Interim Industry, Business and Labor Committee Meeting
Thursday, February 4, 2010
Chairman – Rep. George Keiser

Chairman Keiser and members of the Committee, thanks for the invitation to join you in Grand Forks for this meeting. For the record, my name is Mike Schwab, the Executive Vice President of the ND Pharmacists Association. I was asked to provide information regarding the various pharmacy provisions that currently exist in health care reform. Since we do not know what the final version will look like, I have provided you with a chart showing some of the main pharmacy provisions broken down by House and Senate versions. I will review the chart below and then open it up for any questions you may have.

PROVISIONS	HOUSE VERSION	SENATE VERSION
Hospital Readmissions	**Section 1151.** Creates financial incentives for hospitals to prevent readmissions. Transitional services include an assessment of an individual's medication regimen and adherence. Other transitional care activities include providing a summary of medication orders upon discharge.	**Section 3025.** The Secretary must reduce payments that would otherwise be made to hospitals to account for excess readmissions to the hospital. No later than two years after the date of enactment, the Secretary shall make available a program for eligible hospitals to improve their readmissions rates through the use of patient safety organizations. **Section 3026.** Requires the Secretary to establish a Community Based Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries. An application to participate must include at least one care transition intervention which may include: • Initiate services for a high-risk Medicare patient no later than 24 hours prior to the discharge of the patient. • Arrange timely post-discharge follow-up services to the high risk patient with information regarding responding

APPENDIX G

		to symptoms that may indicate additional health problems or deteriorating condition. • Provide the high risk patient with assistance to ensure productive and timely interactions between patients and post-acute and out-patient providers. • Assessing and engaging the high risk patient through the provision of self-management support and relevant information about the patient condition. • **Conducting comprehensive medication review and management (including counseling and self-management support for those taking medications).**
Integrated Care Models	**Section 1301.** Establishes an Accountable Care Organization (ACO) Pilot Program to test different payment incentive models intended to promote accountability, encourage investment in processes that result in high quality and efficient care, and reward providers for high quality and efficient care. ACO's may involve services not compensated for by Medicare – such as a pharmacist's services. **Section 1302.** Establishing a medical home pilot program to assess the feasibility of reimbursing for qualified patient-centered medical homes. Proposes two models: 1) independent patient-centered; 2) community based. The Community based medical home model must employ community health workers that assist primary care providers in chronic care management services such as medication	**Section 2703.** Beginning in January 1, 2011, through a state plan amendment, a state may provide for medical assistance under Medicaid to eligible individuals with chronic conditions who select a designated provider, a team of health care professionals operating with such a provider, or a health team as the patients health home for purposes of providing the individual with home health services. Defines home health services as: • Comprehensive care management; • Care coordination and health promotion; • Comprehensive transitional care, including appropriate follow-up • Patient and family support; • Referral to community and social support services; • Use of HIT to link services when appropriate. Defines team of health care professionals as a team that may: include physicians, social worker, nurses, **pharmacists**,

	therapy management services. **Section 1312.** Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes primary care teams. An independence at home medical practice is comprised of an individual physician or nurse practitioner that providers care as part of a team that includes physicians, nurses, social workers, pharmacists and others with experience in providing home base primary care. **Section 1730A**. Directs the Secretary to establish a program to allow State Medicaid programs to pilot one or more of the models used in the Medicare ACO pilot program established in Section 1301 of the bill. **Section 1907**. Establishes within CMS a Center for Medicare and Medicaid Innovation to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in Medicare and/or Medicaid.	nutritionists, and other professions deemed by the state. **Section 3021.** Establishes within CMS a Center for Medicare and Medicaid Innovation the purpose of which is to test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished. The Secretary must select models to be tested from models where the Secretary determines there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical health outcomes and/or potentially avoidable expenditures. These models include but not limited to: • Contracting directly with groups of providers of services and suppliers to promote innovative care models, such as through risk-based comprehensive payment or salary-based payment; • Promote care coordination between providers of services and suppliers that transition health care providers away from a fee-for-service reimbursement system. • Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act. • Allowing states to test and evaluate fully integrating care for dual eligible individuals in the state. • Promoting greater efficiencies and timely access to outpatient services (such as a pharmacist or outpatient physical therapy services) through models that do not require a physician or other health professional to refer

