HRI as we see it

Weekly insights from the Health Research Institute pwc.com/hri

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This week's regulatory and legislative news

- **Income test added to debt deal, but ACA stays largely intact**
- **New Employers Centers of Excellence Network draws big-name partners**
- **Federal Agency for Healthcare Research and Quality provides insight into adverse drug events**
- **California governor's veto improves biosimilar prescribing options**
- **Some regions more attractive than others to ACOs**
- **Reduced hospital payments could squeeze medical care**
- **2014 Medicare open enrollment begins, some changes in health plan design**

Income test added to debt deal, but ACA stays largely intact

Insurance exchanges will be under added pressure to verify the eligibility of individuals who apply for premium tax credits or reduced cost sharing under legislation that keeps the government funded until January 15 and raises the debt ceiling until February 7. The provision requires HHS to verify that each exchange has a process to check a person's eligibility for discounted coverage, and it also requires government auditors to submit a report detailing the effectiveness of those procedures. The HHS report is due to Congress by year's end, while the OIG report is due July 1, 2014.

HRI impact analysis: Exchange personnel will need to be extra vigilant as they assist those who are shopping for coverage on the online marketplaces. The legislation, which passed Congress on Wednesday and was signed into law less than 24 hours later, does not detail how exchanges conduct the verification process—only that they have one in place. But documentation will be critical, especially as the federal government works through some of the early glitches that have hindered the purchasing process. Additionally, lawmakers still need to address legislation that holds off a double-digit cut in Medicare physician payments and extend about a half-dozen provisions that aid rural providers.

New Employers Centers of Excellence Network draws big-name partners

Direct employer-provider contracting has quickly gained steam as a way for employers to control costs and improve employee health outcomes. Now, some are taking it further: the Pacific Business Group on Health, a non-profit business coalition, is joining up with big-name employers such as Lowe's and Walmart to launch the Employers Centers of Excellence Network. The network will offer no-cost hip and knee replacements to employees at four designated "centers of excellence" across the US, and will include travel and living expenses for both patients and caregivers.

HRI impact analysis: The new Employers Centers of Excellence Network is a step toward a national "high-performance" network that brings together multiple employers and providers across the US. Both Lowe's and Walmart have independently pursued contracts with high-performing providers before. In HRI's report *Behind the Numbers 2014*, Lowe's indicated that its heart surgery program with one provider had a 98% satisfaction rate and saved the company money through its bundled payment model. While large companies are at the vanguard of this new movement, it could conceivably spread to mid-sized and smaller employers as well.

Federal Agency for Healthcare Research and Quality provides insight into adverse drug events

In a new statistical brief, the Agency for Healthcare Research and Quality examines patient and hospital characteristics linked with adverse drug events. Events may include side effects, improper prescriptions, or administration of the drug. As a result, patients stay in the hospital longer, resulting in increased cost, utilization, and risk of death. Those most at risk were individuals aged 65 and older. The study also reported variability in the incidences of adverse drug events. Government-owned hospitals reported 35.6 incidents per

10,000 discharges compared to private, not-for-profit hospitals at 54.5. At the same time, rural hospitals and urban teaching hospitals showed little difference in rates (52.4 and 53.5, respectively).

HRI impact analysis: While drugs are reviewed and approved for safety and efficacy, some adverse events may be the result of individual health characteristics or organizational errors. Hospitals expend considerable energy every year to improve safety, but workplace and cultural issues—such as poor care coordination and fear of reporting errors—are more difficult to solve. The report says that patients, increasingly keen on becoming joint decision makers in their care, can be engaged more in their treatment. Doing so encourages patients and their caregivers to speak up when they sense something isn't right.

California governor's veto improves biosimilar prescribing options

While the drug industry waits for final FDA guidance on biosimilars—equivalents of specialty drugs derived from living organisms— some state governments are debating whether to regulate the molecules. Over a month after the California state legislature approved a bill requiring pharmacists to notify physicians when a biosimilar is substituted for a branded biologic, California Gov. Jerry Brown vetoed the bill. However, comparable laws are on the books in Utah, Oregon, North Dakota, Florida, and Virginia.

