AN ACT

Amend Insurance Company Law, providing for out-of-network balance billing transparency.

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

Section 1. Insurance Company law is amended by adding a new chapter to read:

CHAPTER 34

OUT-OF-NETWORK SURPRISE BALANCE BILLING TRANSPARENCY

Subchapter

A. General Provisions

B. Procedures

C. Enforcement

SUBCHAPTER A

GENERAL PROVISIONS

Sec.

3401. Scope of chapter.

3402. Declaration of purpose and legislative findings.

3403. Definitions.

3404. Applicability.

§ 3401. Scope of chapter.

This chapter relates to out-of-network balance billing transparency.

§ 3402. Declaration of purpose and legislative findings.

(a) Purpose.--The purpose of this chapter is to protect consumers from unexpected medical bills that result from their receiving care from out-of-network providers.

(b) Findings.--The General Assembly finds and declares that improved disclosures by an insurer, health care practitioners and facilities will help consumers better navigate the insurance processes and reduce the incidence of costly surprise health care bills.

§ 3403. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Balance bill." A bill for a covered service provided to an insured who has coverage through a health care plan in order to collect the difference between an out-of-network provider's fee for a covered service received by the insured from the out-of-network provider and the reimbursement received by the out-of-network provider from the insured's health care plan. Cost sharing is not a balance bill.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Cost-sharing." As follows:

(1) A copayment, coinsurance, deductible or similar charge for an insured response under a health insurance policy.

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

"Covered service." A health care service reimbursable by an insurer under a health care plan.

"EMS agency." As defined in 35 Pa.C.S. § 8103 (relating to definitions), unless exempted by federal law.

"Emergency service." As follows:

(1) A health care service provided to an insured after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in detrimental consequences to the health of the insured or, in the case of a pregnant woman, the health of the insured or her unborn child.

(2) The term includes the following:

(i) Emergency medical services as defined in 35 Pa.C.S. § 8103.

(ii) A health care service that a provider determines is necessary to evaluate and, if necessary, stabilize the condition of the insured so that the insured may be transported without suffering detrimental consequences or aggravating the insured's condition.

(iii) If the insured is placed in observation status

or is admitted into a facility, a health care service rendered prior to transfer or discharge.

"Explanation of benefits." A statement provided by an insurer to the insured that rendered services to the insured that, among any other relevant information determined by the insurer, includes a clear and conspicuous delineation of:

(1) The amount billed by the provider.

(2) The amount paid to the provider.

(3) The amount of cost sharing that is owed by the insured to that provider.

"Facility." A facility providing a health care service, including any of the following:

(1) A general, special, psychiatric or rehabilitation hospital.

(2) An ambulatory surgical facility.

(3) A cancer treatment center.

(4) A birth center.

(5) An inpatient, outpatient or residential drug and alcohol treatment facility.

(6) A laboratory, diagnostic or other outpatient medical service or testing facility.

(7) A physician's office or clinic.

"Health care plan"-- A package of coverage benefits with a particular cost-sharing structure, network, and service area that is purchased through a health insurance policy.

"Health care practitioner." As follows:

(1) An individual who is authorized to practice some component of the healing arts by a license, permit, certificate or registration issued by a Commonwealth licensing agency or board.

(2) The term includes the following:

(i) A health service doctor as defined in section 6302 (relating to definitions).

(ii) An individual accredited or certified to provide behavioral health services.

(iii) A practice group.

(iv) A facility -based provider

(v) A licensed individual who provides health care services to patients in a facility or in conjunction with services provided to patients in a facility.

"Health care service." As follows:

(1) A category of services, including:

(i) A covered treatment.

(ii) An admission.

(iii) A procedure.

(iv) Medical supplies and equipment.

(v) Another service prescribed or otherwise provided or proposed to be provided by a provider to an insured under a health care plan.

(2) Types of services. including:

(i) An emergency service.

(ii) A behavioral health care service.

(iii) A health care service provided in conjunction with any other health care service sought by an insured

in or from a health care practitioner

"Health insurance policy." As follows:

(1) A policy, subscriber contract, certificate or plan issued by an insurer that provides medical or health care coverage.

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

(i) An accident-only policy.

(ii) A credit-only policy.

(iii) A long-term care or disability income policy.

(iv) A specified-disease policy.

(v) A Medicare supplement policy.

(vi) A fixed-indemnity policy.

(vii) A dental-only policy.

(viii) A vision-only policy.

(ix) A workers' compensation policy.

(x) An automobile medical payment policy.

(xi) A policy under which benefits are provided by the Federal Government to active or former military personnel and their dependents.

(xii) Any other similar policies providing for limited benefits.

"In-network provider." A provider who contracts directly or indirectly with an insurer to provide health care services to an insured under a health care plan.

"Insurance Company Law." The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"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 care plan.

