To: AHRA
From: Matt Reiter, Nathan Baugh and Bill Finerfrock
Re: Summary of E&C and HELP Committee Stakeholder Briefing on Surprise Billing Legislation

On Sunday afternoon, the House Energy and Commerce (E&C) Committee and the Senate Health, Education, Labor and Pensions (HELP) Committee announced they reached a bipartisan, bicameral agreement on legislation that addresses a number of healthcare issues. Most notably, the bill includes a long-sought agreement between the two Committees on how to design legislation that protects patients from unexpected out-of-network (OON) “surprise” medical bills as well as how the patient’s health plan should reimburse OON providers in surprise scenarios.

The bill is an updated version of the HELP Committee’s S. 1895, the Lower Health Care Cost (LHCC) Act. The new version will also include language from various E&C bills. Attached to this email is a section-by-section summary provided by the Committees.

At 11:30 a.m. on Monday, the Committees invited Matt Reiter from Capitol Associates to attend a staff briefing for stakeholders for 3 p.m. that same day. Below is a summary of the surprise billing section update from the briefing:

- **Rate Setting**: To address surprise billing, the bill establishes the median in-network commercial rate as the OON rate in surprise scenarios. The median will be benchmarked to January 31st, 2019.

- **IDR Process**: If either party disagrees with that rate, they can trigger an independent dispute resolution process (binding, “baseball-style” arbitration). The arbiter will have to consider the median in-network rate, the provider’s specialty and geographic location and extenuating circumstances such as patient complexity. The bill adds one new item to the arbiter’s criteria: each party’s market share.

- **IDR Threshold**: There will be a $750 per-CPT code threshold for IDR eligibility. It does not appear that providers will have the ability to bundle claims to reach the threshold. This is lower than the E&C’s threshold of $1,250. Despite the lower threshold, many claims will be excluded from the IDR process due to the threshold amount and inability to bundle services.

- **IDR “Cooling” Period**: There will be a 90-day “cooling” period after each IDR case where the party that triggered IDR cannot bring the same party to arbitration for the same item or service for 90-days. The purpose of the cooling period is to prevent overutilization of the IDR process and to make each party more selective over what claims they bring to arbitration.

The cooling period raises immediate concerns for providers. Unless an arbitration decision creates a precedent, providers will have little recourse to arbitrate an identical issue regardless of the arbiter’s decision in the initial case.
I asked the Committee staff how they define the “same item or service.” The answer I received is that it cannot be for the same “claim.” Claims often contain multiple CPT codes. I believe that the cooling period applies to each unique combination of codes on a claim. I am attempting to clarify that interpretation with staff.

- **Applicability of State Law:** Though not addressed in the summary, previous legislative proposals have clarified that the federal law is intended to defer to state law. The federal law will apply in states that do not have a surprise billing law enacted and apply to health plans that states do not have the jurisdiction to regulate e.g. ERISA Plans. The law is also intended to serve as a “floor” for states, meaning state laws must be as adequate as the federal law (however adequacy for this purpose is not clearly defined). The Committee staff fielded a question asking if the new bill maintains this approach to state law. Staff answered that the new version of the bill will take a consistent approach to state law.

- **Beneficiary Card Information:** Plans will have to include a patient’s in- and out-of-network cost-sharing information on beneficiary plan cards. However, plans will not be required to display the plan type (e.g., Commercial, ACA, ERISA, etc.) on the beneficiary card or elsewhere. One provider organization (EDPMA) asked for the plan type to be displayed so that providers know which law (state or federal) applies. The Committee answered that plans will not be required display plan-type but they expressed an openness to the idea.

- **Savings:** Committee staff did not provide a number but they said the surprise billing provision will save “less than $20 billion” over ten years. The original LHCC Act’s surprise billing provisions would have saved $25 billion over ten years while the E&C’s version would have saved $20 billion.

- **Timely Billing for Patients:** Providers will be required to submit claims to health plans within 20 calendar days after discharge or the date of visit. Health plans must return an adjudicated bill to the provider within 20 calendar days of receiving the claim. Providers must send a bill to patients within 20 calendar days of receiving an adjudicated bill from health plans. Patients must receive a bill within 60 calendar days after receiving care. Patients will not have to pay bills received after 60 days. Patients will have 35 days to pay their bill once it is received. An appeal of an adjudicated claim will “pause the clock” until the appeal is resolved, at which point the “clock” will resume.

HHS will be required to issue regulations to account for extenuating circumstances such as global packages.

We still have many unanswered questions that we will not have answered until the Committee releases official legislative text. We will provide an additional summary after the Committees
release legislative text. Meanwhile, Capitol Associates is following up with Committee staff with some questions.