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House Approves Sweeping Health Care Legislation

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On Tuesday, June 19, 2018, the Massachusetts House of Representatives passed comprehensive health care legislation by a vote of 117-32. The bill, titled *The Honorable Peter V. Kocot Act to Enhance Access to High Quality, Affordable, and Transparent Health Care in the Commonwealth*, (**HB4617**) was approved after the House considered 174 amendments proposed to the legislation initially released by the Health Care Financing Committee, ultimately approving 24. The House's approval of the legislation follows the Senate's passage of its own health care bill (**SB2202**) last November (see our coverage of the Senate bill **here**).

The bill notably levies assessments on insurers and large hospitals to generate funds for stabilizing community hospitals, increases transparency around pharmaceutical drug pricing, erects protections for consumers against out-of-network billing, and removes barriers to the use of telemedicine. Below is a summary of the bill's main provisions:

Hospital Assessment

- The bill includes assessments of $247.5 million on insurers and $90 million on certain large hospitals to fund grants for community hospitals. The funds generated through the assessments would be deposited into the Community Hospital Reinvestment Trust Fund. Assessments may be paid in one lump sum or over a three year period beginning on June 30, 2019. During debate, the House adopted an amendment reducing the size of the assessments – $330 million on insurers and $120 million on large hospitals – proposed in the Health Care Financing Committee's bill.
- The assessment applies to hospitals with more than $700 million in total net assets in FY2017 and a public payer mix below 60 percent in FY2016. The assessment on each hospital will be levied in proportion to a hospital's operating surplus in FY2016 as a share of total operating surpluses for all hospitals subject to the assessment. A hospital's assessment may be reduced by up to 50 percent if the hospital receives more than 25 percent of its reimbursement for Medicaid and the hospital's net assets do not exceed $1 billion.
- The insurer surcharge is paid based on an entity's total payments for hospital services as a share of all such payments by surcharge payers.

Pharmaceutical Drugs

- Effective 2020, the Center for Health Information and Analysis (CHIA) is authorized to report annually on outpatient prescription drugs that account for a significant share of state spending as well as those that experienced an increase in Wholesale Acquisition Costs (WAC) greater than 25 percent over the previous year's cost. CHIA is directed to establish an annual list of 10 such prescription drugs. Manufacturers of those drugs must disclose relevant information to CHIA concerning the factors that contributed to the increase in WAC. CHIA must publish an annual report that analyzes the disclosed information.
- CHIA is directed to conduct an analysis of pharmacy benefit manager (PBM) data, including: (1) year-over-year WAC changes; (2) year-over-year trends in formulary, maximum allowable costs list & cost-sharing design, including establishment & management of specialty product lists; (3) information on discounts, utilizations limits, rebates, manufacturer administrative fees, and other financial incentives or concessions related to pharmaceutical products or formulary programs; (4) information on aggregate amount of payments made to pharmacies owned or controlled by the PBM and the aggregate amount of payments made to pharmacies that are not owned or controlled by the PBM; and (5) other information deemed reasonable and necessary by CHIA.
- PBMs are added to the list of health care entities represented on the HPC Advisory Council.
- CHIA and the Health Policy Commission (HPC) are authorized to assess a fee on pharmaceutical manufacturing companies and PBMs to cover the costs of these analyses.
- Three pharmaceutical companies, including one publicly traded company, a generic drug company, and a company in existence for less than ten years, are required to testify at the HPC's annual cost trends hearings on factors underlying prescription drug costs and price increases. Information resulting from the testimony is to be incorporated in the HPC's annual cost trends report.
- Cost trends data from pharmaceutical manufacturing companies and PBMs is included in the information to be examined by the HPC in connection with annual public hearings on the health care cost growth benchmark.
- The HPC is authorized to conduct an annual study of pipeline drugs, including brand, generic, or biosimilar drugs that may significantly impact state costs.

