Highmark's Weekly Capitol Hill Report

Issues for the week ending January 15, 2021

In this Issue:

Federal Issues

Legislative

- **President-elect Biden Unveils $1.9 Trillion COVID-19 Relief Plan**
- **President Signs Competitive Health Insurance Reform Act of 2020**
- **House Republicans Appoints New Committee Members**

Regulatory

- **Medicare Part D Rebate Safe Harbor Rule Challenged in Court**
- **CMS Issues Medicare Advantage and Part D Rule & Rate Notice**
- **CMS Issues Interoperability and Prior Authorization Reforms for Medicaid and Federal Exchange Plans**
- **CMS, Treasury Partially Finalize 2022 Notice of Benefit and Payment Parameters**
- **CMS Finalizes Medicare Coverage of Innovative Technology Rule**
- **Coronavirus Updates**
- **CMS Releases Final 2021 Federal Health Insurance Enrollment Snapshot**

State Issues

Delaware

Federal Issues

Legislative

President-elect Biden Announces $1.9 Trillion COVID-19 Relief Plan

President-elect Biden last week unveiled plans for a roughly $1.9 trillion COVID-19 relief package, which includes a number of provisions that affect insurer, hospitals and health systems. Biden hopes that Congress will consider the legislation soon after he is inaugurated this week. The proposal is expected to be the first of two parts, with a second plan focused on "recovery" coming after Biden enters office.

Why this matters: The package will address priorities Congressional Democrats have been pushing since passing the HEROES Act early last year. A bipartisan deal was reached on a $900 billion package relief package last month, Democrats say another larger package finalized by spring is likely.

It is unclear at this time if it will gain bipartisan support.

Provisions to bolster the nation's COVID-19 health care response include additional resources for vaccines, treatment, personal protective equipment, testing, contact tracing and workforce development. Other health care-related provisions would expand subsidies for certain forms of health care coverage and

create new occupational safety standards that would apply to a wide range of workers.

Other non-health care specific provisions would provide financial support for families and small businesses, as well as extend and expand support for housing, child care, food and the education system. In addition, the plan would require that a broader range of employers, including health care employers, provide COVID-19-related paid leave for all employees. The package also includes some infrastructure and cybersecurity provisions.

The proposal identifies as a priority addressing inequities in the impact of COVID-19 on communities of color and lower-income communities and includes a number of provisions targeted at improving equity in the COVID-19 response and health outcomes.

Regulatory

- **Governor Carney, DPH Announce Transition to Vaccinate Phase 1B**

Pennsylvania

Legislative

- **Pennsylvania Health Care Cost Containment Council Issues Disaster Emergency Report**

Regulatory

- **Department of Health Transfers Administrative Functions of Managed Care Plans to Insurance Department**
- **Pennsylvania Secretary of Health Dr. Rachel Levine Selected to Join Biden Administration**
- **Pennsylvania Allows Pharmacies to Administer COVID-19 Vaccine**
- **Pennsylvania Expands COVID-19 Vaccine Eligibility**

Industry Trends

Policy / Market Trends

- **Drug Companies Raise Prices in 2021**

Provider /Delivery System Trends

- **Report Looks at Economic Outlook for Health Care and Other Sectors**

Highlights of Provisions Important to Hospitals:

COVID Health System Response. The plan would advance a number of proposals aimed at increasing public health and health care system capacity for vaccine deployment, testing, and treatment, among other efforts. These include:

