IAA Legislative Ledger

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Hospital Price Transparency Finally A Reality?

HELP MAKE THE PROPOSED TRANSPARENCY RULES A REALITY

CMS Releases Proposed Transparency Rules

In June, the President signed an executive order aimed at increasing price transparency in the healthcare industry. In response, on July 29 the Centers for Medicare and Medicaid Services (CMS) released a proposed rule aimed at making prices at hospitals more transparent, encouraging site-neutral payment between certain Medicare sites of services, and updating policies under the Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System. The deadline for submitting comments on the proposed rule is September 27, 2019. The hospital price transparency rules, which, if finalized, would take effect on January 1, 2020, would require hospitals to:

- Make public their "s t a n d a r d charges" (defined as two types of charges: gross charges and payer-specific negotiated charges) for all items and services provided by the hospital.
- Make their standard charges available on the Internet in a machine-readable file that includes additional information such as common billing or accounting codes used by the hospital (such as Healthcare Common Procedure Coding System (HCPCS) codes) and a description of the item or service. This provides a common framework for comparing standard charges from hospital to hospital.
- Make public payer-specific carrier negotiated or other service fees. Examples of shoppable services include x-rays, outpatient visits, imaging and laboratory tests or bundled services like a cesarean delivery, including pre-and post delivery care.
- Consumer-friendly means the hospital charge information must be made public in a prominent location online (or in written form upon request) that it is easily accessible, without barriers, and searchable. It also means the service descriptions are in 'plain language' and the shoppable service charges are displayed and grouped with charges for any ancillary services the hospital customarily provides with the primary shoppable service.

Under this rule, "hospital" would be defined as an institution in any State in which State or applicable local law provides for the licensing of hospitals and which is licensed as a hospital pursuant to such law, or is approved by the agency of such State or locality responsible for licensing hospitals as meeting the standards established for such licensing. The proposal would include all Medicare-enrolled institutions that are licensed as hospitals as well any non-Medicare enrolled institutions that are licensed as a hospital. The proposed rule would also complete the Administration's two-year phase-in to remove the significant payment disparity between Medicare payments for clinic visits in

certain off-campus hospital outpatient departments versus the physician office setting.

While the change represents significant savings for the Medicare program, hospitals view it as a payment cut for their clinics. The rule has already drawn heavy opposition from hospitals. It is being reported that the American Hospital Association is warning of potential legal action if the proposal is finalized. It is likely they will also put heavy pressure on Congress to intervene. Although it is likely this rule will face challenges in court before it is finalized and goes into effect, it represents a positive change in favor of transparency at HHS.

A CMS factsheet on the proposed rule is available here: https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospectivepayment-system-and-ambulatory-surgical-center

The proposed rule text is available here: https:// www.federalregister.gov/documents/2019/08/09/2019-16107/medicare-programproposed-changes-to-hospital-outpatientprospective-payment-and-ambulatory-surgical

IRS Expands Preventative Care Benefits

IRS Expands Preventative Care Benefits Permitted to be Provided under a High Deductible Health Plan On July 17, the IRS released Notice 2019-45 (available here: https://www.irs.gov/pub/irs-drop/ n-19-45.pdf). This notice expands the list of preventative care services that are permitted to be covered by a high deductible health plan before the participant has met their deductible. The notice is effective as of its release date, July 17, 2019.

Background

Generally, in order to qualify as a high deductible health plan (HDHP), the plan may not provide any benefits for a year until the minimum deductible for that year is satisfied.

However, section 223(c) (2)(C) provides a safe harbor, allowing plans to provide preventative care benefits without the participant meeting their deductible. To be considered preventative care under this safe harbor, the benefit must either be described as preventive care for purposes of section 1861 of the Social Security Act (SSA) or be determined to be preventive care in guidance issued by the Treasury Department and the IRS.

In prior guidance the Treasury Department and the IRS have stated that preventive care generally does not include any service or benefit intended to treat an existing illness, injury, or condition. However, the IRS is revisiting this guidance. June 2019 Executive Order (EO 13877), which directed federal agencies to, among other things, expand the ability of patients to select HDHPs that cover low-cost preventive care before the deductible and that helps maintain health status for individuals with chronic conditions. Notice 2019-45; In this notice, the Treasury Department and the IRS, in consultation with HHS, determined that certain medical care services received and items purchased, including prescription drugs, for

certain chronic conditions should be classified as preventive care for someone with that chronic condition. Using agency determined criteria, the notice sets out a list of the list of preventive care services and items that will now be considered preventative care under the HDHP (High Deductible Health Plan) preventative care safe harbor provision. The specified services and items are treated as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition, and only when prescribed for the purpose of preventing the exacerbation of the condition or the development of a secondary condition. This change does not mean these services will be considered as preventive care required to be provided without cost sharing under the Affordable Care Act. This expansion does not impact the ACA's definition of preventative care.

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting E n z y m e (A C E) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

Adopting the Expansion

How and when HDHPs plans may adopt this expansion will depend on how their plan documents currently incorporate IRS guidance on what falls under the preventative care safe harbor.

If all IRS guidance is incorporated by reference, the plan may be able to adopt the expansion automatically without changing plan documents. However, if the pre-existing list of preventative care safe harbor benefits are spelled out in the SBC documents, then a change to the documents is required if the plan wants to add the expanded list.

Under the ACA, this would count as a material change and so would require 60 days notice before becoming effective. If the list is NOT in the SBC, but is in the plan documents, then ERISA rules for plan document modification would apply.

I hope this information is helpful. If you want to discuss the changes further, please contact your IAA Broker/Client Advocate.

Enjoy the rest of your day!

Thank you,

Paul Kelly, President