		the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing state law. **Section 3022.** Groups of providers of services and suppliers meeting certain criteria may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an Accountable Care Organization (ACO). ACO's that meet quality performance standards are eligible to receive payments for shared savings. **Section 3502.** The Secretary must establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional teams to support primary care practices within the hospital services areas served by the eligible entities. A health team established pursuant to a grant or contract under subsection (a) must meet certain requirements including: • Establish contractual agreements with care providers to provide support services; • Provide support necessary for local primary care providers to coordinate and/or provide access to services such as providing access to pharmacist-delivered medication management services, including medication reconciliation services. • Transitional care assists with the development of discharge plans and medication reconciliation upon admission to and discharges from institutional settings.

		• Assure post-discharge care plans include medication management services as appropriate.
Medicaid Payment (AMP – Fix Legislation)	**Section 1728.** The generic reimbursement is set at 130% of the weighted average of Average Manufactures Price (AMP). Definition of AMP is redefined to more accurately reflect retail acquisition costs. Prices which are excluded through this "fix" legislation include but not limited to: • Customary promote pay discounts to wholesalers • Bona Fide service fees paid by manufacturers • Reimbursements for unsalable returned goods • Sales, discounts or rebates provided to pharmacy benefits managers, health organizations, mail order pharmacies or insurers because these rebates, discounts or sales are not open to the public nor passed onto the pharmacies or plan members. The new Medicaid benchmark won't be implemented until January 2011 and the current (pre-DRA) benchmark will be used until then.	**Section 2503**: The federal upper limit is set at no less than 175% of the weighted average AMP. Expands the disclosure requirement to include monthly weighted average AMP's and retail survey prices. Definition of AMP is redefined to more accurately reflect retail acquisition costs. Prices which are excluded through this "fix" legislation include but not limited to: • Customary promote pay discounts to wholesalers • Bona Fide service fees paid by manufacturers • Reimbursements for unsalable returned goods • Sales, discounts or rebates provided to pharmacy benefits managers, health organizations, mail order pharmacies or insurers because these rebates, discounts or sales are not open to the public nor passed onto the pharmacies or plan members. Amends the law so that a generic must be widely available in the United States, not just a single state. Requires public posting of the monthly weighted average AMP and the average retail survey price determined.
Medicare Part D Coverage Gap	**Section 1181.** Eliminates the Part D coverage gap (donut hole) beginning with a $500 reduction in 2010 and completing the phase-out by 2019. Funds to accomplish this are raised by requiring prescription drug manufacturers to provide Medicaid rebates for drugs used by dual-eligible patients. **Section 1182.** For brand name drugs, reduces the charge to patients in the donut hole to 50% while counting 100% of the	**Section 3301.** Beginning July 1, 2010, eligible beneficiaries would automatically receive a 50 percent discount off the negotiated price for brand-name prescription drugs that are covered under Part D and covered by their plan's formulary or are treated as being on plan formularies through exceptions and appeals processes. Allows 100% of the negotiated price of discounted drugs (excluding dispensing fees) to count toward

	drug cost towards the patient's true out-of-pocket costs (Troop).	the annual out-of-pocket threshold that is used to annually define the coverage gap.
Medicare Part D "Negotiations Clause"	**Section 1186**. Requires the Secretary to negotiate with the pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to a Medicare Part D prescription drug plan for covered Part D drugs.	Senate has no requirement or like provision included
Medication Therapy Management (MTM Pilots)	**Section 2528**. Directs the Secretary to establish a program to provide grants to eligible entities to implement medication management services (MTM) provided by licensed pharmacists, as a collaborative approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. Services include assessing a patient's medication therapy, developing an action plan, working with the rest of the care team to implement an the action plan, monitoring the patient, and providing education and training to enhance the understanding and use of medications taken by the patient. The services are provided to targeted individuals who: 1) take 4 or more prescribed medications; 2) take any "high risk" medications, 3) have 2 or more chronic diseases; or 4) have undergone a transition of care, or other factors determined by the Secretary.	**Section 3503**. The Secretary shall establish a program to provide grants or contracts to eligible entities to implement medication therapy management (MTM) services provided by licensed pharmacists as a collaborative approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. The Secretary shall commence such a program under this section not later than May 1, 2010. Services include assessing a patient's medication therapy, developing an action plan, working with the rest of the care team to implement an the action plan, monitoring the patient, and providing education and training to enhance the understanding and use of medications taken by the patient. MTM services provided by licensed pharmacists under a grant or contract awarded under subsection (a) shall be offered to targeted individuals who: 1) take 4 or more prescribed medications (including over the counter medications and

