First Regular Session
Seventy-first General Assembly
STATE OF COLORADO

REVISED

This Version Includes All Amendments Adopted on Second Reading in the Second House

LLS NO. 17-0841.01 Kristen Forrestal x4217

HOUSE BILL 17-1173

HOUSE SPONSORSHIP

Hansen,

SENATE SPONSORSHIP

Neville T.,

House Committees
Health, Insurance, & Environment

Senate Committees
Business, Labor, & Technology

SENATE
2nd Reading Unamended
March 21, 2017

HOUSE
3rd Reading Unamended
February 28, 2017

HOUSE
Amended 2nd Reading
February 27, 2017

A BILL FOR AN ACT

CONCERNING REQUIRED PROVISIONS IN A CONTRACT BETWEEN A HEALTH INSURANCE CARRIER AND A HEALTH CARE PROVIDER CONCERNING MEDICAL COMMUNICATIONS REGARDING DISAGREEMENTS IN HEALTH CARE DECISIONS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill requires a contract between a health insurance carrier (carrier) and a health provider (provider) to include a provision that prohibits a carrier from taking an adverse action against the provider due

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

to a provider's disagreement with a carrier's decision on the provision of health care services. Current law requires the contract to state that the carrier cannot terminate the contract for these same reasons.

The bill also requires the contract to contain provisions that prohibit a carrier from: Taking adverse actions for communicating with public officials on health care issues; filing complaints or reporting to public officials about conduct by a carrier that might negatively affect patient care; provides information in a forum concerning the required contract provisions; reporting alleged carrier violations; or participating in an investigation of an alleged violation.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 10-16-121, **amend** (1); and **add** (7) and (8) as follows:

10-16-121. Required contract provisions in contracts between carriers and providers - definitions. (1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan ~~shall~~ MUST make provisions for the following requirements:

(a) The contract ~~shall~~ MUST contain a provision stating that neither the provider nor the carrier ~~shall be~~ IS prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of the carrier or provider.

(b) (I) The contract ~~shall~~ MUST contain a provision that states the carrier ~~shall not terminate the contract with~~ MAY NOT TAKE AN ADVERSE ACTION AGAINST a provider because the provider expresses disagreement with a carrier's decision to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the carrier's decision or because a provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether

covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients.

(II) THE CONTRACT BETWEEN A CARRIER AND THE PROVIDER MUST STATE THAT THE CARRIER MAY NOT TAKE AN ADVERSE ACTION AGAINST A PROVIDER BECAUSE THE PROVIDER, ACTING IN GOOD FAITH:

(A) COMMUNICATES WITH A PUBLIC OFFICIAL OR OTHER PERSON CONCERNING PUBLIC POLICY ISSUES RELATED TO HEALTH CARE ITEMS OR SERVICES;

(B) FILES A COMPLAINT, MAKES A REPORT, OR COMMENTS TO AN APPROPRIATE GOVERNMENTAL BODY REGARDING ACTIONS, POLICIES, OR PRACTICES OF THE CARRIER THE PROVIDER BELIEVES MIGHT NEGATIVELY AFFECT THE QUALITY OF, OR ACCESS TO, PATIENT CARE;

(C) PROVIDES TESTIMONY, EVIDENCE, OPINION, OR ANY OTHER PUBLIC ACTIVITY IN ANY FORUM CONCERNING A VIOLATION OR POSSIBLE VIOLATION OF ANY PROVISION OF THIS SECTION;

(D) REPORTS WHAT THE PROVIDER BELIEVES TO BE A VIOLATION OF LAW TO AN APPROPRIATE AUTHORITY; OR

(E) PARTICIPATES IN ANY INVESTIGATION INTO A VIOLATION OR POSSIBLE VIOLATION OF ANY PROVISION OF THIS SECTION.

(c) Any contract providing for the performance of claims processing functions by an entity with which the carrier contracts ~~shall~~ MUST require such entity to comply with section 10-16-106.5 (3), (4), and (5).

(d) The contract ~~shall~~ MUST contain a provision that the provider shall not be subjected to financial disincentives based on the number of referrals made to participating providers in the health plan for covered

benefits so long as the provider making the referral adheres to the carrier's or the carrier's intermediary's utilization review policies and procedures.

(7) (a) A PROVIDER WHO IS AGGRIEVED BY A VIOLATION OF THIS SECTION MAY BRING AN ACTION FOR INJUNCTIVE RELIEF IN A COURT OF COMPETENT JURISDICTION AND MAY SEEK RECOVERY OF REASONABLE COURT COSTS. THIS SECTION DOES NOT CHANGE THE STANDARDS FOR OBTAINING INJUNCTIVE RELIEF.

(b) IF A COURT DEEMS AN ACTION FRIVOLOUS, THE COURT MAY AWARD COSTS TO THE DEFENDANT.

(8) AS USED IN THIS SECTION:

(a) "ADVERSE ACTION" MEANS A DECISION BY A CARRIER TO TERMINATE, DENY, OR OTHERWISE CONDITION A PROVIDER'S PARTICIPATION IN ONE OR MORE PROVIDER NETWORKS, INCLUDING A DECISION PERTAINING TO PARTICIPATION IN A NARROW NETWORK OR ALLOCATION WITHIN A TIERED NETWORK.

(b) "NARROW NETWORK" MEANS A REDUCED OR SELECTIVE PROVIDER NETWORK THAT IS A SUBGROUP OR SUBDIVISION OF A LARGER PROVIDER NETWORK AND FROM WHICH PROVIDERS WHO PARTICIPATE IN THE LARGER NETWORK MAY BE EXCLUDED.

(c) "TIERED NETWORK" MEANS A PROVIDER NETWORK IN WHICH:

(I) PROVIDERS ARE ASSIGNED TO, OR PLACED IN, DIFFERENT BENEFIT TIERS, AS DETERMINED BY TIERING; AND

(II) PATIENTS RECEIVE BENEFITS AND PAY THE COPAYMENT, COINSURANCE, OR DEDUCTIBLE AMOUNTS THAT ARE ASSOCIATED WITH THE BENEFIT TIER TO WHICH THE PROVIDER FROM WHOM SERVICES WERE RECEIVED IS ASSIGNED.

(d) "TIERING" MEANS A SYSTEM THAT COMPARES, RATES, RANKS,

TIERS, OR CLASSIFIES A PROVIDER'S PERFORMANCE, QUALITY OF CARE, OR COST OF CARE AGAINST OBJECTIVE STANDARDS OR AGAINST THE PRACTICE OR PERFORMANCE OF OTHER HEALTH CARE PROVIDERS. "TIERING" INCLUDES QUALITY IMPROVEMENT PROGRAMS, PAY-FOR-PERFORMANCE PROGRAMS, PUBLIC REPORTING ON HEALTH CARE PROVIDER PERFORMANCE OR RATINGS, AND THE USE OF TIERED OR NARROWED NETWORKS.

SECTION 2. Effective date - applicability. This act takes effect July 1, 2017, and applies to contracts entered or renewed on or after said date.

SECTION 3. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.