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 HB 19-1174 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

For questions or more information, contact Megan Axelrod, CHA manager, regulatory policy, at megan.axelrod@cha.com.

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What You Need to Know

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

Area of Conflict	Conflicting State and Federal Laws Prior to HB 22-1284	Future State with HB 22-1284 in Effect
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 or an out-of-network provider who proves services at an in-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 individuals knowingly accept out-of-network rates for care received from an out-of-network provider. Providers must send informed consent for scheduled out-of-network services 72 hours prior to receiving the service; and three hours before receiving the service if it is scheduled on the same day.	HB 22-1284 eliminates the disclosure requirement and applies the informed consent requirement to state-regulated plans. Moving forward, the standard will be providing the informed consent document 72 hours prior to the patient receiving a previously scheduled service or three hours before a patient receives a non-scheduled service. *Note:* patients can only choose to elect to receive out-of-network care from an out-of-network facility furnishing post-stabilization care or an out-of-network provider furnishing previously scheduled services at in-network facilities. HB 22-1284 incentivizes out-of-network providers providing care at in-network facilities to inform patients 10 days in advance of their previously scheduled service. If this notice does not occur, patients can choose to move forward with their procedure performed by the out-of-network provider who will be paid the in-network rate.
Ancillary Services	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.	HB 22-1284 aligns the definition of ancillary services with federal law and prohibits balance billing for: • Items and services related to emergency medicine, anesthesiology, pathology, 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 health care facility.

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Area of Conflict	Conflicting State and Federal Laws Prior to HB 22-1284	Future State with HB 22-1284 in Effect
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 in-network provider located within a reasonable travel distance that accounts for their medical condition.
Good-Faith 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.	Once CMS promulgates good-faith estimates for insured patients, those requirements will apply to all plans.
Continuous 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.

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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

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