Policy Brief

October 4, 2019

Impeachment Inquiry May Hinder Health Care Legislation

The announcement of an impeachment inquiry by Speaker Nancy Pelosi (D-CA) took over the news last week and fed into rising tensions between both parties. Impeachment proceedings may have large implications for current Congressional efforts to pass drug pricing and surprise billing legislation. Many political analysts believe that the inquiry will stall any legislation from passing this year, but with both parties under pressure to achieve something, it is unclear how the remainder of the year will play out. Below is more about where top health care legislation stands today.

Drug pricing, surprise billing and reauthorizing funding for several health care programs are top priority issues on Congress' fall agenda. The impeachment inquiry will likely bring more gridlock but there is mounting pressure for legislators to pass something before the end of the year.

- *Lowering Drug Pricing* – Right before the impeachment inquiry, House Speaker Nancy Pelosi released a partisan bill to lower drug prices, which despite Republican opposition, was praised by President Trump. Pelosi's top advisor said that he expected a floor vote on the drug pricing bill by the end of October, but it may be unlikely in the current political environment. The White House on Tuesday declined to comment on whether officials planned to continue negotiations with Pelosi on lowering drug costs.

- *Ending Surprise Billing* – Although there is bipartisan consensus on banning surprise billing, there is disagreement on how to set payments for out-of-network services. Currently, there are multiple bills that need to be reconciled before moving forward, and the House Ways and Means Committee is currently drafting another bill that my ignite future discussions during this fall.

- *Continuing Resolution* – Congress will also need to pass another Continuing Resolution (CR) before November 21st to avoid a government shutdown. CRs are often used as vehicles to move different types of legislation and may likely be used to pass health care policies.

New Findings from California's Surprise Billing Ban

Three years into the enactment of California's surprise billing ban, new analyses shed light on possible paths forward for national legislation. With the passage of AB 72, California lawmakers banned surprise billing, protecting patients from out-of-network bills for care provided at in-network facilities. Since 2017, out-of-network providers in California are paid either 125% of Medicare rates or the average payment for their peers—a policy commonly known as "benchmarking." A recently-released Brookings report found that AB 72 did *not* narrow provider networks in the California markets or increase consumer complaints. Read more on the law's patient access implications and what the study results could mean for providers across the nation.

What happened in California?

California's surprise billing ban is one of the toughest in the nation. Critics worried that its strict approach would lead to depressed payment rates, smaller provider networks and increased patient complaints. Instead, the new analysis from USC-Brookings found that providers' participation in insurance networks *rose* by an average of 17%. Its findings corroborate an earlier one from America's Health Insurance Plans that found an increase of up to 26% of in-network specialty doctors in California since 2017. Although physicians did see decreased payment rates, the amount of care provided rose across disciplines, suggesting little negative impact to patient access. This benchmarking approach may not yield the same results nationwide; the Brookings study was unable to capture data on ERISA plans.

Could a similar policy be adopted nationally?

Two bills in Congress (S. 1895 and H.R. 2328) set a similar payment standard for providers, shielding patients from unexpected costs. Providers caution that basing the benchmark on Medicare rates would not cover the full cost of care, jeopardizing access to health care services. Leadership in the House and the Senate are considering both benchmarking and "baseball-style" arbitration to end surprise billing.

Congress appears to be leaning toward the latter, however, targeted ads from private equity firms as well as advocacy groups and the California example still may influence their final decision.

CMS's Final Discharge Planning Rule Reduces Hospital Burden, Promotes Interoperability

After nearly four years, CMS has finalized a rule implementing the discharge planning requirements of the IMPACT Act of 2014. The new requirements apply to hospitals, Critical Access Hospitals (CAHs) and Home Health Agencies (HHAs) participating in Medicare and Medicaid. In response to feedback from health providers, the final rule dramatically scales back many of the proposed requirements from 2015, including a mandatory 24-hour discharge planning initiation window. The final rule allows hospitals greater flexibility in determining how to design their discharge planning process while setting new requirements to enhance the interoperability of medical records. Below are three key highlights from the final rule. For a more detailed summary comparing the proposed and final rules, click here.

Elimination of the 24-Hour Discharge Plan Requirement. The proposed rule required hospitals to "identify anticipated discharge needs" for patients within 24 hours of admission or registration. Recognizing that patient needs can become increasingly complex during the first 24 hours in an acute care setting, the final rule eliminates this in favor of hospital discretion. However, CMS encourages hospitals to initiate discharge planning "as early as possible."

Redefining Applicability. CMS proposed that discharge planning requirements be applied to all inpatients and certain outpatients. Recognizing that this policy would require hospitals to unfeasibly spread limited resources, the final rule eliminates that requirement. Instead, it allows hospitals to identify—ideally at inpatient admission—which patients would be likely to experience an "adverse health consequence upon discharge in the absence of adequate discharge planning." Hospitals are subsequently required to provide discharge planning for patients identified under this standard.

Enhancing Interoperability. The final rule also adds a new requirement that hospitals, CAHs and HHAs, ensure the transfer of a patient's medical records to the next site of care. While there is no set

definition or format for the transmission of medical records, this requirement further supports the Agency's ongoing efforts to foster interoperability.

340B Update

On September 26th, CMS released a Paperwork Reduction Act notice outlining the Agency's intent to begin collecting acquisition cost data on 340B drugs, signaling an intent to continue 340B cuts even if CMS loses its pending appeal. The acquisition cost data, according to the original injunctions against the 2018 and 2019 rate cuts, may allow the Secretary to justify the controversial rate cut from ASP+6 percent to ASP-22.5 percent.

A Look at the Federal Register

Removal of Unnecessary, Obsolete, or Burdensome Regulations for Providers and Suppliers
CMS released a final rule (84 FR 51732) that seeks to increase efficiency and resource stewardship, including integrating quality assessment systems; reducing the number of required reviews for certain types of providers; and requires ASCs to establish policies governing required medical examination prior to surgery. View AHPA's summary of the changes for more detail.

Employer Shared Responsibility Provisions (ESRPs) and Health Reimbursement Arrangement
IRS issued a proposed rule (84 FR 51471) clarifying provisions of the June 2019 final rule (84 FR 28888). The proposed rule seeks to clarify how ESRPs and certain nondiscrimination rules in the Internal Revenue Code apply to health reimbursement arrangements and other account-based group health plans.

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