- **National Vaccine Program.** The proposal would provide $20 billion to launch a national vaccination program that would include community vaccination centers and mobile vaccination units. The plan clarifies that the vaccine will be available to all, regardless of immigration status, and will provide for coverage of the administration fee to ensure that cost will not deter a person from getting vaccinated.
- **Testing Capacity.** The plan includes $50 billion to expand testing capabilities with a particular focus on supporting school reopening, as well as combatting the virus in certain vulnerable settings, such as prisons and long-term care facilities.
- **Public Health Workforce.** The proposal would fund 100,000 public health workers to support vaccination outreach and contact tracing efforts with the intention of maintaining these roles after the conclusion of the COVID-19 public health emergency to help bolster long-term public health capacity.
- **Underserved Populations and Health Disparities.** The plan would provide specific funding to expand access to COVID-19 treatment, care and vaccinations for underserved populations through new investments in community health centers and health services on tribal lands.
- **Resources and Support for Congregate Settings.** The proposal would provide states with funding for "strike teams" to help long-term care facilities experiencing COVID-19 outbreaks and resources for federal, state, and local prisons, jails, and detention centers to deploy mitigation strategies, including deployment of vaccines and physical modifications to allow for social distancing.
- **Personal Protective Equipment (PPE) and Other Supplies.** The proposal would increase the Disaster Relief Fund by $30 billion for the purchase of PPE and other supplies, such as laboratory reagents, as well as invest an additional $10 billion in domestic manufacturing of such supplies. In addition, it would fully fund with federal dollars emergency response services provided by the National Guard.
- **COVID-19 Treatment.** The plan calls for an unspecified increase in the federal investment in the development, manufacturing and purchasing of COVID-19 treatments, as well as studies of the long-term impacts of the disease.
- **Occupational Safety COVID-19 Protection Standard.** The provision would direct the Occupational Safety and Health Administration (OSHA) to, among other things, issue a COVID-19 Protection Standard addressing workplace safety, including protections against retaliation of workers who identify potential violations of the standard. The standard would apply to a broader set of workers than are typically covered by OSHA.
- **COVID-19 Surveillance.** The plan would build the national capacity to track virus outbreaks and mutations.
- **Medicaid.** Expansion of the Federal Medicaid Assistance Percentage (FMAP) to 100% for the administration of vaccines.

Health Care Coverage. The proposal would attempt to address some gaps in coverage by providing an unspecified level of COBRA subsidy through September 2021, as well as increasing the value of and eligibility for subsidies for coverage through the Health Insurance Marketplaces. It is unclear if the changes to the Marketplace subsidies would be permanent.

Extension and Expansion of COVID-related Paid Leave. The proposal would extend through September 2021 the COVID-19-related paid leave made available through the Families First Coronavirus Response Act. It also would increase the amount of leave to 14 weeks and apply this requirement to more employers, including those with more than 500 employees. Tax credits to finance this leave would be available to employers with less than 500 employees and to state and local governments.

Funding for State, Local, Territorial and Tribal Governments. The plan includes $350 billion in emergency funding for state, local, and territorial governments for a number of uses, including supporting front line public workers, distributing the vaccine, expanding testing, reopening schools, and maintaining other vital services. It also would commit $20 billion to support Tribal governments' response to the pandemic.

Additional Health Care Investments. The proposal would provide additional federal resources for behavioral health ($4 billion), veterans' health ($20 billion) and programs aimed at reducing gender-based violence ($800 million).

Support for Small Businesses. The proposal would provide additional resources to small business, including $15 billion in grants to the hardest hit small businesses and a $35 billion investment in state, local, tribal, and non-profit small business financing programs. It is unclear whether the plan includes any additional resources to the Paycheck Protection Program.

Child Care. The proposal includes several provisions to support child care providers and improve access to child care, including by providing an additional $15 billion to the Child Care and Development Block Grant program, as well as increasing eligibility and the value of the child care tax credit.

Hazard Pay. The plan will "call on" business leaders to provide front-line workers, including caregivers, with hazard pay. There are insufficient details on the proposal to know whether this would be a voluntary effort or a requirement and which types of companies would be included.

Cybersecurity. In light of the recent SolarWinds breach, the most prolific and serious cyberattack in history impacting government and private sector alike, the Biden administration has prioritized bolstering U.S. cyber defenses. The administration will be seeking approximately $2 billion to modernize federal information technology to protect against future cyberattacks. This will include requests for funding to surge hiring of cybersecurity experts and for increased funding of the Cybersecurity and Infrastructure Agency (CISA). The bolstering of federal cybersecurity defenses and expansion of the monitoring and incident response capabilities of CISA will assist in defending U.S. critical infrastructure sectors, including health care.

President Signs Competitive Health Insurance Reform Act of 2020

On Wednesday, H.R. 1418, President Trump signed the Competitive Health Insurance Reform Act of 2020 into law. The bill amends the McCarran-Ferguson Act (15 U.S.C. §§ 1011-1015) to provide that federal antitrust laws apply to the business of health insurance (including dental insurance), except for collective development of loss data and policy forms or performance of actuarial services.

