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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1553 Session of 2017

INTRODUCED BY BAKER, PICKETT, FRANKEL, DIAMOND, CALTAGIRONE, V. BROWN, IRVIN, JAMES, MILLARD, DeLUCA, DRISCOLL, SCHLOSSBERG, KAUFER, KINSEY, D. COSTA, M. QUINN, SIMMONS, FABRIZIO, WARREN, WARD, PASHINSKI, ROAE, ENGLISH, EVERETT, RADER, BIZZARRO, GABLER, WHEELAND, ZIMMERMAN, CORR, MARSHALL AND WATSON, JUNE 16, 2017

AS REPORTED FROM COMMITTEE ON HEALTH, HOUSE OF REPRESENTATIVES, AS AMENDED, DECEMBER 11, 2017

AN ACT

Providing for the protection of consumers of health care coverage against surprise balance bills for emergency health care services or for other covered health care services when health care services are sought from in-network ~~facilities~~ PROVIDERS. <-- <--

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

CHAPTER 1

PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Surprise Balance Bill Protection Act.

Section 102. 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:

"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.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Confidential information." Nonpublic personal health information, trade secret or confidential proprietary information which is produced by, obtained by or disclosed to the department, the Department of Health, the Department of State, the Office of Attorney General, a resolution organization

assigned to a dispute under Chapter 3 or any other person in the course of a dispute resolution under this act.

"Confidential proprietary information." Commercial or financial information that:

(1) is privileged or confidential; and

(2) if disclosed, would cause substantial harm to the competitive position of the person that submitted the information.

"Cost-sharing." A copayment, coinsurance, deductible or similar charge. The term does not include premiums, balance billing amounts or the cost of noncovered services.

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

"Department." The Insurance Department of the Commonwealth.

"Emergency medical services agency" or "EMS agency." As defined in 35 Pa.C.S. § 8103 (relating to definitions).

"Emergency service." 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. The term includes the following:

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

(2) 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.

(3) If the insured is admitted into a facility, a health care service rendered prior to transfer or discharge.

"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." 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 all of the following:

(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.

(4) A licensed individual who provides health care

services to patients of a facility under clinical privileges granted by the facility.

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

"Health care service." As follows:

(1) All of the following categories of services:

(i) A covered treatment.

(ii) An admission.

(iii) A procedure.

(iv) Medical supplies and equipment.

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

(2) All of the following types of services:

(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 provider, including, but not limited to, radiology, pathology, anesthesiology, neonatology, ~~hospital~~ HOSPITALIST services and diagnostic interpretation. <--

"Health information." Information or data, whether oral or recorded in any form or medium, created by or derived from a provider or an insured that relates to any of the following:

(1) The PAST, PRESENT OR FUTURE physical, mental or behavioral health or condition of an individual. <--

(2) The provision of a health care service to an individual.

(3) Payment for the provision of a health care service to an individual.

"Health insurance policy." A policy, subscriber contract, certificate or plan issued by an insurer that provides medical or health care coverage. The term does 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 fixed indemnity policy.

(7) A dental only policy.

(8) A vision only policy.

(9) A workers' compensation policy.

(10) An automobile medical payment policy.

(11) A POLICY UNDER WHICH BENEFITS ARE PROVIDED BY THE FEDERAL GOVERNMENT TO ACTIVE OR FORMER MILITARY PERSONNEL AND THEIR DEPENDENTS. <--

~~(11)~~ (12) Any other similar policies providing for limited benefits. <--

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

"Insurance fraud." An offense under 18 Pa.C.S. § 4117 (relating to insurance fraud).

"Insured." 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. 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. NOTHING IN THIS DEFINITION SHALL BE CONSTRUED TO PROHIBIT AN AUTHORIZED REPRESENTATIVE FROM ACTING ON BEHALF OF AN INSURED. <--

"Insurer." An entity licensed by the department with ~~the~~ 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 act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921~~.~~, INCLUDING SECTION 630 AND ARTICLE XXIV OF 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) The provisions of 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Network." The health care providers designated by an insurer to provide health care services to insureds in a health care plan.

