Health Care Policy Outlook: 2021 & Beyond

A perspective from Capitol Hill insider Chris Condeluci

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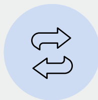
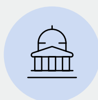
Executive Summary

The 2020 elections are finally behind us. The newly elected 117th Congress has been sworn in. The Democrats still control the U.S. House of Representatives, albeit with a smaller majority than in the 116th Congress. In a surprising turn of events, Democrats have now found themselves taking back the majority in the U.S. Senate with critical victories by Jon Ossoff and Raphael Warnock in Georgia. With 50 seats – plus Vice President Harris casting the 51st vote – the Democrats now control the Senate's agenda and have the opportunity to pursue many, if not all, of the proposals included in the health care plan President Biden campaigned on.

> In this white paper, Capitol Hill attorney and insider Chris Condeluci examines many of the proposals included in "The Biden Health Care Plan" in regards to:

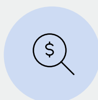


How the proposals might impact the employer-sponsored health system



The process through which these changes will be advanced through Congress

Changes that the Biden Administration may make through administrative guidance



Increasing the transparency of medical prices and health claims data

Potential Legislative Actions

Legislative actions for the new administration are possible, but it'll be difficult. With the surprise victories for the two Georgia Senate seats, the Democrats control all of Washington, DC, at least for the next two years. That means pursuing The Biden Health Care Plan is a greater possibility.

It's important to understand, however, that the Democrats have one of the slimmest majorities in both the House and Senate in U.S. history. For example, depending on the outcome of some races that are still outstanding, House Democrats will only have a nine to eleven seat majority. In the Senate, the margin is even slimmer, where the Democrats only have 50 seats, with Vice President Harris serving as the 51st vote. The implications of this are significant because it means that Democrats have an extremely narrow path to enacting policy changes, and Democratic leadership in both the House and Senate will need to govern carefully and will not be able to fully press their entire policy agenda.

For example, with the margins so tight in both the House and Senate, it's unlikely that Congress will pursue Medicare for All, especially considering that President Biden campaigned against this sweeping policy change. Instead, it's expected that the proposals included in The Biden Health Care Plan will be the main pillars of any health care legislation that Congress and the Biden Administration seek to enact. Other changes, like allowing Americans ages 60 to 64 to "buy into" Medicare and protecting consumers from out-of-pocket health care expenses, will also be pursued through legislation.

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The Legislative Process

Before we discuss the details of (1) the health care policy items that the Biden Administration and Congressional Democrats are likely to pursue and (2) the impact these proposals may have on employer health plans and the Affordable Care Act (ACA), it's important to discuss the process through which Congress and the Biden Administration will seek to enact these policy changes.

General Rule for Passing Legislation in the Senate

According to the general rule for passing legislation in the Senate, at least 60 Senators must vote in favor of allowing the legislation to get a final vote for passage. If the legislation does not receive 60 votes, the legislation will fail to be considered for final passage (and the bill will effectively die). This 60-vote threshold requirement is often times referred to as the "filibuster". There will certainly be a discussion as to whether Senate Democrats should eliminate the filibuster, but it's unlikely this 60-vote threshold requirement will be eliminated at any time over the next two years.

The "Reconciliation" Process

It's important to note that there is an exception to the general rule for passing legislation in the Senate, which only requires 51 votes for final passage of a bill. This exception is known as the "reconciliation" process. The reconciliation process is a limited process where the only proposals that may be included in the underlying legislation are proposals that impact revenue (e.g., taxes) and spending (e.g., government spending increases or decreases). However, even if a proposal impacts revenue or spending, the proposal may not be included in the underlying legislation if the policy associated with the proposed change is so significant that it outweighs the budgetary impact. In addition, if a proposal only has an "indirect" impact on revenue or spending, the proposal will be eliminated from the bill.

The Democrats Will Use the "Reconciliation" Process

The Biden Administration and Senate Democratic Leadership are expected to use the reconciliation process to enact all or a portion of The Biden Health Care Plan into law (only needing 51 votes for final passage). However, the path to 51 votes will not be easy because, among other things, it will require all 50 Senate Democrats voting in favor of the legislation, with Vice President Harris casting the 51st vote. Senate Democratic leadership can – and will – attempt to recruit Senate Republicans to vote in favor of the legislation, but in recent history (e.g., in 2005, 2010, 2015, and twice in 2017), each time the majority party used the reconciliation process, there were no minority party Senators voting in favor of the legislation.

