First Regular Session
Seventy-second General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 19-0777.01 Kristen Forrestal x4217 **SENATE BILL 19-134**

SENATE SPONSORSHIP

Fields and Tate, Williams A.

HOUSE SPONSORSHIP

Soper, Larson

Senate Committees
Health & Human Services

House Committees

A BILL FOR AN ACT

CONCERNING THE PROVISION OF OUT-OF-NETWORK HEALTH CARE SERVICES.

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:

- Sets the reimbursement rate that a health insurance carrier must pay a health care facility if a covered person is treated for emergency services;
- Requires in-network health care facilities and health care providers to make disclosures to patients covered by a

health benefit plan concerning the provision of services by an out-of-network provider;

- Outlines the claims and payment process, including reimbursement rates for the provision of out-of-network services for health care facilities and health care providers; and
- Authorizes arbitration for the payment of health care claims that are in dispute if certain criteria are met.

The commissioner of insurance is required to submit a report annually to the general assembly concerning unanticipated out-of-network services.

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

SECTION 1. Legislative declaration. (1) The general assembly hereby finds and declares that:

(a) Health insurance carriers are increasingly offering narrow network plans and regularly removing health care providers from networks or not renewing their contracts;

(b) Covered persons should be able to access in-network primary care health care providers, including facility-based health care providers, in a timely manner;

(c) Health insurance carriers are increasingly offering high-deductible health plans that include larger cost-sharing, resulting in greater patient responsibility rather than insurer responsibility;

(d) Health care facilities and health care providers must supply covered persons with all the facts necessary to make informed decisions concerning the health insurance coverage that is purchased, and where and from which health care providers they may seek health care services;

(e) Health insurance carriers should clearly disclose, in language that is transparent and meaningful to the covered person, the scope and limitations of any out-of-network benefit they provide and the

methodology for reimbursement for out-of-network services to covered persons, providers, and health care facilities; and

(f) It is imperative that covered persons are protected from the financial impact that can result from narrow networks and cost-shifting trends within health insurance.

SECTION 2. In Colorado Revised Statutes, 10-16-704, **add** (5.5)(c) as follows:

10-16-704. Network adequacy - rules - legislative declaration. (5.5) (c) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE CARRIER SHALL REIMBURSE THE OUT-OF-NETWORK FACILITY THE GREATER OF:

(I) THE CARRIER'S AVERAGE IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA;

(II) ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR

(III) ONE HUNDRED PERCENT OF THE AVERAGE 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, AS DETERMINED BASED ON CLAIMS DATA FROM THE ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

SECTION 3. In Colorado Revised Statutes, **add** 10-16-704.5 as follows:

10-16-704.5. Out-of-network providers - disclosure requirements - payment for out-of-network services - arbitration - rules - definitions - report - repeal. (1) **Definitions.** AS USED IN THIS

SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "AVERAGE ALLOWED AMOUNT" MEANS THE AVERAGE IN-NETWORK AND OUT-OF-NETWORK AMOUNTS PAID, EXCEPT FOR PAYMENTS FOR CLAIMS MADE:

(I) PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4, 5, AND 6 OF TITLE 25.5;

(II) UNDER HEALTH BENEFIT PLANS PURCHASED THROUGH THE EXCHANGE; AND

(III) UNDER MEDICARE, AS DEFINED IN SECTION 10-22-103 (9).

(b) (I) "COST-SHARING" MEANS ANY EXPENDITURE REQUIRED BY OR ON BEHALF OF A COVERED PERSON WITH RESPECT TO HEALTH BENEFITS, INCLUDING COINSURANCE, DEDUCTIBLES, COPAYMENTS, AND OUT-OF-POCKET EXPENSES.

(II) "COST-SHARING" DOES NOT INCLUDE PREMIUMS, BALANCE BILLING AMOUNTS FOR OUT-OF-NETWORK PROVIDERS, AND SPENDING FOR NONCOVERED SERVICES.

