

February 29, 2016

**UPMC Health Plan  
Legal Services Department**

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

Re: ***Comments on Pennsylvania Insurance Department's (PID) "Draft  
Legislation to Protect Consumers from Surprise Balance Billing"***

Dear Commissioner Miller:

Thank you for affording issuers and other stakeholders an opportunity to provide input on the above-referenced draft legislative proposal, as published on January 19, 2016 (the "Draft Legislation"). We at UPMC Health Plan appreciate the open and collaborative approach that your Department has taken to investigating and identifying sound policy solutions for the challenging issues surrounding surprise balance billing. We also agree that these issues should be directly addressed in order to ensure that Pennsylvania's health care economy operates in a fair, stable, and sustainable manner for all constituents. UPMC Health Plan has long-established policies and procedures designed to insulate our members, to the greatest extent possible, from balance billing and related disputes with out-of-network providers. Accordingly, we support the Pennsylvania Insurance Department's efforts to develop a framework for balance billing disputes that protects consumers from unexpected bills, while also minimizing and fairly distributing the burden imposed upon other stakeholders in what is often a complex situation. It is with this support in mind that we respectfully offer for your consideration the following comments.

**General Comments**

The memorandum accompanying the Draft Legislation asks whether the legislative proposal is "the best solution" in light of possible alternatives. We agree that the issues presented by surprise balance billing are appropriately addressed through a comprehensive solution focused on protecting consumers. However, because a legislative solution, as compared to a regulatory change, is not easily adjusted after passage to reflect any unexpected consequences, it is vital that all aspects of such an approach be well-vetted by and among impacted stakeholders. Given the competing financial interests of stakeholders in this matter, as well as the volume and variety of situations that implicate a balance billing scenario, a misstep in this regard could

be significantly harmful to Pennsylvania's health care economy; we encourage the Department to maintain an open and iterative approach as its legislative proposal is finalized.

In addition, given the existing complexities between issuer licensing, various provider types, network development, and reimbursement methodologies, we believe it is important that any final legislative solution be in harmony with the Commonwealth's other, existing laws related to health care delivery and financing. For example, the recently enacted Act 84 of 2015 took an important step toward protecting consumers against being caught "in the middle" regarding payment for emergency ambulance services, while also establishing certain payment guidelines for insurers and ambulance service providers. To the extent Act 84 represented a reasonable compromise between stakeholders while still affording important protections for consumers, we believe that any comprehensive approach to balance billing should permit Act 84, and other laws like it, to apply as originally intended.

**Section 301. Applicability.**

The memorandum accompanying the Draft Legislation seeks comments on whether "surprise bills" associated with providers' differing network tiers is an analogous situation to "surprise balance billing" for consumers. We believe that the issues associated with surprise balance billing are distinguishable from those associated with billing by tiered network providers. Surprise balance billing results from a dispute between two wholly unrelated parties (an issuer and a non-contracted provider). It is this lack of relationship that is a key distinguishing factor insofar as neither party to such a dispute has a contractual basis for taking, or not taking, any particular action; as such, some type of independent administrative resolution may be necessary to avoid placing consumer "in the middle" of any ongoing dispute. Additionally, surprise balance billing for OON services can present large and serious financial hardships for consumers. By contrast, billing by providers within a tiered network is governed by an existing contractual relationship between an issuer and the providers, and will often involve only modest differences in cost-sharing for consumers. As the use of tiered and value-based networks continues to grow, issuers and their contracted providers will increasingly have strong incentives to educate consumers, adopt reliable and readily accessible disclosures regarding network status, and establish member- and patient-friendly approaches to any billing disputes. We would be pleased to discuss the nature of tiered provider relationships and related billing issues with the Department, but respectfully request that any final approach to surprise balance billing remain focused on the OON care delivery scenarios where actual balance billing is implicated.

**Section 302. Hold Harmless.**

With respect to the application of any balance billing dispute process and protections, we are concerned that the Draft Legislation can be read to apply in any circumstance where an out-of-network (OON) provider renders services at a Covered Person's in-network facility. While we agree that no consumer should be penalized for *unknowingly* receiving services from an OON provider, we also feel it is important to clarify that a Covered Person who knowingly elects to receive services from an otherwise OON provider would not qualify for the "hold harmless" approach envisioned by the Draft Legislation. Pennsylvania's HealthChoices program utilizes a similar standard for beneficiaries who knowingly receive non-covered services from certain providers; this experience within the HealthChoices program may provide a reasonable means by which to separate "surprise balance billing" from intentional consumer decision-making. We expect such a clarification to impact relatively few consumers, but believe this is nonetheless an important protection against any potential abuse of the anticipated balance billing framework.

**Section 303-304. Direct Dispute Resolution and Arbitrated Dispute Resolution.**

The Draft Legislation proposes several possible alternatives for Health Carriers' payment(s) to OON providers, some of which include the use of binding arbitration. While we agree that any balance billing framework should establish fair, reliable, and final provider reimbursement amounts, we do not believe that mandated arbitration is an advisable or economical solution to the issue of surprise balance billing. In 2015, UPMC Health Plan processed almost 10,000 claims for OON emergency services alone; requiring even a portion of these claims, let alone those received for non-emergent services, to go before arbitrator(s) would be very costly and time-consuming. As a practical matter, these types of direct administrative costs are necessarily reflected in insurance premiums and thereby borne, at least in part, by consumers.

All stakeholders have an interest in establishing OON reimbursement rates that are fair and balanced with respect to the type and cost of services rendered. To that end, we believe the Draft Legislation identifies, in Section 303(d)(3), a reasonable and efficient compromise. Specifically, Section 303(d)(3) refers to payment of "the median amount the [Carrier] would pay for such Health Care Service if rendered by an In-Network Provider." This reimbursement rate is relatively easy for a Carrier to determine and represents a compromise derived from free market principles; this rate thereby minimizes the administrative burden of negotiating payment for OON services, while also ensuring that the OON provider is compensated in an amount

that generally reflects the market value of the subject service(s) among their peers. In furtherance of ensuring fair compensation in practice, this underlying standard could also appropriately be modified to reflect variation among individual provider types and/or regional differences in reimbursement. While the Draft Legislation's "% of Medicare" approach would also be operationally feasible, we are concerned that such a methodology does not necessarily reflect market variations in reimbursement among commercial lines of business. Medicare's approach to "valid code" updates is also likely to create uncertainty among stakeholders, as there is often a time lag between code adoption and Medicare's publication of an established rate. We therefore recommend that any "% of Medicare" methodology only be adopted where the median amount in Section 303(d)(3) cannot be reliably established (e.g., where a Carrier has no regional in-network provider fee schedules to establish the necessary reference reimbursement amount).

Thank you again for affording UPMC Health Plan and other stakeholders an opportunity to provide input on the Department's anticipated approach to surprise balance billing. We look forward to continued collaboration with the Department and the General Assembly on this very important issue.

Sincerely,

A handwritten signature in cursive script that reads "Sandra E. McAnallen". The signature is written in black ink and extends across the width of the text area.

Sandra E. McAnallen

Senior Vice President, Clinical Affairs and Quality Performance  
UPMC Insurance Services Division