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IN THE NEWS

Treat Social Needs Like Patient Care: Health Industry Group CEO

Health insurers should be allowed to change how they account for their spending on customers’ social needs so that it counts as patient care, the head of a major health insurance trade association said Tuesday. Currently these expenses are treated as administrative costs under regulations that require insurers to spend at least 80% of premiums on medical claims or quality improvements. The requirement applies to individual market plans like Obamacare, as well as private Medicare and Medicaid plans.

Treating coverage of transportation to doctor visits or access to healthy food as quality improvements would mean insurers could spend more money on patients. That, in turn, could lead them to eventually charge higher premiums, which the government subsidizes.

Insurers in recent years have increasingly devoted resources to helping patients address needs that aren’t strictly related to medical care, known as social determinants of health, Matt Eyles, president and chief executive officer of America’s Health Insurance Plans, said at a conference in Washington. Eyles said treating social needs coverage as quality improvement “would allow for greater measurement over time to understand how we might be impacting cost trends.”

The need for social and economic supports in the U.S. “has grown dramatically over the past several years,” Sheila Shapiro, senior vice president of national strategic partnerships for UnitedHealthcare, said at the conference. “There’s significant money within the entire ecosystem to change the model of health care,” including social needs that go beyond traditional health insurance benefits, she said. The U.S. spends less than most other countries on social needs, Shapiro said. The United Kingdom spends $3 on social programs for every $1 it spends on health care, while the U.S. spends $1 on social needs for every $3 it spends on health care, she said. Collaboration between insurers and other groups, such as government agencies and community groups, will be “where we’re going to come up with solutions,” Shapiro said. Spending on social needs by health plans and some employers that cover workers’ health care is “in its infancy, and everyone is trying to understand what the best model might look like,” Shapiro said.

But it isn’t clear that such spending translates into lower health-care costs. A study published in December in the Journal of the American Medical Association tracked more than 4,000 public housing recipients who received vouchers to move to better neighborhoods over about 11 years. It found no significant difference in hospitalization rates, hospital days, or annual health-care spending. The New England Journal of Medicine Jan. 9 published a report that found hospital readmission rates weren’t lower among 800 patients who enrolled in a program to link them with social services. But Eyles said insurers should be allowed to experiment. Health plans are uniquely positioned to address social needs because they are “one of the few entities within the health-care ecosystem that really does touch every single other stakeholder.” But, Eyles added, “I don’t think we can ask the government to just pay more” for insurers’ social spending. It’s really around thinking more innovatively around different funding streams that are out there and how can we leverage them more effectively.”

Political Double Header Promises Health-Care Market Turmoil

Health-care investors should ready themselves for a roller-coaster month ahead of two political events that may threaten the status quo of U.S. policy. Kicking off the month was the Iowa caucus, the first contest in the race for the Democratic nomination for president. Uncertainty over whether the more business-friendly former Vice President Joe Biden will maintain his lead over the surging Senator Bernie Sanders promises to
weigh on markets, particularly the health-care sector and insurers. Sanders’s bid to end private health insurance and expand Medicare threatens the future of managed care companies.

Managed care organizations got a boost from Elizabeth Warren’s pullback to a more moderate three-year timeline to implement Medicare for all in November, and the elimination of some taxes on health insurers in December. But insurance stocks have started to underperform the broader market again. “The widening discount shows Sanders is getting increasingly priced into MCO multiples” and more so in managed care than other market sectors, Goldman Sachs analyst Asad Haider said.

A Biden lead exiting Monday’s Iowa caucus, or the New Hampshire primary on Feb. 11, “could trigger short-lived relief rallies” for health insurers, while a Super Tuesday win on March 3 could set off a longer rally, Haider wrote to clients in a note, adding that it’s hard to tell what the market has already priced in. “If Sanders wins tonight, he is well positioned to win the next two contests in New Hampshire and Nevada. But there is a lane for a liberal and a moderate in this race. Therefore, how everyone finishes matters and will determine whether this is on track for a two-leader race or something far less clear,” said Sarah Bianchi, a policy analyst with Evercore ISI. How the Iowa Caucuses Work and What’s New for 2020: QuickTake A new method of reporting Iowa caucus results aimed at providing more transparency may benefit progressives, particularly Sanders, who is likely to win on one of the three metrics now being tracked, Bianchi said. “The Street is pretty well conditioned for a Sanders victory; the question is more about the final percentages/spread than the result as much as it is the winner,” wrote Jared Holz an equity trading strategist with Jefferies. If Sanders edges out Biden by a small margin, stock movements may be moderate, but if the margin of victory were more than 5% in Iowa, that could set off an investor panic, Holz said. On the other hand, a Biden upset could spark a rally in the $19.5 billion Health Care Select Sector SPDR Fund (ticker XLV).

Options expiring on Feb. 7 anticipate a share price move of 1.9% in the XLV. Options set to expire on Feb. 14 show options investors expect a share price move of 2.6%. Shares of the nation’s largest health insurers are poised to move from 4% to roughly 6% this week. Further fueling the volatility in health care this week will be President Trump’s State of the Union address on Tuesday. Wall Street fears that the President will use the opportunity to attack high drug prices ahead of the election by releasing a proposal for an international price index which aims to align drug prices under Medicare with those paid in other countries. “This would just be the proposed rule, which would start a public comment period before the administration decides to either finalize it, withdraw it, or sit on it,” Bloomberg Intelligence analyst Brian Rye said in an email. “But it would give Trump a talking point about being tough on drug prices.”

Cowen’s policy analysts are doubtful such a proposal would be passed anytime soon. “There is considerable opposition to it within the GOP and it would take several years to implement if it could withstand a likely court challenge should it move forward,” the bank’s analysts wrote in a Jan. 24 note. Michael Shah, Bloomberg Intelligence pharma analyst, said Roche and Amgen are most at risk under the proposed changes to Medicare drug pricing.

**INSIDE CMS**

**Coronavirus Cash Flow Quickens as HHS Seeks to Move $136 Million**

Efforts to fight the new coronavirus may get a $136 million infusion of funds, the Department of Health and Human Services said Monday. The department notified Congress Sunday it could later this month transfer funds to the Centers for Disease Control and Prevention as well as other areas of the agency working to prevent an outbreak of the virus in the U.S., an HHS spokeswoman said.
The notification was made “out of an abundance of caution” to make sure the HHS could respond rapidly, Katie McKeogh, an HHS spokeswoman, said. The disease is expanding rapidly in China, she said, and with more cases being identified in the U.S. the agency is unable to predict how much money it will need in coming weeks. HHS can shift the funds 15 days after it notifies Congress.

The move highlights how quickly the coronavirus response costs could escalate. Officials tapped $105 million from an emergency fund last week, and House Appropriations Chairwoman Nita Lowey (D-N.Y.) told reporters Jan. 29 she didn’t see a supplemental spending measure as necessary yet. There are 11 confirmed cases as of Monday in the U.S. of the a novel coronavirus, first identified in Wuhan, Hubei Province, China, according to the CDC. There are thousands of confirmed cases in China. The agency told congressional offices it would move as much as $75 million to the CDC, as much as $52 million to the HHS Office of the Assistant Secretary for Preparedness and Response, and as much as $8 million to Office of Global Affairs, according to a person familiar with the request. HHS didn’t identify what accounts they are transferring from, the person said.

