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Honorable Teresa Miller
Insurance Commissioner
13th Floor
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Harrisburg, PA 17120

Re: The Insurance Department's draft legislation protecting consumers from surprise billing

Dear Commissioner Miller:

We offer the following comments on the Insurance Department's January 19 draft legislation following your October 1, 2015 hearing on how to regulate and protect consumers from the emerging national problem of surprise bills from out-of-network providers for services provided in network settings.

General comments

1. Protection from surprise balance billing

We agree that consumers should be protected – in legal terms, held harmless – from “surprise billing.” That’s the easy part, as it seems everyone agrees, even the providers who have been surprising consumers with these bills.

Even in this area, any statute will need precision. First, a clear and thorough definition of a “surprise bill” is needed. Connecticut and New York have enacted laws with sound definitions to ensure that a bill is truly a surprise, with the insured not knowingly electing to obtain the billed services from an out-of-network provider. Copies of those laws are attached (in NY, it is on p. 175).

Second, the statute should clearly state the insured's obligation for any cost sharing in the policy. That means not just expressly including copayments, coinsurance and deductibles specified in the policy. It also means the provider and insured cannot have any side agreement to waive or modify those cost sharing obligations.

2. A fair and workable system for paying for these services

This is the harder part – determining how and how much to pay for these services, and making sure any system is clear, consistent and capable of enforcement and monitoring of both insurers and providers. And this has to be done without creating a costly new layer of bureaucracy, both within government and within insurers and providers, and without undermining the development of networks.

The best solution will be to have more providers in networks and therefore fewer surprise bills, as that will obviate the need for a government-controlled billing dispute resolution process. That is the best way to judge any legislation: Does it serve not only to resolve instances of surprise bills, but to reduce them and to encourage those services are performed by network providers?

That's a formidable challenge. The Insurance Department has limited, if any, history and expertise in determining the proper payment for medical services, or in establishing and operating an arbitration system for this; and its jurisdiction is over insurers, not providers. Further, the Commonwealth has limited experience in operating a multi-agency regulatory system to ensure equal enforcement over insurers and providers on billing matters.

Compounding this, we're not sure how many balance billing disputes there might be: Nobody seems to have a sense of how big this problem is in Pennsylvania, and nobody seems to have studied whether it is growing, whether it is regional, whether it is more prominent for some insurance policies than others, and why these providers aren't joining networks in the first place. It is hard to develop a solution without a sense of the scope of the problem being solved.

As a result, we have no idea what the cost of setting up and operating an arbitration system might be – for the Insurance Department and for those using the system. The same holds true for projecting the cost of each arbitration, as well as the prelude of insurer/provider negotiations before arbitration is invoked.

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The number of disputes may go up or down depending on the initial costs and results of any arbitration, which could also make network development harder and could inflate health insurance costs.

To that end, we recommend an alternative to an arbitration system (we also have recommendations for streamlining the draft's arbitration system, which will be covered below:

- **We recommend any legislation provide that insurers pay, and providers accept, network rates for these surprise bills, with insurers obligated to pay providers directly.**

This was done in Connecticut (it also allows the provider and insurer to agree to a higher rate if they want, but doesn't require or regulate that discussion). Closer to home, this matches Pennsylvania's Act 84 of 2015 dealing with emergency services provided by out-of-network ambulances.

The default to the insurer's network rate has the virtues of simplicity, certainty and efficiency. Further, it will not undermine network development or impede prompt payment and resolution of claims, and it will not put inflationary pressure on provider reimbursement and therefore health insurance rates. And it will not mean increased costs for the Insurance Department, other regulators, providers or insurers.

The out-of-network providers currently engaged in surprise billings may object that network rates are too low (although obviously acceptable to their network colleagues). But they will get the certainty of prompt and direct payment, so they need not face the challenge of collecting from past patients. We appreciate the need to protect consumers from surprise bills – but experience shows providers also want protection from having to collect from those consumers, which makes direct payment a valuable consideration for them.

The alternative within this approach would be a fee schedule, as Pennsylvania has done for auto and workers compensation medical services, with payment at 110% and 113% of Medicare rates, respectively. Those fee schedules have been in place for several decades without any shortage of provider availability in those lines, and they merit consideration here.

3. Working within Act 68

This is as much a general concern as a drafting one: We recommend any legislation in this area be drafted as a subchapter to Pennsylvania's Act 68 of 1998, 40 P.S. Sections 991.2101 through 991.2904.

The one change, and it is significant, is in the scope of this draft as opposed to Act 68. Act 68 applies to managed care plans that use gatekeepers. We recommend that any legislation dealing with surprise billing extend to all major medical insurance policies with network components, since that is the scope of the underlying problem.