- Responsibility for the academic detailing program is transferred from the Department of Public Health (DPH) to the HPC. The program, which is to be established by July 1, 2019, must be designed to improve drug prescribing practices, improve communication with MassHealth providers, and reduce costs related to unnecessary prescriptions.
- Pharmaceutical manufacturing companies and PBMs are included among the entities to be consulted by CHIA in connection with the adoption of rules and regulations.
- Pharmacies are required to inform customers that they may request the retail price for any pharmaceuticals they plan to purchase. If the retail price is less than the cost-sharing amount, the customer can choose to pay the retail price. Pharmacists must comply regardless of contractual obligations, and the pharmacist can submit a claim to the consumer's health plan if the medication is covered.
- Contracts between pharmacy benefits managers and pharmacies are prohibited from prohibiting/restricting the right of a pharmacist to provide an insured person with information about their cost share for a prescription or a more affordable alternative. Contracts are also prohibited from allowing pharmacy benefits managers from charging a fee related to the adjudication of a claim.
- Several amendments relevant to the pharmaceutical industry were withdrawn during debate, including: amendment #3 on formulary posting; amendment #9 on medication management; amendment #25 on data exemptions from disclosure; amendment #53 on patient adherence to medication; amendment #79 on non-medical switching; amendment #112 on direct-to-consumer advertising; amendment #115 on maximum allowable drug costs; amendment #120 on biosimilar applications; amendment #128 on wholesale acquisition cost floors; amendment #145 on technical corrections; amendment #150 on the section 1115 waiver; and amendment #164 on prescription drug transparency.
- A technical amendment (amendment #174) was adopted that establishes ongoing funding for the Community Hospital Trust Fund starting in 2023 by directing 10 percent of the amounts in the Marijuana Regulation Fund and renewing a $10 million annual transfer from CHIA.

Out-of-Network/Surprise Billing

- Out-of-network billing protections are extended to instances where a patient chooses to receive services from an out-of-network provider.
- Carriers must disclose information on out-of-network service costs and cost sharing in the Explanation of Benefits.
- In the case of a network provider that contracts to participate in the carrier's network but is out-of-network in an enrollee's specific health benefit plan, emergency services will be reimbursed at the carrier's in-network contracted rate. For all other out-of-network services, if the provider failed to meet the consumer protection requirements under surprise billing, the out-of-network provider will be paid the greater of: (A) 115 percent of the carrier's average rate, or (B) 125 percent of the Medicare rate.
- The Department of Insurance (DOI) is directed to establish a fair and efficient dispute resolution process for emergency or surprise bills.

Telemedicine

- Group Insurance Commission (GIC) plans are required to cover telemedicine services, and the GIC is required to ensure that carriers or third-party administrators use the Standard Quality Measure Set (SQMS) established by CHIA.
- The Board of Registration in Medicine is directed to develop regulations regarding the appropriate use of telemedicine.
- MassHealth is allowed to provide coverage for appropriate telemedicine services.
- Individual insurance policies are prohibited from declining coverage for services due to the fact that the services were delivered by telemedicine.

HPC/CHIA Mandates

- The bill requires that any legislation aimed at changing the scope of practice of a health care provider be reviewed and evaluated by CHIA and be subject to a recommendation by the HPC.
- The Health Planning Council within the Executive Office of Health and Human Services is eliminated and reestablished under the HPC.
- Monitoring the location and distribution of health care services and resources is added to the charge of the HPC.
- Proposals that appropriately redirect inpatient/post-acute care to community settings are added to the list of proposals that the HPC can consider for the use of Health Care Payment Reform Funds.
- Control of the Prevention and Wellness Trust Fund is transferred from DPH to the HPC, and the allowable expenditures for the fund are amended.
- The Prevention and Wellness Trust Fund is designated an eligible source of CHIA assessment funds.
- CHIA is directed to develop and adopt a uniform method for communicating information on the assignment of tiers to health care providers, health care services, PBMs, and carriers.
- CHIA is directed to annually evaluate and report on the Prevention and Wellness Trust Fund.
- Requirements and penalties related to information disclosures to CHIA are amended to increase weekly penalties for failure to comply from $1,000 to $5,000 and the maximum penalty from $50,000 to $200,000.

