Federal Issues
Regulatory

IRS Rule Allows Tax Advantages to Direct Primary Care Arrangements and Health Care Sharing Ministries

Almost a year after an Executive Order calling for the Department of Treasury and Internal Revenue Service (IRS) to consider regulations on the subject, a newly proposed rule would clarify or expand the types of expenses which are eligible for the medical expense deduction and health reimbursement arrangements (HRAs) funded primarily by employers.

Why this matters: The rule addresses direct primary care (DPC) arrangements —where a patient pays a physician for care or membership and the physician does not bill a third party for the service— and health care sharing ministry (HCSM) memberships, defining them as “expenses for medical care” under the Internal Revenue Code. The effect of this definition is that expenses for DPC arrangements and HCSM memberships may be:

- Treated as itemized income tax deductions by individual taxpayers: The deduction applies if the all expenses for medical care exceed 7.5% of an individual’s adjusted gross income; and

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• **Paid for by a health reimbursement arrangement (HRA) provided by an employer:** An HRA generally may reimburse an employee for DPC arrangement and HCSM membership payments.

Furthermore, to the extent a particular government-sponsored health program requires individuals to pay premiums or enrollment fees for coverage under the program, those amounts are eligible for income tax deduction by individuals as a medical expense.

**The Proposed Rule defines the following government-sponsored health care programs as medical insurance subject to deduction:**
- Medicare, including Parts A, B, C, and D;
- Medicaid;
- Children’s Health Insurance Program;
- TRICARE and medical coverage under chapter 55 of title 10, U.S.C; and
- Veterans’ health care programs under chapter 17 or 18 of Title 38 U.S.C.

Comments to the proposed rule are due August 10.

**HHS Publishes Final 1557 Rule on Nondiscrimination**
The Department of Health and Human Services’ (HHS) Office of Civil Rights (OCR) published a prepublication version of the Nondiscrimination in Health and Health Education Programs or Activities Final Rule under Section 1557 of the Affordable Care Act (ACA) (fact sheet). The new final 1557 rule is expected to be published in the federal register on June 19, 2020 and to be effective on August 18, 2020. This rule updates the previous final rule issued in 2016.

**Background:**
- Section 1557 “prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs or activities.”
In May of 2016, a rule was issued implementing section 1557; interpreting the ban on sex discrimination to include protections for individuals regardless of gender identity, sexual orientation, and pregnancy status.

However, certain provisions of this 2016 rule related to the definition of sex discrimination were challenged in court.

The Trump Administration published a proposal in June of 2019 that would significantly modify the regulation. The action taken by OCR finalizes those changes, reversing some of the 2016 rulemaking.

**Why this matters:** The rule finalizes updates largely as originally proposed, including:
- Eliminating gender identity, sexual orientation, and pregnancy status as categories protected under the term “sex”;
- Eliminating requirements for meaningful language access for people with limited-English proficiency; and
- Limiting the scope of the rule to programs that receive federal financial assistance.

By eliminating the definitions of key terms like “on the basis of sex,” explicit references to specific protections were also removed.

“HHS will enforce Section 1557 by returning to the government’s interpretation of sex discrimination according to the plain meaning of the word ‘sex’ as male or female and as determined by biology,” the department stated in a press release.

**Supreme Court ruling impact:** The legal question of whether the federal civil rights laws incorporated into section 1557 apply to sexual orientation and gender identity could be resolved before the final rule goes into effect. The Supreme Court ruled on June 15 that Title VII of the Civil Rights Act of 1964 prohibits employment discrimination on the basis of sexual orientation and gender identity.

**Insurer perspective:** AHIP President and CEO Matt Eyles released a statement following the finalization of the rule, stating that “[AHIP] resolutely disagrees with any attempt to remove protections in federal law that prohibit discrimination based on gender identity, sex stereotyping, and pregnancy status. We also firmly believe that non-English speakers should have ready access to health information. Discrimination is wrong – period.” AHIP previously submitted a comment letter on the proposed rule last August.

**Hospital perspective:** The American Hospital Association had strongly urged HHS not to finalize their proposal, expressing concerns that “narrowing the current regulation’s protections against discrimination based on sex, including gender identity, sexual orientation, and sex stereotypes, could have an adverse impact on access to care and the health of individuals." The association also raised concerns that the proposed changes would limit the circumstances in which prohibitions against discrimination would apply to health insurers. Without meaningful access to coverage, there is no meaningful access to care.” The AHA also submitted a comment letter on the proposed rule last August.