The additional funding would have to come from existing pots of money within the HHS, said Chris Meekins, former deputy assistant secretary for preparedness and response in the department. Typically, those funds have come out of the National Institutes of Health or the CDC. “This will probably be a down payment on what will be needed to address this issue for the long-term,” Meekins, a health-care policy research analyst at Raymond James, said.

Asking for this funding is a preemptive measure to make sure the HHS has what it needs to address the outbreak, Meekins said.

The CDC has quickly run through the $100 million it has now, Meekins said. They have and will continue to use the funds for quarantining patients, running labs, and tracking the disease both in the U.S. and China.

The HHS assistant secretary for preparedness and response has been brought in to assist with coordinating care for people repatriated from Wuhan on government-sponsored flights and making sure there are enough resources in the national stockpile and local facilities if the outbreak spreads, Meekins said.

The HHS now has the authority to fund development of new diagnostic tests, antivirals, and repurposing existing treatments through the private sector. The question is if they choose to do so, as with Ebola and Zika, Meekins said.

**LEGISLATIVE/REGULATORY**

**HHS Would See $9.4 Billion Decrease Under Trump’s Budget Request**

The Department of Health and Human Services would face $9.4 billion in funding cuts under the Trump administration’s fiscal 2021 budget request, a 9% reduction from last year.

The White House is reiterating its call for Congress to pass measures to lower prescription drug prices. The administration for the first time is not calling for the repeal of Obamacare, according to the proposal released Monday.

The proposed budget comes as the Affordable Care Act is facing a constitutional challenge that could decide the fate of the entire law. It also comes as the HHS has struggled to accomplish some of President Donald
Trump’s most ambitious goals he campaigned on four years ago. The administration is asking for $5 billion in funding to address the opioid epidemic, including an $85 million increase for state grants. The administration is also asking for $716 million for its plan to lower new HIV infections by more than 90% in the next decade. The proposal also includes a request for $74 million to improve maternal health.

HHS Assistant Secretary for Health Brett Giroir said in an interview that he was pleased with the amount of funding for the HIV initiative and that “it’s what we thought we needed” as the program is scaling up. The funding will be used to improve epidemiology and data collection in certain areas, he said. Most of the Centers for Disease Control and Prevention HIV funds will go to local jurisdictions, and HIV funds for the Health Resources and Services Administration will primarily go to community health centers and fund free distribution of the HIV prevention drug Truvada.

The budget proposal is a statement of the administration’s priorities for the next year. Congress decides how much funding agencies get and has been reluctant to cut funding to the department in the past.

The administration’s request would reduce the HHS’ annual discretionary budget—the amount the agency receives through the appropriations process—to $96.4 billion for fiscal 2021.

The administration is seeking “comprehensive” drug pricing reform that would decrease the federal deficit by $1 billion in the next fiscal year, and $135 billion in the next decade. The proposal says the administration supports legislative efforts to establish an out-of-pocket maximum for the Medicare prescription drug benefit. Senate Finance Committee Chairman Chuck Grassley (R-Iowa) said in a statement that he appreciated Trump’s commitment to his prescription drug pricing bill.

The proposal includes aspects of an executive order aimed at increasing organ donations and shortening wait times for transplants. The administration is calling on Congress to extend immunosuppressant drug coverage for kidney transplant patients, which House lawmakers are already considering. The administration also is seeking to regulate the number of federal contractors responsible for connecting organ donors to recipients in specific geographic regions and how often they need to be certified. The HHS recently proposed changes to the evaluation standards for such contractors.

The request seeks to improve access to rural health care by expanding access to telehealth services under Medicare, preserving access to emergency hospitals in rural areas, and modernizing payment for rural health clinics. The administration has been working on an initiative to improve rural care for more than a year but has yet to release any proposals, multiple sources familiar with the work said. For the first time, the budget proposal calls for Congress to partially roll back a longtime restriction on federal Medicaid funds for inpatient drug treatment programs. A provision rolling back that restriction was included in the House version of the 2018 bipartisan opioids bill, but wasn’t included in the final measure.

The largest cuts to the department—$8 billion—stems from the administration’s expectation that its proposal to let states require some Medicaid recipients to work to receive benefits would take effect, according to the budget plan. That proposal has been struck down in Arkansas, Kentucky, and New Hampshire by the U.S. District Court for the District of Columbia. All three rulings have been appealed. Kentucky dropped its requirements in December, and that case was dismissed. The other two cases are ongoing. Indiana’s program has also been challenged in court.

The next-largest cuts—$4.2 billion—would come from another proposal aimed at ensuring Medicare pays the same rate for services at off-campus hospital outpatient departments as at doctors’ offices. A federal
district court struck down a similar proposal in September 2019. The 2020 proposal is facing two challenges in court.

**Surprise Billing Effort Jump-Started by Ways and Means Committee**

The House Ways and Means Committee Friday released its own version of legislation designed to curb unexpectedly high medical bills that often come from out-of-network specialists and emergency room visits. The committee is expected to mark up the measure Feb. 12, signaling new momentum on a bipartisan effort that stalled late last year when a separate version failed to make it into a year-end spending bill.

A key point of contention in the debate is how insurers and hospitals resolve unpaid bills from out-of-network providers. The Ways and Means version is an attempt to recognize a “free market” within the health industry through an “independent mediated negotiation process,” according to a statement.

The committee proposes a dispute resolution process that would require mediators to consider median contracted rates used by health plans, and mediators would be prohibited from considering “usual and customary charges,” also known as “billed charges.” The prices that insurers pay for in-network services, are typically much lower than the provider list prices. In that way, the measure is similar to a bipartisan agreement between House Energy and Commerce Committee leaders and Senate Health, Education, Labor and Pensions Committee Chairman Lamar Alexander (R-Tenn.).

However, the Ways and Means version also requires the secretary of Health and Human Services to establish “an independent, unbiased process for resolving payment disputes.” That could complicate the process considerably, Joel White, president of the Council for Affordable Health Coverage, a group of 35 insurers, employers, drug companies, medical providers, and patients, said. “The government’s now going to be in the process of resolving the dispute, another way to get the government more entrenched in this process,” White said.

Unlike the HELP-Energy and Commerce agreement, the Ways and Means draft does not set a minimum threshold for charges that could go through mediation. The HELP-Energy and Commerce agreement specifies the bill must be at least $750. “That means that any claim could be disputed” and go through the mediation process, White said. “This could swamp the system with frivolous claims.”

The mediation process in the Ways and Means plan would result in higher administrative costs for insurers, which could increase premiums for consumers, White said. “What we’re left with is this kind of bizarre set of mandates on plans and providers.” In addition, the Ways and Means bill appears to require that health plans pay providers while bills are being disputed, White said. “It raises serious questions about the process, how it works and the implication this requirement has on the end result and fairness of the process,” he said in an email.

