Testimony on Surprise Balance Billing

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House Insurance Committee

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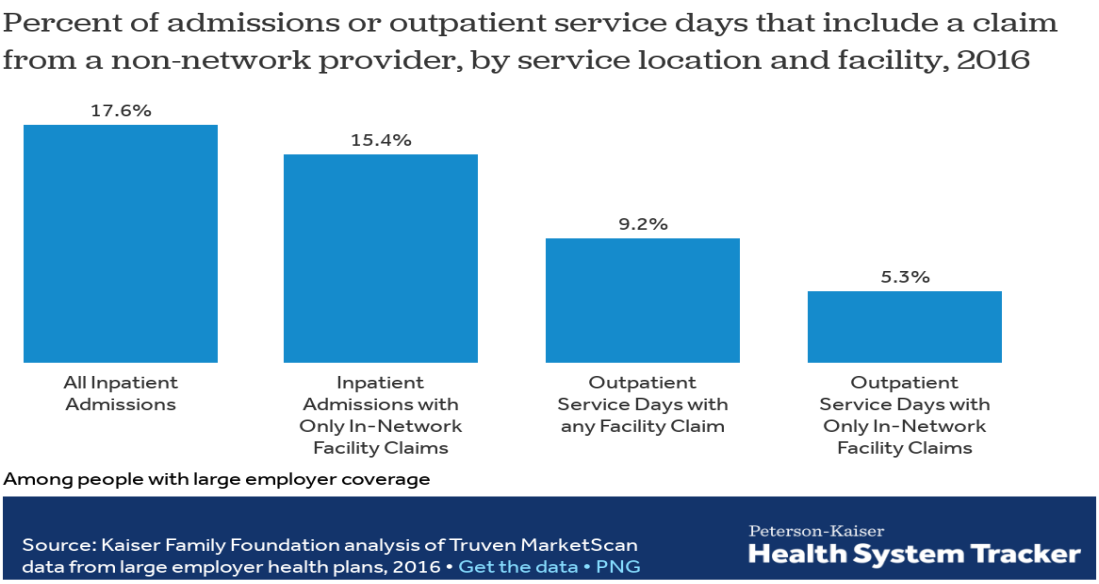
Chairwoman Pickett, Chairman DeLuca and Honorable Members of the House Insurance Committee, thank you for holding a hearing on surprise balance billing, an issue that affects many Pennsylvanians. Thank you also for the opportunity to submit this written testimony. Surprise balance billing is an issue that needs to be addressed and I appreciate your leadership in achieving this goal.

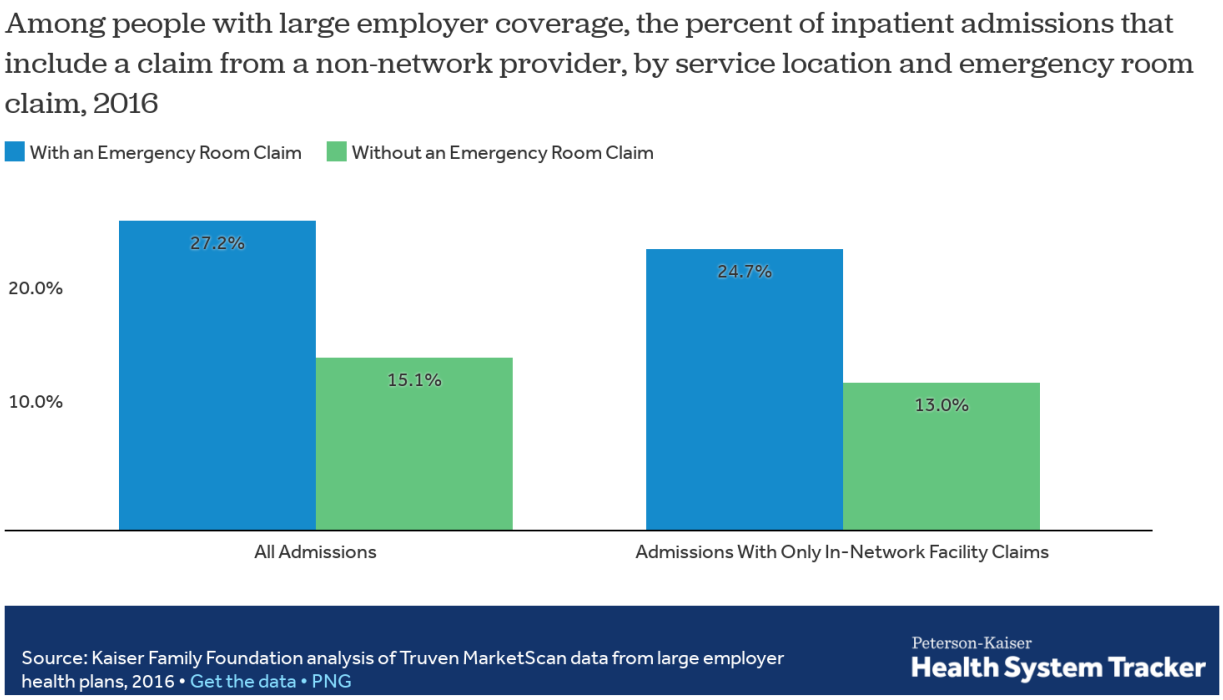
Surprise balance billing happens when an individual seeks medical care from providers and facilities they believe are in their health insurance plan's network, but unknowingly receives a service(s) from an out-of-network provider. At some later point, the consumer receives a surprise bill from the out-of-network provider, for which, depending on their insurance plan's out-of-network benefit, they will be responsible for paying a large portion, if not all, of the cost.

