COLORADO
Department of Regulatory Agencies
Division of Insurance

Health & Insurance Committee
House of Representatives
Colorado General Assembly
200 East Colfax, Room 307
Denver, Colorado 80203

Public & Behavioral Health & Human Services Committee
House of Representatives
Colorado General Assembly
200 East Colfax, Room 307
Denver, Colorado 80203

Health & Human Services Committee
Colorado State Senate
Colorado General Assembly
200 East Colfax
Denver, Colorado 80203

July 1, 2021

Dear Representatives and Senators,

The Colorado Division of Insurance (Division), part of the Department of Regulatory Agencies, is pleased to submit the first HB 19-1174 Report on Out-of-Network Utilization and Implementation covering calendar year 2020, pursuant to § 10-16-704 C.R.S. HB 19-1174 protects consumers from surprise medical bills. The legislation establishes payment methodologies for carriers to use when reimbursing providers or facilities for out-of-network services and creates an arbitration process to settle out-of-network billing disputes.

Under the law, carriers are required to report to the Division the use of out-of-network providers and facilities by covered persons and the impact on premium affordability. The Division is also required to report the number of arbitrations filed, settled, arbitrated, and dismissed in the previous calendar year. This report provides an analysis of the information submitted to the Division and the arbitrations completed in 2020.

The Division remains committed to protecting consumers from out-of-network costs and improving health care affordability for all Coloradans. Thank you for your engagement on this issue. Please do not hesitate to contact me should you have questions or comments about the information contained in this report.

Sincerely,

Michael Conway
Commissioner of Insurance

COLORADO

Department of Regulatory Agencies

Division of Insurance

HB 19-1174 Report on Out-of-Network Utilization and Implementation by the Colorado Division of Insurance

Presented to the Health and Insurance Committee and the Public and Behavioral Health and Human Services Committee of the Colorado House of Representatives and the Health and Human Services Committee of the Colorado State Senate, in accordance with § 10-16-704 C.R.S.

July 1, 2021

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Introduction

The Colorado Division of Insurance (The Division) welcomes the opportunity to share with the Public and Behavioral Health and Human Services and Health and Insurance Committees of the Colorado State House of Representatives and the Health and Human Services Committee of the Colorado State Senate a summary of information submitted by carriers regarding out-of-network claims and arbitrations completed in 2020 as required by HB 19-1174, Out-of-Network Health Care Services.

HB 19-1174, which took effect on January 1, 2020, protects consumers with health benefit plans regulated by the Division from surprise medical bills. The bill establishes payment methodologies for carriers to use when reimbursing providers or facilities for out-of-network services. The bill also requires insurers, providers and facilities to develop and provide disclosures to consumers about the effects of receiving out-of-network services. Finally, the bill creates an arbitration process for carriers and providers, or carriers and facilities, to use to settle out-of-network billing disputes.

Data was first collected under HB 19-1174 for the 2020 plan year. As required by § 10-16-704(16), C.R.S., this report provides an analysis of the information submitted to the Division from carriers for calendar year 2020, including the use of out-of-network providers and facilities by covered persons and the impact on premium affordability for consumers. This report also summarizes the number of arbitrations filed, settled, arbitrated, and dismissed in 2020 and a summary of whether the arbitrations were decided in favor of the carriers or the out-of-network provider or facility. This is the first report submitted pursuant to HB 19-1174.

Overview of State and Federal Actions on Surprise Billing

Out-of-network medical bills, or surprise bills, occur when a covered person is billed for services received from a provider or facility that is not in their carrier's network. Patients may inadvertently be treated and subsequently billed by an out-of-network provider even while receiving their care at an in-network facility, or they may receive such bills from an out-of-network provider or facility in an emergency situation. The surprise bill is usually the difference between the total bill for the claim and what the patient's insurance carrier paid toward the claim. According to the Kaiser Family Foundation, among privately insured patients, an estimated 1 in 5 emergency claims and 1 in 6 in-network hospitalizations include an out-of-network bill.

