PHAN Pennsylvania Health Access Network

Protecting Pennsylvanians from "Surprise Medical Bills"

Balance Billing Consumer Principles

Pennsylvanians buy health insurance to protect themselves from getting hit with huge medical bills, choosing plans that include the doctors and hospitals they want to see. However, loopholes and a lack of transparency around which providers are in-network can create headaches and financial hardship for patients who seek treatment in their plan's network but later discover that someone involved in their care is out-of-network.

When this occurs, a patient can be billed the difference between what their insurance plan pays and what the provider wants as payment for that service, which in some cases, can be thousands of dollars. This is called balance billing and it's a costly and unwelcome surprise. Patients are caught in the middle, asked to pay high out-of-network costs that they — by seeking care in their health plan's network — did everything to avoid.

Pennsylvania law does not adequately protect patients from getting hit with "surprise" medical bills when they inadvertently receive care from an out-of-network provider. That needs to change. Patients should not be billed high out-of-network charges by medical providers they didn't choose or have any control over seeing. Pennsylvanians should also have accurate, up-to-date information about the providers in a plan's network and a guarantee that hospitals or health systems that subcontract care within a facility (a growing trend with emergency departments) disclose that information before a patient gives consent for treatment. In emergency situations, or those when no other suitable in-network choice is available, patients should be protected from being charged higher out-of-network rates.

Pennsylvanians who make a good-faith effort to get care in-network need greater protection from "surprise" medical bills. The Pennsylvania Health Access Network and our coalition partners support a solution that puts patient first, provides them with the protection and transparency needed to avoid unintended out-of-network charges in the future, and keeps them from being caught in the middle of payment disputes between insurers and providers.

We need a solution in Pennsylvania that incorporates the following five principles:

BALANCE BILLING IS BANNED IN ALL EMERGENCY SITUATIONS

Pennsylvanians covered in all private health insurance plans cannot be balance billed by a health care provider when they receive emergency medical treatment or asked to pay any more than in-network costs for care. Patients should be removed from the process of settling payment between the provider and their health plan. Payment for out-of-network emergency services must be the greater of:

- the allowed amount for in-network services,
- the usual and customary reasonable rate for such services, or
- the amount Medicare would pay for the service.

PENNSYLVANIANS ARE GUARANTEED ACCESS TO CLEAR, CURRENT, AND CONSUMER-FRIENDLY INFORMATION FROM:

- Any entity providing a health care service that discloses out-of-network rates and relationship with the patient's health plan;

- The patient's health insurance plan that explains their provider network (including any applicable tiers relating to providers, hospitals or pharmacies), out-of-network rates and allows the consumer to easily search for the network status of their preferred health care providers. Provider directories must be updated monthly to ensure consumers have access to timely, accurate information.
- Providers and insurers will be held accountable meaningful disclosure about networks, relationships, and costs through periodic audits, with additional measures for non-compliance as needed.

Janice Nathan considers herself a loyal UPMC customer. After undergoing a kidney transplant at a UPMC hospital in 2001, Nathan continued seeing UPMC doctors. When UPMC and insurer Highmark started fighting over contracts, Nathan bought insurance through UPMC Health Plan to keep her doctors.

So she was surprised when she learned her UPMC primary care physician had referred her to a cardiologist at UPMC Shadyside who, it turned out, wasn't part of her UPMC health plan's network. The cardiologist billed her $325 for the visit.

"I feel betrayed, to be honest," said Nathan, who lives in Pittsburgh. "I know it's a strong word, but their whole advertisement was, 'If you stay with us, you won't lose your doctors and you won't pay out-of-network.'"

— Tribune-Review, Sept. 29, 2015

PENNSYLVANIANS COVERED IN ALL PRIVATE HEALTH INSURANCE PLANS ARE PROTECTED FROM BALANCE BILLING IN NON-EMERGENCY SITUATIONS, BY:

- Requiring meaningful disclosure and informed consent before a patient is treated by out-of-network providers. Asking patients, upon hospital admission, to sign a blanket acknowledgement that they may be treated and balance billed by an out-of-network provider at some unspecified point is not a meaningful protection.
- Banning balance billing when a patient has not signed a written consent form authorizing treatment from an out-of-network provider after the provider's network status with the patient's health plan and the expected cost for treatment has been disclosed and clearly explained.
- Creating a concrete process for resolving balance billing disputes between providers and insurers.

PENNSYLVANIANS SHOULD BE TAKEN OUT OF ANY DISPUTE BETWEEN A PROVIDER & AN INSURER OVER BALANCE BILLING CHARGES

Through an "assignment of benefits," a patient may authorize their provider to directly seek reimbursement from the patient's health plan.

PENNSYLVANIANS RECEIVE CLEAR, ACTIONABLE INFORMATION ON THEIR RIGHTS & PROTECTIONS AGAINST "SURPRISE" MEDICAL BILLS

And where to report complaints and understand the next steps if they do receive a balance bill. If a patient receives a bill from an out-of-network provider, it should be accompanied by an "assignment of benefits" form, and clear notice that a consumer is not required to pay the bill.

For more information, visit: www.pahealthaccess.org