Department of Regulatory Agencies

Report of the
Commissioner of Insurance

to

The Colorado General Assembly

on

§10-16-704(3), C.R.S.
Consumer Protections Against Balance Billing

January 21, 2010

Department of Regulatory Agencies

Division of Insurance
Marcy Morrison
Commissioner of Insurance

Bill Ritter, Jr.
Governor

Barbara J. Kelley
Executive
Director

January 21, 2010

Dear Committee Members,

I am pleased to submit this report pursuant to §10-16-704(3), C.R.S., that requires the Commissioner of Insurance to evaluate the effects of Subsection (3) prior to its repeal on July 1, 2010. This report presents my recommendation that the consumer protections against balance billing currently in place should remain. Repealing Subsection (3) will harm consumers in situations where they have followed the rules of their managed care health plans and expect to pay in-network rates for services provided at in-network facilities.

The Division of Insurance appreciates having the opportunity to evaluate the statute and how it affects Colorado consumers. If you have any questions, please contact me at the Division.

Sincerely,

Marcy Morrison
Commissioner of Insurance

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Consumer Protection

Table of Contents

Executive Summary

In 2006, the Colorado General Assembly enacted Senate Bill 06-213 prohibiting out-of-network health care providers from charging consumers in managed care plans over and above the in-network benefit rate for services provided at in-network facilities. The legislation addressed consumer concerns regarding out-of-network doctors and ancillary service providers who worked at in-network facilities, and billed patients for any amount not paid by the patient's managed care plan. Typically, the consumer had no way to know a provider was out-of-network until after the service was performed. The out-of-network provider would "balance bill" the consumer for any charges not reimbursed by the managed care plan. The amended law, §10-16-704(3), C.R.S., prohibits this type of balance billing and requires health insurance carriers to hold consumers harmless from being balance billed by the provider for services received at in-network facilities. Subsection (3) is automatically repealed on July 1, 2010 unless continued by legislative action in the 2010 session of the Colorado General Assembly.

Prior to its repeal, subsection (3) requires the Department of Regulatory Agencies-Division of Insurance (Division) to conduct an evaluation of the statute. This report meets the requirements of §10-16-704(3), C.R.S., and analyzes quantitative and qualitative information provided by insurance carriers currently issuing managed care health plans in Colorado.

This report focuses on the following four items as outlined in subsection (3):

1. The effects of subsection (3) on network adequacy;
2. The frequency that out-of-network providers submit more than network reimbursement rates for services rendered in an in-network facility compared to the carrier's book of business for that line of insurance;
3. The amounts paid by carriers to out-of network providers; and
4. The impact of subsection (3) on consumers.

The Division surveyed insurance carriers to obtain information relating to the effects of §10-16-704(3), C.R.S. Key findings include:

- Total number of processed claims dropped 34 percent between 2007-2009. Both in-network and out-of-network processed claims fell equally over the three-year period.
- The ratio for processed claims between in-network and out-of-network providers remained steady. In-network providers submitted close to 92 percent of processed claims.
- In 2008, the total allowable charges for in-network providers fell by one percent while the total allowable charges for out-of-network providers rose by nine percent. In the first six months of 2009, this pattern reversed with in-network provider allowed charges rising an estimated four percent and out-of-network provider allowable charges falling an estimated one percent.
- The gap in billed charges made between in-network and out-of network providers decreased over the last three years from nine percent to three and one half percent. The percent of billed charges paid to out-of-network providers also decreased by almost six percent.
- The Division received nine complaints regarding balance billing in 2009 compared to 43 in 2003. Inquiries have remained fairly constant around 10 per year, from 2003-2009.
- Some carriers have found ways to negotiate with out-of-network providers and keep out-of-network billed charges for in-network services at reasonable rates. Other carriers continue to feel that §10-16-704(3), C.R.S., puts carriers at the mercy of providers who take advantage of subsection (3) and charge exorbitant amounts.

