Chairman White, Chairman Wiley and members of the Senate Banking and Insurance Committee, my name is Jeff Bechtel and I am the senior vice president for health policy and economics for The Hospital and Healthsystem Association of Pennsylvania, or HAP. HAP represents and advocates for nearly 240 acute and specialty care hospitals and health systems across the state. We appreciate the opportunity to discuss how HAP and Pennsylvania hospitals are working to promote transparency in patient billing and to provide comments relating to Senate Bill 1158.

The issue of balance billing is very complicated, and we applaud the Committee for scheduling this hearing to secure the perspectives of consumers and other stakeholders, and to discuss the framework proposed by Senate Bill 1158.

I will provide background on this issue, describe efforts by the hospital community to help improve transparency for patients, recommend some steps the Commonwealth could take now to address this issue, and provide some observations relating to Senate Bill 1158.

Background

Health insurance has grown more complex. These complexities include new insurance product designs, such as tiered and narrow networks, which involve higher out-of-pocket costs for consumers when they see providers which are categorized in a less preferred tier or out-of-network. This can result in increased deductibles and/or copays for the patient.

In addition, health insurers contract separately with health care facilities and physician groups, which means that not all physician groups providing services in the hospital setting will participate with the same insurers as the hospital.

These factors—and others—make it more and more difficult for consumers to navigate the health care system. This also has led to the problem of “surprise” bills, which arise when the hospital is in-network, but some hospital-based physicians providing care are not, for example, an emergency department physician, anesthesiologist, pathologist, or radiologist.
Hospital Efforts to Improve Transparency

To help address this complexity, more than 70 percent of Pennsylvania’s licensed, general acute care hospitals already have adopted HAP’s Principles and Operational Guidelines for Consumer-focused Hospital Financial Services. These principles demonstrate the commitment of the hospital community to ensure that consumers have a better understanding of their financial responsibilities, and ways to get assistance to meet those responsibilities, if needed. These principles are based upon national best practices developed by the Healthcare Financial Management Association and the American Hospital Association.

These principles recognize that, as consumers become more involved in making decisions about their medical care, they need and deserve up-front information about their financial responsibility. The goals are to eliminate surprises and to help consumers navigate a complex billing system that involves many parties, including insurance companies, patients themselves, physician practices, hospitals, employers, and government entities.

Hospitals and health systems are at various stages in implementing these principles, but they all are committed to integrating transparency practices and adopting technology, such as customer billing estimators, to enhance the consumer interaction about financial issues.

Specific examples of transparency efforts include:
- St. Luke’s University Health Network’s posting of bundled prices online for some of its procedures and diagnostic tests
- Lancaster General Health’s Pricing Guide
- WellSpan Health’s Cost of Care Patient Guide
- Washington Health System’s Patient Cost Estimator

I would encourage committee members to check these efforts to see how transparency is occurring.

Recommended Preliminary Steps

Dealing with “surprise” balance billing cannot and should not be resolved in a vacuum. The Commonwealth could take at least two preliminary steps to address network adequacy and transparency, which would, in large part, help address the issue of “surprise” balance bills.

First, it is important to continually ensure that insurance products meet the existing network adequacy standards set forth in Pennsylvania law. Network adequacy is more important than ever with the proliferation of tiered networks. Pennsylvania could consider adopting the National Association of Insurance Commissioner’s (NAIC) recently revised Network Adequacy Model Act. Among other things, the NAIC Model Act updates the network adequacy criteria and includes provisions to address “surprise” balance bills.

Second, Pennsylvania could take steps to ensure that consumers have access to their insurer’s most recent network status information. Among other things, insurers should be required, consistent with the NAIC Network Adequacy Model Act, to maintain up-to-date provider directories. Insurers also should be encouraged to proactively take all reasonable steps to
ensure that consumers better understand their health insurance coverage, particularly around possible out-of-pocket costs.

**HAP’s Observations—Senate Bill 1158**

Senate Bill 1158 is closely modeled after New York’s balance billing legislation. For emergency services, patients insured by state-regulated health plans are held harmless for costs beyond the in-network cost sharing amounts that would otherwise apply. For non-emergency care, patients who receive “surprise” out-of-network bills can submit a form authorizing the provider to bill the insurer directly. Patients are held harmless to pay no more than the otherwise applicable in-network cost sharing.