"Nonpublic personal health information." Health information that:

(1) identifies an individual who is the subject of the information; or

(2) ~~can provide a reasonable basis~~ AN INDIVIDUAL WOULD REASONABLY BELIEVE COULD BE USED to identify an individual. <--

"Out-of-network provider." A provider who does not contract with an insurer to provide health care services to an insured under the insured's health care plan.

"Practice group." Any of the following:

(1) Two or more health care practitioners legally organized in an entity recognized by the Commonwealth, including a partnership, professional corporation, limited liability company formed to render health care services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity, if any of the following are satisfied:

(i) Each health care practitioner provides ~~a substantial amount of the same~~ SUBSTANTIALLY THE FULL range of services that each health care practitioner routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel. <--

(ii) The ~~entity provides a substantial amount of its~~ HEALTH CARE PRACTITIONERS PROVIDE A SUBSTANTIAL AMOUNT OF THEIR services through the entity, services are billed in the name of the entity and payments are treated as receipts ~~to~~ OF the entity. <--

(iii) The entity's overhead expenses and the ENTITY'S income are assessed or distributed in accordance with methods previously determined by members of the entity. <--

(2) An entity in which the entity's shareholders, partners or owners include single-practitioner professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual health care practitioners.

"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 in this Commonwealth.

"Record custodian." The department, the Department of Health, the Department of State, a resolution organization assigned to a dispute under section 304 or a person who possesses or controls confidential information.

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

"Service area." The geographic area where a health care plan is offered.

~~"Surprise balance bill." A balance bill for any of the following:~~ <--

~~(1) A covered emergency service provided to an insured by an out-of-network provider, not including a bill for an emergency medical service for which an emergency medical services agency may register with the Department of Health for direct reimbursement under section 635.7 of The Insurance Company Law of 1921.~~

~~(2) A covered service provided to an insured by an out-of-network provider at an in-network facility in circumstances when the insured did not know the provider was out-of-network or did not choose to receive the service from the out-of-network provider by having requested to receive the service from an in-network provider.~~

~~(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, in circumstances when the insured did not~~

~~know the provider was out-of-network or did not choose to receive the service from the out-of-network provider by having requested to receive the service from an in-network provider.~~

"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, NOT INCLUDING A BILL FOR AN EMERGENCY MEDICAL SERVICE FOR WHICH AN EMERGENCY MEDICAL SERVICES AGENCY HAS REGISTERED WITH THE DEPARTMENT OF HEALTH FOR DIRECT REIMBURSEMENT UNDER SECTION 635.7 OF THE INSURANCE COMPANY LAW OF 1921.

(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 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 THE PROVIDER WAS OUT-OF-NETWORK OR DID NOT CHOOSE TO RECEIVE THE SERVICE FROM THE OUT-OF-NETWORK PROVIDER.

(IV) A COVERED SERVICE PROVIDED TO AN INSURED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY WHEN THE INSURED DID NOT HAVE THE ABILITY TO MAKE AN INFORMED CHOICE OF THE PROVIDER OF THE HEALTH CARE SERVICE.

(2) 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 AN IN-NETWORK

PROVIDER IS AVAILABLE 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.

(3) NOTHING IN THIS DEFINITION SHALL BE CONSTRUED TO PROHIBIT AN INSURER FROM APPROPRIATELY UTILIZING REASONABLE MEDICAL MANAGEMENT TECHNIQUES.

"Trade secret." Information that:

(1) derives independent economic value, actual or potential, from not being generally known to and not being readily ascertainable by proper means by other persons who can obtain economic value from disclosure or use of the information; and

(2) is the subject of efforts that are reasonable under the circumstances to maintain the secrecy of the information.