The Biden Health Care Plan: ACA "Improvements"

On the campaign trail, President Biden and Vice President Harris explained that their Administration would "build on" and "strengthen" the ACA. It's important to understand that the majority of these changes to the ACA are focused on the individual health insurance market (i.e., the insurance market where individuals without an offer of an employer health plan can purchase health coverage). However, many of these suggested policy changes – whether intended or not – could adversely impact the employer-sponsored health system. Below is a discussion of these ACA "improvements" that are a part of The Biden Health Care Plan.

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The ACA's Premium Subsidies: Expanded Eligibility and Increased Subsidy Amounts

It's likely that President Biden and Congressional Democrats will attempt to expand access to the ACA's premium subsidies that are currently available to low- and middle-income individuals and families purchasing an individual market plan through an ACA Exchange in the manner discussed below. Note, these policy changes will be pursued through the reconciliation process. Further note, because changes to the ACA's premium subsidies involve taxes and government spending, these changes can permissibly be included in a reconciliation bill.

Premium Subsidies Available at Any Income Level

The Biden Health Care Plan proposes to eliminate the ACA's 400 percent of Federal Poverty Level ("FPL") income limit that governs when an individual is eligible for a premium subsidy. Currently, under the ACA, an individual with a household income in excess of 400 percent of FPL is not eligible for a premium subsidy. Under The Biden Health Care Plan, however, an individual at any income level would be able to purchase an individual market plan through an ACA Exchange and qualify for a premium subsidy. For example, an individual at 800 percent of FPL (which is around $100,000 for this individual) could receive a subsidy if they purchase an "individual" market ACA Exchange plan.

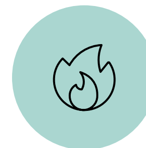
Eliminating the "Firewall" Between Subsidy Eligibility and an Offer of an Employer Plan

The Biden Health Care Plan would also eliminate what experts call the "firewall" between (1) access to a premium subsidy and (2) an employee who is offered an "affordable/ minimum value plan." Currently, under the ACA, if an employee is offered an affordable/minimum value plan, the employee is not eligible for a premium subsidy. Again, this firewall would go away under The Biden Health Care Plan.

Increasing the Premium Subsidy Amounts

The Biden Health Care Plan proposes to increase the premium subsidy amounts for both individuals and employees purchasing an individual market ACA Exchange plan. This would be accomplished in two ways:

- First, the amount of the premium subsidy would be based on the cost of the second-lowest cost gold plan, instead of the existing second-lowest cost silver plan (gold plan premiums are higher than silver plan premiums, so the subsidy amount would correspondingly increase based on this higher benchmark).
- Second, the amount of money a person is required to pay for an individual market ACA Exchange plan would be reduced from the current 9.83 percent of their income down to 8.5 percent of their income. This proposed change would also be coupled with lowering the percentage of income an individual/employee must pay at lower income levels (which essentially increases the government's share of the premiums, and lowers out-of-pocket spending for low- and middle-income individuals/employees).



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How Might Expanding Eligibility and Increasing the Premium Subsidy Amounts Impact Employer Health Plans?

As discussed, the Biden Health Care Plan would allow employees at any income level to:

- Opt out of their employer plan
- Purchase an individual market ACA Exchange plan
- Qualify for a premium subsidy irrespective of whether they |are offered an affordable/minimum value plan

For low- and middle-income employees who would qualify for generous government subsidies, such a proposal would be attractive. This would include younger employees who are typically lower income because they are just starting out in the workforce. As discussed more fully below, if these younger (and probably healthier) employees choose to opt out of their employer plan and effectively leave the employer's risk pool, only older and/or sicker employees would remain in most cases. This would result in adverse selection, which would increase costs for employers.

Another important aspect to consider is the impact these proposed changes will have on the ACA's employer mandate. For example, the affordability test under the employer mandate requirement is tied to the maximum limit on the percentage of income a person is required to pay for their own subsidized individual market plan. For 2021, this maximum limit is 9.83 percent (the original statute said 9.5 percent, but the limit is indexed, so the limit has increased over the years). It's unclear if the employer mandate's affordability test would be tied to 8.5 percent of income (instead of the current 9.83 percent of income), consistent with the proposal to increase the premium subsidy amounts, discussed above. If such a change were made, it would mean that employers would be required to pay more for their employees' health coverage or pay a penalty tax.