In both situations, out-of-network providers are prohibited from balance billing the patient; although providers who dispute the reasonableness of health plan reimbursement may appeal to a state-run arbitration process to determine a binding payment amount.

Pennsylvania hospitals and health systems believe that patients and their families should be protected from the financial burdens of unexpected bills. There are many instances—including emergencies—where the consumer has little to no control over the selection of a treating provider.

Although the New York model is seen as an option by some, there are other approaches that warrant consideration including model guidance adopted by the National Association of Insurance Commissioners.

I will briefly provide some general observations relating to Senate Bill 1158 and identify some areas where the Committee may want to consider alternative approaches to this model.

1) **The legislation could better define the role of the insurer in prohibiting surprise bills.** Insurers have the primary responsibility to ensure that their networks include adequate providers and that hospital-based physicians are included in their directories and on their websites. Insurers also should be encouraged to take all reasonable steps to proactively educate their members, so they better understand their coverage and its limitations. Taking these steps to better define the role of the insurer could serve to reduce the incidences of balance billing.

2) **The committee should carefully evaluate how best to empower consumers.** If consumers are provided with more complete and timely information, they may in some instances be empowered to avoid “surprise” bills.

Under the proposed legislation, consumers in a non-emergency care situation are simply required to submit a form authorizing the provider to bill the insurer directly. Some may argue that this approach is contrary to the shift in health care, which aims to make the consumer/patient an integral part of their own health.

Other models that address this issue have adopted a somewhat different approach that involves the consumer in the process. For example, the National Association of Insurance Commissioners (NAIC) model act, requires providers to notify a patient that
he or she can forward the bill to their insurer, who must have a process in place for resolving it. Patients have to be proactive, and take the initiative to pass the bill to their insurers. The Texas law also requires a three-way conference call between the provider, insurer, and consumer prior to mediation.

Other models—including the Texas model and the NAIC Model Act—do not provide recourse if a balance bill in a non-emergency situation is below a certain threshold (e.g. $500). This approach appears to be designed, in part, to incentivize consumers to attempt to take more ownership over the provision of care. The Committee should consider the pros and cons of these options as it evaluates this issue.

3) **The committee should evaluate the mediation process to ensure a level playing field.** HAP member hospitals have expressed concerns relating to the mediation process. Among other things, concerns have been expressed about the arbitration protocols used by New York. Specifically, we understand that model has imposed significant administrative burdens on providers, and may not have met the goal of establishing a process that appropriately balances the interests and resources of providers and insurers. The concern is that insurers are better equipped, administratively, to handle the process than small physician practices. The Committee may want to evaluate possible provisions to permit aggregating of claims with like disputes. In addition, the participation of other parties that are not directly involved in the dispute, such as hospitals, should not be mandated.

4) **The committee should carefully evaluate the rate setting standard incorporated into the legislation.** Under the proposed approach, consumers are held harmless—other than for in-network cost sharing—and providers can bill the carrier for the service. Carriers can pay a fee that they deem reasonable, and providers may submit a dispute to a resolution organization. The resolution organization must choose, absent settlement by the parties, the carrier’s payment or the out-of-network provider’s fee. However, the legislation includes criteria for making this determination, and one criterion considered is the “usual and customary cost” of the service. This is defined as the 80th percentile of all charges, as reported in a benchmarking database maintained by a non-profit organization not affiliated with providers and/or carriers.

This approach, which avoids setting a default rate, has promise. The appropriate rate should be a “competitive” payment rate based on market data, rather than an arbitrary rate tied to existing fee schedules. The success of competitive insurance health care delivery is that providers are able to negotiate with insurers. An approach that establishes a “default rate” removes the incentive for fair negotiations between insurers and providers.

In conclusion, the issue of “surprise” bills is a complicated problem for consumers and the health care system. HAP is committed to working with the General Assembly, consumers, and other stakeholders to address the issue. Thank you for the opportunity to comment during today’s hearing. I am happy to take any questions you may have.

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