Second Regular Session
Seventieth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 16-0652.02 Kristen Forrestal x4217 **SENATE BILL 16-152**

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A BILL FOR AN ACT

CONCERNING NOTIFICATIONS OF HEALTH CARE BILLING CHARGES FOR COVERED PERSONS.

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://www.leg.state.co.us/billsummaries.)

The bill requires:

- A facility that is in network to provide a covered person with a written disclosure concerning charges for out-of-network services whenever the network facility schedules a procedure or seeks prior authorization from a carrier for nonemergency services for the covered person;

- An out-of-network, facility-based provider to include specific notices regarding charges in plain language on any billing notice sent to a covered person; and
- A carrier to provide a list in plain language to a covered person or the covered person's authorized representative at the time of preauthorization for a covered benefit to be provided at a facility that is in network.

The bill requires carriers to submit information about the use of an out-of-network provider to the commissioner of insurance.

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

SECTION 1. In Colorado Revised Statutes, **add** 6-1-726 as follows:

6-1-726. Facility-based providers - carriers - notifications to consumers - rules - definitions. (1) WHENEVER A FACILITY OR PROVIDER THAT IS IN NETWORK SCHEDULES A PROCEDURE OR SEEKS PRIOR AUTHORIZATION FROM A CARRIER FOR NONEMERGENCY SERVICES FOR A COVERED PERSON, THE IN-NETWORK PROVIDER SHALL PROVIDE THE COVERED PERSON WITH A LIST CONTAINING A DESCRIPTION OF THE SPECIFIC TYPES OF COVERED OUT-OF-NETWORK PROVIDERS THAT A COVERED PERSON MAY ENCOUNTER WITHIN THE IN-NETWORK FACILITY AND STATING, IN PLAIN LANGUAGE, THAT:

(a) SOME FACILITY-BASED PROVIDERS MAY BE CALLED UPON TO PROVIDE CARE TO THE COVERED PERSON DURING THE COURSE OF TREATMENT;

(b) A FACILITY-BASED PROVIDER MAY NOT HAVE A CONTRACT WITH THE COVERED PERSON'S CARRIER AND, IN THAT CASE, IS CONSIDERED TO BE AN OUT-OF-NETWORK PROVIDER, WHICH MAY RESULT IN HIGHER COSTS;

(c) IF THE COVERED PERSON'S HEALTH COVERAGE PLAN IS

REGULATED BY THE DIVISION OF INSURANCE, THE COVERED PERSON MAY BE RESPONSIBLE FOR PAYING ONLY THE APPLICABLE IN-NETWORK COST-SHARING AMOUNT; AND

(d) THE COVERED PERSON MAY OBTAIN A LIST OF IN-NETWORK, FACILITY-BASED PROVIDERS FROM HIS OR HER HEALTH COVERAGE PLAN AND REQUEST A PROVIDER FROM THE LIST FOR HIS OR HER TREATMENT OR SERVICES.

(2) AN OUT-OF-NETWORK, FACILITY-BASED PROVIDER SHALL INCLUDE IN PLAIN LANGUAGE, ON ANY BILLING NOTICE SENT TO THE COVERED PERSON, A STATEMENT THAT:

(a) THE OUT-OF-NETWORK PROVIDER IS NOT PARTICIPATING WITH THE COVERED PERSON'S PLAN, BASED ON THE HEALTH COVERAGE PLAN INFORMATION MADE AVAILABLE TO THE PROVIDER;

(b) IF THE COVERED PERSON'S HEALTH COVERAGE PLAN IS REGULATED BY THE DIVISION OF INSURANCE, THE COVERED PERSON MAY BE RESPONSIBLE FOR PAYING ONLY THE APPLICABLE IN-NETWORK COST-SHARING AMOUNT; AND

(c) IF THE COVERED PERSON RECEIVES A BALANCE BILL, THE PERSON MAY FORWARD THE BILL TO HIS OR HER CARRIER FOR CONSIDERATION OF THE REMAINING BALANCE.

