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Colorado Hospital Association

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Mr. Mortier:

On behalf of our more than 100 hospital and health system members statewide, the Colorado Hospital Association (CHA) thanks you for the opportunity to provide informal feedback on the proposed draft regulations to implement House Bill (HB) 19-1174, Additional Requirements for Carrier Out-of-network Reimbursements. CHA looks forward to working with the Division of Insurance (DOI) to ensure the regulations protect Coloradans from surprise billing and do not dis-incentive carriers and providers from contracting or otherwise create perverse incentives for network exclusions.

DRAFT 4-2-6X, ADDITIONAL REQUIREMENTS FOR CARRIER OUT-OF-NETWORK REIMBURSEMENTS

Definitions
While the law's reimbursement methodology is prescriptive, several important terms remain undefined. Careful consideration must be made when defining the following terms in the proposed regulation.

- "**Similar facility**" – Colorado hospitals are diverse and payment structures vary depending on populations served (e.g., pediatrics), patient acuity level, trauma designation, CMS certification type, etc. Therefore, it may be difficult to establish a "similar facility" against which reasonable rates can be weighed. In order to ensure the comparisons are as accurate as possible, the term must account for age and include at a minimum:
  - Licensure/certification type;
  - Offering comparable suite of emergency services; and
  - Any certification or designation recognized by the Colorado Department of Public Health and Environment, including trauma designation, stroke center designation and heart attack center designation.

- "**Service**" – CHA recommends that the definition of "service" include medical care and items such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment and medical social services. Again, CHA requests that the term include consideration of age.

  Further, it is important that all carriers create a standardized process for handling different services and levels of service rendered within the scope of emergency services. For example, if a specific carrier "bundles" emergency services or develops a flat per-encounter rate, how might that carrier choose the appropriate benchmark when determining the amount owed to a provider? Could an emergency department (ED) visit without an MRI and an ED visit with an MRI look the same to a carrier and trigger the same payment? The Association has some concern that overly broad bundling of services may miss important treatment distinctions. CHA urges the

Division to require carriers to provide as much differentiation/gradation in service detail as possible, such that "comparable services" truly are comparable.

- **"Geographic Area" –** What is the Division's rationale for selecting the nine DOI rating areas? Was there any consideration to alternative ways in defining the term? The Association has concerns that the DOI rating areas may result in situations where a carrier does not offer an in-network rate or benefit for a specific service, especially in rural areas. CHA requests that the Division conduct an impact analysis to determine if certain DOI rating areas would experience significant gaps in data.

Transfer

HB 19-1174 requires reimbursement that applies to emergency treatment and stabilization *only*. As such, hospitals are not required to transfer a patient to an in-network facility. Instead, insurance carriers have the responsibility for arranging transfer and should pay for this transportation by ambulance. In order to make the transfer as seamless as possible, the insurance carrier should publish phone numbers that operate 24/7 to assist with out-of-network transfers. The regulation should clarify that HB 19-1174 does not apply to post-stabilization services. If a carrier is unable to arrange a timely transfer to an in-network facility, the carrier cannot rely on the "greater of" formula for reimbursement purposes.

Payment Determination and Carrier Compliance Verification

Under HB 19-1174, carriers are obligated to pay out-of-network providers and facilities using the "greater of" formula. The law does not contemplate a scenario in which there is "insufficient claims data" to determine adequate reimbursement. In such situations, neither the Division nor carriers have the legal authority to determine a "default payment" (i.e. Medicare reimbursement rate) as proposed in the draft regulation.

CHA also recommends developing a transparent process to allow out-of-network facilities and providers to verify carrier compliance with payment under the "greater of" formula, otherwise it will be difficult to assess how a carrier arrived at a specific reimbursement rate. CHA recommends that the Division standardize the information carriers must share with DOI, providers and health care facilities when rendering a payment (e.g. "there was insufficient claims data available in the APCD for the region, so the carrier utilized the statewide in-network rate, which was the highest verifiable rate."). It would also be useful if these payments were either auditable, or otherwise open to case-by-case verification by providers and facilities.

For example, the Division should require carriers to publish the rates paid for out-of-network services by diagnosis on a provider accessible website. Historical rates should be left on the site so facilities and providers can verify past dates of service were paid correctly. This data should be in a machine-readable format.