The Biden Health Care Plan: A "Public Option" Health Plan

President Biden and Vice President Harris also explained that – as part of The Biden Health Care Plan – their Administration would seek to add a "public option" to the individual market.

The Democrats' pursuit of a public option is not new. In 2009, the Obama Administration and Congressional Democrats wanted to add a public option to the ACA's newly reformed individual market. However, those efforts were unsuccessful. One might say that the Biden Administration and Congressional Democrats now have a second bite at the apple.

However, whether efforts to add a public option to the law will prove successful remain unclear on account of Senate Democrats only having a 50-seat majority. Despite the lack of clarity, we do believe that efforts will indeed be made to include this public option proposal in reconciliation legislation. Because a public option will impact government spending and the ACA's premium subsidies (which are structured as advance-refundable tax credits), there is a chance that this proposal could get the green-light for inclusion in a reconciliation bill (but there is no guarantee because other aspects of the public option – such as its plan design – may be found to only have an "indirect" impact on spending and revenue).

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Here's how a public option might be structured under The Biden Health Care Plan and the impact the addition of a public option to the individual market could have on employer health plans:

Who is Eligible to Enroll in a Public Option Health Plan?

During the Democratic Presidential Primary debates, then-Candidate Biden explained that if elected, he would incorporate a public option into the ACA's individual market, and he further explained that it would only be available to individuals who do not have an offer of an employer health plan that is both "affordable" and provides "minimum value" (i.e., an "affordable/minimum value plan"). In the first Presidential debate in September 2020, Candidate Biden once again explained that his public option plan would be limited to individuals in the individual market, the presumption being that these are individuals who are not offered an affordable/minimum value plan.

However, the Biden campaign website told us a different story, explaining that employees would be permitted to "buy into" a public option plan regardless of whether these employees were offered an affordable/minimum value plan.[1] The Kaiser Family Foundation analyzed this aspect of The Biden Health Care Plan back in October 2020, validating this proposal (i.e., employees "buying into" a public option) despite the rhetoric to the contrary.[2]

What Other Aspects of a Public Option Health Plan are Important?

Although the most important aspect of a public option is who would be eligible to enroll in this new health plan, it's also helpful to understand the following factors:

What benefits and services would be covered under a public option? A public option health plan would cover a prescribed set of benefits, likely a mix of the ACA's "essential health benefits" and benefits covered under Medicare.

How would a public option lower premiums? The Federal government would establish the reimbursement rates for the benefits and services covered under the plan. To achieve lower premiums, the reimbursement rates would likely be somewhere between standard Medicare rates and 150 percent, 180 percent, or 200 percent of Medicare, which are currently lower than private insurance reimbursement rates.

How would the public option be administered? Although the Federal government would establish the prices, it's likely that private health insurance carriers would offer and administer the plan (similar to Medicare Advantage).

1. See https://joebiden.com/healthcare/#.
2. See Kaiser Family Foundation, Affordability in the ACA Marketplace Under a Proposal Like Joe Biden's Health Plan, Sept. 28, 2020 at https://www.kff.org/health-reform/issue-brief/affordability-in-the-aca-marketplace-under-a-proposal-like-joe-bidens-health-plan/. The Potential Impact to Employer Health Plans

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The Potential Impact to Employer Health Plans

As stated, if the public option plan is available only to individuals who are not offered an affordable/minimum value plan, the addition of this government-driven program should have a limited impact on the employer-sponsored system, at least in the short-run. However, if employees are allowed to "buy into" a public option – with or without a government subsidy – this could have a lasting impact on employer health plans.

A Public Option Limited to Individuals Without an Offer of an Employer Plan

In the case where access to a public option plan is limited to individuals who are not offered an affordable/minimum value plan, the employer-sponsored system should remain intact because employees would be prohibited from opting out of their employer plan and receiving a premium subsidy for any type of individual market health plan (including a public option plan). This is how the ACA works today, where – as stated above – there is currently a firewall between (1) access to a premium subsidy and (2) an employee who is offered an affordable/minimum value plan.