"USUAL, CUSTOMARY AND REASONABLE RATE." THE SEVENTY-FIFTH PERCENTILE OF ALL CHARGED 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 BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION DESIGNATED BY THE COMMISSIONER AND NOT AFFILIATED WITH AN INSURER OR PROVIDER. <--

CHAPTER 3

BALANCE BILLING AND PAYMENT

Section 301. Duty of facilities to provide written disclosure.

(a) Disclosure.--Whenever an in-network facility schedules a health care service or seeks prior authorization from an insurer for the provision of a health care service to an insured that is

expected to include the provision of a health care service by an out-of-network provider~~, but not earlier than 10 business days prior to admission or date of service~~ AND THERE ARE 10 BUSINESS DAYS BETWEEN THE DATE WHEN THE HEALTH CARE SERVICE IS SCHEDULED AND THE DATE WHEN THE HEALTH CARE SERVICE IS SCHEDULED TO BE PROVIDED, the facility shall provide the insured with an out-of-network service written disclosure. ~~Nothing in this act shall prohibit an insurer from appropriately utilizing reasonable medical management techniques.~~ NOTICE PROVIDED LESS THAN 10 BUSINESS DAYS BEFORE THE DATE WHEN THE HEALTH CARE SERVICE WILL BE PROVIDED SHALL NOT BE CONSIDERED FAIR NOTICE TO ALLOW THE INSURED TO MAKE AN INFORMED CHOICE TO RECEIVE A HEALTH CARE SERVICE FROM AN OUT-OF-NETWORK PROVIDER. <-- <-- <--

(b) Provisions.--The out-of-network service written disclosure under subsection (a) shall include the following:

(1) One or more named out-of-network providers that are expected to be called upon to render a health care service to the insured during the course of treatment.

(2) The out-of-network ~~providers~~ PROVIDER may not have a contract with the insurer and is therefore considered to be out-of-network. <--

(3) A health care service rendered by the named provider will be provided on an out-of-network basis.

(4) A description of the range of the charges for the out-of-network health care service.

(5) The manner in which the insured may obtain from the insurer an identification of in-network providers who may render the health care service and on how the insured may request and receive the health care service from an in-network provider.

(6) The insured may rely on the rights and remedies that may be available under Federal or State law, contact the insurer for additional assistance or agree to accept and pay the charges for the health care service by the out-of-network provider on an out-of-network basis.

Section 302. Surprise balance bills.

(a) Prohibition.--The following apply:

(1) An out-of-network provider which renders a health care service COVERED BY THIS ACT to an insured may not surprise balance 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. Upon request, the insurer shall furnish to the out-of-network provider a statement of the applicable in-network cost-sharing amounts owed by the insured to the provider. The insured shall be responsible for no more than the cost-sharing amounts that would have been due if the service had been rendered by an in-network provider. <--

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

(b) ~~Assignment of benefits~~ FORM SUBMISSION.--The following apply: <--

~~(1) An out-of-network provider of a health care service which does not surprise balance bill an insured shall be deemed to have received an assignment of benefits from the insured and any reimbursement paid by the insurer shall be paid directly to the out-of-network provider.~~ <--

~~(2)~~ If an insured receives a surprise balance bill, the insured may submit to the insurer a surprise balance bill form as specified under subsection (c) for the purpose of

declaring the bill to be a surprise balance bill. ~~Submission of the surprise balance bill form to the insurer by the insured shall effect an assignment of the insured's benefits to the out-of-network provider.~~ An insured who submits a surprise balance bill form to the insurer, except in the case of insurance fraud, shall be held harmless from all costs except the in-network cost-sharing amount that would otherwise have been due. <--

(c) Form.--The following apply:

(1) The department shall specify the content and format of the surprise balance bill form. A draft of the surprise balance bill form and any substantive revisions of the draft shall be published on the department's publicly accessible Internet website and in the Pennsylvania Bulletin for a 30-day comment period prior to the final form being published. The final form and any substantive revisions of the final form shall be published on the department's publicly accessible Internet website and in the Pennsylvania Bulletin. Upon request, the department shall make the surprise balance bill form available in hard copy. The surprise balance bill form shall include the following:

(i) A description of a surprise balance bill.

