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Colorado Hospital Association

June 18, 2019

The Honorable Ken Buck
2455 Rayburn House Office Building
Washington, DC 20515
Via email to Janessa.lopez@mail.house.gov

Dear Congressman Buck:

On behalf of our more than 100 hospital and health system members, Colorado Hospital Association (CHA) is pleased to provide an important update on actions taken by the 2019 Colorado legislature to address surprise billing. Additionally, we want to ensure there is a full understanding of the areas of importance to Colorado hospitals as well as some of the issues on which there could be potential conflicts. CHA encourages you to take advantage of insight from Colorado's experience as you and your staff work towards developing a meaningful federal solution.

House Bill (HB) 19-1174, Out-of-network Health Care Services
During the 2019 legislative session, the Colorado General Assembly set its sights on efforts to protect consumers from large – and sometimes unexpected – medical bills. Competing bills were introduced to ensure consumers covered by Colorado Division of Insurance (DOI) 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 was enacted into law.

The Association and its members have a longstanding commitment to ensuring that patients are informed of their rights and protected from unexpected financial consequences when they receive care. CHA strongly supported the out-of-network provisions of the Health Benefit Plan Network Access and Adequacy Model Act as approved by the National Association of Insurance Commissioners' (NAIC) in 2015. The Association has also actively engaged with consumer advocates, insurers, providers and the General Assembly over the past several years to find a path forward.

Receiving a bill for health care services rendered is typically anticipated by most consumers – *denial* of payment by a consumer's health insurer is what comes as a surprise. CHA and its members have a shared commitment to removing Colorado consumers from the middle of provider/health insurer billing disagreements and protecting them from these often costly "surprise denials." With this primary policy principle guiding the Association's legislative work, CHA partnered with HB 19-1174 bill sponsors to secure several important consumer protections, including prohibiting balance billing by out-of-network providers and facilities, ensuring savings from reduced medical costs are passed directly on to consumers and requiring insurers to apply a consumer's out-of-network payments to their in-network out-of-pocket maximum.

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

Applicability
- Applies to consumers covered under a Colorado 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 chooses to voluntarily 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 their in-network cost-sharing limit.

Default Payment Parameters

- If a covered person receives emergency services at an out-of-network facility, the carrier must directly reimburse the out-of-network facility the greater of:
    - 105% 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 (APCD).
- If a covered person receives covered services at an in-network facility from an out-of-network provider, the carrier must directly reimburse the out-of-network provider the greater of:
    - 105% of the carrier's median in-network rate for that service provided in a similar facility or setting in the same geographic area; or
    - 60 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 Colorado APCD.
- If the out-of-network provider submits a claim after 180 days, the health plan must reimburse the out-of-network provider 125% of Medicare.
- Colorado Commissioner (upon request) must collect data from the health plan to evaluate the health plan's compliance in paying the highest rate required. The information requested may include the methodology for determining the health plan's 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 will appoint an arbitrator to resolve the dispute. The commissioner 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 ($2000 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% per year.

Transparency and Reporting

- By Jan. 1, 2020, 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 (including billing statements, billing notices, etc.) and content (including 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 DOI on developing 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.

Throughout these out-of-network debates over the past several years, it has been important to create a balanced solution among providers, health insurers and hospitals to better protect the consumer. Developing a thoughtful and nuanced approach – one that protects patients but also one that will not create unintended market consequences – is challenging, and Colorado did not fully achieve this goal with the passage of HB 19-1174. While CHA reached a neutral position on this legislation, the Association fears that the current emergency facility payment parameters outlined in statute will likely have unforeseen impacts on hospitals and the health care system.

Specifically, CHA believes that establishing a benchmark on how much out-of-network facilities are paid for certain emergency services has rippling impacts within facilities and their negotiations with insurance carriers. These impacts are likely different – and larger – than those for benchmarks on services provided by individual out-of-network providers. As such, CHA firmly argued throughout negotiations at the Colorado legislature that out-of-network emergency services *must* be reimbursed at a higher rate than in-network emergency services to maintain incentives to enter into network contracts and to ensure consumers have access to a robust network of health facilities.

CHA also recognizes the limitations of HB 19-1174, as it only protects consumers covered under a DOI-regulated health benefit plan. Colorado does not have oversight of self-funded plans, which have minimal surprise billing protections and represent approximately 30% of insured lives in Colorado. As such, CHA strongly supports a federal solution in addition to Colorado's solution to help encompass the full Colorado market.

Assessing Federal Legislative Proposals Addressing Surprise Medical Billing
Several federal proposals have been introduced or released in draft form to address this growing issue. To help assess how these varying proposals intersect with Colorado state law and how they might impact various components of the market, CHA developed a topline comparison of the three Congressional bills and HB 19-1174. As Congress works towards developing a meaningful solution, the Association recommends that you review the crosswalk and consider the following key questions:

- Will a federal solution apply to the entire Colorado market? If not, how does Congress plan to develop a solution that does not conflict with Colorado's statute, creating unnecessary consumer confusion and greater disruptions to Colorado's already complex health care system (i.e., different default payments, dispute resolution processes, penalties, patient notification requirements, etc.)?
- If a default payment is considered, how will Congress ensure that the advantages of network configurations are not undermined? Furthermore, how will Congress safeguard consumer access to adequate networks if health plans are less incentivized to enlist providers and facilities to join their networks because they can rely on a favorable default payment?
- How will Congress incorporate and execute an educational component to help consumers understand the scope of their health care coverage and how to access their benefits?
- Plans hold the information necessary to help patients make a decision about their care, including network status and cost estimates. How will the plans assist providers in helping share this information with patients? Should plans have an equally strong requirement or greater in sharing information with patients?
- The bundled payment approach is being suggested as a key solution – it would combine the payment for physician services with the cost of the rest of care into a single payment. Hospitals would take on the role

of contracting with physician services to set a negotiated rate – as insurers currently do. How does this approach bring value if the insurers are no longer negotiating the rate and responsible for the coverage?

- Surprise medical billing is not an issue for patients covered by Medicare and Medicaid, because unlike care provided under ERISA insurance plans, robust patient protections are in place. A patient's *type* of insurance (i.e., self-insured, ERISA plans) is the underlying factor that determines whether the patient is protected from surprise billing – not the facility at which they seek care nor the clinician providing the health care services. As an insurance issue, should Congress include patient protections under ERISA plans that mirror protections seen in Medicare and Medicaid?

I hope you find the background information on HB 19-1174 and list of key questions for consideration helpful as you assess and soon vote on these federal proposals. We look forward to being a thought partner with you knowing how important it is that the federal solution to this pressing issue also works for all Coloradans.

Sincerely,

Steven Summer
President and CEO, Colorado Hospital Association

cc: Janessa Lopez