After reviewing the information, the Division believes §10-16-704(3), C.R.S., protects consumers who have chosen to receive services in an in-network facility and expect to only pay the in-network rates. Repealing this statute will harm consumers in situations where they have followed the rules of their managed care plan.

Introduction

In 2006, the Colorado General Assembly enacted Senate Bill 06-213 prohibiting out-of-network health care providers from charging consumers in managed care plans over and above the in-network benefit rate for services provided at in-network facilities. The legislation addressed consumer concerns regarding out-of-network doctors and ancillary service providers who worked at in-network facilities, and billed patients for any amount not paid by the patient's managed care plan. Typically, the consumer had no way to know a provider was out-of-network until after the service was performed. The out-of-network provider would "balance bill" the consumer for any charges not reimbursed by the managed care plan. The amended law, §10-16-704(3), C.R.S., prohibits this type of balance billing and requires health insurance carriers to hold consumers harmless from being balance billed by the provider for services received at in-network facilities. Subsection (3) is automatically repealed on July 1, 2010 unless continued by legislative action in the 2010 session of the Colorado General Assembly.

Prior to its impending repeal, subsection (3) requires the Department of Regulatory Agencies-Division of Insurance (Division) to conduct an evaluation of the statute before the repeal date in July. This report meets the requirements of §10-16-704(3), C.R.S., and analyzes quantitative and qualitative information provided by insurance carriers currently issuing managed care health plans in Colorado.

Legislative History, Division Interpretation and Court Challenge

The current network adequacy laws, §10-16-704, C.R.S., were first passed in 1997 and subsequently amended in 2001, 2002, 2003, and 2006. Section 10-16-704(3), C.R.S., was part of the original legislation, HB97-1122, and stated:

> When a covered person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit.

From 1997 to 2006, the Division's interpretation of this subsection was the consumer should be held harmless from any additional charges from out-of-network providers who provided service in an in-network facility, unless the consumer specifically chose the out-of-network provider to perform the services.

In 2006, Pacific Life and Annuity Co. challenged the Division and the Division's interpretation was invalidated by the Colorado Court of Appeals in Pacific Life & Annuity Co. v. Colorado Division of Insurance, No 04CA216 (Slip Op.) (Feb 23, 2006).

Following the 2006 court decision, the General Assembly amended subsection (3) to clearly state the original intent of the law and support the Division's interpretation. Section 10-16-704 (3)(a)(III), C.R.S., currently states:

> The General Assembly finds, determines, and declares that the Division of Insurance has correctly interpreted the provisions of this section to protect the insured from the additional expense charged by an assisting provider who is an out-of-network provider, and has properly required insurers to hold the consumer harmless.

The intent is further emphasized in §10-16-704(3)(a)(V), C.R.S., which states:

> Therefore, the General Assembly finds, determines and declares that the purpose of Senate Bill 06-213 is to codify the interpretation of the Division of Insurance that holds consumers harmless for charges over and above the in-network rates for services rendered in a network facility.

The entire subsection (3) is repealed effective July 1, 2010. When it is repealed, insurance carriers will no longer be required to accept out-of-network providers' billed charges as the "allowable charge." The providers will be allowed to balance bill consumers for services provided at in-network facilities.

Evaluation of §10-16-704(3), C.R.S.

This report focuses on the following four items as outlined in subsection (3):

1. The effects of subsection (3) on network adequacy;
2. The frequency that out-of-network providers submit more than network reimbursement rates for services rendered in an in-network facility compared to the carrier's book of business for that line of insurance;
3. The amounts paid by carriers to out-of network providers; and
4. The impact of subsection (3) on consumers.