Unlike the HELP-Energy and Commerce agreement, the Ways and Means measure wouldn’t prohibit surprise bills for air ambulance charges, which can run into the tens of thousands of dollars. The Ways and Means draft would only require air ambulance providers to report cost data and insurers to submit claims data to the HHS. The legislation also includes other consumer protection provisions, such as a requirement that patients with complex conditions be covered for up to 90 days at in-network cost-sharing rates if providers change network status during their treatment. That means patients would only have to pay the charges they would normally pay for in-network treatment.

The draft bill would require, beginning in 2022, that consumers receiving emergency services at any facility, or receiving services by out-of-network providers at a facility that is in their insurance networks, would only
have to pay their share of in-network rates, a section-by-section explanation of the measure said. Health plans would be required to provide up-to-date information on doctors, hospitals, and other medical providers participating in their plans, and providers would be required to update information on their health plan participation in a timely manner. If inaccurate information is provided, consumers cost-sharing would be limited to their share of in-network rates. Health plans would be required to provide advance explanations of benefits for scheduled services at least three days ahead.

Democratic and Republican leaders of the House Energy and Commerce and the Senate HELP Committee issued a statement Friday noting that the two committees approved surprise billing legislation in the summer of 2019 and announced their agreement on their bills in December. That bill also includes provisions to lower prescription drug costs and require greater transparency in health-care prices. “We look forward to working together to deliver a bill to the president’s desk that protects patients and lowers health care costs,” the two committees’ leaders said.

Supporters of surprise billing legislation hope an agreement can be reached by late-May, when funding must be approved for other health-care programs, such as community health centers. In addition to the Ways and Means markup, the House Education and Labor Committee has scheduled a markup on its own surprise billing measure for Feb. 11. A fact sheet on the bill says it “protects air ambulance patients and takes steps to address ground ambulance surprise bills.” Ground ambulances are not covered by either the HELP-Energy and Commerce legislation or the Ways and Means draft.

The Education and Labor bill would establish two mechanisms to resolve payment disputes. For amounts up to $750, or $25,000 for air ambulance services, the median in-network rate would be the benchmark to be followed. For bills above those amounts, air ambulance companies and insurers could use an independent dispute resolution.

**Disrupter Trump Sees Mixed Success Tackling Tough Health Agenda**

President Donald Trump made changing the U.S. health-care system a top priority, but his administration has struggled to accomplish the most ambitious goals he campaigned on four years ago while lower-profile policies are seeing success.

As Trump seeks re-election, he has been adamant that voters hear about his record on health care, but most of his major proposals are tied up in litigation or haven’t gotten much notice from voters. Voters consistently say health care is their most important domestic policy issue. However, former officials from both Democratic and Republican administrations say the Trump administration has accomplished about as much as any other and hasn’t been afraid to try to change areas of the system that other presidents haven’t addressed.

In particular, the former officials pointed to the administration’s willingness to take on the pharmaceutical industry, hospitals, and the issue of kidney care. They said Trump came to Washington to disrupt, and he has done that in health care. “President Trump has an exciting vision for health care, which we’ve articulated and worked toward this past year: a system with affordable, personalized care, a system that puts you in control, provides peace of mind, and treats you like a human being, not a number,” Health and Human Services Secretary Alex Azar said in a Thursday speech outlining his agency’s goals.

The Trump administration has made some significant accomplishments in a health-care system that is “large, complex, and has a lot of inertia against change,” said Mark McClellan, former Centers for Medicare & Medicaid Services administrator and Food and Drug Administration commissioner in the George W. Bush
administration. Its accomplishments include releasing over a dozen demonstration projects for medical providers, moving forward on regulations to encourage more home dialysis and better organ procurement, and rules that promote private Medicare plans.

What the administration lacks is a big legislative win, like the Medicare prescription drug benefit under George W. Bush or the Affordable Care Act for Barack Obama, said Chris Meekins, former Trump administration HHS deputy assistant secretary for preparedness and response. In addition, many of the final regulations where the administration has sought the greatest change have been tied up in the courts, and the HHS has been unable to implement them. The most notable case among these involves the regulation requiring that drugmakers disclose their products’ list prices in television ads. The HHS has tried to aggressively advance its priorities, but the courts have “handcuffed them” and limited what they—and any future presidents—can do, said Meekins.

The administration hasn’t really succeeded on the priorities that Trump had talked about consistently—repealing the Affordable Care Act, lowering prescription drug prices, and not cutting Medicare and Medicaid, said Chris Jennings, former health policy adviser in the Obama and Clinton administrations. For example, the administration has been hampered on drug pricing because significant action requires legislation, McClellan, director of the Duke-Margolis Center for Health Policy, said.

Trump called for bipartisan legislation to lower drug prices in his Feb. 4 State of the Union address. “Get a bill on my desk, and I will sign it into law immediately,” the president said. Trump has rejected legislation passed by the House (H.R. 3) that would allow Medicare to directly negotiate drug prices. Meanwhile, Azar’s priorities and the traditional day-to-day work of the department have seen “documentable achievements and impact,” Jennings said. Administrative changes, including organ procurement and reforms to the physician self-referral law, have been “notable” and reflect the traditional work of the staff in the agencies. These second-tier priorities “sometimes have the most potential to get done and can be more sustainable” because they avoid the heat of third rail issues, Jennings said.

The administration has been or looks like it will be successful in places where it hasn’t had to issue new regulations or faced pushback, like turning a corner in the opioids crisis, stymieing the spread of HIV, and encouraging more people to choose private Medicare plans over traditional Medicare, Meekins, a health-care policy research analyst at Raymond James, said. The administration’s efforts to pay doctors and hospitals based on patients’ overall health appear to be on track, with the HHS and outside observers waiting to see how many doctors actually choose to participate. The Trump administration is doing the hardest part of moving to value-based care, McClellan said. The Bush and Obama teams were testing out models, but to progress further, this administration needs significantly more participation by big health systems. It’s important the administration follows through on finalizing its mandatory demonstration projects and its proposal to tie Medicare reimbursements to foreign countries’ drug prices, Adam Boehler, former HHS senior adviser and head of the Center for Medicare and Medicaid Innovation under Trump, said.

The administration has either been “ineffective” or planted the seeds for a slow movement toward success in its big visible policies, Jennings, founder and president of Jennings Policy Strategies, said. The public “will see the things they’ve done will play out significantly over the next couple of years,” Boehler, CEO of the U.S. International Development Finance Corporation, said.

The first thing the Trump administration had to do when trying to take on a big issue like how health care is paid for is change the narrative, William Pierce, former HHS deputy assistant secretary for public affairs in the George W. Bush administration, said. It has been successful in that, even if its list of actual policy accomplishments is “middling” at best, said Pierce, a senior director at APCO Worldwide. Pierce argues
that the administration has moved the conversation to focus on the cost of care and the necessity of moving to value-based care rather than the issue of access, on which the Obama administration focused. “We’re not going to talk about the cost of health care the same anymore,” and that conversation is starting to trickle down to the public, Pierce said.

