Hoosiers for Affordable Health Care 2021 Policy Priorities
January 8, 2021

Legislative Items

1. Price Disclosure

Action: Codify the federal hospital price transparency rule (finalized in November 2019) and the insurance company transparency rule (finalized in October 2020). If the state codifies the federal rules, it should strike the weighted average price disclosure requirement for 100 shoppable services that was enacted last year and that is scheduled to take effect on March 31, 2021.
Note: By codifying the federal rule, Indiana will relieve hospitals of the obligation to comply with two different price disclosure rules—one issued by the federal government and another issued by the state. Nor will state insurance regulators have to enforce both sets of rules.

Background on Federal Rules: The existing federal hospital price transparency rule, effective January 1, 2021, requires hospitals to post the prices that they negotiate with health insurance companies as well as their cash prices in a standardized, machine-readable format. This rule also requires hospitals to post price information for 300 shoppable services in a consumer-friendly format on their website or have a price estimator tool on their website. The federal rule penalizes non-compliant hospitals $300 per day. Indiana can start with this penalty but consider escalating it with repeated violations.

Starting on January 1, 2022, the federal insurance transparency regulation requires group health plans and health insurance issuers to publicize the rates they pay providers for specific services. This data would be standardized, in a machine-readable format, and updated monthly. They would need to provide 3 separate machine-readable files: 1) negotiated rates for in-network providers/facilities, 2) both the historical payments to, and billed charges from, out-of-network providers, and 3) the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

The insurer price transparency rule also requires health plans to offer an online shopping tool that shows the negotiated rate between the provider and plan plus a personalized estimate of their out-of-pocket cost for 500 of the most shoppable items and services starting on January 1, 2023. Starting on January 1, 2024, health plans must show the negotiated rates and personalized out-of-pocket estimate for all remaining procedures, services, drugs, and durable medical equipment. In addition to the consumer tool, insurers must provide complete price information. Violations of the insurer transparency rule would be enforced under ACA provisions, with a penalty of up to $100 per patient per day. States take the lead on enforcement.

Rationale: The federal rules were the result of a thoughtful and deliberate process, which included public review and comment. Indiana should codify these rules for three reasons. First, a subsequent administration in Washington could weaken or remove the requirements. Second, although the hospital rule was upheld by both a federal district and a federal appeals court and seems legally protected, insurers will likely file suit that the insurance rule exceeds the statutory authority that the Affordable Care Act granted the federal departments. Third, aligning state and federal requirements can ease reporting burdens on hospitals and insurers if accompanied by repeal of average price disclosure that state enacted last legislative session.

2. Site of Service

Action: Adopt the National Academy for State Health Policy model legislation to prohibit any health care facility that is located more than 250 yards from a hospital campus from charging a facility fee for services provided at that location and prohibit providers from charging facility fees for certain classes of outpatient services, including but not limited to evaluation and management services, regardless of the location where that specific service was provided. This legislation is modeled after Medicare requirements. The legislature should consider exempting rural, independent hospitals and rural, independent physician practices from this requirement.

Rationale: Hospitals and hospital-affiliated facilities often charge "facility fees." A facility fee is a charge that reimburses for the use of a hospital's facility, equipment, and non-physician personnel. It is added to professional service fees, which compensate physicians and other medical providers. Bills for office visits at a hospital-affiliated medical practice often include a facility fee, meaning that an insurance company will pay much more for the same care in the hospital-owned facility than at a physician-owned clinic or office. Operationally, the physician fee is billed using a standard form for all insurers called the CMS form 1500. The facility fee is billed on a standard form called the CMS 1450, aka UB-04 form. In a physician-owned clinic, only a CMS form 1500 is submitted. In a hospital-affiliated clinic, both forms are typically billed for physician services even though the service is the same.

Employers in the state are concerned that hospital-affiliated facilities or hospital-affiliated doctors' offices are filing a form that leads to facility fee payments in addition to the professional fee payment when a facility fee is inappropriate. According to Medicare's payment structures, facility fees are inappropriate if the location is a facility more than 250 yards from a hospital campus or for basic evaluation and management services.

While inappropriate facility fees directly raise total health care spending, they also lead to more consolidated health care markets, as hospitals purchase independent physician practices, imaging centers, and ambulatory surgical centers to increase their revenue. This consolidation reduces competition in the health care market and serves to increase prices.

