Federal Issues
Regulatory

Rules Issued on Disclosure of Hospital and Health Plan Negotiated Rates
Two rules were issued last week that require hospitals and insurers to make pricing information available to the public:

- A final rule requiring hospitals to disclose payer-specific negotiated rate; and

- A proposed rule that would impose new requirements on private insurers in the individual and group markets to publicly disclose negotiated rates and out-of-network allowed amounts, and give their enrollees real-time, personalized access to cost-sharing information.

The first of these rules is the Calendar Year (CY) 2020 Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) Price Transparency Requirements for Hospitals to Make Standard Charges Public Final Rule; the second is the Transparency in Coverage Proposed Rule.

Key provisions of price transparency requirements for hospitals:

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- Takes effect on January 1, 2021, rather than 2020, in response to public comments
- Hospitals must disclose the rates they negotiate with insurers
- Provide patients with clear, accessible information about their “standard charges” which includes gross charges, payer-specific negotiated charges, discounted cash prices, and the minimum and maximum negotiated charges

- Make information available to the public in two ways:
  1. **Comprehensive Machine-Readable File**: Hospitals must post standard charges for all items and services on the Internet in a single data file that can be read by other computer systems. The file must include additional information such as common billing or accounting codes used by the hospital. Hospitals must include a description of the item or service so consumers can compare standard charges from hospital to hospital.
  2. **Display of Shoppable Services in a Consumer-Friendly Manner**: Hospitals must post public payer-specific negotiated charges online in a searchable and consumer-friendly format. This information includes the amount the hospital is willing to accept in cash from a patient for an item or service; and the minimum and maximum negotiated charges for 300 common shoppable services. Shoppable services are services a consumer can schedule in advance such as x-rays, outpatient visits, and laboratory tests. They also include bundled services such as a cesarean delivery, including pre- and post-delivery care. Hospitals must update the information at least annually.

- The final rule gives CMS new enforcement tools and the ability to impose civil monetary penalties of $300 per day.
Health plan transparency rule key provisions:
- Requires most employer-based group health plans and health insurance issuers to disclose price and cost-sharing information on a public website
- Includes negotiated rates for in-network providers and allowed amounts paid for out-of-network providers
- Health plans would be required to make available - through an internet-based self-service tool, or by paper upon request - a patient’s real-time, personalized estimates of out-of-pocket costs they must pay to meet their plan’s deductible, co-pay, or co-insurance requirements before receiving services, through an internet-based self-service tool, or by paper upon request
- The goal is to make previously unavailable price information accessible to members in a standardized way, allowing them to shop and compare provider costs
- Seeks input on two requests for information related to making this information available through an API, and whether quality information should be disclosed as well.
- Comments on the proposed rule are due January 14, 2020. The final rule would be effective for plan years beginning on or after 1 year after the effective date of the final rule.

Federal Issues
Legislative

Short Term Funding Extension Likely
Congressional leaders are aiming to pass a short term extension of government funding this week, giving negotiators until Dec. 20 to clear the remaining FY2020 spending bills. Current funding expires on Friday and negotiations on a funding package have been mired in debate over spending caps and border wall funding.

House Panel Advances Health Bills
On Wednesday, the House Energy and Commerce (E&C) Subcommittee on Health held a markup session to consider four key health-related bills. All were approved without objection.

- **H.R. 2339**, would raise the minimum age to purchase tobacco to 21 and would restrict flavoring of nicotine products. Additionally, the bill would ban all non-face-to-face sales of tobacco products to protect youth from predatory marketing.
- **H.R. 4995** and **4996** would address gaps in maternity care and mortality, particularly in rural areas and allow states the option of extending Medicaid coverage to 12 months postpartum
- **H.R. 2387**, would help address the abuse of citizen petitions that delay or impede generic drugs from coming to the market

The bills are likely to be taken up by the full Energy and Commerce Committee soon.