**Trump Faces Struggle to Defend Hospital Outpatient Pay Cuts**

The Trump administration will have a tough time defending its effort to ensure that Medicare pays the same rates for services provided at hospital outpatient clinics as at doctors’ offices.

The American Hospital Association and dozens of hospitals around the country are challenging the Centers for Medicare & Medicaid’s decision to lower payments to off-campus clinics by 40%.

The plaintiffs, in two separate lawsuits, want to topple the agency’s 2020 “site-neutral” payment policy after a federal district court judge tossed a similar policy last year. The administration wants to equate payments for services given at hospital outpatient facilities to the lower payments for the same services at doctors’ offices. Currently, hospital outpatient facilities are paid more based on their attachment to that hospital.

The renewed legal challenge suggests the hospitals will be successful in keeping Medicare payment disparities in outpatient services. The agency is already making extra payments to hospitals for 2019 Medicare claims that were paid at the reduced rate. The AHA estimates that amount to be $380 million. “I think they’ve got a tough case, both on the law and the policy,” Lawrence Vernaglia, a partner at Foley & Lardner in Boston, said of the government’s position. “Nothing has changed, except that they’re reprocessing the 2019 payments. But their position on the law hasn’t changed.”

Paying the same rate for care at doctor’s offices and hospital outpatient departments would be a crucial cost saver for Medicare as it braces for a wave of aging baby boomers who could double the cash-strapped program’s annual spending to more than $1.5 trillion by 2028, according to the Medicare Payment Advisory Commission.

The CMS estimates that lowering reimbursements to hospital outpatient clinics would save Medicare $650 million in 2020, and beneficiaries would save another $160 million in out-of-pocket costs. The U.S. District Court for the District of Columbia, in September 2019, found that the CMS exceeded its authority in implementing the policy, and that the reduced rates violated a federal budget neutrality requirement in the Medicare law.

Facing a new legal challenge over the same issues on the heels of last year’s defeat, the CMS might be better served moving its fight to Capitol Hill, some analysts and lawmakers say. “I think Congress needs to step in” and pass more up-to-date site-neutral payment legislation, Rep. Brad Wenstrup (R-Ohio), a podiatrist and member of the House Ways and Means Committee, said. “I think we have some bipartisan support. Maybe not enough yet, but I think we can get there.” Wenstrup last year introduced an amendment, that ultimately wasn’t adopted, to a broad House Democratic drug pricing bill to require Medicare to pay the same rates for services provided at hospital outpatient facilities and doctor’s offices. The House passed the bill in December, but it’s unlikely to go any further because it includes a controversial provision to allow Medicare to negotiate drug prices directly with manufacturers.

The site-neutral payment proposal is having better luck in the Senate. A bipartisan drug pricing bill under negotiation by the Senate Finance Committee Chairman Chuck Grassley (R-Iowa) and ranking member Ron Wyden (D-Ore.) includes language on site-neutral payments.
The AHA and the hospitals are counting on the same arguments that fueled their successful lawsuit in 2019 to overturn the CMS’s 2020 pay cuts, which took effect Jan. 1. The plaintiffs claim that the Department of Health and Human Services violated the Medicare statute by failing to provide reimbursement increases to offset the payment cuts. The law requires certain Medicare payment adjustments to be budget-neutral.

They also say the cuts violate a provision of the Bipartisan Budget Act of 2015 that allows hospital outpatient departments built before November 2015 to be grandfathered in at a higher Medicare reimbursement rate. Legal issues arise due to “murky” definitions for various sites of service, Shawn Martin, senior vice president at the American Academy of Family Physicians, said. Hospital ownership of a facility “doesn’t necessarily make it a ‘hospital outpatient department,’” he said. Congress should make the definitions of various service sites more complete and precise “so that CMS policy can be implemented in a more consistent manner,” Martin said.

Higher payments for outpatient facilities are reasonable because those facilities incur higher costs to maintain round-the-clock operations and meet legal and regulatory obligations—such as providing care to people regardless of their ability to pay—that doctor’s offices aren’t required to meet, Vernaglia said.

The CMS has said the changes are meant to discourage hospitals from building new facilities to get the higher Medicare rates and curb increases in program services now performed at outpatient departments. Higher Medicare payment rates for outpatient facilities lead hospitals to buy physician practices and then place the doctors in their clinics—where they can charge more for services, according to the Alliance for Site Neutral Payment Reform, a coalition of providers, employers, and insurers.

From July 2016 to January 2018, hospital-owned practices increased by nearly 8,000, according to a study by the nonprofit Physicians Advocacy Institute. As a result, Medicare billing has largely moved from doctor’s offices to hospital outpatient departments. Medicare payments for doctor’s office visits have fallen 2% since 2012, while payments for hospital outpatient departments have jumped 37%, according to the Medicare Payment Advisory Commission. The commission also found that chemotherapy provided to Medicare beneficiaries fell 16.6% in doctor’s offices, but increased 53% at outpatient departments over the same period.

The plaintiffs’ concerns mirror those raised in an October 2018 letter by Sen. Ron Wyden (D-Ore.) to CMS Administrator Seema Verma about the then-proposed 2019 rate cuts. Wyden wrote that he supports efforts to reduce “beneficiary cost-sharing and unnecessary Medicare spending,” but that he questions “CMS’ ability to make this payment reduction under existing authority.”

**Pharmaceutical Companies Avoiding Taxes Get Scrutiny From House**

The leading tax-writing body in the House is investigating pharmaceutical tax write-offs, including charitable donations, the financial benefits of certain drug approval pathways, and how the 2017 tax law affected drug prices.

Pharmaceutical companies are abusing the U.S. tax system by making “taxable income disappear overseas,” Rep. Lloyd Doggett (D-Texas), chairman of the House Ways and Means health subcommittee, said at a hearing Wednesday. Doggett is investigating how companies “avoid taxes” and use patient assistance programs to “steer patients to high cost drugs and make insurers pay the price,” driving up deductibles and premiums, he said.
Congress has debated for years how to lower health-care costs for Americans but to no avail. President Donald Trump urged lawmakers in Tuesday’s State of the Union to bring him a bill that would ease financial burdens for patients.

Doggett also is looking into how the tax cuts Republicans spearheaded in 2017 are affecting drug prices. The law included a permanent reduction in the corporate tax rate.

One economics specialist told lawmakers Wednesday that stock buy-backs increased dramatically after the bill passed while growth of research and development stayed the same. Brad Setser, the international economics fellow at the Council on Foreign Relations, also disputed Trump’s assertion at Tuesday night’s State of the Union that drug prices have gone down.

Price increases have slowed over the past 12 months, he said, but prices have risen in the past 24 months. Republicans like Rep. Devin Nunes (R-Calif.), the ranking member of the subcommittee, pushed for passing bipartisan drug proposals like capping out-pocket costs for seniors.

**Asthma, Disease Worsening from Climate Change, House Panel Told**
Climate change is worsening heart and lung disease, raising asthma rates, causing post-traumatic stress, and increasing people’s exposure to infectious diseases carried by mosquitoes that thrive in warmer weather, witnesses told a House committee.

