Subject: REDC Policy Update 12.13.19

Good Afternoon REDC Members,

Below you will find your policy update for the week.

A brief update on Timely Billing for Patients:

The Senate held an outside stakeholder meeting earlier this week on a section-by-section update of the Lower Health Care Costs Act of 2019, which we were invited to attend.

The Timely Billing Provision has been modified largely in part by the mental health community, specifically the eating disorders community as stated by the Senate HELP Committee—this is a BIG deal our community was mentioned by name!

Pasted below is the summary of the revised section; however, numerous questions remain and we are unable to provide additional clarifying information at this time until the Senate releases final text.

To add an addition wrinkle to negotiating, the House Ways & Means Committee released an outline of their own on surprise billing, which includes a bullet on Timely Billing, but we have learned that legislative text would not be released until January.

It is unclear if this topic will be solved before the end of the year or if enough disagreement continues that it will be taken up next year—a lot still in play and under discussion.

Sec. 205. Timely bills for patients.	• Requires health care facilities and practitioners to give patients a list of services received upon discharge or end of a visit or by postal or electronic communication as soon as practicable and not later than 15 calendar days after discharge or date of visit. • The health care facility or practitioner shall submit to the health plan the bill not later than 20 calendar days after discharge or date of visit of the individual. A health plan, after receiving the bill from the health care facility or practitioner, shall complete adjudication of the bill not later than 20 calendar days after receiving the bill. The health care facility or practitioner shall send the adjudicated bill to the patient not later than 20 calendar days after receiving the adjudicated bill from the health plan. • If a patient receives a bill more than 60 calendar days after receiving care, the patient is not obligated to pay. • The Secretary of HHS shall promulgate regulations to account for any extenuating circumstances or types of billing (such as global packages) that may prevent a provider, facility, or health plan from complying with this provision. • Requires facilities and practitioners to give patients at least 35 days after the postmark date to pay bills.

SERVE Act

No updates to report

ACA Congressional

House Energy & Commerce Health Subcommittee Hold Hearing on Universal Coverage Proposals *(full summary memo attached)*

Earlier this week, the E&C Committee examined different legislative proposals that have been put forth in the House on various health insurance coverage models from Medicare for All to various public options/buy-in bills.

It is important to reiterate that this hearing was held to appease the Democratic Caucus' progressive wing to have a forum to discuss these ideas. However, Medicare for All continues to not have the support from Democratic leadership.

Critics of these proposals point to failures they see in other single-payer systems, they believe many rural hospitals will close, life-saving drugs won't be available, and costs will be unsustainable in the long run.

Supporters argue the legislation would lower healthcare costs in the long-term, establish healthcare as a human right, and prevent bankruptcy caused by medical bills—although they disagree on the exact solution.

ACA Taxes In Limbo

Congressional leaders are still debating what to do about two ACA taxes.

The medical device tax has been suspended by Congress since 2016 and there is bipartisan support for continuing to suspend the 2.3% tax on medical devices.

The Cadillac tax, which is a 40% tax on generous employer plans is also supposed to start in January. Senate Democrats pitched a bill earlier this year to repeal the tax starting in 2022.

As Leader Pelosi is focused on corralling her caucus around H.R. 3, one of their landmark drug pricing legislation, Congressional staff think a late-breaking and expensive deal on taxes is unlikely before the year's end.

ACA Regulatory

Supreme Court Hears Arguments Regarding ACA Risk Corridor Payments

The risk corridor program was designed to help health plans recover some losses in the first 3 years of the ACA marketplaces. Congress gave the incentive because of the uncertainty many insurers faced regarding how sick or costly this previously uninsured population would be.

Insurers that made large profits were to pay some of it back to the government to share with money-losing insurers. However, the money taken in under the program fell billions short of the amount owed to insurers.

The Obama Administration told insurers the Centers for Medicare and Medicaid Services would make up the difference in funds. However, the GOP-led Congress stripped out most funding for the program using spending riders on appropriations bills in 2014 and 2015.

