

HB19-1174: OUT-OF-NETWORK HEALTH CARE SERVICES

Concerning out-of-network health care services provided to covered persons

Details

Bill Sponsors:	House – Esgar (D) and Catlin (R) Senate – Gardner (R) and Pettersen (D)
Committee:	House Health & Insurance
Bill History:	2/7/2019- Introduced in House- Assigned to Health & Insurance
Next Action:	Hearing by House Health & Insurance Committee
Fiscal Note:	Not available at time of submission.

Bill Summary

The bill requires health insurance carriers, health providers, and facilities to provide patients covered by health insurance plans with information concerning the provision of services by out-of-network providers in the cases where a person gets emergency care at an out-of-network facility or they receive either emergency or covered nonemergency care from an out-of-network provider at an in-network facility. In these situations, the bill mandates that the carrier shall reimburse the out-of-network provider or facility the greater of:

- The carrier's average in-network rate of reimbursement for that service in the same geographic area
- 125 percent of the Medicare reimbursement rate for that service in the same geographic area
- 100 percent of the median in-network rate of reimbursement for that service in the same geographic area for the prior year as determined by claims data from the All-Payer Health Claims Database (APCD)

Issue Summary

Out-of-Network Billing

"Surprise" out-of-network medical bills occur when patients are treated by providers outside their health plan's contracted network under circumstances that cannot reasonably be avoided. Typically, balance bills happen when patients are treated by an out-of-network provider that they did not choose. The health plan will often limit its payment to an amount that it determines is fair. The individual may then be billed by the out-of-network provider for the difference between what the health plan paid and what the provider charges.

Balance Billing: Emergency Services

Balance billing in emergency events occurs when a patient is taken to an out-of-network facility, primarily due to the fact that in these situations a facility is typically chosen for its proximity to where the patient is located and its ability to handle the level of care necessary to treat the patient. Under the Affordable Care Act (ACA), carriers cannot have higher cost sharing for emergency services received from out-of-network providers, and must count payments by the patients for deductibles, copayments or coinsurance toward the health plan's out-of-pocket limits. These provisions, however, do not prevent out-of-network providers from

balance billing patients beyond what the plans have allowed.¹² A study found that approximately 20 percent of inpatient emergency department (ED) admissions and 14 percent of outpatient ED visits were likely to result in a balance bill to the patient.³ This is consistent with another study that found between 2011 and 2015, 22 percent of patients who attended an in-network ED were treated by an out-of-network physician.⁴

Balance Billing: Nonemergency Services

Balance billing in nonemergency cases occurs when a patient goes to an in-network facility but some provider that attends to their care is out-of-network. This can occur even if a patient has been diligent of ensuring that both the facility and primary provider are both in-network. For example, patients undergoing surgery at an in-network hospital performed by an in-network surgeon (of their choosing) may be surprised to learn after the fact that their anesthesiologist (who they did not choose) was out-of-network. In this case, the patient may receive an unexpected balance bill. For inpatient admissions, enrollees in large employer health plans using only in-network facilities still have at least one claim from an out-of-network provider in over 15 percent of admissions.⁵ A study found that approximately 10 percent of elective inpatient admissions were likely to result in a balance bill to the patient.⁶

Action in Other States

Some states have attempted to address balance billing for out-of-network services by enacting laws that cap or limit the reimbursement rate of out-of-network services, improve cost transparency in service costs and/or provider networks, set up an arbitration process to resolve balance bills between the carriers and providers, or investments to study the impact of the issue on consumers.⁷ As of the end of 2018, 25 states allow cases involving balance billing to be brought to the state consumer protection bureau, but only 9 (California, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, New York, and Oregon) have provisions that meet a standard for “comprehensive” protections to address balance billing.⁸ Even then, analysts suggest that current state protections do not do enough to protect consumers.