The testimony to the House Select Committee on the Climate Crisis on Wednesday will feed into the recommendations the committee sends to congressional leaders before the end of March. A handful of extreme weather events in 2012—including wildfires in Colorado and Washington, a Lyme disease outbreak in Michigan, and algae blooms in Florida—imposed $10 billion in health care costs, one of the witnesses, former EPA Administrator Gina McCarthy, said.

About 65% of those costs were borne by Medicare and Medicaid, pointing to the outsized impact of climate-related illnesses on older adults and low-income people, McCarthy, now president of the Natural Resources Defense Council, said. Disease-carrying mosquitoes thrive in standing water, especially in warm areas, said witness Aparna Bole, a pediatrician at Rainbow Babies and Children’s Hospital in Cleveland, who testified on behalf of the American Academy of Pediatrics.

That can raise threats for coastal communities and areas that weren’t previously exposed to mosquito-borne threats and therefore may not have the public health infrastructure to respond, Bole said.

Rep. Garret Graves (R-La.), the panel’s top Republican, said that importing oil from other countries raises the risk of spills. Graves also said renewable energy creates its own impacts, ranging from child labor in China to the “bird blender” threats of wind turbines. Rep. Carol Miller (R-W.Va.) said hospitals need reliable, fossil fuel-derived baseload energy to keep running. “The science is there” to capture carbon emissions from power plants, Miller said.

Also during the hearing, Arturo S. Rodriguez, president emeritus of the United Farm Workers, said agricultural workers are exposed to greater levels of heat than ever before. Workers on H-2A visas for temporary agricultural workers are particularly vulnerable because they “will work to the limits of their endurance” to stay in the U.S., Rodriguez said.
Trump’s Call for Drug-Pricing Law Faces Uphill Battle
The effort to enact legislation reducing drug prices will remain fractured despite President Donald Trump’s call for unity on the issue. Trump, in his annual State of the Union address Tuesday, highlighted his administration’s work to lower the price of drugs. He credited Sen. Chuck Grassley (R-Iowa) with working on it, although he fell short of endorsing the Finance Committee chairman’s drug-pricing package. Trump called on Congress to “get something done,” asking for legislation without singling out a particular bill. “I am calling for bipartisan legislation that achieves the goal of dramatically lowering prescription drug prices,” Trump said. “Get a bill on my desk, and I will sign it into law immediately.”

The president used his speech to claim credit for the reduction of overdose deaths under his watch and for expanding the availability of low-cost health insurance plans that don’t have to comply with many of Obamacare’s rules. Grassley has been seeking a much-needed boost from Trump for the drug-pricing package he put together with Sen. Ron Wyden (Ore.), the top Finance Committee Democrat. Grassley has said he needs more support from his Senate colleagues to get a vote in that chamber this year.

Grassley said Wednesday Trump’s call out to him during the speech was the “impetus we needed to get more Republicans” to support the bill. He added that he’s unsure if this will get them over the finish line, but it could. House Democrats spent the day Tuesday arguing that Trump and his administration have done little to reduce what Americans pay at the pharmacy. They pointed to legislation (H.R. 3) the House passed last year that would empower Medicare to pressure drugmakers to lower their prices. The Senate hasn’t taken up the bill.

Trump’s comments on drug pricing during his speech prompted Democrats in the chamber to shout “H.R. 3! H.R. 3!” Democrats also argued Trump has undermined Obamacare, their signature health policy achievement, by supporting a lawsuit challenging the constitutionality of the health law. “I will work with President Trump if he will help us lower the cost of prescription drugs, if he will drop this lawsuit for the American people,” Rep. Debbie Dingell (D-Mich.) said.

Democrats see themselves as holding the high ground on health care and therefore don’t need to support whatever Trump and Republicans in the Senate can agree on. Without their support, any drug-pricing bill could be doomed.

Recent polling from the Democratic firm Public Policy Polling found that a thin majority of voters in Florida, Michigan, North Carolina, Pennsylvania, and Wisconsin would more likely trust Democrats on prescription drug matters than Trump and that most voters favor allowing Medicare to negotiate for lower prices. The poll was conducted on behalf of the Democrat-aligned advocacy group Protect Our Care. “If President Trump is serious about tackling the cost of prescription drugs, he will reverse course, announce his support for the House-passed Lower Drug Costs Now Act, and urge Senate leaders to stop delaying and send it to his desk,” said Eli Zupnick, a former spokesman for Sen. Patty Murray (D-Wash.) who now works for the drug pricing advocacy group Patients Over Pharma.

Trump’s announcement that his administration will proceed with a plan to tie the price of drugs in the U.S. to their cost overseas was similarly met with skepticism from Democrats. Leslie Dach, chair of Protect Our Care, called it “nothing more than a proposal for a proposal for a proposal.” “Even under the most optimistic timeline, this policy wouldn’t take effect for years and Americans would likely only see a modest benefit if any at all,” Dach said. “Meanwhile the president gave billions of dollars in tax breaks to drug companies and opposes giving Medicare the power to negotiate for lower drug prices, the one proven way to lower costs from millions.”
Protect Our Care on Tuesday also launched an ad campaign in Florida, Michigan, North Carolina, Pennsylvania, and Wisconsin—all 2020 battleground states—that says the president is lying when he claims he’s maintained Obamacare’s popular protections for people with pre-existing health conditions. The administration has declined to defend the Affordable Care Act—including safeguards for those with pre-existing conditions—in a lawsuit by a group of Republican-led states that seeks to strike down the law.

**Can’t Text Your Doctor? Blame the Health Privacy Law**

Virtual check-ins between doctors and sick patients would save time and money, but slashing the regulatory red tape has been no small order in health care. The health technology industry wants to make it easier for patients to text with their providers for routine services. However, there’s one federal hurdle in the way: the Health Insurance Portability and Accountability Act (HIPAA).

The medical world pitches texting as convenient for patients and doctors and a way to boost the quality of care provided at little cost. But making that happen is a little harder than hitting send. The health privacy law means telephone providers would be roped in, requiring them to take steps to ensure that any patient data sent via text message is protected. “Patients can’t always text physicians because AT&T and other phone companies don’t have HIPAA in place, so our model brings you into this secure chat room,” said Bryan Fine, CEO of Norfolk, Va.-based Percentric, which offers HIPAA-compliant communications outside of the doctor’s office. “Just a tincture of common sense on this HIPAA conversation, to me, is reasonable, and I think it’s going to need to be a part of the solution going forward,” he said.

Telemedicine companies and physician groups have urged the Department of Health and Human Services to weigh in on how doctors and patients could legally text one another under HIPAA. An HHS spokeswoman said the agency plans to offer guidance on text messaging and HIPAA, but didn’t provide further details.

Texting in health care requires a balancing act between federal regulators who need to protect patient data and those same patients demanding that access to their doctors evolve with technology. More than 41 million people were impacted by health records breaches in 2019, the highest number in the last four years, according to the HHS’ Office for Civil Rights.

