HEALTH & WELFARE PLAN LUNCH GROUP

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Summary Comparison Legislative Proposals Regarding Surprise Medical Billing

The following table provides a summary of three bi-partisan proposals addressing the issue of surprise medical bills:

- A discussion draft of the "No Surprises Act," released by House Energy and Commerce Committee Chairman Frank Pallone, Jr (D-NJ) and Ranking Member Greg Walden (R-OR) on May 13, 2019;
- S 1531, the "STOP Surprise Medical Bills Act of 2019," introduced on May 16, 2019, by Senators Bill Cassidy, M.D. (R-LA), Michael Bennet (D-CO), Todd Young (R-IN), Maggie Hassan (D-NH), Lisa Murkowski (R-AK), and Tom Carper (D-DE); and
- A discussion draft of the "Lower Health Care Costs Act", released on May 23, 2019, by Senate HELP Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA).

Please note that the table is a summary only and does not include full details of the various provisions. Some provisions may be further clarified as the legislative process progresses.

	No Surprises Act (House E&C Discussion Draft)	*Stopping the Outrageous Practice of (STOP) Surprise Medical Bills Act of 2019 (S. 1531)*	*Lower Health Care Costs Act (Senate HELP Discussion Draft)*
Applicability[1]	Generally intended to apply to group health plans and health insurance issuers in connection with group or individual coverage. Generally would not apply to STLDI or excepted benefits.	Same as "No Surprises Act"	Same as "No Surprises Act".
Emergency Services	• Enrollees are responsible for in-network cost-sharing (expressed as a copayment or coinsurance). • Providers may not balance bill the enrollee. Providers may be subject to a civil penalty (amount TBD) if they balance bill. • Health plan/insurer must count cost-sharing paid by the enrollee toward any deductible or OOP max. • Health plan/insurer must pay the OON provider the "recognized amount" for the services (see below).	Similar approach as under "No Surprises Act", but the amount the health plan/insurer has to pay the provider is determined in a different manner (see below). The normal PHSA civil penalties apply (i.e., $100 per violation per day) to a provider or health plan/insurer that balance bills.	Similar approach as under "No Surprises Act", except that plans/insurers can only impose the in-network deductible, copayment and/or coinsurance on enrollees and the amount that the plan/insurer has to pay the provider is determined in a different way. The bill summary indicates that the intent is that the deductible paid by the enrollee counts toward the OOP max. Providers who balance bill are subject to a fine of $10,000.
Non-Emergency Services Provided by OON Provider	• Similar to emergency services approach **except** that providers may balance bill patients if the individual consents to the OON services.	Same as treatment of OON emergency services under the bill, including prohibition on balance billing and calculation of the amount the health/plan insurer has to pay.	• Enrollees are responsible for in-network copayments, coinsurance, and deductible. • Providers may not balance bill the enrollees, subject to a $10,000 fine.

[1] Technical changes may be needed in some cases to incorporate the provisions into ERISA and the Internal Revenue Code as appears to be the intent.

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	• The consent exception does not apply to "facility-based providers," which means emergency medicine providers, anesthesiologists, pathologists, neonatologists, assistant surgeons, hospitalists, intensivists, and other providers as determined by the Sec. of HHS. • Before obtaining a consent, the individual must be provided written and oral notice on the date the appointment is made and on the date the services are furnished. The notice must state that the provider is OON and include an estimate of the amount the provider will charge the individual for the services. The consent must be obtained not less than 24 hours before the services are performed. • Balance billing is not permitted if consent is not provided. • Civil penalties [amount TBD] may be imposed on providers that improperly balance bill.		• Health plan/insurer must count amounts paid by the enrollee toward the in-network deductible and OOP max. • Health plan/insurer must pay the provider the amount as determined under the proposal.
Additional OON Provider Services Following Emergency Care	• No special rule. The provisions for general non-emergency services could potentially apply (see above).	• Rules depend on condition of the patient following the emergency services. • In general, where the patient enters a hospital for emergency services and then receives required nonemergency services after the enrollee has been stabilized, the same emergency services rules apply. • However, the protections of the bill do not apply if the enrollee has been stabilized and is able to travel in nonmedical transport, has been provided notice of OON charges, and assumed in writing full responsibility for OOP expenses for the OON care.	Generally similar to S. 1351. If the patient is stabilized following the emergency services and consents after receiving specified notice, then the patient is responsible for OON co-payments for the non-emergency services and can be balance billed by the provider.

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Ambulances/Air Ambulances	No provision.	No provision.	Requires emergency air ambulance providers to separately state the amount of charges for medical care and air travel.
Insurer/Plan Payment Amount	Health plan/insurer must pay the provider the "recognized amount" which is either: • The amount provided under applicable state law (which generally would not apply to self-funded plans under ERISA), or • The "median contracted rate"; in general, this is the median in-network rate recognized by the plan for the service in the same geographic area. Further detail on calculating the median contracted rate is to be provided in regulations. Note, there is no arbitration available under this legislation.	The amount the plan/insurer has to pay the OON provider is subject to a binding independent dispute resolution (IDR) process between the provider and plan/insurer. • The plan/insurer must automatically pay the provider the median in-network rate under the plan. • The provider has 30 days to initiate the IDR process. • The IDR reviewer is to consider commercially reasonable rates (based on in-network rates) for the geographic area when making its determination and other factors submitted by the parties. • The IDR process is "baseball style" meaning the parties submit one final offer and the reviewer picks one. Losing party pays the prevailing party's costs. • The cost of the IDR process is treated as a claims cost for MLR purposes in the group market.	The draft includes three different options for payment resolution between the provider and plan/insurer. One or more (or a combination of these options) may be included when the bill is introduced. <u>Option 1: In-Network Guarantee</u> In-network guarantee for OON professionals at in-network facilities: • Health plans/insurers may not contract with a health care facility unless (a) each health care practitioner at the facility is also an in-network provider and (b) all lab/diagnostic services provided in the facility are in-network and all referrals for such services by the facility are to in-network providers. • Providers may elect to be considered in-network for purposes of this provision if they agree to be paid through the facility and agree not to balance bill the enrollee. OON emergency services: • The plan/insurer and the provider have 30 days to reach agreement on the amount to be paid for the services. If no agreement is reached the plan/insurer must pay the median contracted rate for the same geographic area. Note: It is not clear under Option 1 how payment disputes between plans/insurers and providers would be resolved in the case of OON non-emergency services provided after emergency care and after the patient has been stabilized where the patient has not consented to the OON charges.