Beyond that, though, it is important to keep this draft consistent with Act 68 and its regulation of networks and its protection of consumers. This will give consistency in the many common terms, and in the mechanics of regulation. Further, experience under Act 68 may help determine the actual scope of surprise bills and how legislation may impact that number.

4. Possible inclusion of tiering

We recommend this draft not extend to services provided by a network provider in a different tier. Without knowing the facts and problems the Department is seeing, that seems a different scenario: It involves two different levels of network providers, and it seems any problems are best addressed within network contracts rather than lumping these instances into an out-of-network billing dispute resolution system.

The draft legislation

Section 102 – Definitions

Many of these definitions are different – some significantly, some slightly – from the definitions in Act 68, 40 P.S. Section 991.2101 et seq., which controls managed care networks.

We're not sure if those differences are intentional; if not, they should be avoided or at least reconciled. As noted above, that may best be done by folding this into Act 68 as a new subchapter, albeit one that applies to all major medical policies with network components. There may be other definitions in Act 68 that merit modification, too, and there may be some new terms – as with “surprise billing” – but whether this is done within or separately from Act 68, it should use the same terms and definitions or explain the distinction.

Further, a number of the definitions do not seem to be used in the key sections of the draft and should either be deleted or explained.

As to specific terms:

- [“Affiliated” is a new term for providers and services, which are both defined in Act 68 as health care providers and health care services. Is there a way to separately define “affiliated” and keep Act 68’s underlying definitions?](#) Otherwise, what differences are intended and why?

Aren't we really dealing with out-of-network providers here? What is the difference between an “affiliated provider” and an out-of-network provider”?

Also, the term “affiliated service” is not used in the key provisions of the draft, Sections 301-304. We endorse limiting this to the “ologies” listed in the definition, but they seem subsumed by the references to “hospitalist services” and “other general or specialized health care services” – what else is there? We were confused by the exclusion of referrals, which wouldn't seem to enter into this

A cleaner approach may be that of the Connecticut law's “surprise bill” definition noted above, which better defines the instances and bills subject to this legislation.

- [“Balance billing” uses terms different than in Act 68. It also differs from Act 84, the recent ambulance law which refers to “except for a copayment, coinsurance or deductible as specified in the health insurance policy.” This also adds “in-network”, which may be superfluous.](#) Further, as with “affiliated service,” this term isn't used in the key sections of the bill; in any event, the better term is surprise bills, not balance bills.

- “Carrier or health carrier” differs from Act 68’s “managed care plan.” We recommend the term “insurer” consistent with other insurance laws, and applying this to all major medical policies with network components issued by insurers.
- “Covered person” seems the same as Act 68’s “enrollee”, although worded slightly differently, and we recommend using Act 68 terms where possible.
- “Emergency service” is again somewhat different from that in Act 68.
- “Health care facility, practitioner, plan and service” definitions again have seemingly needless deviations from those in Act 68.
- “Health insurance policy” should be major medical policies with network components.
- “In-network provider” can be shortened to “network provider”. We question whether it should include “affiliated providers,” since those seem to be non-network providers performing services in network facilities and sending surprise bills – if they were part of the insurer’s network, they wouldn’t be billing enrollees beyond any cost-sharing obligations.
- “Provider network” also differs somewhat from the same term in Act 68; again, it doesn’t seem integral to or used in the key provisions of the draft.
- “Out-of-network provider” seems longer than needed – what does the second sentence add?
- “Patient” seems reasonable but the limit to being treated in Pennsylvania may create problems (as with telemedicine or if a Pennsylvania resident insured gets treatment at a network facility in another state). In any event, the term doesn’t seem integral to or used in the key provisions of the draft.

- “Practice group” doesn’t seem integral to or used in the key provisions of the draft.
- “Provider” and “health care provider” need to be cleaned up and reconciled with Act 68. As the term comes up in the draft, things get confusing: Throughout the key provisions, the draft refers to a “provider” but generally in the context of an out-of-network provider only.
- “Service area” is defined with a slight difference from Act 68 and needs to be reconciled.
- “Testing facility” is a new term already covered in Act 68’s definition of “health care provider.”

Chapter 3 – Balance billing and payment

Section 301 – Applicability

We recommend this apply, as in the Connecticut and New York laws, to all “surprise bills” that arise under major medical policies with network components.

We also recommend limiting this to what we described as the “ologies” set forth in the definition of “affiliated service” – radiology, pathology, anesthesiology and neonatology, as well as, perhaps, cardiology and baby delivery services. We don’t believe this needs to extend to services such as chiropractic care, physical therapy or primary care. That’s not where the problems of surprise bills are occurring, so extending this to those fields risks creating more problems than it solves.

