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Healthcare Pricing Transparency

Price Transparency Executive Order Expected Soon

On Monday, June 24, the President signed an executive order designed to increase price transparency in healthcare. "To make fully informed decisions about their healthcare, patients must know the price and quality of a good or service in advance," the order states. "With the predominant role that third-party payers and Government programs play in the American healthcare system, however, patients often lack both access to useful price and quality information and the incentives to find low-cost, high-quality care."

The order further states that the federal government's aim is to "to eliminate unnecessary barriers to price and quality transparency; to increase the availability of meaningful price and quality information for patients; to enhance patients' control over their own healthcare resources, including through tax-preferred medical accounts; and to protect patients from surprise medical bills."

The order directs the Department of Health and Human Services (HHS) to propose a regulation within 60 days to "require hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format using consensus-based data standards that will meaningfully inform patients' decision making and allow patients to compare prices across hospitals."

The order also directs HHS and the Department of Labor within 90 days, to solicit comments on a proposal to require healthcare providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care.

The order also covers and calls for agency action on other transparency and healthcare issues, including:

- Calling for a government report on impediments to price transparency;
- Increasing access to de-identified claims data from taxpayer-funded healthcare programs and group health plans;
- Expansion of high deductible health plans and HSAs;
- Treating direct primary care arrangements and healthcare sharing ministries as eligible medical expenses under section 213(d);
- Increasing the amount of funds that can carry over without penalty at the end of the year for flexible spending arrangements; and
- Addressing surprise medical bills.

Senate Health, Education, Labor and Pensions (HELP) Committee Introduces Bill to Lower Healthcare Costs

On June 19, Chairman Lamar Alexander (R-Tenn.) and Ranking Member Patty Murray (D-Wash.) introduced S.1895, the Lower Health Care Costs Act of 2019. The bill contains five sections dealing with different healthcare components: surprise medical bills, prescription drug costs, price transparency, public health, and health IT.

Surprise Medical Bills

The bill would address surprise medical bills first by holding the patient harmless beyond the plan's in-network cost-sharing amount. The plan would pay the provider a benchmark rate – the median contracted rate under the applicable plan or coverage for the same or similar service that is provided by a provider in the same or similar specialty and in the geographic region in which the service is furnished.

The bill also includes a provision for surprise air ambulance bills. Patients are held harmless beyond in-network cost-sharing. Plans would also pay these bills on with a benchmark approach using the median contracted rate.

Price Transparency

The bill's price transparency provisions are largely similar to what was in the discussion draft. It would:

- Ban gag clauses in contracts between providers and plans on price and quality information.
- Ban "anti-competitive" contract terms between providers and plans: For example, it would prevent "anti-tiering" and "anti-steering" clauses in contacts between providers and health plans that restrict the plan from directing or incentivizing patients to use specific providers and facilities with higher quality and lower prices.
- Designate a nongovernmental, nonprofit transparency organization to improve transparency in healthcare costs. The nonprofit would use deidentified health care claims data from self-insured plans, Medicare, and participating states to help provide information on cost and quality of care.
- Require health plans to have up-to-date directories of their in-network providers, available to patients online or within 24 hours of an inquiry.
- Require all patients to be billed within 45 business days.
- Prohibits PBMs from engaging in spread pricing, or charging a plan or patient more for a drug than the PBM paid to acquire it. It lso requires the PBM to pass on 100% of any rebates or discounts to the plan sponsor.
- Requires providers and health plans to give patients good faith estimates of their expected out of pocket costs for specific healthcare services, and any other services that could reasonably be provided, within 2 business days of a request.

Administration Releases Final HRA Rule

The Administration has released the final rule on Health Reimbursement Arrangements (HRAs). As in the proposed rule, the final rule will allow employers to use a new individual coverage HRA to provide subsidies for employees to purchase insurance on the individual market.

The final rule will apply for plan years beginning on or after January 1, 2020.

The rule creates two new forms of HRAs:

- Individual Health Insurance Coverage HRA: This HRA would allow employers to provide an HRA that is integrated with a health plan from the individual market. Short term limited duration insurance, coverage that is only excepted benefits (i.e. dental, vision, LTC, voluntary), health care sharing ministries. TRICARE will not be included.
- Excepted Benefit HRA: This allows employers to provide up to $1,800 in an HRA that could be used to pay premiums for excepted benefits, short term plans, and COBRA premiums.

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Employers are not permitted to offer both an Individual Coverage HRA and a group health plan to the same class of employees. The final rule enumerates ten classes of employees:

- Full-time employees,
- Part-time employees,
- Employees working in the same geographic location (generally, the same insurance rating area, state, or multi-state region),
- Seasonal employees,
- Employees in a unit of employees covered by a particular collective bargaining agreement,
- Employees who have not satisfied a waiting period,
- Non-resident aliens with no U.S.-based income,
- Salaried workers,
- Non-salaried workers (such as hourly workers),
- Temporary employees of staffing firms, or
- Any group of employees formed by combining two or more of these classes.

The final rule also imposes a minimum class size rule in an attempt to prevent adverse selection in the individual market, based on the size of the employer. For employers with fewer than 100 employees, the minimum class size is 10 employees. For employers with 100-200 employees, the minimum class size is 10% of the total number of employees. For employers with more than 200 employees, the minimum class size is 20 employees.

Summary

More options and flexibility gives each employer and employee a path to a better health insurance solution. When was the last time you're purchased any product or service without knowing the cost upfront? Transparency in pricing will create a more competitive healthcare environment resulting in lower cost and higher quality care for all.

Enjoy the rest of your day!

Thank you,

Paul Kelly, President