		dietary supplements); 2) Take any "high risk" medications; 3) Have 2 or more chronic diseases; or 4) Have undergone a transition of care, or other factors as determined by the Secretary, that are likely to create a high risk of medication-related problems.
PBM Transparency	**Section 233.** An adopted amendment would require PBMs to disclose: 1) An estimate of average per-prescription payments, made to mail order facilities and retail pharmacies, versus the average per-prescription amount that the PBM received from the plan for these prescriptions. 2) The volume of prescriptions under the contract that are filled via mail order and at retail pharmacies. 3) An estimate of the average payment, per prescription, received from pharmaceutical manufacturers, factoring in all the various types of rebates, price concessions, discounts and other payments the PBM receives from manufacturers. 4) The overall percentage of generic drugs dispensed under the contract at retail and mail order, and the percentage of cases in which a generic drug is dispensed when available. 5) The number of times when a prescription is switched to a more costly version. **Section 1451**. Measures physician providers (which includes pharmacists and pharmacies) financial relationships with	**Section 6004**. Not later than April 1 of each year (beginning in 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary the following information with respect to the preceding year: The PBM will be required to confidentially disclose to the Secretary and plans information on: (1) The percent of all prescriptions that are provided through retail pharmacies compared to mail order pharmacies, and the generic dispensing and substitution rates in each location; (2) The aggregate amount and types of rebates, discounts and price concessions that the PBM negotiates on behalf of the plan and the aggregate amount of these that are passed through to the plan sponsor; (3) The average aggregate difference between the amount the plan pays the PBM and the amount that the PBM pays the retail and mail order pharmacy. There are not mandates that these rebates be passed through, only that they be reported to plans.

	manufacturers and distributors of drugs, devices, or supplies covered by Medicare, Medicaid, and Children's Health Insurance Program. Requires manufacturers and distributors to report "gifts" they have given to health care providers.	**Section 6005**. Penalties apply to health benefits plan or PBM that fails to provide required information on a timely basis or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under that section.

Respectfully Submitted,

Mike Schwab
Executive Vice President
NDPhA

HR POLICY ASSOCIATION
The Association of Chief Human Resource Officers

Effective Dates of Proposed Health Care Reforms

The health care legislation being considered by the House of Representatives and the Senate have a rolling series of effective dates starting immediately upon passage of the legislation and running all the way into 2018. The following chart has been assembled to provide an overview on what becomes effective when.

Effective 2010:

- House provisions
    - The time health plans can look back for pre-existing conditions is reduced from 6 months to 30 days
    - Insurers must disclose new health premium rate increases
    - Individuals may maintain COBRA coverage until Health Exchange is in effect
    - Plans must pay for reconstructive surgery for children with deformities
    - Employers prohibited from reducing retiree health benefits for retirees, unless the same reduction is made to active employees' benefits
    - So called CLASS ACT is implemented in order to provide public long-term disability insurance, which would supplement Medicaid or private LTD benefits
    - Funding to community health centers significantly increased
    - Funding for preventative health services at local or community level
    - Primary care physicians and training for nurses expanded
    - Grants for employer wellness programs established
    - States to receive grants for immediate health care reform initiatives
    - Consumer Operated and Oriented Program (CO-OP) created to facilitate the establishment of a non-profit, member run health insurance cooperative through the Exchange
    - States can extend Medicaid coverage to HIV infected individuals
    - Reimbursement rate for Medicaid begins to be raised up to Medicare levels for primary care physicians
    - States required to provide 12-month continuous eligibility for children in CHIP
    - HHS Secretary required to set standards for expanding Medicare accountable organizations and medical home pilot programs and to test such programs in a variety of settings and regions