In 2019, the Colorado legislature passed HB 19-1174. This bill protects individuals with health benefit plans regulated by the Division from receiving a surprise bill when receiving emergency care from an out-of-network provider or facility, or when receiving non-emergency care at an in-network facility from an out-of-network provider. In such situations, HB 19-1174 instead sets up

a payment framework for carriers to utilize for out-of-network providers and facilities. Carriers must reimburse the out-of-network provider the greater of:

1) 110% of the carrier's median in-network rate of reimbursement for that service in the same geographic area;
2) The 60th percentile of the in-network rate of reimbursement for the same service in the same geographic area for the prior year based on commercial claims data from the Colorado All-Payer Health Claims Database (APCD); or
3) A negotiated independent reimbursement rate.

Carriers must reimburse the out-of-network facility the greater of:

1) 105% of the carrier's median in-network rate of reimbursement for that service provided in a similar facility or setting in the same geographic area;
2) The median in-network rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado APCD; or
3) A negotiated independent reimbursement rate.

The law also includes a separate reimbursement rate for emergency services received at an out-of-network facility operated by the Denver Health and Hospital Authority. The carrier must reimburse those facilities the greater of:

1) The carrier's median in-network rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area;
2) 250% of the Medicare reimbursement rate for the same service provided in a similar facility or setting in the same geographic area;
3) The median in-network rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado APCD; or
4) A negotiated independent reimbursement rate.

Colorado is one of a few states to pass surprise bill legislation that includes both a standard reimbursement methodology for carriers and a dispute resolution process for providers. According to the Commonwealth Fund, 18 states have passed comprehensive laws prohibiting out-of-network billing.

Analysis of Out-of-Network Data

Section 10-16-704(14), C.R.S., requires carriers to submit information "concerning the use of out-of-network providers and facilities by covered persons and the impact on premium affordability for consumers." To implement this requirement; the Division adopted Colorado Insurance Regulation 4-2-74. The data reporting requirements in this regulation apply to all carriers offering individual, small group, and large group health benefit plans in Colorado,

including student health plans and managed care plans, that received bills from out-of-network providers and facilities on or after January 1, 2020, and that are subject to the requirements of §§ 10-16-704(3)(d) and (5.5), C.R.S.

Pursuant to Colorado Insurance Regulation 4-2-74, carriers must submit the following data to the Division:

- Aggregated out-of-network claims data, by geographic area, concerning claims for non-emergency services received at an in-network facility by an out-of-network provider and concerning claims processed for emergency services received at an out-of-network facility;
- The total amount charged by and paid to five out-of-network provider types:
    - Anesthesiologists;
    - Radiologists;
    - Surgical Assistants;
    - Emergency Room Physicians; and
    - Pathologists;
- The ratio of total out-of-network claims to in-network claims processed by number and dollar amount;
- The total number of unique non-contracted providers who submitted out-of-network claims to the carrier for payment by the five out-of-network provider types;
- Aggregated claims data for services, by facility type, by geographic area, including total amount charged, total amount paid, and total number of claims denied and resolved;
- The total number of out-of-network facility claims processed;
- De-identified aggregated claims data for ambulance service providers including the total amount charged, total amount paid and the total number of out-of-network claims processed;
- A narrative description of how the carriers' networks have changed due to the passage of HB 19-1174 and the factors that contributed to those changes; and
- A detailed analysis of the impact of using out-of-network providers and facilities on premium affordability for consumers based on the data reported, presented by market (individual, small group, large group) and by geographic area.

For the 2020 plan year, the Division received information from 11 carriers operating in the state. A summary of key information from the data is provided below. As used in this report, the notation "all carriers" refers to data available and submitted by all 11 carriers. Large carriers are defined as carriers with 5% or more of the total health market based on written premiums in Colorado in 2019. Four carriers were identified as large carriers.

A. Out-of-Network Provider Utilization Data

On average, across all carriers, approximately 8% of total aggregate provider claims were out-of-network. These claims were either for non-emergency services received at an in-network facility by an out-of-network provider or for emergency services received at an out-of-network

facility. The range for specific carriers was from 1% to 19%. For large carriers, approximately 6% of total aggregate provider claims were out-of-network.

In looking at the total dollar amount carriers spent on out-of-network provider claims, approximately 6% of total provider claims by paid dollar amount were out-of-network, with a range of 1% to 15%. For large carriers, approximately 3% of total provider claims by paid dollar amount were out-of-network.

