WSC POLICY BRIEF

WASHINGTONSTRATEGICCONSULTING

THE LOWER HEALTH CARE COSTS ACT OF 2019

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On May 23, the Senate Health, Education, Labor, and Pensions (HELP) Committee released a discussion draft on legislation that would address healthcare costs, patient financial responsibility, surprise medical bills, and public health. The **Lower Health Care Costs Act of 2019** aims to improve the overall patient experience of care while cutting down on out-of-pocket patient spending.

This WSC Brief outlines the major provisions of the bill, with emphasis on those that directly affect providers and health facilities.

Title I: Ending Surprise Medical Bills

Title I of the Act, entitled "Ending Surprise Medical Bills," includes many of the same surprise medical bills provisions included in other congressional proposals. Specifically, the bill would require out-of-network providers practicing in in-network facilities to accept in-network rates. Providers may choose to contract with the payer or go through the hospital for this billing.

Unlike the other proposals, however, the HELP Committee proposal includes three different options for a legislative approach to payment dispute resolution. A breakdown of these options is below.

ALL OPTIONS: Definition of Median Contracted Rate and State Applicability

- For all of the below options, the term 'median contracted rate' means the median negotiated rate under the applicable plan or for the same or a similar service in the geographic region.
- For all of the below options, states may choose to enact or continue in effect state laws or regulations relating to surprise billing (such as arbitration or benchmarking), *only for markets regulated by the state* (i.e., self-funded plans, also known as ERISA plans, would still not be subject to state laws and would instead conform to one of the below options).

OPTION 1: In-Network Guarantee

- Requires that an in-network facility guarantee to patients and health plans that every practitioner at that facility will also be considered in-network.

- Practitioners and facilities have two options to be considered in-network: 1) Practitioners can choose to join the networks for health plans that have a network agreement with the facility; OR 2) Practitioners who choose not to go in-network can choose to bill the health plan through the facility, rather than sending separate bills to the patient or the health plan.

- For emergency care delivered out of network, the health plan and facility/provider have 30 business days to privately determine the appropriate reimbursement for such services.

- If, after a 30-business-day period, the health plan and the facility/provider do not reach an agreement, the health plan will pay the facility/provider based on the median contracted rate.

OPTION 2: Independent Dispute Resolution

Applicability

- For surprise bills that are $750 or less, the health plan will pay the practitioner or facility based on the median contracted rate for services in that geographic area.
- For surprise bills that are greater than $750, either the health plan or the facility or practitioner can elect to initiate an independent dispute resolution IDR process, using a third-party arbiter certified by HHS.

Settlement/Determination of Amount

- If a certified IDR entity determines, based on the amounts indicated in the request, that a settlement between the group health plan or health insurance issuer and the facility or practitioner is likely, the entity may direct the parties to attempt, for a period not to exceed 10 days, a good faith negotiation for a settlement.
- In the absence of a settlement, the health plan and facility/provider will each submit to the certified IDR entity their final offer. The entity will then determine which of the two amounts is more reasonable based on relevant factors including the median contracted rate (using the methodology outlined in this bill).

Responsibility for IDR Costs

- The party whose final offer is not chosen shall be responsible for paying all fees charged by the certified IDR entity. If the parties reach a settlement prior to completion of the IDR process, the costs of such process shall be divided equally between the parties.

OPTION 3: Benchmark for Payment

- For surprise bills, the health plan will pay the practitioner or facility based on the median contracted rate for services in that geographic area.

Title II: Improving Transparency in Health Care

Gag Clauses

- Bans gag clauses in contracts between providers and health plans that prevent enrollees, plan sponsors, or referring providers from seeing cost and quality data on providers.
- Bans gag clauses in contracts between providers and health insurance plans that prevent plan sponsors from accessing de-identified claims data that could be shared, under HIPAA business associate agreements, with third parties for plan administration and quality improvement purposes.

"Anticompetitive" Contract Terms

- Prevents "anti-tiering" and "anti-steering" clauses in contracts between providers and health plans that restrict the plan from directing or incentivizing patients to use specific providers and facilities with higher quality and lower prices.
- Prevents "all-or-nothing" clauses in contracts between providers and health plans that require health insurance plans to contract with all providers in a particular system or none of them.
- Prevents "most-favored-nation" clauses in contracts between providers and health plans that protect an insurance company's dominant position in a market by requiring that the insurance company be given the most favorable pricing of any health plan in the market.
- Prohibits obligations on plan sponsors to agree to terms of contracts that the sponsor is not party to and cannot review, which could conceal anti-competitive contracting terms.

Availability/Accuracy of Provider Network Information

- Requires health plans to have up-to-date directories of their in-network providers, which shall be available to patients online, or within 24 hours of an inquiry.
- If a patient provides documentation that they received incorrect information from an insurer about a provider's network status prior to a visit, the patient will only be responsible for the in-network cost- sharing amount.

Patient Billing

- Requires health care facilities and providers to give patients a list of services received upon discharge.
- Requires all bills to be sent to a patient within 30 business days. If bills are received more than 30 days after receiving care, the patient is not obligated to pay.
- Requires providers and facilities to give patients at least 30 business days to pay bills upon receipt.

Out-of-Pocket Cost Estimates

- Requires providers and health plans to give patients good faith estimates of their expected out-of- pocket costs for specific healthcare services, and any other services that could reasonably be provided, within 48 hours of a request.

Title III: Reducing the Prices of Prescription Drugs

Drug and Biologic Exclusivity

- In March 2020, a small subset of biological products, including insulin, will transition from the drugs pathway to the biologics pathway, opening the biological products up to biosimilar competition.
- Ensures that marketing applications submitted six months prior to the transition that are still under FDA review at the time of the transition date will not have to be resubmitted, avoiding delays in product availability.
- Clarifies that biological products, including insulin products, that will transition from the drugs pathway to the biologics pathway in March 2020, cannot receive new, extended market exclusivities.

Timely Access to Generics

- Provides that FDA may deny a citizen petition that is submitted with the primary purpose of delaying the approval of an application and clarifies criteria that FDA may use to make this determination.
    - Requires HHS to establish procedures for referring a petitioner to the Federal Trade Commission if determined that a petition was submitted with the primary purpose of delaying the approval of another application.
- Prevents first-to-file generic drug applicants from blocking, beyond a 180-day exclusivity period granted by FDA, the entrance of subsequent generic drugs to the market.
- Clarifies that eligibility for five-year new chemical entity (NCE) exclusivity is available only for a drug containing no active moiety (i.e., the molecular part of the drug that is responsible for the physiological or pharmacological action) that has been previously approved in the U.S.

Education on Biological Products

- Requires FDA to establish an internet website to provide educational materials for health care providers, patients, and caregivers on biological products, including biosimilar and interchangeable biological products.
- Provides that the Secretary may develop and improve continuing medical education for health care providers regarding biosimilar biological products.