Texting patient information among members of the health-care team is allowed if it is sent through a secure platform, according to the Centers for Medicare & Medicaid Services. Sending information electronically through a computer is the preferred method for now. HIPAA only covers data collected by health-care providers, health plans, and clearinghouse billing systems in the industry. But those requirements extend to business associates, which could include phone companies if they handle sensitive information. The HHS issued a request for information in 2018 for the health-care industry to share how HIPAA slows progress to value-based health care. It received nearly 1,500 comments. The American Medical Association believes creating guidance around texting would ease nerves in the medical industry.

Patients demand doctors keep up with 21st Century technology, but health-care companies are hesitant because HIPAA violations can be severe. “If I make any mistakes at all, my whole life is going to get ruined and my business is going to get destroyed,” Fine said. Text messages aren’t encrypted or protected, so using them to send sensitive patient data violates HIPAA. Another risk is that patients may change their phone numbers without updating their physicians. That incurs the risk of sending personal information to the wrong recipient. “Telephone numbers can be reassigned in ways that e-mail addresses typically are not,” Kevin Coy, a partner and co-chair of the privacy and consumer regulatory practice at Arnall Golden Gregory LLP, said.
Another hurdle would be getting phone carriers on board with business associate agreements under HIPAA. “Access controls are very important as well because you never know who is looking at the phones, so providers would need a protocol to ensure they are texting the right person and complying with rules regarding the ‘minimum necessary,’ which means that only the bare minimum amount of protected health information should be included in texts,” said Sarah Weatherhead, general counsel of Maven Clinic, a New York-based telehealth startup that provides health-care services to parents and families. Despite the risks, medicine is still moving in a direction where text communication will be necessary, according to Fine. “There needs to be a way to allow patients and doctors to innovate and make some choices together so that the common themes and threads around HIPAA aren’t so frightening,” Fine said. “HIPAA as it stands now, is something that is stifling. There’s always going to be a crack that someone will fall through,” he said. “How can telehealth companies help the most people without being so frightened of being an outlier or crack faller?”

**White House Wants to Reduce Opioid Deaths by 15% in 2021**
The Trump administration is aiming to reduce drug overdose deaths by 15% by next year—to 59,701 deaths—according to a [2020 strategy document](https://www.whitehouse.gov) released Monday.

The report by the White House’s Office of National Drug Control Policy comes amid increasing concerns from state health officials that the federal government isn’t doing enough to address rising stimulant use amid an ongoing opioid crisis.

Fatal drug overdoses dropped by 4.1% in 2018 from the year before, the first decline in 28 years, according to a Jan. 30 [Centers for Disease Control & Prevention report](https://www.cdc.gov). The same report found that the rate of deaths involving cocaine and methamphetamine increased exponentially from 2012 to 2018.

The administration plans to double the availability of facilities that provide medication-assisted treatment and increase the number of practitioners who can prescribe buprenorphine, a drug used in medication-assisted treatment. Medication-assisted treatment combines medication and behavioral therapy in helping people recover from opioid use disorder and is seen widely as one of the most effective treatments for the disorder.

Doubling the specialty treatment facilities that provide medication-assisted treatment would increase it to 20% of facilities, according to the report. Four percent of eligible providers can prescribe buprenorphine, according to December 2019 data from the Drug Enforcement Agency, and the administration aims to increase it to 10% of providers.

The federal government also intends to reduce the number of dispensed opioid prescriptions by 33% in 2020, and maintain that reduction over the next two years.

Pain management advocates have worried that reducing access to opioids could make it harder for people with chronic pain to get the treatment they need. James Carroll, director of the White House Office of National Drug Control Policy, emphasized the importance of ensuring patient access to the drugs in a March 2019 [hearing](https://www.whitehouse.gov).

A [December 2019 Government Accountability Office report](https://www.gao.gov) found that the 2019 National Drug Control Strategy lacked information that was required by statute, including planned steps, milestones, time frames, or resource investments in meeting its goals.
**Telemedicine Company Owners Accused of $56 Million Medicare Scam**

A husband and wife who owned two telemedicine companies together were arrested and charged with running a massive $56 million scheme to defraud Medicare by trading illegal kickbacks and bribes for orders of medically unnecessary orthotic braces, federal prosecutors announced on Wednesday.

Reinaldo Wilson and Jean Wilson, the owners of Advantage Choice Care LLC and Tele Medcare LLC, were arrested Wednesday following the unsealing of an indictment. They each have a bail hearing scheduled for Feb. 11, according to the U.S. Department of Justice.

The Wilsons are accused of receiving illegal considerations from patient recruiters, pharmacies, and brace suppliers in exchange for brace orders for Medicare beneficiaries between March 2017 and April 2019. The couple allegedly obtained the orders from doctors by paying illegal kickbacks and bribes to healthcare providers.

The orders allegedly supported more than $56 million in fraudulent Medicare claims that resulted in more than $28 million in unwarranted payouts.

The Wilsons are also accused of engaging in transactions of criminally derived property worth more than $10,000 over two years.

The Wilsons were each charged with one count of conspiracy to defraud the U.S. and to pay and receive health care kickbacks, one count of conspiracy to commit health care fraud and wire fraud, three counts of receiving health care kickbacks, and one count of conspiracy to commit money laundering.


**Supreme Court Will Weigh Expediting Democrats’ Obamacare Appeals**

The U.S. Supreme Court signaled it will use its Feb. 21 private conference to discuss whether to consider the fate of the Affordable Care Act on a fast-track schedule that would mean a decision by the end of June. The indication came on the online dockets of two Democratic appeals that seek a definitive ruling upholding Obamacare during the court’s current term.

The appeals challenge a Dec. 18 federal appeals court decision that found a key piece of the original 2010 law unconstitutional and raised questions about the rest of it. The Trump administration is seeking to invalidate the law in much of the country, throwing its support behind a suit filed by Republican-led states. An Obamacare case would supercharge a Supreme Court term already full of polarizing issues. The court is considering cases involving abortion, guns, LGBT discrimination, the DACA deferred-deportation program and subpoenas for President Donald Trump’s financial information. All are scheduled to be decided well in advance of the November election.

Democrats are urging the justices to hold arguments during the last week of April -- the court’s last scheduled week to hear cases -- or during a highly unusual special sitting in May. Either approach would mean sharply expediting the briefing schedule, something the court is usually reluctant to do.

The New Orleans-based appeals court ruling threw out a provision that, as originally crafted, required people to acquire health insurance or pay a tax penalty. The Supreme Court in 2012 upheld this provision, known as...
the individual mandate, with Chief Justice John Roberts saying it was a legitimate use of Congress’s taxing power.

A Republican-controlled Congress joined with Trump to zero-out the tax penalty in 2017, leaving the mandate without any practical consequences. States led by Texas are trying to use that change to invalidate the entire Affordable Care Act, including provisions that protect people with pre-existing conditions and expand the Medicaid insurance program for the poor.

The New Orleans-based appeals court didn’t decide whether the rest of the law could stand, instead returning the case to a federal trial judge for closer scrutiny. The Supreme Court appeals attempt to bypass that process, arguing that the nation’s health care system is too important to allow continued uncertainty. The Supreme Court has sent mixed signals about its interest in the Obamacare appeals, filed by the House and Democratic-led states. Last month the court rejected their request to expedite its handling of the appeals, but the justices later refused to give Republican opponents extra time to file their brief arguing against review. The combination of those actions put the appeals on track for the court’s next private conference -- and leave open at least the possibility the court could hear the case this term. If the court grants review, an announcement could come as early as the day of the Feb. 21 conference.