Survey

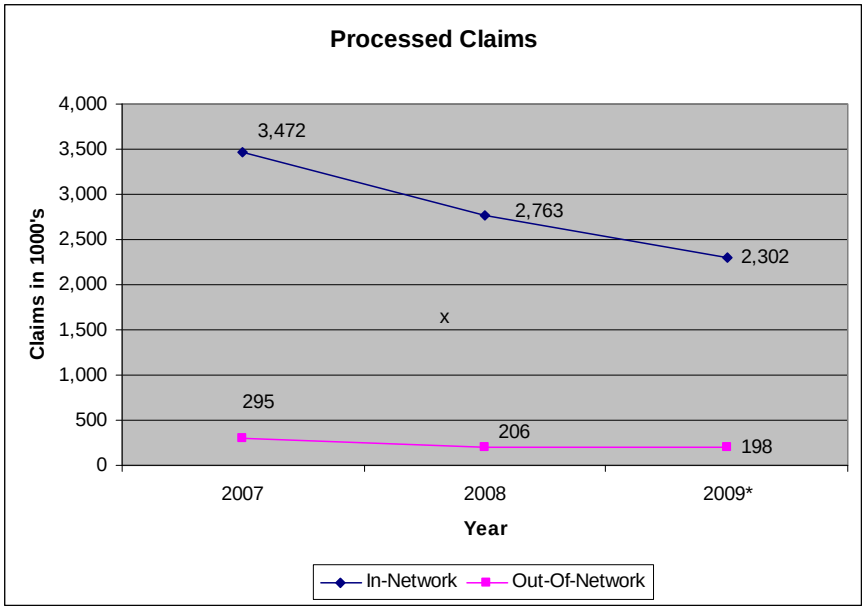
The Division surveyed 77 carriers to obtain information relating to the effects of §10-16-704(3), C.R.S., on network adequacy and consumers with managed care plans. Seventy-two carriers representing 80 percent of the market responded to the survey. Fifty-two of the respondents issued managed care plans during the evaluation period between January 1, 2007 and July 1, 2009. The following analysis reflects the information provided by the 52 respondents who issued managed care policies. The complete survey is included as Appendix A.

One large carrier, representing 20 percent of the accident and health insurance market, did not respond to the survey within the necessary deadlines. The absence of the carrier's data does alter the report's findings.

1. Effect on Network Adequacy

Processed Claims
The total number of processed claims dropped almost 34 percent between 2007-2009 from 3,767,000 to 2,500,000. In-network processed claims fell 33.7 percent and the out-of-network drop was similar at 32.82 percent.

From year to year, the number of processed claims between in-network and out-of-network providers showed more variability. In 2008, the number of processed claims from out-of-network providers dropped 30 percent, while the number of claims from in-network providers only dropped 20 percent. In the first six months of 2009, the number of processed claims dropped an estimated 17 percent for in-network providers, while the number of out-of-network provider claims dropped only an estimated four percent. The changes in number of claims processed is shown in the chart on the next page.

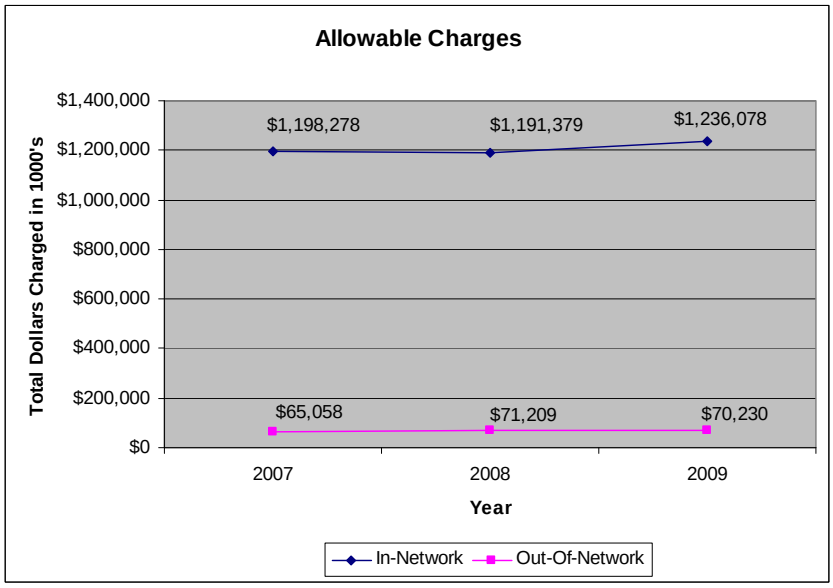


*For comparison purposes, the 2009 data received from 1/1/09-6/30/09 was doubled.

