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, 2022

Dear Representatives and Senators,

The Colorado Division of Insurance (Division), part of the Department of Regulatory Agencies, is pleased to submit the second HB 19-1174 Report on Out-of-Network Utilization and Implementation covering calendar year 2021, 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 2021.

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, 2022

Table of Contents

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 2021 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 and released in a Division report in 2020. 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 2021, 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 2021 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 second 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 room visits result in an out-of-network medical bill. The study also found between 9% and 16% of in-network hospitalizations for non-emergency care included a surprise bill from an out-of-network provider.

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.

In December 2020, Congress passed the No Surprises Act (NSA). The law protects individuals from surprise medical bills when receiving emergency services, non-emergency services from an out-of-network provider at an in-network facility and services from an out-of-network air ambulance provider. The law became effective January 1, 2022. The NSA also added protections for consumers, including a prohibition against surprise medical bills for post-stabilization services and a prohibition on certain types of providers from balance billing patients regardless of consent.

During the 2022 Colorado legislative session, the Division worked with the General Assembly on legislation to align Colorado's surprise billing law with the NSA and adopt many of the new consumer protections created in the NSA. On June 8, 2022, Governor Polis signed HB22-1284 Health Insurance Surprise Billing Protections.

This report summarizes data from the 2021 year before the NSA became effective. The impact of the NSA and HB 22-1284 will be addressed in the 2022 Division of Insurance Report on Out-of-Network Utilization.

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 and amended the regulation in December 2021 to provide more clarity and streamline the reporting requirements.

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 provider 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 and amount allowed prior to the application of the covered person's cost-sharing requirements for each of the payment methodologies contained in §10-16-704(3)(d), C.R.S., including the number and amount of any negotiated alternative reimbursements;
- Aggregated claims data for services, by facility type and geographic area, including total amount charged, total amount paid, and total number of claims denied or 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.

In 2021, the Division received data 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 2% to 20%. For large carriers, approximately 7% of total aggregate provider claims were out-of-network. In 2020, the data also showed that approximately 8% of total aggregate provider claims were out-of-network. The percentage of out-of-network provider claims for larger carriers increased from 6% in 2020 to 7% in 2021.

In looking at the total dollar amount carriers spent on out-of-network provider claims, approximately 7% of total provider claims by paid dollar amount were out-of-network, with a range of 2% to 28%. For large carriers, approximately 5% of total provider claims by paid dollar amount were out-of-network. The total amount carriers spent on out-of-network provider claims increased from 6% in 2020 to 7% in 2021. For larger carriers, the percentage increased from 3% to 5%.

The data below summarizes out-of-network utilization by geographic area and provider type, out-of-network provider payment methodology utilization, and out-of-network provider claim denials.

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 aggregate out-of-network provider claims was reported in the Denver area (33,911 claims). Colorado Springs had the second largest number of out-of-network claims (5,388 claims), and Rating Area 9, the western portion of the state, had the third largest (3,050 claims).

Total Aggregated Out-of-Network Claims by Provider Type and Geographic Area

	Anesthesiologist Claims	Radiologist Claims	Pathologist Claims	Emergency Room Physician Claims	Surgical Assistant Claims	Total
Rating Area 1 Boulder	182	277	732	398	477	**2,066**
Rating Area 2 Colorado Springs	773	1,824	1,734	660	397	**5,388**
Rating Area 3 Denver	5,045	4,279	12,670	8,436	3,481	**33,911**
Rating Area 4 Ft. Collins	181	232	961	374	148	**1,896**
Rating Area 5 Grand Junction	68	122	255	193	3	**641**
Rating Area 6 Greeley	38	128	124	283	72	**645**
Rating Area 7 Pueblo	22	74	21	96	12	**225**
Rating Area 8 East	304	429	106	654	21	**1,514**
Rating Area 9 West	269	720	696	1,223	142	**3,050**
Total	**6,882**	**8,085**	**17,299**	**12,317**	**4,753**	**49,336**

Provider Types

Pursuant to Colorado Regulation 4-2-74, carriers are required to provide data on the total amount charged by and paid to five provider types: Anesthesiologists, Radiologists, Pathologists, Emergency Room Physicians, and Surgical Assistants. According to a 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, pathologists submitted the largest number of out-of-network claims by carrier across all geographic areas (17,299 claims). However, based on aggregated claims data, the provider that charged the highest amount and was paid the highest amount by total spend was anesthesiologists. Out-of-network anesthesiologists in the aggregate charged $75,312,153 to carriers and were paid $18,056,577 for out-of-network claims in 2021.

