LEGISLATIVE UPDATE

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FEDERAL
Congress

Months ahead of the end of the fiscal year (Sept. 30), predictions of a government shutdown are already brewing. Senate Republicans and the Trump administration are struggling to reach an agreement on tough budget decisions within their own respected party.

It's all about the timing. Congress must pass a budget that President Trump will sign by Oct. 1. Around the same time, Congress will need to raise the federal debt limit otherwise they will be forced to decided which obligations will be paid and which could be defaulted, sounding an alarm in the economy by spiking interest rates and a potential stock market crash. Lastly, they will need to agree on how to lift budget caps, known as the "sequester," by years end. Without action, $125 billion would be cut from domestic and military programs.

House Speaker Nancy Pelosi (D-Calif.) has made it clear that a spending deal must be reached before a deal can be made on raising the debt limit. If we have learned anything over the years, stalling the passage of a federal budget has turned into a risky opportunity for more contentious items to get attention. Last winter, Congress did not meet the Oct. 1 deadline and forced the government to shutdown for a record-long 35 days. To look ahead, contentious debates like the funding of a U.S.-Mexico border wall have yet to be negotiated. Meanwhile, it seems a lot of attention in Congress is on impeachment and a looming presidential campaign.

Health care issues continue to draw a lot of attention on the Hill. The House Ways and Means Health Subcommittee held a hearing on June 12 to discuss the highly partisan topic- universal health coverage. The testifier from Kaiser Family Foundation offered a nonpartisan preview of the five means to accomplish universal health coverage-

1. **Medicare-for-all.** Replaces all current forms of public and private health insurance with a new federal program that would guarantee health coverage for all U.S. residents regardless of age. Would cover comprehensive medically necessary or appropriate services- including dental, vision, long-term care services, transportation. No premium, deductible or cost sharing. To help constrain health care cost growth, Medicare-for-all would establish payment rates for hospitals, physicians and other providers and would be subject to a global budget process.
2. **Medicare for America.** Would establish a federal public program with an opt-out option for people who choose qualified coverage under an employer plan. This plan is imilar to Medicare-for-all as it would dissolve Medicare, Medicaid, CHIP and private insurance (other than qualified employer health plans). The public program would provide comprehensive benefits without a deductible, premium or cost share for people with incomes below 200 percent of poverty.
3. **Federal public plan option in the marketplace.** People who choose this plan option would be able to apply cost-sharing subsidies to coverage under the public plan, as they would with other marketplace plans. There are many bills introduced to retain current sources of public and private coverage while offering a new plan in the marketplace. But the recent failure of the co-ops have flawed this design in many opinions.
4. **Medicare Buy-In (ages 50-64).** Would cover Medicare benefits Part A, B and D rather than the essential health benefits typically covered under the federal plan. Would use Medicare rates to pay hospitals, physicians and providers rather than the higher rates typically paid by private insurers. This does not simply lower the age of

Medicare eligibility. Financing would be separate and would prohibit the new program from having any impact on premiums and benefits currently in the Medicare program.

5. **Medicaid Buy-In for states.** In states that would elect this option, individuals eligible to purchase coverage in the marketplace could choose the Medicaid buy-in plan. States, rather than the federal government, would set premiums for the program. Individuals would be able to apply their marketplace premium tax credits and cost sharing subsidies to the Medicaid-buy-in plan and pay no more than 9.5 percent of household incomes on premiums, extending subsidies to people with incomes above 400 percent of poverty.

While status quo is not a popular choice, the conclusion of the hearing proves that any of those options on the table will be a heavy lift with a potentially drastic cost. The Congressional Budget Office (CBO) has estimated that Medicare for All, the most popular plan, would cost the federal government $32 trillion, requiring a significant tax increase. One of the testifiers from the Galen Institute offered concern for the most medically complex patients across the country. Her concern lies in the expected provider shortage should the United States adopt a plan like Medicare for All. Under one federally run plan, hospitals are expected to see a 40 percent cut in reimbursement, physicians 30 percent. Discussion was lengthy about wait times and how other countries lack the quality of care found in the United States. A fact some argued with a high mortality rate for pregnant mothers. With the upcoming presidential election, it is likely to be a platform for debate as both parties try to find a means to reduce the cost of health care in our country.