The ratio for processed claims between in-network and out-of-network providers held steady. In-network providers submitted 92 percent of all processed claims in 2007, 93 percent in 2008, and 92 percent in 2009.

Allowable Charges[1]

In 2008, the total allowable charges for in-network providers fell by one percent while the total allowable charges for out-of-network providers rose by nine percent. In the first six months of 2009, this pattern reversed with in-network provider allowed charges rising an estimated four percent and out-of-network provider allowable charges falling an estimated one percent. The following chart reflects these changes.



*For comparison purposes, the 2009 data received from 1/1/09-6/30/09 was doubled, as only the first six months of data is available.

[1] Allowable charges represents the total bill after adjustment for contracted rates that will be paid before any application of deductible, co-pay, or other cost-sharing requirements.

Written Responses on the Effect of §10-16-704(3), C.R.S., on Network Adequacy

To gather additional information about any change in network adequacy, the survey included the question "*How has §10-16-704(3), C.R.S., affected network adequacy for your company since 2006?"*

- Seven carriers reported a positive effect on network adequacy. Responses included the following themes:
  - carriers continue to pay in-network prices,
  - carriers are not receiving consumer complaints regarding network adequacy,
  - an adequate network meets insureds' needs, and
  - positive comments from internal colleagues.
- Twenty carriers indicated no change. Responses included the following themes:
  - no major change in current payment policy,
  - insufficient experience or time to quantify change,
  - plans already cover providers at in-network levels,
  - payment is not based on "in-network" facility,
  - no significant spike in data has emerged, and
  - no shift in claims between in-network and out-of-network providers.
- Twenty-one carriers indicated a negative effect on network adequacy. Responses included the following themes:
  - hospital-based physicians have greater leverage when negotiating contracts with managed care plans,
  - administrative costs increased due to manual review of all out-of-network claims,
  - out-of-network providers are encouraged not to join networks because they will receive in-network reimbursement regardless,
  - out-of network surgical assistants and certain technicians charge excessive amounts and demand full payment of billed charges which causes inequities in payment,
  - clear disincentives for providers not to contract with carriers have been institutionalized by the statute and the Division's enforcement,
  - managed care companies are compelled to pay billed charges,
  - providers are able to obtain payment for unlimited billed charges with the effective "endorsement" of the Colorado Division of Insurance, and
  - §10-16-704(3), C.R.S., has been an exacerbating factor driving up both the cost of care and the cost of health insurance, and this carrier has been advised more than once by out-of-network providers that they refuse to contract when a carrier is required to pay billed charges.
- Four carriers indicated insufficient experience and time to evaluate change.