~~(ii) A description of the assignment of benefits affected by submission of the surprise balance bill form.~~ <--

~~(iii)~~ (II) A description of the hold harmless protection ~~affected~~ EFFECTED by submission of the surprise balance bill form. <--

~~(iv)~~ (III) An explanation of the purpose of submitting the surprise balance bill form and the surprise balance bill to the insurer. <--

~~(v)~~ (IV) An explanation of what constitutes insurance fraud in the context of submitting the surprise balance bill form, including the criminal and civil penalties for insurance fraud under the laws of this Commonwealth. <--

(2) An insurer shall make available on the insurer's publicly accessible Internet website and include in the insured's health insurance policy form information on how to access and submit a surprise balance bill form.

(3) When an insured receives a health care service that may be subject to a surprise balance bill, a provider or insurer associated with the service shall make a good faith effort to notify the insured of the protections specified under this act, including all of the following:

(i) The surprise balance bill form as specified under this subsection.

(ii) The method to submit the surprise balance bill to the insurer. This may include referencing the availability of the surprise balance bill form on a provider bill, explanation of benefits or the insurer's Internet website or making the surprise balance bill form available in hard copy.

(d) Overpayment.--If the insured pays an out-of-network provider more than the in-network cost-sharing amount, all of the following apply:

(1) The OUT-OF-NETWORK provider shall refund to the insured within 30 business days of receipt any amount paid in excess of the in-network cost-sharing amount. <--

(2) If an out-of-network provider has not made a full refund of any amount paid in excess of the in-network cost-

sharing amount to the insured within 30 business days of receipt, interest shall accrue at the rate of 10% per annum beginning with the first calendar day after the 30-business day period. A violation of this ~~paragraph~~ SECTION shall be a violation of the act of December 17, 1968 (P.L.1224, No.387), known as the Unfair Trade Practices and Consumer Protection Law. <--

(e) Cost-sharing amount.--An insurer shall count each payment that an insured makes to satisfy a surprise balance bill toward an insured's in-network deductible and maximum out-of-pocket cost-sharing amount.

(f) Applicability.--The following apply:

(1) For a health insurance policy which requires rates or forms be filed with the Federal Government or the department, this section shall apply to any policy for which a form or rate is first permitted to be used within 180 days of the effective date of this subsection.

(2) For a health insurance policy which does not require rates or forms to be filed with the Federal Government or the department, this section shall apply to any policy issued or renewed on or after 180 days from the effective date of this subsection.

Section 303. Direct dispute resolution.

(a) Mutual agreement.--The following apply:

(1) Nothing in this section 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 section.

(2) Nothing in this section shall prevent an insurer from addressing the availability and use of in-network

providers in the insurer's contracts with in-network facilities and in-network providers who make referrals to other providers.

(3) NOTHING IN THIS SECTION SHALL SUPERSEDE EXISTING AGREEMENTS BETWEEN INSURERS AND PROVIDERS IN INSTANCES OF SURPRISE BALANCE BILLING. <--

~~(b) Health care service payments.--If an insurer receives a~~ <--

(B) HEALTH CARE SERVICE PAYMENTS.-- <--

(1) IF AN INSURER RECEIVES A surprise balance bill form ~~and bill from an insured~~, or if an out-of-network provider submits to an insurer a ~~bill~~ CLAIM for a health care service covered by this act, the following apply: <--

~~(1) The insurer shall pay, in accordance with the prompt~~ <--

(2) PAYMENT UNDER PARAGRAPH (1) SHALL BE IN ACCORDANCE WITH THE FOLLOWING: <--

(I) IF THE CLAIM BY THE OUT-OF-NETWORK PROVIDER IN EXCESS OF $500, EITHER PARTY MAY INITIATE THE INDEPENDENT DISPUTE RESOLUTION PROCESS UNDER SECTION 304.

