



Balance Billing Legislation – Proposed DRAFT 01-19-16

AN ACT providing for the protection of consumers against balance billing for emergency services or for other services when services are sought in-network.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Chapter 1. Preliminary Provisions.

Section 101. Short Title.

This act shall be known and may be cited as the “Balance Billing Protection Act.”

Section 102. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

“Affiliated Provider.” A Health Care Provider that provides an Affiliated Service.

“Affiliated Service.” A Health Care Service provided in conjunction with a Health Care Service for which a Covered Person presents to a Health Care Facility, Health Care Practitioner, or Testing Facility, including radiology, pathology, anesthesiology, neonatology, hospitalist services, diagnostic interpretation and other general or specialized Health Care Services. The term does not include a referral to another Health Care Practitioner.

“Balance Billing.” Charging a Covered Person, who is insured through a Health Care Plan that uses a Provider Network, to recover from the Covered Person the balance of an Out-of-Network Health Care Provider's fee for a Health Care Service received by the Covered Person from the Health Care Provider that is not fully reimbursed, exclusive of In-Network Cost-Sharing, by the Covered Person's Health Care Plan.

“Carrier” or “Health Carrier.” An entity licensed by the Department to issue any health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health

care coverage by a Health Care Facility or Licensed Health Care Provider that is offered or governed under any of the following:

- (1) The act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921, including section 630 and Article XIV hereof.
- (2) The act of December 29, 1972 (P.L. 1701, No. 364), known as the Health Maintenance Organization Act.
- (3) 40 Pa. C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

“Commissioner.” The Pennsylvania Insurance Commissioner.

“Cost-Sharing.” A copayment, coinsurance, or deductible, or any other form of financial obligation of the Covered Person other than premium or share of premium, or any combination of any of these financial obligations.

“Covered Person.” A person on whose behalf a Health Carrier is obligated to pay health care expense benefits or provide Health Care Services under a Health Care Plan. The term includes a policyholder, certificate holder, subscriber, dependent or other individual who is eligible to receive Health Care Services through a Health Care Plan.

“Department.” The Pennsylvania Insurance Department.

“Emergency Service.” Any Health Care Service provided to a Covered Person after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in detrimental consequences to the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or her unborn child. Emergency Service includes “emergency medical services” as that term is defined in the act of August 18, 2009 (P.L. 308, No. 37), known as the Emergency Medical Services System Act. Emergency Service also includes any Health Care Service that a Health Care Provider determines is necessary to evaluate and, if necessary, stabilize the condition of the Covered Person such that the Covered Person may be transported without suffering detrimental consequences or aggravating the Covered Person's condition.

“Facility.” A Health Care Facility or a Testing Facility.

“Facility-Based Practitioner.” Either of the following:

(1) A Health Care Practitioner to whom a Health Care Facility has granted clinical privileges and who provides Health Care Services to patients of that Facility under those clinical privileges.

(2) A Health Care Practitioner who provides Health Care Services to patients in, or in conjunction with, services provided to that patient in a Health Care Facility.

“Health Care Facility.” A facility providing a health service, including: a general, special, psychiatric, or rehabilitation hospital; an ambulatory surgical facility; a cancer treatment center; a birth center; an inpatient, outpatient or residential drug and alcohol treatment facility; a laboratory, diagnostic, or other outpatient medical service facility; a physician office or clinic.

“Health Care Practitioner.” An individual who is authorized to practice some component of the healing arts by a license, permit, certificate or registration issued by a Commonwealth licensing agency or board. The term includes a health service doctor as that term is defined in the act of November 15, 1972 (P.L. 1063, No. 271) (relating to professional health services plan corporations), and an individual accredited or certified to provide behavioral health services. The term includes a Practice Group.

“Health Care Plan.” A package of coverage benefits with a particular cost-sharing structure, Provider Network, and Service Area that is purchased through a Health Insurance Policy.

“Health Care Service.” Any covered treatment, admission, procedure, medical supplies and equipment or other services, including an Affiliated Service or a behavioral health service, prescribed or otherwise provided or proposed to be provided by a Health Care Provider to a Covered Person under a Health Care Plan. The term includes an Emergency Service.