House Republicans Appoint New Committee Members

Last week, House Republicans announced new members of several key health-related committees. The announcement comes after the unexpected gain in House seats for the GOP in the November election expanded the number of slots available on each committee.

Why this matters: The new members will hold more influence over health care and other key issues in the moving forward.

House Appropriations Committee:

- Rep. David Valadao (R-CA); **Rep. Guy Reschenthaler (R-PA)**; Rep. Mike Garcia (R-CA); Rep. Ben Cline (R-VA); Rep. Tony Gonzales (R-TX); Rep. Ashley Hinson (R-IA)

House Energy and Commerce Committee:

- Rep. Kelly Armstrong (R-ND); Rep. Dan Crenshaw (R-TX); Rep. John Curtis (R-UT); Rep. Neal Dunn (R-FL); **Rep. John Joyce (R-PA)**; Rep. Debbie Lesko (R-AZ); Rep. Gary Palmer (R-AL); Rep. Greg Pence (R-IN)
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House Ways and Means Committee:

- Rep. Kevin Hern (R-OK); **Rep. Lloyd Smucker (R-PA)**; **Rep. Carol Miller (R-WV)**

Federal Issues

Regulatory

Medicare Part D Rebate Safe Harbor Rule Challenged in Court

A rule designed to increase affordability for Part D beneficiaries using highly rebated prescription drugs is being challenged in federal court per a complaint filed by a trade group last week.

Background: The lawsuit surrounds the issuance of a final rule by the HHS Office of the Inspector General which, if upheld, will make significant changes to the Anti-Kickback Statute (AKS) safe harbors that protect pharmaceutical manufacturer arrangements with Medicare Part D plans. The key provisions of the rule will eliminate existing discount safe harbor protection for rebates to Part D plan sponsors and their PBMs, unless the rebates are price reductions required by law, effective January 1, 2022, and create two new safe harbor protections. One new safe harbor would incentivize reductions to be passed through at the point-of-sale to lower costs for beneficiaries who fill highly rebated drugs. Complicating the final rule is a number of prior estimates inside and outside of government finding the rule would increase Medicare spending over 10 years and lead to premium increases for unsubsidized Part D enrollees. A July 2020 presidential executive order conditioned the final rule's issuance on a finding that costs to beneficiaries and the government would not increase.

The lawsuit claims HHS exceeded its statutory authority and violated the Administrative Procedure Act, among other arguments. Timing of the court's ruling will be a key factor as Part D plans must submit their bids for 2022 coverage in early spring. The final rule's fate could be determined by several potential outcomes: (1) the court could strike it down; (2) Congress could rescind it through the Congressional Review Act authority; or (3) HHS could issue a new proposed rule to reinstate the existing safe harbor or exercise enforcement discretion (at least on a temporary basis).

Insurer Perspective: Following the filing of the legal complaint by the Pharmaceutical Care Management Association (PCMA) on the Trump Administration's "rebate rule," AHIP President and CEO Matt Eyles issued a statement supporting the invalidation of the rule and urges policymakers to instead support relief from high drug costs for America's seniors. "The Trump Administration's own actuaries have found that the rebate rule will increase Medicare premiums for all seniors by 25%, give drug makers another $100 billion bailout, and have taxpayers foot the bill for higher costs. This rule not only violates the Administration's own Executive Order, it threatens health care affordability even as America's seniors remain among those most vulnerable to COVID-19."

The Campaign for Sustainable Rx Pricing (CSRxP) also released a statement supporting PCMA's lawsuit, noting it looks forward to working with the next administration and lawmakers to focus drug pricing efforts on market-based solutions to increase transparency and boost competition.

