Policy Brief

May 17, 2019

Policymakers Ramp Up Efforts to Address Surprise Bills

Last week, President Trump outlined guiding principles for Congress to tackle surprise medical bills. He stated, "We're going to hold insurance companies and hospitals totally accountable and we're going to be announcing something, I think over the next two weeks, that's going to bring transparency to all of it." Since his announcement, both the House and the Senate have released legislation to tackle surprise medical bills. If passed in their Chambers, the bills would have to be reconciled before becoming law.

In the announcement, the President urged Congress to follow four guiding principles to tackle surprise medical bills:

1. Balance billing, the practice of a health provider charging a patient for the amount the insurance did not cover, should be prohibited for emergency care.
2. Patients receiving scheduled care should have information about whether providers are in or out of their network and what costs they may face.
3. Patients should not receive surprise bills from out-of-network providers they did not choose.
4. Legislation on surprise medical bills should *not* increase federal health care expenditures.

Both the House and the Senate bills follow at least the first three principles, as neither bill has been scored yet for financial impact. However, the bills set up payment rates very differently. The House bill, called

the “No Surprises Act,” bases the payment rate for out-of-network services to the average in-network rate for that geographic area. The Senate bill, called the “STOP Surprise Medical Bills Act,” mandates that providers be paid the difference between a patient's in-network rate and the median in-network rate for out-of-network services performed at an in-network facility. The Senate bill also requires providers to include any ancillary services, such as those done by lab technicians, within the patient's hospital bill.

During the White House announcement, the President also indicated that he’s not in favor of arbitration policies to address surprise medical bills. Instead of arbitration, the President voiced support for contract reform or bundling physician services into the hospital facility fee. However, the Senate bill would set up an arbitration process for providers and insurers to dispute payment rates. The House bill released by the Energy and Commerce Committee excludes arbitration. For a summary of the different policy options being considered by Congress, click here.

Trump Administration Considers Redefining Poverty

The Office of Management and Budget (OMB) is seeking comments on redefining the way the government calculates poverty. The policy would slow the rate at which the poverty threshold increases with inflation. A calculation change could decrease federal spending, but only because less people would be enrolled in health care, food assistance and early-learning programs. Because these programs all rely on the poverty threshold to calculate eligibility, a slower increase would mean less low-income families qualify as “poor enough.” Read more on the recalculation and its potential implications for community wellness.

What is being considered?

The OMB is exploring changing the way poverty is calculated by using the Chained Consumer Price Index (C-CPI) instead of the standard Consumer Price Index. The C-CPI rises more slowly and has been criticized as an inaccurate reflection of costs, especially in the health care sector. This isn’t the first time this has been proposed; the Obama Administration toyed with the idea in 2014 to bipartisan disapproval.

What would it mean?

Many safety-net programs use the federal government's poverty guidelines to determine enrollee eligibility. Lowering the poverty threshold would cause enrollment to drop in Medicaid, SNAP, Head Start and other programs—increasing uninsured, food insecurity and child illiteracy rates. Further limiting who qualifies as "poor" would make it harder for low-income families to stay healthy.

What happens next?

It is important to emphasize that this idea is still in the preliminary stages. The Administration would still have to propose and finalize the change before any redefinition could occur. **Comments on the idea must be submitted by June 21st to the OMB.**

DSH Funding – Delay or Reform?

Congress continues to deliberate whether or not to postpone payment cuts to Disproportionate Share Hospitals (DSH) that were implemented under the Affordable Care Act (ACA) in 2014. While a bipartisan group of 305 representatives have signed on to postpone the $17.5 billion cuts that start in October, Senator Grassley wants to reform how DSH dollars are disbursed instead of delaying the reductions again. He believes that the longer Congress waits to reform the outdated system, the harder it will be for safety net hospitals to adjust to the cuts. Below are the arguments for and against postponing the DSH cuts. For the payment reductions that AHPA states could face, click here.

Why Delay the Cuts?

The cuts were initially included in the ACA to account for Medicaid expansion, which would have decreased uncompensated care costs. However, because many states did not expand Medicaid, the DSH cuts would negatively impact safety-net hospitals in non-expansion states. This is due to the greater uninsured rate and the shortfall in Medicaid reimbursement. For this reason, many legislators have already signed onto a letter requesting to delay the cuts. MACPAC has also recommended that Congress phase in the cuts more slowly to give hospitals more time to adapt.

Why Reform the System?

In an op-ed, Senator Grassley argues that the current formula for determining DSH payments to hospitals is outdated and varies greatly among states. He intends to reform the current system during his tenure as the chair of the Senate Finance Committee, a very influential committee that will likely be able to move legislation. He also believes that delaying the payment cuts will make it more difficult for hospitals to adjust to the payment reductions. The question that remains, however, is if Congress will allow these cuts to take place in October before they overhaul the existing formula.