In turn, insurers filed suit and the Supreme Court heard consolidated cases this week of Maine Community Health Options, Moda Health Plan and the now-defunct Land of Lincoln Mutual Health.

There is $12 billion at stake and the justices seemed sympathetic to the insurers during oral arguments this week and a ruling is expected in the spring.

2020 Healthcare.gov Open Enrollment Closes This Weekend

Nearly 3.9 million people have signed up for 2020 coverage through Healthcare.gov, putting sign-ups about 6% behind last year's pace on the federal enrollment website serving 38 states.

It will likely be weeks before the Administration will issue final enrollment reports—including numbers for state-run marketplaces. In all, 11.4 million signed up through Healthcare.gov and state-based marketplaces in last year's enrollment season.

IRS Study Shows Positive Impact of Health Insurance

3 years ago 3.9 million Americans received a letter from the IRS stating they had recently paid a fine for not carrying health insurance.

3 Treasury Department economists have published a working paper finding these notices increased health insurance sign-ups.

Obtaining insurance reduced premature deaths—especially for Americans in the 45 to 64 age range. For every 1,648 who received a letter, one fewer death occurred than among those who hadn't received a letter.

In all, the researchers estimated that the letters may have saved 700 lives.

This experiment occurred by accident as the Obama Administration had planned to send letters to all 4.5 million Americans paying tax fines for not carrying health insurance, only to learn the budget was not big enough. About 600,000 uninsured taxpayers were randomly left out of the mailing.

This created a randomized controlled trial and the results produced today.

54 Million American Have Pre-Existing Conditions That Would Make Them Uninsurable in the Individual Market Without The ACA

An updated Kaiser Family Foundation analysis estimates that almost 54 million people or 27% of adults under the age of 65 have pre-existing health conditions that would likely have made them uninsurable in the individual markets before the ACA.

The share of adults under 65 with declinable pre-existing conditions varies significantly across states from at a least a third in W. VA, AR, KY and MS to a little more than 1 in 5 in Colorado.

FCC Moves To Designate 988 National Suicide Prevention Hotline Number

Earlier this week, 5 FCC commissioners voted in favor of a proposal to designate 988 as the country's national suicide-prevention hotline number.

The proposal, which is now open to public comment, asks telecom companies to ensure users can dial 988 to reach the National Suicide Prevention Lifeline within 18 months.

Last year alone, the government-based suicide hotline answered more than 2 million calls, and the FCC is predicting that the 988 designation will lead to even more.

State Actions

CALIFORNIA

The State Dept. of Managed Health Care hit Anthem Blue Cross with $9.6 million in fines from January 2014 through early November 2019, which is about 44% of the $21.7 million in penalties the department issued against full-service health plans during that period.

Anthem only covers 10-13% of Californians with department-regulated plans. By comparison, Kaiser Permanente covered nearly 1/3 of Californians in department-regulated plans in that timeframe but only received 11% of the penalties.

The fines against Anthem are related to many of the 553 enforcement actions that the department has taken against the health plan for taking too long to respond to enrollee grievances, inappropriately denying claims and not covering the cost of out-of-network care that should have been covered.

The Dept. of Managed Health Care, which oversees health plans that cover about 26 million Californians, is the state's largest health insurance regulator. Since 2000, when the agency was created, it has levied $73 million in fines to licensed health plans.

SOUTH CAROLINA

The Trump Administration will allow South Carolina to impose work requirements on certain Medicaid beneficiaries.

Under SC's requirements, adults on Medicaid will need to work or volunteer at least 80 hours per month, beginning no earlier than next December, in order to keep their eligibility.

People who can't meet the requirements for 3 consecutive months will have their benefits suspended until the work requirements are met and will be able to re-enroll whenever they can prove they're in compliance.

SC's own estimates found that 7,100 beneficiaries could lose their coverage as a result.

Best,
Katrina, Luke & Allison