

Statement before the Senate Banking and Insurance Committee

**Committee Hearing on SB 1158**

**Surprise Balance Billing**

Presented by:

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9:30am, Hearing Room 1, North Office Building

Good morning Senator White, Senator Wiley and Honorable Members of the Senate Banking and Insurance Committee. Thank you for the opportunity to be here today to speak about this important issue. Thank you especially to Senators White and Wiley for holding this hearing and to Senator Schwank for introducing Senate Bill 1158 (SB 1158). SB 1158 aims to address what is a very important issue for consumers concerning the cost of health care, and we applaud Sen. Schwank for her work in this area.

Surprise balance billing happens when someone gets medical care from providers and at facilities they believe are in their health insurance plan’s network, but unknowingly receives services from an out-of-network provider. A few weeks or a couple months later, the consumer receives a surprise bill from the out-of-network provider, which can often be very large.

The Insurance Department has received numerous complaints about this practice over the past few years. We have heard from consumers who had done their research and thought the providers and facilities they received care from were all in-network, only to find that despite these efforts, they received unexpected and upsetting bills. This is because somewhere in their treatment, an out-of-network facility was used or an out-of-network provider participated in their care.

I’d like to share some real life examples (with identifying information changed to protect confidentiality) from the complaints we have received:

* A consumer from State College was billed over $2,000 for blood tests that were taken at an in-network hospital by an in-network doctor, but sent for analysis at an out-of-network laboratory.
* A consumer from Lancaster had surgery at an in-network hospital performed by an in-network surgeon, but an out-of-network anesthesiologist participated in the procedure, resulting in a $1,300 bill.
* A consumer from Scranton had a baby at an in-network hospital delivered by an in-network OB/GYN, but complications led the baby to be seen by an out-of-network neonatologist, resulting in a surprise $750 bill.

In many of these cases, the consumers did everything right. They may have checked that their hospitals and surgeons were in-network, and some even reported calling the hospital or their insurance company before receiving care to confirm the in-network status of their providers. But, despite these best efforts, they received a significant surprise bill. Our health care system is complicated enough as it is, and consumers who do their best to navigate it in good faith deserve to be protected from costs that cannot be predicted and therefore cannot be avoided.

Given Governor Wolf’s and my priority of consumer protection, and the Wolf Administration’s goal of expanding the accessibility of affordable health care, I believe this is an issue worth exploring, and we have been doing so.

Last October, the Department held a public informational hearing on the issue of surprise balance billing to assess stakeholder interest and better understand varying perspectives on the issue. The hearing allowed the Department to hear from consumers, insurance companies, hospitals, private physician practices, and other impacted stakeholders in a transparent environment.

At that hearing, the Department was pleased to see a general consensus among all the stakeholders that surprise balance billing is a problem and that it should be addressed in a manner that protects consumers. Following the hearing, the Department carefully reviewed all of the testimony and researched actions taken by other states to address balance billing, in order to work towards a potential solution for interested parties to comment upon.

The Department circulated a draft proposal for public comment earlier this year and continues to work on refining the specifics as a result of stakeholder input and recommendations. SB 1158, though currently not identical to the proposal circulated by the Department, works toward the same goal of taking consumers out of these situations and protecting them from surprise balance bills by creating a process for the provider and the insurer to negotiate fair reimbursement for these services.

Both proposals work by:

* Taking consumers out of the middle and holding them harmless for the costs of these services, other than their in-network cost-sharing.
* Instructing insurers to negotiate with providers to determine fair payment for these services.
* Establishing an independent arbitration process to determine fair payment if the insurer and provider are unable to come to agreement.

When someone undergoes a major medical procedure, they need to focus on their recovery. Especially when they and their families have taken the time to research and use providers and facilities that are in their insurer’s network, the last thing these people need is to get a bill in the hundreds, or thousands of dollars, from an out-of-network doctor or facility that the consumer may not have even known was involved in their care.

The Insurance Department looks forward to continuing discussions on this issue with both stakeholders and the General Assembly. We’d also like to take the opportunity to offer ourselves as a resource if we can be helpful or provide information during your own work and deliberations on this topic. Thank you again for the opportunity to testify here today, and I welcome any questions that you may have.