PENNSYLVANIA HEALTH ACCESS NETWORK
STRONGER VOICES FOR BETTER HEALTH

Testimony to the Pennsylvania Insurance Department re: Protecting Consumers from "Surprise" Medical Bills

Submitted by the Pennsylvania Health Access Network
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Harrisburg, PA

My name is Patrick Keenan, and I'm the Consumer Engagement Manager for the Pennsylvania Health Access Network. I want to begin my testimony today by thanking you, Commissioner Miller, and your staff, for hosting this hearing and being pro-active in making sure Pennsylvanians are treated fairly by issuers and providers when they seek medical care.

We share that goal, and as the state's leading consumer health advocacy organization, we work to make our health care system affordable and accessible for all Pennsylvanians.

Since our founding in 2007, PHAN has worked to expand access to and improve the quality of the Commonwealth's health coverage options. As a Navigator and Certified Application Counselor-Designated organization, we're privileged to now enroll Pennsylvanians in the health coverage options we fought so hard to make available.

To date, PHAN has enrolled 4,500 Pennsylvanians in health insurance through the Marketplace and Medicaid. Despite our small staff, we've been able to enroll people in 45 of Pennsylvania's 67 counties and field 10,000 calls to our helpline over the past two years.

Our robust enrollment program reaches consumers where they are — be it at their workplace, their church, their favorite restaurant, or, in some cases, their neighborhood bar. In addition to our targeted outreach efforts, PHAN also operates a toll-free helpline to answer consumer questions and help Pennsylvanians from all corners of our diverse state get covered, use their benefits and resolve any problems that may arise. This work gives us a unique perspective into the barriers Pennsylvanians face with the day-to-day logistics of managing their insurance and in seeking medical care — one of which is the topic of today's hearing: balance billing.

One of the first questions we ask when helping a consumer enroll is who their health care providers are. *Do they have a primary care doctor, or any specialists? Which hospital do they prefer?* Using the issuer's online provider directories, we carefully go through to investigate which plans available to the consumer cover their preferred providers at "in-network" rates. We

do this to help consumers make an informed decision and select the plan that best meets their needs.

Depending on a consumer's medical needs and unique situation, we may spend several hours reviewing the differences in plans and what that means for their care — how much it will cost and where they can get it. We never want consumers to be caught off guard by a "fine print" detail or have problems accessing the care they're now paying for as new enrollees. That's why we're so troubled by the growing problem of "surprise" medical bills.

When a consumer seeks care at an ""in-network"" hospital clinic or has a medical emergency, they have every reason to assume their care will be covered. But, increasingly this is not the case. Every year, Pennsylvanians receive out of network services without their knowledge. When this happens, the patient is stuck paying the difference between what the provider has charged for their care and what the insurance company has paid them to do that. So, for example, if the provider charges $1,000 for a patient's treatment but the issuer thinks the charge is too high, and will only pay for $600, it's that patient — and their family — that are stuck (surprise!) paying the balance.

Balance billing is usually prohibited when a consumer seeks treatment from a facility or provider in their insurance plan's network; that's because, in agreeing to join an insurer's network of health care providers, that doctor or hospital is agreeing accept the insurance company's rate for each service as payment in full. Consumers choose their plans on the basis of whether their preferred providers are included "in-network", and they know, in cases where medical need or other factors necessitate, that they'll be charged higher "out-of-network" rates if they go outside their health plan's network.

Problems with "surprise" medical bills occur when, without the consumer's knowledge, someone involved with their care — received at an ""in-network"" facility — is a contractor of that facility rather than a participant in the consumer's health plan. This makes that provider ""out-of-network"" for the consumer, and leaves the consumer open to big bills which are an unexpected and unwelcome surprise.

Earlier this year, Consumer Reports conducted a national survey of consumers' experiences with "surprise" medical bills. Looking at only Americans with private health insurance, they found that nearly a third of those surveyed had been hit with a "surprise" medical bill within the last two years — and that, among those respondents:

- Fifty-three percent reported that the issue was not resolved to their liking or resolved at all. Among this group, fifty-seven percent were stuck paying the "surprise" bill in full, with another eighteen percent having to set up a payment plan.

- Twenty-five percent reported getting a bill from a doctor that they did not expect to receive.[1]

Further, the survey revealed that most Americans hit with “surprise” medical bills did not know where to turn for help. Nearly 3 in 4 of those struggling to resolve a balance billing claim were unsure or unaware of their rights to appeal their health plan’s decision and eighty-seven percent did not know which state agency to turn to for help resolving problems with health insurance.[2]

This is unfortunate, but not surprising, considering that most Americans don’t complain to government agencies. The Consumer Reports survey revealed that eighty-three percent of Americans have never complained to a government agency about any issue.[3] What that means for us in Pennsylvania is that this problem of “surprise” medical bills is likely much larger than we realize, with consumers shouldering the burden on their own. Holding this hearing is an important step in helping Pennsylvanians realize they’re not alone when it comes to resolving disputes and problems with their health coverage.

Moving forward, we need to:

1. Educate consumers about their rights when it comes to health insurance and balance billing;

2. Encourage consumers to report problems as they arise and support them throughout the appeals process; and finally,

3. Enact policy solutions to strengthen consumer protections and hold patients harmless when they are hit with “surprise” bills — despite doing their homework and seeking care "in-network".

I’ll discuss each of these areas briefly. First, educating consumers about their rights. Here, there’s a role for organizations like ours, for the Insurance Department, for health care providers, and for issuers.

Pennsylvanians actually do have some protections from “surprise” medical bills — but those protections are limited and only apply in certain situations. There are separate rules for HMOs[4] and PPOs[5] and the statutory language is complex and needs to be strengthened.