(2) The term includes a policyholder, certificate holder, subscriber, member, dependent or other individual who is eligible to receive health care services through a health care plan.

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

(1) The Insurance Company Law, including section 630 and Article XXIV of the Insurance Company Law.

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

(3) The provisions of Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Network." As follows:

(1) The providers and health care facilities who have contracted directly or indirectly to provide health care services to the insureds under a health insurance policy plan.

"Network plan." A health care plan that uses a network to provide services to insureds,

"Observation Status." When a patient receives onsite services from a hospital, including a hospital bed and meals, and the patient has not been formally admitted as a inpatient at the hospital.

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

"Out-of-network provider." A health care provider who is not contracted with an insurer to provide services to insureds of a health insurance policy.

"Payment rate." Allowed amounts for a particular health care service performed by a provider which is in the same or similar specialty and provided in the same geographic area as reported in a conflict-free, independent benchmarking database maintained by a nonprofit organization designated by the commissioner and not financially affiliated with an insurer or provider.

"Practice group." A group practice consists of a single legal entity operating primarily for the purpose of being a physician group practice in any organizational form recognized by the Commonwealth of Pennsylvania, including, but not limited to, a partnership, professional corporation, limited liability company, foundation, nonprofit corporation, faculty practice plan, or similar association. The single legal entity may be organized by any party or parties, including, but not limited to, physicians, health care facilities, or other persons or entities, (including, but not limited to, physicians individually incorporated a professional corporations). The single legal entity may be organized or owned(in whole or in part) by another medical practice.

"Provider." A facility, health care practitioner, institution or organization, whether for profit or nonprofit,

which has the primary purpose of providing health care services and is licensed or otherwise authorized to practice or provide health care services in this Commonwealth.

"Surprise balance bill." As follows:

(1) A balance bill for any of the following:

(i) A covered emergency service provided to an insured by an out-of-network provider.

(ii) A covered service provided to an insured by an out-of-network provider at an in-network facility when the insured did not know that the provider was out-of-network or did not choose to receive the service from the out-of-network provider.

(iii) 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, when the insured did not know that the provider was out-of-network or did not choose to receive the service from the out-of-network provider.

(3) The term does not include any of the following:

(i) A balance bill for a health care service rendered by an out-of-network provider when the insured has the ability to select an in-network provider and the insured has elected to receive the service from an out-of-network provider rather than an in-network provider.

(ii) A health care service for which an entity, other than an insurer under a health insurance policy, is responsible.

(iii) A bill for health care service which an

insurer has determined is not covered or payable as per the health insurance policy.

(iv) Cost-sharing, such as a copayment, coinsurance, deductible or similar charge.

(4) Nothing in this definition shall be construed to prohibit an insurer or provider from appropriately utilizing reasonable medical management techniques for nonemergency, services.

§ 3404. Applicability.

(a) General rule.--Except as provided in subsection (b), this chapter applies to any of the following:

(1) Insurer

(2) A health care practitioner.

(3) A facility.

(b) Bills and services. --This chapter does not apply to any of the following:

(1) A balance bill for a health care service rendered by an out-of-network provider when an in-network provider is available and the insured has elected to receive the service from an out-of-network provider instead of an in-network provider.

SUBCHAPTER B

PROCEDURES

Sec.

3411. Surprise balance bills process.

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3413. Provider notice to insureds.

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3419. Mutual agreement.

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3422. Written disclosure by facilities and providers.

3423. Contents of written disclosures.

3411. Surprise balance bills process.

(a) Claims.--An out-of-network provider that renders a health care service covered by this chapter to an individual known to be covered by a health insurance policy that the provider is non participating, shall when submitting a claim to the insurer identify the claim as originating from an out-of-network provider.

(b) The out-of-network provider shall submit a claim for the payment as defined in this chapter, for the health care service to the insured's insurer, rather than a bill to the insured, and may not bill the insured for any amount in excess of the cost-sharing amounts that would have been imposed if the health care service had been rendered by an in-network provider.

(c) Collections. --An out-of-network provider may not advance a surprise balance bill to collections.

(d) Liability.--An out-of-network provider who, on a case-by-case basis, determines to waive a cost for an insured in a health plan based upon economic circumstances of the insured, including a balance

billed amount, copayment or coinsurance, shall not be subject to any of the following:

(1) A civil cause of action by a health plan.

(2) Prosecution for a violation of this chapter in a court of competent jurisdiction.

(3) A sanction before any State oversight board.

(4) An approval requirement of a health plan

§ 3412. Notice to insureds.

(a) Mandatory information. An insurer shall supply upon request or make available on a public accessible website to each insured required disclosures as required in Section 2136 of the Insurance Company Law.