AROUND THE STATES

State Drug-Pricing Laws Hampered by Resistance, Lack of Teeth
State laws aimed at forcing the pharmaceutical industry to account for rising prescription-drug costs have done little to dampen price increases, in part because the companies skirt robust disclosure with relative impunity.

At least 11 states have laws requiring manufacturers to provide data on drugs’ costs, warnings before some prices increase, and justifications for changes. But many companies are complying only partly or not at all, saying the information is confidential under federal law, and some of the laws have few or no enforcement powers, Bloomberg Law found. The companies’ actions come amid congressional gridlock over controlling prices and the drug industry’s fight over the Trump administration’s efforts to force them to disclose list prices in TV ads. “The federal government is moving as fast as it can on these pieces but drug prices are continuing to rise, even with more pressure” from the public, said Justin Mendoza, who works with the nonprofit Families USA to develop state campaigns to lower health care costs. “Price increases are baked into their business model,” he said, and “public pressure alone isn’t forcing their business model to change.” To be sure, several states say their laws have gotten results. New York, as of January, said it had negotiated 30 rebates with drug companies, saving more than $85 million. Nevada and California have fined companies to track down late or missing information.

Supporters of state transparency laws say they’re the first step in identifying why drug costs are increasing and that knowing about increases beforehand can help big purchasers negotiate. A chorus of policymakers saying “you can’t do that” helps curb price hikes, said Vermont state Rep. Anne Donahue, a Republican who was vice chair of a legislative health care committee when that state’s law was passed. It requires drug manufacturers to report various data including justifications for price increases. “Being one state and then having other states and public attention on the dramatic, seemingly unjustified increases, I think the attention it brought helped some of those get pulled back,” she said.
All of the manufacturer-focused state laws analyzed by Bloomberg Law require disclosure rather than regulate drugs’ base prices. Maryland tried the latter approach but a federal court ruled its anti-price-gouging law illegally regulated interstate commerce. States mostly require manufacturers to report the wholesale cost of their products and why they raised prices above a designated threshold. Several laws include carve-outs that don’t require companies to report proprietary information or go beyond what’s in the public domain.

Many of the states also have transparency requirements for insurers, pharmacy benefit managers, and others that influence drug costs. Some have tried other methods of reducing costs, such as Colorado’s cap on co-pays for insulin. The idea is to collect neutral information about an opaque supply chain in which every player says it isn’t the root of rising prices, said Nevada state Sen. Yvanna Cancela, who sponsored a law requiring reporting on certain diabetes medications and, later this year, asthma drugs. Pharmaceutical companies argue they already have to disclose a lot of information because many of them are publicly traded. “There’s a lot of finger pointing,” Cancela said.

The leading lobbying group for brand-drug companies, PhRMA, has sued over a number of the state laws. A complaint filed in Oregon Dec. 9 argues that state’s law requires manufacturers to disclose trade secrets. PhRMA also sued over California’s and Nevada’s laws, though it dropped the latter effort after the addition of confidentiality provisions. Priscilla VanderVeer, a PhRMA spokeswoman, said consumers don’t care enough about the information companies are required to provide to offset the damage of disclosing trade secrets. “They want to know, ‘Is the medicine I need covered by my insurance company?’, and ‘What is my out of pocket?’” she said of the surveys PhRMA has taken of consumers.

Laws like California’s that require companies to give advanced notice of price increases put companies and the public in a precarious position, VanderVeer said. “When you signal a price increase that encourages some less-than-high-quality people in the system to buy up the product at the lower price... That could potentially limit the supply and create a shortage,” she said. The approach that New York says worked requires drugmakers to report financial information if they fail to negotiate a supplemental drug rebate for the state, according to the state’s Department of Health. Health officials say they consider those financial reports proprietary, however, making the law less about price transparency and more about using disclosure as leverage. The California law requiring advanced notice of cost increases for drugs that meet certain thresholds has likely kept prices lower than they would have been without it, said Mendoza from Families USA. Bloomberg reported several drugmakers rescinded planned cost hikes in 2018, but new data shows so far this year drugmakers raised prices on medications by an average of 5.3%. “A number of companies decided not to increase price beyond what would trigger California’s transparency law,” Mendoza said.

Several companies, including Teva Pharmaceutical Industries Ltd., Mylan NV, and Par Pharmaceutical Holdings Inc. declined in some disclosures to provide reasons for price increases or information about other marketing tactics, citing trade secret or proprietary protections. Most state laws, including Vermont’s, allow companies to protect what they consider proprietary information. PhRMA said it couldn’t comment on specific companies’ actions, and what they decide to disclose or not is their choice. When asked for comment, Mylan referred to a recent statement from the Association for Accessible Medicines, the lobby group for generic drugs. The group said generic drug prices aren’t driving up states’ costs. High brand drug prices “overwhelm falling generic prices,” the group wrote in a briefing on state drug reforms. It encouraged policy makers to tackle expensive products in their policies.

Companies that don’t comply with transparency laws face penalties from $1,000 to $10,000 a day in a handful of states, though not all have fines. Nevada has cited roughly two dozen companies and asked them to pay about $24 million, though many have since provided information and are in dispute resolution with
the state. Only about half of impacted drug manufacturers in Nevada reported on time in 2019, with some citing staff turnover or unfamiliarity with the law, said Scott Jones, who previously worked with the drug price transparency program in the state’s Department of Health and Human Services. California regulators sent 17 penalty notices for late reports totaling nearly $11 million in fines, according to Jan. 22 data released to Bloomberg Law under the state’s public records law. Five companies paid in full, while others reached settlements to pay reduced amounts or nothing, or are still appealing.

Additionally, most drug manufacturers reporting to California didn’t give reasons for price increases in the last reporting period, and they aren’t required to if the data isn’t in the public domain. Louisiana has no penalties for noncompliance and doesn’t track which manufacturers are following transparency provisions. Oregon has no requirement that companies register with the program, which a recent analysis by program staff recommended changing to increase compliance. Enforcement of Colorado’s law, which requires manufacturers to provide a drug’s wholesale acquisition cost to prescribers, is complaint based. No complaints were received as of early January, according to the state board of pharmacy. The onus is on doctors hearing from manufacturers or their marketers to know what information they should receive and to raise the red flag if they don’t, said Adam Fox, director of strategic engagement for the Colorado Consumer Health Initiative, which supported the legislation. “It’s hard to know how well this law is being followed,” he said.

State officials say they hope initial transparency laws can lead to bigger changes. The approach follows a physician’s process to “diagnosis and then treat” a problem, said Texas state Rep. Tom Oliverson, an anesthesiologist who sponsored a recent drug price transparency law that has yet to report manufacturer data. Several states have analyzed initial data to draw conclusions on what types of drugs are rising in cost and why—new information supporters say will influence legislation in the coming years. Additional states collecting data in the coming year may shed more light on how effective these laws are. Nevada legislators, for example, plan on using data collected through its transparency law to write and introduce new drug price bills in 2021, said Cancela, the state senator. The existing law is achieving its goal of collecting accurate and neutral data, she said. “It’s been helpful to see all that data together,” Cancela said.