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[1] Consumer Reports® National Research Center, Survey Research Report: “Surprise Medical Bills Survey 2015 Nationally-Representative Online Survey.” May 2015. Available at: http://consumersunion.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf.

[2] Consumer Reports, as cited above. Page 2.

[3] Consumer Reports, as cited above. Page 3.

[4] **PA Code 31 § 301.122. Hold harmless.**
http://www.pacode.com/secure/data/031/chapter301/chap301toc.html#301.314
A contract between an HMO and a participating provider of health care services shall include a provision to the following effect: ‘‘(Provider) hereby agrees that in no event, including, but not limited to non-payment by the HMO, HMO insolvency or breach of this agreement, shall (Provider) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than HMO

Pennsylvanians need a clear, loophole-free guarantee that they will be protected by law from having to pay any more than “in-network” rates when they are hit with “surprise” medical bills in emergency and non-emergency situations when they have no control over whether they will see an "out-of-network" provider.

When problems do arise for consumers in getting their health plans to cover needed treatment, it’s important that the Department supports them in resolving these issues. We applaud you for actively working to do this, and for adding a Consumer Liaison to better connect Pennsylvanians with the services and oversight the Department provides. It’s important that consumers know where to turn to appeal not only balance billing claims, but also denials of services they thought would be covered, and other issues that arise in seeking treatment.

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acting on their behalf for services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on the HMO’s or provider’s behalf made in accordance with the terms of the applicable agreement between the HMO and subscriber/enrollee.

‘‘(Provider) further agrees that (1) the hold harmless provisions herein shall survive the termination of the (applicable Provider contract) regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee and that (2) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf. ‘‘Any modification, addition, or deletion to the provisions of this section shall become effective on a date no earlier than fifteen (15) days after the Secretary of Health has received written notice of such proposed changes.’’

PA Code 31 § 301.62(c). Subscriber contracts and evidences of coverage.
http://www.pacode.com/secure/data/031/chapter301/chap301toc.html#301.62
Emergency benefits and services. The contract and evidence of coverage shall contain a specific description of benefits and services available for emergencies 24 hours a day, 7 days a week, including disclosure of restrictions on emergency benefits and services. The forms shall explain the procedures to be followed to secure medically necessary emergency health services. Emergency care service shall be covered in and out of the service area. No contract or evidence of coverage may limit the availability of emergency services within the service area only to affiliated providers. No emergency room copayment in excess of primary care copayment may be charged if the member has been referred to the emergency room by a primary care physician or the HMO and the services could have been provided in the primary care physician’s office.

PA Code 31 § 301.203(b)(1)(vii). Filing requirements.
http://www.pacode.com/secure/data/031/chapter301/chap301toc.html#301.203
Emergency coverage shall be provided under provisions of the basic HMO coverage without application of "out-of-network" deductibles or coinsurance.

[5] **PA CODE 31 § 152.15. Emergency services.**
http://www.pacode.com/secure/data/031/chapter152/chap152toc.html
If an enrollee requires emergency health care services, and cannot reasonably be attended to by a preferred provider or physician, the preferred provider arrangement shall pay for the emergency health care services so that the enrollee is not liable for a greater out-of-pocket expense than if the enrollee were attended to by a preferred provider or physician.

§ 152.104(a)(3)(i). Filing requirements. (applicable to gatekeeper PPOs only)
http://www.pacode.com/secure/data/031/chapter152/chap152toc.html
(a) A PPO desiring to offer a gatekeeper product shall submit a formal product filing to the Division of HMOs/PPOs of the Department and the Bureau of Health Financing and Program Development of the Department of Health. Two copies shall be filed with each Department and shall include: […]
(3) Copies of preferred provider contracts, which should contain features required by the Department of Health in HMO contracts, including:
(i) NAIC/National Association of HMO Regulators enrollee hold harmless language.

Finally, we need to use the data on complaints filed and evidence from other states to look at policy solutions to both clarify our existing state statutes and build on them to strengthen protections for consumers.

Some states — including New York, Colorado and California — have banned balance bills in emergency situations. Colorado goes a step farther and bans “surprise” bills even in non-emergency situations. In Florida and Texas, there are emergency balance bill bans for HMOs, but additional action is needed to expand that protection to other types of plans, like PPOs. Other states help consumers avoid having to pay balance bills, or the full amount of the balance bill, when they are received.

For non-emergencies, under New York’s new surprise billing law, consumers can “assign” the bill to the provider and pay only what they would pay if they received the care “in-network.” It’s then up to the provider and insurer to work out the remaining balance. Under New York’s law, this protection is available for:

- consumers who receive "out-of-network" medical services when there were no "in-network" providers available, or
- consumers who do not receive the disclosures required by the new law, and includes disclosures about:
    - whether the provider is in the patient’s network,
    - the patient’s right to know their estimated costs for care,
    - who will be involved in their care if other providers will be involved, and
    - what the network status of those providers is.

If the provider and insurer can’t agree on the reimbursement rate for a consumer who as assigned a bill to an "out-of-network" provider, they can go through an independent arbitration process. In this process, the consumer is completely protected from paying any more than "in-network" costs.

Texas has somewhat similar protections, though they are not as strong. The Texas statute allows consumers in PPOs and the state employee health plan to go through mediation of surprise bills larger than $500 from facility-based physicians. Consumers must stay involved in the process and may end up paying a portion of the balance bill, but their share can be reduced by the process.

This hearing today is an important first step in ending the growing problem of “surprise” medical bills. We look forward to working with you, Commissioner Miller, and your staff to strengthen protections for Pennsylvanians and ensure that consumers can be confident that when they buy insurance, their plan will connect them with the services they need at an affordable price, with no unwelcome surprises.