However, even if this firewall is preserved and a public option is limited to individuals in the individual market, it's highly likely this public option plan could result in increased costs for employers due to an expansion of the current "cost-shift" between publicly-subsidized health programs and private employer-sponsored health plans. For example, a recent RAND Corporation ("RAND") study illustrated the existing cost-shift when documenting the prices private-employer-sponsored health plans paid to hospitals relative to what Medicare pays these providers.[1]

> According to RAND, payments from employer plans in 2018 averaged 247 percent of what Medicare would have paid for the same benefits or services, with a range of 200 percent of Medicare in some states to close to 350 percent of Medicare in other states.

If a public option is indeed limited to the individual market – and if this new health plan reimburses hospitals and other providers at lower rates (e.g., 150 percent, 180 percent, or even 200 percent of Medicare) – it's likely that the current cost-shift would be exacerbated. If the current cost-shift increases such that private employer plans are required to pay an even greater percentage of Medicare rates to hospitals (e.g., 300 percent or 400 percent of Medicare), the increased costs would certainly burden employers that currently offer health benefits to their employees.

A Public Option Available to All Employees

If the firewall is eliminated – and employees are permitted to opt out of their employer health plan and buy into a public option – this could have a significant impact on the employer-sponsored health system. In this case, younger, healthier employees may be attracted to the lower-cost health coverage provided through a public option plan, especially if they're eligible for a generous government subsidy (because in some cases, enrolling in the public option plan could cost $0). As previously mentioned, this could result in adverse selection and increase costs for employers. In some cases, certain employers

1. RAND Corporation, Nationwide Evaluation of Health Care Prices Paid By Private Health Plans, Sept. 19, 2020 at file:///C:/Users/17032/Downloads/RAND_RR4394%20(2).pdf.

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could even discontinue their health plan (depending on, for example, employer size and industry).

Over time, the costs for employers would likely grow due to resulting adverse selection (plus an increase in the cost-shift), thereby making it that much more difficult for any employer to offer its employees an affordable and quality health plan. In addition, it's likely that the Federal government would ensure that premium increases for the public option plan are moderated, thus making the price tag for the public option plan that much more attractive to employees relative to their employer plan.

As stated, there may be cases where employers discontinue their employer plan due to the increased costs of offering health benefits to their employees. Other employers may simply observe that their employees may easily access government-financed health coverage, and these employers may voluntarily discontinue their health plan and encourage their employees to enroll in the public option plan. Even if there is some form of a "tax" that would be imposed on employers who shift their employees onto the Federal government (either voluntarily or due to increased costs), the tax liability may be lower than an employer's increased health care liabilities, thus creating a perverse incentive to discontinue their employer plan.

The Biden Health Care Plan: A Medicare "Buy In" Program for Ages 60-64

President Biden and Vice President Harris have also spoken about a program that would allow individuals aged 60 to 64 to "buy into" Medicare (i.e., a Medicare "Buy In" Program). Similar to the ACA changes and the public option, it's expected that this Medicare Buy In Program would be included in reconciliation legislation. And, because changes to Medicare directly impact spending – and such changes could also impact taxes (such as payroll or income taxes) – a Medicare Buy In Program can permissibly be included in a reconciliation bill.

How Would It Work?

Currently, we do not know how this Medicare Buy In Program would be structured, who would be eligible to "buy into" it, or how it would be funded. However, similar to a public option plan, we would expect that this Medicare Buy In Program would cover a prescribed set of benefits and services. Also similar to a public option plan, it's expected that this program would reimburse medical providers at a rate that is currently lower than private insurance reimbursement rates, most likely standard Medicare rates, as opposed to a percentage of Medicare that we would likely see under a public option.

What is unclear is whether the Medicare Buy In Program would be extended to employees. For example, if an employee between the ages of 60 and 64 is offered an affordable/minimum value employer plan, would this employee be able to opt out of their employer plan and "buy into" the program? Could employers choose to enroll their employees who are between the ages of 60 and 64 in the Medicare Buy In Program? These questions will need to be answered when legislation for this Medicare Buy In Program is formally introduced.

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How Might a Medicare Buy In Program Impact Employer Health Plans?