(c) (I) "MINIMUM BENEFIT STANDARD" MEANS:

(A) THE GREATER OF ONE HUNDRED FIFTY PERCENT OF AN AMOUNT EQUAL TO THE SEVENTY-FIFTH PERCENTILE OF ALL IN-NETWORK AMOUNTS OR THE AVERAGE ALLOWED AMOUNT FOR THE HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHIC AREA AS THE PROVIDER THAT PROVIDED THE SERVICES, AS REPORTED IN A 2019 BENCHMARKING DATABASE MAINTAINED BY AN INDEPENDENT, NONPROFIT ORGANIZATION THAT IS NOT AFFILIATED WITH A CARRIER AND AS SPECIFIED BY THE COMMISSIONER; OR

(B) FOR SERVICES PROVIDED IN A RURAL AREA, AS DEFINED BY THE

COMMISSIONER BY RULE, THE GREATER OF TWO HUNDRED PERCENT OF THE HIGHEST IN-NETWORK AMOUNT OR TWO HUNDRED PERCENT OF THE AVERAGE ALLOWED AMOUNT FOR THE HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHIC AREA AS THE PROVIDER THAT PROVIDED THE SERVICES, AS REPORTED IN A 2019 BENCHMARKING DATABASE MAINTAINED BY AN INDEPENDENT, NONPROFIT ORGANIZATION THAT IS NOT AFFILIATED WITH A CARRIER AND AS SPECIFIED BY THE COMMISSIONER.

(II) THE MINIMUM BENEFIT STANDARD AS DEFINED IN SUBSECTION (1)(c)(I) OF THIS SECTION IS ADJUSTED ON JANUARY 1 OF EACH YEAR BASED ON THE PREVIOUS YEAR'S BENCHMARKING DATABASE.

(d) (I) "UNANTICIPATED OUT-OF-NETWORK SERVICES" MEANS:

(A) EMERGENCY SERVICES PROVIDED TO A COVERED PERSON BY AN OUT-OF-NETWORK PROVIDER; OR

(B) NONEMERGENCY SERVICES PROVIDED TO A COVERED PERSON AT AN IN-NETWORK FACILITY BY AN OUT-OF-NETWORK PROVIDER WHERE THE COVERED PERSON DID NOT HAVE THE ABILITY TO SELECT THE SERVICES FROM AN IN-NETWORK PROVIDER.

(II) "UNANTICIPATED OUT-OF-NETWORK SERVICES" DOES NOT INCLUDE NONEMERGENCY SERVICES PROVIDED TO A COVERED PERSON BY AN OUT-OF-NETWORK PROVIDER AFTER THE COVERED PERSON VOLUNTARILY SELECTS THE PROVIDER AFTER A FULL AND ACCURATE DISCLOSURE.

(2) **Disclosures.** (a) AT THE TIME AN IN-NETWORK FACILITY SCHEDULES HEALTH CARE SERVICES OR SEEKS PRIOR AUTHORIZATION FROM A CARRIER FOR NONEMERGENCY SERVICES, THE IN-NETWORK FACILITY SHALL NOTIFY THE COVERED PERSON IN WRITING:

(I) THAT IF AN OUT-OF-NETWORK PROVIDER IS CALLED UPON BY THE IN-NETWORK FACILITY TO PROVIDE COVERED SERVICES AT THE FACILITY, THE CARRIER IS REQUIRED TO TREAT THE COVERED SERVICES AS AN IN-NETWORK BENEFIT;

(II) OF THE SPECIFIC TYPES OF ANCILLARY SERVICES THE COVERED PERSON MAY NEED WITHIN THE FACILITY; AND

(III) THAT THE COVERED PERSON MAY OBTAIN A LIST OF IN-NETWORK PROVIDERS FROM THE COVERED PERSON'S CARRIER AND THAT THE COVERED PERSON MAY REQUEST AND RECEIVE AN IN-NETWORK PROVIDER, IF AVAILABLE.

(b) AT OR BEFORE THE TIME OF ADMISSION TO AN IN-NETWORK FACILITY WHERE A COVERED PERSON WILL RECEIVE NONEMERGENCY SERVICES, THE FACILITY SHALL PROVIDE THE SAME WRITTEN NOTIFICATION AS IS REQUIRED IN SUBSECTION (2)(a) OF THIS SECTION AND OBTAIN THE SIGNATURE OF THE COVERED PERSON OR THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE ACKNOWLEDGING THAT THE NOTIFICATION WAS RECEIVED AT OR BEFORE THE TIME OF ADMISSION TO THE FACILITY.

(c) IF AN OUT-OF-NETWORK PROVIDER PROVIDES OUT-OF-NETWORK SERVICES, THE PROVIDER SHALL SUBMIT A CLAIM DIRECTLY TO THE COVERED PERSON'S CARRIER, IF KNOWN, AND SHALL ACCEPT AN ASSIGNMENT OF BENEFITS FROM THE COVERED PERSON. THE OUT-OF-NETWORK PROVIDER SHALL INCLUDE THE FOLLOWING STATEMENT ON ANY BILLING NOTICE SENT TO THE COVERED PERSON:

I EITHER DO NOT HAVE YOUR INSURANCE COVERAGE INFORMATION OR I DO NOT PARTICIPATE WITH YOUR HEALTH INSURANCE PLAN. IF YOU RECEIVED SERVICES FROM ME AT AN IN-NETWORK FACILITY, THEN YOU MAY BE

ENTITLED TO CERTAIN OUT-OF-NETWORK PROTECTIONS ACCORDING TO COLORADO LAW. IF THERE ARE QUESTIONS CONCERNING PAYMENT FOR THE SERVICES, PLEASE CONTACT YOUR INSURANCE CARRIER DIRECTLY.