DRAFT 4-2-6X, CARRIER DISCLOSURES FOR POTENTIAL EMERGENCY AND NON-EMERGENCY OUT-OF-NETWORK SERVICES

Alignment and Timing

Pursuant to HB 19-1174, the Commissioner of Insurance must consult with the State Board of Health and the Director of the Division of Professions and Occupations to adopt rules to specify the disclosure requirements. Specifically, the language used must be plain language to "ensure that carriers, health care facilities, and providers use language that is consistent". CHA would like to ensure that all three entities are effectively coordinating and aligning the regulatory language accordingly.

- What is the timeline and process around which this alignment will occur? CHA recommends that all three entities host a joint stakeholder meeting in advance of rulemaking.

During the 2019 legislative session, CHA relayed concerns with regards to the bill's implementation timeline. Gleaning from New Jersey's recent experience implementing out-of-network regulations, the law went into effect *before* rules had been adopted. As a result, there was no consistency in facility disclosure language, ultimately leading to increased consumer confusion and facility call times. Facilities, providers and carriers must be given sufficient time to come into compliance with the new regulations (draft and adopt policies, train frontline staff, develop FAQs for consumers, etc.). Finalizing the emergency regulations in December does not provide facilities with a reasonable timeframe for meaningful implementation.

"Appendix A: Surprise Billing Disclosure"
The language provided in the proposed disclosure document is an important educational opportunity for consumers. CHA recommends defining the following key terms throughout the document to ensure greater consumer understanding:

- Copayments, deductibles and/or coinsurance
- Provider network
- Emergency services
- Out-of-pocket limit

To better reflect HB 19-1174 language, CHA requests that bullet three be revised under "additional protections" as follows:

- "Your provider~~, hospital,~~ or facility must refund any amount you overpay within 60 days ~~of being notified~~ AFTER THE DATE THAT THE OVERPAYMENT WAS REPORTED TO THE PROVIDER OR FACILITY.

Under HB 19-1174, a covered person is not protected from balance billing when the covered person voluntarily uses an out-of-network provider. CHA recommends the following language be included in Appendix A to better reflect the bill's language:

- You are not protected from balance billing when you voluntarily use an out-of-network provider. Under the law, "voluntarily" means that there is a participating provider available to provide the required or requested services but the covered person has chosen to receive health care services from an out-of-network provider.

DRAFT 4-2-6X, ESTABLISHMENT OF A CARRIER PAYMENT ARBITRATION PROGRAM FOR NON-PARTICIPATING PROVIDERS

Section 4 – Definitions
The definition of "de-identified" should be the same definition as used in the Health Insurance Portability and Accountability Act, providing an industry-accepted benchmark for this term.

Also, the definition of "qualified arbitrator" should include the minimum number of required qualified arbitrators on the list (this may be most appropriate to include later on in the regulation) so all parties can ensure there is an unbiased pool of arbitrators.

Section 5 – Arbitration Process and Timelines
It appears that the four regulations, including Appendix A: DOI Standard Arbitration Request Form, refer to "out-of-network provider" and "non-participating provider" interchangeably. CHA urges the Division to strike all references to "non-participating provider" as it is not defined in HB 19-1174. For purposes of

consistency and clarity, CHA encourages the Division to use "out-of-network provider" throughout the regulations.

Paragraph H – This could be interpreted as a default judgment. CHA recommends that there be final notice and 5 days to cure.

Paragraph G (should be revised as "Paragraph I") – This language presents a significant problem. HB 19-1174 provides that the parties will mutually agree when a claim doesn't qualify for arbitration. However, this provision gives the carrier and the Commissioner the authority to make this judgment, which is inconsistent with the statute and could allow carriers and the Commissioner to arbitrarily hinder the arbitration process.

Paragraph I – There should not be a payment of legal fees provision – this would chill providers from bringing a claim. Instead, the language should be revised so that both parties pay their own fees.

Paragraph J – "Re-adjudicated" is the wrong word; it implies that the carrier can re-look at the claim. Instead, the carrier should "re-process" the claim in accordance with the arbitrator's decision.

Lastly, coding disputes pertaining to level of care or denial of rendered service should not be subject to the arbitration process. If a carrier relies on HB 19-1174, any change of codes or level of care conducted by carriers for out-of-network payment must be done retrospectively and must have physician review. CHA urges the Division to clarify in regulation that the prepayment reductions in level of care for out-of-network providers are prohibited under HB 19-1174.

Thank you for your consideration.

Sincerely,

Amber Burkhart
Manager, Public Policy
Colorado Hospital Association