Connecticut has prohibited facility fees for outpatient services that use a CPT evaluation and management code when that service is provided at a hospital-based facility since January 1, 2017. The law also states that facility fee charges for uninsured individuals cannot exceed the Medicare rate. The requirement does not apply to services provided at remote emergency departments, i.e., those located off the hospital campus.

3. Pharmacy Benefit Manager Payment Disclosures

Action: Last year, the legislature required that insurers disclose to the policyholder or subscriber the amount of the commission, service fee, or brokerage fee to be paid to an insurance producer for selling, soliciting, or negotiating the policy or contract and whether the commission or fee is based on a percentage of total plan premiums or a flat per member fee. The information must be disclosed at the outset and upon renewal of the policy or contract. These requirements have been in effect since July 1, 2020. In December 2020, the U.S. Congress passed legislation that contained similar requirements.

This year, we recommend requiring that PBMs make similar disclosures to the group health plan sponsor. These payments would include the rebates that the PBM has negotiated with the insurer or TPA as well as any additional payments made to insurers, brokers, and benefit consultants.

Rationale: Employers and individuals consider their health consultants and brokers to be trusted advisors. Some consultants and brokers receive sales fees or commissions from third parties to promote their services or products. Efforts to mitigate any potential conflict of interest that could result from a purchaser procuring services or products based on considerations other than identifying the best value for each client would promote transparency and accountability. Consultants and brokers should disclose any financial arrangement they have with third party organizations for which they are promoting services or products.

4. Make the short-term regulatory relief permanent

Action: Make permanent Governor Holcomb's coronavirus-related regulatory relief that allowed out-of-state health care professionals to gain licenses more easily in the state and that expanded telehealth services.

Rationale: During the pandemic, Governor Holcomb issued several directives that expanded the ability of providers to treat patients and made it easier for patients to access care. There were three main expansions: 1) expanding patients' ability to remain in their homes and receive health care services through telehealth, 2) expanding out-of-state health care professionals' and retirees' ability to more easily obtain licenses to practice in the state, and 3) allowing residents and medical students to obtain certain practice privileges before they are licensed. The first two of these should be made permanent, as they serve to restrict alternative sources of care—reducing patient access and raising costs—and are not justified under normal conditions either.

5. Scope of Practice Limitations

Actions:

1) Establish a process where an independent set of researchers produce an objective analysis of how Indiana's scope of practice regulations compares to those in other states, the benefits and costs of a more liberalized approach, as well as a recommendation to the legislature. An analysis of at least two health care occupations must be conducted each year. The review must contrast Indiana's requirements with those of its contiguous states, similar to reviews that the Governor's Health Workforce Council has conducted for certified nurse aides, licensed practical nurses, emergency medical technicians/ paramedics, and dental hygienists. In addition to contrasting states' occupational licensing rules, the review must also include an assessment of the regulatory approach of states that have the broadest practice ability. The review must also include a summary of the effect, on price, access, spending, and outcomes between the least restrictive approach and more restrictive approaches to licensing and practice requirements for that health care occupation. Finally, the review should make a recommendation to the legislature based on its review of Indiana's regulations compared to other states as well as the empirical evidence.

2) Expand pharmacists' scope of practice so that they can independently prescribe vaccines (something that is crucial given the advent of the new coronavirus vaccines) and refill

expired ‘maintenance’ prescriptions for up to 180 days. Permit patients to authorize their prescription medications to be shared with third parties.

Rationale: Legislators are not in an ideal position to understand the full set of issues around scope of practice. Many legislators have indicated that it would be helpful to have an independent body provide the legislature with an objective review of the impact of restricting health professionals’ practice ability, a comparison of Indiana’s approach to other states, and a recommendation. Given the importance of quickly distributing forthcoming coronavirus vaccines, the state should start with expanding pharmacists’ scope of practice. The federal government has by emergency order allowed pharmacists in all states to prescribe vaccines approved by the CDC for children ages 3-18 years old. Indiana statute already permits pharmacists to administer vaccines for people age 11 and older. This should be updated so that pharmacists can order vaccines per their scope of practice. (For this policy to be most effective, insurers must act so that pharmacists can be paid for providing these services.) Permitting pharmacists to refill expired ‘maintenance’ prescriptions lowers patient costs and will thus increase adherence to their medications.

