Key Changes in HELP's Updated Lower Health Care Costs Act

On June 19, 2019, the US Senate Committee on Health, Education, Labor & Pensions (HELP) released its updated Lower Health Care Costs Act (S. 1895). This new version includes several noteworthy changes, outlined below. Click here for the full legislative text and here for a section-by-section summary.

Surprise Billing Rate: The Committee chose to address surprise billing through a benchmark rate that is pegged to the median in-network rate for a geographic area. (In the discussion draft, the Committee did not pick an option to address how to resolve disputes over surprise billing, and instead laid out three options for consideration.) Health plans would pay providers the local median contracted commercial amount that insurers have negotiated and agreed upon with other providers in that geographic area. Although an official Congressional Budget Office (CBO) report has not yet been released, it has been reported that the CBO estimated that the benchmark proposal would save $25 billion over 10 years—the largest cost saver out of the three proposals considered. The House Energy and Commerce No Surprises Act also uses this approach.

Air Ambulances: The original discussion draft would have required that bills for air ambulance trips be broken out by air and medical charges. In the new version, however, patients are held harmless from surprise air ambulance bills. Patients' cost-sharing for out-of-network air ambulance services would be equal to the amount if such services were provided by an in-network practitioner, and any coinsurance or deductible shall be based on in-network rates. Additionally, a group health plan or health insurance issuer shall pay out-of-network air ambulance providers at the median in-network rate for that service in the same geographic area.

Drug Pricing: Four new sections were added to Title II, which focuses on prescription drug pricing:

- Provisions relating to orphan drug designations
- Provisions giving the US Food and Drug Administration (FDA) authority for prompt approval of follow-on or generic drugs, and including necessary safety information in labeling
- Provisions clarifying that biosimilar applicants can include in submissions the information that conditions for use have already been approved through the reference product
- Provisions giving FDA new authorities in addressing outdated drug labeling for generics

Transparency: There were also a few noteworthy changes within Title III, which focuses on transparency:

- Section 302, which bans anticompetitive terms in facility and insurance contracts, now includes an exception for certain group model issuers. The prohibition of anticompetitive clauses outlined in the bill does not apply when a group health plan or a health insurance issuer offers group or individual health insurance coverage with respect to a health maintenance organization (HMO) if that HMO operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such HMO and its affiliates.

- Section 304 now includes a provision to add business processes that providers must have in place to ensure timely delivery of directory information to plans. Providers are required to submit directory information to plans when 1) the provider begins a network agreement with a plan, 2) the provider terminates a network agreement with a plan, 3) there are material changes to provider directory information, and 4) every 90 days throughout the duration of the network agreement with the plan. There are civil monetary penalties if the provider fails to meet requirements.

- Section 305 also includes changes to timely bills for patients. First, the new draft expands on the provision by requiring providers to give patients a list of services rendered during their visit to such facility or practitioner—and, in the case of a facility, the name of the provider for each service—upon discharge or by postal or electronic communication as soon as practicable and not later than five calendar days after discharge. The new draft extends the timeframe in which facilities and practitioners must send a bill to patients from 30 days to 45 days. The new bill also adds a safe harbor from penalties associated with this section for facilities and practitioners if there is a good faith attempt to bill the patient, or extenuating circumstances. The provision dictates that plans must implement business processes that allow these requirements to be implemented.

- Section 306, which relates to the oversight of pharmacy benefit managers (PBMs), also includes changes. Overall, this section requires that plan sponsors receive a quarterly report on the costs, fees and rebate information associated with their PBM contracts. Reporting will be structured to prevent the release of information that could lead to higher drug prices. It also prohibits PBMs from engaging in spread pricing or charging a plan sponsor, health insurance plan or patient more for a drug than the PBM paid to acquire the drug. This section includes reporting and pricing requirements for PBMs that own mail-order, specialty or retail pharmacies. It also requires the PBM to pass on 100% of any rebates or discounts to the plan sponsor.

Title III: Title III adds three new sections. As outlined in the section-by-section summary, Section 310 requires group and individual health plans to conduct comparative analysis of non-quantitative treatment limitations used for medical and surgical benefits as compared to mental health and substance use disorder benefits. It requires the Secretary of the US Department of Labor to request that a group and individual health plan submit the comparative analysis if it receives a complaint from an enrollee, and requires the Secretary to request random submissions from 50 plans per year. If, upon review of the analysis, the Secretary finds that a plan or coverage is out of compliance with mental health parity law, the Secretary must specify actions for the plan or coverage to come into compliance. The bill also adds technical amendments relating to ERISA (Section 311) and third-party administrators (Section 312).

Titles IV and V: Minor non-substantive changes and clarifying language were added in Titles IV and V. New sections were also added in Title IV that address some of the health care extenders that are up for reauthorization at the end of September 2019. Section 411 adds an extension of mandatory funding for community health centers, the National Health Service Corps and the Teaching Health Center Graduate Medical Education Program at current levels for each of fiscal years 2020 through 2024. Additionally, section 412 extends mandatory funding for the Special Diabetes Program for Type I Diabetes and the Special Diabetes Program for Indians at current levels for each of fiscal years 2020 through 2024.

The Chairman has scheduled a mark-up on this bill for Wednesday, June 26, 2019. We expect more changes to be made before then, including the possibility of new provisions, as Members and stakeholders continue to push for priorities within the bill.

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