Sen. Jay Costa, Senate Democratic Leader

Testimony Regarding "Surprise" Balance Billing

October 1, 2015

Commissioner Miller, my name is Jay Costa. I am a state Senator representing the 43rd District which is located in Allegheny County. My district includes wards in th e City of Pittsburgh, East Hills communities, a number of municipalities in the Sout h Hills and the Monongahela Valley. I have been a member of the State Senate sin ce 1996. I currently serve as the Senate Democratic Leader.

Thank you for providing me an opportunity to express my significant concerns reg arding "surprise" balance billing, its impact on health care consumers, and a few p otential solutions.

As you know, I have been very active in trying to find a resolution to the ongoing d isagreements between UPMC and Highmark, which are causing turmoil in the We stern Pennsylvania health care market. A side effect of the breakup in the contrac tual relationship between the two is that "surprise" balance billing is becoming m ore prevalent. It is one side effect that we must find a solution to in the immediat e future to protect consumers and their pocketbooks.

In the often opaque world of health care billing and pricing, the increasing use of balance billing cannot be taken lightly. 45 million Americans are behind on paying medical bills, and 50 per ent of bankruptcies are a result of such debt. After going through a medical procedure the last thing a patient needs is to find a startling bill in the mailbox for services they thought were covered by their healthcare insuran ce.

The story is rather simple. A patient arrives for a procedure at a health care facilit y with a doctor that is covered by their insurance product as in-network. The patie nt expects to pay a deductible and/or co-pay, but these are predictable costs that the patient knows must be covered.

However, it later turns out that someone providing a particular service related to the procedure is out-of-network, requiring a wide range of costs that the patient

was not expecting to pay. This can quickly add up to tens of thousands of dollars, and perhaps more. To make matters worse, the costs may not be known or comm unicated to the patient until months later, disabling them from being able to prop erly pursue an appeal of the charges.

Consumers confronting the health care system often find it confusing on its face. Choosing health insurance, finding a primary care physician to match that health i nsurance, and then, in the midst of illness, trying to find the right in-network speci alists to provide a cure are all difficult tasks. Being confronted by surprise, out-of-network charges that can cost a patient thousands is not an acceptable outcome.

Pennsylvania currently only protects patients in emergency situations from surpri se balance billing. We must expand this protection further to protect patients that are being treated at in-network facilities or are referred to out-of-network servic es without proper disclosure.

Currently there are protections in 13 states for consumers with HMO health care plans and nine states for those with PPO plans. While many of these are similar to Pennsylvania in that they only cover emergency services, other states have taken a more aggressive, and I would say appropriate position, that surprise balance billi ng should also be restricted.

New York has adopted a best practice statute within the last year that should bec ome a model for Pennsylvania. Under the New York law, patients are generally pr otected from owing more than their in-network copayment, co-insurance or dedu ctible on bills they receive for out-of-network emergency services or on surprise b ills.

A bill is considered a surprise if, for example, patients at a hospital or ambulatory surgical center that's in their network receive services from a doctor who, without their knowledge, is out-of-network. In addition, if consumers are referred to out-of-network providers but don't sign a written consent form saying they understan d the services will be out-of-network and may result in higher out-of-pocket costs, it's considered a surprise bill.

Lastly, the patient isn’t made to fight between the insurer and the health care provider. To get relief from a surprise bill a consumer needs to complete an "assignment of benefits" form that allows the provider to pursue payment from the health plan. The patient then sends the form and the bill to her insurer and to the provider. As long as the patient has taken that step, he won't be responsible for any charges beyond her regular in-network cost sharing.

Some states have adopted hotlines that allow for educated patients to proactively determine whether they will be, or have been, subject to surprise billing. This is a piece of the protection that should be provided to consumers, but does not go far enough.

Additionally, disclosure of the contractual relationships between an insurer and all of the health care providers involved in a procedure should be required so that patients are informed in writing about the potential for out-of-network charges.

Health care is confusing at the best of times. It can be physically, emotionally, and financially overwhelming at the worst of times. Surprise billing, merely one element amongst all the confusion, should not be something that we tolerate as the health care marketplace continues to evolve. We are seeing first hand in Western Pennsylvania how the changing relationships between health care providers and insurers can damage patients. We must adopt a strong legal structure to protect consumers.

Thank you for accepting my testimony. I look forward to working closely with you in the coming months to address this pressing issue.