(3) A CARRIER SHALL PROVIDE A WRITTEN NOTICE IN PLAIN LANGUAGE TO A COVERED PERSON OR THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE AT THE TIME OF PREAUTHORIZATION, IF APPLICABLE, FOR A COVERED BENEFIT TO BE PROVIDED AT A FACILITY THAT IS IN NETWORK. THE NOTICE MUST STATE THAT:

(a) THE COVERED PERSON MIGHT BE TREATED BY A HEALTH CARE PROVIDER THAT IS NOT IN THE COVERED PERSON'S IN-NETWORK PLAN;

(b) IF THE COVERED PERSON'S HEALTH COVERAGE PLAN IS REGULATED BY THE DIVISION OF INSURANCE, THE COVERED PERSON IS RESPONSIBLE ONLY FOR PAYING THE APPLICABLE IN-NETWORK COST-SHARING AMOUNT;

(c) THE COVERED PERSON MAY REQUEST ASSISTANCE FROM THE CARRIER TO IDENTIFY AN AVAILABLE PARTICIPATING PROVIDER; AND

(d) IF THE COVERED PERSON RECEIVES A BALANCE BILL FROM AN OUT-OF-NETWORK, FACILITY-BASED PROVIDER, THE COVERED PERSON SHOULD CONTACT THE CARRIER'S CUSTOMER SERVICE DEPARTMENT FOR ASSISTANCE.

(4) NOTHING IN THIS SECTION ALTERS A COVERED PERSON'S PROTECTION AGAINST BALANCE BILLING IN SECTION 10-16-704 (3) (b) OR (5.5) (a), C.R.S.

(5) AS USED IN THIS SECTION:

(a) "FACILITY" MEANS A FACILITY THAT IS LICENSED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT PURSUANT TO SECTION 25-1.5-103, C.R.S.

(b) "FACILITY-BASED PROVIDER" MEANS A HEALTH CARE PROVIDER WHO PROVIDES HEALTH CARE SERVICES OR TREATMENT TO PATIENTS WHO ARE IN AN IN-PATIENT OR AMBULATORY FACILITY WHERE THE SERVICES OR TREATMENTS ARE TYPICALLY ARRANGED BY THE FACILITY BY CONTRACT OR WHERE THE PROVIDER IS CREDENTIALED TO WORK AT THE FACILITY OR, FOR SURGICAL PROCEDURES, WHERE THE SERVICES OR TREATMENTS ARE TYPICALLY ARRANGED BY THE SURGEON OR THE SURGEON'S OFFICE. "HEALTH CARE SERVICES OR TREATMENT" INCLUDES PATHOLOGY, ANESTHESIOLOGY, EMERGENCY CARE, RADIOLOGY, SURGICAL ASSISTANCE, OR OTHER SERVICES.

(c) "HEALTH COVERAGE PLAN" HAS THE SAME MEANING AS IN SECTION 10-16-102 (34), C.R.S.

SECTION 2. In Colorado Revised Statutes, 6-1-105, **add** (1) (iii) as follows:

6-1-105. Deceptive trade practices. (1) A person engages in a deceptive trade practice when, in the course of the person's business, vocation, or occupation, the person:

(iii) VIOLATES SECTION 6-1-726.

SECTION 3. In Colorado Revised Statutes, **add** 10-16-143 as follows:

10-16-143. Carrier reporting requirements - use of out-of-network providers - repeal. (1) (a) EACH CARRIER SHALL SUBMIT INFORMATION TO THE COMMISSIONER, IN A FORM AND MANNER PRESCRIBED BY THE COMMISSIONER, REGARDING USE OF OUT-OF-NETWORK PROVIDERS BY COVERED PERSONS, INCLUDING THE SPECIALTY OF THE OUT-OF-NETWORK PROVIDER AND WHETHER THE CHARGES WERE PAID IN FULL OR AT A NEGOTIATED PRICE.

(b) ON OR BEFORE FEBRUARY 1, 2018, AND FOR THE NEXT THREE YEARS THEREAFTER, THE COMMISSIONER SHALL PROVIDE A WRITTEN REPORT TO THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE AND THE HEALTH, INSURANCE, AND ENVIRONMENT AND THE PUBLIC HEALTH CARE AND HUMAN SERVICES COMMITTEES OF THE HOUSE OF REPRESENTATIVES OR THEIR SUCCESSOR COMMITTEES.

(2) THIS SECTION IS REPEALED, EFFECTIVE FEBRUARY 2, 2021.

SECTION 4. Act subject to petition - effective date. This act takes effect January 1, 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 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 2016 and, in such case, will take effect on January 1, 2017, or on the date of the official declaration of the vote thereon by the governor, whichever is later.