CMS Issues Medicare Advantage and Part D Final Rule & Rate Notice

CMS released a pre-publication version of Part II of the final regulation revising rules for the Medicare Advantage and Part D Prescription Drug Benefit programs for 2022 (fact sheet).This final rule is expected to be published in the Federal Register on January 19. The agency states in this final rule "CMS addresses the remaining proposals, with a few exceptions" not included in Part I of the final rule published this past June. According to CMS, most of the provisions are applicable for 2022. CMS specifically does not address two remaining provisions from the proposed rule: (1) Maximum Out-of-Pocket (MOOP) Limits for Medicare Parts A and B Services and (2) Service Category Cost Sharing Limits for Medicare Parts A and B Services and per Member per Month Actuarial Equivalence Cost Sharing.

Highlights from CMS' final regulation include the following:

- Requires Medicare Advantage and Part D plans to provide enrollees with access to Real Time Benefit Tools that permit members and prescribers to see the cost of the drug being prescribed in comparison to the cost of alternative drugs beginning January 1, 2023.
- Allows Part D sponsors to establish a second "preferred" specialty tier at a lower cost sharing threshold than the current specialty tier beginning January 1, 2022.
- Requires Part D plans to disclose pharmacy performance measures to CMS beginning January 1, 2022.
- Revising Star Rating rules to allow for alternative calculations due to plan consolidations and uncontrollable circumstances, such as disaster and emergency declarations.

Other highlights and further detail can be found here.

CMS also released the 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. The MA ratebook, Part D rate information, and related documents are available on the CMS website.

CMS Issues Interoperability and Prior Authorization Reforms for Medicaid and Federal Exchange Plans

The Centers for Medicare & Medicaid Services (CMS) released the *Interoperability and Prior Authorization Final Rule*.

Why this matters:

- The rule places new requirements on Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs, and qualified health plan issuers on the federally-facilitated Exchanges (FFEs) to advance the electronic exchange of health care data and streamline processes related to prior authorization (fact sheet).
- The rule requires payers to include a specific reason for a denial of a prior authorization request, issue prior authorization decisions (Except for QHP issuers on the FFE) within 72 hours (urgent) or seven calendar days (standard), and publicly report prior authorization data, such as the percent of requests approved, denied, or approved after appeal, and average time between submission and determination.
- Starting in 2023, the rule requires payers to include information about the patient's pending and active prior authorization decisions as part of a previously finalized Patient Access API and the Payer-to-Payer API. Further, starting in 2024, impacted payers must build a new API specific to prior authorization that is intended to facilitate adjudicating prior authorization requests and approvals in an electronic fashion that is integrated into provider's clinical workflow to ease burden. Further detail on these and other provisions can be found here.
- Unlike other recent health interoperability policies, the rule exempts Medicare Advantage and Part D plans which adopt prior authorization as one of many tools used to manage costs and care.

Insurer Perspective: In response to the Final Rule's publication, AHIP issued a statement calling out the inadequacy of the rulemaking process, and arguing the midnight rule cannot be implemented as written as it leaves patients' data vulnerable and detracts from the critical work to defeat COVID-19.

If the rule is not published by January 20, it is possible the rule will be pulled from formal publication and withdrawn, given criticisms that the comment period should have been the more standard 60 days and that the rule's development and completion was rushed.

CMS, Treasury Partially Finalize 2022 Notice of Benefit and Payment Parameters

The Centers for Medicare & Medicaid Services (CMS) and the Department of Treasury issued a rule finalizing a portion of proposed provisions for the annual Notice of Benefit and Payment Parameters for 2022 (fact sheet impacting states, Exchanges, and issuers in the individual and small group markets.

Many of these proposals are expected to be revisited by the incoming Biden Administration. Of note, this final rule does not address risk adjustment, special enrollment periods, 2022 cost sharing amounts, the premium adjustment percentage, medical loss ratio, prescription benefit manager reporting (PBM), the quality rating system (QRS) and many other provisions that were proposed in the December 4, 2020 proposed rule.