(d) THE REQUIRED NOTIFICATIONS IN SUBSECTIONS (2)(a) AND (2)(b) OF THIS SECTION ARE NOT A WAIVER OF THE COVERED PERSON'S PROTECTIONS IN SECTION 10-16-704 (3)(b), AND, IN ACCORDANCE WITH THAT SECTION, THE COVERED SERVICES AND TREATMENT PROVIDED AT THE FACILITY ARE COVERED AT NO GREATER COST TO THE COVERED PERSON THAN IF THE SERVICE OR TREATMENT WAS OBTAINED FROM AN IN-NETWORK PROVIDER.

(3) **Payment for services.** (a) (I) EXCEPT AS PROVIDED IN SUBSECTIONS (3)(a)(III) AND (3)(a)(IV) OF THIS SECTION, A PROVIDER SHALL SEND A CLAIM FOR UNANTICIPATED OUT-OF-NETWORK SERVICES TO THE COVERED PERSON'S CARRIER. THE CARRIER SHALL REIMBURSE THE PROVIDER DIRECTLY AT A RATE THAT IS THE LESSER OF THE FULL AMOUNT OF BILLED CHARGES OR THE MINIMUM BENEFIT STANDARD.

(II) A CARRIER SHALL PAY AN OUT-OF-NETWORK PROVIDER DIRECTLY FOR UNANTICIPATED OUT-OF-NETWORK SERVICES.

(III) IF A PROVIDER DOES NOT KNOW WHETHER A PATIENT IS COVERED UNDER A HEALTH BENEFIT PLAN, THE PROVIDER SHALL INCLUDE IN THE FIRST NOTICE OR BILLING STATEMENT TO THE PATIENT:

(A) A QUESTION ASKING WHETHER THE PATIENT IS INSURED;

(B) A STATEMENT THAT THE PATIENT SHOULD NOTIFY THE PROVIDER IF THE PATIENT HAS HEALTH CARE COVERAGE; AND

(C) A STATEMENT EXPLAINING THAT IF THE PATIENT IS COVERED UNDER A HEALTH BENEFIT PLAN, THE CARRIER MAY BE RESPONSIBLE FOR

SOME PORTION OF THE PATIENT'S BILL.

(IV) THE OUT-OF-NETWORK PROVIDER MAY BILL THE COVERED PERSON ONLY FOR THE REQUIRED IN-NETWORK COST-SHARING AMOUNT FOR UNANTICIPATED OUT-OF-NETWORK SERVICES AND SHALL NOT BILL THE COVERED PERSON FOR ANY DIFFERENCE BETWEEN THE AMOUNT ALLOWED BY THE CARRIER AND THE AMOUNT OF THE PROVIDER'S BILLED CHARGE.

(b) (I) A COVERED PERSON'S CARRIER SHALL NOTIFY THE OUT-OF-NETWORK PROVIDER OF THE AMOUNT OF THE COVERED PERSON'S IN-NETWORK COST-SHARING WITHIN TEN BUSINESS DAYS AFTER RECEIVING A BILL FROM THE PROVIDER FOR UNANTICIPATED OUT-OF-NETWORK SERVICES.

(II) WHEN UNANTICIPATED OUT-OF-NETWORK SERVICES ARE PROVIDED, THE COVERED PERSON IS RESPONSIBLE FOR PAYING ONLY THE APPLICABLE IN-NETWORK COST-SHARING AMOUNT.

(III) FOR THE PURPOSES OF UNANTICIPATED OUT-OF-NETWORK SERVICES, THE CARRIER SHALL APPLY THE SAME COST-SHARING REQUIREMENTS RELATED TO THE COVERED PERSON'S DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS AS THOSE THAT APPLY FOR SERVICES PROVIDED BY AN IN-NETWORK PROVIDER.

(IV) THE CARRIER SHALL HOLD THE COVERED PERSON HARMLESS FOR CHARGES FOR UNANTICIPATED OUT-OF-NETWORK SERVICES IN EXCESS OF THE PERSON'S IN-NETWORK COST-SHARING AMOUNT.