Texas, which has a more limited approach to the issue, is overwhelmed by a backlog of cases that have increased since 2013 from 43 to 4,519 in 2018.⁹ Part of the problem comes from a patient with high enough claims triggering a dispute-resolution process, requiring that patient to take on a cumbersome and time-

¹ Claxton, G., Rae, M., Cox, C., & Levitt, L. (Aug. 13, 2018). An analysis of out-of-network claims in large employer health plans. *Kaiser Family Foundation*. Retrieved from <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start>

² Adler, L., Hall, M., Brandt, C., Ginsburg, P.B., & Lieberman, S. (Feb. 1, 2017). Stopping Surprise Medical Bills: Federal Action is Needed. *Health Affairs Blog*. doi: 10.1377/hblog20170201.058570

³ Garmon, C. & Chartock, B. (2017). One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills. *Health Affairs*, 36(1) 177-181. doi: 10.1377/hlthaff.2016.0970

⁴ Cooper, Z., Morton, F.S., & Shekita, N. (July 2017). Surprise! Out-of-Network Billing for Emergency Care in the United States. *Yale Institution for Social and Policy Studies*, Retrieved from https://isps.yale.edu/sites/default/files/publication/2017/07/surpriseoutofnetwrokbilling_isps17-22.pdf

⁵ Claxton, G., Rae, M., Cox, C., & Levitt, L. (Aug. 13, 2018). An analysis of out-of-network claims in large employer health plans. *Kaiser Family Foundation*. Retrieved from <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start>

⁶ Garmon, C. & Chartock, B. (2017). One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills. *Health Affairs*, 36(1) 177-181. doi: 10.1377/hlthaff.2016.0970

⁷ Cousart, C. (Sept. 18, 2018). State Legislators Take Action to Protect Consumers from Surprise Billing. *National Academy for State Health Policy*. Retrieved from <https://nashp.org/state-legislators-take-action-to-protect-consumers-from-surprise-billing/>

⁸ Hoadley, J., Lucia, K., & Kona, M. (Jan. 18, 2019). State Efforts to Protect Consumers from Balance Billing. *Commonwealth Fund*. Retrieved from https://www.commonwealthfund.org/sites/default/files/2019-01/To_the_Point_BalanceBilling.pdf

⁹ Root, J. & Najmabadi, S. (Feb. 13, 2019). Thousands of Texans Shocked by Medical Bills Face a State Backlog of Requests for Help. *The Texas Tribune*. Retrieved from <http://www.governing.com/topics/health-human-services/tt-texans-medical-bills-state-backlog.html>

consuming process. Few consumers use the process and many cases do not reach mediation as the parties settle on a payment amount.¹⁰ For example, of the 900 cases in 2014, only one reached mediation.

Federal Action

Draft legislation from the previous Congress by a bipartisan group of senators, including Senator Michael Bennet (D-CO), addresses out-of-network medical charges that arise from two situations: emergency room visits to out-of-market sites, and care provided by an out-of-network physician at an in-network facility.¹¹ While the bill offers states the option to set specific rate methodologies, the federal default methodology under the bill would cap these payments to either the median in-network rate for services in the geographic area or 125 percent the average allowed amount in the same area. Senator Maggie Hassan (D-NH) introduced a comprehensive bill in 2018 that would eliminate surprise billing by requiring prices to be set through binding arbitration instead of using the 125 percent rate outlined in the bipartisan draft bill.

Emergency Medical Treatment and Labor Act (EMTALA)

The Emergency Medical Treatment and Labor Act (EMTALA) was passed in 1986 to ensure that patients have access to emergency services regardless of their ability to pay. It imposes specific responsibilities on all Medicare participating hospitals and apply to all patients. The three important provisions are, according to the American Academy of Emergency Medicine:¹²

1. The hospital must provide an appropriate medical screening exam to anyone coming to the emergency department (ED) seeking medical care;
2. For anyone that comes to the hospital and the hospital determines that the individual has an emergency medical condition, the hospital must treat and stabilize the emergency medical condition, or the hospital must transfer the individual; and
3. A hospital must not transfer an individual with an emergency medical condition that has not been stabilized unless several conditions are met that includes effecting an appropriate transfer.

The requirements of EMTALA only apply to hospitals that accept Medicare and would also likely apply to the many freestanding emergency departments (FSEDs) that are associated with such a hospital or hospital system. However, some FSEDs are independent facilities with no connection to hospitals and no need to comply with these EMTALA requirements. The Colorado Department of Public Health and Environment (CDPHE) currently regulates both hospital-affiliated and independent FSEDs with an EMTALA look-alike rule that mandates that these entities adhere to the core concept of the three provisions listed above.^{13,14}

This Legislation

The bill makes it a deceptive trade practice when in the course of the person's business or occupation the person violates the requirements of the bill. It also makes it an unfair method of competition and unfair or deceptive act or practices in the business of insurance to violate the requirements of the bill.