Allowing employees between the ages of 60 and 64 to enroll in this Medicare Buy In Program may actually benefit employers from a cost perspective, unlike the previously discussed changes. Specifically, if older employees leave the employer's risk pool, this would likely reduce the plan's overall health care utilization, thereby reducing costs for the employer sponsor.

However, if costs do indeed go down for employers under this proposal, the Biden Administration and Congressional Democrats may seek to claw-back at least a portion of those savings through some form of an "employer tax," which could be used to fund a portion of the Medicare Buy In Program.

Other Changes to the ACA

In addition to pursuing the policy changes set forth in The Biden Health Care Plan, Congress will likely seek other changes to the ACA, including the following:

Caps on Out-of-Pocket Expenses

While not specifically articulated in The Biden Health Care Plan, the Biden Administration and Congressional Democrats are expected to pursue policy changes intended to protect people from out-of-pocket expenses. In this case, the White House and Congress could seek to lower the ACA's current out-of-pocket maximum limits (currently $8,550 for single and $17,100 for family coverage). This could be accomplished by simply capping the out-of-pocket maximums at a lower amount. The cap could also vary by income level. For example, families making more than $250,000 may be stuck with the ACA's current out-of-pocket maximum limits. While families with much lower incomes (like families at 100-200 percent of FPL) may only be required to pay one-fourth of the current limits, while families between 200-400 percent of FPL are required to pay half of the current limits, and families between 400 percent of FPL and $250,000 would pay three quarters of the current limits.

Improving the Individual Market Risk Pools Through Federal Reinsurance

The ACA included three risk mitigation programs to help stabilize the individual market risk pools:

- The transitional reinsurance program
- The risk corridor program
- The risk adjustment program

The transitional reinsurance and risk corridor programs were temporary, 3-year programs, while the risk adjustment program is permanent. A growing number of states are establishing their

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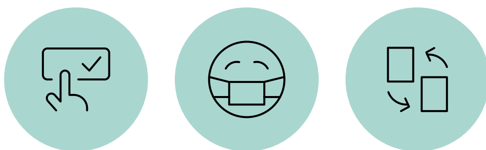
own state-based reinsurance program through a Section 1332 Waiver. These reinsurance programs have successfully provided a one-time reduction in premium costs for individual market plans ranging from a five to 30 percent reduction in premium costs, depending on the state. In 2017 and 2018, Congress attempted to enact a permanent, Federal reinsurance program, but those efforts failed.

The Biden Administration and Congressional Democrats are expected to seek to enact a Federal reinsurance program, fully funded by the Federal government. Other risk mitigation programs could also be added to the law, like a new and improved risk corridor program that is also made permanent.

In the case of the caps on out-of-pocket limits, as well as a Federal reinsurance program, it's unlikely that these proposals would make it into a reconciliation bill because these proposals will likely be found as only having an indirect impact on spending and/or revenue.



Changes the Biden Administration May Make Through Administrative Guidance

The discussion above focused on what the Biden Administration and Congressional Democrats may seek to accomplish through the legislative process. Along with these legislative efforts, the Biden Administration is expected to be active when it comes to making health care policy changes through administrative guidance and regulations. The following are some changes the Biden Administration will likely pursue in the first 100 days and over the course of the next four years.

COVID "Special Enrollment" Period for the Federally-facilitated Exchange

As expected, the Biden Administration directed HHS to open a COVID "special enrollment" period. This will allow any individual living in one of the 36 states that rely on the Federally-facilitated Exchange who do not have health coverage through their employer, or otherwise, to enroll in an individual market Exchange plan during the course of 2021 on account of the pandemic.

The ACA Exchanges

If and when Congressional Democrats seek to make health care policy changes by using the Senate's reconciliation process, any changes to the rules governing the ACA Exchanges will not be permitted to be included in a reconciliation bill (because changes to the ACA Exchanges will have little to no impact on revenue or spending, and thus, will not meet the criteria for being included in reconciliation legislation). However, the Biden Administration will be in a position to make changes through regulations known as the annual "Notice of Benefit and Payment Parameters." These changes could include the following:

"Standardized" Plans

If the Biden Administration cannot add the plan design for a public option to the law through a reconciliation bill, the Biden Administration may seek to replicate the plan design of the public option by mandating that health insurance carriers offer "standardized" plans. Similar to a public option, standardized plans have a prescribed set of benefits and services that must be covered, and these plans also have prescribed deductibles and co-pays for certain covered benefits (e.g., dollar caps on things like prescription drugs and physician visits and other outpatient services). In this case, insurance carriers would not be permitted to design the deductibles, co-pays and other cost-sharing

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under the plan. Instead, the government prescribes the benefit design and cost-sharing.