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**CMS Issues Guidance on Commercial Market 2019 MLR Reporting Timeline and Early 2019 MLR Rebates**
CMS issued guidance on issues related to the 2019 medical loss ratio (MLR) filing timeline and rebates impacting the individual, small group and fully-insured large group markets. The guidance addresses:

- **2019 Reporting Deadline**: CMS will not take enforcement action against an issuer that submits the 2019 MLR Annual Reporting Form by August 17, 2020 instead of July 31, 2020 as required by 45 CFR 158.110(b).
- **Early 2019 Rebate Payments to Policyholders**: CMS will not take enforcement action against issuers that make early 2019 rebate payments to policyholders. A number of issues related to early payment of rebates are addressed in the guidance.

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**IRS Issues Patient-Centered Outcomes Research Institute Fee Reminders and Clarifications**

Under the Affordable Care Act, an annual fee is assessed on health insurance issuers and health plan sponsors to help fund the Patient-Centered Outcomes Research Institute (PCORI). The IRS issued Notice 2020-44, which provides the adjusted dollar amount for calculating the annual fee to fund the PCORI. The PCORI Fee imposed for plan years that end on or after October 1, 2019 and before October 1, 2020 is $2.54 times the average number of lives covered for the plan year.

Since the PCORI fee assessments were scheduled to end after September 19, 2019, the IRS will allow insurers and health plan sponsors to use “any reasonable method” to calculate the average number of covered lives. The PCORI fees were extended under the Further Consolidated Appropriations Act of 2020 and are now not scheduled to expire until plan years ending after September 30, 2029.

**Why this matters**: The notice, typically released in the late Fall, is much later than past years and the FY 2020 PCORI Fee payment deadline remains July 31, 2020.

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**Federal COVID-19 Policy Guidance and Other Developments**

**FDA Revokes EUAs for Hydroxychloroquine, Chloroquine for COVID-19 Treatment**: The Food and Drug Administration said it no longer authorizes the use of hydroxychloroquine or chloroquine as an effective treatment of COVID-19.

FDA cited serious side effects, such as cardiac adverse events in its decision, stating that it considered results from a large trial and found neither drug to “be effective in treating COVID-19, nor is it reasonable to believe that the known and potential benefits of these products outweigh their known and potential risks.” FDA said patients who have already been administered the drugs that were distributed under the original emergency use authorization may continue their use if deemed necessary by physicians.

**CDC Releases Guidance on Telehealth Benefits, Strategies and Safeguards**: The Centers for Disease Control and Prevention last week released guidance on using telehealth to expand access to health care services during the COVID-19 pandemic and beyond. The guidance describes the landscape of telehealth services and considerations for health care systems, practices, and providers.

**CDC Consolidates Testing Guidance**: The Centers for Disease Control and Prevention has consolidated its recommendations for COVID-19 testing, which it will update as additional information becomes available. The agency also released testing strategy options for high-density critical infrastructure workplaces, such as law enforcement, agriculture and critical manufacturing.
The Congressional Budget Office (CBO) released a report on the budgetary effects of the Coronavirus Pandemic, including how tax deferrals will affect federal revenues and what laws enacted in response to the pandemic will have the largest effect on the federal budget deficit.

FDA Authorizes COVID-19 Point-of-Care Test: The Food and Drug Administration issued an emergency use authorization for Cue Health Inc.’s new SARS-CoV-2 nasal swab test in patient care settings.

Point-of-care tests eliminate the need for off-site lab testing and instead allow patient settings, like hospitals and emergency departments, to produce results and provide patients with more immediate access to those test results.

Twenty-four Percent of Workers Vulnerable to Severe Illness From COVID-19: Nearly one in four workers, about 37.7 million, are at higher risk for serious illness if infected by COVID-19 due to age or underlying health conditions, according to a study released by the Kaiser Family Foundation. The estimate includes 10 million workers aged 65 or older and people with diabetes, chronic obstructive pulmonary disease, heart disease, a body mass index above 40, moderate to severe asthma, or a functional limitation due to cancer. In addition, 12 million at-risk adults who do not work are at risk for indirect exposure because they live with someone who does, the authors estimate.