Current law encourages facilities, carriers, and providers to provide consumers with a disclosure about the potential impact of receiving services from an out-of-network provider. The bill amends this by requiring

¹⁰ Hoadley, J., Ahn, S., & Lucia, K. (June 2015). Balance Billing: How Are States Protecting Consumers from Unexpected Charges?. *Center on Health Insurance Reform & Robert Wood Johnson Foundation*. Retrieved from <https://www.insurance.pa.gov/Documents/Balance%20Billing/Kevin%20Lucia.pdf>

¹¹ Senator Bill Cassidy Official Website. (2018). *Draft Legislation*. Retrieved from <https://www.cassidy.senate.gov/imo/media/doc/Discussion%20Draft-%20Protecting%20Patients%20from%20Surprise%20Medical%20Bills%20Act.pdf>

¹² American Academy of Emergency Medicine. (n.d.) *Regulatory Resources: EMTALA*. Retrieved from <https://www.aaem.org/resources/key-issues/emtala>

¹³ 6 CCR 1011-1 Chapter 9 18.102(2)

¹⁴ It is assumed that this regulation would continue if HB19-1010, which creates a distinct FSED license type, were to pass.

facilities, carriers, and providers to provide consumers with disclosures about the potential impact of receiving services from an out-of-network provider or health care facility and their rights. Covered persons must have access to accurate information about their health care bills and payment obligations to enable them to make informed decisions about their health care and financial obligations.

If a covered person receives services at an in-network facility from an out-of-network provider, the carrier shall pay the out-of-network provider directly. At the time of the disposition of the claim, the carrier is to advise the out-of-network provider and covered person of a required deductible, copayment, or coinsurance. In this situation, the carrier shall reimburse the out-of-network provider the greater of:

- The carrier's average in-network rate of reimbursement for that service in the same geographic area
- 125 percent of the Medicare reimbursement rate for that service in the same geographic area
- 100 percent of the median in-network rate of reimbursement for that service in the same geographic area for the prior year as determined by claims data from the All-Payer Health Claims Database (APCD)

Payment in compliance with this is presumed to be full payment for the services, except from any required coinsurance, deductible, or copayment from the covered person. Therefore, a provider that has received the payment from the insurance company and the patient's required cost sharing shall not balance bill the patient. Nothing prevents the carrier and out-of-network provider from voluntarily negotiating an independent reimbursement rate. If negotiations fail, the rates listed above apply.

A carrier that provides any emergency service benefits shall cover those services at the in-network benefit level with the same coinsurance, deductible, or copayment as would apply if the services were provided by an in-network provider or facility.

The bill states that if a covered person receives emergency services at an out-of-network facility, the carrier shall directly reimburse the facility the greater of:

- The carrier's average in-network rate of reimbursement for that service provided in a similar facility or setting in the same geographic area
- 125 percent of the Medicare reimbursement rate for that service provided in a similar facility or setting in the same geographic area
- 100 percent of the median in-network rate of reimbursement for that service provided in a similar facility or setting in the same geographic area for the prior year as determined by claims data from the APCD

Payment in compliance with this is presumed to be full payment for the services, except from any required coinsurance, deductible, or copayment from the covered person. Nothing prevents the carrier and out-of-network provider from voluntarily negotiating an independent reimbursement rate. If negotiations fail, the rates listed above apply.

On and after January 1, 2020, carriers are to develop and provide disclosures to covered individuals about the potential effects of receiving health services from an out-of-network provider or at an out-of-network facility. The disclosures must comply with rules adopted by the Division of Insurance, in consultation with the Colorado Board of Health, Division of Professions and Occupations. At a minimum, the rules must address the following:

- Timing for providing the disclosures for emergency and nonemergency services, considering the potential limitations due to the federal law EMTALA
- Requirements regarding how the disclosures must be made such as: include them on billing statements, billing notices, prior authorizations, or other forms of communications with covered individuals
- The contents of the disclosures, including the person's rights and payment obligations if the person's plan is under the DOI's jurisdiction

- Disclosure requirements specific to carriers, which includes the possibility of being treated by an out-of-network provider, whether a provider is out-of-network, types of services an out-of-network provider may provide, and the right to request an in-network provider
- Requirements about the wording to be used in the disclosures, including the use of plain language and ensuring that carriers, health care facilities, and providers use consistent wording in this disclosure and others required under this bill

Receiving a disclosure does not waive the covered person's protections from this bill or the right to benefits under the plan at the in-network benefit level for all covered services and treatment received.