- Senate provisions

  - The use of some annual coverage limits prohibited
  - Plans must provide first dollar coverage for preventative care
  - Plans must annually report the share of premium dollars spent on health care and provide rebates to participants for excessive loss ratio (2010-2013)
  - Process to be established for reviewing health coverage premium increases
  - Consumer Operated and Oriented Program (CO-OP) created to facilitate the establishment of a non-profit, member run health insurance companies in all 50 states and DC
  - Insured plans must establish an effective appeals process for coverage determinations and claim denials with states to set standards for effective appeals process
  - Community First Choice Option established to permit states to offer home and community based services to disabled through Medicaid
  - New quality requirements established for nonprofit hospitals
  - Non-profit Blue Cross & Blue Shield required to have a medical loss ratio of 85 percent or higher to take advantage of tax benefits under Section 833
  - Medicare payment protections established to increase reimbursements for health care providers in rural areas
  - HHS to receive additional resources to develop a national quality strategy
  - HHS Secretary to establish website through which residents of any state may find affordable coverage options in the state
  - $2.3 billion non-deductible annual fee imposed on the pharmaceutical manufacturing industry and is to be allocated by market share
  - $2 billion non-deductible annual fee imposed on the medical device manufacturing sector and is to be allocated by market share
  - $6.7 billion non-deductible annual fee imposed on the health insurance sector and is to be allocated by market share
  - 10 percent tax imposed on indoor tanning

- House and Senate provisions

  - Insurance policies prohibited from being rescinded when an individual gets sick
  - Uses new discounts from drug manufacturers to provide a 50 percent discount on brand name drugs in the "donut hole" under Medicare Part D
  - Lifetime dollar limits for coverage prohibited
  - Individuals up to age 26 (Senate) and 27 (House) not otherwise covered may remain on parents coverage
  - Temporary reinsurance assistance established for employers providing early retiree health benefits (ages 55-64)

- $5 billion fund created to finance immediate insurance for uninsured due to pre-existing conditions
- Standards for financial and administrative transactions adopted to promote simplification

Effective January 1, 2011:

- House provisions
  - Low-income individuals to have more access to subsidies for Part D drug benefits
  - Cost-sharing for services in Medicare Advantage limited to that of traditional Medicare services
  - Health Benefits Advisory Committee to submit report on recommended essential benefits package to HHS Secretary
  - 5.4 percent tax imposed on high income individuals
  - 2.5 percent excise tax imposed on the first taxable sale of medical devices
  - The implementation of the worldwide interest allocation repealed
  - Second generation biofuel producer tax credit restricted

- Senate provisions
  - Employers must report the value of health care benefit provided on each employee W-2
  - Tax penalty increased to 20 percent for non-qualified expenses under health savings tax vehicles such as Health Savings Accounts
  - The amount of contribution to Flexible Spending Accounts limited to $2,500
  - Employer deductions eliminated for subsidies currently received for providing prescription drug plans for Medicare Part D retirees
  - 10 percent Medicare reimbursements paid to primary care and surgeons
  - New CMS Innovation Center established to test payment and service delivery models
  - Medicare coverage for annual wellness visit and cost sharing for prevention is prohibited
  - Community Care Transitions Program established to provide transition to high-risk Medicare recipients
  - Access to primary care and nursing increased through Medicare Graduate Education Program
  - Small business tax credit to begin for qualified employers purchasing health care for their employees
  - Simple Cafeteria Plans established and available for small businesses
  - Transition to competitive bidding process for insurers in Medicare Advantage

Effective January 1, 2012:

- House provisions
    - Personal asset limits for Medicare Savings Program and Part D increased
    - Limitations on Medicare coverage for drugs for kidney transplants lifted
- Senate provisions
    - Businesses paying providers of property or services of $600 or more per year required to file reports with IRS and providers specifying the amounts paid
    - Deductibility of executive compensation under Section 162(m) limited to $500,000 for insurance providers if 25 percent or more of gross income comes from health plans that meet the minimum creditable coverage requirements
    - Physician payment reforms implemented to increase payment for primary care physicians
    - Hospital value-based purchasing program established to provide incentives to acute care hospitals for quality outcomes
    - CMS tracks hospital readmission rates certain high cost conditions and hospitals with the highest readmission rates to be penalized
    - Funding for community health centers increased