Rule on Religious and Moral Exemptions

The Office of Civil Rights (OCR) released a final rule that broadens religious and moral protections provided to health care workers. The rule will allow non-medical staff, such as patient registration staff, to refuse to perform or assist in the performance of a health service based on religious or moral grounds. This could adversely impact access to care, particularly in rural areas with few health providers.

Who does the rule apply to?

The rule applies to any entity that receives federal funds for a health service program (e.g. Medicare and Medicaid) or research activity. It broadens the definition of "health entity," extending moral and religious protections to individuals instead of just organizations. These include nurses, front desk staff, ambulance providers, paramedics, pharmacists and "any other health care personnel or facility."

How will the rule impact women and LGBTQ patients?

The rule may inhibit timely access to care for both women and LGBTQ patients. Because it applies to medical referrals, there is the concern that health workers may object to recommending another doctor for services such as HIV education or infertility treatment. In response to comments on issues such as gender dysphoria surgery or treatment for an ectopic pregnancy, the OCR was vague and only stated that the application of the protections would depend on the facts and circumstances.

Will the rule impact vaccinations?

The rule clarifies that in reference to vaccinations, providers must comply with any state laws relating to any religious or other exemptions.

Is EMTALA affected?

According to OCR, not really. When asked about what liability hospitals have under EMTALA if a clinician in the Emergency Department declines to provide services based on religious or moral grounds, the OCR stated: "The requirement under EMTALA that certain hospitals treat and stabilize patients who present in an emergency does not conflict with Federal conscience and anti-discrimination laws. The Department intends to give all laws their fullest possible effect."

Did the rule change the compliance requirements?

The rule expands OCR's authority to enforce the regulations through actions such as withholding federal financial assistance, suspending award activities, or referring a case to the U.S. Attorney General. OCR will now take enforcement action based on complaints, referrals and other information, such as news articles. Additionally, the rule will require health entities seeking federal financial assistance to submit both an assurance and a certificate of compliance.

340B Update

Last week, a U.S. District Court found both the 2018 and 2019 payment cuts for the 340B drug discount program unlawful. The judge also ordered HHS to submit a remedy to the situation by August 5th. As regulatory reform to the 340B program is showing to be unsuccessful, we anticipate legislators to start moving on this issue in the near future.

A Look at the Federal Register

Regulatory season is here! But do not worry, AHPA has it all covered. Below are the most recent regulations released in the Federal Register.

Veterans Care Agreements Interim Final Rule. The VA is seeking comments on an interim final rule on Veterans Care Agreements. The rule establishes a certification process for providers who will furnish such care or services. It outlines a methodology by which rates will be calculated for payment of care or services under an agreement. The rule also includes a framework for an administrative process for adjudicating disputes, including those pertaining to claims for payment for care or services provided. *This comment opportunity hasn't been fully published on the Federal Register.* **Comments are due 60 days after the date of publication in the Federal Register.**

Notification of Enforcement Discretion Regarding HIPAA Civil Money Penalties. The Department of Health & Human Services (HHS) released a notice to inform the public that the Agency is exercising its discretionary authority to assess Civil Money Penalties (CMPs) under the Health Insurance Portability and Accountability Act (HIPAA). Congress authorized HHS to impose a maximum CMP of $100 for each violation, subject to a calendar year cap of $25,000 for all violations of an identical requirement or prohibition. This exercise of enforcement discretion is effective indefinitely. *HHS is not seeking comments on this notice.*

Enrollment and Re-Certification of Entities in the 340B Drug Pricing Program. The Health Resources and Services Administration (HRSA) is seeking comments regarding the release of a notification that states the following 340B program requirement forms are being revised: 1) 340B Program Registrations & Certifications for Hospitals (applies to all hospital types); 2) 340B Program Registrations for STD/TB Clinics; 3) 340B Registrations for Ryan White Entities; and 4) Medicaid Billing. **Comments are due July 8, 2019.**

Medicare and Medicaid Programs; Regulation to Require Drug Pricing Transparency. CMS is seeking comments on a final rule that revises the Federal Health Insurance Programs for the Aged and Disabled. The rule amends regulations for the Medicare Parts A, B, C and D programs, as well as the Medicaid program, to require direct-to-consumer (DTC) television advertisements of prescription drugs and biological products for which payment is available through or under Medicare or Medicaid to include the Wholesale Acquisition Cost (WAC or list price) of that drug or biological product. **Comments are due July 9, 2019.**

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