



February 29, 2016

Commissioner Teresa D. Miller
Pennsylvania Department of Insurance
1209 Strawberry Square
Harrisburg, PA 17120

Dear Commissioner Miller,

Consumers Union, the policy and advocacy division of Consumer Reports, is pleased to submit comments on the Department of Insurance's proposed solution to protect consumers from surprise balance billing. We commend the Department of Insurance for your strong interest and attention to surprise medical bills, which can be a very significant and onerous problem for consumers.

As you note in the request for comments, "...these unexpected and significant bills are troubling and can be unaffordable for consumers, who have done everything right when choosing to receive care in-network." Further, as we found in our national survey, consumers often do not know who to turn to when they receive a surprise medical bill. Nearly three-quarters of survey respondents were unsure if they had the right in their state to appeal to the state or an independent medical expert if their health plan refused coverage for medical services they think they need. Most consumers (87 percent) did not know which agency or department in their state government is tasked with handling complaints about health insurance.

We therefore think the role that Insurance Departments can play on this issue is very significant. Your department's leadership can help forge effective policy solutions that prevent and reduce the incidence and severity of surprise bills. In addition, your work to help consumers get assistance and resolve their medical billing problems and complaints is incredibly important. Maintaining a strong information and complaint-handling capacity is critical for understanding the problems that patients have, and identifying levers and opportunities for action to make the health care system work better for everyone.

As you know, surprise medical bills can happen to literally anyone, including providers, insurance executives and legislators. This is an issue that affects people from all walks of life, but it is especially worrying when it affects working people and people on fixed incomes, who have limited resources to handle additional, unexpected medical expenses. Your efforts to address the surprise medical bill problem therefore send an important and inspiring message that all patients, from all walks of life, are important in the Commonwealth of Pennsylvania.

[continued]

As discussed by the New York Department of Financial Services in its report “An Unwelcome Surprise,”¹ **consumers receive surprise bills for many different reasons:**

1. Comparison shopping for insurance policies is difficult
2. Lack of disclosure of provider status for non-emergency care
3. Excessive bills for emergency room care
4. Missing protections for inadequate networks
5. Reduced insurance coverage
6. Difficulties in submitting claims

Your attention to the sources of surprise medical bill complaints in Pennsylvania is therefore very important to determining the policy changes to adopt. We urge you to study the complaints and consumer concerns you receive carefully, to make sure the proposed solution addresses the problem comprehensively, and can result in a sustainable and continued reduction of surprise out-of-network charges over time. Further, we hope you will share the complaints and concerns you receive with providers, insurers, the public and the media, so we all might better understand how current problems are fueling a public movement for investigation and reform.

Along with other consumer and patient groups that are commenting on the proposed solution, Consumers Union strongly agrees with and supports the principles developed by the Pennsylvania Health Action Network (PHAN), which state in summary that:

- 1) **Balance Billing Should Be Banned in All Emergency Situations**
- 2) **Pennsylvanians Should Be Guaranteed Access To Clear, Current And Consumer-Friendly Information**
- 3) **Pennsylvanians Covered in All Private Health Insurance Plans Should Be Protected From Balance Billing in Non-Emergency Situations**
- 4) **Pennsylvanians Should Be Taken Out Of The Middle Of Any Dispute Between A Provider And An Insurer Over Balance Billing Charges.**
- 5) **Pennsylvanians Should Receive Clear, Actionable Information On Their Rights And Protections Against “Surprise” Medical Bills. This Includes Where To Report Complaints And Understand The Next Steps If They Do Receive A Balance Bill ²**

While the devil is definitely in the details for a durable solution to this problem, as you state in the request for comment, the principles and spirit in which you craft the solution have to consider the experiences of patients who make a good faith effort to stay in-network, who should be protected against surprise medical bills. **Disclosures and consumer information should not just meet some technical or pro forma standard.** Instead, information for patients **has to actually prevent and reduce the problem**, so that it becomes very hard to impossible for people to make the wrong decision that results in an additional \$500, \$1,000, \$5,000 or \$25,000 bill.

Consumers Union believes **we should have a health care system where it is very hard for patients to fall through the cracks.** Disclosure is often a weak and ineffective remedy for poorly organized networks and delivery systems. To be meaningful, disclosure has to be given clearly and effectively within meaningful time frames, so patients can make other arrangements for care where indicated. Getting a signature for permission to see an out-of-network provider on a clipboard immediately prior to surgery is **not** a meaningful disclosure.

¹ New York Department of Financial Services. “An Unwelcome Surprise: How New Yorkers Are Getting Stuck with Unexpected Medical Bills From Out-of-Network Providers,” 2012. Available at: <http://www.governor.ny.gov/sites/governor.ny.gov/files/archive/assets/documents/DFS%20Report.pdf>

² “Protecting Pennsylvanians from “Surprise” Medical Bills, Pennsylvania Health Access Network, Policy Brief, Nov. 2015, accessed at: <https://pahealthaccess.org/sites/pahealthaccess.org/files/Protecting%20Pennsylvanians%20from%20Surprise%20Medical%20Bills.pdf> Please refer to full document for critically important details.

In our view, it is far better to create solutions that **ELIMINATE** the balance billing problem altogether, so that consumers who are seeking treatment in in-network facilities can routinely receive in-network services with no unpleasant financial surprises. If no suitable in-network provider is available, consumers should be protected against out-of-network charges. If we do not understand this core principle, we will continue to fail patients, and the surprise medical bill complaints will keep piling up. Conversely, if Pennsylvania solves this issue, you will be a national model, and other policymakers and stakeholders will look to your model to study and emulate.