Corollary: Institute a sunrise review of proposed health care regulations, particularly occupational restrictions

Action: Require a similar review of all proposals to create new restrictions or to expand upon existing restrictions both for health professionals’ practice ability as well as on the ability of health care facilities or providers to expand capacity or supply.

Rationale: Thirteen states have sunrise review processes that attempt to ensure there are not unnecessary health care regulations and restrictions being imposed.

6. Annual Non-Profit Hospital Public Meeting and Disclosure

Action: Require tax-exempt hospitals, including county hospitals, to hold an annual public forum where the hospital, including its board of directors, receives feedback from the community about the hospitals’ performance and includes a specific discussion about pricing. In advance of the meeting, the hospitals would submit a standardized set of information, including a simple-form balance sheet, a one-page income statement, and the compensation for all employees with at least $500,000 in total annual compensation. Repeal the secrecy clauses that prohibit the disclosure of hospital executive compensation at county hospitals.

The hospital would need to provide a written explanation of its prices, how they relate to Medicare and why they are so much higher. They would also have to justify their price increases. The hospitals would also need to disclose any facility that the hospital owns, including nursing homes, as well as the amount of Medicaid and Medicare supplemental payments received by facilities, including nursing homes, owned by the hospital.

Rationale: Tax-exempt hospitals should have to provide information to the public about its performance and receive feedback from the community.

7. Annual Insurer Public Meeting and Disclosure

Action: Require health insurance companies to hold an annual public forum to hear feedback from the community about the insurers’ performance and to include a specific discussion about premiums. In advance of the meeting, the insurers would submit a standardized set of information, including a simple-form balance sheet, a one-page income statement, and the

compensation for all employees with at least $500,000 in total annual compensation. The insurers would need to provide a written explanation of their premiums and steps they are taking to lower health care costs.

Rationale: Like tax-exempt hospitals, insurers, which benefit from many public programs and favorable tax rules, should have to provide information to the public about its performance and receive feedback from the community.

8. Community-Focused Hospital Board

Action: Require the board of directors for a tax-exempt hospital to consist of only people from the community served by the hospital.

Rationale: Tax-exempt hospitals should be providing a community benefit and it is important that the board of directors come from that community. Community members should be the most responsive to the community sentiment and whether the hospital is providing sufficient community benefit to justify the favorable tax treatment.

9. Addressing anticompetitive contract provisions in insurers-hospital contracts

Action: Review and potentially address or limit all-or-nothing contracts, anti-tiering clauses, and anti-steering clauses in contracts between health insurers/TPAs and health systems/hospitals.

Rationale: *Anti-steering clauses* can be deployed by dominant hospital systems to prevent insurers from "steering" patients to higher-value (lower-cost and higher-quality) providers. Some insurers have tried to use a milder alternative to narrow networks, in which providers are tiered based on value, such that patients enjoy lower cost-sharing if they use higher-value providers. Dominant hospital systems may employ *anti-tiering clauses* to prevent insurers from deploying such measures.

Another potentially anti-competitive contract provision that has been used with great effect by hospitals is the *all-or-nothing* clause. All-or-nothing provisions force insurers to contract with all hospitals in a given system if insurers want to contract with one hospital in that system. For example, an urban hospital system in a competitive market that buys a rural hospital can force an insurer that contracts with the rural hospital to also accept the urban hospital's high prices. All-or-nothing contracts amplify the power of hospital consolidation; a seemingly innocuous merger between an urban hospital and a rural hospital can lead to substantially increased market power for the urban hospital. Of note, the state likely cannot regulate self-insured plans in this manner.

10. Develop a state process to closely scrutinize proposed mergers and acquisitions for impact on competition

Action: Develop a process to review and potentially block mergers and acquisitions—hospital-hospital mergers, hospital-medical office mergers, and medical office-medical office mergers—for their effect on market competition and prices.

Rationale: Hospital mergers, hospital acquisitions of physician practices, and mergers of physician practices often reduce competition and raise health care prices. The State has an interest in ensuring that competition in Indiana's health care market is not further diminished.

Non-legislative recommendations

Reform of the state employee health program

Action: Utilize the upcoming RFP process to solicit proposals from third-party administrators for managing the state employee health benefit plan. The proposal would require the TPA to provide the plan with claims data files (both medical and pharmacy) at the plan's request, use smart analytics to reduce plan costs and improper utilization, implement payment designs like reference-based pricing and shared savings, and prohibit facility fees in the state plan in certain cases.