SBA Issues Rule Easing Paycheck Protection Program Restrictions: The Small Business Administration released an interim final rule implementing the Paycheck Protection Program Flexibility Act, legislation enacted two weeks ago.

The rule provides additional flexibility for borrowers by extending the loan period through 2020, as well as the timeframe for repayment if required. It also changes the parameters for potential loan forgiveness; allows borrowers to use up to 40% of the loan on non-payroll expenses; provides different scenarios under which borrowers may be eligible for forgiveness; and allows borrowers who seek forgiveness of the loan to qualify for deferred payment of the employer’s portion of certain payroll taxes.

The provisions related to loan forgiveness and deferral periods are effective March 27; the maturity date provision is effective June 5; and the other provisions are effective immediately. SBA will accept comments on the rule for 30 days after its June 16 publication in the Federal Register. The Coronavirus Aid, Relief, and Economic Security Act created the program to provide loans to small businesses, primarily to help keep their workers on the payroll.

Minority Health Research Funding Available to Support Health Conditions Secondary to COVID-19: The National Institute on Minority Health and Health Disparities is accepting applications through December 15 for funding to expand and improve digital health interventions to identify, treat, and provide services for health conditions secondary to the COVID-19 pandemic in health disparity populations and those with medical or social vulnerabilities. The interventions may use telephone and/or video delivery, app-based approaches, Web-based platforms, wearable devices and/or new technologies. See the announcement for more information on eligibility and the application process.

FDA Approves First COVID-19 Diagnostic Test with Genomic Sequencing; Updates Clinician App: The Food and Drug Administration authorized the first COVID-19 diagnostic test with next generation sequencing, which can generate information about the genomic sequence of the SARS-CoV-2 coronavirus.
The emergency use authorization allows laboratories certified to perform high complexity tests under the Clinical Laboratory Improvement Amendments to use the test during the public health emergency.

“Having a next generation sequencing diagnostic tool available will continue to expand our testing capabilities,” said FDA Commissioner Stephen Hahn, M.D. “Additionally, genetic sequencing information will help us monitor if and how the virus mutates, which will be crucial to our efforts to continue to learn and fight this virus.”

In other news, FDA and the National Institutes of Health recently made updates to the CURE ID app, which allows health care providers to share experiences treating COVID-19 patients not enrolled in clinical trials. FDA encourages providers worldwide to use the app for communicating about new ways to use existing drugs to treat COVID-19 and other difficult infectious diseases.

FDA Approves New Tracheal Intubation Drug: The Food and Drug Administration approved a new injection to assist in tracheal intubation and provide muscle relaxation during surgeries or mechanical ventilation. FDA said side effects include anaphylaxis, hyperkalemia, and malignant hyperthermia.

Study Sheds Light on COVID-19 in Young Adults: About 60% of participants in a study of young adults infected with COVID-19 on a U.S. aircraft carrier had reactive antibodies to the virus, 59% of whom also had neutralizing antibodies at the time of specimen collection, according to a report released by the Centers for Disease Control and Prevention.

“The presence of neutralizing antibodies, which represent antibodies that inhibit SARS-CoV-2, among the majority (59.2%) of those with antibody responses is a promising indicator of at least short-term immunity,” the authors said.

Information about COVID-19 among young adults has been limited. One-fifth of the 382 study participants reported no symptoms, suggesting that symptom-based surveillance might not detect all infections. Participants who reported taking preventive measures, such as using face coverings and observing social distancing, had a lower infection rate than those who did not, reinforcing the importance of preventive measures to lower infection risk in congregate settings, the authors said.

Johnson & Johnson Accelerates Human Trial of Coronavirus Vaccine: Johnson & Johnson recently announced it accelerated the initiation of its first human trials of its coronavirus vaccine candidate, with the trial slated to begin in the second half of July.

In J&J’s first human trial, it will combine Phase I, usually a small study to test safety, with a Phase IIA trial to evaluate immune response and effectiveness. Both phases will enroll a total of 1,045 people between 18 and 55 years old and older than 65.

The company in March received $456 million from the Biomedical Advanced Research and Development Authority to develop its vaccine and is one of several being evaluated under Operation Warp Speed, a public-private partnership to facilitate, at an unprecedented pace, the development, manufacturing, and distribution of COVID-19 countermeasures.