(II) IF THE CLAIM BY THE OUT-OF-NETWORK PROVIDER IS $500 OR LESS, THE INSURER SHALL REIMBURSE THE OUT-OF-NETWORK PROVIDER THE GREATER OF:

(A) THE AMOUNT THAT WOULD HAVE BEEN PAID FOR THE CLAIM UNDER THE INSURED'S HEALTH INSURANCE POLICY HAD THE SERVICE WHICH IS THE SUBJECT OF THE CLAIM BEEN RENDERED BY AN IN-NETWORK PROVIDER; OR

(B) THE USUAL, CUSTOMARY AND REASONABLE RATE FOR THE OUT-OF-NETWORK PROVIDER'S SERVICES.

(III) THE INSURER SHALL PAY, IN ACCORDANCE WITH THE PROMPT payment requirements under section 2166 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance

Company Law of 1921, the out-of-network amount due under the health insurance policy or as required by Federal law.

~~(2) Payment under paragraph (1) shall be made directly~~ <--

(IV) PAYMENT UNDER SUBPARAGRAPH (I) SHALL BE MADE <-- DIRECTLY to the provider in accordance with section 302(b).

~~(3) The insurer and provider may reach agreement as to~~ <--

(V) THE INSURER AND OUT-OF-NETWORK PROVIDER MAY <-- REACH AN AGREEMENT AS TO an additional amount to be paid for the OUT-OF-NETWORK provider's services, payment of <-- which, in addition to the applicable in-network cost-sharing amount owed by the insured, shall constitute payment in full to the OUT-OF-NETWORK provider for the <-- health care service rendered.

~~(4) If the provider and insurer do not reach an~~ <--

(VI) IF THE OUT-OF-NETWORK PROVIDER AND INSURER DO <-- NOT REACH AN agreement on a payment amount within 60 calendar days after the insurer receives the bill for the health care service, the OUT-OF-NETWORK provider or <-- insurer may submit the dispute for independent dispute resolution under section 304. The OUT-OF-NETWORK provider <-- or insurer may aggregate claims from the OUT-OF-NETWORK <-- provider to the insurer that are submitted for independent dispute resolution~~, including~~ TO INCLUDE all <-- claims pertaining to an insured from a single encounter.

Section 304. Independent dispute resolution.

(a) Arbitration.--The following apply:

(1) An independent dispute resolution process for the purpose of arbitrating disputes between an insurer and a

provider for payment for an out-of-network service covered by this act shall be administered in accordance with this section. The independent dispute resolution process shall permit private negotiations. Nothing in this section shall be construed to preclude an insurer and a provider from reaching a resolution of their dispute before the arbitrator issues a final award.

(2) The independent dispute resolution process shall be conducted by a resolution organization with the procedures as of the effective date of this section of the American Arbitration Association or similarly qualified organization as specified by the department. Except as otherwise set forth in this section, the independent dispute resolution process shall be in accordance with the procedures of the American Arbitration Association Healthcare Payor Provider Arbitration Rules, Desk/Telephonic Track, with fees calculated pursuant to the standard fee schedule and based on the monetary amount in dispute between the out-of-network provider's initial bill and the insurer's initial out-of-network payment.

(3) An arbitrator appointed to administer the independent dispute resolution process shall be impartial and independent of the parties and shall perform the arbitrator's duties with diligence and in good faith.

(4) The award obtained through the independent dispute resolution process shall be binding on ~~insurer and provider~~ <-- THE INSURER AND PROVIDER FOR ANY DISPUTE <-- involving the same claim code put forth in the demand for arbitration for a period of one year from the date of the award and shall not be appealable.

