AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," in quality health care accountability and protection, providing for protections for consumers receiving surprise balance bills for health care services from out-of-network providers.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding a section to read:

Section 2167. Protections for Consumers Receiving Surprise Balance Bills for Health Care Services from Out-of-network Providers.--(a) Notwithstanding any provision to the contrary,
this section applies to a surprise balance bill. This section
does not apply to a health care service for which an entity,
other than an insurer under a health insurance policy, is
responsible.

(b) If an out-of-network provider renders a health care
service to an insured, the following shall apply:

(1) The out-of-network provider may bill the insurer and be
reimbursed directly for a covered service at the commercially
reasonable rate directly for that service, unless the insurer
has a contract that addresses payment for an out-of-network
provider or the insurer and out-of-network provider agree
otherwise.

(2) An out-of-network provider may not bill the insured for
the difference between the out-of-network provider's charge and
the amount of the commercially reasonable rate paid by an
insurer for the covered service. The out-of-network provider may
bill the insured for no more than the in-network cost-sharing
amount.

(c) The following apply:

(1) The insurer shall inform the out-of-network provider of
the insured's applicable in-network cost-sharing obligation.

(2) The insured shall be responsible for no more than the
cost-sharing amount that would have been due if the health care
service had been rendered by an in-network provider.

(3) The out-of-network provider may not advance a surprise
balance bill to collection.

(d) The following apply:

(1) Insurers and health care providers shall provide the
following notices to insureds and patients:

(i) At the time of initial enrollment or upon request, an
insurer shall provide the insured with a notice outlining the insured's rights under this section. The notice shall be subject to approval by the Insurance Department.

(ii) At the time of scheduling a patient for a nonemergency health care service or upon request, a health care provider shall provide a patient with a notice outlining the patient's rights under this section. The notice shall be subject to approval by the Department of Health.

(2) The notice under paragraph (1) shall include at least the following:

(i) The rights of insureds under this section.

(ii) The identification of the Insurance Department as the proper Commonwealth agency to receive complaints relating to surprise balance bills prohibited under this section.

(iii) Contact information for the Insurance Department.

(iv) A general description of the types of health care services that could be provided by out-of-network providers even if a patient is receiving health care in an in-network facility and why this can happen.

(v) A general notice that the insured may contact his insurer and health care provider if there are any questions about coverage before receiving treatment.

(vi) An explanation of how surprise balance bills or bills for services rendered by out-of-network providers are addressed by this section and that an insured is only responsible for any applicable in-network cost-sharing amount under the insured's health insurance policy.

(vii) If provided by a health care provider, the contact information for the health care provider's patient advocate.

(e) A violation of this section by a health care provider
shall be considered a violation of the act of December 17, 1968
(P.L.1224, No.387), known as the "Unfair Trade Practices and
Consumer Protection Law."

(f) The following apply:

(1) Any controversy or claim arising out of or relating to
the payment of a commercially reasonable rate not being
accurate, shall be settled by arbitration administered by the
American Arbitration Association under its Healthcare Payor
Provider Arbitration Rules using the expedited desk/telephonic
track procedures.

(2) If the arbitrator determines that the insurer
incorrectly calculated the reimbursement rate, the insurer shall
issue a payment to the provider using the correct calculation.

(3) Judgment on an award rendered by the arbitrator may be
entered in any court having jurisdiction.

(g) Notwithstanding the provisions of section 2102, as used
in this section the following words and phrases shall have the
meanings given to them in this subsection unless the context
clearly indicates otherwise:

"Commercially reasonable rate." For the purposes of this
section, with respect to health care services covered by a group
or individual health insurance policy, the median in-network
contracted rate under the applicable policy that the insurer
would pay to an in-network provider, minus the in-network cost-
sharing for the service under the policy, for the same specialty
and geographic region in which the service is provided.

"Cost-sharing." As follows:

(1) A copayment, coinsurance or deductible for an insured's
responsibility under a health insurance policy.

(2) The term does not include a premium, surprise balance
billing amount or the cost of a noncovered service.

"Health care service." A covered treatment, admission, procedure, medical supply or equipment or other service, including behavioral health, prescribed or otherwise provided or proposed to be provided by a health care provider to an insured under a health insurance policy.

"Health insurance policy." As follows:

(1) An insurance policy, subscriber contract, certificate or plan that provides medical or health care coverage, including emergency services.

(2) The term does not include any of the following types of policies:

(i) Accident only.
(ii) Fixed indemnity.
(iii) Credit.
(iv) Dental only.
(v) Vision only.
(vi) Specified disease.
(vii) Medicare supplement.
(viii) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.
(ix) Long-term care.
(x) Disability income.
(xi) Workers' compensation.
(xii) Automobile medical payment insurance.
(xiii) Homeowners insurance.

"Insured." As follows:

(1) A person on whose behalf an insurer is obligated to pay covered health care expense benefits or provide health care services under a health insurance policy.
(2) The term includes a policyholder, certificate holder, subscriber, member, dependent or other individual who is eligible to receive health care services under a health insurance policy.

"Insurer." An entity licensed by the Insurance Department with accident and health authority to issue a policy, subscriber contract, certificate or plan that provides medical or health care coverage, including emergency services, and is offered or governed under any of the following:

(1) This act, including section 630 and Article XXIV.
(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Out-of-network provider." A health care provider that has not contracted with an insurer to provide health care services to insureds covered by a health insurance policy.

"Surprise balance bill." A bill for a covered service provided to an insured that seeks to collect from the insured the difference between an out-of-network provider's fee for a covered service received by the insured and the reimbursement received from the insured's health insurance policy where the covered service is one or more of the following:

(1) A covered emergency service provided to an insured by an out-of-network provider, including the service provided in the episode of care originating in an emergency setting through stabilization.
(2) A covered service provided to an insured by an out-of-network provider at an in-network facility.
(3) A covered service provided to an insured by an out-of-network provider, in conjunction with a health care service for which the insured presented for care to an in-network provider.

Section 2. This act shall take effect in 180 days.