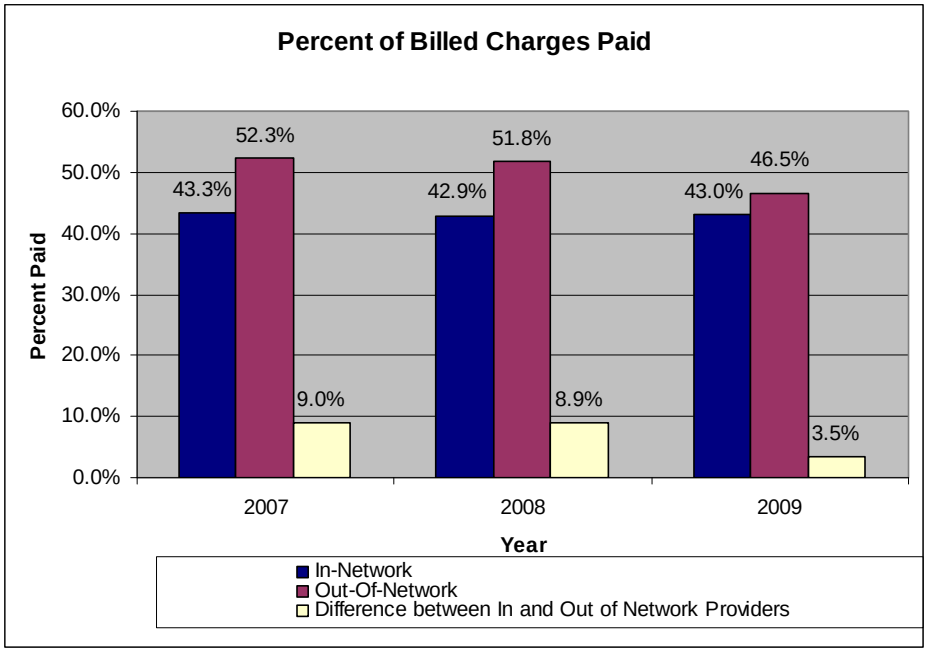
2. Frequency That Out-of-Network Providers Charge More Than Network Rates

Carriers do not collect data that show the frequency of in-network and out-of-network claims. To provide data relevant to charges, the Division asked carriers to report the percent of the contracted rate, billed charge and amount the carrier pays. The chart on page 9 shows the reimbursement gap for billed charges between in-network and out-of network providers has decreased over the last three years. The percent of billed charges paid to out-of-network providers has also decreased by almost six percent.

The average in-network percentage of billed charges may be artificially high because some carriers reported their in-network billed charges as equal to their in-network contracted rate. Therefore, some of the reported rates were close to 100 percent, driving the overall average higher. Other carriers provided different in-network contracted rates and billed rates. These responses were typically far below 100 percent. This

reporting discrepancy carries over to the difference between in-network and out-of network charges. The difference may therefore be artificially low.

It is important to note that once subsection (3) is repealed the balance of out-of-network charges not paid by a carrier – currently at 53.5 percent of initial billed charges for 2009 - will be billed directly to consumers. The carrier will still pay at least the contracted portion of the rate, but the remaining charges will be balance billed. Using 2009 data, if an out-of network provider charges $100, the carrier will pay $46.53 and the consumer will be balance billed $53.50 once the statute is repealed.



3. Amount Paid to Out-of-Network Providers

The following chart shows the amount paid to out-of-network and in-network providers over the evaluation period. The 2009 numbers reflect payments from 1/1/09-6/30/09.

	Total	Out of Network	In Network
2007	$1,263,335,266	$65,057,584	$1,198,277,681
2008	$1,262,606,125	$71,209,094	$1,191,397,030
2009*	$653,153,893	$35,114,954	$618,038,939

*data is from 1/1/09-6/30/09

4. The Impact of §10-16-704(3), C.R.S., on Consumers

To obtain the carriers' position about how the subsection (3) impacts consumers, the survey included the question *"In your opinion, what has the impact of §10-16-704(3), C.R.S., been on your policyholders since 2006?"*

- Seventeen carriers reported a positive effect on policyholders. Responses included the following themes:
  - Policyholders do not owe any additional money beyond their in-network deductible, copay, or coinsurance,

- Statute has provided consumers a higher level of benefits for services from an out-of-network provider when an in-network provider is not available within a reasonable distance,
- There are no longer out-of-network expenses when treated by out-of-network providers at in-network facilities,
- All services performed by out-of-network providers in in-network facilities are processed at in-network rates. Out-of-network claims are processed based on billed charges,
- Policyholders receive higher benefits when claims are paid in-network in situations where they have no control and are unable to affect the use of an out-of-network provider,
- Carrier has not received any complaints, and
- The group policy is so structured that any insured, who receives services from a participating or in-network facility, is provided the participating level of benefits.