(5) A payment made by an insurer to a provider for an

award obtained through the independent dispute resolution process set forth under this subsection, in addition to the applicable cost-sharing owed by the insured who received the health care service that is the subject of the independent dispute resolution process, shall constitute payment in full for the health care service rendered.

(6) If an insurer or out-of-network provider submits ~~the~~ <-- A dispute for resolution, the insurer or out-of-network <-- provider shall also participate in the process as described in this section.

(b) Process.--The following apply:

(1) The party initiating the independent dispute resolution process shall file a demand for arbitration and the applicable administrative filing fee with the resolution organization and simultaneously send a copy of the demand to the department and the other party. The initiating party shall include on the demand the claim code, claim amount and complete contact information for both parties. The demand shall be transmitted in accordance with the resolution organization's procedures.

(2) Within 14 days after notice of the filing of the demand is sent under paragraph (1), the parties named in the demand shall EACH submit their best and final offer for the <-- amount in dispute with any supporting documents to each other and the resolution organization. The parties may negotiate a settlement within the 14-day period after notice of the filing is sent. If a settlement is reached, both parties shall advise the resolution organization and the department in writing. If the parties do not notify in writing the resolution organization that a settlement was reached during

the 14-day period after notice of the filing is sent, an arbitrator shall be appointed in accordance with the procedures of the resolution organization.

(3) Upon appointment of the arbitrator, the resolution organization shall require the parties to deposit the funds it deems necessary to cover the expense of arbitration, including arbitrator's fee, if any, and shall render an accounting to the parties and return any unexpended balance at the conclusion of the case. The deposit for arbitrator's fees shall be split evenly.

(4) After the arbitrator is appointed, the resolution organization shall transmit the parties' previously submitted best and final offers with any supporting documents to the arbitrator.

(5) In making an award under this subsection, the arbitrator may consider any of the following:

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

(ii) The provider's usual charge for comparable health care services provided in-network and out-of-network with respect to any health care plans.

(iii) The insurer's usual payment for comparable health care services provided in-network and out-of-network in the service area.

(iv) The payment for comparable health care services provided in the service area by any recognized standard, including Medicare or a median index.

(v) The availability of the health care service for the insured from in-network providers.

(vi) The propensity of the provider to be included

in networks and the propensity of the insurer to include providers in networks.

(vii) Payments made in prior surprise balance bill disputes between the provider and the insurer.

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

(ix) Any final awards between the insurer and provider for the same claim code from a period of one year prior.

(6) The arbitrator's award shall be one of the two amounts submitted by the parties as their best and final offers and shall be binding on both parties.

(7) The arbitrator shall issue a final binding award in writing, which shall include the final offers from each party and the claim code. The final binding award shall be issued within 30 days after the arbitrator receives the parties' best and final ~~offer~~ OFFERS and any supporting documents. Electronic copies of the final award shall be provided to both parties and the department. <--

(c) Cost allocations.--The following apply:

(1) In the final award, the arbitrator shall apportion the administrative fees, arbitrator compensation and expenses ~~between the parties~~ TO THE PREVAILING PARTY. <--

(2) A party that fails to pay all amounts due to the other party within 30 days of receiving the final award shall:

(i) pay interest to the prevailing party, calculated and paid in accordance with section 2166 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance

Company Law of 1921; and

(ii) be subject to a penalty of $100 per day, which the department shall transmit to the State Treasurer for deposit into the General Fund, until all payments are made in full.

(d) Resolution organization records.--A resolution organization shall ~~comply with all of the following~~: <--

(1) ~~Maintaining~~ MAINTAIN, in an easily accessible and retrievable format and delineated by year, records of the following: <--

(i) The written demand filed by the initiating party establishing the date the resolution organization receives a request for an independent dispute resolution.

(ii) Complete materials received from both parties.

(iii) The award.

(iv) The date the award was communicated to parties.

