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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1862 Session of 2019

INTRODUCED BY PICKETT, DeLUCA, BROWN, CIRESI, COX, DRISCOLL, EVERETT, FREEMAN, FRITZ, GABLER, IRVIN, JAMES, KAUFER, KAUFFMAN, KORTZ, MALONEY, MILLARD, B. MILLER, MULLERY, OWLETT, RADER, READSHAW, SAYLOR, SIMMONS, WARREN, YOUNGBLOOD, ZABEL AND ZIMMERMAN, OCTOBER 25, 2019

REFERRED TO COMMITTEE ON INSURANCE, OCTOBER 25, 2019

AN ACT

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

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

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

20 <u>Section 2167. Protections for Consumers Receiving Surprise</u>
21 <u>Balance Bills for Health Care Services from Out-of-network</u>
22 <u>Providers.--(a) Notwithstanding any provision to the contrary,</u>

1 this section applies to a surprise balance bill. This section
2 does not apply to a health care service for which an entity,
3 other than an insurer under a health insurance policy, is
4 responsible.
5 (b) If an out-of-network provider renders a health care
6 service to an insured, the following shall apply:
7 (1) The out-of-network provider may bill the insurer and be
8 reimbursed directly for a covered service at the commercially
9 reasonable rate directly for that service, unless the insurer
10 has a contract that addresses payment for an out-of-network
11 provider or the insurer and out-of-network provider agree
12 otherwise.
13 (2) An out-of-network provider may not bill the insured for
14 the difference between the out-of-network provider's charge and
15 the amount of the commercially reasonable rate paid by an
16 insurer for the covered service. The out-of-network provider may
17 bill the insured for no more than the in-network cost-sharing
18 amount.
19 (c) The following apply:
20 (1) The insurer shall inform the out-of-network provider of
21 the insured's applicable in-network cost-sharing obligation.
22 (2) The insured shall be responsible for no more than the
23 cost-sharing amount that would have been due if the health care
24 service had been rendered by an in-network provider.
25 (3) The out-of-network provider may not advance a surprise
26 balance bill to collection.
27 (d) The following apply:
28 (1) Insurers and health care providers shall provide the
29 following notices to insureds and patients:
30 (i) At the time of initial enrollment or upon request, an

1 insurer shall provide the insured with a notice outlining the
2 insured's rights under this section. The notice shall be subject
3 to approval by the Insurance Department.
4 (ii) At the time of scheduling a patient for a nonemergency
5 health care service or upon request, a health care provider
6 shall provide a patient with a notice outlining the patient's
7 rights under this section. The notice shall be subject to
8 approval by the Department of Health.
9 (2) The notice under paragraph (1) shall include at least
10 the following:
11 (i) The rights of insureds under this section.
12 (ii) The identification of the Insurance Department as the
13 proper Commonwealth agency to receive complaints relating to
14 surprise balance bills prohibited under this section.
15 (iii) Contact information for the Insurance Department.
16 (iv) A general description of the types of health care
17 services that could be provided by out-of-network providers even
18 if a patient is receiving health care in an in-network facility
19 and why this can happen.
20 (v) A general notice that the insured may contact his
21 insurer and health care provider if there are any questions
22 about coverage before receiving treatment.
23 (vi) An explanation of how surprise balance bills or bills
24 for services rendered by out-of-network providers are addressed
25 by this section and that an insured is only responsible for any
26 applicable in-network cost-sharing amount under the insured's
27 health insurance policy.
28 (vii) If provided by a health care provider, the contact
29 information for the health care provider's patient advocate.
30 (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.

(2) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(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.

1 (3) A covered service provided to an insured by an out-of-
2 network provider, in conjunction with a health care service for
3 which the insured presented for care to an in-network provider.
4 Section 2. This act shall take effect in 180 days.