State Issues

Pennsylvania
Legislative

Health Care / Insurance Bills Slated for Consideration by Senate and House
Next week the Pennsylvania General Assembly is slated to consider several health care / insurance measures that could impact Highmark and the Allegheny Health Network. The following bills are tentatively scheduled to receive consideration via House or Senate floor vote or by a committee:

- **Surprise Balance Billing and Emergency Department Out-of-Network**
  House Bill 1862, the Surprise Balance Bill Protection Act, would provide consumers with protections from balancing billing practices by certain out-of-network (OON) health care providers—specifically emergency services and services provided at an in-network facility by an OON provider. Both of these limited instances involve customer/patient being involuntarily exposed to an OON provider. *(House floor vote)*

  Several amendments have been filed to House Bill 1862, including one that would institute an arbitration process.

  **Why this matters**
  House Bill 1862 would:
  - Ensure that consumers are only responsible for their in-network cost-sharing obligations;
  - Allow consumers to trigger protections if they do receive a balance bill; and
  - Instruct OON providers to bill insurers directly, and in return they would be paid directly—a fair, market-based rate.

  Two other measures, House Bill 1347, which requires insurers to directly reimburse out-of-network emergency medical service providers and House Bill 546 (assignment of benefits), which requires insurers to pay all clean claims directly to a participating or non-participating healthcare provider, may also be considered.

- **Telemedicine Mandate and Practice Guidelines**
  Senate Bill 857 mandates coverage and establishes guidelines for the use of telemedicine in the Commonwealth. The bill is currently in the House Insurance Committee awaiting further consideration.

- **Dense Breast Ultrasound, MRI Mandate**
  Senate Bill 595, as currently drafted, would expand access to breast cancer screening for women found to have dense breast, including breast ultrasounds and MRIs.

- **House Bill 427** prohibits health insurance providers from restricting access to Stage IV metastatic cancer treatments if the drugs are FDA approved and consistent with Stage IV metastatic cancer best medical practices.

- **PBM Managed Care Organization Prohibitions**
  House Bill 945 prevents Medicaid Managed Care Organizations (MCOs) from contracting with a pharmacy benefit manager that owns – or is owned by – a retail pharmacy.

- **Workplace Safety**
  Senate Bill 842 would remove the requirement for last names to be displayed on health care employees’ identification badges *(Senate Appropriations Committee vote)*. Its companion, House Bill 1880, is on the House voting calendar.
Why this matters
According to the Hospital and Healthsystem Association of Pennsylvania (HAP), 60 percent of all workplace assaults occur in health care facilities. Senate Bill 842 and House Bill 1880 would protect workers from being targeted by name.

- **PHC4 Reauthorization**
  Senate Bill 841 would reauthorize the Pennsylvania Health Care Cost Containment Council (PHC4) as an independent agency consisting of public officials and representatives from business communities, organized labor, consumers, hospitals, physicians, nurses and the insurance industry to collect and disseminate health care cost data. PHC4 currently operates under a gubernatorial executive order. PHC4 would have a five-year sunset date.

Public Hearing Scheduled for Senate Bill 675, Buprenorphine Licensure and Prescribing
On Tuesday, November 19, the House Human Services Committee will hold a public hearing on Senate Bill 675, the Buprenorphine Medically Assisted Treatment Act. The proposal would require the Department of Drug and Alcohol to establish a program verifying that buprenorphine office-based prescribers are qualified to prescribe buprenorphine.

