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Federal Health Policy Report for CalPERS
February 2017

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

A. National Business Group on Health Releases Recommendations on Rx Drug Costs: On January 30, the National Business Group on Health released a policy issue brief intended to help stem the skyrocketing costs of specialty drugs. The 31-page report provides policy recommendations to create more sustainable and affordable pricing for specialty medications. Policies promoted by the brief included: encouraging use and development of biosimilars by reducing market exclusivity from 12 to 7 years and eliminating loopholes that allow for extensions of exclusivity including pay-for-delay; expanding and improving value based payment structures; and reducing incentives for prescribing more expensive drugs in Part B.

B. White House Reiterates Support for Medicare Direct Negotiation: On February 7, White House press secretary Sean Spicer announced that President Trump remains committed to pushing for government negotiations of drug prices. Many had speculated that President Trump was walking back from his campaign pledge for negotiations in Medicare's prescription drug program after a meeting with pharmaceutical executives last week. Adding to the mixed signals, both Health and Human Services (HHS) Secretary Price and the Centers for Medicare & Medicaid Services (CMS) nominee Seema Verma refrained from directly answering questions on drug negotiations during their separate confirmation hearings in the Senate Finance Committee.

C. Express Scripts Reports Slower Growth on Drug Spending: According to a February 7 Express Scripts report, per-person prescription drug spending increased 3.8% for health plans covering employees and their families. The increase was less than the 5.2% increase observed in 2015. The moderation may in part be due to consumer backlash over drug prices, including widespread outrage over Mylan Pharmaceuticals' pricing of the EpiPen. Utilization of traditional drugs increased modestly in 2016, while specialty drug use increased 7.1%. Specialty drugs used for inflammatory conditions and oncology saw some of the biggest increases in utilization, and continue to account for some of the highest spending amounts across therapy classes, along with diabetes medication. One of every five dollars spent on prescription drugs was for a diabetes or specialty inflammatory conditions drug.

D. Generic Pharmaceutical Association Rebrands: On February 14, the Generic Pharmaceutical Association (GPhA) rebranded as the Association for Accessible Medicine (AAM) to emphasize its role in providing cheaper drugs to U.S. patients and savings to the health care system. The move comes as the brand drug industry has launched its own massive advertising campaign to shore up its image. Pharmaceutical Research and Manufacturers of America (PhRMA) is placing much of the blame for rising drug prices on the "bad actors" — makers of older off-patent drugs that have raised prices

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without providing any new medical benefits. One of the branded lobby's top targets is GPhA's 2016 board chair, Mylan CEO Heather Bresch, who became a household name for hiking the price of the allergy antidote EpiPen by hundreds of dollars. The generic lobby's new campaign seeks to counter that narrative.

E. **Broad Array of Senators Urge Rx Drug Reimportation to Lower Prices:** On February 15, Senators Grassley (R-IA), Klobuchar (D-MN), and McCain (R-AZ) sent a letter to HHS Secretary Price, urging him to use his statutory authority to allow the importation of prescription drugs from Canada under circumstances in which competition is lacking or there are sudden price hikes. In addition, on February 28, Senators Bernie Sanders (I-VT), Cory Booker (D-NJ) and Bob Casey (D-PA) introduced a bill that would help facilitate drug importation. Both Senators Booker and Casey were among 13 Democrats who voted against a drug importation amendment that Senator Sanders offered during the Senate budget debate. They also hail from states with substantial pharmaceutical manufacturing presence. As such, their involvement in the new legislation sends an encouraging signal to bill supporters that opposition may be decreasing.

F. **Patients for Affordable Drugs Launches:** A patient group, with no financial ties to health plans or industries involved in the making and distribution of drugs, is the latest to join the growing number of organizations focused on rising drug prices. Patients for Affordable Drugs launched to connect lawmakers to patients. As a 501(c)(3) organization, however, it cannot lobby extensively. Patients for Affordable Drugs is being initially funded by a half a million dollar grant from the Laura and John Arnold Foundation, and it will not take money from health care industries, even from providers that are not involved in drugs sales, manufacture, or distribution.

CalPERS Implications: Continued public pressure and President Trump's tough rhetoric about the drug industry could yield helpful policies for CalPERS in constraining drug costs if he can develop, pass, and/or implement meaningful administrative or legislative reforms.

Recommended Positioning and Actions for CalPERS: In an environment where President Trump and an array of consumer, business, labor, health plan, and provider stakeholders are raising consistently loud, public criticisms on the pricing practices of the pharmaceutical industry, CalPERS is liberated to be even more aggressive than usual in publicly embracing and advocating for policies that it believes will provide positive impact and relief. This includes direct engagement with stakeholder partners, as well as individual advocacy by CalPERS with the incoming Administration and the new Congress on policies that will expand competition, eliminate barriers to competition, or use the government's leverage to lower costs. In addition to direct lobbying/advocacy, CalPERS can and should proactively engage and advance priority positions in the various coalitions in which it is a member, as well as co-sign or author coalition and/or stand-alone letters, hearing testimony, and op-eds that clearly convey and promote progress in this area. Finally, CalPERS should collect and release data of relevance on drug spending that highlight cost drivers to the System.