Consumers receive surprise balance bills much more frequently than one would think. According to a Kaiser Family Foundation (KFF) analysis[1] that was published in February 2018, nearly one in five inpatient admissions includes a claim from an out-of-network provider. Almost 18 percent of inpatient admissions by enrollees in large employer health plans include at least one claim from an out-of-network provider. In the same analysis, KFF noted that patients using in-network facilities still face claims from out-of-network providers, particularly for inpatient admissions. In fact, the percentage of inpatient admissions with a claim from an out-of-network provider remains significant (15.4%) even when enrollees use in-network facilities.

[1] https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start



The KFF's analysis also found, as shown in the chart below, that inpatient admissions that include an emergency room claim are more likely to include claims for an out-of-network provider than admissions without an emergency room claim. This is true whether or not enrollees use in-network facilities.



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 their 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.

Surprise balance bills may also occur when a consumer has out-patient services. This may happen, for example, when they go to their in-network provider for services, and get blood drawn or an x-ray taken down the hall, only to have the blood sample sent to an out-of-network lab or the x-ray read by an out-of-network radiologist. While the dollar amounts may not be as traumatic as when the patient is hospitalized and subjected to surprise out-of-network services, it is nonetheless troubling and may be financially devastating for a consumer who does not have a savings cushion.

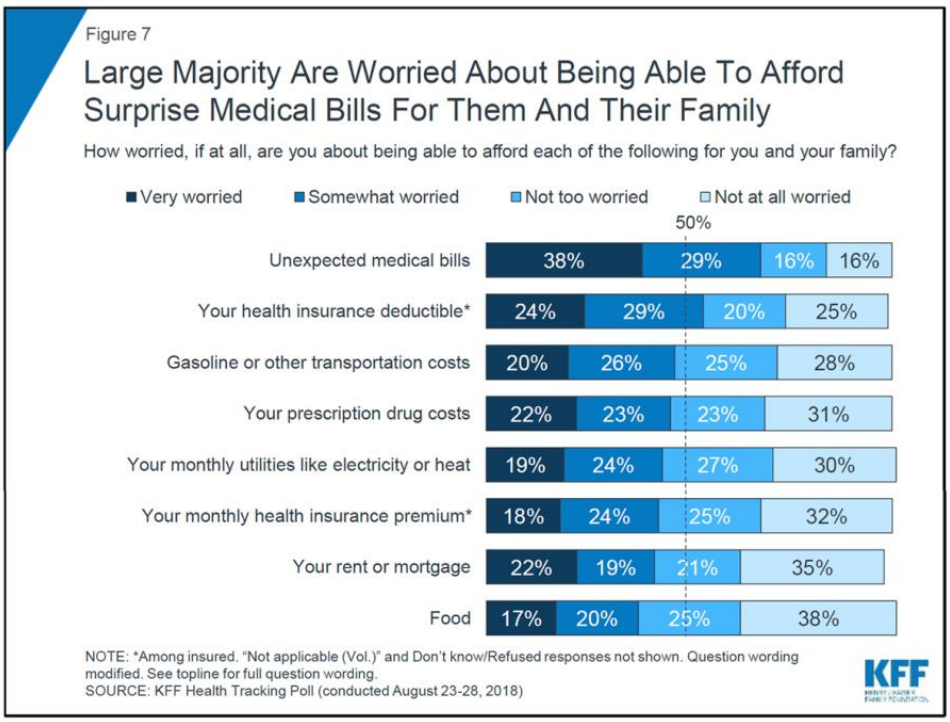
I'd like to share some recent real-life examples (with identifying information changed to protect confidentiality) from the complaints we have received:

- A consumer carefully researched her obstetrician provider and delivery site. When she delivered there were complications with the newborn requiring services from a neo-natal specialist and NICU involvement. The insurance company denied the claims as out-of-network, even though she was an inpatient at a network facility. The consumer was billed $83,452.98.

