

# Health Insurance Surprise Billing Protections

ISSUE BRIEF | House Bill 22-1284

# Background

HB 22-1284 aligns duplicative and conflicting state and federal out-of-network billing laws. In 2019, Colorado passed <u>HB 19-1174</u> to institute out-of-network billing protections, and on Jan. 1, 2022, separate federal requirements from the No Surprises Act went into effect. HB 22-1284 aligns several technical differences that created significant confusion and operational challenges for both providers and patients.

## HB 22-1284: Health Insurance Surprise Billing Protections

The legislation tackles two main problems for CHA member hospitals: elimination of disclosure requirements and lack of resources devoted to payment rate adherence. CHA successfully secured language to eliminate the state disclosure requirements that contradicted the federal informed consent requirements and aligned state and federal informed consent timelines. CHA also worked with the sponsors and Division of Insurance on language to convene a workgroup and devote resources to payment rate adherence to ensure that HB 19-1174 works as intended. Additionally, the legislation aligns the state and federal definitions for post-stabilization care and good-faith estimates.

## What You Need to Know

See detailed chart on following pages.

## Implementation Timeline

Aug. 10, 2022 – Most of the provisions go into effect. Note: CHA secured language to ensure that the
good-faith estimate requirements will not go into effect until implementation of the future federal
rules.

#### **Additional Resources**

- Fiscal Note
- Final Bill
- CMS No Surprises Act FAQ



# HB 22-1284: Health Insurance Surprise Billing Protections – continued

### What You Need to Know

The chart below outlines the five relevant places where HB 22-1284 aligns state and federal law:

| Conflict  HB 22-1284  Disclosure vs. Informed Consent  State-Regulated Plans: Prior to enactment of HB 22- 1284, facilities must provide patients a disclosure about the potential effects of receiving services from an out-of-network facility, which patients or their designated representative must sign prior to the start of the services.  Federally Regulated Plans: Facilities must provide written notice for patients to explicitly consent to that includes detailed information designed to ensure that includes detailed information for scheduled out-of-network services 72 hours prior to receiving the service; and three hours before receiving the service; and three hours before receiving the service if it is scheduled on the same day.  Both state and federal law prohibit balance billing for ancillary services associated with emergency medicine.  State-Regulated Plans: Prior to HB 22-1284, no definition.  Both state and federal law prohibit balance billing for ancillary services associated with emergency medicine.  State-Regulated Plans: Prior to HB 22-1284, no definition.  Federally Regulated Plans: Detailed definition of what services cannot be balance billed.  Figure State With HB 22-1284 liminates the disclosure requirement and applies the informed consent requirement to state-regulated plans: Moving forward, the standard plus providing the informed consent focument?  HB 22-1284 eliminates the disclosure requirement and applies the informed consent focument?  HB 22-1284 eliminates the disclosure requirement and applies the informed consent focument?  The provider when fereit to elicite state-regulated plans: Provider who facility furnishing portions the state-regulated plans: patients can only chose to elect to receive out-of-network from an out-of-network facility furnishing post-stabilization care or  | Auga of   | Confliction Chata and Endough Lavas Dainets             | Fortune Charles with LID 22 4204 in Effect          |
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| definition.  medicine, anesthesiology, pathology, radiology, and neonatology, provided by either a physician or non-physician practitioner;  ltems and services provided by assistant surgeons, hospitalists, and intensivists;  Diagnostic services, including radiology and laboratory services; and, ltems and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network   |           | State-Regulated Plans: Prior to HB 22-1284 no           | Items and services related to emergency             |
| radiology, and neonatology, provided by either a physician or non-physician practitioner;  Items and services provided by assistant surgeons, hospitalists, and intensivists;  Diagnostic services; including radiology and laboratory services; and,  Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network  |           | _   |   |
| Federally Regulated Plans: Detailed definition of what services cannot be balance billed.  either a physician or non-physician practitioner;  ltems and services provided by assistant surgeons, hospitalists, and intensivists;  Diagnostic services, including radiology and laboratory services; and,  Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network   |           |   |   |
| services cannot be balance billed.  practitioner;  Items and services provided by assistant surgeons, hospitalists, and intensivists;  Diagnostic services, including radiology and laboratory services; and,  Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network  |           | Federally Regulated Plans: Detailed definition of what  |   |
| <ul> <li>Items and services provided by assistant surgeons, hospitalists, and intensivists;</li> <li>Diagnostic services, including radiology and laboratory services; and,</li> <li>Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network</li> </ul>   |           |   |   |
| surgeons, hospitalists, and intensivists;  • Diagnostic services, including radiology and laboratory services; and,  Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network  |           |   | •   |
| Diagnostic services, including radiology and laboratory services; and,  Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network   |           |   |   |
| laboratory services; and, Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network   |           |   |   |
| Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network   |           |   | ,             |
| provider when there is no in-network provider who can provide the item or service at the in-network  |           |   |   |
| can provide the item or service at the in-network  |           |   | · · · · · · · · · · · · · · · · · · ·               |
| health care facility.  |           |   |   |
|  |           |   | l   |