For comparison, of the five out-of-network provider types, emergency room physicians charged carriers the second highest total amount ($45,822,027) for out-of-network claims in the aggregate based on total spend and were paid the second largest total amount for those claims ($12,793,991). Based on the data submitted, there is a difference of $134 million between total amount charged and total amount paid to these provider types in 2021.

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	$75,312,153	$18,056,577
Radiologist	$27,150,310	$7,383,665
Surgical Assistant	$14,764,374	$788,368
Emergency Room Physician	$45,822,027	$12,793,991
Pathologist	$14,084,030	$3,685,603
Total	**$177,132,894**	**$42,708,204**

Carriers are also required to provide data on the total aggregated out-of-network claims to the top five out-of-network provider types, outside of the five specified providers. The provider types that were listed as also submitting out-of-network claims were general practice (19,448 out-of-network claims), family practice (9,400 out-of-network claims) and general surgery (2,397 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 (64,049 total claims utilizing this payment method). In comparison, 16,292 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 (33,922 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	64,049	29,453	16,292

Out-of-Network Provider Claim Denial

Colorado Regulation 4-2-74 requires carriers to report the number of claims denied by the five out-of-network provider types, Anesthesiologists, Radiologists, Pathologists, Emergency Room Physicians, and Surgical Assistants, and provide a reason for the claim denial based on five specified classifications:

> (1) Duplicative charge, claims denied because of a duplicate charge from the provider;
>
> (2) Enrollment and eligibility, claims denied because the member was no longer eligible, member had coverage with another carrier, or member failed to make a premium payment;
>
> (3) Missing or incorrect claims, claims denied because of an invalid diagnosis code, incomplete information, claim was filed outside of a specified time limit, incorrectly billed, or because the provider was unresponsive;
>
> (4) Prior authorization, claims denied because the service was not authorized by the carrier or authorization was denied;
>
> (5) Benefit issue, claims denied because the service was determined not medically necessary, or the claim was incorrectly submitted without being bundled with another service; the service or procedure was not covered, or the service was outside the providers' scope of practice.

Based on the data provided, claims by out-of-network providers were frequently denied because of missing or incorrect claim information (135,612 claims denied) or because the claim was a duplicative charge (9,384 claims denied).

Number of Claims Denied by Out-of-Network Provider Types by Classified Reason

Provider Type	Duplicative Charge	Enrollment Eligibility	Missing or Incorrect Claim	Prior Authorization	Benefit Issue
Anesthesiologist	598	197	993	199	492
Radiologist	3,117	2,149	2,258	586	2,398
Surgical Assistant	113	16	722	46	272
Emergency Room Physician	2,055	358	1,235	72	1,796
Pathologist	3,501	1,413	130,404	895	3,364
Total	**9,384**	**4,133**	**135,612**	**1,798**	**8,320**

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 8% of total aggregate facility claims were out-of-network. Similarly, in 2020, approximately 10% of total aggregate facility claims were out-of-network, but for larger carriers only 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, 5% of total facility claims by paid dollar amount were out-of-network. Again, these percentages are similar to the data submitted in 2020. However, for larger carriers, the percentage of total facility claims by paid dollar amount that were out-of-network increased from 4% in 2020 to 5% in 2021.

Out-of-Network Facility Type

For the 2021 calendar year, all carriers provided aggregated claims data including total amount charged and paid by carriers for covered emergency services at an out-of-network hospital.

The rating area with the largest amount charged to carriers for emergency services at an out-of-network hospital was reported in the Denver area ($248,385,481). Denver-area out-of-network hospitals were also paid the largest amount by total spend ($53,895,560). Rating Area 9, the western portion of the state, had the second largest amount charged to carriers for emergency services at an out-of-network hospitals ($53,312,998), and Grand Junction had the second largest amount paid by carriers for emergency services at an out-of-network hospital ($27,342,566). Based on the data submitted, there is a difference of $345 million between total amount charged and total amount paid to hospitals in 2021.