(2) ~~Documenting~~ DOCUMENT measures taken to appropriately safeguard the confidentiality of the records and prevent unauthorized use and disclosures under applicable Federal and State law. <--

(3) ~~Reporting~~ REPORT annually to the department in the aggregate: <--

(i) The total number of demands for arbitrations received by the resolution organization.

(ii) The total number of arbitrations concluded.

(iii) The method of disposition for arbitrations concluded, including arbitrations withdrawn due to settlement and the awards made.

(4) ~~Protecting~~ PROTECT from disclosure, except as set forth in section 502, any information specifically <--

identifying the insured who received the health care services that were the subject of an arbitration decision. The information shall be protected and remain confidential in compliance with all applicable Federal and State laws and regulations~~.~~ AND SHALL BE CONFIDENTIAL AS NONPUBLIC PERSONAL HEALTH INFORMATION. <--

(5) ~~Reporting~~ REPORT immediately to the department a change in the resolution organization's status which would cause the resolution organization to cease performing or being qualified to perform arbitrations in accordance with this act. <--

Section 305. Applicability.

~~This chapter shall 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.~~

~~(2) A health care service for which an entity, other than an insurer specified under a health insurance policy, is responsible.~~

THIS CHAPTER APPLIES TO SURPRISE BALANCE BILLS. NOTHING IN THIS ACT SHALL PROHIBIT AN INSURER FROM APPROPRIATELY UTILIZING PRIOR AUTHORIZATION OR OTHER REASONABLE MEDICAL MANAGEMENT TECHNIQUES. <--

CHAPTER 5

~~INSURERS~~ COMMUNICATIONS, RECORDS AND ENFORCEMENT <--

Section 501. 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 act.

(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.

(b) Provider communications.--The following apply:

(1) A sign which sets forth the following shall be posted in a prominent place or be included in an appropriate written or electronic communication by a provider and a facility in which health care services are rendered to patients covered by a health care plan who may not be covered at in-network rates:

(i) The rights of insureds under this act.

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

(iii) Contact information for the department.

(2) The department may specify the form and content of the notice required under paragraph (1).

(3) A communication detailing the cost of a health care service covered by this act must clearly state that an insured will only be responsible for payment of the applicable cost-sharing amounts under the insured's health care plan.

(c) Insurer communications.--The following apply:

(1) An insurer shall provide a written notice to each insured of the protections provided under this act. The

notice shall include information regarding how an insured may contact the department to report and dispute a surprise balance bill. The insurer shall post the notice on the insurer's publicly accessible Internet website and make it available upon request within 90 days of the effective date of this section. The notice shall include an explanation of benefits for any claim submitted beginning not more than 90 days after the effective date of this section.

(2) The department may specify the form and content of the notice required under paragraph (1).

(3) A communication detailing the cost of a health care service covered by this act must clearly state that an insured will only be responsible for payment of the applicable cost-sharing amounts under the insured's health care plan.

Section 502. Records and confidentiality.

(a) General rule.--A record custodian may not disclose ~~information which is confidential and privileged and not subject~~ <-- CONFIDENTIAL INFORMATION. CONFIDENTIAL INFORMATION UNDER THIS <-- SECTION SHALL NOT BE SUBJECT to any of the following:

(1) The act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

(2) A subpoena.

(3) ~~A discovery or admissible evidence~~ DISCOVERY OR <-- ADMISSIBLE EVIDENCE in any private civil action.

(b) Exception.--A record custodian may disclose CONFIDENTIAL <-- information ~~which meets the criteria under subsection (a)~~ to the <-- department, the Department of Health, the Department of State, the Office of Attorney General or a resolution organization to facilitate the fulfillment of a duty or obligation, including

any of the following:

(1) Arbitration of a disputed claim.

(2) Resolution of a consumer complaint.

(3) Investigation and enforcement of an alleged violation of this act.