(4) **Arbitration.** (a) AN OUT-OF-NETWORK PROVIDER THAT WAS REIMBURSED PURSUANT TO SUBSECTION (3)(a)(I) OF THIS SECTION AT THE MINIMUM BENEFIT STANDARD AMOUNT MAY INITIATE ARBITRATION WITH A COVERED PERSON'S CARRIER BY FILING A REQUEST FOR ARBITRATION

WITH THE COMMISSIONER IF:

(I) THE PROVIDER BELIEVES THE PAYMENT RECEIVED FOR UNANTICIPATED OUT-OF-NETWORK SERVICES DOES NOT PROPERLY RECOGNIZE:

(A) THE PROVIDER'S TRAINING, EDUCATION, AND EXPERIENCE;

(B) THE NATURE OF THE SERVICES PROVIDED;

(C) THE AVAILABLE CAPACITY OF THE PROVIDER'S PRACTICE;

(D) THE PROVIDER'S USUAL CHARGE FOR COMPARABLE SERVICES PROVIDED;

(E) THE CIRCUMSTANCES AND COMPLEXITY OF THE PARTICULAR CASE, INCLUDING THE TIME AND PLACE OF THE SERVICES; OR

(F) OTHER ASPECTS OF THE PROVIDER'S PRACTICE THAT MAY BE RELEVANT TO THE PAYMENT; AND

(II) THE AMOUNT IN DISPUTE, AFTER DEDUCTION OF THE COVERED PERSON' REQUIRED COST-SHARING AMOUNT, IS AT LEAST FIFTY DOLLARS.

(b) A PROVIDER IS AUTHORIZED TO BUNDLE SIMILAR CLAIMS AND CLAIMS REPRESENTING A COMMON ISSUE OF FACT TO BE ADJUDICATED IN A SINGLE ARBITRATION PROCESS.

(c) IN AN EFFORT TO SETTLE THE CHARGES FOR UNANTICIPATED OUT-OF-NETWORK SERVICES BEFORE ARBITRATION, THE COMMISSIONER SHALL ARRANGE AN INFORMAL SETTLEMENT TELECONFERENCE TO BE HELD WITHIN THIRTY DAYS AFTER THE COMMISSIONER RECEIVES THE REQUEST FOR ARBITRATION. THE PARTIES SHALL NOTIFY THE COMMISSIONER OF THE RESULTS OF THE SETTLEMENT TELECONFERENCE.

(d) UPON RECEIPT OF NOTICE THAT THE DISPUTE HAS NOT BEEN SETTLED OR THAT A PARTY HAS FAILED TO PARTICIPATE IN THE TELECONFERENCE, THE COMMISSIONER SHALL APPOINT AN ARBITRATOR

FROM THE LIST OF QUALIFIED ARBITRATORS CREATED IN ACCORDANCE WITH RULES ADOPTED PURSUANT TO SUBSECTION (4)(h)(II) OF THIS SECTION AND NOTIFY THE PARTIES OF THE DATE OF THE ARBITRATION, THE PROCESS TO BE FOLLOWED, AND THE APPOINTED ARBITRATOR.

(e) THE PROVIDER AND THE CARRIER SHALL SHARE EQUALLY THE COST OF THE ARBITRATION.

(f) (I) THE ARBITRATION PROCESS MUST CONCLUDE WITHIN THIRTY DAYS AFTER THE APPOINTMENT OF THE ARBITRATOR. THE ARBITRATION IS A PAPER PROCESS WITH EACH PARTY SUBMITTING ITS FINAL BEST OFFER. THE ARBITRATOR SHALL TAKE INTO ACCOUNT ANY APPLICABLE FACTORS IN SUBSECTION (4)(a) OF THIS SECTION AND THE FOLLOWING WHEN MAKING A DETERMINATION:

(A) THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHIC AREA AS THE PROVIDER THAT PROVIDED THE SERVICES, AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY AN INDEPENDENT, NONPROFIT ORGANIZATION SPECIFIED BY THE COMMISSIONER; AND

(B) THE AVERAGE IN-NETWORK RATE FOR COMPARABLE SERVICES PROVIDED IN THE SAME GEOGRAPHIC AREA.

(II) THE ARBITRATOR SHALL MAKE A DETERMINATION UNDER THIS SUBSECTION (4) IN CONSULTATION WITH A NEUTRAL AND IMPARTIAL PROVIDER LICENSED PURSUANT TO TITLE 12 WHO IS ACTIVELY PRACTICING IN THE SAME OR SIMILAR SPECIALTY AS THE PROVIDER THAT PROVIDED THE SERVICES THAT ARE THE SUBJECT OF THE ARBITRATION.