The data below summarizes out-of-network utilization by geographic area and provider type and also provides an overview of the reimbursement methodology most commonly used.

Out-of-Network Provider Utilization by Geographic Area

While out-of-network provider claims were reported in all nine rating areas, the rating area with the largest number of unique non-contracted providers who submitted out-of-network claims was reported in the Denver area (5,485 providers).[1] Colorado Springs had the second largest number of non-contracted providers submitting out-of-network claims (992 providers), and Rating Area 9, the western portion of the state, had the third largest (779 providers).

Total Unique Non-Contracted Providers who Submitted Out-of-Network Claims by Provider Type and Rating Area

	Anesthesiologist Claims	Radiologist Claims	Pathologist Claims	Emergency Room Physician Claims	Surgical Assistant Claims	Total
Rating Area 1 Boulder	30	105	87	238	67	**527**
Rating Area 2 Colorado Springs	166	220	116	340	80	**992**
Rating Area 3 Denver	538	937	1,570	1,970	470	**5,485**
Rating Area 4 Ft. Collins	81	73	104	267	7	**532**
Rating Area 5 Grand Junction	42	54	8	53	5	**162**
Rating Area 6 Greeley	43	11	5	162	10	**231**
Rating Area 7 Pueblo	11	32	9	49	3	**104**
Rating Area 8 East	23	45	13	146	0	**227**
Rating Area 9 West	88	182	30	458	21	**779**
Total	**1,022**	**1,659**	**1,942**	**3,683**	**663**	**8,969**

[1] As used in this section, these data aggregate the number of unique non-contracted provider claims reported by each carrier. There could be overlap among carriers as to providers submitting out-of-network claims.

Provider Types

Pursuant to Colorado Regulation 4-2-74, carriers are required to provide data on the total amount changed by and paid to five provider types: Anesthesiologists, Radiologists, Pathologists, Emergency Room Physicians, and Surgical Assistants. According to a recent study from Yale University, anesthesiologists, pathologists, radiologists and surgical assistants at in-network hospitals billed out-of-network in about 10% of cases. A similar study found over 1 in 5 patients who went to in-network emergency departments were treated by out-of-network emergency physicians.

Based on the data collected, out of the five required provider types, unique non-contracted emergency room physicians submitted the largest number of out-of-network claims by carrier across all rating areas (3,683 providers). Out-of-network emergency room physicians also charged carriers and were paid by carriers the largest total amount based on total spend. Out-of-network emergency room physicians in the aggregate charged $28,603,036 to carriers and were paid $6,517,575 for out-of-network claims in 2020.

For comparison, of the five required provider types, Surgical Assistants charged carriers the second largest total amount ($12,798,004) for out-of-network claims in the aggregate based on total spend. Radiologists were paid the second largest total amount ($2,078,960) for out-of-network claims in the aggregate based on total spend.

Total Amount Charged by and Paid to Out-of-Network Provider Types by Total Spend

Provider Type	Total Amount Charged Based on Aggregate Claims Data	Total Amount Paid Based on Aggregate Claims Data
Anesthesiologist	$12,564,325	$1,911,122
Radiologist	$8,036,362	$2,078,960
Surgical Assistant	$12,798,004	$641,293
Emergency Room Physician	$28,603,036	$6,517,575
Pathologist	$2,297,253	$696,111
Total	**$64,298,980**	**$11,845,061**

Carriers are also required to provide data on the total amount charged by and paid to the top five out-of-network provider types, by total spend, outside of the five specified providers. The provider types that were listed as also charging out-of-network claims were family medicine (1,117 unique non-contracted providers submitted out-of-network claims), internal medicine (874 unique non-contracted providers submitted out-of-network claims) and obstetrics and gynecology (397 unique non-contracted providers submitted out-of-network claims).

The Division will continue to review current and future carrier data submissions to determine whether additional or different provider types should be included as required reporting categories.

Out-of-Network Provider Reimbursement Methodology
As specified in HB 19-1174, carriers must reimburse out-of-network providers the greater of: (1) 110% of the carrier's median in-network rate of reimbursement for that service in the same geographic area; (2) the 60th percentile of the in-network rate of reimbursement for the same service in the same geographic area for the prior year based on commercial claims data from the APCD; or (3) a negotiated independent reimbursement rate.

