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Affordability & Value of Health Care
Focus of MAHP 2017-2018 Legislative Agenda

Transparency of Pharmaceutical Prices, Addressing Provider Prices, Integration of Behavioral Health

Boston, MA – Seeking to address the major factors driving health care costs and ensuring the integration of behavioral health services by providers, the Massachusetts Association of Health Plans (MAHP) today outlined its legislative agenda for the 2017-2018 session, focusing on measures to make health care more affordable and accountable for employers and consumers.

"Nearly 90 percent of the premium dollar is spent on medical care and services that benefit and support patients, but the persistent increases in the prices that doctors, hospitals and pharmaceutical companies charge will continue to threaten the Commonwealth's cost benchmark," said Lora Pellegrini, MAHP President & CEO. "Our member health plans are doing everything they can to improve the value of the health care system, but it requires every segment to do its part. Our legislative agenda seeks to ensure that the entire system is accountable, so that health care is more affordable for employers and consumers."

Among the measures included in MAHP's legislative agenda:

- **Transparency of Prescription Drug Prices**
  While breakthrough medications offer tremendous clinical benefits for patients, the prices charged for prescription drugs is a major threat to keeping health care affordable for Massachusetts employers and consumers. State reports have concluded that exorbitant increases in prescription drug prices have been a major factor for rising health care spending and, as the Attorney General's examination on specialty drugs noted, "Even after accounting for all discounts and rebates, growth in the health plans' spending on prescription drugs has significantly outpaced overall health care spending growth." MAHP's legislative agenda would require transparency by pharmaceutical companies for increases in their prices, notice in advance of new increases, and participation in the state's Health Care Cost Trends hearings before the Health Policy Commission.

- **Addressing Provider Prices**
  Over the past eight years, more than two dozen state reports have examined the health care costs and cost drivers in the Commonwealth. Report after report has found that provider prices remain the most significant factor driving health care costs. Further, the wave of mergers, acquisitions and affiliations among hospitals, physicians and other providers will reshape the health care system for years to come. It is essential that these changes lead to better care and lower prices rather than higher costs through enhanced bargaining power. MAHP's legislative agenda proposes greater oversight of provider mergers, measures to restrain rates of high-priced providers, and efforts to protect consumers from surprise billing practices for providers that do not participate in a health plan's network.

- **Promoting Evidence-based Behavioral Health Care**:
  MAHP member health plans integrate mental health and substance abuse, medical care and pharmacy services, following nationally recognized evidence-based clinical guidelines, with care management

– more –

programs to ensure that health plan members receive the appropriate education, support, and coordination of care to follow through with prescribed therapies. As providers seek certification as accountable care organizations (ACOs) through the Health Policy Commission, it is important that they demonstrate that patient care will be integrated and coordinated across the continuum. MAHP's legislative agenda would require certified ACOs to develop guidelines for the evidence-based delivery of behavioral health services, access to 24/7 care, and treatment and discharge planning protocols. It would also direct the Health Policy Commission to examine providers' adherence to evidence-based standards of care, quality measures, outcome measures, discharge planning, and transitions of care to ensure that patients have access to the full continuum of care.

About MAHP

The Massachusetts Association of Health Plans represents 17 health plans covering more than 2.6 million Massachusetts residents. It is dedicated to improving health for all in Massachusetts by promoting affordable, safe and coordinated health care.

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MAHP's 2017-2018 Legislative Agenda

Transparency of Prescription Drug Prices

Promoting Transparency in Prescription Drug Prices

Sponsors: Senator Linda Forry (D-Boston) & Representative Christine Barber (D-Somerville)

Require the Health Policy Commission (HPC) in collaboration with the Center for Health Information and Analysis (CHIA) to identify up to 15 prescription drugs on which the state spends significant health care dollars and for which the wholesale acquisition cost has

- increased by 50% or more over the last five years;
- increased by 15% or more over the last 12 months; or
- is a new drug whose price may have a significant impact on the cost benchmark.

The list shall be provided to the Attorney General's office and shall require the manufacturer to provide justification for the price increase or the level set for a new drug that may have a significant impact on the cost benchmark. The Attorney General would issue a report to the HPC, CHIA and Legislature on its findings and the AG would also have the ability to seek injunctive relief if a manufacturer fails to comply.

Additionally, 30 days before increasing prices more than 10% or the introduction of a new drug whose price may threaten the cost benchmark, pharmaceutical and biotech companies would be required to submit a report to the HPC justifying the price, and include the following elements:

- An explanation of the price, including any proposed increases;
- Information on manufacturing costs for the drug;
- Research and development costs for the qualifying drug;
- Net profits attributable to the qualifying drug;
- Marketing and advertising spending on the qualifying drug, and
- Other information as deemed appropriate

Further, pharmaceutical and biotech companies would be required to submit data to the HPC as part of the cost trends hearing and to be called as witnesses to present testimony under oath.

Addressing Provider Prices

Strengthen the Performance Improvement Plan (PIP) Process

Sponsor: Representative Jim Arciero (D-Westford)

Any provider whose relative price exceeds the statewide average relative price or has a total medical expense in excess of the statewide average physician group health status adjusted total medical expense would be required to submit a PIP and outline a strategy for lowering its prices below the identified threshold.

Enhancing the Market Review Process
Sponsor: Representative David Nangle (D-Lowell)
Enhances the tools available to the Attorney General in overseeing the changes taking place in the delivery system through 93A powers by establishing that any provider that meets the criteria set forth in Chapter 224, which states that a provider that has or will likely have (as a result of a material change) a dominant market share, materially higher prices, and materially higher medical spending, has engaged in an unfair method of competition or unfair and deceptive trade practice. The AG may take action under 93A and may use the report of the HPC as evidence. When the HPC refers a report on a provider to the AG, the report creates a rebuttable presumption that the facts and conclusions in the report are true.