Provider directories. (Amend Section 2136 15 (b)?? to add this to Provider directories Question for LRB

(1) Each directory shall contain the following general information in plain language for each network plan:

(i) If applicable, a description of the criteria the insurer has used to tier providers.

(ii) If applicable, how the insurer designates in its directory the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network the tier in which each type of facility is placed, such as by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier.

(iii) A customer service e-mail address and telephone number or electronic link that insureds or the public may use to

notify the insurer of inaccurate provider directory information.

(iv) Written and online directories shall in plain language display the last date is was updated.

(b) Online directory.--For the provider directory posted online, the insurer shall:

(1) Update the provider directory at least every seven days.

(2) Make available in a searchable format the following information for each network plan:

(i) For a health care professional:

(A) The name, contact information, gender and each participating office location of the health care professional.

(B) If applicable, the specialty, medical group affiliations, facility affiliations, participating facility affiliations and spoken languages, other than English, of the health care professional.

(C) Whether the health care practitioner is accepting new patients.

(ii) For a facility:

(A) The name and contact information of the facility.

(B) The type of facility, such as acute, rehabilitation, children's, outpatient, or cancer hospital.

(C) The location of each participating facility.

(D) The accreditation status of the facility.

§ 3413. Health care practitioner notice to insureds.

(a) Applicability. --This section applies only to the provision of nonemergency services.

(b) Disclosure.--At the time an appointment is scheduled and in writing or through a publicly accessible Internet website

prior to providing services, a health care provider or the provider's representative shall disclose to the insured in writing or through the website the health insurance plans in which the health care practitioner participates and the hospitals with which the provider is affiliated. The insured must affirmatively acknowledge receipt of written disclosure in writing.

§ 3414. Facility notices to insureds.

(a) Applicability. --This section applies only to the provision of nonemergency services.

(b) List of charges.--A facility shall establish, update and make public through posting on its publicly accessible Internet website, to the extent required by Federal guidelines, a list of the facility's standard charges for items and services provided by the facility, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395ww(d)(4)).

(c) Website information. --A facility shall post on its publicly accessible Internet website the following:

(1) The networks in which the facility is a participating provider.

(2) A statement that:

(i) health care practitioners' services provided in the facility are not included in the facility's charges;

(ii) health care practitioners who provide services in the facility may or may not participate with the same health benefit plans as the facility;

(iv) the insured should check with the provider

arranging for the insured to receive services in the facility to determine whether that provider participates in the insured's health care plan network.

§ 3415. Emergency services provided by out-of-network provider.

(a) Effect on consumer. --An out-of-network emergency service bill, subject to this chapter, is a surprise balance bill, and the consumer shall be held harmless, except for cost-sharing.

(b) Direct billing and rate. --The out-of-network emergency provider shall directly bill the insurer the payment rate for the health service rendered. The insurer shall directly pay the out-of-network provider.

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§ 3419. Mutual agreement.

(a) Insurer and out-of-network provider.--Nothing in this chapter shall prevent an insurer and an out-of-network provider from mutually agreeing to a payment amount for a health care service which is different from the requirements under this chapter.

§ 3420. Health service payments.

If an out-of-network provider submits to an insurer a surprise balance bill claim for a health care service covered by this chapter, the following apply:

(1) The insurer shall pay the claim at the payment rate under the current procedural terminology code directly to the out-of-network provider in accordance with the payment

requirements under section 2166 of the Insurance Company Law, minus the amount determined under paragraph (2). The insurer shall deduct the applicable patient cost-sharing amount owed by the patient under the insured's health insurance policy from the payment made under this paragraph and provide an explanation of benefits within 45 days to the insured which delineates the cost-sharing amount that is the responsibility of the insured.

(2) The out-of-network provider may bill the insured for the cost-sharing amount as determined from the insurer.

§ 3421. Communications to consumers.

(a) Departmental notice.--The department shall provide a notice on the department's publicly accessible Internet website containing the following:

(1) Information for consumers of health care coverage specifying the protections provided under this chapter.

(2) Information regarding the process by which consumers may report and file complaints with the department or another appropriate regulatory agency relating to surprise balance bills.

§ 3422. Written disclosure by facilities and health care practitioners.

(a) Disclosure. --

(1) Whenever a facility or health care practitioner schedules, either through registration or admission, a nonemergency health care service for an insured, or seeks prior authorization from an insurer for a health care service to an insured that may include a health care service by an

out-of-network provider, the facility or health care practitioner shall provide the insured with an out-of-network service written disclosure.

(2) Whenever a facility or emergency service provider provides emergency services, the written disclosure notice shall be provided to the insured when the insured has been stabilized and is clinically able to receive the written disclosure notice.

(c) Form and content of written disclosure.--The department may specify the form and content of any written disclosure required under this section.

§ 3423. Contents of written disclosures by facilities and health care practitioners.