Across all carriers, the rate calculated based on 110% of a carrier's median in-network rate of reimbursement was the most commonly utilized payment methodology for provider out-of-network claims (36,515 total claims utilizing this payment method). In comparison, 10,266 out-of-network provider claims were paid based on a negotiated independent rate. Amongst the large carriers, all three payment methodologies were used. The rate calculated based on 110% was also the most commonly utilized payment methodology amongst large carriers (33,217 total large carrier claims utilizing this payment method).

Payment Methodology Utilization – Providers

	Total number of claims utilizing 110% of carrier's median in-network rate of reimbursement	Total number of claims utilizing the 60th percentile of in-network rate of reimbursement for the prior year based on commercial claims data from the APCD	Total number of claims utilizing a negotiated alternative reimbursement
Total number of provider claims	36,515	33,809	10,266

B. Out-of-Network Facility Utilization Data

On average, across all carriers, approximately 10% of total aggregate facility claims were out-of-network. These claims were for covered emergency services at an out-of-network facility. For large carriers, on average, approximately 6% of total aggregate facility claims were out-of-network.

Out-of-network facility claims, on average across all carriers, accounted for approximately 7% of total facility claims by paid dollar amount. For large carriers, 4% of total facility claims by paid dollar amount were out-of-network.

Out-of-Network Facility Reimbursement Methodology
HB 19-1174 included three payment methodologies for carriers and facilities to use when a claim is received from an out-of-network facility. The payment methodology for an out-of-network facility must be the greater of: (1) 105% of the carrier's median in-network rate of reimbursement for that service provided in a similar facility or setting in the same geographic area; (2) the median in-network rate of reimbursement for the same service provided in a similar

facility or setting in the same geographic area for the prior year based on claims data from the APCD; or (3) a negotiated independent reimbursement rate. For facilities operated by Denver Health, the reimbursement structure cited in the Overview section of this report applies.

Across carriers, based on data reported on non-Denver Health reimbursement methodologies, the rate calculated based on 105% of a carrier's median in-network rate of reimbursement was the most commonly utilized payment methodology for facility out-of-network claims (9,589 total claims utilized this payment method). Across all carriers, all three payment methodologies were utilized. The rate calculated based on 105% was also the most commonly utilized payment methodology amongst large carriers (7,699 total large carrier claims utilizing this payment method).

Payment Methodology Utilization - Facility

	Total number of claims utilizing 105% of carrier's median in-network rate of reimbursement	Total number of claims utilizing the median in-network rate of reimbursement for the prior year based on commercial claims data from the APCD	Total number of claims utilizing a negotiated alternative reimbursement
Total number of facility claims	9,589	8,439	8,837

Out-of-Network Facility types
The facilities reported as submitting the most out-of-network claims were hospitals and freestanding emergency rooms. However, because of the variability in reporting based on facility type, it was difficult to identify patterns or make comparisons across carriers based on type or geography.

C. Out-of-Network Ambulance Service Providers Utilization Data

HB 19-1174 excludes emergency ambulance services provided by publicly funded fire agencies from the law. For a majority of carriers that submitted out-of-network data, over 90% of ambulance claims were out-of-network. Only two carriers had less than 50% of ambulance claims out-of-network. On average, across all carriers, 77% of total aggregate ambulance service provider claims were out-of-network.

On average, approximately 74% of total ambulance claims by paid dollar amount were out-of-network. However, only 4 out of the 11 carriers reported that ambulance service providers were one of the carriers' top 10 out-of-network provider types, as measured by total spend.

Geographically, the same trends were noticed with ambulance service providers as other providers. Denver and Colorado Springs had the largest amount charged by and paid to out-of-network ambulance service providers by total spend.

