PENNSYLVANIA HEALTH ACCESS NETWORK

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February 29, 2016

The Honorable Teresa D. Miller
Commissioner
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120

Dear Commissioner Miller:

Thank you for the opportunity to offer comments on the Pennsylvania Insurance Department's proposed draft legislation concerning balance billing. Consumers who confront a surprise medical bill are often confused, frustrated, and unaware of their options. This proposed legislation takes important steps to alleviating what is a growing issue of concern for us in the Commonwealth.

Our primary concern is to ensure that consumers are not caught in between providers and insurance companies in these disputes. To that end, we offer the following comments:

Section 102 – In other states that use certain definitions of "emergency services," emergency transportation is excluded from the balance billing protections applied to emergency services. We believe the emergency transportation should be specifically protected under this legislation.

We support the opportunity to address issues that arise as a result of tiered networks and therefore would propose that tiered network be added to the scope and definitions.

Section 301 – We believe that included in the applicability should be provisions for when: (1) provider directories are inaccurate; and (2) The insured person is not properly informed when his/her provider moves from a low-cost to a high-cost tier or moves out of network in the middle of the year.

Additionally, we recommend strengthening the language here to include the foreseeable scenarios under which a consumer might receive a surprise bill. This could include: (1) Unavailability of in-network providers for a covered service; (2) Unexpected utilization of out-of-network care at an in-network facility for a covered service; (3) Emergency care; (4) Unexpected utilization of out of network care as a result of inaccurate provider directories. The current language might encompass all of these scenarios, but we would suggest explicitly listing reasons why surprise bills occur (and, of course, including the caveat "including, but not limited to…").

Section 302 – We recommend adding provisions that ensure continuity of care. We recommend a provision that allows insured persons in active treatment to continue until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates in cases where their provider is terminated from the network. This is an important step to minimize disruptions in care and access to medically necessary services.

We believe that the 90-day transition period should be the minimum length of time for patients being treated for a life-threatening condition, a serious acute condition, pregnancy, or another health condition (such as severe depression or a mental health condition) that would be worsened by discontinuing care by the treating health care provider.

We recommend that patients who have been diagnosed with a terminal illness, defined as a disease or condition that cannot be cured or adequately treated and that is reasonably expected to result in the death of the patient within six months, be allowed to continue with their provider until the end-of-life, even though this may extend beyond 90 days.

In situations when providers in tiered networks are moved from a lower cost sharing tier to a higher one, instead of being terminated from the network, we believe the above recommendations should allow consumers to receive treatment at the lower cost sharing tier in the same manner specified above for the different kinds of consumers.

Section 303 & 304 - The objective of this legislation should be to keep consumer out of the dispute resolution process and the arbitrated dispute resolution process. Both of these sections involve the interests of the providers and issuers. We support whichever options emerge from provider and issuer comments as the most readily agreed upon options, understanding that the support of these two groups is critical to ensuring the consumers are not involved. No matter the process or outcome of the arbitration, consumers must not be liable for costs beyond the applicable cost sharing.

We do support the movement toward more objective measures of cost, such as the Medicare rates for the service and the amounts the carrier would pay in-network providers, rather involving rates specific providers set for out of network services.

Section 501 – We would recommend strengthening the provider communication notices by proposing that providers be required to communicate with consumers at least 72 hours in advance of procedures should consumers opt to receive out of network services for non-emergency procedures. For example, last year, New Jersey introduced a bill that requires health care facilities and providers to (1) provide written disclosure form to consumer at least 30 days prior to procedure or upon scheduling appointment; and (2) disclose they are in-network or out of network with disclosures about billing rules.
http://www.njleg.state.nj.us/2014/Bills/S0500/20_I1.HTM

We believe this section is critical. In states like Colorado, with laws that do not have notice requirements, consumers report that they are unaware of the protections they have.

We believe the notification process should specifically address out of network referrals by in-network primary care providers, similar to the New York law. Failure for the out-of-network providers to disclose their status should avail consumers to the protections under this law.

Lastly, we believe that notice requirements should specifically include information on the number and percentage of out of network physicians at in-network facilities and an estimate of charges.

Section 503 – We believe in the consumer notification process outlined in Section 501 and would like to emphasize that enforcement provisions should also ensure that issuers and providers are communicating with consumers as specified in Section 501.

We recommend the following additional provisions:

1. Language requiring more accurate provider directories, as this is often the reason for surprise out of network costs. For example, California requires that health plans must (1) update provider directories weekly; (2) maintain an accuracy rate of 97%, and (3) use a uniform template across insurance programs developed by Department of Managed Health Care and the Department of Insurance:
   http://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201520160SB137

2. We do believe that tiered networks should be addressed within the scope of this legislation, especially when the consumer has no choice in the tier of care, such as emergency situations, or when providers are moved between tiers in the middle of the year. We recommend at a minimum a continuity of care provision that allows consumers to see their provider at in-network rates for a certain time period if their doctors leave the network or are reclassified into a higher cost-sharing tier in the middle of a plan year.

Please know that the Pennsylvania Health Access Network appreciates this opportunity to comment on the work of the Department, and looks forward to the Department's continued work on this.

Sincerely,

Antoinette Kraus, Director
PENNSYLVANIA HEALTH ACCESS NETWORK

Submitted electronically via ra-in-comment@pa.gov