The rule finalizes changes including:

- Finalizing the new option for a state to adopt an Exchange direct enrollment approach. Under this approach, a state would approve direct enrollment entities to operate private-sector websites to facilitate Exchange enrollment and eligibility rather than having a centralized Exchange enrollment

website. State Exchanges may elect this option beginning with the 2022 plan year, and states using the federal platform may elect this option beginning with the 2023 plan year;

- Decreasing the user fee for qualified health plans sold through a Federally-facilitated Exchange (FFE) to 2.25%, and 1.75% for issuers offering plans through State-based Exchanges on the federal platform (SBE-FPs);
- Codifying guidance published in 2018 to give states greater certainty over how the federal government will evaluate and monitor section 1332 waivers moving forward;
- Clarifying that issuers of individual market QHPs must accept premium payments made by or on behalf of an enrollee in connection with an individual coverage health reimbursement arrangement or qualified small employer health reimbursement arrangement (QSEHRA); and
- Clarifying that issuers of insurance plans that do not use a provider network need not pursue compliance with network adequacy requirements applicable to QHPs, as their benefits do not vary based on a provider's network status, among others.

Because the Notice, which does not take effective immediately, will be subject to a regulatory freeze, and the fact that many policies proposed in the November proposed rule were not finalized, the stage is set for a new notice-and-comment rulemaking by the incoming Biden Administration.

CMS Finalizes Medicare Coverage of Innovative Technology Rule

CMS finalized a rule establishing a new Medicare coverage pathway for FDA-approved breakthrough devices.

Why this matters: Under the new pathway, national Medicare coverage (both traditional fee-for-service Medicare and Medicare Advantage) would begin on the same day a breakthrough device receives FDA approval, and last up to four years. The rule also codifies regulatory standards Medicare uses to make "reasonable and necessary" determinations for items and services furnished under Parts A and B. The final rule is effective on March 15, 2021.

Insurers, including AHIP, submitted comments on the proposed rule citing concerns that the coverage pathway could put seniors, people with disabilities, and the solvency of the Medicare Trust Fund at risk. They also expressed concern over the lack of requirements on manufacturers to provide outcomes data or enter into clinical studies during the coverage period. In finalizing the pathway, CMS maintained that FDA requirements for demonstrating safety and efficacy are sufficient in determining whether to grant coverage to a breakthrough device under the MCIT. The final rule encourages, but does not require, manufacturers to develop the clinical evidence needed for coverage beyond the MCIT coverage period.

The comments also raised a number of questions and concerns with proposed modifications to Medicare's "reasonable and necessary" definition that would reference commercial coverage as evidence of appropriateness. The final rule does not include the proposed reference to commercial coverage and instead codifies the definition of "reasonable and necessary" based on the factors currently found in the Program Integrity Manual. The rule also includes language giving CMS authority to review the majority of commercial insurers in the event that an item or service does not meet the statutory appropriateness criteria.

No later than 12 months after the rule's effective date, CMS will publish for public comment a draft methodology by which commercial insurer's policies are determined to be relevant based on the measurement of a majority of covered lives.

Coronavirus Updates

- The Department of Health and Human Services (HHS) announced it will no longer hold back second doses of coronavirus shots and is asking states to start vaccinating adults over 65 and people with high-risk medical conditions in an effort to accelerate vaccinations. Beginning in two weeks, Operation Warp Speed, the government's vaccine accelerator, will distribute shots to states based on how quickly they are administering the vaccine and the size of its 65 and older population. HHS is also recommending states expand the venues where people can get vaccinated to include community health centers and more pharmacies.

- President-elect Joe outlined key highlights of his plan to efficiently and equitably vaccinate the U.S. population. These include a public education campaign, increasing the public health work force, creating more vaccination sites, releasing the vaccines once they become available, and utilizing the Defense Production Act to increase manufacturing, among other provisions.

CMS Releases Final 2021 Federal Health Insurance Enrollment Snapshot

CMS released the final enrollment snapshot over the cumulative open enrollment period between November 1-December 21. This snapshot provides data on plan selections in the 36 states using Healthcare.gov platform, including new plan selections, active plan renewals, and automatic enrollments.

CMS reports approximately 8.3 million people selected individual market plans through the Marketplaces using the federal platform during the 2021 Open Enrollment Period, nearly the same as enrollments during the 2020 Open Enrollment Period, even though New Jersey and Pennsylvania transitioned to State-based Exchange platforms starting with the 2021 Open Enrollment Period. Removing New Jersey and Pennsylvania total plan selections from the 2020 Open Enrollment numbers shows plan selections this year increased by 7.0% from 2020.