Strengthening the Market Impact Review Process
Sponsor: Representative David Nangle (D-Lowell)
Grants the HPC and the Attorney General with the authority to prohibit any proposed material change by a provider that has not been shown to meet a set of criteria, including lowering health care costs, cutting waste from the system, integrating care, and improving quality, and would otherwise be against the interest of the Commonwealth's consumers. Further, entities would be required to explain how they will direct care to the appropriate and lowest costing setting within its system and eliminate unnecessary duplication of health care services within the system.

Prohibition of Material Changes for Above Benchmark Providers
Sponsor: Representative David Nangle (D-Lowell)
Prohibits any provider that has been found by CHIA to exceed the Annual Cost Growth Benchmark for any given year or whose average relative price for the prior three years exceeds 1.0 from making any material change to its operations until the provider can demonstrate that its cost are below the Benchmark.

HPC Annual Review of All Material Changes
Sponsored by Senator Joan Lovely (D-Salem)
Requires providers that merge or affiliate to file an annual plan on how they have reduced costs and improved quality as part of their testimony to the HPC's annual cost trends hearings. For providers that fail to meet the goals outlined in their material change submissions, the HPC may require the provider to complete a corrective action plan and if the provider is deemed to be above the state benchmark it would be required to issue a refund to help employers and consumers.

Transparency in hospital margins
Sponsor: Representative Mark Cusack (D-Braintree)
Hospitals that report an operating margin in excess of 5 percent would be subject to an annual public hearing held by CHIA. Additionally, CHIA would be required to examine hospitals' efficiency by annually publishing the margins for hospitals for commercial, Medicare and Medicaid lines of business and utilizing data submitted as part of the Registered Provider Organization process to report on the underlying cost structure for hospitals. Additionally, academic medical centers (AMCs) would be required to report to CHIA and HPC information on the portion of revenues and expenses that are devoted to teaching and research and CHIA would be required to annually issue a report on the case-mix of hospitals and the relationship of case-mix to commercial reimbursements.

Ban hospital facility fees and surprise billing
Sponsor: Representative Paul Donato (D-Medford)
Prohibit hospitals from imposing facility fees for services provided in a hospital or at a facility not on a hospital's campus, prohibit surprise billing to consumers, and establish an out-of-network default rate of 100% of the Medicare fee schedule or a rate actuarially equivalent to 100% of Medicare for surprise billing.

The Affordable Health Plan
Sponsor: Senator Michael Moore (D-Shrewsbury)
The Affordable Health Plan would create a new product designed to provide immediate relief to small businesses by requiring health care providers and health insurers to share in the responsibility for holding down costs for

small businesses. To improve the functioning of this product, the state would be directed to seek authority to waive the product from the Risk Adjustment calculation.

Ensuring Care is Provided in the Most Appropriate Setting
Sponsor: Representative Thomas Golden (D-Lowell)
The HPC and CHIA would be required to conduct a study to estimate the potential savings associated with providing services in the community rather than within an AMC.

Out-of-Network Provider Default Rate
Sponsor: Representative Aaron Michlewitz (D-Boston)
Establishes a statutory default rate for out-of-network providers for emergency services. For Medicaid MCOs, the rate would be 100 percent of the Medicaid fee schedule or a rate equivalent to 100% of Medicaid and 100% of the Medicare fee schedule or a rate actuarially equivalent to 100% of Medicare for commercial health plans.

Rate Convergence
Sponsor: Representative Michael Finn (D-West Springfield)
Health plans and high-cost providers would be prohibited from entering or renewing a contract until those rates are lowered below a health plan's 80th percentile and establishes a default rate of the health plan's median relative price if the entities reach a contract impasse with health plans utilizing the savings to support lower paid providers and provide savings to consumers and employers. Providers over the 80th percentile would be brought down over a five-year period.

Hospital Billing and Licensure
Sponsor: Representative Paul Mark (D-Dalton)
Require each facility in a system to have separate license, tax identification number (TIN) and national provider identification (NPI) number for providers providing treatment at particular facility. Require hospitals that provide services at a new facility to obtain a new license for that facility and require new national provider identification numbers for providers delivering care at the facility. Require the new facility to negotiate separate rates from the parent facility. For hospitals that acquire a competing facility and reopen it using their outpatient license, the new facility shall be required to maintain the TIN for providers delivering service at that location. HPC should review such transactions as part of its market review authority.

Provider Joint Negotiations
Sponsor: Representative Mark Cusack (D-Braintree)
Prohibits providers that are a part of a system from including "all-or-nothing" provisions in contracts with commercial health plans and MCOs.

UR Approvals
Sponsor: Senator Linda Forry (D-Boston)
Would amend the state's Patient Bill of Rights (Chapter 141 of the Acts of 2000) to eliminate the requirement that health plans provide written notices of approvals to doctors and patients if they have already notified the provider that a procedure or service has been approved.

Promoting Evidence-based Behavioral Health Care:
An Act to Promote High Value and Evidence-based Behavioral Health Care
Sponsor: Senator Jen Flanagan (D-Leominster)
Requires the HPC to conduct a study on the variation of the practice of behavioral health providers, including adherence to evidence-based standards of care, quality measures, outcome measures, and access to the full continuum of care, and shall make recommendations for improving quality and outcomes for patients. The bill would also require accountable care organizations (ACOs) that are certified by the HPC to develop guidelines for the evidence-based delivery of BH services and report to CHIA and the HPC on outcomes. Requirements shall include 24/7 access, treatment and discharge planning, and improving communication with all treating providers and payers. Requires all ACOs that are certified by the HPC are required to report on the percentage of total payments that go towards BH providers.