“Health Care Provider” or “Provider.” A Health Care Practitioner or Health Care Facility.

“Health Insurance Policy.” A health, sickness or accident policy or subscriber contract or certificate issued by a Carrier that provides medical or health care coverage by a Health Care Facility or licensed Health Care Provider. The term shall not include any of the following:

- (1) An accident only policy.
- (2) A credit only policy.
- (3) A long-term care or disability income policy.
- (4) A specified disease policy.
- (5) A Medicare supplement policy.

- (6) A TRICARE policy, including a Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policy.
- (7) A fixed indemnity policy.
- (8) A dental only policy.
- (9) A vision only policy.
- (10) A workers' compensation policy.
- (11) An automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).
- (12) Any other similar policies providing for limited benefits.

“Hospital.” The term has the same meaning as in the act of August 18, 2009 (P.L. 308, No. 37), known as the Emergency Medical Services System Act.”

“In-Network Provider.” A Provider having a contract with a Carrier to provide Health Care Services to a Covered Person under a Health Care Plan. The term includes a Facility-Based Practitioner and an Affiliated Provider.

“Medicare.” The federal Medicare program established pursuant to Pub. L. 89-97 (42 U.S.C. §1395 et seq.).

“Network” or “Provider Network.” The Health Care Providers designated by a Carrier to provide Health Care Services to Covered Persons in a Health Care Plan.

“Out-of-Network Provider.” A Provider not having a contract with a Carrier to provide Health Care Services to a Covered Person under the Covered Person’s Health Care Plan. The term includes a Facility-Based Practitioner and an Affiliated Provider.

“Patient.” A person who receives a Health Care Service, including an Emergency Service, in this Commonwealth.

“Practice Group.” Two or more Health Care Practitioners, legally organized in a partnership, professional corporation, limited liability company formed to render Health Care Services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity that satisfies one of the following criteria:

- (1) In which each Practitioner who is a member of the group provides substantially the full range of services that the Practitioner routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel.

(2) For which substantially all of the services of the Practitioners who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group.

(3) In which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of Practice Group under this section shall be considered a Practice Group although its shareholders, partners or owners of the Practice Group include single-Practitioner professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual Practitioners.

“Provider.” An individual, Hospital, institution, organization, or other person, whether for profit or nonprofit, whose primary purpose is to provide Health Care Services and is licensed or otherwise authorized to practice in the Commonwealth. The term includes a Facility, a Health Care Practitioner and an Affiliated Provider.

“Resolution Organization.” A qualified independent third-party claim dispute resolution entity selected by and contracted with the Department.

“Service Area.” The geographic area in which a Health Care Plan is offered.

“Testing Facility.” A Facility that performs screening, diagnostic or laboratory Health Care Services.

Chapter 3. Balance Billing and Payment.

Section 301. Applicability.

This act applies to:

- (a) An Emergency Service provided to a Covered Person.
- (b) A Service provided to a Covered Person by a Facility-Based Practitioner or Affiliated Provider, where that Facility-Based Practitioner or Affiliated Provider is not In-Network, but the Facility or Practitioner from whom the Covered Person sought the Health Care Service is In-Network.

Section 302. Hold Harmless.

(a) If a Covered Person receives a Health Care Service covered by this Act from a Facility-Based Practitioner or Affiliated Provider, the Provider may not hold the Covered Person financially responsible for any amount in excess of any Cost-Sharing amounts that would have been imposed if such Health Care Service had been rendered by an In-Network Provider. The Provider shall request from the Carrier, and the Carrier shall provide to the Provider, a written explanation of benefits that specifies the applicable In-Network Cost-Sharing amounts owed by the Covered Person.

(b) Overpayment.

(1) If an Out-of-Network Facility-Based Practitioner or Affiliated Provider has received from the Covered Person more than the In-Network Cost-Sharing amount, the Provider shall refund to the Covered Person within 30 business days of receipt any amount paid in excess of the In-Network Cost-Sharing amount.