On and after January 1, 2020, health care providers are to develop and provide disclosures to covered persons about the potential effects of receiving emergency or nonemergency from an out-of-network provider. The disclosures must comply with the rules adopted by the Division of Professions and Occupations, in consultation with the DOI and State Board of Health. The rules are to be consistent with the rules adopted by the DOI and State Board of Health. At a minimum, the rules must address the following:

- Timing for providing the disclosures for emergency and nonemergency services, considering the potential limitations due the federal law EMTALA
- Requirements regarding how the disclosures must be made such as: include them on billing statements, billing notices, prior authorizations, or other forms of communications with consumers
- The contents of the disclosures, including the person's rights and payment obligations pursuant to the person's health coverage plan
- Disclosure requirements specific to providers, which includes whether the provider is out-of-network, the types of services an out-of-network provider may provide, and the right to request an in-network provider
- Requirements about the wording to be used in the disclosures, including the use of plain language and ensuring that carriers, health care facilities, and providers use consistent wording in this disclosure and others required under this bill

Receiving a disclosure does not waive the covered person's protections from this bill or the right to benefits under the plan at the in-network benefit level for all covered services and treatment received.

If an out-of-network provider provides emergency services or covered nonemergency services to a person at an in-network facility, the out-of-network provider is to submit a claim and the entire cost of the services to the person's carrier and not bill or collect payment from a person for any outstanding balance for services not paid by the carrier except the applicable coinsurance, deductible or copayment. If an out-of-network provider provides services in the above conditions and they receive a payment from a covered person for services which the person is not financially responsible for, the provider is to reimburse the person with 60 calendar days after the overpayment was reported to the provider. If the provider fails to reimburse the person for the overpayment, they are to pay interest at a rate of 10 percent per annum, beginning on the date the provider received the overpayment notice. The covered person is not required to request the accrued interest from the provider in order to receive it in addition to the original overpayment. An out-of-network provider is to provide an individual a written estimate of the amount for which the person will be financially responsible for within three days after a request from the person. An out-of-network provider must send a claim for a covered service to the insurance carrier within 180 days after the services were delivered in order to receive reimbursement. The rate of that reimbursement is the greater of:

- The carrier's average in-network rate of reimbursement for that service provided in the same geographic area
- 125 percent of the Medicare reimbursement rate for that service provided in the same geographic area
- 100 percent of the median in-network rate of reimbursement for that service in the same geographic area for the prior year as determined by claims data from the APCD

If the provider submits a claim after this period, the carrier is to reimburse them 125 percent of the Medicare reimbursement rate for that service provided in the same geographic area. The provider is to not bill the individual for any outstanding balance for a covered service not paid by the carrier, except for any required coinsurance, deductible, or copayment.

On and after January 1, 2020, health facilities are to develop and provide consumer disclosures about the potential effects of receiving services from an out-of-network provider at an in-network facility or emergency services at an out-of-network facility. The disclosures must comply with the rules adopted by the State Board of Health, in consultation with the DOI and the Division of Professions and Occupations. The rules are to be consistent with the rules adopted by the DOI and Division of Professions and Occupations. At a minimum, the rules must address the following:

- Timing for providing the disclosures for emergency and nonemergency services, considering the potential limitations due the federal law EMTALA
- Requirements regarding how the disclosures must be made such as: include them on billing statements, billing notices, or other forms of communications with consumers
- The contents of the disclosures, including the person's rights and payment obligations pursuant to the person's health coverage plan
- Disclosure requirements specific to facilities, which includes whether the facility is out-of-network, the types of services an out-of-network provider may provide, and the right to request an in-network provider
- Requirements about the wording to be used in the disclosures, including the use of plain language and ensuring that carriers, health care facilities, and providers use consistent wording in this disclosure and others required under this bill

Receiving a disclosure does not waive the covered person's protections from this bill or the right to benefits under the plan at the in-network benefit level for all covered services and treatment received.

