From: Moore, Sunshine <SMOORE@AHIP.ORG>
Sent: Tuesday, October 2, 2018 2:35 PM
Subject: AHIP "homework" from last week's hearing

Dear Members of the Nevada Interim Legislative Committee on Health Care:

Thank you again for inviting AHIP to testify last week. Please find below the "homework" we promised to provide to you regarding:

1) impact of copay coupons on health care spending;
2) copay coupons as a kickback;
3) network adequacy, timely access, and cultural/linguistic standards among accreditation organizations;
4) freestanding or "neighborhood" ERs;
5) federal and state activity to insulate consumers against drug price increases; and,
6) health plan medical loss ratio and PBM transparency requirements.

Finally, I would like to reiterate our concern that underlying drug prices continue to be a problem and that plans are interested in lowering costs for all Nevadans, whether they take expensive medications or not. Something Senator Ratti said last week has lingered with me, and that is that "the market is not working." I think health plans would have to agree.

We are doing what we can to foster competition, negotiate lower prices, and balance affordability between premiums and cost-sharing while working with our clients to design and offer competitive products that account for the entire spectrum of health care costs (doctors, hospitals, durable medical equipment, Rx drugs, etc.). We believe the drug pricing market is dysfunctional because the list price is the starting point for negotiations and because we are limited in our ability to reward value over volume as we do for hospital/physician contracts. We would like to work with you to see whether/how the state might play a role in helping find market-oriented solutions to correct these distortions.

We are always available to answer additional questions or follow-up with additional documentation/resources.
Thank you.

I. Impact of copay coupons on health care spending:

- *JAMA* on how coupons increase costs on everyone (through higher drug spending) as well as patients with chronic conditions because coupons are not available for the entire duration the patient takes the drug, leading to higher out-of-pocket costs for the patient and/or medication nonadherence when they can no longer use the coupon.
- *Annals of Internal Medicine* issue brief/op-ed with short- and long-term policy recommendations (attached). I can connect you with Dr. Peter Bach of Memorial Sloan Kettering Cancer Center in NY if you would like.
- Findings from the 2011 Visante study (commissioned by PCMA) estimating that if Massachusetts were to repeal its ban on copay coupons, prescription drug costs for employers and other plan sponsors in that state would increase by $750 million over the next decade; copay coupons would increase ten-year prescription drug costs by $32 billion for employers, unions and other plan sponsors if current trends were to continue; and that if Medicare did not enforce its ban on copay coupons, costs to the Medicare Part D program would increase by $18 billion over the next decade.

- The Massachusetts vs. New Hampshire study referenced in our slide deck confirms that drug spending is in fact higher in NH where coupons are allowed and that rates of generic prescribing are lower in NH than in Mass. National Bureau of Economic Research: "We find that coupons increase branded sales by 60+ percent, entirely by reducing the sales of bioequivalent generics. During the five years following generic entry, we estimate that coupons increase total spending by $30 to $120 million per drug, or $700 million to $2.7 billion for our sample alone."
- They note that their study was limited to branded drugs for which there is a generic equivalent. (The sample size did **not** include brand-to-brand competitors for which coupons incent patients to use the higher-cost or non-preferred brand vs. the lower-cost preferred brand.)
- However, a *New England Journal of Medicine* analysis does shed light on how coupons undermine tiering and reduce manufacturer willingness to reduce prices through preferred formulary placement; which is in direct contrast to efforts to move toward "value-based" purchasing across the health care spectrum.

- Colorado published a cost driver spot analysis on two prescription brand name drugs that are priced at $1,400+ per month (list price) but which could easily be purchased over-the-counter for ~$50 per month. Both of these drugs have copay coupons (Vimovo and Duexis).

II. Copay Coupons as a Kickback

- As shown in our slide deck, copay coupons are prohibited in Medicaid/Medicare under federal anti-kickback statutes. DOJ and IRS have investigated several charities and patient assistance groups that offer copay coupons: examples here, here, here, here, here, and here.
- Medicare and Medicaid are not the only taxpayer-funded and/or subsidized health insurance programs, and copay coupons have the same effect on purchasers of private health insurance – federal and state employee plans, local government, school districts, labor trusts, large and small businesses, individuals and families, Tricare/VA, etc. Plans administer the benefits, but the employer/employees pay the premiums.
- As referenced in my presentation, CitiResearch found that "Every $1 million donated to charities can lead to up to $21 million in sales for drug companies."