(2) If an Out-of-Network Facility-Based Practitioner or Affiliated Provider does not make a full refund of any amount paid in excess of the In-Network Cost-Sharing amount to the Covered Person within 30 business days of receipt, interest shall accrue at the rate of [10/15/20] percent per annum beginning with the first calendar day after the 30-business day period.

(c) Collections.

An Out-of-Network Facility-Based Practitioner or Affiliated Provider may not advance to collections any charges other than any In-Network Cost-Sharing amount that the Covered Person has failed to pay.

(d) Assignment of Benefits.

A Facility-Based Practitioner or Affiliated Provider of a Health Care Service covered by this Act, who does not hold the Covered Person financially responsible for any amount in excess of any Cost-Sharing amounts that would have been imposed if such Health Care Service had been rendered by an In-Network Provider, is deemed to have received an assignment of benefits from the Covered Person, and any reimbursement paid by the Carrier shall be paid directly to the Out-of-Network Provider.

Section 303. Direct Dispute Resolution.

(a) A bill to a Health Carrier by an Out-of-Network Facility-Based Practitioner or Affiliated Provider seeking reimbursement for a Health Care Service covered to this Act shall be accompanied by a written affirmation by the Provider that it has not attempted and will not attempt to collect any payment from the Covered Person other than any In-Network Cost-Sharing amount for the Health Care Service provided.

(b) Unless a bill from an Out-of-Network Provider for a Health Care Service covered by this Act satisfies the requirements of subparagraph (i), it will not trigger the prompt payment requirements under section 2166 of the act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921.

(c) Nothing in this section shall prevent a Carrier and a Facility-Based Practitioner or Affiliated Provider from mutually agreeing to a payment amount for a Health Care Service covered by this Act outside of the mechanism set forth in this section.

[Option 1: Different processes for Emergency and Non-Emergency Services]

(d) Payment for an Emergency Service.

If an Emergency Service is rendered to a Covered Person by an Out-of-Network Provider, the Provider may bill the Health Carrier for, and the Health Carrier shall pay to the Provider

[Option 1a] the lesser of:

- (1) The Provider's charges.
- (2) XXX% of the amount Medicare would reimburse for such Service.

[Option 1b] the greater of:

- (1) The median amount the Covered Person's Health Care Plan would pay for such Service if rendered by an In-Network Provider.
- (2) XXX% of the amount Medicare would reimburse for such Service.

[Option 1c - detailed version of 1b] the greater of:

- (1) The amount negotiated with In-Network Providers in the Service Area for the Emergency Service furnished, excluding any In-Network Cost-Sharing amount. If there is more than one amount negotiated with In-Network Providers in the Service Area for the Emergency Service, the amount shall be the median of these amounts, excluding any In-Network Cost-Sharing amount. In determining the median, the amount negotiated with

each In-Network Provider shall be treated as a separate amount (even if the same amount is paid to more than one Provider).

(2) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.) for the Emergency Service, excluding any In-Network Cost-Sharing amount.

A payment made by the Health Carrier to a Provider of an Emergency Service as specified in this section, in addition to the applicable In-Network Cost-Sharing amount owed by the Covered Person, shall constitute payment in full for the Emergency Service rendered.

(e) Health Care Service Other Than Emergency Service. If a Health Care Service covered by this Act, other than an Emergency Service, is rendered to a Covered Person by an Out-of-Network Facility-Based Practitioner or Affiliated Provider, when the Provider submits the bill:

(1) The Provider may bill an amount certain or may indicate a willingness to accept payment at a rate of XXX% of Medicare if offered.

(2) If the Provider indicates a willingness to accept XXX% of Medicare, the Carrier may offer to pay that amount and the Provider shall accept that amount as full compensation for the Health Care Service provided.

(3) If the Provider bills an amount certain, the Carrier may pay that amount or may counter with an offer to pay the median amount the Covered Person's Health Care Plan would pay for such Health Care Service if rendered by an In-Network Provider.

