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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1158 Session of 2015

INTRODUCED BY SCHWANK, COSTA, SABATINA, FONTANA, YUDICHAK, TARTAGLIONE, BLAKE, FARNESE, HAYWOOD AND WILLIAMS, MARCH 22, 2016

REFERRED TO BANKING AND INSURANCE, MARCH 22, 2016

AN ACT

Prohibiting emergency medical and health care services surprise billing.

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

Section 1. Short title.

This act shall be known and may be cited as the Emergency Medical and Health Care Services Surprise Billing Prevention Act.

Section 2. Definitions.

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

"Carrier." An entity licensed by the department to issue a health insurance policy that is offered or governed under any of the following:

(1) The Insurance Company Law of 1921.

(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).

"Department." The Insurance Department of this Commonwealth.

"Emergency." The term as defined in 35 Pa.C.S. Ch. 81 (relating to emergency medical services system). ????

"Emergency services." A health care service provided to a patient after the onset of an emergency. The term includes:

(1) "Emergency services" as defined in section 2102 of the Insurance Company Law of 1921.

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

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

"Health insurance policy." A health, sickness or accident policy or subscriber contract or certificate issued by a carrier that provides medical or health care coverage by a health care facility or licensed health care provider. The term shall not include any of the following:

(1) An accident only policy.

(2) A credit only policy.

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

(4) A specified disease policy.

(5) A Medicare supplement policy.

(6) A TRICARE policy, including a Civilian Health and

Medical Program of the Uniformed Services (CHAMPUS) supplement policy.

(7) A fixed indemnity policy.

(8) A dental only policy.

(9) A vision only policy.

(10) A workers' compensation policy.

(11) An automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).

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

"In-network." Having a contract with a carrier of a health care plan to provide health care services to an insured individual.

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

"Insured individual." A patient covered under a health insurance policy.

"Out-of-network." Not having a contract with a carrier of a health care plan to provide health care services to an insured individual.

"Patient." An individual who receives health care services, including emergency services.

"Provider." 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. The term includes:

(1) A health service doctor as defined in 40 Pa.C.S. § 6302 (relating to definitions).

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

(3) A practice group.

"Resolution organization." A qualified independent third-party claim dispute resolution entity selected by and contracted with the department.

"Surprise bill." A bill for health care services, other than emergency services, received by any of the following:

(1) An insured individual for services rendered by an out-of-network provider at an in-network hospital or ambulatory surgical center, if an in-network provider is unavailable, an out-of-network provider renders services without the insured individual's knowledge or unforeseen medical services arise at the time the health care services are rendered. The term shall not include a bill received for health care services if an in-network provider is available and the insured individual has elected to obtain services from an out-of-network provider.

(2) An insured individual for services rendered by an out-of-network provider, if the services were referred by an in-network provider to an out-of-network provider without explicit written consent of the insured individual acknowledging that the in-network provider is referring the insured individual to an out-of-network provider and that the referral may result in costs not covered by the health insurance policy.

"Usual and customary cost." The 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization which is specified by the department and is not affiliated with another entity subject to

this act.

Section 3. Applicability.

(a) Surprise bill.--Except as provided under subsection (b), this act shall apply to the determination of and dispute resolution process for bills for emergency service and surprise bills.

(b) Exemption.--This act shall not apply to health care services, including emergency services, if provider fees are subject to schedules or other monetary limitations under any other law.

Section 4. Hold harmless and assignment of benefits.

If an insured individual assigns benefits for a surprise bill in writing to an out-of-network provider that knows the insured individual is an insured individual under a health care plan, the out-of-network provider may not bill the insured individual except for an applicable copayment, coinsurance or deductible that would be owed if the insured individual utilized an in-network provider.

Section 5. Dispute resolution process.

(a) Establishment.--The department shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved.

(b) Selection and certification.--The department shall promulgate regulations establishing standards for the dispute resolution process, including a process for certifying and selecting resolution organizations.

(c) Revocation.--The department may grant and revoke certifications of resolution organizations to conduct the dispute resolution process.

Section 6. Reasonable fees.

In determining the appropriate amount to pay for a health care service, a resolution organization must consider all relevant factors, including:

(1) If there is a gross disparity between the fee charged by the provider for services rendered as compared to:

(i) Fees paid to the involved provider for the same services rendered by the provider to other patients in health care plans in which the provider is out of network.

(ii) In the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified providers for the same services in the same region who are out of network with the health care plan.

(2) The level of training, education and experience of the provider.

(3) The provider's usual charge for comparable services with regard to patients in health care plans in which the provider is not in network.

(4) The circumstances and complexity of the particular case, including time and place of the service.

(5) The individual patient's characteristics.

(6) The usual and customary cost of the service.

Section 7. Dispute resolution for emergency services.

(a) Insured individual.--

(1) If a carrier receives a bill for emergency services from an out of network provider, the carrier must:

(i) Pay an amount that the carrier determines is reasonable for the emergency services rendered by the out-of-network provider in accordance with section 2116

of The Insurance Company Law of 1921, except for the insured individual's copayment, coinsurance or deductible.

