ISSUE BRIEF | House Bill 19-1174

Out-of-Network Health Care Services

Background

Competing bills (HB 19-1174 and SB 19-134) were introduced to ensure consumers covered by state-regulated insurance plans are held harmless when they receive treatment from an out-of-network provider at an in-network facility or when they seek emergency services at an out-of-network facility. After more than five years of failing to address "surprise billing," HB 19-1174 passed – capping reimbursement to out-of-network providers and facilities – while SB 19-134 failed to advance out of the Senate. Ultimately, CHA secured several consumer protections, including ensuring savings from reduced medical costs are passed directly on to consumers and requiring insurers to apply consumers' out-of-network payments to their in-network out-of-pocket maximums, and took a neutral position on the bill.

What You Need to Know

HB 19-1174 will take effect Jan. 1, 2020, and establishes the following new state-level requirements:

Applicability

- Applies to consumers covered under a Division of Insurance (DOI)-regulated health benefit plans as defined in CRS 10-16-102(32).
- Providers and hospitals are prohibited from sending balance bills when receiving scheduled services from an out-of-network provider working at an in-network facility or when receiving emergency services from an out-of-network emergency department.
- Does not apply to a consumer that voluntarily chooses to use an out-of-network provider.

Patient Payment Responsibility

- Consumers are responsible for paying any coinsurance, deductible or copayment.
- Health insurers must apply any payment made by a consumer to his/her in-network cost-sharing limit.

Transparency and Report

- Health insurers, providers and facilities must develop and provide disclosure to covered persons about the potential effects of receiving out-of-network services. Disclosure language must be consistent across plans, providers and facilities and address timing, types of disclosure (e.g., billing statements, billing notices, etc.) and content (e.g., consumer's rights and payment obligations).
  - The Colorado Department of Public Health and Environment (CDPHE) will conduct a stakeholder process to develop rules for disclosures at health care facilities and work with the Division of Regulatory Agencies (DORA) to develop consistent rules for carriers and providers.
- As part of the annual rate filing process, health insurers must provide information about the utilization of out-of-network providers and facilities and the aggregate costs savings/impact on premium affordability as a result of HB 19-1174.

This guidance does not constitute legal advice to CHA members or others. Each hospital should consult with legal counsel on these matters and have legal counsel review any policies proposed as a result of this guidance.

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Default Payment Parameters

- If a covered person receives emergency services at an out-of-network facility, the carrier must reimburse the out-of-network facility the greater of:
  - 105 percent of the carrier's median in-network rate for that service provided in a similar facility or setting in the same geographic area; or,
  - The median in-network rate for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado All-Payer Health Claims Database (CO APCD).
- If a covered person receives covered services at an in-network facility from an out-of-network provider, the carrier shall pay the out-of-network provider directly the greater of:
  - 110 percent of the carrier's median in-network rate for that service provided in a similar facility or setting in the same geographic area; or,
  - 60th percentile of the in-network rate for the same service in the same geographic area for the prior year based on commercial claims data from the CO APCD.
- If the out-of-network provider submits a claim after 180 days, the health plan must reimburse the out-of-network provider 125 percent of Medicare.
- Colorado Commissioner of Insurance (upon request) must collect data from the health plans to evaluate the health plans' compliance in paying the highest rate required. The information requested may include the methodology for determining the health plans' median in-network rate or reimbursement for each service in the same geographic area.

Dispute Process

- Arbitration may be requested if a provider believes a payment made in accordance with this bill was not sufficient given the complexity and circumstances of the services provided.
- When the parties to a billing dispute are unable to resolve the matter through an informal settlement teleconference, the Commissioner of Insurance will appoint an arbitrator to resolve the dispute. The Commissioner of Insurance will monitor the arbitration process and will report to the General Assembly on outcomes listed in the bill.

Penalty for Deceptive Trade Practices

- A provider or facility found in violation of the payment requirements may be found to have committed a deceptive trade practice ($2,000 for first violation and up to $10,000 for subsequent violations).
- Providers and facilities must reimburse a covered person for any overpayment within 60 days. Failure to do so will result in an interest on the overpayment at the rate of 10 percent per year.

Additional Resources

- HB 19-1174 Final Bill and Fiscal Note
- HB 19-1174 takes effect Jan. 1, 2020

For questions or more information, contact Amber Burkhart, CHA public policy manager, at 503.333.7973.

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