(4) If the Carrier offers to pay the median amount described in clause (iii), the Provider may accept that amount as full compensation for the Health Care Service provided.

(5) If the Carrier and Provider reach agreement as to the amount to be paid, a payment of that amount by the Carrier to the Provider as specified in this paragraph, in addition to the applicable In-Network Cost-Sharing amount owed by the Covered Person, shall constitute payment in full for the Health Care Service rendered.

(6) If the Provider and Carrier do not reach agreement on a payment amount, either through the negotiation process outlined in this subsection or otherwise, within [60/90/120] calendar days after the Carrier receives the bill for the Health Care Service, the party that last rejected an offer shall submit the dispute for formal dispute resolution pursuant to section 305.

[Option 2: Same process for Emergency and Non-Emergency Services]

(d) Payment for Health Care Service.

If a Health Care Service covered by this Act, including an Emergency Service, is rendered to a Covered Person by an Out-of-Network Facility-Based Practitioner or Affiliated Provider, when the Provider submits the bill:

- (1) The Provider may bill an amount certain or may indicate a willingness to accept payment at a rate of XXX% of Medicare if offered.
- (2) If the Provider indicates a willingness to accept XXX% of Medicare, the Carrier may offer to pay that amount and the Provider shall accept that amount as full compensation for the Health Care Service provided.
- (3) If the Provider bills an amount certain, the Carrier may pay that amount or may counter with an offer to pay the median amount the Covered Person's Health Care Plan would pay for such Health Care Service if rendered by an In-Network Provider.
- (4) If the Carrier offers to pay the median amount described in clause (iii), the Provider may accept that amount as full compensation for the Health Care Service provided.
- (5) If the Carrier and Provider reach agreement as to the amount to be paid, a payment of that amount by the Carrier to the Provider as specified in this paragraph, in addition to the applicable In-Network Cost-Sharing amount owed by the Covered Person, shall constitute payment in full for the Health Care Service rendered.
- (6) If the Provider and Carrier do not reach agreement on a payment amount, either through the negotiation process outlined in this subsection or otherwise, within [60/90/120] calendar days after the Carrier receives the bill for the Health Care Service, the party that last rejected an offer shall submit the dispute for formal dispute resolution pursuant to section 305.

Section 304. Arbitrated Dispute Resolution.

- (a) Arbitrated dispute resolution process established.
- (1) The Department shall establish an independent dispute resolution process for the purpose of arbitrating disputes between Carriers and Providers for payment for an Out-of-Network Service covered by this Act.
 - (2) The Department may establish written procedures for the submission, receipt, processing, and resolution of payment disputes pursuant to this section.
 - (3) The Department may contract with one or more Resolution Organizations to conduct dispute resolution proceedings. The Department shall maintain and periodically update a list of approved Resolution Organizations.
 - (4) A Resolution Organization arbitrating a dispute shall be independent of either party to the dispute. The Department may establish conflict-of-interest standards, consistent with the purposes of this section, which a Resolution Organization shall meet in order to arbitrate disputes under this section.
 - (5) If either a Carrier or a Facility-Based Practitioner or Affiliated Provider submits the dispute for resolution, the other party shall also participate in the process as described in this section.
 - (6) The determination obtained through the resolution process shall be binding on both parties and not appealable.
 - (7) A payment made by a Health Carrier to a Provider pursuant to a determination obtained through the resolution process set forth in this section, in addition to the applicable Cost-Sharing owed by the Covered Person who received the Health Care Service that is the subject of the resolution process, shall constitute payment in full for the Health Care Service rendered.
- (b) Binding Resolution Process. *[Option 1]*
- (1) The party initiating the process shall notify the Department so that the dispute may be assigned. The initiating party shall provide to the Department complete contact information for all parties.
 - (2) The Department shall assign the dispute to a Resolution Organization within two business days of receiving the notice and shall notify the parties of the assignment.

(3) The initiating party, within two business days of assignment, shall submit to the arbitrator assigned by Resolution Organization and the responding party its final offer for resolution. Within two business days of receiving the initiating party's final offer, the responding party shall submit to the arbitrator and the initiating party its final offer for resolution.