- A consumer took his son to the emergency department of a hospital with a severe hand injury. After he was triaged, the consumer was advised that due to the complexity of the injury the on-call specialist would have to evaluate his son. The consumer obtained emergency services for his son from a network hospital and had no idea that the specialist was out-of-network until he received a bill for the $3,862.50. This figure represented the difference between what the actual charge and the amount paid by his insurance company.

- A consumer contacted his insurance company prior to his doctor appointment to confirm that his cardiologist was in network. During his appointment, the cardiologist determined that an external monitor was necessary to further evaluate his condition. The monitor was set up by the office staff; however, there was no mention that an out-of-network third party monitoring service was involved. The consumer was billed $2,000.00.

In many instances of surprise balance bills, the consumers did everything right: they 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. If the General Assembly enacts legislation to address this issue and take consumers out of the middle of disputes between insurers and out-of-network providers, it will do a great service to the people of this Commonwealth. Rather than worrying about surprise balance billing, which, as the chart below shows, has risen to the top of the issues that consumers are most worried about being able to afford, Pennsylvanians will be able to focus their energy on their families and their employment and their communities.



Given Governor Wolf's and my priority of consumer protection, and the Wolf Administration's goal of expanding the accessibility of affordable health care, the department has invested time and energy in delving into the issue of surprise balance billing and working toward a resolution. The department began exploring the issue in late 2015, when it held a public informational hearing on the issue of surprise balance billing to assess stakeholder interest and to get a better understanding of the varying perspectives on the issue. The hearing allowed the department to engage with consumers, insurance companies, hospitals, private physician practices, and other impacted stakeholders in a transparent environment. The department was pleased to see a general consensus among all the stakeholders – including insurers and providers – 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.

Since that time, strong bi-partisan legislation has been introduced in both chambers of the General Assembly that the department supports. We are appreciative of the work that the legislature has put into resolving this issue of critical importance to Pennsylvania's consumers and look forward to supporting the Committee in its work over the coming session. While there remain challenging issues that will be difficult to achieve consensus on, Pennsylvanians need and deserve protections from these surprising and often financially devastating bills.

If Pennsylvania does not take action, it may be subject to a federal default solution to this issue, as Congress has shown an interest in addressing this issue. U.S. Senators Bill Cassidy, M.D. (R-LA), Michael Bennet (D-CO), Chuck Grassley (R-IA), Tom Carper (D-DE), Todd Young (R-IN), and Claire McCaskill (D-MO), members of the bipartisan Senate health care price transparency working group, released draft legislation to protect patients from surprise medical bills.[2] The federal bill seeks to address three scenarios:

- Emergency services provided by an out-of-network provider in an out-of-network facility.

[2] *See* https://www.cassidy.senate.gov/newsroom/press-releases/cassidy-bipartisan-colleagues-release-draft-legislation-to-end-surprise-medical-bills; https://www.cassidy.senate.gov/imo/media/doc/Discussion%20Draft-%20Protecting%20Patients%20from%20Surprise%20Medical%20Bills%20Act.pdf.

- Non-Emergency services following an emergency service from an out-of-network facility.
- Non-Emergency services performed by an out-of-network provider at an in-network facility.

The draft bill would also require the secretary of Health and Human Services to conduct a study and issue a public report that includes recommendations to Congress regarding the impact the bill would have on the prevalence of patient cost-sharing, patients' access to care and the quality of that care, the price of insurance premiums, any change in overall health care costs, the use of emergency rooms, access to new and improved drugs and technology, and the adequacy of insurance networks.

However, the federal proposal also recognizes the numerous states that have chosen to take action on this issue already by ensuring any state-based solution will remain in place and the federal legislation, if implemented, would only apply to states with no such protections. Pennsylvania has an opportunity to take the lead on this issue and enact a law that protects its citizens in a way that best appreciates Pennsylvania's market dynamics. We can adopt a law that fits the needs of our Commonwealth and takes into account the concerns of all the stakeholders that are involved. If Pennsylvania does so, the federal bill, as currently drafted, contemplates that payment would be in accord with state law. However, if Pennsylvania fails to act, the federal default resolution process would apply.

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. Again, 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 important topic. Thank you again for the opportunity to submit this testimony.