This week, the Senate Health, Education, Labor and Pensions (HELP) Committee will have a full committee hearing on the bill, *Lower Health Care Costs Act of 2019*. Since last Congress, the Senate health committee has held five hearings on how to reduce health care costs and four hearings to explore the costs of prescription drugs. Chairman Lamar Alexander (R-Tenn.) worked with stakeholders asking for specific recommendations to help lower the cost of health care services. The committee plans to mark up this legislation by the end of June.

Among the many provisions in the bill is legislation aiming to tackle surprise medical bills. The language states that patients would only be required to pay the in-network amount- whether they receive out-of-network emergency care or non-emergency care at in-network facilities and are treated by out-of-network providers. There are three opportunities the Committee is considering-

1. **Choosing an in-network hospital means receiving in-network care.** For patients, if a hospital takes your insurance card, then every practitioner at that hospital also has to take your insurance card. For providers, they can choose to join the insurance networks that cover that hospital or they can choose to send the bill through the hospital rather than sending separate bills to the patient or insurer.
2. **Benchmark.** For surprise bills, insurance companies would pay providers the median contracted rate for the same services provided in that geographic area.
3. **Arbitration.** For surprise bills over $750, the insurer or the provider can initiate an independent dispute resolution process. The insurer and provider would each submit a best final offer and the arbiter would make a final, binding decision on the price to be paid. For surprise bills less than $750, the insurer will pay the provider the median contracted rate for the same services provided in that geographic area.

Other provisions within the *Lower Health Care Costs Act of 2019*-

- **Prescription drugs.** Ensuring makers of brand drugs are not preventing new, lower cost generics. Eliminating a loophole where the first generic drug to submit an application to the FDA can block other generics from being approved. Helping generic-drug and biosimilar companies speed drug development.
- **Transparency.** Designs a nongovernmental entity to use de-identified data so patients, states and employers are able to better understand their health care costs and take steps to reduce those costs. Ban gag clauses that prevent employers and patients from knowing the price and quality of health care services. Bans anti-competitive terms in health insurance contracts that prevent patients from seeing other, lower-cost, higher-quality providers. Requires health care facilities to provide a summary of services when a patient is discharged from a hospital to make it easier to track bills. Requires providers and insurers to give patients price quotes on expected out-of-pocket costs for care to allow them the ability to shop around. Requires insurance companies to keep up-to-date provider directories so patients can know if a provider is in network. Bans Pharmacy Benefit Managers (PBMs) from charming employers, health insurance plans and patients more for a drug than the PBM paid to acquire the drug, "spread pricing."
- **Medical records.** "Make it as easy to get your personal medical records as it is to book a an airplane flight." Gives patients the full, electronic access to their own health claims information. Incentivized health care systems

to keep personal health information secure by requiring HHS to evaluate provider's health technology firms and their best practices. Also will study privacy protections for third-party mobile applications.

- **Help Americans Lead Healthier Lives.** Increase vaccination rates; expand the use of technology-based health care models specifically for underserved and rural areas; preventing obesity; reducing maternal mortality.

STATE

Nebraska Legislature

July 1 is the first day of the fiscal year in Nebraska, which means the impact of the $9.3 billion biennium budget is nearly upon us. Nebraska public schools will soon experience the first sizable increase in their state aid formula, known as TEEOSA, which adds up to a $65.5 million boost for FY 19-20 and another $6.6 million in FY 20-21. The increase will significantly help those districts experiencing growth. Nebraska Medicaid will see funds to prepare for Medicaid expansion in the Fall of 2020 as well as to distribute rate increases for behavioral health. Provider rates will also see a larger budget for the next two years, but flexibility with funds in the Medicaid program may require that funding to be used elsewhere. This budget will become a larger moving target over the next two years, something we will work with Nebraska DHHS leadership closely on.

It is equally important to keep an eye on monthly receipts distributed by the Nebraska Department of Revenue. On Friday, Tax Commissioner Tony Fulton released the General Fund Receipts for May 2019, highlighting the 3.1 percent increase above the certified forecast. It was estimated that May receipts would bring in $500 million, but in his final report, Commissioner Fulton suggested receipts came in at $515 million. This suggests a healthy economy and that the Nebraska budget is on track.

We will be opening our doors to a number of lawmakers this summer and fall and would ask that you join us in your respected area or to say hello. If you have a personal relationship with a legislator or candidate for office, and would like to invite them to Children's, please contact Liz Lyons directly.

(Sources: CHA, Ways and Means Committee, Washington Post, Congress.gov, Omaha World Herald)