(4) The two parties shall make simultaneous written submissions to the arbitrator and to the opposing party within fifteen days of submission of the responding party's final offer, or such other time as established by the arbitrator, in support of their final offers.

(5) In making a determination pursuant to this subsection, the arbitrator may consider:

(i) The level of training, education, and experience of the Provider.

(ii) The Provider's usual charge for comparable Health Care Services provided Out-of-Network with respect to any Health Care Plans.

(iii) The Carrier's usual payment for comparable Health Care Services provided Out-of-Network in the Service Area.

(iv) The payment for comparable Health Care Services provided in the Service Area by any recognized standard, including Medicare or a median index.

(v) The availability of the Health Care Service for the Covered Person from In-Network Providers.

(vi) The propensity of the Provider to be included in Networks.

(vii) The absence of the identification of the Provider, in the Carrier's Provider Directory for the Covered Person's Health Care Plan, on the date of service and for the 10 days prior to the date of service.

(viii) The circumstances and complexity of the particular case, including the time and place of the Health Care Service.

(6) The arbitrator's decision shall be one of the two amounts submitted by the parties as their final offers, with interest, and shall be binding on both parties. The Resolution Organization's expenses and fees shall be paid as provided in the decision. Each party shall be responsible for its own costs and fees, including legal fees if any.

(7) Any interest charges for overdue payments, calculated in accordance with section 2166 of the act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921, shall not apply during the pendency of a decision under this subsection and any interest required to be paid a Provider under section 2166 of The Insurance Company Law of 1921 shall not accrue until after 30 days following an arbitrator's decision as provided in this subsection.

(8) The final determination shall be issued in writing, shall include written findings of fact, and shall be issued within 30 days after the request is filed with the Department. Copies shall be provided to both parties and the Department by the same means, whether electronic or hard-copy.

(9) A party that fails to pay all amounts due to the other party and to the arbitrator within thirty days of receiving the final determination shall be subject to a penalty of \$XXX per day until payment is made in full.

(b) Binding Resolution Process. *[Option 2]*

(1) The party initiating the process shall notify the Department so that the dispute may be assigned. The initiating party shall provide to the Department complete contact information for all parties.

(2) The In-Network Facility or Practitioner from whom the Covered Person sought the Service shall also participate in the process.

(3) The Department shall assign the dispute to a Resolution Organization within two business days of receiving the notice and shall notify the parties of the assignment.

(4) The Resolution Organization shall contact the parties to outline procedures for the submission and arbitration of the dispute. Such procedures must include a requirement that any submission to the arbitrator assigned by the Resolution Organization also be provided simultaneously to the opposing party.

(5) If the arbitrator determines that the documentation initially provided is not sufficient, it may request additional documents from the initiating party. The initiating party shall provide any requested documents within not less than 15 days after receipt of the request from the arbitrator.

(6) The arbitrator shall require any other party in the claim dispute to submit all documentation in support of its position within not less than 15 days after receiving a request from the arbitrator for supporting documentation.

(7) The arbitrator may take a negative inference from a failure by a party to submit requested documentation within the time period specified.

(8) The arbitrator shall issue a written decision, based on findings of fact, within 60 days after all requested information is received by the arbitrator, but in any event no later than 90 days following receipt of the dispute by the Resolution Organization.

(9) In making a determination pursuant to this subsection, the arbitrator may consider:

(i) The level of training, education, and experience of the Provider.

(ii) The Provider's usual charge for comparable Health Care Services provided Out-of-Network with respect to any Health Care Plans.

(iii) The Carrier's usual payment for comparable Health Care Services provided Out-of-Network in the Service Area.

(iv) The payment for comparable Health Care Services provided in the Service Area by any recognized standard, including Medicare or a median index.

(v) The availability of the Health Care Service for the Covered Person from In-Network Providers.

(vi) The propensity of the Provider to be included in Networks.