III. Accreditation Organizations' Standards for Network Adequacy and Timely Access:

- Please find attached two summaries of the NCQA and URAC standards for network adequacy. They reference consumer wait times for various types of appointments as well as cultural/linguistic standards.
- I have also attached NCQA's issue brief regarding network adequacy in the exchanges. (I believe your focus is on the commercial market, but if you would like more information about Medicaid Managed Care or Medicare Advantage, I can pull that together for you.)

  The specific methodology that each accreditation organization uses is proprietary information; however, I would like to connect you with Kristine Thurston Toppe (202-955-1744; toppe@ncqa.org) from NCQA who is available to provide more specific

information on their methodology. She is based in California, and I gave her a heads up that you might be calling. I also have a contact at URAC if you are interested.

- Here are some of the items I was able to find online after the July hearing (some are behind a firewall but screen shots were included in the PPT):
    - NCQA's accreditation for network management (page 5) and credentialing/recredentialing (page 8), member rights page 9
    - URAC frequently asked questions -- see "who develops URAC's standards?"
    - URAC network accreditation snapshot
    - URAC QHP standards for networks and credentialing (here)

IV. Freestanding or "neighborhood" ERs

- We discussed better consumer transparency/disclosure so that patients do not think they are visiting an urgent care center and later find out they got billed ER rates. Here is a bill that was enacted in Texas to help address this issue. **Freestanding Emergency Medical Facilities:** HB 3276 requires freestanding facilities to post notice of lists of health benefit plans in which the facility is a participating provider, or a statement that the facility is not participating in any network.
- The Texas Association of Health Plans has a lot of materials on freestanding ERs. I would be happy to connect you with Jamie Dudensing, CEO of TAHP, for more information.
- We supported legislation in 2011 and 2017 to ban the practice of balance billing (both of which were vetoed) and would be interested in working with you on legislation for 2019.

V. Federal and State Activity to Protect Consumers from Drug Price Hikes

- Nevada is a leader among states in promoting generic substitution and AB 245 ensures that when the FDA approves more biosimilars, Nevada pharmacists will be ready and able to offer consumers lower-cost options.
- SB 539 ensures pharmacists can tell patients about a lower cost alternative and that patients will pay no more than their copay or the cash price at their in-network pharmacy.
- Relating to diabetes medications, SB 539 requires plans to notify patients during open enrollment if "essential" diabetes medications have been or will be removed from the formulary so that they can shop for a different plan or talk to their doctor about medication options.
- DOI regs and AB 381 "freeze" the formulary except in limited circumstances. As noted above, formulary management is one tool to compel drug companies to lower their prices through competition/bidding. Frozen formularies insulate patients from mid-year price hikes but inadvertently protect drug company pricing patterns at the expense of everyone who pays premiums/taxes.
- The IRS sets the maximum out of pocket limit annually. Under ACA-compliant health products, plans (at the request of their clients) can set a lower, but not higher, MOOP.
- Plans are required to cover medically necessary treatment. Under the ACA, health plan formularies must include every category and class of drug listed in the US Pharmacopeia. If the state's benchmark plan includes more than one drug per category and class, the plan must cover equal to or greater than the same number of drugs in the benchmark plan.

- Under the ACA, health plans offer four metal tiers that offer consumers/small businesses choices of lower copays and deductibles with more moderate premiums (gold/platinum) or more moderate copays and deductibles with lower monthly premiums (bronze/silver).
- Most Nevadans on the Exchange receive subsidies to lower their monthly premiums, and those enrolled in "enhanced silver plans" have the premium of a silver plan but the lower copays and deductibles of a gold or platinum plan. In this way, cost-sharing reductions "raise" the actuarial value of a silver plan to that of a gold/platinum plan.