White House Task Force Projects N95 Supply Could Soon Meet Demand: The White House Supply Chain Task Force projects the nation will have enough N95 masks to meet pandemic demand for July through October, according to a report released to the Senate Homeland Security and Governmental Affairs
Committee for a hearing yesterday on federal efforts to procure and distribute supplies to fight the pandemic.

The report also projects that the nation will have enough gowns (including reusable ones), surgical masks, nitrile gloves, and face shields in July, but does not include later projections for those supplies. Federal Emergency Management Agency Director Peter Gaynor released the report at the request of Sen. Maggie Hassan, D-(NH), who said the estimates should have been available sooner and requested longer-term projections for personal protective equipment and similar projections for testing supplies.

Sens. Elizabeth Warren, D-(MA), Chuck Schumer, D-(NY), and Richard Blumenthal, D-(CT), asked a federal oversight committee to investigate whether the administration's Project Air Bridge initiative to obtain and distribute PPE and medical supplies for the pandemic has been cost-effective.

AHA Urges Medicare to Enhance SNF Funding for COVID-19 Testing: The American Hospital Association last week submitted comments to the Centers for Medicare & Medicaid Services on the agency’s proposed skilled nursing facility prospective payment system for fiscal year 2021, urging CMS to support additional funds to offset the cost of critically important COVID-19 testing. AHA said COVID-19-positive patients “are widely acknowledged to generally require substantial additional clinical and other resources... While a portion of these costs have been supported with much-appreciated emergency funds, COVID-19 testing remains a particularly costly ongoing need, with the added expectation that it will resurface during future pandemics.”

Also, the AHA agreed it was appropriate for CMS to exclude selected data from the SNF value-based purchasing program, to recognize the impact of the pandemic. Read AHA’s full comments.

FDA Issues Guidance on Drug Sample Delivery Requirements During the Pandemic: The Food and Drug Administration does not intend to object to a manufacturer or authorized distributor delivering prescription drug samples directly to licensed practitioners or their patients at their homes during the COVID-19 emergency when requested by the practitioner in accordance with requirements, according to guidance recently released.

The FDA also does not intend to take action during the emergency against a manufacturer or authorized distributor that accepts alternatives to a signature to verify delivery and receipt of drug samples if the receipt complies with other requirements, the guidance states.

CMS Encourages Reopening of Health Care Facilities: The Centers for Medicare & Medicaid Services last week released a guide for patients considering in-person, non-emergency treatment as the country continues to reopen and COVID-19 cases decline. The agency also released a summary of its previous recommendations for providers reopening facilities to non-emergency care.

HHS Announces Distribution of Funds to Hospitals Serving High Numbers of Medicaid and Uninsured Patients: The Department of Health and Human Services last week announced that it will distribute $10 billion from the Public Health and Social Services Emergency Fund to hospitals that serve a disproportionate number of Medicaid patients or provide large amounts of uncompensated care.

The Department identified eligible hospitals as those with:
  * A Medicare Disproportionate Payment Percentage of 20.2% or greater;
• Average uncompensated care per bed of $25,000 or more. For example, a hospital with 100 beds would need to provide $2.5 million in uncompensated care in a year to meet this requirement; and
• Profitability of 3% or less, as reported to the Centers for Medicare & Medicaid Services in the most recently filed cost report.

Eligible hospitals will receive a minimum distribution of $5 million and a maximum distribution of $50 million. This payment is being sent via direct deposit. Hospitals serving high numbers of Medicaid and uninsured patients care for our nation’s most vulnerable patients and communities, which have suffered disproportionately from the pandemic. Due in large part to underlying health conditions, the patients these hospitals treat have been hospitalized at greater rates and require more care and resources once hospitalized. This emergency funding will help these hospitals, many of which were already facing serious financial pressures before the pandemic, continue to deliver care to their patients and communities.

The American Hospital Association continues to urge the department to distribute substantial additional funds to hospitals and health systems in an expedited manner as the COVID-19 virus continues to spread, hospitalizations continue to occur, and many Americans continue to forgo care, including primary care and other specialty care visits.

The White House and Coronavirus Response Coordinator and Ambassador Deborah Birx unveiled an addendum to the “Opening Up America Again Testing Blueprint,” which will focus on using tests for diagnosis and proactive surveillance. This document provides additional guidance regarding the optimal deployment and use of testing formats and testing platforms for both the diagnosis of and proactive surveillance for COVID-19. Additional specificity is provided for high-risk settings including long-term care facilities and colleges and universities.