(ii) Ensure that the insured individual will incur no greater out-of-pocket costs for the emergency services than the insured individual would have incurred with an in-network provider under the Insurance Company Law of 1921.

(2) An out-of-network provider or a carrier may submit a dispute regarding a fee or payment for emergency services for review to a resolution organization.

(3) A resolution organization must make a determination within 30 days of receipt of the dispute for review.

(4) In determining a reasonable fee for the services rendered, a resolution organization must select either the carrier's payment or the out-of-network provider's fee. The resolution organization must determine which amount to select based upon the conditions and factors under section 6. If a resolution organization determines, based on the carrier's payment and the out-of-network provider's fee, that a settlement between the carrier and out-of-network provider is reasonably likely or that both the carrier's payment and the out-of-network provider's fee represent unreasonable extremes, the resolution organization may direct both parties to attempt a good faith negotiation for settlement. The carrier and out-of-network provider may be granted up to 10 business days for the negotiation, which shall run concurrently with the 30-day period for dispute resolution.

(b) Noninsured individual.--

(1) A patient who is not an insured individual or the

patient's provider may submit a dispute regarding a fee for emergency services for review to a resolution organization upon approval of the department.

(2) A resolution organization must determine a reasonable fee for the services based upon the same conditions and factors under section 6.

(3) A patient who is not an insured individual may not be required to pay the provider's fee in order to be eligible to submit the dispute for review to a resolution organization.

(c) Determination.--A determination of a resolution organization shall be binding on the carrier, provider and patient and admissible in a court proceeding between the carrier, provider or patient or in any administrative proceeding between the Commonwealth and the provider.

Section 8. Dispute resolution for surprise bills.

(a) Assigned benefits.--The following shall apply to a surprise bill received by an insured individual who assigns benefits:

(1) If an insured individual assigns benefits to an out-of-network provider, the carrier must pay the out-of-network provider in accordance with paragraphs (2) and (3).

(2) The out-of-network provider may bill the carrier for the health care services rendered and the carrier must pay the out-of-network provider the billed amount or attempt to negotiate reimbursement with the out-of-network provider.

(3) If the carrier's attempts to negotiate reimbursement for health care services provided by an out-of-network provider does not result in a resolution of the payment dispute between the out-of-network provider and the carrier,

the carrier must pay the out-of-network provider an amount the carrier determines is reasonable for the health care services rendered, except for the insured individual's copayment, coinsurance or deductible, in accordance with the Insurance Company Law of 1921.

(4) Either the carrier or the out-of-network provider may submit the dispute regarding the surprise bill for review to a resolution organization, except that the carrier may not submit the dispute unless the carrier has complied with the requirements of paragraphs (1), (2) and (3).

(5) The resolution organization must make a determination within 30 days of receipt of the dispute for review.

(6) If determining a reasonable fee for the services rendered, the resolution organization shall select either the carrier's payment or the out-of-network provider's fee. A resolution organization must determine which amount to select based upon the conditions and factors under section 6. If a resolution organization determines, based on the carrier's payment and the out-of-network provider's fee, that a settlement between the carrier and out-of-network provider is reasonably likely or that both the carrier's payment and the out-of-network provider's fee represent unreasonable extremes, the resolution organization may direct both parties to attempt a good faith negotiation for settlement. The carrier and out-of-network provider may be granted up to 10 business days for the negotiation, which shall run concurrently with the 30-day period for dispute resolution.

(b) Nonassigned benefits or noninsured individual.--

(1) An insured individual who does not assign benefits

in accordance with subsection (a) or a patient who is not an insured individual and who receives a surprise bill may submit a dispute regarding the surprise bill for review to a resolution organization.

(2) The resolution organization must determine a reasonable fee for the services rendered based upon the conditions and factors under section 6.

(3) A patient or insured individual who does not assign benefits in accordance with subsection (a) may not be required to pay the provider's fee to be eligible to submit the dispute for review to the resolution organization.

(c) Determination.--The determination of a resolution organization shall be binding on the patient or insured individual, provider and carrier and admissible in a court proceeding between the patient or insured individual, provider or carrier or in an administrative proceeding between the Commonwealth and the provider.

Section 9. Payment for resolution organization.

(a) Insured individual.--For disputes involving an insured individual one of the following shall apply:

(1) If the resolution organization determines the carrier's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the out-of-network provider.

(2) If the resolution organization determines the out-of-network provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the carrier.

(3) If a good faith negotiation directed by the resolution organization under section 7(a)(4) or section 8(a)

(6) results in a settlement between the carrier and out-of-network provider, the carrier and the out-of-network provider must evenly divide and share the prorated cost for dispute resolution.

(b) Noninsured individual.--For disputes involving a patient who is not an insured individual one of the following shall apply:

(1) If the resolution organization determines the provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient. The department shall promulgate a regulation to determine payment for the dispute resolution process in cases of hardship.

(2) If the resolution organization determines the provider's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the provider.

Section 10. Effective date.

This act shall take effect in 60 days.