In California, advocacy groups want to work with the state on ways to make manufacturers “more forthcoming” about price increases, said Anthony Wright, executive director of Health Access California, which supported California’s law. His group is also looking at other ways to strengthen the law, such as including more drugs in the reporting. “Some of our work is trying to figure out what is doable at the state level,” Wright said.

California

**Newsom to Keep Pushing Managed-Care Tax After Feds Reject Plan**

California will keep trying to win federal approval to renew a tax on managed care organizations that would generate $1.7 billion in funding for Medicaid.

The California Department of Finance expects “no immediate fiscal impact” from the Centers for Medicare & Medicaid Services’ decision to reject a tax plan the state submitted as a waiver request, spokesman H.D. Palmer said. The administration of Gov. Gavin Newsom (D) will work with the CMS to address the concerns, he said. “We believe and expect that we can reach an agreement that allows this type of financing to continue,” Palmer said.
The CMS has approved tax plans for managed care organizations in two other states, Michigan and Ohio. The revenue allows states to boost their share of Medicaid funding and qualify for more federal funds. The administration alerted the California Department of Health Care Services of its decision in a Jan. 30 letter. The new tax structure would unevenly apply tax liability depending on how many Medicaid enrollees a managed care organization accepts, the CMS told the state.

Under the new tax structure, managed care plans would recoup all but $16 million of the $2.5 billion in taxes they pay through reimbursements for services they provide to Medicaid enrollees. Plans that don’t serve Medicaid patients would receive more reimbursements than those that do.

The CMS approved a slightly different version of the tax plan in 2016. The agency found that the five managed care organizations exempted from the tax weren’t exempted based on a lack of participation in Medicaid. That arrangement is allowed under federal rules, a CMS spokeswoman said. The 2019 request, however, would have exempted 12 managed care organizations based on their lack of participation in Medicaid, violating rules that prohibit a connection between the receipt of Medicaid payments and taxes. “The proposed tax structure means that there is a correlation between the Medicaid payment and the tax liability; if the managed care organizations receive a Medicaid payment, they incur tax liability. Conversely, if they do not receive Medicaid payments, they do not incur a tax liability,” CMS Acting Deputy Administrator and Director Calder Lynch wrote in the letter.

Newsom signed the tax bill in September that would assess an enrollment-based tax on all full-service health plans licensed by the state’s Department of Managed Health Care. Two different tiered systems are put in place for Medicaid and non-Medicaid patients. The new tax differs slightly from the one that expired last year and is designed to be more broad-based and uniform than its predecessor.

Newsom didn’t count on federal funding from the tax in the current fiscal year or the next one that starts July 1 because federal approval was needed to carry it out. A similar tax that received CMS approval expired July 1. But the move could jeopardize Newsom’s budget priorities. He plans to use some revenue from the tax to extend through 2026, a sales tax exemption on diapers and menstrual products, which is set to expire at the end of 2021. He also wants to waive the $800 minimum franchise tax on new limited liability companies in their first year.

The governor will continue to push for those tax items in the state budget plan that must be enacted by July 1 despite the federal denial, Palmer said. The California Association of Health Plans, Local Health Plans of California, Health Access California, and Service Employees International Union California all supported the tax as it won approval in the Legislature in 2019.

North Carolina

Budget Impasse Is a Setback for Health Insurers
A months-long budget standoff in North Carolina has turned into a headache for health-insurance companies counting on $6 billion in contracts from an ambitious revamp of the state’s Medicaid program. A high-profile plan to switch 1.5 million North Carolinians into private Medicaid managed-care health plans was supposed to begin in November. The effort to transform the state’s safety net for low-income residents drew national attention for innovative experiments to promote preventive health and address social needs. But the state has put the plan on hold indefinitely with the state’s Republican-controlled legislature and Democratic governor at an impasse. The two sides were unable to reach a deal when lawmakers convened for a one-day session in January. They’re not scheduled to meet again until late April.
At the heart of the dispute is a fight over whether the state should expand eligibility for Medicaid, as 36 states have done under the Affordable Care Act. Republicans oppose the idea, while Governor Roy Cooper has made it a priority and vetoed proposals that don’t include the expansion. The deadlock has caused some companies awarded contracts last year to rein in their financial forecasts and, in some cases, put operations on hold.

Centene Corp. told investors in December it was planning for its North Carolina contract to begin on Oct. 1, 2020. The delay reduced the insurer’s forecast for 2020 revenue by $500 million and shaved 6 cents from its projected earnings per share for the year, it said at the time. Centene expects to gain 200,000 Medicaid members from the contract. It will report its latest quarterly results on Tuesday. UnitedHealth Group Inc. had included the North Carolina Medicaid contract in its outlook for this year, with the assumption that the program would begin in mid-2020, executives said on a call with analysts Jan. 15. However, a delay until 2021 “would not affect our expectations for the year,” said Chief Executive Officer Dave Wichmann. Anthem Inc., which is working with Blue Cross Blue Shield of North Carolina, is preparing for a delay until next year, CEO Gail Boudreaux said on an earnings call last week. “Based on where we are sitting today, it’s our expectation that the business won’t be going live until 2021,” she said.

Medicaid, the public health-insurance program for low-income Americans jointly funded by the federal and state governments, has become an increasingly important business for health insurers. States paid more than $265 billion to privately run Medicaid health plans in 2018, according to data from the Kaiser Family Foundation, and six large for-profit insurers accounted for 44% of the market in 2017.

It’s unclear how long the health plans will have to wait for North Carolina’s plan to move forward. State officials aren’t committing to any timeframe. “The longer the delay, lots of things get stale and we’ll have to redo more things as we’re preparing to go live,” said Dave Richard, deputy secretary for NC Medicaid. Some Medicaid beneficiaries had already selected private health plans that are now on hold, Richard said. “What we don’t want to do is start all of those things again and have providers and others spending money that they don’t need to until we know the date that we have a budget,” he said. Cityblock Health, a venture-backed startup working with the state Blue Cross Blue Shield plan to improve care for high-cost patients, had opened several new locations in Greensboro, Charlotte, and elsewhere last fall in anticipation of the new Medicaid program.

In mid-January, with the funding still on hold, the company said it would pause most of its operations in the state and keep locations open “with minimal staff.” One of Cityblock’s board members, Sidewalk Labs Chairman Dan Doctoroff, was CEO of Bloomberg News parent Bloomberg LP until 2014. Still, health care companies have little doubt North Carolina will eventually make the switch, said Mark McClellan, a former federal health official and director of the Duke-Margolis Center for Health Policy. “The reason that the plans are sticking with it, even though this is definitely not what they would prefer, sticking with their investments in North Carolina, is they know this is going to happen,” McClellan said. “It’s just a question of when and how exactly these Medicaid expansion issues are going to get worked out.”