The Department of Health and Human Services (HHS) published a fact sheet outlining the initiatives the Administration has taken to address the disparate impact of COVID-19 on African Americans and other racial and ethnic minorities.

The Department of Labor’s Occupational Safety and Health Administration (OSHA) published a series of frequently asked questions and answers regarding the use of masks in the workplace. The new guidance outlines the differences between cloth face coverings, surgical masks, and respirators and notes the need for social distancing measures, even when workers are wearing cloth face coverings.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) issued guidance on how the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule permits covered health care providers to contact their patients who have recovered from COVID-19 to inform them about how they can donate their blood and plasma containing antibodies to help other patients with COVID-19.

The Centers for Disease Control and Prevention (CDC) released guidance on safety practices while living daily life.

State Issues
Delaware Regulatory

**Phase II of Delaware’s COVID-19 Recovery Plan Begins**
Monday, June 15, 2020 marked the initiation of Phase II in Governor John Carney's Three-phase COVID-19 Recovery Plan. For a complete guide to Phase II protocols, [click here](#).

Governor Carney would not commit to when Phase III might start, however at a recent press briefing he did indicate it would rely largely on the administration's ability to conduct effective contact tracing of confirmed positive cases. To obtain statistical information on Delaware's COVID-19 cases go to: "My Healthy Community." For the latest information on the state's COVID-19 response, go to: [de.gov/coronavirus](http://de.gov/coronavirus).

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State Issues

Pennsylvania Legislative

**Legislation Targets State False Claims, Medicaid Fraud**
Legislation that would create a state false claims act to combat fraud in the Medicaid program was among the bills considered this week by the House Human Services Committee. The following measures were amended and approved by the panel:

- **House Bill 2352** would create a Pennsylvania State False Claims Act to address fraud occurring in the Medicaid program. According to the bill’s sponsor, Rep. Seth Grove (R-York), the proposal was specifically developed to target fraud in the Commonwealth, therefore it differs from other states' false claims statutes. Prior to advancing the bill, the committee approved amendments to provide protections for whistleblowers, allowing them to notify their employers and the Office of the Attorney General, and language that ensures resources are specifically directed at combatting fraud.

- **House Bill 2350** would require a provider seeking to participate in the Medicaid program to use either a National Provider Identifier (NPI) or register for State Provider Identifier (SPI). The measure also requires the Department of Human Services to establish and implement a standardized training program for individuals seeking to deliver services via the Medicaid program. The panel approved a technical amendment.

- **House Bill 2351** would increase the penalties for making a false claim against the Medicaid Program under section 1407 of the state’s Human Services Code: a felony of the second degree for claims $100,000 or more; felony of third degree for claims between $2,000 and $100,000; and third degree misdemeanor for claims $2,000 or less. The bill was amended to exclude persons receiving public services from being charged, unless they have committed a fraudulent act.

- **House Bill 2355** would require any Medicaid Managed Care Organization (MCO) to enter into an agreement with the Department of Human Services (DHS) to allow the Department to recoup any Medicaid funds which were spent on Provider Preventable Conditions (PPC). DHS is authorized to levy a fine ranging between .5% and 5% of the total claims the MCO made under Medicaid. The bill was amended to allow the DHS to annually adjust the Medical Assistance MCO financial reporting that is used as the basis of rate setting, by the value of provider-preventable conditions.
The bills have been referred to the full House for further consideration.

**Senate Committee Approves Interstate Licensure Compact Measures**
The Senate Consumer Protection and Professional Licensure Committee voted this week to approve several bills addressing interstate provider licensure compacts:

- **Senate Bill 655** authorizes Pennsylvania to join the Nurse Licensure Compact to create a mutual agreement among the states for professional licensing activities and will provide licensing reciprocity among the member states. The proposal was amended to authorize the sharing of criminal background information that is required for licensure.

- **Senate Bill 1186** updates the Interstate Medical Licensure Compact passed in 2012 by amended the Medical Practice Act to permit the sharing of criminal background check data required for licensing purposes under the Compact. This change allows Pennsylvania to fully participate in the Compact.

