

SB19-134: OUT-OF-NETWORK HEALTH CARE DISCLOSURES AND CHARGES

Concerning the provision of out-of-network health care services.

Details

Bill Sponsors:	Senate – <i>Fields (D) and Tate (R)</i> , Williams, A. (D) House – <i>Soper (R)</i> , Larson (R)
Committee:	Senate Health & Human Services
Bill History:	2/7/2019- Introduced in Senate- Assigned to Health & Human Services
Next Action:	Hearing by Senate Health & Human Services
Fiscal Note:	Not available at time of submission.

Bill Summary

The bill addresses balance billing 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. If a covered individual receives emergency services at an out-of-network facility the carrier is to reimburse the facility the greater of:

- The carrier's average in-network rate for the same service provided in a similar facility in the same geographic area
- 125 percent of Medicare reimbursement rate for the same service provided in a similar facility in the same geographic area
- 100 percent of the average in-network reimbursement rate for the same service provided in a similar facility in the same geographic area for the prior year, based on claims data from the All-Payer Claims Database (APCD)

The process for payment by a carrier to an out-of-network provider who provided services in an in-network facility is a more complex process that may result in the carrier and provider entering a binding arbitration process.

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 be 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 charges 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.

This Legislation

The bill declares that health insurance carriers are increasingly offering narrow network plans and removing providers from networks or not renewing their contracts. Covered individuals should be able to access in-network primary care providers, including those that are based in facilities, in a timely manner. Increasingly, carriers are offering high-deductible plans that require higher cost-sharing that results in greater patient financial responsibility rather than insurer responsibility. Facilities and providers must supply covered individuals with all the facts needed to make informed decisions about the coverage that is purchased and where and from which providers they may seek services. Carriers should clearly disclose, in transparent and meaningful language, the scope and limitations of any out-of-network benefit they provide and the reimbursement methodology for out-of-network services to covered persons, providers, and facilities. It is imperative that covered individuals are protected from financial impact that can result from narrow networks and cost-shifting trends within health insurance.

If a covered individual receives emergency services at an out-of-network facility the carrier is to reimburse the facility the greater of:

- The carrier's average in-network rate for the same service provided in a similar facility in the same geographic area
- 125 percent of Medicare reimbursement rate for the same service provided in a similar facility in the same geographic area
- 100 percent of the average in-network reimbursement rate for the same service provided in a similar facility in the same geographic area for the prior year, based on claims data from the All-Payer Claims Database (APCD)

The bill defines "average allowed amount" as the average in-network and out-of-network amounts paid, expect for payments for claims made under the Medicaid program, plans purchased through Connect for Health Colorado, and Medicare plans. "Cost-sharing" is defined as any expenditure required for a covered individual for health benefits including coinsurance, deductibles, copayments, and out-of-pocket expenses and does not include premiums, balance billing amounts, and spending for non-covered services. The "minimum benefit standard" is the greater of 150 percent of an amount equal to the 75th percentile of all in-network amounts or the average allowed amount for the service performed by a provider in the same/similar specialty and provided in the same geographic area (as reported in benchmarking databased

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>

administered by an independent organization that is not affiliated with a carrier and specified by the commissioner). For services provided in a rural area, defined by DOI rules, the “minimum benefit standard” is the greater of 200 percent of the highest in-network amount or 200 percent of the average allowed amount for the service performed by a provider in the same/similar specialty and provided in the same geographic area (as reported in benchmarking databased administered by an independent organization that is not affiliated with a carrier and specified by the commissioner). The bill defines “unanticipated out-of-network services” as emergency services provided to a covered individual by an out-of-network provider or nonemergency services provided to a covered person at an in-network facility by an out-of-network provider where the person did not have the ability to select the services from an in-network provider. This does not include nonemergency services provided by an out-of-network provider after the person voluntarily selects the provider after a full and accurate disclosure.

At the time that an in-network facility schedules services or seeks prior authorization from a carrier for nonemergency services the facility is to notify the covered individual in writing:

- That if an out-of-network provider is called upon by the facility to provide covered services at the facility, the carrier is required to treat the covered services as an in-network benefit
- Of the specific types of ancillary services that the person may need within the facility
- That the covered person may obtain a list of in-network providers from their carrier and the person may request and receive an in-network provider, if available

At or before admission to an in-network facility for nonemergency services, the facility is provide the same written notification as above and have the person or their authorized representative sign to acknowledge that they received the notification before admission. If an out-of-network provider provides out-of-network services the provider is to submit a claim to the person’s carrier (if known) and accept an assignment of benefits from the person. The provider is to include the following statement on any billing notice sent to the person: “I either do not have your insurance coverage information or I do not participate with your health insurance plan. If you received services from me at an in-network facility, then you may be entitled to certain out-of-network protections according to Colorado law. If there are questions concerning payment for the services, please contact your insurance carrier directly.” The written notifications that are required to be presented to the person does not waive their protections.

A provider is to send claims for unanticipated out-of-network services to the person’s carrier. The carrier is to reimburse the provider directly at a rate that is lesser of the full amount of billed charges and the minimum benefit standard. Carriers are to pay the out-of-network directly for any unanticipated out-of-network services. If a provider does not know if the person is covered, the provider is to include the following in the first notice or billing statement to the patient: a question asking if the person is insured, a statement that they should notify the provider if they are insured, and a statement that explains that if the person is insured, the carrier may be responsible for a portion of the bill. The out-of-network provider may bill the person only for the required in-network cost sharing amount for unanticipated out-of-network services and not bill them for any difference between the amount allowed by the carrier and the amount billed by the provider. The carrier is to notify the out-of-network provider of the amount of the in-network cost sharing within 10 business days after receiving the bill from the provider for unanticipated out-of-network services. When these services are provided, the person is responsible for payment only the applicable in-network cost sharing. For the purposes of these services, the carrier is to apply the same cost sharing requirements related to the person’s deductibles and out-of-pocket maximums as those for an in-network provider. The carrier is to hold the covered individual harmless for charges for unanticipated out-of-network services that are in excess of their in-network cost sharing amount.