Finally, we recommend this apply to all emergency services not otherwise covered under Act 84 of 2015 (ambulance services). As noted above, we recommend a solution consistent with Act 84 – direct payment to the provider at the network rate – so this would bring all emergency services under a consistent standard. That standard was sought by the ambulance community, reflecting the value of direct reimbursement to out-of-network providers.

Section 302 – Hold harmless

This could be written with greater clarity and brevity by adopting the approach in Act 84 and Connecticut law:

- With respect to a surprise bill, an insurer shall reimburse an out-of-network provider at the same rate it has established for a network provider, and the out-of-network provider may not bill the enrollee directly or indirectly or otherwise attempt to collect from the enrollee for the service provided, except for a billing to recover a copayment, coinsurance or deductible as specified in the health insurance policy. The reimbursement by the insurer shall be paid directly to the out-of-network provider.

This would cover subsection (b) and possible overpayment by an enrollee, as well as subsection (c) and collections and subsection (d) and deemed assignment of benefits.

We also recommend language expressly prohibiting an out-of-network provider from waiving any cost-sharing provisions, either here or in Section 303.

Subsection (a): We don't think the out-of-network provider needs a copy of the insurer's Explanation of Benefits. This should be limited to setting forth the cost-sharing amounts the enrollee would owe had the service been provided by a network provider.

Section 303 – Direct dispute resolution

We are concerned that this establishes a needlessly complicated, cumbersome and slow billing system and protocol for surprise bills – and all before any billing dispute even goes to arbitration.

Subsections (a) – (c): We're not sure how the provider's "written affirmation" can be handled under most insurers' electronic claims and billing systems. We're also not sure how subsection (c) meshes with the direct resolution options in subsections (d) and (e): What is the purpose of that direct resolution process if the out-of-network provider and insurer can negotiate a settlement regardless?

Subsections (d) and (e) set forth the direct resolution options. We recommend the same process extend to emergency services as with surprise bills. But the process in the draft seems unduly complicated:

- An out-of-network provider will always bill “an amount certain,” whether it is a statutory percentage of Medicare or some other amount; if the insurer pays it, or if the insurer offers a different amount and the out-of-network provider accepts it, the dispute is resolved.
- The draft arguably reads that an insurer must offer to pay either the amount requested by the out-of-network provider or the “median amount” the insurer would pay a network provider. That opens needless ambiguities – is the median amount statewide, etc.? This isn’t a term we’ve heard in other laws, and it isn’t defined in the draft.

It would be clearer to offer what the insurer would pay if the out-of-network provider were a network provider, or to offer what the insurer believes to be a fair and reasonable amount.

- The timing here could take months – the shortest timeframe the draft allots is 60 days, and that may not be realistic for the back-and-forth this establishes. And that is before either side can invoke the arbitration process, which will take considerable time itself. Either side should be able to invoke the arbitration system at any time.

Billing systems are heavily automated, which saves consumers money and providers time. This process doesn’t seem compatible with that. If the Insurance Department and the General Assembly elect to adopt this type of dispute resolution process – as opposed to the more succinct process in Act 84 and Connecticut law – everyone should at least be prepared for delayed payments and systems problems. Every step should be taken to reduce that, especially if it interferes with an enrollee’s ongoing care.

Section 304 – Arbitrated dispute resolution

The appeal of binding arbitration in dealing with surprise bills is closure of the billing dispute, and to that extent, we support the concept – although for reasons

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outlined below and elsewhere, we believe the approach in Act 84 and Connecticut (apply the network rate) is more consistent, efficient and balanced.

If there is to be an arbitration system, it needs to provide not just closure to individual billing disputes, but efficiency in resolving those disputes and some degree of consistency, as well as disclosure on how much this costs. We are concerned that the arbitration system proposed in this draft falls short of that.

This draft has the Insurance Department establishing the arbitration process and selecting and assigning the arbitrators, but under standards that are solely in the Department's discretion. We're not sure what entities the Department envisions will qualify as "Resolution Organizations," or what standards these organizations must meet: How will the Department ensure that each Resolution Organization is qualified to evaluate all the items listed in subsections (b)(5) or (9)?

Do these types of organizations exist today, in Pennsylvania or elsewhere, and with what record of service? How many such organizations does the Department envision needing? How will the Department monitor these organizations, and will it be able to promote consistency among them? The system benefits nobody if it is random, with decisions depending more on which organization is assigned than on the underlying facts.

Further, how will the Department determine proper costs of these organizations? Is there to be a fixed cost, or will it vary depending on the amounts being reviewed? And who should pay? The draft leaves this within the discretion of each selected and assigned organization. We recommend the losing party pay (assuming the Department elects a system where the organization chooses from the amounts submitted as opposed to fashioning its own amount).