"Active Purchasing"

It's a possibility the Biden Administration gives HHS the authority to act as an "active purchaser" in the 36 states that rely on the Federally-facilitated Exchange (similar to the California Exchange). As an active purchaser, HHS would have the authority to kick out an insurance carrier from the Exchange if HHS finds that carrier is:

- Arbitrarily increasing premiums
- Failing to promote consumer choice, quality and value
- Deviating from the standardized plan design requirement

However, some may argue that it would be too administratively burdensome to ask HHS to do more when it comes to working with insurance carriers selling Exchange plans, but it is something to look out for.

Increased Funding for Exchange Enrollment and Paring Back Web-Broker Entities

The Biden Administration is expected to take steps to increase the role that Navigators play with respect to ACA Exchange enrollment. This effort could correspond with paring back the role Web-Broker Entities play through the Enhanced Direct Enrollment function that both the Obama and Trump Administrations built. These efforts would also include increased funding for Exchange outreach and enrollment efforts, with money going to Navigators and direct funding for State-based Exchanges and the Federally-facilitated Exchange.

Rescinding the Trump Administration's Health Care Policy Changes

The Trump Administration allowed states to pick another state's "essential health benefits" (EHB) benchmark plan, effectively allowing states to limit some of the coverage provided under the state's existing EHB benchmark plan. The Biden Administration will likely change this rule. In addition, it's likely that the Biden Administration will re-limit "short-term health plans" to plans that can only provide coverage for up to three months. The Trump Administration's 1332 Guidance – which provided more flexibility when it comes to getting a Waiver approved – may also be rescinded.

Individual Coverage HRAs (ICHRAs)

Interestingly, the individual coverage HRA (ICHRA) regulations is a Trump-era rule, but unlike the short-term health plan regulations, ACA supporters did not file a lawsuit against the ICHRA rules. Why? Because ACA supporters are likely to think that the ICHRA regulations are good for the ACA (because ACA supporters believe that these arrangements have the potential of increasing enrollment in the individual market, and thus, increasing the size of risk pool). As a result, it's doubtful that the Biden Administration will rescind the ICHRA regulations. But, it's also doubtful that the Biden Administration will "build on" and "strengthen" the ICHRA rules. It is likely going to be status quo.

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Transparency of Medical Prices and Health Claims Data

Upon the election of President Biden, questions were immediately raised.

- Will the Biden Administration move forward with implementing the Trump Administration's transparency regulations?
- Will the Administration rescind these rules?
- Will the Biden HHS seek to modify them through the normal rulemaking process?

The Trump Administration's Efforts to Increase Transparency

A top priority for the Trump Administration was increasing the transparency of medical prices and health claims data. Early on in the Trump Administration, HHS announced the MyHealthEData initiative. Implementing this policy initiative yielded three sets of regulations –all intended to increase the transparency of medical prices and health claims data.

The first set of regulations are what most call the "interoperability" rules. These new rules require all health care companies doing business in Medicare, Medicaid, and selling individual market plans through the Federally-facilitated Exchange to share health claims data and other important information electronically with their policy holders/beneficiaries. It's estimated that 85 million people will have access to their health claims information, in addition to the 40 million who already have access through Blue Button 2.0 in Medicare (another component of the interoperability rules).

The Trump Administration also finalized a rule requiring hospitals to post the negotiated rates insurance carriers and self-insured plans actually pay for medical services, along with the cash price the hospital is willing to accept from an uninsured person or in an out-of-network scenario. The hospital community filed a lawsuit to invalidate these regulations, but on December 29, 2020, the DC Circuit Court upheld the regulations and HHS is now implementing these new requirements (the regulations were effective January 1, 2021).

Last is the set of transparency regulations that apply to individual market plans and fully-insured and self-insured employer health plans. These regulations were finalized on October 26, 2020, and they require insurance carriers and self-insured plans to disclose on a public website:

- Their plan's negotiated in-network rates
- The net price for prescription drugs covered under the plan
- Payments to out-of-network providers

The final regulations also require insurers and self-insured plans to provide participants with cost-sharing liability information for medical items and services covered under the plan through an electronic, online tool that can be accessed directly by participants at any given time during the plan year.