(c) Construction.--Nothing in this section shall be construed to prevent the department from using ~~information which meets the criteria under subsection (a)~~ CONFIDENTIAL INFORMATION <-- for internal analysis, or from disclosing the AGGREGATED <-- information in a manner that the identity of the subject of the information cannot be ascertained.

(d) Waiver prohibited.--The sharing of ~~information which meets the criteria under subsection (a)~~ CONFIDENTIAL INFORMATION <-- by the department, the Department of Health, the Department of State, the Office of Attorney General or a resolution organization as authorized by subsection (b) does not constitute a waiver of any applicable privilege or claim of confidentiality.

Section 503. Enforcement.

(a) Authority.--The following apply:

(1) The department, the Department of Health, the Department of State and the Office of Attorney General shall have authority to enforce this act. The appropriate Commonwealth agency may investigate potential violations under this act based upon information received from insureds, insurers, providers and other sources in order to ensure compliance with this act.

(2) Nothing in this act shall be construed to limit the ability of the department, the Department of Health, the Department of State or the Office of Attorney General from

using information received under this act in the course of its duties under any other law of the Commonwealth.

(b) Insurer violations.--The following apply:

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

(2) The enforcement remedies imposed under this subsection 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. Violations of this act 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.

(3) Upon receipt or discovery of evidence of a potential violation of this act 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.

(c) Health care practitioner violations.--The following apply:

(1) A violation of a provision of this act by a health care practitioner shall constitute unprofessional conduct and subject the health care practitioner to disciplinary action under the applicable law of this Commonwealth relating to professional licensure under which the individual is licensed.

(2) Money collected under this section 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.

(d) EMS agency and facility violations.--The following apply:

(1) A violation of section 302 or section 501(b) by an EMS agency shall constitute a violation of AND MAY BE SUBJECT TO THE PENALTIES PROVIDED FOR IN 35 Pa.C.S. Ch. 81 (relating to emergency medical services system). <--

(2) A violation of section 302 or section 501(b) by a facility shall constitute a violation of AND MAY BE SUBJECT TO THE PENALTIES PROVIDED FOR IN the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act. <--

(3) Money collected under this subsection shall be deposited into the General Fund.

(e) Unfair trade practices.--A violation of this act shall be deemed a violation of AND MAY BE SUBJECT TO THE PENALTIES PROVIDED FOR IN the act of December 17, 1968 (P.L.1224, No.387), known as the Unfair Trade Practices and Consumer Protection Law. <--

(f) Administrative procedure.--The administrative provisions of this section shall be subject to 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies). 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).

(g) Enforcement remedies.--The enforcement remedies imposed under this section shall be in addition to any other remedies or penalties that may be imposed under the laws of this

Commonwealth.

(h) 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 act shall notify the department of the imposition of the penalty.

Section 504. Private cause of action.

Nothing in this act shall be construed to create or imply a private cause of action for a violation of this act 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.

CHAPTER 7

MISCELLANEOUS PROVISIONS

Section 701. Regulations.

The department, the Department of Health and the Department of State may EACH promulgate regulations as may be necessary to implement and enforce this act. <--

SECTION 702. PUBLICATION OF BENCHMARKING DATABASES. <--

(A) DATABASES.--THE DEPARTMENT SHALL COMPILE AND MAINTAIN A LIST OF BENCHMARKING DATABASES MAINTAINED BY NONPROFIT ORGANIZATIONS NOT AFFILIATED WITH AN INSURER OR PROVIDER.

(B) PUBLICATION.--THE DEPARTMENT SHALL PUBLISH THE LIST OF BENCHMARKING DATABASES ON THE DEPARTMENT'S PUBLICLY ACCESSIBLE INTERNET WEBSITE AND ANNUALLY IN THE PENNSYLVANIA BULLETIN ON OR BEFORE JULY 1.

Section ~~702~~ 703. Effective date. <--

This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

(i) This section.

(ii) Section 302(f).

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