Effective January 1, 2013:

- House provisions
    - All individuals required to obtain acceptable health care coverage or pay penalty of 2.5 percent of their income
    - Contribution amount to Flexible Spending Arrangement limited to $2,500
    - Employers required to offer health coverage to employees (and families) with minimum contributions and standards or pay an 8 percent payroll tax; employers with annual payrolls below $500,000 are exempt from the employer mandate
    - Small businesses that provide health coverage to employees are eligible for a tax credit up to 50 percent of the amount paid for coverage (credit lasts 2 years)
    - Insurance companies prohibited from refusing to sell or renew policies on the basis of an individual's health
    - Exclusion of coverage because of pre-existing conditions is prohibited
    - Insurance companies cannot charge higher premiums based on health status, gender, etc., and premiums can vary only on age (no more than 2:1), geography, and family size

- Coverage through the Health Insurance Exchange provided to the uninsured and to employees of employers with 25 or fewer employees
- Public health plan option established and is only available in the Health Insurance Exchange
- Health Insurance Affordability Credits to purchase insurance in the Exchange provided to individuals with income above Medicaid eligibility and below 400 percent of poverty who are not offered acceptable health coverage

- Access to Medicaid expanded to all individuals under 65 with incomes up to 150 percent of poverty
- Medicaid coverage provided for up to 60 days for newborn babies without proof of insurance

- Senate provisions

  - 40 percent excise tax imposed on so called "Cadillac health plans"
  - Income threshold increased from 7.5 to 10 percent in order for individuals to deduct medical expenses
  - Medicare hospital insurance tax rate increased by .05 percent on individuals earning $200,000 ($250,000 for married filed jointly)
  - Physician value-based payment program implemented for treatment of Medicare beneficiaries
  - Standards for electronic exchange of health information is adopted
  - National pilot program on payment bundling established to encourage physicians, hospitals, and post-acute care providers to work together in order to create savings for Medicare

- House and Senate provisions

  - Tax deduction for employers for the subsidy that they receive for continuing to provide a qualified retiree drug benefit is eliminated

<u>Effective January 1, 2014</u>:

- House provisions

  - Individuals offered employer-sponsored coverage may opt-in to the Health Insurance Exchange if the employer's premium is equal to or greater than 12 percent of family income
  - Health Insurance Exchange expanded to include employers with 50 or fewer employees
  - Medicare Advantage program must spend at least 85 percent of premium on health care

- Senate provisions
    - Individuals required to obtain acceptable health care coverage or pay an annual tax penalty of $95 graduated up to $750 by 2016
    - Employers with 50 or more employees must offer health coverage to employees (and families) or pay an annual $750 penalty for each full-time employee
    - Employers with more than 200 employees must automatically enroll employees into employer-sponsored plans although employees may opt out
    - Employers with eligibility waiting periods over 60 days must pay $600 annually for each full-time employee subject to the waiting period
    - Health Insurance Exchanges created in each state
    - Insurance companies prohibited from refusing to sell or renew policies on the basis of an individual's health
    - Exclusion of coverage because of pre-existing conditions is prohibited
    - Insurance companies cannot charge higher premiums based on health status, gender, etc. and premiums can vary only on age (no more than 3:1), geography, and family size
    - Tax credits to purchase insurance through the Exchange are provided to individuals with income above Medicaid eligibility limit and between 100- 400 percent of poverty who are not offered acceptable coverage
    - Access to Medicaid expanded to all individuals under 65 with incomes up to 133 percent of poverty level
    - Competitive bidding process completed for insurers in Medicare Advantage
    - Temporary reinsurance program (2014-2016) established to collect payments from health insurers to provide payments to plans in the individual market that cover high-risk individuals

Effective January 1, 2015:

- House provisions
    - Health Insurance Exchange expanded to employers with 100 or fewer employees
- Senate provisions
    - Independent Medicare Advisory Board established to submit proposals to Congress regarding the solvency of Medicare

Effective January 1, 2017:

- Senate provisions
    - States may permit businesses with more than 100 employees to purchase coverage in the Health Insurance Exchanges

Effective January 1, 2018:

- House provisions
    - Employer-sponsored plans must meet the acceptable coverage standards (grace period ends)