The requirement to disclose the plan's negotiated in-network rates and payments to out-of-network providers on a public website is effective January 1, 2022. However, the requirement to provide specific cost-sharing information to participants is not effective until 2023 and 2024. More specifically, by January 1, 2023, plans must provide cost-sharing liability information on 500 "shoppable" medical items and services. The final regulations specifically list out the 500 medical items and services that are subject to this requirement. By January 1, 2024, plans must provide cost-sharing liability information on each

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and every medical item or service that is utilized by a participant.

Will the Biden Administration Implement, Rescind or Modify Transparency Regulations?

With respect to the hospital transparency regulations, these rules have already withstood a legal challenge at the District Court and Circuit Court level, although the hospital community may appeal the decision to the Supreme Court. However, many believe that an appeal to the Supreme Court is unlikely, especially based on the fact that HHS is already implementing these requirements and hospitals are already taking steps to comply. While there is a chance that the Biden HHS decides to make some modifications to the hospital transparency regulations to make them more tolerable for the hospital community, it's unlikely that the Biden HHS will make any significant changes to these Trump-era regulations.

Similarly, we believe that the Biden Administration will refrain from rescinding the transparency regulations applicable to fully-insured and self-insured employer health plans. However, the Biden HHS has more leeway when it comes to making modifications to these rules before they become effective (as stated, these transparency requirements are not effective until 2022, 2023 and 2024). It's expected that the insurance carrier community will undertake efforts to advocate for changes to these rules, even though these requirements are final.

If changes are indeed made to the final individual and employer health plan transparency regulations, such changes must be made through the normal rulemaking process, which requires (1) proposed regulations, (2) a public comment period, (3) a time period over which the Administration considers these public comments, culminating in (4) the issuance of final regulations. This process takes time and effort, but again, with the staggered, delayed effective dates, the Biden HHS may feel that taking the time and effort to modify these rules in some way is worthwhile. However, any forthcoming modifications are not likely to eliminate the requirement to disclose a plan's negotiated in-network rate and to provide cost-sharing liability information to participants upon their request.

Congressional Action on Transparency

At the end of 2020, Congress approved three transparency-related provisions that President Trump signed into law. These requirements include making available to participants a "price comparison tool." Participants must also be provided an Advanced Explanation of Benefits in cases when a participant knows they will be utilizing a medical item or service in a non-emergency situation (e.g., when the participant schedules a medical procedure). The end-of-year legislation also provides federal grants to states to establish an All-Payer Claims Database and to states that already have this type of database to make improvements.

Electronic Price Comparison Tool

The law now requires insurance carriers and self-insured plans to provide plan participants with an electronic price comparison tool, which is intended to disclose the price of medical items and services to participants (similar to what the final hospital transparency regulations as well as the transparency regulations for individual and employer health plan are trying to accomplish). This price comparison tool is also intended to provide participants with information about their cost-sharing liability associated with a particular medical item or service covered under the plan (similar to the online cost-sharing liability tool created under the transparency regulations for individual and group health plans).
It's likely that these somewhat duplicative transparency requirements will force the incoming Biden Administration to coordinate between implementing this new legislative provision and the existing Trump-era

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transparency rules. This statutory requirement also signals that the Trump Administration's regulatory requirement of providing cost-sharing liability to participants through an online tool is not going anywhere anytime soon. The Biden HHS may provide some relief for the administrative burdens that the current regulatory requirements present, but substantive changes are not expected.

Advanced Explanation of Benefits

Congress also required insurance carriers and self-insured plans to provide an Advanced Explanation of Benefits (AEOB) to participants before a scheduled medical procedure. The AEOB must inform the participant, among other things:

- Whether the provider that is performing the medical service is in-network or out-of-network
- The amount of the in-network rate for the service
- If the provider is out-of-network, a list of in-network providers that can perform the same service
- The good faith estimate of the cost of the medical service furnished by the provider scheduled to perform the service
- A good faith estimate of any cost-sharing associated with the service
- A good faith estimate of the plan's deductible that the participant has used to date, if any

This AEOB is similar to the type of information that the Trump Administration's transparency regulations are trying to get into the hands of participants. Interestingly, the legal basis for the Trump-era transparency requirements is that all of the information that insurers and self-insured plans are required to disclose to participants through, for example, the online cost-sharing liability tool is information that must be provided to a participant in a traditional Explanation of Benefits (EOB). The Trump HHS argues that all the Department is requiring is that this traditional EOB information be provided to participants in advance through the online tool.