# HB 22-1284: Health Insurance Surprise Billing Protections – continued

| Area of                      | Conflicting State and Federal Laws Prior to  | Future State with HB 22-1284 in Effect  |
|------------------------------|--|---|
|                              |  | Tuture State With His 22-1204 in Effect   |
| Conflict Post- Stabilization | Both state and federal law allow patients to opt-in to out-of-network care after a patient is stabilized following an emergency episode.  State-Regulated Plans: Prior to HB 22-1284, the emergency event is considered to be complete (i.e., subject to balance billing) when a patient is stabilized to the point that there would be no material deterioration of the condition likely to result from, or occur during, the transfer of an individual from a facility.  Federally Regulated Plans: Detailed definition of post-stabilization. | HB 22-1284 aligns the post-stabilization definition for state and federal plans. Moving forward, a patient is considered to be stabilized when a patient can consent:  • Without threat of immediacy or need for treatment;  • Only if there are reasonable options regarding post-stabilization services, transport, or service provider or facility;  • Voluntarily (free from influence, fraud, or duress); and,  • With adequate time for patients to make a clear-minded decision.  The attending emergency physician or treating provider must determine that the participant, beneficiary, or enrollee is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into consideration the individual's medical condition.  Individuals must also be able to travel to an innetwork provider located within a reasonable travel distance that accounts for their medical condition. |
| Good-Faith<br>Estimates      | State-Regulated Plans: No requirement that providers give patients a good-faith estimate.  Federally Regulated Plans: Currently, the good-faith estimate requirement only applies to uninsured and self-pay patients per CMS regulation. In the future, under federal law, CMS will promulgate regulations to require good-faith estimates for all patients.   | distance that accounts for their medical condition.  Once CMS promulgates good-faith estimates for insured patients, those requirements will apply to all plans.  |
| Continuous<br>Coverage       | State-Regulated Plans: Allows patients to continue receiving care from a provider 60 days after a participating provider is terminated by the plan without cause.  Federally Regulated Plans: Allows patients to continue receiving care for up to 90 days after the carrier notifies the patient that the contract with the provider is terminated.   | HB 22-1284 strengthened the state's protections for patients to continue receiving care once the insurer terminates a contract. Patients may now continue receiving care for 90 days following a termination.   |



# HB 22-1284: Health Insurance Surprise Billing Protections – continued

#### **Payment Rate Compliance**

One additional issue CHA member hospitals raised was to ensure payers are compliant with the existing payment rates under HB 19-1174. In response, CHA secured a Commissioner of Insurance-led workgroup to address outstanding payment rate compliance concerns, which will include equal numbers of representatives from hospitals, carriers, providers, and consumers. The group will identify barriers to verifying the accuracy of statutorily specified payment amounts and managing payer-provider disputes and develop recommendations to streamline payment rates. The work group will submit initial recommendations to the DOI March 15, 2023, and final recommendations before July 1, 2023