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II. CADILLAC TAX UPDATE:

A. Employer Groups Urge Repeal of Cadillac Tax: Twenty-seven employer groups are urging the Trump Administration to repeal the tax on high-value health care plans and to ensure that employer-provided insurance continues to be a tax-free benefit. The employer groups wrote a letter on February 15 to National Economic Council Director Gary Cohn calling for full and permanent repeal of the 40% "Cadillac Tax" on health benefits. Members of Congress, business groups, and advocacy organizations, including the Public Sector Healthcare Roundtable, have supported repealing the tax.

B. Committee for a Responsible Federal Budget: On February 22, the Committee for a Responsible Federal Budget published a blog on the Affordable Care Act's (ACA) "Cadillac Tax," the employer health exclusion, and options to address both moving forward. The blog suggests various changes that could be made to limit the employer exclusion to help cover the costs of repealing the "Cadillac Tax" such as capping the exclusion; replacing it with a fixed tax credit or deduction; or phasing out the exclusion entirely for people making above $250,000.

CalPERS Implications: It is expected (based on the leaked document -- detailed below) that the House Republican proposal to repeal and replace the ACA will repeal the "Cadillac Tax" and include a cap on the employer health care tax exclusion. Because this policy is viewed necessary to produce revenue offsets to pay for the proposal, there is speculation that it has to be designed much more aggressively than the "Cadillac Tax" and, as such, could prove to be more damaging to employer-sponsored insurance. What remains outstanding, however, is whether such a proposal has enough support to pass the Senate and whether the lack of a consensus around the specific alternative to the "Cadillac Tax," whether it be an outright repeal, the substitution of a new tax cap, or another alternative, can be bridged.

Recommended Positioning and Actions for CalPERS: CalPERS has consistently and strongly objected to the enactment and implementation of the "Cadillac Tax". Recognizing that health care tax incentives will be front and center in both the ACA repeal/"repair" and tax reform debates, CalPERS should continue to advocate against limits on federal tax incentives for health coverage that create inordinate pressure on employers to excessively reduce benefits and/or increase cost sharing. This position can be conveyed individually or collectively through labor/business coalitions, as well as other creative communication mechanisms such as op-eds or hearing testimony.

III. DELIVERY REFORM DEVELOPMENTS:

A. CMS Delaying Medicare Bundled Payments Regulation: On February 15, CMS announced that it is delaying implementation of new Medicare bundled payment models, citing a "regulatory freeze" that was imposed following President Trump's election. The agency said it will push the effective date for the rule's first elements to March 21, roughly a month later than initially planned. The models overhaul provider Medicare payments for cardiac rehabilitation treatments. The announcement also delays until March 21 planned changes to Medicare's payment model for hip and knee replacement surgeries. New HHS Secretary Tom Price has criticized bundled payments in

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the past for restricting the way hospitals and doctors treat patients. Having said this, he is in the process of reconciling that position with his general support of a broader shift toward value-based care, which he is now championing as HHS Secretary.

B. **CMS Announces Assistance for Small Group Practices:** On February 17, CMS awarded approximately $20 million to 11 organizations for the first year of a five-year program to provide on-the-ground training and education about the Quality Payment Program, enacted as part of the Medicare physician payment overhaul and intended to encourage value-based payment, for clinicians in individual or small group practices of 15 clinicians or fewer. CMS intends to invest up to an additional $80 million over the remaining four years.

C. **JAMA Study on Accountable Care Organizations:** On February 14, studies published by *JAMA Internal Medicine* found that accountable care organizations (ACOs) are a favorable way to reduce costs and improve the quality of care for Medicare and Medicaid patients. According to one study, participation in the Medicare Shared Savings Program (MSSP) was associated with a 9% reduction in post-acute spending from 2012-2014, resulting in savings of $106 per beneficiary.

CalPERS Implications: While delivery reforms will likely be more targeted and voluntary in the Trump Administration than they were in the Obama Administration, it appears that they will continue. It will be important to monitor changes happening to the ACA for potential changes to delivery reform efforts such as CMMI.

Recommended Positioning and Actions for CalPERS: Because of CalPERS' ongoing leadership and interest in delivery reforms that accelerate the health system's movement away from fee for service to "value purchasing," it is advisable for the System to promote continued progress. To that end, CalPERS can and should proactively engage and advance priority positions in the various coalitions in which it is a member as well as co-sign or author coalition and/or stand-alone letters, hearing testimony, and op-eds where possible and when aligned with CalPERS' position. To further encourage progress, CalPERS should also collect and release data on the successes of its more aggressive delivery reforms in an attempt to not only highlight the best practices of the System but encourage more aggressive action from the federal government.