Total Amount Charged by and Paid to Out-of-Network Hospitals by Total Spend and Geographic Area

Rating Area	Total Amount Charged Based on Aggregated Claims Data	Total Amount Paid Based on Aggregated Claims Data
Rating Area 1 Boulder	$35,755,666	$6,900,821
Rating Area 2 Colorado Springs	$25,354,932	$5,025,002
Rating Area 3 Denver	$248,385,481	$53,895,560
Rating Area 4 Ft. Collins	$13,395,058	$3,552,405
Rating Area 5 Grand Junction	$47,905,732	$27,342,566
Rating Area 6 Greeley	$9,774,455	$2,310,549
Rating Area 7 Pueblo	$3,217,937	$698,116
Rating Area 8 East	$51,333,438	$16,913,761
Rating Area 9 West	$53,312,998	$26,281,840
Total	**$488,435,697**	**$142,920,620**

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, a negotiated independent reimbursement rate was the most commonly utilized payment methodology for facility out-of-network claims (52,375 total claims utilized this payment method). Across all carriers, all three payment methodologies were utilized. A negotiated independent reimbursement rate was also the most commonly utilized payment methodology amongst large carriers (51,923 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	33,438	16,813	52,375

Out-of-Network Facility Claim Denial

Similar to data collected on out-of-network claim denials for provider types, Colorado Regulation 4-2-74 requires carriers to report on the number of claims denied by facility type and provide a reason based on the same five specified classifications: (1) duplicative charge, (2) enrollment and eligibility, (3) missing or incorrect claims, (4) prior authorization, or (5) benefit issue.

Based on the data provided, claims by out-of-network hospitals were frequently denied because of a benefit issue (9,724 claims denied) or enrollment or eligibility issues (4,592 claims denied).

Facility Type	Duplicative Charge	Enrollment Eligibility	Missing or Incorrect Claim	Prior Authorization	Benefit Issue
Hospital	6,901	4,592	7,861	489	9,724

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. On average, across all carriers, 75% of total aggregate ambulance service provider claims were out-of-network. Amongst the larger carriers, 71% of total aggregate ambulance service provider claims were out-of-network. Three carriers had 99-100% of total aggregate ambulance service provider claims that were out-of-network.

On average, approximately 70% of total ambulance claims by paid dollar amount were out-of-network. Amongst the larger carriers, 77% of total ambulance claims by paid dollar amount were out-of-network. However, only five out of the 11 carriers that submitted data 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 Geographic Area

Rating Area	Total Amount Charged Based on Aggregate Claims Data	Total Amount Paid Based on Aggregate Claims Data
Rating Area 1 Boulder	$1,592,313	$824,523
Rating Area 2 Colorado Springs	$3,462,478	$1,975,750
Rating Area 3 Denver	$22,645,698	$12,479,493
Rating Area 4 Ft. Collins	$1,630,877	$820,204
Rating Area 5 Grand Junction	$115,226	$83,081
Rating Area 6 Greeley	$1,324,133	$460,111
Rating Area 7 Pueblo	$1,035,902	$621,887
Rating Area 8 East	$2,786,288	$1,188,322
Rating Area 9 West	$2,742,781	$1,553,962
Total	**$37,335,696**	**$20,007,333**

Across carriers, the rating area with the largest number of unique non-contracted ambulance service providers who submitted out-of-network claims was reported in the Denver area (304 ambulance providers).[1] Rating Area 9 had the second largest number of non-contracted ambulance service providers submitting out-of-network claims (139 ambulance providers), and Rating Area 8, the eastern portion of the state, had the third largest (104 ambulance providers).

In 2021, data was also collected on in-network contracted ambulance service provider claims. Across carriers, Ft. Collins had the smallest number of unique contracted ambulance service providers (6 unique contracted providers). Carriers also reported a small number of unique contracted ambulance service providers in Greeley and Pueblo (10 unique contracted providers).