(a) Contents generally.--A written disclosure shall include the following:

(1) The rights of insureds under this chapter.

(2) The identification of the department as the proper Commonwealth agency to receive complaints relating to surprise balance bills prohibited under this chapter.

(3) Contact information for the department.

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

(5) A general notice that the insured may contact the insured's health insurance insurer and provider if there are any questions about coverage before receiving treatment.

(6) An explanation of how surprise bills or bills for services rendered by out-of-network providers are addressed

by this chapter and that an insured is only responsible for any applicable cost-sharing under the insured's insurance policy.

(7) The contact information for a health care facilities patient advocate, if the consumer is sent a surprise balance bill.

SUBCHAPTER C

ENFORCEMENT

Sec.

§ 3431. Authority.

(a) Enforcement and investigations.--

(1) The department, the Department of Health, the Department of State shall have authority to enforce this chapter.

(2) The appropriate Commonwealth agency may investigate potential violations under this chapter based upon information received from insureds, insurers, providers and other sources in order to ensure compliance with this chapter.

(b) Effect of chapter.--Nothing in this chapter shall be

construed to limit the ability of the department, the Department of Health, the Department of State from using information received under this chapter in the course of its duties under any other law of this Commonwealth.

§ 3432. Insurer violations.

(a) Imposition of penalties.--Upon satisfactory evidence of a violation of this chapter by an insurer, the commissioner may, in the commissioner's discretion, impose any of the penalties specified under section 5 of the act of June 25, 1997 (P.L.295, No.29), known as the Pennsylvania Health Care Insurance Portability Act.

(b) Nonexclusive remedies.--The enforcement remedies imposed under this section are in addition to any other remedies or penalties that may be imposed under any other applicable law of this Commonwealth, including the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act. A violation of this chapter by an insurer shall be deemed to be an unfair method of competition and an unfair or deceptive act or practice under the Unfair Insurance Practices Act.

(c) Referral. --Upon receipt or discovery of evidence of a potential violation of this chapter by a provider, the department may refer the matter to the Department of Health, the Department of State or the Office of Attorney General, as may be appropriate.

§ 3433. Health care practitioner violations.

(a) Disciplinary action.-- A practitioner who violates this chapter is subject to an administrative penalty of one hundred dollars ($100) for the first through tenth violations and two

hundred and fifty dollars ($250) for each subsequent violation after the tenth violation, up to a maximum of five thousand dollars ($5,000) per calendar year. Violations shall reset and shall not carry over to subsequent calendar years. The assessment of an administrative penalty pursuant to this chapter by the department to a practitioner alleged to have violated shall not be considered a disciplinary action or need to be reported by the practitioner as a violation to the practitioner's appropriate licensing board.

(b) Fines. --Money collected under this section as a fine shall be deposited into the fund specified under the applicable law of this Commonwealth relating to professional licensure under which the disciplinary action is taken.

§ 3434. EMS agency and facility violations.

(a) EMS agency. --A violation of section 3415 (relating to surprise balance bills) or 3423(b) (relating to contents of written disclosures) by an EMS agency shall subject the EMS agency to the penalties provided for in 35 Pa.C.S. Ch. 81 (relating to emergency medical services system).

(b) Facility. --A violation of section 3415 or 3423(b) by a facility shall subject the facility to the penalties provided for in the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

(c) Penalties. --Money collected under this section as a penalty shall be deposited into the General Fund.

§ 3435. Administrative procedures.

(a) Procedures generally. --The administrative provisions of this subchapter shall be subject to 2 Pa.C.S. Ch. 5 Subch. A

(relating to practice and procedure of Commonwealth agencies).

(b) Appeals. --A party against whom penalties are assessed in an administrative action may appeal to Commonwealth Court as provided in 2 Pa.C.S. Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

§ 3436. Enforcement remedies.

The enforcement remedies imposed under this subchapter shall be in addition to any other remedies or penalties that may be imposed under the laws of this Commonwealth.

§ 3437. Duplicative penalties.

Two or more Commonwealth agencies may not impose a penalty on the same insurer or provider for the same violation. A Commonwealth agency that imposes a penalty under this chapter shall notify the department of the imposition of the penalty.

§ 3438. Private cause of action.

Nothing in this chapter shall be construed to create or imply a private cause of action for a violation of this chapter other than as permitted under the act of December 17, 1968 (P.L.1224, No.387), known as the Unfair Trade Practices and Consumer Protection Law.

§ 3439. Regulations.

The department, the Department of Health and the Department of State, in conjunction and collaboration, may each promulgate regulations as may be necessary to implement and enforce this chapter.

Section 3. This act shall take effect as follows:

(1) The following shall take effect immediately:

(i) This section.

(2) The remainder of this act shall take effect in 180 days.

Question for LRB: Repeal Act 84 of 2015 ?????? or use exemption language.