ASMBS Advocacy Report

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HEADLINES:

Obesity Advocates Visit White House
CMS to Tweak Health Exchange Regulations

Obesity Care Continuum Visits White House on Treat and Reduce Obesity Act

Member groups of the Obesity Care Continuum joined with the Campaign to End Obesity and the Medicare Part D Coalition in meeting with members of President Obama's Domestic Policy Council to discuss the Treat and Reduce Obesity Act (TROA) – legislation that would provide Medicare recipients and their health care providers with meaningful tools to treat and reduce obesity by improving access to obesity screening and counseling services, and new prescription drugs for chronic weight management.

The purpose of the meeting was to inform White House staff regarding the tremendous bipartisan support of over 120 members of the House and Senate for CMS to implement the key aspects of the TROA through administrative means. Obesity advocates highlighted how CMS has taken administrative actions in the past that serve as precedent for the agency to act on repealing the prohibition on Medicare Part D coverage of FDA-approved obesity drugs as well as expanding the list of eligible providers that could

provide intensive behavioral therapy services. The hope is that President Obama will include language in his budget plan for fiscal year 2016 that will support this administrative change.

CMS Issues Proposed Regulations for State Health Exchanges

On November 26, 2014, the Centers for Medicare & Medicaid Services (CMS) issued proposed regulations entitled, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016." Among other things, the notice includes proposed changes for state exchanges surrounding essential health benefits, prescription drug coverage and provider network adequacy.

Following are the highlights of the proposed changes:

States May Select New EHB Benchmark Plan for 2017 & QHPs will Have to Provide Comprehensive Coverage Information

CMS is proposing that states would be allowed to select a new benchmark plan for the 2017 plan year to define the state's essential health benefits. In proposing this, CMS cites an administrative mistake in the previous EHB regulations that deleted a section on data collection requirements. In addition to offering advocates another opportunity to influence the state's benchmark plan selection process, the new data collection requirement would mandate qualified health plans (QHPs) to provide CMS with "administrative data and descriptive information pertaining to all health benefits in the plan, treatment limitations, drug coverage, and exclusions." CMS believes that this information is already included in the issuer's form filing that the issuer submitted to the State regulator.

Prescription Drug Coverage Changes

Because CMS has heard complaints from a number of stakeholders regarding the use of the United States Pharmacopeia (USP) in defining drug coverage in the exchanges – including that the "USP system was developed for the Medicare population, some drugs that are likely to be prescribed for the larger EHB population were not reflected." In addition, CMS is proposing to replace the drug count standard with a requirement in that plans adopt a pharmacy and therapeutics (P&T) committee and use that committee to ensure that the plan's formulary drug list covers a sufficient number and type of prescription drugs.

As an alternative to, or in combination with, the above-proposed P&T committee requirements, CMS is also considering whether to replace the USP standard with a standard based on the American Hospital Formulary Service (AHFS). CMS states that:

"the AHFS is a widely used formulary reference system in the private insurance market and is often used for developing formularies for the population being covered by EHB. The AHFS system is a 4-tier hierarchical drug classification system that is updated and published annually by the American Society of Health-System Pharmacists. These tiers are grouped based on similar pharmacologic, therapeutic, and chemical characteristics. Compared to the USP system, the AHFS system is more gradual and has more classifications than the USP system. We believe that using the AHFS system that incorporates these additional classifications would better ensure that a broader distribution of drugs would be required to be covered to the meet the drug count standard than in the current USP system where there are fewer categories and classes."

Prohibitions on Discriminatory Benefit Language

In the EHB Final Rule, CMS stated that an issuer "does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."

In the November 26th proposed regulations, CMS states that "we have become aware of benefit designs that we believe would discourage enrollment by individuals based on age or based on health conditions, in effect making those plan designs discriminatory, thus violating this prohibition. Some issuers have maintained limits and exclusions that were included in the State EHB-benchmark plan."

In response to these concerns, CMS is now "cautioning issuers to avoid discouraging enrollment of individuals with chronic health needs – citing a number of examples such as "if an issuer places most or all drugs that treat a specific condition on the highest cost tiers, we believe that such plan designs effectively discriminate against, or discourage enrollment by, individuals who have those chronic conditions."

Network Adequacy Standards

In previous regulations, CMS established the minimum network adequacy criteria that health and dental plans must meet to be certified as QHPs. CMS is now proposing to clarify that requirement to specify that this section only applies to QHPs that use a provider network and that a provider network includes only providers that are contracted as in-network. This means that the general availability of out-of-network providers will not be counted for purposes of meeting network adequacy requirements.