Patients are generally willing to do their homework and follow the rules of their health plan network, especially if staying within network can help keep care affordable. But most consumers are not experts in health care delivery or medical billing, and they have little concept of the surprisingly convoluted and confusing rules that often leave them owing large piles of money, based on arcane rules or interpretations that seem to make sense only to providers or insurance companies.

There is also little in regular life (unless perhaps you are a nurse, a doctor or medical billing specialist) that prepares you for some of the rough edges and confusing aspects of the current health care delivery system. As patients -- who are often seriously injured, sick or gravely ill -- we should not have to be insurance specialists, billing experts or health care lawyers to navigate confusing instructions, incomplete information systems, inaccurate provider directories, and medical billing codes to navigate the medical system and avoid expensive medical "gotchas."

We strongly support the proposed solution's efforts to create strong rules of the road for payment procedures for emergency and non-emergency care, so that bills for emergency and non-emergency care can be routinely processed and paid efficiently without putting the patient in the middle of the process. While we appreciate the details of these rules may cause concerns among insurers and providers, there is much to be gained from creating a predictable, rules-based framework for health care payments in surprise bill situations, so that such disputes can be efficiently and cleanly resolved. Further, payment disputes may result in protracted delays in payments to providers and hospitals, litigation, and wrenching billing disputes causing terrible stress for patients, who are often in the midst of recovering from illness, surgery or other treatment.

As Insurance Commissioner, we urge you to uphold the public interest in an efficient, smoothly functioning payment process for providers, insurers and patients. We do understand that you do have to carefully consider the concerns of individual stakeholders. At the same time, there is an overriding public interest in being able to seek and accept emergency and non-emergency treatment from the health care system, with a minimum of billing hassles, financial arguments and delays in payment. Because we are all current and prospective patients, we have to protect the health care system for the use value of its ultimate beneficiaries, to make sure that providers and caregivers can help their patients get well, and that insurance will pay the bills it is supposed to pay.

Whatever specific processes are adopted for emergency and non-emergency care as a result of your discussions and negotiations, we also urge you to protect the consumer and public interest against price-gouging and excessive charges for surprise bills and unanticipated out-of-network care, to ensure that insurance premiums are affordable to maximum possible extent. If excessive charges are permitted, at the margin, middle-class and working families will be priced out of basic coverage, or will be compelled to accept health plans with very high cost sharing, that are inadequate, impractical and counterproductive to our broader goals of promoting good health care for all. We understand that negotiating the details of payment issues can be a difficult and thorny issue in your discussions with providers and insurers. But we urge you to appeal to their higher values for a fair, inclusive health care system, that allows people to get care with dignity and respect, that meets the standard of quality care at reasonable cost, that they would wish for a loved one, a friend or co-worker.

We also strongly support the proposal's provisions to create an independent dispute resolution process, for those bills that may involve special circumstances, and cannot be resolved through the routine payment procedures. In our experience, this type of dispute between providers and insurers has been among the harshest, most unreasonable and most unfair for consumers, precisely because it cannot be easily resolved, it often results in charges being referred to collection and credit reporting agencies, and it drags on for months and even years.

As you know, consumers have no magic wand to resolve such disputes, although it appears sometimes that one side or the other may want to use patients as leverage in the argument. (THEY won't pay the right amount, or THEY are charging an excessive fee. WE, the patients, have no way of knowing. And hence, we keep phoning and calling the insurance company, the doctor and the hospital, to try to sort it out.)

As consumers, we have no supernatural power to solve these intractable billing disputes, where insurers and providers may be miles apart on the amount to be paid. We, the patients, overwhelmingly want the Insurance Department or the independent dispute resolver to handle it!! All our votes are for taking us completely out of the dispute.

On the positive side, we are very confident that the number of such billing disputes will be relatively minimal, and that the proposed process would provide better results for almost all parties than the current non-process. In New York, the number of eligible requests for Independent Dispute Resolution for the first six months our law from April 1 to December 1 was 186. So far, according to our Department of Financial Services:

- 29 were resolved through settlement (28 Emergency & 1 Surprise)
- 35 were resolved in favor of the health plan (35 Emergency)
- 25 were resolved in favor of the provider (24 Emergency & 1 Surprise)
- 13 were a split decision (12 Emergency & 1 Surprise)³

Other requests remain pending. But what is evident from these numbers is that in a state of nearly 20 million people, the number of intractable, provider-insurer disputes is relatively small, and that when it happens, it is often not a slam dunk for either side. **Dispute resolution is a big step forward from not having it.** Do stakeholders really want to stand in the way of something that would be a practical solution for patients? Rules-based dispute resolution gives each side an incentive to be reasonable, and not swing for the fences. Also, the positive result will be that if medical billing disputes over surprise out-of-network charges can be resolved more quickly and efficiently, providers will get payment more quickly, and health plans will be able to move on. Everyone will save on legal fees, bad PR and emotional and regulatory stress.

As we stated in our previous testimony, if all parties to this debate are reasonable and fair-minded, the surprise medical bill issue can be solved, and consumers will have better financial security and peace of mind. As you proposed, we need a *solution*, not a protracted fight or argument. With these new stronger protections in place in Pennsylvania, the incidence of surprise medical bills can be greatly reduced, relieving consumers and their families of unwanted administrative and financial hassles, while freeing up health system resources to improve quality of care and medical outcomes. This issue offers a great opportunity to help improve the patient experience of health care, on a hot-button issue that really matters to the people that you serve.

Thank you so much for the opportunity to comment about this critically important consumer protection issue. We deeply appreciate your efforts to protect consumers against surprise out-of-network medical bills.

Sincerely,

Chuck Bell, Programs Director

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³ Email to Chuck Bell from Lisette Johnson, Bureau Chief, Health Care Bureau, New York Department of Financial Services, 2/8/16.