- **Senate Bill 1187** is a companion to Senate Bill 1186. It amends the Osteopathic Medical Practice Act to permit the sharing of criminal background check data required for licensing purposes under the Compact. This change allows Pennsylvania to fully participate in the Compact.

The bills have been referred to the Senate floor for further consideration.

**House Speaker Mike Turzai Resigns**
On Wednesday, June 10, Speaker of the House Mike Turzai (R-Allegheny) announced his resignation from the House of Representatives, effective June 15. Turzai announced in January that he would not seek reelection.

Speaker Turzai was first elected to the House in 2001 in a special election, after serving as an assistant district attorney in Allegheny County. In 2010 he was elected to become the House GOP’s majority leader before being chosen to serve as speaker in 2015.

The House is scheduled to elect a new speaker in the near future.

**State Issues**

**Pennsylvania Regulatory**

**DOH Announces New Attestation Process for Approving New Services and Equipment**
Last week, the Pennsylvania Department of Health (DOH) announced its new attestation process to streamline approvals for new services and equipment.

Effective June 5, 2020, hospitals are allowed to provide the DOH Division of Acute and Ambulatory Care (DAAC) with an attestation for the initiation of new services and new or replacement equipment. Attestation
only replaces the DAAC portion of the occupancy survey. If the project involves any renovations, new construction, or use of space which has not previously been surveyed by DAAC, the facility will still need to have an onsite survey for the Facility Guidelines Institute (FGI) portion of the project. DAAC surveyors will review the attestation and provide the facility with approval for the new services and new or replacement equipment.

DAAC surveyors will evaluate 20 percent of the attestations submitted by the facility during the facility's next onsite survey. Please find the overview of the attestation process and attestation forms posted at the DOH hospital web page.

Why this matters: The Division of Acute and Ambulatory Care has been evaluating its survey process for some time. DOH recognizes that the demand for surveys has outpaced its staffing resources which on occasion has left hospitals waiting to have occupancy surveys for new services and equipment.

Over the past several months, DOH has been working on an attestation process for hospitals for new services and new or replacement equipment. This included the development of attestation forms, the internal protocols, discussing with staff, and obtaining the necessary approvals.

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Secretary of Health Issues Order to Protect Hospital Staff and Patients
The Pennsylvania Department of Health (DOH) has issued an Order by the Secretary of Health that takes effect June 10, 2020. This order requires the creation of policies and procedures in consultation with medical and nursing staff, including professional and auxiliary nursing staff members.

Implementation of these policies and procedures are required by 12:01 a.m. June 15, 2020, and must be adhered to and made available to hospital staff.

A summary of the Health Order finds that these policies and procedures must provide at a minimum for:

- An exposure notification process for notification of “close contacts” as outlined in PA-HAN 510 or its successor. Hospitals must notify staff who have close contact with a confirmed or probable COVID-19 case as soon as is practical, but within 24 hours of known contact. Staff receiving notice must be given instructions for quarantine or work exclusion as outlined in PA-HAN 484 or its successor;
- Following a COVID-19 confirmed or probable COVID-19 close contact notice, hospitals must have a process in place for offering COVID-19 testing upon request for all symptomatic and asymptomatic staff. Instructions for quarantine and work exclusion should be given to staff upon receipt of a positive result as outlined in PA-HAN 484 or its successor;
- Personal Protective Equipment (PPE) distributed to hospital staff providing direct patient care to COVID-19 positive or suspected cases, and to staff providing direct care in COVID-19 units. Policies and procedures are required for respirator distribution and sets minimal requirements. This order identifies the types of respirators allowed, and requires distribution at the beginning of a shift and when soiled, damaged, or ineffective; and
- Policies and procedures for universal masking of patient and visitors with select exceptions.

Why this matters: Across Pennsylvania, nurses and other front-line workers are treating patients around the clock in hospitals fighting the COVID-19 pandemic. Hospitals are already taking steps to protect their staff from this dangerous virus as much as possible.
DOH indicated that they heard complaints from unions representing nurses and staff, and this Order responds directly to many of their safety concerns. DOH believes this order ensures that the necessary steps are in place to deliver a safer environment so these workers can continue providing high-quality care during these extraordinary times.