(vii) The absence of the identification of the Provider, in the Carrier's Provider Directory for the Covered Person's Health Care Plan, on the date of service and for the 10 days prior to the date of service.

(viii) The circumstances and complexity of the particular case, including the time and place of the Health Care Service.

(10) The final determination shall include the amount(s) that the Carrier or any other party must pay the Provider, with interest if appropriate, plus an apportionment of the costs of the Resolution Organization to be borne by the parties, and shall be binding on both parties. The amount of costs owed by each party will be determined by the arbitrator based on the reasonableness of the parties' positions.

(11) Any interest charges for overdue payments, calculated in accordance with section 2166 of the act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921, shall not apply during the pendency of a decision under this subsection and any interest required to be paid a Provider under section 2166 of The Insurance Company Law of 1921 shall not accrue until after 30 days following an arbitrator's decision as provided in this subsection.

(12) The final determination shall be issued in writing, shall include written findings of fact, and shall be issued within 30 days after the request is filed with the Department. Copies shall be provided to both parties and the Department by the same means, whether electronic or hard-copy.

(13) A party that fails to pay all amounts due to the other party and to the arbitrator within thirty days of receiving the final determination shall be subject to a penalty of \$XXX per day until payment is made in full.

(c) Nothing in this section shall preclude the parties from reaching a resolution of their dispute before the arbitrator issues its decision. If such resolution is reached, both parties shall promptly provide notice to the arbitrator, and the arbitrator shall split its costs evenly between the parties. Each party shall pay the arbitrator its share of the costs within thirty days of receiving the bill, and failure to make timely payment shall subject the party to a penalty of \$XXX per day until payment is made in full.

(d) Resolution Organization Records.

Each Resolution Organization shall comply with the following:

(1) Maintain written documentation establishing the date it receives a request for dispute resolution, the time it took to receive complete materials from both parties, the determination, and the date the determination was communicated to parties, all in an easily accessible and retrievable format for the calendar year in which it received the information plus the two prior calendar years.

(2) Be able to document measures taken to appropriately safeguard the confidentiality of the records and prevent unauthorized use and disclosures under applicable Federal and State law.

(3) Report annually to the Department by June 1 in the aggregate and for each Health Carrier the following:

(i) The total number of requests received for dispute resolution.

(ii) The total number of arbitrations conducted.

- (iii) The number of arbitrations withdrawn due to settlement prior to determination.
 - (iv) For each arbitration completed:
 - (A) The identity of the Out-of-Network Facility-Based Practitioner or Affiliated Provider.
 - (B) An indication of whether the decision was in favor of the Carrier or the Out-of-Network Facility-Based Practitioner or Affiliated Provider.
 - (C) The initial arbitration amounts offered by each side and the award amount.
 - (D) The category and practice specialty of each Out-of-Network Facility-Based Practitioner or Affiliated Provider involved in an arbitration decision, as applicable.
 - (E) A description of the Health Care Service that was provided and billed for.
 - (v) Any other information the Department may require.
- (4) Protect from disclosure, including in the information provided to the Department, any information specifically identifying the Covered Person who received the Health Care Services that were the subject of an arbitration decision. Such information shall be protected and remain confidential in compliance with all applicable Federal and State laws and regulations, and shall be confidential by law and privileged, shall not be subject to the act of June 21, 1957 (P.L. 390, No. 212), referred to as the Right-to-Know Law, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action.
- (5) Report immediately to the Department a change in its status which would cause it to cease meeting a qualification required of a Resolution Organization for purposes of performing arbitrations pursuant to this act.

Chapter 5. Miscellaneous Provisions.

Section 501. Communications to Consumers.

(a) The Department will provide a notice on its website containing information for consumers relating to the protections provided by this Act and information on how consumers may report and file complaints with the Department or another appropriate regulatory agency relating to any Out-of-Network charges.

(b) Provider Communications.

(1) A sign which sets forth the following shall be posted by a Health Care Provider who provides Health Care Services to patients covered by any Health Care Plan that may not be covered at In-Network rates:

(i) The rights of Covered Persons under this Act.