Other Provisions

- Licensing fees for Physicians, Nurses, Pharmacists, Dentists, Genetic Counselors, Optometrists, and Podiatrists are increased by 25 percent over the amount charged on July 1, 2017, and again by 25 percent over the amount charged on July 1, 2019.
- DOI rate approval processes are to include warranted and unwarranted factors related to price variation. If a contract is deemed to be influenced by unwarranted price variation, DOI is to refer the matter to the HPC for a PIP.

- Three changes are made to the Accountable Care Organization (ACO) certification process: (1) the care coordination standard is amended to replace references to success in reducing “adverse events and emergency room visits” with “adverse events, rates of institutional post-acute care, and unnecessary emergency room visits or extended emergency department boarding;” (2) references to the Prevention and Wellness Trust Fund are amended to reflect the move under HPC; and (3) a new standard is added for certification of evidence-based delivery programs.
- Rule or regulation changes proposed by the Board of Registration in Medicine must be approved by DPH. Rules or regulations not approved by DPH within 30 days are deemed disapproved.
- Changes are made to the Community Hospital Reinvestment Fund limiting the relative price eligibility standard for payment to the 90th percentile (currently the 120th percentile), directing payments to eligible acute care hospitals, and requiring an annual expenditure of at least $15 million from the fund to community health centers.
- A Mobile Integrated Health Care Trust Fund is created to be administered by DPH to support administration and oversight of the mobile integrated health program.
- Changes are made to the mission of the e-Health Institute directing it to partner with the health care and technology community to accelerate digital health sector activity, expanding the scope of the institute’s activities to include the advancement of the commonwealth’s economic competitiveness, and authorizing the institute to prioritize improving the Commonwealth’s use of electronic health records.
- The DPH is directed to establish rules, regulations, and standards for the licensing of office-based surgical centers and urgent care centers. The bill sets certain requirements for these rules, including: licenses are to be issued/renewed for two year terms; DPH can suspend or revoke licenses at its own discretion in the best interests of health, safety, or public welfare; licensure violations are subject to fines of $10,000 per day; and DPH may issue provisional licenses to urgent care centers meeting certain accreditation/certification requirements.
- MassHealth is required to disregard income up to 150 percent of the federal poverty line for the purpose of determining eligibility for Medicare Savings or Medicare Buy-In programs.
- DOI is directed to issue a report at least once every five years on the performance of the merged non-group and small-group health insurance market.
- Special commissions are created to study and make recommendations on how to license foreign-trained medical professionals and examine factors that contribute to unnecessary administrative costs in the health care system.
- An emergency task force is created to review the financial sustainability of nursing homes in the Commonwealth.
- Amendments of interest to the hospital industry adopted include: amendments #54, 55, and 56 related to default rates and notifications of patients with respect to out-of-network billing; amendment #118 establishing a task force to develop recommendations to improve collection and dissemination of provider information, streamline the interactions between providers and payers, enhance updates to provider information, and research the feasibility of making real-time updates to provider directories; and amendment #125 that would establish pre-hospital care protocols, evaluate and design designation models for Massachusetts hospitals treating stroke, and design a new reporting system to evaluate stroke care.
- Amendments of interest to the hospital industry that were withdrawn include: amendment #38 aligning facility-fee notification standards with existing Medicare standards; amendment #116 prohibiting insurers from passing through any portion of their new surcharge assessment to self-insured acute care hospitals; amendment #127 on telemedicine; amendment #135 adding a hospital member to the HPC; and amendment #64 altering ICU penalties.

Next Steps

The House and Senate will now attempt to resolve the differences between their respective bills, which are significant, before the end of the legislative session on July 31. Negotiations on reconciling the bills will take place in a six-member conference committee whose members have yet to be named. Any final legislation that the House and Senate ultimately approve must be signed by Governor Charlie Baker.

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