IV. ADDITIONAL UPDATES:

A. Updates Around ACA Changes/Repeal/Replace:

i. **House Republican Plan Leaks:** On February 20, news outlets obtained a copy of a draft ACA repeal bill currently being considered by the House. The bill eliminates the individual mandate, eliminates Medicaid expansion in 2020, and gives money ($100 billion) to states for high-risk pools. The bill includes age-based tax credits that would roll out in 2020--$2,000 for those aged 30, up to $4,000 for those over 60. The bill imposes up to a 30% premium penalty increase on individuals who do not maintain continuous coverage. The proposal repeals the "Cadillac Tax", but includes a cap on the employer health care tax exclusion for their workers.

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ii. **President Trump Provides Broad Strokes of Health Care Priorities:** On February 28, in his address to Congress, President Trump outlined his priorities going forward, including those on health care. He reiterated many past priorities, including repealing and replacing much of the ACA, bringing down prescription drug costs, and selling insurance across state lines, but he offered few details. He made clear, though, that he embraced the need to have tax credits, albeit different than those in the ACA, to help subsidize premiums. In recent days, some conservatives in both the House and Senate have raised opposition to these tax credits because of their belief that it creates a new permanent entitlement. Without at least some of these conservatives support, a Republican replacement with tax credits may not pass Congress. Following the speech, Speaker Paul Ryan stated, though, that he felt President Trump's speech would help move things in the right direction for the Republican leadership's agenda on health care.

iii. **CMS Acts to Attempt to Stabilize the Marketplace:** On February 15, CMS issued a proposed rule aimed at strengthening financial stability for insurers selling coverage through the ACA marketplaces and in the individual market. Many of the proposed changes were aimed at preventing "gaming" of enrollment by tightening rules around enrollment and were applauded by insurers but derided by consumer advocates as limiting access to insurance. Separately, CMS extended the deadline for health plans to apply to offer coverage from May 3 to June 21.

iv. **CMS Extends Transitional Plan Policy:** On February 23, CMS extended its transitional policy allowing insurers in certain states to continue offering plans that do not meet the ACA's benefit requirements and consumer protections for another year, through December 31, 2018. Critics of this policy argue this will increase premiums for insurance products in the exchange markets because it will bifurcate healthier from sicker populations (as it has done in other states previously).

v. **Administration and House of Representatives Agree to Delay ACA Cost-Sharing Lawsuit:** On February 21 both House Republicans and the Administration asked to keep frozen a lawsuit over appropriations for cost-sharing subsidy payments to health insurance providers under the law, estimated at $175 billion over 10 years. Top Republicans now say they're willing to make the payments as they implement a health policy overhaul, despite a previous unwillingness to do so under the Obama Administration. The joint filing seeks to keep the case on hold until May 22. House Republicans filed the lawsuit in 2014 to stop the payments in response to a series of President Obama's executive actions that they said were unconstitutional.

B. **National Health Expenditures Down in 2016, but Expected to Increase in Out-Years:** National health expenditure growth is expected to average 5.6% annually over 2016-2025, according to a report from CMS's actuary. The report states that total national health spending growth is projected to have been 4.8% in 2016, down from 5.8% growth in 2015, due to slower Medicaid and prescription drug spending growth. Drug spending growth is anticipated to have been 5% in 2016, down from 9% in 2015, primarily due to

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slowing use of costly hepatitis C drugs. Growth is expected to average 6.4% per year for 2017–25, due to increased spending on specialty drugs.

C. **Administration Health Care Team Continues Through Process:** On February 10, the Senate confirmed Representative Tom Price, 52-47, as HHS secretary, despite the Democratic party's objections to his views over the future of Medicare, the 2010 health care law, and Medicaid. Democrats emphasized their concerns about Secretary Price's bid to undo much of the health care law, turn Medicare into a program that would give senior citizens federal subsidies to pay for insurance, and cap the flow of federal funds to state Medicaid plans. On February 16, Seema Verma testified before the Senate Finance Committee, which is expected to vote on her nomination to be Administrator of the CMS on March 1.

CalPERS Implications: The ACA replace/"repair" debate offers a vehicle for opportunities and challenges for CalPERS. On the positive side, it may offer a vehicle to repeal reform or delay the "Cadillac Tax" and engage in a possibly positive discussion around delivery system reform. On the other hand, the primary challenge related to the ongoing debate relates to the issue of cost shifting to states, public/private purchasers, and consumers through the imposition of a new employer tax exclusion cap, excessively deep cuts to Medicare/Medicaid and/or significant declines in the number of insured Americans.

Recommended Positioning and Actions for CalPERS: Because the debate of issues surrounding the ACA can be so political, it is advisable for CalPERS to stay focused on the changes to the underlying law that could directly impact the System. To this end, it is recommended that CalPERS focus its engagement on embracing policies that could reduce the System's cost or cost exposure (such as limiting or repealing the "Cadillac Tax") and opposing policies with potential to shift cost burdens to CalPERS (such as Medicare, Medicaid, and coverage loss cost shifting) through direct advocacy and strategic individual or coalition letters/communications.