(ii) The identification of the Department as the proper commonwealth agency to receive Patients' complaints relating to Balance Billing prohibited under this Act.

(iii) Contact information for the Department.

(2) The Department may by notice specify the form and content of the notice required under clause (1).

(3) Any communication detailing the cost of a Health Care Service covered by this Act must clearly state that a Covered Person will only be responsible for payment of the applicable Cost-Sharing amounts under the Covered Person's Health Care Plan.

(c) Carrier Communications.

(1) A Carrier shall provide a written notice to each Covered Person of the protections provided to Covered Persons under this Act. The notice shall include information on how a Covered Person may contact the Department or another appropriate regulatory agency to report and dispute an Out-of-Network charge. The Carrier shall:

(i) Post the notice on its website and make it available upon request within 90 days of the effective date of this Act.

(ii) Include the notice with an explanation of benefits for any claim submitted beginning not more than 90 days after the effective date of this Act.

(2) The Department may by notice specify the form and content of the notice required under clause (1).

- (3) Any communication detailing the cost of a Health Care Service covered by this Act must clearly state that a Covered Person will only be responsible for payment of the applicable Cost-Sharing amounts under the Covered Person's Health Care Plan.

Section 502. Records.

Any records required to be maintained under this act shall be maintained for not less than five (5) years, and shall be provided to the Department upon request.

Section 503. Enforcement.

(a) General rule. – Upon satisfactory evidence of a violation of this act by any Carrier or other person, the Commissioner may, in the Commissioner's discretion, pursue any one of the following courses of action:

- (1) Suspend, revoke or refuse to renew the license of an offending insurance licensee.
- (2) Enter a cease and desist order.
- (3) Impose a civil penalty of not more than \$5,000 for each action in violation of this act.
- (4) Impose a civil penalty of not more than \$10,000 for each action in willful violation of this act.
- (5) Refer a Health Care Provider to the Department of Health or the Department of State, as may be appropriate.
- (6) Impose any other penalty or remedy deemed appropriate by the Commissioner, including restitution.

(b) Limitation. – Fines imposed against an individual Carrier, an individual Health Care Practitioner or Practice Group, or an individual Facility under this act shall not exceed \$300,000 in the aggregate during a single calendar year.

(c) The enforcement remedies imposed under this section are in addition to any other remedies or penalties that may be imposed under any other applicable statute, including the act of July 22, 1974 (P.L. 589, No. 205), known as the "Unfair Insurance Practices Act," and any other applicable statute. Violations of this act are deemed and defined to be an unfair method of

competition and an unfair or deceptive act or practice pursuant to the Unfair Insurance Practices Act.

(d) Upon referral of a Health Care Practitioner to the Department of State, the licensing board of the Bureau of Professional and Occupational Affairs under which the Health Care Practitioner is licensed may do the following:

- (1) Publicly reprimand the Health Care Practitioner.
- (2) Order the Health Care Practitioner to repay the Covered Person the amount of excess payments made and received, plus interest on that amount at the maximum legal rate from the date payment was made until the date repayment is made.
- (3) Take such other action as it may deem appropriate under its laws.

(e) Before a penalty may be imposed under this section, an order to show cause shall be filed against the Provider or Carrier and notice of and an opportunity for a hearing shall be given as provided in 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies). Either party to the administrative action may appeal to the Commonwealth Court as provided in 2 Pa.C.S. Ch. 7 Subch. A (relating to administrative law and procedure).

Section 504.

The Department, the Department of Health, and the Department of State shall ensure compliance with this act. The appropriate Department may investigate potential violations of the act based upon information received from Covered Persons, Health Carriers, Health Care Providers and other sources in order to ensure compliance with this act.

Section 505. Private Cause of Action.

Nothing in this article shall be construed to create or imply a private cause of action for a violation of this article.

Section 506. Regulations.

The Department, the Department of Health, and the Department of State may promulgate regulations as may be necessary or appropriate to implement this Act.

Section 507. Effective Date.

This act shall take effect [60/90/120] days after enactment.