- Seventeen carriers reported no changes. Responses included the following themes:
  - Our company routinely allows facility-based physicians at the in-network benefit level, regardless of network affiliation, whenever the facility is in-network,
  - Forced provider provisions are included in our plans,
  - Insufficient time to quantify change and determine any impact,
  - No major changes for our plans,
  - Our plans include a forced provider provision for the ancillary services performed at in-network facilities,
  - We could not determine a significant spike in the data following the date,
  - We have seen no significant change as a result of the changes to the regulation,
  - Our plans already covered these providers,
  - Carrier has no method in place to measure the effect of the law on our policyholders.

- Fourteen carriers reported a negative effect on policyholders. Responses included the following themes:
  - Although this law protects consumers from balance billing by non-contracted providers when they receive covered services at an in-network facility, it has created incentives for many surgical and technical assistants to either terminate their contracts with carriers or to refuse to contract. Without a contract, and with the law requiring all services at an in-network facility to be paid, such surgical and technical assistants are free to bill amounts that are unreasonable and beyond usual and customary rates,
  - Non-contracted ambulance companies, anesthesiologists, ER doctors, radiologists and pathologists often are paid significantly above market rates for their services. Certain groups appear to have a general business policy to refuse to participate in health plan networks to ensure payment of billed charges,
  - Consumers have been negatively affected by 10-16-704 (3) because claims from non-contracted providers with excessive billed charges cause overall healthcare expenditures to increase. Consumers with plans which include coinsurance in the benefit design are negatively impacted with higher out-of-pocket costs when claims must be paid above market rates. The increased costs paid by the plan are ultimately passed on to consumers in member premiums,
  - Because managed care plans must reimburse non-participating providers at no greater cost to the covered person than if services were obtained from an

in-network provider, covered persons are immune from liability for excessively high charges, further eroding competitive market pressures that could control increasing health costs, and

- Carriers are not able to manage provider costs through the network. The customer is protected from non-covered charges, but, in the end, everyone pays in the form of higher premiums.

- Four carriers indicated insufficient experience and time to evaluate change.

Division of Insurance Activity Involving Balance Billing

The Division of Insurance continues to receive both informal inquiries and formal complaints regarding balance billing issues. The table below shows the numbers before and after §10-16-704(3), C.R.S., was implemented.

Balance Billing Complaints and Inquiries Received by Division of Insurance
2003-2009

	2003	2004	2005	2006	2007	2008	2009*
Complaints	43	20	27	21	18	26	9
Inquiries	13	7	10	5	9	8	10

*data from 1/1/09-12/31/09

While some of the contacts pertain to subsection (3), others involve balance bills that legitimately need to be paid because a consumer voluntarily requested a particular out-of network provider to perform services. Even though a policy may only require a consumer to pay a higher co-pay, the provider can charge the consumer the remainder of the billed charges not covered by the carrier.

Division analysts report they do speak to consumers who are confused about the balance billing issues and their financial responsibilities. Some may pay certain balance bills because they do not fully understand the consumer protections currently in place and they worry the unpaid balance may be forwarded to a collection agency.

Other State Activity

According to an April 2009 report by the California HealthCare Foundation, only nine states have laws protecting consumers from balance billing, including Colorado, Delaware, Florida, Indiana, Maryland, New York, Rhode Island, West Virginia and Wisconsin. The full report including detailed descriptions of the state statutes or regulations is available at http://www.chcf.org/topics/healthinsurance/.

Conclusions and Recommendations

Balance billing continues to stir controversy between providers and insurance carriers. Over the last three years, some carriers have found ways to negotiate with out-of-network providers and keep out-of-network billed charges for in-network services at reasonable rates, without balance billing consumers. Other carriers continue to feel that §10-16-704(3), C.R.S., puts carriers at the mercy of providers who take advantage of subsection(3) and charge exorbitant amounts, which are then cost shifted to the consumer in their premiums.