Importantly, we now have a statutory requirement that is also trying to get important coverage and cost-sharing liability information into the hands of the participant in advance. This means the Biden Administration is going to have to coordinate between implementing this new legislative requirement and Trump's final transparency regulations. All the more reason to believe the Biden Administration will not be making substantive changes to the final transparency regulations for individual and employer health plans.

All-Payer Claims Database

Lastly, Congress is giving Federal grants (1) to states that want to establish an All-Payer Claims Database and (2) to states that already have an All-Payer Claims Database to further improve their database.

An All-Payer Claims Database is a database that houses health claims data from insurance carriers and self-insured plans, and it allows employers, insurance carriers, researchers and policymakers to identify health care utilization trends (e.g., a spike in diabetes or heart disease). Analyzing the data – and the health care trends – could then allow employers, insurance carriers and policymakers to take certain steps to better control health care costs.

It's important to point out that encouraging the creation of these All-Payer Claims Databases is different from efforts to increase the transparency of medical prices through the Trump Administration's transparency regulations.

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Again, these databases increase the transparency of health claims, while the transparency regulations increase the transparency of the prices people pay for medical items and services that are charged by hospitals and negotiated down by insurance carriers and self-insured plans.

While these databases do not accomplish the same thing as the Trump Administration's "interoperability" rules (because the "interoperability" rules require health plans to share the health claims data of a particular patient with that patient directly, and the All-Payer Claims Database is merely a repository of all patients' health claims data), it is another example of the continued push for increasing transparency – a push that is expected to continue in the months and years to come.

Key Takeaways

- **The changes to the ACA that the Biden Administration and Congressional Democrats are expected to pursue are focused on the individual market**, however, if all or some of these changes are enacted into law, employer-sponsored health plans could experience increased costs through adverse selection and reduced reimbursement rates as a result.
- **Depending on its structure, a Medicare Buy In Program could reduce costs** for employers by offering an option for older employees.
- **Standardized plans, active purchasing, and increased funding for Exchange enrollment are potential changes** the Biden Administration could make through regulations to deliver on their campaign promise to "build on" and "strengthen" the ACA.
- **The transparency regulations that were issued by the Trump Administration are likely to be implemented** by the Biden Administration with certain modifications that could help reduce administrative burdens.

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Conclusion

Many would argue that The Biden Health Care Plan includes sweeping health care policy changes that would fundamentally change the law. Others argue that the proposed changes are merely improving the ACA and expanding access to health coverage, while also increasing the affordability of such coverage. Regardless of your view, a fierce debate over health care policy is to be expected throughout 2021 and 2022.

In addition, the 2022 mid-term elections loom large. Specifically, Senate Democrats may be able to expand their 50-seat majority to a more comfortable margin come 2023 irrespective of the history of a sitting President typically losing Congressional seats in the mid-terms (e.g., there are 21 Republican incumbents up for re-election in 2022, compared to 13 Democrat incumbents up for re-election). However, with only a nine to eleven seat majority, House Democrats could lose their majority.

If the Democrats control all of Washington, DC in 2023 and 2024, the Biden Administration and Congressional Democrats will certainly try to enact any of the health care policy items they are unable to enact over the next two years, and more. So the next two, and quite possibly the next four years could see some impactful changes.

About the Author

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Christopher E. Condeluci is principal and sole shareholder of CC Law & Policy, a legal and policy practice that focuses on the Patient Protection and Affordable Care Act ("ACA") and its impact on stakeholders ranging from employers and third-party administrators to health IT companies and hospital/health systems. Prior to forming CC Law & Policy, Chris served as Tax and Benefits Counsel to the U.S. Senate Finance Committee. During his time in Congress, Chris participated in the development of portions of the ACA, including the Exchanges, the State insurance market reforms, and all of the taxes enacted under the law. Based on his experience as an employee benefits attorney, Chris possesses a unique level of expertise on matters relating to tax law, ERISA, and the ACA.

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