An out-of-network provider that was reimbursed at the minimum benefit standard amount may initiate arbitration with the carrier by filing a request with the Division of Insurance (DOI) if the amount in dispute

after deducting the person's required cost sharing is at least \$50 and the provider believes the payment received does not properly recognize:

- The provider's training, education and experience
- The nature of the services provided
- The available capacity of the provider's practice
- The provider's usual charge for comparable services
- The circumstances and complexity of the case, including the time and place of the services
- Other aspects of their practice that may be relevant

A provider can bundle similar claims and claims representing a common issue or fact to be determined in a single arbitration process. In an effort to settle the charges before arbitration, the DOI is to arrange an informal settlement teleconference held within 30 days after they receive the arbitration request. The parties are to notify the DOI of the results of the teleconference. If the DOI receives notice that the dispute has not been settled or a party did not participate in the teleconference, an arbitrator is to be appointed from a list of qualified arbitrators created by DOI rule. The parties are to be notified of the arbitration date, the process to be followed, and the appointed arbitrator. The provider and carrier are to equally split the cost of the arbitration. The process must conclude within 30 days of the appointment of the arbitrator. The process is done on paper with each party submitting its final best offer. The arbitrator is to take into account the above list of applicable factors and the following when making a determination:

- 80th percentile of all charges for the service performed by a provider in the same/similar specialty and provided in the same geographic area, as report in a benchmarking database
- Average in-network rate for comparable services provided in same geographic area

The arbitrator is to make a determination in consultation with a neutral and impartial provider that is actively practicing in the same/similar specialty as the provider the provided the services in question. The decision of the arbitrator is final. A subsequent dispute between the parties about the same, previously arbitrated service is not subject to re-arbitration. If the decision requires additional payment by the carrier, the carrier is to do so promptly, in accordance with current law. If the DOI becomes aware of a carrier or provider routinely using arbitration of the same issue, despite an arbitrator's decision, the DOI shall require the party to pay the full cost of the arbitration. The DOI is to promulgate rules to:

- Establish a standard arbitration form
- Establish a process to create a list of qualified arbitrators. To be qualified an arbitrator must be independent and impartial, not be affiliated with a carrier, facility, or professional association of carriers or providers, not have any material, professional, family or financial conflict of interest, and have training and experience in health care billing
- Establish procedures and contracts with qualified arbitrators
- Determine the cost of the arbitration process
- Monitor and evaluate the arbitrators

On or before February 1, 2021, and each February 1 thereafter, each carrier is to report to the DOI the number of times unanticipated out-of-network services were provided, including provider types, types of services, regions where they occurred, and total number of minimum benefit standard payments. On or before January 1, 2022 and each January 1 thereafter, the DOI is to submit a report to the House Health and Insurance Committee and the Senate Health and Human Services Committee that compiles the data from the carrier reports, the total number of arbitrations in the previous calendar year, and the number of arbitration decisions in favor of providers or in favor of carriers.

This section on out-of-network services provided by out-of-network providers is repealed January 1, 2025.

The bill is effective January 1, 2020, 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. Proponents assert that 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.¹² Some may assert that the advantage of the binding arbitration process is that it encourages each side to submit reasonable offers, allows for some flexibility in the rate chosen for differing circumstances, and gives the involved parties more input into what that rate should be than a rate chosen by policymakers or regulators.

Supporters

- Colorado Cross-Disability Coalition

Reasons to Oppose

Opponents may assert that this bill allows for too high of reimbursement rates to providers for nonemergency out-of-network events. By allowing for higher reimbursement rates, providers may not have as great of an incentive to join a carrier's network. Some may argue that the bill still may place consumers in the middle of the process as a bill can still be sent to patients if for some reason it is unknown who they are insured by- consumers may continue to pay bills that they are not required to pay. The binding arbitration approach may add administrative burden to the issue. It is not necessarily clear that the arbitrator will always choose the "right" rate or be any better at selecting an appropriate rate than lawmakers. The arbitration approach may come with administrative costs for the carrier. If those administrative costs are high enough, they could undermine the effectiveness of the policy by leading carriers to simply accede to providers' demands rather than pursue arbitration.

Opponents

- Aetna

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 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.¹³ It is interesting to note that the legislative declaration of the bill states that "it is imperative that covered persons are protected from financial impact that can result from [...] cost-shifting trends within health insurance." The Colorado Health Institute recently published a report that the cost-shift does not exist, which enforces what many health

¹² 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

¹³ 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>

economists have claimed before.¹⁴ Further, it will be important to monitor the publication of the fiscal note to determine how many state resources would need to be devoted to the creation and maintenance of an arbitration process. Making the arbitration decisions public, as New Jersey's law does, may additionally make settlement before arbitration more likely as both sides would then know roughly what rate arbiters tend to select.¹⁵

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.

¹⁴ Colorado Health Institute (Feb. 13, 2019). *The Cost Shift Myth: New Sate Report Suggests Existing Policies Haven't Controlled Hospital Costs. Will New Strategies Be Needed?* Retrieved from <https://www.coloradohealthinstitute.org/research/cost-shift-myth>

¹⁵ Adler, L., et al. (Feb. 2019). *State Approaches to Mitigating Surprise Out-of-Network Billing. USC-Brookings Schaeffer Initiative for Health Policy.* Retrieved from <https://www.brookings.edu/wp-content/uploads/2019/02/State-Approaches-to-Mitigate-Surprise-Billing-February-2019.pdf>