



GOVERNMENT RELATIONS

Lockton Companies



June 25, 2019

Executive order encourages HSA changes and promotes transparency

The Trump administration released an executive order proposing to increase cost and quality transparency in an effort to help patients make more informed healthcare decisions and to *"increase competition, innovation and value in the healthcare system."* Several provisions in the order could impact employer plan sponsors.

The order itself does not make law, but instead directs federal regulatory agencies, including the Departments of Labor, Health and Human Services (HHS), and Treasury, to issue guidance over the next 60 to 180 days to accomplish the order's purpose.

Changes to health savings accounts and health flexible spending accounts

Treasury, which oversees the IRS, is directed to issue guidance allowing individuals to be eligible to make health savings account (HSA) contributions even when their health plan provides predeductible coverage for low-cost preventive care that helps *maintain* health status for individuals with chronic conditions.

Lockton comment: Current law allows an HSA-compatible high-deductible health plan (HDHP) to provide predeductible benefits for preventive care only when a disease has not yet manifested (e.g., statins to prevent high cholesterol but not to control it) or to prevent the reoccurrence of a disease (e.g., drugs used to prevent the reoccurrence of a heart attack). A new rule in line with the order could allow first-dollar coverage for conditions that commonly require maintenance drugs or therapies, such as diabetes, hypertension or arthritis, without running afoul of the HSA rules. In short, coverage of maintenance drugs and/or therapies for chronic conditions would not prevent individuals enrolled in an otherwise HSA-compatible HDHP from making HSA contributions.

Treasury is also directed to propose regulations that expand what can be considered a medical expense and can therefore be paid on a tax-free basis – either by the employer on the employee’s behalf or by the employee using a tax-favored account (e.g., HSA or health flexible spending arrangement). The order specifically mentions direct primary care arrangements (e.g., concierge medicine) and costs for participating in healthcare sharing ministries.

Lockton comment: The order does not specifically address other HSA changes that Lockton and others have pressed Congress to make, such as allowing individuals to receive reduced or no- cost medical care through a telemedicine provider or an on-site medical clinic prior to reaching the deductible. However, the order is vague enough we imagine regulators will consider this and other similar changes during their deliberations.

Another provision in the order directs Treasury to issue guidance to increase the amount individuals enrolled in flexible spending accounts can “carry over” to a new plan year. Currently the rules allow individuals to carry over a maximum of \$500 of the remaining account balance at the end of one plan year to the following plan year.

Addressing surprise medical billing

The order directs HHS to provide the president with more information on how to address surprise medical bills in accordance with the prior principles released by the White House related to surprise medical billing. No official action has been taken on surprise medical bills since the president laid out those principles in early May.

Surprise medical bills occur when a patient receives care from an out-of-network physician or at an out-of-network facility and the patient had no effective opportunity to decide who the care was provided by or where (e.g., an out-of-network anesthesiologist or emergency department).

Lockton comment: There are several bipartisan legislative proposals currently aimed at addressing surprise medical bills. In all cases, the proposals would make patients pay only the in-network cost for the care. Where the bills differ is how they calculate how much the out-of-network provider or facility should be paid by the plan. The proposals generally adopt one of three options:

1. The plan pays the provider or facility the median in-network rate for like services in a similar geographic area.
2. The same as (1), but either the plan or the provider or the facility can appeal to an arbitrator if they think the median in-network rate is inappropriate in the given situation.
3. All physicians at an in-network facility are required to accept the rates negotiated with the facility.

Some provisions may have an indirect impact on employers

Other provisions of the order provide for additional transparency that may not directly impact employer plan sponsors but could still disrupt the current system.

Service costs: A requirement that healthcare providers and facilities post information about actual costs for common services so that patients can review the information before services are performed.

Lockton comment: This provision extends a prior rule that generally requires hospitals to disclose non-negotiated charges. Unlike that rule, this proposal would require disclosure of what is charged after discounts negotiated by carriers and third-party administrators (TPA). Think of it as the difference between the sticker price of a new car and what's paid for the car.

Out-of-pocket cost information: A provision requiring comments on how healthcare providers, carriers and self-funded plans can provide or facilitate patient access to information about expected out-of-pocket costs before they are incurred.

Lockton comment: The reference to self-funded plans is curious, considering most self-funded plans use a TPA to help negotiate rates and already disclose, in multiple forms, the plan's cost-sharing requirements. Regardless, this is a contentious provision as providers, carriers and TPAs argue that their negotiations are proprietary.

Claims data access: This provision increases access to de-identified claims data from group health plans and public healthcare programs (e.g., Medicare). The data would be used to develop tools that would identify ways healthcare could be improved, as well as to develop tools that would provide patients more information to make better informed decisions.

Lockton comment: This provision could ultimately provide plan sponsors with more data that could provide them more negotiating leverage with TPAs and in direct-contracting situations with providers.

The order's pronouncements are vague in many respects. This makes it difficult to predict with certainty how the regulatory agencies will respond and what guidance will ultimately be issued. In other words, plan sponsors should stay tuned but wait for future guidance before making any plan design changes.

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