HRI impact analysis: The veto puts California's pharmacists and state policy back on the side of insurance plans, retirement benefit managers, and generic drugs manufacturers. All three benefit from the promise of lower drug costs. A recent study of the biosimilars experience in Europe, which has had an approval mechanism in place since 2005, concludes that biosimilars cost about 70% less than the original drug compared to traditional generic drugs, which are typically 20% less. In 2012, the FDA released three draft guidance documents and also earmarked about $128 million in user fees in the 2012 FDASIA law to review biosimilar submissions. During the government shutdown, the FDA stated that the agency did not have access to biosimilar user fees and suspended all reviews. Specialty biologic drug costs are an inflationary factor in this year's medical cost growth rate, offsetting cost reductions from generic drug use.

Some regions more attractive than others to ACOs

Accountable Care Organizations (ACOs) are forming more quickly in the Midwest and Northeast—regions with a greater portion of risk-sharing payments, integrated health systems, and large primary care groups—according to new research published in the journal *Health Affairs*. Most ACOs formed in regions where a majority of hospitals were affiliated with a health system. In low ACO areas, the study reports, physician partnerships and hospital joint ventures were in the minority.

HRI impact analysis: An understanding of where ACOs develop—and the reasons that drive those decisions—could help spur more growth in the relatively new care delivery models, potentially lowering costs. The study is based primarily on Medicare's Shared Savings and Pioneer ACO models, but also includes 77 private sector efforts. While the Northwest may have little ACO development, systems such as Sutter Health, Kaiser Permanente, and Washington's Group Health Cooperative, which operate in an ACO-like structure, have thrived under the model. What's more, recent mergers such as the one between Baylor Health Care System and Scott & White Healthcare could also lead to greater ACO development because of its massive reach and physician-hospital alignment.

Reduced hospital payments could squeeze medical care

New research conducted by the Center for Studying Health System Change suggests that the ACA's hospital payment cuts could lead to reduced inpatient utilization and fewer services to seniors. "Hospitals do not appear to leave beds empty in response to Medicare price cuts," the report states. "Instead, they appear to reduce their scale of operations by shutting down beds." Slowing Medicare price growth could result in reductions to discharge rates and shorter length of stays—trends that when taken together could save the federal government tens of billions of dollars, according to the report.

HRI impact analysis: It's unclear how reduced inpatient utilization will impact patient care and health outcomes. The study found that when faced with Medicare cuts, hospitals changed how they operate, primarily by closing beds. The results run counter to the idea that hospitals would increase volume as a means to make up for lost Medicare payment.

2014 Medicare open enrollment begins, some changes in health plan design

The 2014 Medicare open enrollment period officially began on Tuesday, and some seniors will see changes in the cost and benefits of their Medicare plans. Average monthly Medicare Advantage premiums will go up by $1.64 to $32.60, an increase of 5.3%; however, both Medicare Advantage and prescription drug plans show

significant variation in premium increases and benefit design changes such as co-insurance, deductibles, and types of drugs covered.

HRI impact analysis: Although enrollees in current Medicare plans will receive a notice about plan changes prior to open enrollment, some may not fully understand the changes to their benefit designs—especially when it comes to prescription drugs. Insurers could see a bump in inquiries when seniors try to use their benefits.

Upcoming events & deadlines

- **October 23 –** PwC webinar on the positioning of insurers within health insurance exchanges and the impact of narrow networks on hospitals
- **October 30 –** Webinar on impact of health insurance exchanges with the Medicaid Health Plans of America
- **November 12 –** Webinar on the effects of health insurance exchanges on hospitals, including strategy for new exchange customers and research by the Health Research Institute
- **November 18** – Comments due on proposed rule for new prospective payment system for Federally Qualified Health Centers
- **November 25 –** Comments due on the proposed rule on the Basic Health Program. The program provides states the option to establish a health benefits coverage program for low-income individuals who would otherwise be eligible to purchase coverage through health insurance exchanges.
- **December 15 –** Deadline for individuals to enroll in state exchange plans in order to secure coverage beginning on January 1.

Quote of the week

"Just being bilingual isn't enough," said Frank Rodriguez, executive director and founder of the Latino Healthcare Forum, which hopes to use community outreach workers known as *promotoras* to reach more than 50,000 uninsured people in the Austin area over the next six months. "What we're doing is recruiting people from the community that know the norms and the customs of the people."

In the news

A recent article from *Kaiser Health News* discusses how health insurance exchanges that are managed by the state—rather than by the federal government—are making more progress than federal exchanges, mainly due to the increased funds available at the state level.

Factually correct

$455 billion – the amount the global medical technology market is expected to grow, from 2011 to 2018. There is less growth anticipated in developed countries.

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