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

Total Unique Contracted Ambulance Service Providers, and Unique Non-Contracted Ambulance Service Providers who Submitted Out-of-Network Claims by Geographic area

Rating Area	Contracted	Non-Contracted Claims
Rating Area 1 Boulder	12	46
Rating Area 2 Colorado Springs	34	65
Rating Area 3 Denver	94	304
Rating Area 4 Ft. Collins	6	21
Rating Area 5 Grand Junction	27	24
Rating Area 6 Greeley	10	34
Rating Area 7 Pueblo	10	12
Rating Area 8 East	80	104
Rating Area 9 West	73	139
Total	**346**	**749**

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, the reimbursement rate based on 325% of Medicare was more frequently utilized for out-of-network ambulance service claims (10,377 claims) instead of a negotiated alternative reimbursement rate (3,221 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	10,377	3,221

D. Network Data and the Impact on Premiums

Carriers submitted information on the impact HB 19-1174 had on networks, including a description of how the carriers' networks changed due to the passage of HB 19-1174 and the factors that contributed to those changes.

The first year of implementation, most carriers reported no change to their networks. For the 2021 calendar year, six carriers reported no change in their networks due to the passage of HB 19-1174 and four carriers reported their networks expanded over the past year.[2] Of the carriers that expanded their networks, several carriers reported additional contracting interest from emergency physicians, anesthesiologists, and radiologists. Two carriers stated they expanded their networks to add additional ambulance service providers. The carriers that reported no change to their networks acknowledged that over the past year some contracts had been terminated and some new providers added, but none were specifically related to the passage of HB 19-1174. One carrier reported physician groups that were unwilling to engage in contract discussions prior to HB19-1174 remained unwilling to engage.

For the second year of data reporting, carriers were able to provide more information regarding the impact HB 19-1174 had on premiums. In the 2021 year submissions, three carriers reported no savings or premium impact as a result of HB19-1174, six carriers reported a decrease in premiums as a result of HB 19-1174 and two carriers did not have data to report. Of the six carriers that reported a reduction in premiums, the impact ranged from a 0.2% to a 3.2% reduction depending on the market. On average, across all six carriers, the average reduction to premiums was 1.3%. For larger carriers, the average reduction to premiums was 1.5%.

Summary of 2021 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 2021, the Division received approximately 570 arbitration requests. Of those requests, 285 went to arbitration. After the arbitrations were completed, 141 arbitrations were decided in favor of the carrier and 144 arbitrations were decided in favor of the provider. On average, the difference between the carrier's final offered amount and provider's final offered amount was about $547. For claims decided in favor of the provider, the final payment received, on average, was approximately 40% higher than the payment offered by the carrier.

Of the remaining requests, 86 requests were settled outside of arbitration and 97 requests were withdrawn by the provider as a result of a contract negotiation. Approximately 100 requests were not arbitrated either because the request was determined ineligible, the request was withdrawn by the provider or the request was determined to be incomplete.

[2] One carrier did not have previous year data available to make a comparison.

Conclusion

The data collected under HB 19-1174 for the 2021 calendar year provided more clarity on the impact of the legislation on out-of-network claims and premiums. Based on the data collected from carriers, HB19-1174 helped to reduce facility and provider payments in 2021, which helped to control health care costs.

Overall, the percentages of out-of-network provider and facility claims remained consistent with the data reported in 2020 - provider out-of-network claims made up 10% or less of total claims and carrier spend. In the second year of data, ambulance service providers continued to be largely out-of-network; out-of-network ambulance provider claims made up over 70% of total ambulance provider claims.

Data for the 2022 calendar year will require an evaluation of out-of-network claims based on implementation of the No Surprises Act. The Division will be reviewing how to refine the reporting process to account for changes in the NSA.

	Total Out-of-Network Claims	Total Out-of-Network Claims by Paid Dollar Amount
Out-of-Network Provider	8% of provider claims	7% of total provider costs
Out-of-Network Facility	10% of facility claims	7% of total facility costs
Out-of-Network Ambulance Provider	75% of ambulance service provider claims	70% of total ambulance provider costs

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