First Regular Session
Seventy-first General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 17-0328.01 Kristen Forrestal x4217 **SENATE BILL 17-151**

SENATE SPONSORSHIP

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Senate Committees
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A BILL FOR AN ACT

CONCERNING CHANGES IN THE REQUIREMENTS FOR THE COVERAGE OF HEALTH CARE BENEFITS TO ALLOW FOR INCREASED CONSUMER ACCESS TO 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 requires a health insurance carrier or an intermediary that conducts credentialing, utilization management, or utilization review to:

- Base health care coverage authorizations and medical necessity determinations on generally accepted and evidence-based standards and criteria of clinical practice;

- Disclose to a carrier's policyholders and providers the evidence-based standards and criteria of clinical practice and processes that the carrier uses for coverage authorizations and medical necessity determinations of health care services;
- Ensure that coverage authorizations and medical necessity determinations are performed by a health care provider;
- Categorize a condition as a new episode of care if the same provider has not treated the policyholder for the condition within the previous 30 days; and
- Ensure that tiered prior authorization criteria are based on generally accepted and evidence-based standards and criteria of clinical practice.

The bill prohibits:

- An intermediary from requiring coverage authorization or a medical necessity determination prior to the evaluation and management services provided by a health care provider to a policyholder during an initial health care visit; and
- A carrier from creating incentives to reduce or deny coverage authorizations or medical necessity determinations.

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

SECTION 1. In Colorado Revised Statutes, **add** 10-16-145 as follows:

10-16-145. Requirements for carriers and intermediaries that provide credentialing, utilization management, or utilization review - participating providers - rules - definitions. (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "CREDENTIALING" MEANS THE COLLECTION AND VERIFICATION OF A PROVIDER'S PROFESSIONAL QUALIFICATIONS.

(b) "UTILIZATION MANAGEMENT" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-1002 (10).

(c) "UTILIZATION REVIEW" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-112 (1)(b).

(2) A CARRIER OR AN INTERMEDIARY THAT CONDUCTS CREDENTIALING, UTILIZATION MANAGEMENT, OR UTILIZATION REVIEW SHALL:

(a) BASE HEALTH CARE COVERAGE AUTHORIZATIONS AND MEDICAL NECESSITY DETERMINATIONS ON GENERALLY ACCEPTED AND EVIDENCE-BASED STANDARDS AND CRITERIA OF CLINICAL PRACTICE;

(b) DISCLOSE IN WRITING TO A CARRIER'S POLICYHOLDERS AND PROVIDERS THE EVIDENCE-BASED STANDARDS AND CRITERIA OF CLINICAL PRACTICE AND PROCESSES THAT THE CARRIER USES FOR COVERAGE AUTHORIZATIONS AND MEDICAL NECESSITY DETERMINATIONS OF HEALTH CARE SERVICES;

(c) ENSURE THAT COVERAGE AUTHORIZATIONS AND MEDICAL NECESSITY DETERMINATIONS ARE PERFORMED BY A HEALTH CARE PROVIDER WHO IS LICENSED IN A SIMILAR HEALTH FIELD AS THE REQUESTING PROVIDER AND WHOSE LICENSE IS IN GOOD STANDING IN THE REVIEWER'S STATE OR IN A UNITED STATES JURISDICTION;

(d) CATEGORIZE A CONDITION AS A NEW EPISODE OF CARE IF THE SAME PROVIDER HAS NOT TREATED THE POLICYHOLDER FOR THE CONDITION WITHIN THE PREVIOUS THIRTY DAYS; AND

(e) ENSURE THAT TIERED PRIOR AUTHORIZATION CRITERIA ARE BASED ON GENERALLY ACCEPTED AND EVIDENCE-BASED STANDARDS AND CRITERIA OF CLINICAL PRACTICE.

(3) AN INTERMEDIARY DESCRIBED IN SUBSECTION (2) OF THIS SECTION SHALL NOT REQUIRE A COVERAGE AUTHORIZATION OR MEDICAL NECESSITY DETERMINATION PRIOR TO THE EVALUATION AND MANAGEMENT SERVICES PROVIDED BY A HEALTH CARE PROVIDER TO A POLICYHOLDER DURING AN INITIAL HEALTH CARE VISIT.

(4) A CARRIER SHALL NOT CREATE INCENTIVES, THROUGH CONDITIONAL OR CONTINGENT PAYMENTS OR BY ANY OTHER MEANS, FOR AN INTERMEDIARY AS DESCRIBED IN SUBSECTION (2) OF THIS SECTION TO REDUCE OR DENY COVERAGE AUTHORIZATIONS OR MEDICAL NECESSITY DETERMINATIONS.

(5) NO LATER THAN JULY 1, 2018, THE COMMISSIONER SHALL ENFORCE THIS SECTION BY ADOPTING RULES AS AUTHORIZED BY SECTION 10-1-109 AND BY EXERCISING ALL OTHER POWERS CONFERRED UPON THE COMMISSIONER UNDER THIS ARTICLE 16, INCLUDING DEVELOPING A DISPUTE RESOLUTION PROCESS FOR A POLICYHOLDER OR PROVIDER AND AN INTERMEDIARY DESCRIBED IN SUBSECTION (2) OF THIS SECTION.

(6) A CARRIER OR AN INTERMEDIARY DESCRIBED IN SUBSECTION (2) OF THIS SECTION SHALL NOT REQUIRE A PROVIDER TO PARTICIPATE OR BE CREDENTIALED BY A SPECIFIC CARRIER OR ANY INTERMEDIARY AS A CONDITION FOR PARTICIPATION IN A HEALTH INSURANCE NETWORK.

(7) THIS SECTION DOES NOT APPLY TO A MEDICAL DIRECTOR EMPLOYED DIRECTLY BY A CARRIER.

SECTION 2. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 9, 2017, if adjournment sine die is on May 10, 2017); 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 such period, 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 2018 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.