BRIEFING

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LOWER HEALTH CARE COSTS ACT OF 2019: PROPOSED LEGISLATION TO ESTABLISH NEW COMPENSATION DISCLOSURE & TRANSPARENCY REQUIREMENTS

In early December, Democrats and Republicans in Congress continued to take steps toward enacting the Lower Health Care Costs Act of 2019, the most significant federal health insurance legislation since the Affordable Care Act (ACA). The legislation, which was authored by Senator Lamar Alexander (R-TN), Chair of the Senate Health Education, Labor and Pensions (HELP) Committee, and Representatives Frank Pallone (D-NJ) and Greg Walden (R-OR), leaders of the House Energy and Commerce Committee, would establish new compensation disclosure and transparency requirements, and restrict the ability of out-of-network providers to balance-bill patients (so-called "surprise billing"). While the bill language itself has not yet been released, the Senate HELP committee has released a detailed, section-by-section outline of the bill, which can be found at:

https://www.help.senate.gov/imo/media/doc/LHCC%20Section-by-Section_FINAL.pdf

Most relevant to Keenan clients would be Titles II, III, and IV of the bill, as summarized below.

TITLE II: TRANSPARENCY

The bill includes a number of measures that have a stated aim of improving transparency in health care contracting and pricing. As set forth below, the bill would:

- Ban 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
  - prevent plan sponsors from accessing de-identified claims data that could be shared with third parties for plan administration and quality improvement purposes
- Prohibit anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care, such as anti-tiering, anti-steering, all-or-nothing and most favored nation clauses
- Establish a grant program to create and improve state All Payer Claims databases
- Require health plans to have up-to-date directories of their network providers
- Require health facilities and practitioners to give patients a list of services received within 15 days of discharge or date of visit and submit bill to payers within 20 days
- Require providers and plans to give patients good faith estimates of expected out-of-pocket costs

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- Require health benefit brokers and consultants to disclose to customers any direct or indirect compensation the brokers and consultants may receive

- With regard to Pharmacy Benefit Managers (PBMs):

  - Prohibit "spread" pricing where the PBM charges more for a drug than the manufacturer charged the PBM
  - Require PBMs to pass on 100% of rebates or discounts to plan sponsors
  - Require that group health plan sponsors receive a semi-annual report on the costs, fees and rebate information associated with their PBM contracts

- Strengthen the enforcement of mental health parity in health insurance plans

- Require group health plans to report information on plan medical cost and prescription drug spending to the Department of Health and Human Services (HHS)

TITLE III: "NO SURPRISES ACT"

Title III of the legislation addresses so-called surprise medical billing, by prohibiting certain practices of health care providers as summarized below. Title III of the bill would:

- Provide that patients are only required to pay the in-network cost-sharing amount for out-of-network emergency care, ancillary services provided by out-of-network providers at in-network facilities, and out-of-network care provided at in-network facilities without the patient's informed consent

  - Resolves billing disputes between payer and provider by requiring payers to pay at minimum the market-based median in-network rate for service in the geographic area where the service was delivered. If the median in-network rate is above $750, either party may elect to go to arbitration

  - Prohibit out-of-network facilities and providers from sending patients balance bills for more than the in-network cost-sharing amount

  - Prohibits certain out-of-network providers from balance billing patients unless they give the patient notice of their network status and an estimate of charges 72 hours prior to providing services and the patient provides consent

- Hold patients harmless from surprise air ambulance medical bills and prohibit balance billing for more than the in-network cost-sharing amount for air ambulance services

  - Resolves billing disputes between payer and air ambulance provider by requiring payers to pay at minimum the market-based median in-network rate for service in the geographic area where the service was delivered. If the median in-network rate is above $25,000, either party may elect to go to arbitration

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- Health plan ID cards must include the amount of in-network and out-of-network deductibles and out-of-pocket maximum

Title IV: Improving Competition to Lower Drug Costs

The legislation contains a number of provisions aimed at lowering the price of prescription drugs, most notably by helping biosimilar and generic products get FDA approval, limiting exclusivity and requiring price increase reporting to HHS. Specifically, the bill would do the following:

- With regard to biological products (like insulin), the bill would:
  - require patent information to be submitted to the Food and Drug Administration (FDA) and published in a single, searchable list of information about each biological product
  - clarify that those products cannot receive new, extended market exclusivities
  - clarify the process of FDA approval of biosimilar products
- Regarding generics, the bill would:
  - Prevent first-to-file generic applicants from blocking the entrance of subsequent generic drugs to the market after the first 180 days
- Limit the availability of new chemical entity (NCE) exclusivity to drugs to ensure that drug manufacturers cannot receive exclusivity for making small tweaks to old drugs and that only the most innovative or novel drugs qualify for exclusivity
- Require manufacturers of certain prescription drugs to report information to HHS regarding the price of the drug, an explanation for the price increase and other information if the price increases 10% or more in a single year or 25% or more within three consecutive years

Employers and their employees will likely welcome the provisions that directly impact out-of-pocket and other costs. However, without the full bill language it is difficult to gauge what impact reporting will have on fully-insured plans and how onerous new plan reporting obligations will be for self-insured employers and groups. While this bill appears to be a high priority among lawmakers in both parties, it still faces an uncertain prospect for passage in 2020.

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