About 1.9 million plan selections were due to new consumers and roughly 6.4 million were due to consumers renewing their coverage. These results are consistent with recently released data showing higher effectuated enrollment mid-year due to fewer people dropping coverage and more people enrolling through special enrollment periods. CMS will release a comprehensive report on 2021 Open Enrollment, including State-based Exchanges that do not use Healthcare.gov, in Spring 2020.

State Issues

Pennsylvania

Legislative

Pennsylvania Health Care Cost Containment Council Issues Disaster Emergency Report
On January 15, the Pennsylvania Health Care Cost Containment Council (PHC4) issued its COVID-19 Disaster Emergency Report, which confirms the enormous and damaging impact that the COVID-19 pandemic has had on the financial health of hospitals during the first three quarters of 2020. The report, which includes information submitted by most hospitals throughout the commonwealth, found that hospitals reported $4.9 billion in COVID-19-related expenses and revenue losses for the period between January and September, 2020.

PHC4 has issued this report to provide data on the effect of the COVID-19 disaster emergency on Pennsylvania hospitals and health care facilities as directed by Act 15 of 2020. This report represents the first installment in a series that will be updated quarterly for one year following the termination or expiration of the COVID-19 disaster emergency. In completing the report, PHC4 aggregated data related to COVID-19 expenses and lost revenue as reported by hospitals and health systems in the Commonwealth.

The PHC4 report includes data from 91% of hospitals reporting information.

Specifically, hospitals:

- Experienced revenue losses of $4.1 billion, due to the suspension of scheduled services and decreases in non-elective/emergent services not related to COVID-19
- Incurred $81 million in costs related to COVID-19 testing, including costs related to commercial lab services
- Expended $349 million for increased staffing and labor costs to expand services and staff emergency operations centers
- Devoted $258 million to purchase additional supplies and equipment, such as personal protective equipment, computer hardware, and temporary tents
- Incurred $21 million in costs to set up emergency operations centers, including construction and retrofitting facilities to provide separate screening and security areas
- Expended $89 million for other miscellaneous activities, such as providing housing and care for patients who do not require hospitalization; obtaining consulting services to comply with COVID-19 related operations; and other states to prevent, prepare, and respond to the pandemic

The report was posted at PHC4's website and provided to the Wolf Administration and legislative leaders.

Why this matters: Hospitals continue to deal with the financial fallout of COVID-19 as they take extraordinary steps to treat patients suffering from COVID-19 and provide vaccinations to health care workers and other eligible citizens. Hospitals continue to advocate for sufficient financial resources and relief at the federal and state level to allow them to fulfill their critical mission.

State Issues

Delaware
Regulatory

Governor Carney, DPH Announce Transition to Vaccinate Phase 1B

Governor John Carney and the Delaware Division of Public Health (DPH) announced that the state will transition to Phase 1B in its COVID-19 vaccination plan starting Tuesday, January 19, with a focus on persons 65 and up. More than 200,000 Delawareans qualify for vaccination in this phase, and multiple options for residents to be vaccinated will begin this week and then expand in coming weeks, including large vaccination events with a new appointment request system. For more information on Phase 1B eligibility visit de.gov/covidvaccine.

Pennsylvania
Regulatory

Department of Health Transfers Administrative Functions of Managed Care Plans to Insurance Department

A memorandum of understanding (MOU) has been made between the Pennsylvania Department of Health (DOH) and the Pennsylvania Insurance Department (PID) regarding the transfer of administrative functions and responsibilities relating to the regulation of managed care plans. The MOU is intended to facilitate the transfer of certain managed care functions and responsibilities from DOH to PID and is not intended to amend the statutory authority, obligations, or duties of either department. The MOU outlines the responsibilities of each of the departments separately and their joint responsibilities with the active functions in overseeing managed care going to the PID.

Pennsylvania Secretary of Health Dr. Rachel Levine Selected to Join Biden Administration

President-elect Joe Biden announced that he will nominate Dr. Rachel Levine to be his assistant secretary of health. President elect Biden said, “Dr. Rachel Levine will bring the steady leadership and essential expertise we need to get people through this pandemic-no matter their zip code, race, religion, sexual orientation, gender identity or disability –and meet the public health needs of our country in this critical moment and beyond.”