**Insurance Department Highlights Guidance on Section 1557 Protections**

The Department of Health and Human Services’ (HHS) Office of Civil Rights (OCR) released a final rule under Section 1557 of the Affordable Care Act (ACA), which “prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs or activities.” A 2016 rule interpreted the ban on sex discrimination to include protections for individuals regardless of gender identity, sexual orientation, and pregnancy status. The new rule released last week reverses that interpretation.

"HHS will enforce Section 1557 by returning to the government’s interpretation of sex discrimination according to the plain meaning of the word ‘sex’ as male or female and as determined by biology," the department stated in a press release.

**Why this matters:** As a result, the Insurance Department highlighted state guidance to health insurance companies that Pennsylvania’s LGBTQ+ community is protected from the potential negative impact of the new federal rule. “The PID [issued guidance] in 2016 that addresses our expectations that all consumers have access to robust and affordable coverage regardless of one’s gender identity,” the Insurance Department stated. Consistent with that guidance, PID will continue to expect that:

- A policy will not contain any discriminatory terms, conditions or benefit provisions contrary to State and Federal laws;
- A policy affirmatively will include nondiscriminatory terms, conditions and benefit provisions consistent with State and Federal laws;
- A policy will not exclude services based on gender identity and will not contain a categorical exclusion of coverage for all health services related to gender transition; and
- A policy will affirmatively provide that medically necessary covered services will be available to a policyholder regardless of their gender identity.

**Industry Trends**

**Policy / Market Trends**

**FCC Proposes $225 Million Fine against Health Insurance Telemarketer**

The Federal Communications Commission (FCC) proposed a $225 million fine against a Texas-based health insurance telemarketer selling short-term limited-duration health insurance.

- According to the FCC’s statement, the telemarketer operates under different names that include Rising Eagle and JSquared Telecom. The FCC claims that the telemarketer “made approximately one billion spoofed robocalls across the country during the first four-and-a-half months of 2019” on behalf of insurers selling short-term limited-duration health insurance.
- The FCC also claims that the telemarketer knowingly called people on the national Do Not Call list and falsely claimed an association with well-known health insurance companies such as Aetna, Blue Cross Blue Shield plans, Cigna, and UnitedHealth Group.
**Why this matters:** Critics of short-term limited-duration insurance have long worried that these products, which are often low-cost while paying higher broker commissions and other administrative expenses, is prone to unethical marketing. The telemarketer will be given the chance to respond to the FCC’s complaint before the FCC finalizes its action. If it stands as proposed, the $225 million fine would be the largest in FCC history.

**Updated Analysis on Projected Costs of COVID-19 on Health System**

AHIP retained Wakely Consulting Group to update its analysis from March 30 on potential cost implications of COVID-19 testing and treatment. The update includes new data on COVID costs, utilization, and deferred care. While this new information has improved the analysis, significant uncertainty remains on the ultimate impact of COVID-19 on the United States and particularly the health care industry.

The primary changes from the prior report include:

- The overall assumed rates of hospitalization for infected individuals has been reduced to align with recent studies. The rate has also been adjusted for age and morbidity differences by line of business;
- The estimated unit cost of a hospital admission has been increased based on health plan experience using survey data provided by AHIP members; and
- An estimated impact of deferred care on overall healthcare spending was included and combined with the COVID treatment costs to arrive at a combined impact on cost of care by line of business.

Wakely’s previous report estimated the direct impact of COVID-19 treatment costs to be between $56 and $556 billion, while the updated analysis estimates costs of $30 to $547 billion (without accounting for deferred care).

**New Study Explores Potential Costs of COVID-19 Testing**

AHIP published a new study conducted by Wakely Consulting Group exploring the potential costs of COVID-19 testing. The study includes both diagnostic (molecular or antigen) and antibody testing and explores the costs of testing and different testing frequencies. The study found that diagnostic testing would cost between $6 billion and $25 billion a year, and antibody testing would cost between $5 billion and $19 billion a year. These estimates include both the cost of the tests, as well as affiliated health care services (e.g., provider visit, urgent care visit) for administering the tests.
Interested in reviewing a copy of a bill(s)? Access the following web sites:

Pennsylvania Legislation: [www.legis.state.pa.us](http://www.legis.state.pa.us).
West Virginia Legislation: [http://www.legis.state.wv.us/](http://www.legis.state.wv.us/)
For copies of congressional bills, access the Thomas website – [http://thomas.loc.gov/](http://thomas.loc.gov/).

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