Total Amount Charged by and Paid to Out-of-Network Ambulance Service Providers by Total Spend and Rating Area

Rating Area	Total Amount Charged Based on Aggregate Claims Data	Total Amount Paid Based on Aggregate Claims Data
Rating Area 1 Boulder	$837,967	$435,060
Rating Area 2 Colorado Springs	$1,988,574	$996,131
Rating Area 3 Denver	$14,528,041	$8,603,312
Rating Area 4 Ft. Collins	$601,776	$292,206
Rating Area 5 Grand Junction	$114,724	$64,076
Rating Area 6 Greeley	$754,455	$319,070
Rating Area 7 Pueblo	$1,179,452	$368,586
Rating Area 8 East	$257,930	$131,335
Rating Area 9 West	$949,371	$505,597
Total	**$21,212,290**	**$11,715,373**

Out-of-Network Ambulance Service Provider Reimbursement Methodology

The payment reimbursement methodologies created for ambulance service providers are outlined in Colorado Insurance Regulation 4-2-66, Concerning the Payment Methodology for Non-Contracted Service Agencies that Provide Emergency Ambulance Services. Under this regulation, carriers must reimburse a non-contracted service agency that provides emergency ambulance services to a covered person at (1) 325% of the Medicare reimbursement rate for the same service provided in the same geographic area, including mileage or (2) a negotiated independent reimbursement rate.

For ambulance service providers, an alternative negotiated reimbursement rate was more frequently utilized to determine the reimbursement amount for out-of-network ambulance service claims (3,150 claims) instead of the rate based on 325% of the Medicare reimbursement rate (2,958 claims).

Payment Methodology Utilized - Ambulance Service Providers

	Total number of claims utilizing 325% of Medicare reimbursement	Total number of claims utilizing a negotiated alternative reimbursement
Total number of ambulance provider claims	2,958	3,150

D. Network Data and the Impact on Premiums

For the first year of data reporting, limited information is available to evaluate premium impact. In the 2020 plan year submissions, one carrier reported an average reduction in premiums ranging from 0.5% to 1.7% depending on the market, as a result of HB 19-1174. Several carriers reported that they were unable to draw any conclusions regarding premium impacts at this time. Based on carrier responses, the Division is evaluating the need to release additional guidance to ensure consistency in how this data is reported in the future.

Carriers also submitted information on the impact HB 19-1174 had on networks. Based on the information collected, most carriers reported no change to their networks. Two carriers reported an overall increase in their networks in 2020, including an increase in contracting interest from certain practice groups. The Division will continue to further refine data collected regarding networks and the impact on premiums.

Summary of 2020 Arbitration Requests

HB 19-1174 creates a process for out-of-network providers or facilities to initiate arbitration if they believe that the payment received from a carrier was insufficient given the complexity and circumstances of the services provided.

In 2020, 26 requests for arbitration were filed with the Division. All requests were settled outside of the arbitration process. Therefore, the Division has no information regarding the number that were determined in favor of the facility or carrier, or the final amount paid.

The number of arbitrations are expected to rise as more providers and facilities become familiar with the arbitration process. As of late April 2021, the Division has received over 450 requests for arbitration.

Conclusion

Data was first collected under HB 19-1174 for the 2020 plan year. Based on this first year of data, it appears that out-of-network provider and facility claims made up 10% or less of total

claims and carrier spend whereas out-of-network ambulance providers claims made up over 70% of total ambulance provider claims and carrier spend. For future reports, the Division will be evaluating whether to refine and streamline the reporting process. The Division is committed to learning more about the impact of out-of-network utilization, and in future reports hope to be able to look at trends over time.

	Total Out-of-Network Claims	Total Out-of-Network Claims by Paid Dollar Amount
Out-of-Network Provider	8% of provider claims	6% of total provider costs
Out-of-Network Facility	10% of facility claims	7% of total facility costs
Out-of-Network Ambulance Provider	77% of ambulance service provider claims	74% of total ambulance provider costs

Total Aggregate Out-of-Network Claims by Providers, Facilities, and Ambulance Service Providers

	Aggregate Out-of-Network Claims by Number of Claims	Aggregate Out-of-Network Claims by Paid Dollar Amount
Providers	198,799	$21,470,494
Facilities	39,960	$49,326,755
Ambulance Service Providers	14,062	$11,715,373

Appendix A

Rating Area 1: Boulder
Rating Area 2: Colorado Springs
Rating Area 3: Denver
Rating Area 4: Fort Collins
Rating Area 5: Grand Junction
Rating Area 6: Greeley
Rating Area 7: Pueblo
Rating Area 8: East
Rating Area 9: West