Pennsylvania Allows Pharmacies to Administer COVID-19 Vaccine

As part of the Wolf Administration's effort to rollout COVID-19 vaccine, Governor Tom Wolf has approved a temporary waiver allowing pharmacists licensed by the Department of State to order and administer COVID-19 vaccines without a physician's order when vaccines are available to the public. The addition of pharmacists to the list of qualified immunizers will expand options for people to have the vaccine administered once it becomes available to the public.

"Pharmacists, as well as pharmacy interns and technicians, are critical partners in the commonwealth's plan to distribute the COVID-19 vaccine," Secretary of State Kathy Boockvar said. "Many Pennsylvanians will go to their local pharmacy for vaccination. This waiver will enable pharmacies to offer the COVID-19 vaccines without a physician's order."

Pennsylvania pharmacists who meet certain training and other requirements can obtain authorization to administer injectable medications, biologicals and immunizations. If a pharmacist has that authorization, he or she can administer any immunization, including COVID-19 immunizations, to persons 18 years of age or

older. This waiver applies solely to COVID-19 vaccines for the duration of the Governor's Disaster Emergency Declaration plus 90 days.

Pennsylvania Expands COVID-19 Vaccine Eligibility
Pennsylvania announced on Tuesday that it is expanding Phase 1A of its vaccine distribution plan to include people age 65 and over as well as younger people with serious health conditions that put them at higher risk. The Department of Health has updated its coronavirus vaccine plan based upon recommendations from the federal government. There is, however, uncertainty around the expanded rollout given the slow pace of vaccine distributions and limitations on supplies.

Industry Trends

Policy / Market Trends

Drug Companies Raise Prices in 2021

More than 100 pharmaceutical companies raised prices on over 600 drugs at the beginning of the new year, according to a new report from the advocacy group Patients for Affordable Drugs.

Report findings:

- **99%** of hikes were above the rate of inflation
- **4.99%** median percent hike
- **95%** of hikes were on brand name drugs

AHIP published a blog post spotlighting the pharmaceutical industry's routine practice of hiking the price of hundreds of drugs, despite Americans continuing to face the economic fallout from the COVID-19 crisis. "The incoming Biden-Harris administration should focus on bipartisan, workable solutions to protect patients, taxpayers, and all Americans from higher drug prices, especially in the midst of the ongoing COVID-19 crisis," AHIP President and CEO Matt Eyles said. The post emphasizes that health insurance providers are working hard on behalf of patients and consumer to negotiate lower prices and will continue to use bargaining power to increase savings for millions of patients.

The Campaign for Sustainable Rx Pricing (CSRxP) published two new posts focused on Pharma's new year price hikes. The first post highlights the latest round of drug price increases, underscoring the need for Congress to act and pass bipartisan based solutions to lower prescription drug costs. Another CSRxP post highlights a new analysis conducted by the Institute for Clinical and Economic Review (ICER), which found that drug companies hiked prices on several popular drugs in 2019 with no evidence that the drugs had been improved.

Industry Trends

Provider / Delivery System Trends

Report Looks at Economic Outlook for Health Care and Other Sectors

The U.S. Chamber of Commerce recently released a compilation of perspectives on the economic impact of the COVID-19 pandemic on various sectors and the outlook for 2021.

The American Hospital Association and Federation of American Hospitals contributed to the health care section, noting that reports released in May and June projected at least $323.1 billion in financial losses for hospitals and health systems through 2020.

Why this matters: The $178 billion in the CARES Act Provider Relief Fund falls far short of covering these losses – and hospitals and health systems only received a little more than half the $124 billion in funding released by HHS so far. As we enter 2021 with spiking COVID-19 infections and hospitalizations across the country, the long-term impacts of the COVID-19 pandemic on hospitals, health systems and the communities they serve are difficult to project, but it is already clear they will be severe.

Interested in reviewing a copy of a bill(s)? Access the following web sites:

Delaware State Legislation: **http://legis.delaware.gov/.**
Pennsylvania Legislation: **www.legis.state.pa.us.**
West Virginia Legislation: **http://www.legis.state.wv.us/**
For copies of congressional bills, access the Thomas website – **http://thomas.loc.gov/.**

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