Technical Advisory for Gatekeeper and Point-of-Service Plans seeking to offer benefit plans with less than 80% plan paid co-insurance for out-of-network covered services.

Notice is hereby given that, pursuant to 28 Pa. Code §9.603, the Department of Health, Bureau of Managed Care (the Department), is issuing a technical advisory on Department of Health review of a preferred provider organization (PPO) for purposes of determining that PPO arrangements permitting enrollees to be held liable for payment for out-of-network services of more than 20% of the payment that a preferred provider would receive from the PPO for the same health care service do not lead to under-treatment or poor quality health care. (31 P.S. §152.4 (relating to scope of Department of Health review of a preferred provider organization). Nothing in this advisory shall abrogate the requirements imposed by 40 P.S. §776.4 (relating to minimum standards fro benefits) and the applicable regulations.

The Department, under Article XXI of the Insurance Company Law of 1921 (40 P.S. §§991,2101-991.2193), commonly referred to as "Act 68," the HMO Act (40 P.S. §§1551-1567) and the PPO Act (40 P.S. §764a), has the responsibility to protect the public from under-treatment and poor quality health care provided through managed care plans. Managed care plans (MCOs) that offer products or benefits plans that include coverage both for services provided in-network and out-of-network typically provide a lower level of coverage when services are obtained from non-network health care providers (other terms include "non-participating providers" and "out-of-network providers"). Enrollees receiving care from non-network health care providers typically face deductibles, co-payments and co-insurance in amounts designed to discourage them from seeking care from a non-network provider, and to provide an incentive for them to seek care from an in-network provider. This is and has been common practice in the health care market place. In the past, MCOs with products or benefit plans under which an enrollee who received a health care service from a non-preferred provider was liable for more than 20% of the payment that a preferred provider would receive from the PPO for the same health care service were required to demonstrate to the Department that such arrangements do not lead to under-treatment or poor quality health care. (See 31 Pa. Code §152.4).

MCOs have a responsibility under Act 68, the HMO Act and the PPO Act to maintain a participating health care provider network so that the plan is able to assure availability and accessibility of adequate health care providers in a timely manner, which enables enrollees to have access to quality care and continuity of health care services. (40 P.S. §2111(1); 40 P.S. §1555.1(b); 40 P.S. 764a(e)). Further, MCOs are required to cover services provided by a non-participating health care provider at no less than the in-network level of benefit when the plan has no available network provider. (28 Pa. Code §9.769(k) (relating to access requirements in service areas)).

An MCO expends less on a health care service provided by a non-network provider, because the MCO's cost for coverage is reduced by the deductible the enrollee must pay, and by the enrollee's higher level of cost-sharing through higher co-payments and enrollee coinsurance. For example, a service provided in-network is covered at 100% by

the plan and paid according to the plan's contracted rate with the health care provider. The MCO's cost for coverage of out-of network services, however, is reduced to 80% of the contracted rate, less the deductible and applicable co-payments, which are paid by the enrollee. To the extent MCOs may benefit economically from out-of-network utilization by providing less coverage overall*, the enrollees' interests must be protected by ensuring that an enrollee is not forced out-of-network by the MCO's inadequate provider network, but, rather, makes a conscious decision to obtain out-of-network services. From the Department's review of an increasing number of enrollee complaints concerning the practice of balance billing, however, it is evident that enrollees receiving services from out-of-network providers are largely if not completely unaware of the practice of provider balance billing and the significant financial liability that can result from this practice. Most enrollees, when faced with significant balance bills offer that had they known they would be responsible for so much money, they would have gone to in-network providers. While balance billing is distinctly outside the control of the MCO, it is in the MCO's best interest and would reinforce the incentive for enrollees to receive health care services from in-network providers, if the MCO provides an example, not only of out-of-network versus in-network covered benefits, but of the implications and consequences of balance billing as a financial obligation enrollees may be incurring by going to non-network providers.

Consequently, to clarify the requirements of 31 Pa. Code §152.4, any MCO offering an HMO, Point-of Service or Gatekeeper PPO product that provides less than 80% plan coverage for out-of-network services, in order to demonstrate to the Department that the arrangements it contemplates do not lead to under-treatment or poor quality health care, and in support of the plan's contention that it has an adequate provider network, must provide the Department with an updated provider network listing and an estimate of how much out-of-network utilization by enrollees is anticipated. An MCO must also provide the Department with the information it intends to provide to enrollees regarding implications and consequences of balance billing as referenced above. Information for enrollees will be adequate to demonstrate that the arrangement will neither lead to under-treatment or poor quality care if it includes a description and an example of balance billing in examples and information provided concerning the out-of-network benefits covered by the plan.

* For purposes of this technical advisory, the Department is not considering additional economic consequences of poor quality care such as extended care or services required due to complications or other negative health consequences or outcomes.