, Judge Rosemary Collyer ruled that the Obama Administration has been improperly funding the Affordable Care Act (ACA) subsidy program, and that the Administration does not have the power to spend money on subsidies to insurers without an appropriation from Congress. The decision will not go into effect so long as it is pending appeal.

C. **EEOC Issues Final Wellness Rules:** The Equal Employment Opportunity Commission lowered the maximum financial penalty employers may use to pressure employee spouses into participating in a workplace wellness program under the Genetic Information Nondiscrimination Act. The final GINA rule, which applies only to employee spouses, limits the penalty to "30 percent of the total cost of self-only coverage under the group health plan." That's a change from the proposed rule, which capped the penalty at 30 percent of the cost of (more expensive) family coverage. Under the final ADA rule, an employer may similarly impose a penalty limited to 30 percent of self-only coverage, which in this instance is unchanged from the proposed rule. The ADA rule also clarifies that the law's "safe harbor provision," which permits insurers to use employee medical information to assess the cost of insurance, does not apply to workplace wellness programs.

D. **Senate Legislative Action:**

   i. **Opioid Abuse:** House leadership last week appointed conference committee members to resolve differences with the Senate over the Comprehensive Addiction and Recovery Act (CARA) intended to address opioid addiction. The Senate has not yet named its negotiators, but the goal is to have a bill on the President's desk by July 4. The House Commerce, Science and Justice appropriations bill that advanced through subcommittee last week would provide $103 million for CARA's grant programs. At the same time, the American Society of Addiction Medicine, the American College of Emergency Physicians and several other national organizations kicked off a campaign on Capitol Hill to press Congress to enact CARA and encourage other regulatory and legislative steps that address the opioid epidemic - especially expanding access to medication-assisted treatment.

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ii. **Zika Epidemic:** The House passed $622 million in Zika funding while cutting other health programs to pay for it; the White House threatened a veto. The Senate cleared a measure to provide $1.1 billion in emergency funds. However, it is attached to a transportation and military funding bill that faces hurdles of its own. The Chairman of the House Appropriations Labor-HHS subcommittee announced that he will provide "very substantial" funding for Zika in the next appropriations bill, which covers the fiscal year that begins Oct. 1. That would come on top of the House's $622 million package and would result in funding "very comparable" to the $1.1 billion advanced by the Senate. The Senate's plan covers both fiscal years. The different timetables could be an issue if the House and Senate go to conference with separate funding packages. The Senate is expected to pass a standalone Zika bill as well. The Centers for Disease Control is monitoring the outcomes of at least 157 Zika-infected pregnant women living in the continental United States and another 122 in Puerto Rico and other U.S. territories. The women are at risk of delivering babies with microcephaly.