(g) (I) THE DECISION OF THE ARBITRATOR IS FINAL. A SUBSEQUENT DISPUTE BETWEEN AN OUT-OF-NETWORK PROVIDER AND A CARRIER ABOUT

THE SAME OUT-OF-NETWORK SERVICE THAT WAS PREVIOUSLY ARBITRATED UNDER THIS SUBSECTION (4) IS NOT SUBJECT TO REARBITRATION.

(II) IF THE ARBITRATOR'S DECISION REQUIRES ADDITIONAL PAYMENT BY THE CARRIER, THE CARRIER SHALL PAY THE PROVIDER IN ACCORDANCE WITH SECTION 10-16-106.5.

(III) IF THE COMMISSIONER BECOMES AWARE OF A CARRIER OR AN OUT-OF-NETWORK PROVIDER ROUTINELY USING ARBITRATION FOR THE SAME ISSUE IN DISPUTE, DESPITE AN ARBITRATOR'S DECISION, THE COMMISSIONER SHALL REQUIRE THE PARTY ATTEMPTING TO REARBITRATE TO PAY THE FULL COST OF THE ARBITRATION.

(h) THE COMMISSIONER SHALL PROMULGATE RULES TO:

(I) ESTABLISH A STANDARD ARBITRATION FORM;

(II) ESTABLISH A PROCESS TO CREATE A LIST OF QUALIFIED ARBITRATORS FROM WHICH THE COMMISSIONER MAY SELECT AN ARBITRATOR TO ARBITRATE A DISPUTE UNDER THIS SUBSECTION (4). TO BE QUALIFIED, AN ARBITRATOR MUST:

(A) BE INDEPENDENT AND IMPARTIAL;

(B) NOT BE AFFILIATED WITH A CARRIER, HEALTH CARE FACILITY, OR PROFESSIONAL ASSOCIATION OF CARRIERS OR PROVIDERS;

(C) NOT HAVE ANY MATERIAL, PROFESSIONAL, FAMILY, OR FINANCIAL CONFLICT OF INTEREST WITH THE PARTIES INVOLVED IN THE ARBITRATION; AND

(D) HAVE TRAINING AND EXPERIENCE IN HEALTH CARE BILLING;

(III) ESTABLISH PROCEDURES AND CONTRACTS WITH ARBITRATORS QUALIFIED TO ADMINISTER BILLING DISPUTES BETWEEN CARRIERS AND OUT-OF-NETWORK PROVIDERS;

(IV) DETERMINE THE COST OF THE ARBITRATION PROCESS; AND

(V) MONITOR AND EVALUATE ARBITRATORS CONDUCTING ARBITRATIONS UNDER THIS SUBSECTION (4).

(5) **Reports.** (a) ON OR BEFORE FEBRUARY 1, 2021, AND EACH FEBRUARY 1 THEREAFTER, EACH CARRIER SHALL REPORT TO THE COMMISSIONER THE NUMBER OF TIMES UNANTICIPATED OUT-OF-NETWORK SERVICES WERE PROVIDED, INCLUDING PROVIDER TYPES, TYPES OF SERVICES, REGIONS OF THE STATE WHERE THE SERVICES OCCURRED, AND THE TOTAL NUMBER OF MINIMUM BENEFIT STANDARD PAYMENTS.

(b) NOTWITHSTANDING SECTION 24-1-136 (11)(a)(I), ON OR BEFORE JANUARY 1, 2022, AND EACH JANUARY 1 THEREAFTER, THE COMMISSIONER SHALL SUBMIT A REPORT TO THE HEALTH AND INSURANCE COMMITTEE OF THE HOUSE OF REPRESENTATIVES AND THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE, OR THEIR SUCCESSOR COMMITTEES, THAT COMPILES THE DATA SUBMITTED PURSUANT TO SUBSECTION (5)(a) OF THIS SECTION, THE TOTAL NUMBER OF ARBITRATIONS IN THE PREVIOUS CALENDAR YEAR, AND THE NUMBER OF ARBITRATION DECISIONS IN FAVOR OF PROVIDERS AND IN FAVOR OF CARRIERS.

(6) **Repeal.** THIS SECTION IS REPEALED, EFFECTIVE JANUARY 1, 2025.

SECTION 4. Act subject to petition - effective date. This act takes effect January 1, 2020; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within the ninety-day period after final adjournment of the general assembly, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2020 and, in such case, will take

effect on the date of the official declaration of the vote thereon by the governor.