With a mission of consumer protection, the Division believes §10-16-704(3), C.R.S, protects consumers in situations when they are receiving services in an in-network facility and expect to pay in-network reimbursement rates. Repealing this statute will harm consumers in situations where they believe they have followed the rules of their managed care plan.

Appendix A

Colorado Participating and Non-Participating Provider Survey

The Colorado Division of Insurance is conducting a survey to obtain information on the effect § 10-16-704(3), C.R.S., has had on network adequacy and policyholders and to prepare a report to be presented to Colorado's Senate Health and Human Services Committee and the House of Representatives Business Affairs and Labor Committee.

New 10-5-09 "Processed Claims" include all claims paid or that fall within the deductible or co-pay levels of the plan.

Contact Person Name:

Contact Person Title:

Contact Person Telephone Number:

Contact Person E-mail Address:

Company Name:

Company NAIC Number:

"Managed care plan" means a policy, contract, certificate, or agreement offered by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services through the covered person's use of health care providers managed by, owned by, under contract with, or employed by the carrier because the carrier either requires the use of or creates incentives, including financial incentives, for the covered person's use of those providers.

1. Did your company have managed care health insurance policies in effect any time between January 1, 2007 and July 1, 2009?

- ☐ Yes
- ☐ No

1a. If you answered No above please describe your company's health benefit plan business.

2. How has § 10-16-704(3), C.R.S., affected network adequacy for your company since 2006? Please provide as much information as possible.

- ☐ Positive effect
- ☐ Negative effect
- ☐ No change

2a. Please explain:

3. In your opinion what has the impact of § 10-16-704 (3), C.R.S., been on your policyholders since 2006? Please provide as much information as possible

- ☐ Positive impact
- ☐ Negative impact
- ☐ No change

3a. Please explain:

4. If you cannot provide full information in the table below please explain as completely as possible why you are unable to fill in some of the fields.

Definitions

"Facility" is any in-network location where health care service is provided for both inpatient and outpatient procedures.
"Amount Billed" represent how much each provider submits for reimbursement.
"Contracted Rate" represents the contracted reimbursement rates for participating provider services before any application of deductible, co-pay, or other member cost-sharing requirements.
"Allowed Charges" represents the total bill after adjustment for contracted rates that will be paid before any application of deductible, co-pay, or other member cost-sharing requirements.
"Processed Claims" include all claims paid or that fall within the deductible or co-pay levels of the plan.

For the Table below, please organize your claim counts and charges into three distinct categories. All claims should be for services performed at in-network facilities.
1. Claims by participating providers.
2. Claims by non-participating providers for which participating providers of the same specialty are also contracted.
3. Claims by non-participating providers for which no participating providers of the same specialty are contracted.

Provider charges and claims at In-Network Facilities

All charges and claim counts should be calculated on a claim received date basis	1. Claims by participating providers.	2. Claims by non-participating providers for which participating providers of the same specialty are also contracted.	3. Claims by non-participating providers for which no participating providers of the same specialty are contracted.
Number of claims received in 2007			
Number of claims received in 2008			
Number of claims received from 1/1/09 to 6/30/09			
Number of processed claims received in 2007			
Number of processed claims received in 2008			
Number of processed claims received from 1/1/09 to 6/30/09			
Total amount billed for claims received in 2007			
Total amount billed for claims received in 2008			
Total amount billed for claims received from 1/1/09 to 6/30/09			
Total of Contracted rate charges for claims received in 2007			
Total of Contracted rate charges for claims received in 2008			
Total of Contracted rate charges for claims received from 1/1/09 to 6/30/09			
Total allowed charges for claims received in 2007			
Total allowed charges for claims received in 2008			
Total allowed charges for claims received from 1/1/09 to 6/30/09			

5. If you have any further comments please share them with us below.