The following individuals are scheduled to present testimony: Dr. Rachel Levine, secretary of the Pennsylvania Department of Health; Dr. Michael Lynch, medical director of the Pittsburgh Poison Center and professor at the University of Pittsburgh School of Medicine; Dr. Perry Meadows, medical director of government programs with Geisinger Health Plan; Dr. William Santoro, public policy chair with the Pennsylvania Society of Addiction Medicine; Dr. Donna Eget, co-chair of the Lackawanna Opioid Coalition; Dr. J. Michael Kowalski, medical director of the emergency department at Einstein Medical Center; Dr. Thomas Farley, Philadelphia health commissioner; Susan Friedberg Kalson, CEO of Squirrel Hill Health Center; Jason Snyder, regional director of strategic partnerships at Pinnacle Treatment Centers; Ken Dickinson; co-founder and past president of the Pennsylvania Recovering Pharmacists Program; and Deb Beck, president, Drug and Alcohol Service Providers Organization of Pennsylvania.

Highmark and Allegheny Health Network, which have submitted comments for the public hearing record, have identified a number of concerns with the bill, including:

- The bill’s duplicative certification requirements, as well as the proposed licensing fee for Office-Based Opioid Treatment (OBOT) practices -- which could result in decreased access to lifesaving care;
- The licensure program created by the Department of Drug and Alcohol Programs for OBOT providers would create a duplicative process for physicians, nurse practitioners, and physician assistants to practice OBOT as established by the federal Drug Addiction Treatment Act (DATA) of 2000 and expanded by the Comprehensive Addiction and Recovery Act (CARA) of 2016;
- Physicians are already required to receive 8 hours of training on treating opioid use disorder with Food and Drug Administration (FDA)-approved medications, while nurse practitioners and physician assistants must receive 24 hours of training;
- These federal requirements provide for sufficient training and experience in order for these clinicians to engage in OBOT. Duplicating that process can disincentivize clinicians from offering these treatment services.

Why this matters
The licensing fees established by Senate Bill 675 could seriously impede clinicians’ interest in providing OBOT. OBOT providers who treat patients on Medicaid and private insurance likely would not be able to afford the high fee that the legislation would require and thus would discontinue providing care for their patients with addiction;

- There are shortages of physicians and clinicians willing to treat this patient population and the new requirements could exacerbate the lack of available providers; and
- Pennsylvania’s addiction treatment system should be aligned with the standards and best practices of the addiction medicine field. It is imperative that patients have access to the right care they need when they need it.

State Issues

Pennsylvania
Regulatory

Pennsylvania Insurance Department Seeks Public Comment on Section 1332 Innovation Waiver Application
The Pennsylvania Insurance Department began accepting public comments on its Section 1332 waiver application on Friday, November 15, 2019. Comments will be accepted through Saturday, December 14, 2019.

Background
- On July 2, 2019, Governor Wolf signed Act 42, which created an opportunity for a state-based exchange and for a reinsurance program to help moderate premium increases in the Commonwealth’s individual health insurance market and maintain and protect coverage gains in the Commonwealth.
- The program would use reinsurance funds to partially reimburse insurers for certain claims for higher-cost members in the individual market.
- This will potentially allow insurers to lower premiums for all members.

According to the Commonwealth’s press release, section 1332 waivers empower states to pursue innovative programs and modify certain rules outlined in the Affordable Care Act (ACA) to tailor health care coverage options to meet the unique needs of their markets and their residents. State programs must meet four guardrails to take advantage of this waiver. A waiver program must:

- Provide coverage that is at least as comprehensive as ACA coverage;
- Provide coverage that is at least as affordable as ACA coverage;
- Provide coverage to a comparable number of state residents; and
- Not increase the federal deficit.

Section 1332 general information, frequently asked questions, and a comprehensive description are available for review at www.insurance.pa.gov/PA1332Waiver.

The department will host two public hearings on December 3 and 5 that will provide an opportunity to Pennsylvanians to learn more and submit comments on the 1332 waiver application.
The Pennsylvania General Assembly is in session November 18-20.

The Delaware Legislature has adjourned for the year.

The West Virginia Legislature has adjourned for the year.

Congress
The U.S. Congress is in session November 18-21. The U.S. Senate is in session November 22.

Interested in reviewing a copy of a bill(s)? Access the following web sites:

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

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