If a person receives emergency services at an out-of-network facility, the facility is to submit a claim and the entire cost of the services to the person's carrier and not bill or collect payment from a person for any outstanding balance for services not paid by the carrier except the applicable coinsurance, deductible or copayment. If an out-of-network facility provides emergency services and they receive a payment from a covered person for services which the person is not financially responsible for, the facility is to reimburse the person with 60 calendar days after the overpayment was reported to the facility. If the facility fails to reimburse the person for the overpayment, they are to pay interest at a rate of 10 percent per annum, beginning on the date the facility received the overpayment notice. The covered person is not required to request the accrued interest from the facility in order to receive it in addition to the original overpayment. The facility must send a claim for a covered service to the insurance carrier within 180 days after the services were delivered in order to receive reimbursement. The rate of that reimbursement is the greater of:

- The carrier's average in-network rate of reimbursement for that service provided in a similar facility or setting in the same geographic area
- 125 percent of the Medicare reimbursement rate for that service provided in a similar facility or setting in the same geographic area
- 100 percent of the median in-network rate of reimbursement for that service provided in a similar facility or setting in the same geographic area for the prior year as determined by claims data from the APCD

If the facility submits a claim after this period, the carrier is to reimburse them 125 percent of the Medicare reimbursement rate for that service provided in a similar facility or setting in the same geographic area. The facility is to not bill the individual for any outstanding balance for a covered service not paid by the carrier, except for any required coinsurance, deductible, or copayment.

The bill makes it unlawful for any person, association, or corporation to violate the above requirements for facilities regarding disclosures and billing practices.

The bill is effective August 2, 2019 is the last day of session is May 3, 2019, unless a referendum petition is filed against the bill.

Reasons to Support

The consumer disclosures in the bill may prompt consumers to do their due diligence in checking to see if a provider or a facility is in-network in nonemergency situations. This would decrease the frequency that balance billing would occur, thus decreasing the amount of times that carriers must reimburse providers the greater of the mandated rates. This bill would work at not placing consumers in the middle of balance billing disputes between carriers and providers. This would save consumers money and financial stress, as the average potential surprise bill from a 2016 study was \$622.55 and nearly half of Americans do not have the liquidity to pay an unexpected \$400 expense without taking on debt.¹⁵

Supporters

- AARP Colorado
- Aetna
- Anthem Blue Cross and Blue Shield
- Colorado Association of Health Plans
- Colorado Business Group on Health
- Colorado Center on Law and Policy
- Colorado Children's Campaign
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition
- Colorado State Association of Health Underwriters
- Family Voices Colorado
- Healthier Colorado
- Mental Health Colorado
- One Colorado Education Fund
- Small Business Majority
- Young Invincibles

Reasons to Oppose

Some assert that this may place physicians at a disadvantage by restricting their billing practices and denying them fair compensation. Many of the same bills do not require health insurers to disclose the limitations of their plans. When physicians are compensated adequately, they are less likely to balance bill. Some may raise concerns about physician shortages or reduced access to care if compensation is insufficient to incentivize physicians to train for specialties. Further, some state that this solution may not address the root of the problem of inadequate preferred provider insurance plans and the failure of insurers to appropriately disclose coverage gaps to their customers.

Opponents

- Any opposition has not been made public at this time.

Other Considerations

States can pass laws that regulate health insurers and providers, but they cannot regulate the conduct (including the payment arrangements or reimbursement amounts) of private employer health plans that are self-funded (i.e., they pay for care directly and not through insurance). A large share of people with job-based coverage are covered under self-funded plans, which means that states cannot regulate how these plans handle cost sharing in out-of-network situations. While states could limit how much out-of-network providers can charge as balance bills, they cannot assure that the self-funded plan will pay a reasonable amount for services. A comprehensive approach therefore requires federal action. It will be important to

¹⁵ Cooper, Z., Morton, F.S., & Shekita, N. (July 2017). Surprise! Out-of-Network Billing for Emergency Care in the United States. *Yale Institution for Social and Policy Studies*, Retrieved from https://isps.yale.edu/sites/default/files/publication/2017/07/surpriseoutofnetwrokbilling_isps17-22.pdf

monitor the rulemaking by the DOI in regards to the consumer disclosures to ensure that they adhere to EMTALA and do not discourage consumers from seeking the treatment they need. It is important to note that there are many different ideas on how to tackle balance billing and some legal experts claim that contract law could provide another avenue to challenging these bills.¹⁶

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

¹⁶ Appleby, J. (Dec. 18, 2018). Taking Surprise Medical Bills to Court. *New York Times*. Retrieved from <https://www.nytimes.com/2018/12/18/well/live/taking-surprise-medical-bills-to-court.html>