This area is far removed from the Department's expertise: Setting the value of specific claims, whether directly or through supervision of a third party, isn't part of insurance regulation; it doesn't go to coverage disputes, but to the fair value of particular medical services.

That goes to the virtue of Act 84 and the Connecticut approach. It also goes to simplifying this section, if the Insurance Department is committed to an arbitration system, by taking an approach consistent with Section 7(G) of the NAIC model: While that section is written for mediation rather than pure arbitration, it requires

that insurers and providers submit to a process that complies with arbitration standards of entities like the American Arbitration Association.

The Department should also consider a requisite that, if it intends to have an arbitration system controlled by Resolution Organizations it selects, assigns and supervises, it first promulgate regulations.

Subsection (b) – The arbitration processes: We recommend the draft's first option for any arbitration system, where the Resolution Organization picks between the two amounts of the two parties, as opposed to fashioning a third amount on its own. That will help promote consistency and efficiency in the arbitration system, and will encourage both sides to be reasonable in the amounts they seek.

The criteria for consideration also merit further discussion and refinement. For instance, why is the insurer's network rate not listed?

Timing is also a concern. This subsection envisions taking 30 days from when arbitration is first requested – but roughly 20 of those days cover the parties learning of the assignment and submitting information to the Resolution Organization. We're not sure that allows sufficient time for full consideration of whatever information has been submitted.

Subsection (c) – Settlement during arbitration: This is allowed, with the cost of arbitration split evenly. As noted above, should the dispute be resolved by the Resolution Organization, we recommend a "loser pays" standard. The Department should also provide for how much these organizations can charge, possibly with a cap on any amounts.

Subsection (d) – Resolution Organizations records: We appreciate the information sought here, but it highlights the cost and complexity of the system the Department is proposing. In any event, it should provide some guidance as to what records will be made public and what will be confidential, especially in tabulating the results for any particular provider or insurer.

This goes to a concern noted at the outset: The Department's draft proposes an intricate system it will run, but without knowing how many disputes the system will handle, the range of those disputes, or the availability and cost of the entities handling arbitration. All that needs to be considered before moving forward. It also argues in favor of the approach in Act 84 of 2015 and in Connecticut's law. While these are new laws with little track record, the Department should at least reach out to counterparts in Connecticut to examine the considerations that state made.

Section 501 – Communications to consumers

Subsection (b) – Provider communications: We're wary of the effectiveness of signs at a doctor's office, especially if these aren't services a patient necessarily knows about until "on the table." We recommend the more thorough communications in the New York law running from p. 168, line 29 n through p. 170, line 14 (Section 24 of that law).

This seems the only section that refers to "patients." It would make more sense to simply refer to enrollees/Covered Persons as in other sections.

Subsection (c) – Insurer communications: This should be redrafted consistent with Section 2136 of Act 68's provisions on "information to enrollees," recognizing that this applies to more than the managed care plans covered under Act 68.

Section 502 – Records

This could be a lot of records. As noted earlier with respect to Resolution Organization records, there should at least be confidentiality protections, as these go to payment levels as well as patient records.

Section 503 – Enforcement

Subsection (a) – General rule: This highlights the inequity in this draft, albeit not one intended by the Insurance Department. The Department only has power over insurers, not providers, so the penalties here and in subsection (c) only apply to insurers. Those penalties are significant, including revocation of an insurer's license and coming in addition to those in the Unfair Insurance Practices Act.

The Department, however, has no jurisdiction over providers, so it presumably is limited to referring violations by providers to the Health or State Department, as appropriate, under subsection (a)(5). We're not sure what level of oversight the Health Department has, but the comparison of penalties between insurers and providers is stark: Under subsection (d), providers have to repay with interest and get a public reprimand, while insurers face possible revocation of license and massive fines.

Both providers and insurers should be subject to equally stringent penalties. This might not be as big a problem if this bill were more self-executing – another reason the approach in Act 64 and Connecticut law makes sense.

Section 506 – Regulations

We recommend this draft take effect only upon promulgation of regulations, as with the selection of Resolution Organizations their standards. In contrast, the approach in Act 84 and the Connecticut law would be capable of prompt implementation.

Section 507 – Effective date

Depending on which of the alternatives the Department and General Assembly elect, the effective date for this will take considerably longer than 120 days – especially with setting up the draft's proposed arbitration system.

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Thank you for the opportunity to comment on this. We recognize this is a draft, and we look forward to working with all stakeholders, the Insurance Department and the General Assembly in arriving at legislation that addresses the problem of surprise bills.

Sincerely,

Samuel R. Marshall