Policy Brief

May 31, 2019

Senate Releases Bill to Tackle Health Care Costs

Last week, the Senate's Health, Education, Labor and Pension (HELP) Committee released draft legislation aimed to improve price transparency, address surprise bills and reduce health care costs. Notably, the bill proposes to designate a nonprofit entity charged with collecting claims data that would facilitate initiatives to lower the cost of care. The bill would also require hospitals to ensure that every clinician at the facility is considered in-network. Because the bill is so broad, its language will likely change with some provisions being modified if consensus is not reached. The Committee aims to bring the bill to the floor in July. Below are the key highlights on the bill.

Transparency

- Designates a non-profit entity to improve the transparency of health care costs. The entity would collect de-identified claims data with the goal of facilitating state-led initiatives to lower the cost of care.
- Bans "all-or-nothing" clauses between health providers and insurers, which currently allow health systems to pressure insurers to contract with all their facilities instead of just a few.
- Prevents "most-favored-nation" clauses that protect an insurance company by requiring that the insurance company be given the most favorable pricing of any health plan in the market.
- Prohibits "anti-tiering" or "anti-steering," where hospitals through their insurance contracts keep patients from choosing treatment at competing health systems.

- 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 would not be obligated to pay.

Surprise Medical Bills

- Prohibits balance billing or charging patients for the amount not reimbursed by the health insurer.
- Requires that hospitals guarantee to patients that every practitioner at that facility will be considered in-network. This could be accomplished through network-matching or by having physicians submit their charges through the hospital so the insurer gets only one bill.
- Provides three options for providers and insurers to address surprise medical bills:
    - 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, the provider and health plan will have the option to enter into arbitration if they do not agree with the payment rate.
    - For emergency care delivered out of network, practitioners and facilities would have 30 days to privately determine reimbursement.

Drug Prices

- Clarifies that biological products, such as insulin, that will transition from the drugs pathway to the biologics pathway in March 2020, cannot receive new, extended market exclusivities.
- Prevents first-to-file generic drug applicants from blocking, beyond a 180-day exclusivity period granted by FDA, the entrance of generic drugs to the market.
- Requires health care facilities and providers to give patients the list of services received upon discharge.
- Requires providers and health plans to give patients good faith estimates of their out-of-pocket costs within 48 hours of request.

Public Health

- Authorizes the Department of Health and Human Services (HHS) to provide several grants to improve maternity care and care for postpartum women and their infants.
- Authorizes grants for medical training related to implicit bias in the provision of maternal services.
- Authorizes a national campaign to increase awareness of vaccines and combat misinformation.

Congress Tackling Mothers' Mortality and Its Disparities

The rise in U.S. maternal mortality, particularly among black women, has sparked Congress' interest. Last week, the House Ways and Means Committee had a hearing on the issue and more efforts are likely to follow. A New York Times article linked providers' implicit bias to death disparities as educated, wealthy black mothers were three to four times as likely to die than a white mother from any economic class. Legislators' early actions indicate they want to understand the reasons behind the high maternal mortality rates and find solutions to tackle this issue. Below is more about the current rise in maternal mortality and the steps that legislators are taking.

The U.S. maternal mortality rate has doubled over the last two decades, making it the only developed nation with a rising maternal mortality rate. A CDC report found that three in five of these deaths could have been prevented. That same report also found that African-American, Native American and Alaska Native women are three times more likely to die from a pregnancy-related death than white women. A 2015 study shows that black women are more likely to experience preventable maternal death than white women even if they are more educated and earn a higher income.

Late last year, Congress enacted the Preventing Maternal Deaths Act, which encouraged the creation of committees in every state to understand why mothers are dying and the causes of the disparities. Last week, the House Ways and Means Committee held a hearing on how to overcome racial disparities and social determinants when addressing the maternal mortality crisis. In addition, the Committee sent a letter to HHS requesting a review of their programs that combat maternal mortality. It also sent a letter to the Government Accountability Office (GAO) for a report on maternal mortality data. The Senate's recent draft legislation also includes provisions aimed to improve education and funding to address the U.S' maternal mortality rates. We expect to see more movement around this issue soon.

Anti-Abortion Laws Limit Provider Autonomy

Recently, a total of eight states have passed varying degrees of anti-abortion legislation, eliciting outcry from activists and providers. Many laws restrict access to abortion care regardless of providers' professional assessment; some even threaten to jail doctors delivering the care. In Alabama and Missouri, the bills contain no exceptions for pregnancies that are the result of criminal activity such as rape or incest. Many ban women from receiving abortion care after six weeks—often before she and her OBGYN are aware of the pregnancy. READ MORE on recent legislation and what it could mean for our patients.

Which states have anti-abortion laws?

Laws restricting abortion have been passed this year in Utah, Ohio, Missouri, Kentucky, Arkansas, Mississippi, Alabama and Georgia. Of these, Alabama and Missouri are the most restrictive. These laws target providers through limiting admitting privileges, mandatory waiting periods and even criminal sentences of up to 99 years in prison. Dr. Colleen McNicholas, a Missouri OBGYN serving the St. Louis and Kansas City populations, worries the laws are "just another vehicle to intimidate doctors like me and to push abortion out of reach for patients."

What does this mean for patients?

Abortion bans restrict patient access. Many providers become wary of performing the procedure, regardless of the reason or medical necessity, limiting patients' options. Some states are already down to only one health center providing abortions. States with the most restrictive abortion laws are also the states with the highest maternal and neonatal mortality. These laws may be headed to the Supreme Court: the goal for many anti-abortion proponents.

Maryland Innovation Marries Tax Returns and Insurance Enrollment

This month, Maryland Governor Larry Hogan signed a new law that helps connect residents with health care coverage options. The bill creates the Maryland Easy Enrollment Health Program, which evaluates tax return financial information for insurance eligibility. Residents who are eligible for Medicaid will be automatically enrolled. Those who are over the limit will be redirected to the state's Health Insurance Exchange and alerted to any government subsidies for which they qualify.

Health policy experts hope that other states follow Maryland's example. Many call the program a "win-win," since it doesn't require a large amount of additional state funding. Currently, more than 100,000 uninsured Maryland residents are eligible for enrollment but go without coverage. The Maryland Easy Enrollment Health Program is an important step toward closing that gap.

A Look at the Federal Register

Changes to the Medicare Claims and Medicare Prescription Drug Coverage Determination Appeals Procedures. CMS is seeking comment on a final rule that revises the regulations setting forth the appeals process that Medicare beneficiaries, providers, and suppliers must follow in order to appeal adverse determinations regarding claims for benefits under Medicare Part A and Part B or determinations for prescription drug coverage under Part D. These changes help to streamline the appeals process and reduce administrative burden on providers, suppliers, beneficiaries, and appeal adjudicators. These revisions,

which include technical corrections, also help to ensure the regulations are clearly arranged and written to give stakeholders a better understanding of the appeals process. **Comments are due July 8, 2019.**

Request for Information Regarding State Relief and Empowerment Waivers. CMS is seeking comments on innovative programs and waiver concepts that states could consider in developing a 1332 waiver plan. Specific feedback is requested on how states might take advantage of new flexibilities published in October 2018. The goal of these waivers is to give Americans the opportunity to gain high value and affordable health coverage regardless of income, geography, age, gender, or health status while empowering states to develop health coverage strategies that best meet the needs of their residents. **Comments are due July 2, 2019.**

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