VI. Health Plan Medical Loss Ratios & PBM Rebate Transparency

- Under the ACA, health plans are *transparent* in how they set their rates and *accountable* under the MLR. Rates are filed with regulators and include detailed information on hospital, physician, and drug spending, utilization, risk mix, and various other factors. Rates must be certified by actuaries, and regulators generally also employ in-house or contract with independent actuaries to review health plan rates.
- Plans must spend 80-85 percent of every premium dollar on direct medical care. If they do not, they must issue a rebate back to the purchaser at the end of the year. These MLRs are publicly reported on the CMS website. You can look up the state, company, year, number of checks, and average check amounts here. For Nevada 2016, you can see a summary on page 3 here. You will notice that no rebates were issued in the individual market. This means that health plans *met or exceeded* the medical loss ratio. (As I mentioned, some of our plans have had MLRs exceeding 100 percent in some states for some years.) On page 6, you can see which companies owed rebates in which markets. This is the total rebate amount, but the more detailed database will show you that sometimes these checks are for very small amounts. KFF also has a searchable, user-friendly database.
- Per CMS's annual MLR filing instructions, health plans are required to **deduct** drug rebates in their MLR calculation (see top of page 33): "Prescription drug rebates, refunds, incentive payments, bonuses, discounts charge backs, coupons, grants, direct or indirect subsidies, direct or indirect remuneration, upfront payments, goods in kinds or similar benefits received by the issuer." This means that while plans pay the full list price for drugs up front (and sometimes wait up to two years for rebates to be processed by the manufacturer), we do subtract drug rebates from our expenditures when calculating our MLR.
- Regarding pharmacy benefit managers, SB 539 establishes that PBMs have a "fiduciary duty" to the client (health plan, state agency, self-insured labor trust/gaming). PBMs must notify their clients of any conflicts of interest that interfere with the PBM's ability to discharge fiduciary duty.
- SB 539 also requires PBMs to report the amount of rebates negotiated for the drugs included on the list; the amount of the rebate retained by the PBM; and, the total amount of all rebates that were negotiated for: recipients of Medicare, Medicaid, or third parties that are governmental entities, or third parties that are non- governmental. (PBMs that fail to provide the information to the department may be fined up to $5,000 per day.)
- As mentioned above, SB 539 also prohibits the use of "gag clauses" and "claw backs" in PBM contracts with pharmacies.

Attachments:

1. Bach/Ubel copay assistance
2. NCQA standards for network adequacy
3. URAC standards for network adequacy
4. NCQA – network adequacy in the exchanges

Thank you.

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NCQA Standards for Network Adequacy

Currently applies to health plan networks under product lines (HMO, POS, PPO) and narrow networks.

Ensures the network has sufficient #s and types of practitioners for primary, behavioral health and specialty care.

Plans are responsible for monitoring how effectively their network meets member's needs and preferences at least annually; process in place to evaluate quantifiable metrics and member satisfaction (member surveys and self-reported, and access data from practitioners, supplemented by complaints) and adjusts network as needed.

Plan is scored on variety of factors:

- Network considers cultural, ethnic, racial and linguistic needs of members
- Establishes quantifiable and measureable standards for the number of each type of practitioner (primary care, behavioral health and specialty care) and geographic distribution (within "x" number of miles of member)
- Process includes definition of high volume specialists and includes OB/GYN, cardiologists, dermatologists, opthalmologists, orthopedic surgeons, and gastroenterologists.
- Geographic access includes the ratio-to-specialist type for each zip code; for example members within 20-25 minutes driving time from specialist; ratio of # of members per specialist, etc.
- Behavioral health, unless carved out or excluded, must be provided through an organized delivery system across a continuum of care and meet quantifiable metrics same as above
- Common types of practitioners in behavioral health delivery system: child, adolescent and adult psychiatrists, addiction medicine specialists, clinical psychologists and social workers, psychiatric clinical nurse specialists, substance abuse counselors and marriage and family therapists.

Plans also assess availability of # and types of practitioners for regular and routine care appointments, urgent care, after-hours care and member services by phone.

Enrollees also provide information on access of care though the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

URAC Standards for Network Adequacy

Currently applies to health plan networks (includes narrow networks) under a health plans book of business.

Health plans are evaluated on a variety of factors:

- Scope of services with respect to types of health care services offered within the provider network and the geographic area served by provider network
- Access and availability of providers to provide care through established goals, measure of performance to goals and reports of results, and making improvements where necessary to meet and maintain the provider network and its contractual requirements
  - Number of primary care providers within 25 or 25 minutes
  - Number of specialists within 50 miles
  - Consumer wait times for emergent, urgent and routine visits
  - Hours of operation
- Implements policies to assure access to covered services that are not available from participating providers, and emergency care in and outside of the service area

Health plans are also measured against several Patient Centeredness and Engagement measures on an annual basis which include:

- An assessment of the number of specialists accepting new patients, stratification by specialist/facility type and zip code for: hospitals, home health agencies, cardiologists, oncologists, pulmonologists, endocrinologists, skilled nursing facilities, rheumatologists, ophthalmologists, and urologists

- Assessment of primary care providers accepting new patients and stratified by practitioner type and zip code for: general medicine, family medicine, internal medicine, obstetricians, pediatricians, state licensed nurse practitioners.

- Enrollees also provide assessment of the quality of care and services received at the health plan level (HMP, PPO, Medicare, Medicaid, Commercial) through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

Due to copyright laws, the following attachments were not uploaded:

1. Bach/Ubel copay assistance; and

4. NCQA—network adequacy in the exchanges.

Contact the Research Library at 775-684-6827 for a copy.