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			Option 2: IDR • The IDR process would apply to claims in excess of $750 (indexed). For claims of $750 or less, the plan/insurer would be required to pay the provider the median contracted rate. • If the parties do not settle the claim through the IDR process, the IDR reviewer determines the amount to be paid through "baseball" style arbitration, meaning each party submits a final proposal and the IDR reviewer picks one. • The IDR reviewer is to consider relevant factors, including the median contracted rate. • The losing party pays the costs of the IDR process (costs are split equally if a settlement is reached). Option 3: Benchmark Payment • Plan/insurer must pay the "median contracted rate" developed pursuant to HHS regulations.
Interaction with State Law	States may set their own payment standards for plans regulated by the State (which would generally not include self-funded plans subject to ERISA).	The ability of States to enact greater patient protections is specifically preserved. In the case of fully-insured plans, a State may establish its own methodology for resolution of provider compensation for surprise medical bills, as long as the patient protections of the bill apply.	Notwithstanding ERISA preemption, a State may adopt its own method for determining the appropriate compensation for services addressed in the bill. In the absence of a State method, the provisions of the bill apply. The provisions of the bill apply to self-insured group health plans that are not subject to state regulation.
Transparency/Reporting		Includes a number of provisions relating to transparency, including: • Plans/insurers must notify in-network providers of new products for which the provider would be eligible. • Plans/insurers must include information on deductibles and OOP max on the plan or insurance identification card. • Plans/insurers cannot contract with a provider unless the provider agrees to	Includes a number of provisions relating to transparency, including the following. Price and quality transparency: • 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

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		provide enrollees with certain information regarding cost-sharing for a particular health care service. • Requirements for hospitals. • Annual reporting for plans/ insurers of detailed information regarding claims.	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 provider contract terms: Prohibits health plans/issuers from entering into contracts with providers that: • Restrict the plan/insurer from directing or incentivizing patients to use specific providers and facilities with higher quality and lower prices, • Require the plan/insurer to contract with all providers in a particular system or none of them, or • Contain "most-favored-nation" clauses that restrict other plans/insurers not a party to the contract from paying a lower rate for items or services than the contracting plan/insurer. Prohibits self-funded plans from entering into an agreement with a provider or provider network, if such agreement, directly or indirectly, requires the plan to agree to terms of contracts that the plan is not a party to and cannot review. This provision is aimed at agreements which may conceal anti-competitive contracting terms. Provider directories: Plans/insurers are required to have up-to-date network provider directories, which are to be available on-line or within 24 hours of an inquiry. The enrollee is required to pay only the in-network amount if they demonstrate they received incorrect information from the plan/insurer. PBM oversight: • Requires that plan sponsors receive a quarterly report on the costs, fees and rebate

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			information associated with their PBM contracts. • Prohibits plans/insurers and PBMs from charging the plan/insurer or enrollee more for a drug than the actual price paid to the pharmacy to provide the drug to the enrollee. (Intended to limit spread pricing.) • Requires the PBM to pass on 100% of any rebates or discounts to the plan sponsor. <u>Disclosure of direct/indirect compensation</u>: Amends the prohibited transaction provisions of ERISA to require health benefit brokers and consultants to disclose to group health plans any direct or indirect compensation the brokers or consultants may receive for referral of services, using a format similar to rules proposed in 2007 for health and pension plan brokers. Disclosure rules would also apply in the individual market. <u>Cost-sharing disclosure:</u> • Plans/insurers cannot contract with a provider unless the provider agrees to provide enrollees with an estimate of expected cost-sharing at the time of scheduling or not later than 48 hours after a request. • Plans/insurers must provide enrollees with an estimate of expected cost-sharing for specific services not later than 48 hours after a request.
All-Payer Claims Database	Provides federal grants to states to provide for an All Payer Claims Database.		Amends ERISA to provide for the establishment of an all-payer claims database by a nongovernmental, nonprofit entity chosen by the Sec. of Labor in consultation with the Sec. of HHS.

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			The nonprofit entity, in compliance with current privacy and security protections, will use de-identified health care claims data from self-insured plans, Medicare, and participating states to help patients, providers, academic researchers, and plan sponsors better understand the cost and quality of care, and facilitate state-led initiatives to lower the cost of care, while prohibiting the disclosure of identifying health data or proprietary financial information. Self-funded group health plans are required to submit data if the plan is self-administered or is administered by an insurer or TPA that (a) administers benefits for more than 50,000 enrollees, and/or (b) is one of the five largest TPAs or insurer/administrators in the State as measured by the number of enrollees. Allows the creation of custom reports for employers and employee organizations seeking to utilize the database to lower health care costs. Authorizes grants to States for similar initiatives.
Other			Includes provisions relating to: • Reducing the price of prescription drugs (Title II), • Improving public health (Title IV), and • Improving the exchange of health information (Title V), which includes a provision that requires plans/insurers to provide certain information regarding claims, networks, and costs.