Second Regular Session
Seventy-first General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 18-0974.02 Christy Chase x2008 **SENATE BILL 18-237**

SENATE SPONSORSHIP

Gardner,

HOUSE SPONSORSHIP

Esgar,

Senate Committees
Health & Human Services

House Committees

A BILL FOR AN ACT

CONCERNING HEALTH CARE SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER THAT ARE COVERED BENEFITS UNDER A COVERED PERSON'S HEALTH BENEFIT PLAN, AND, IN CONNECTION THEREWITH, REQUIRING CARRIERS TO COVER EMERGENCY SERVICES RENDERED BY AN OUT-OF-NETWORK PROVIDER AT THE IN-NETWORK BENEFIT LEVEL; REQUIRING HEALTH CARE FACILITIES, OUT-OF-NETWORK PROVIDERS, AND CARRIERS TO DISCLOSE SPECIFIED INFORMATION TO A COVERED PERSON REGARDING SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER; AND SPECIFYING BILLING PROCEDURES FOR OUT-OF-NETWORK PROVIDERS.

Bill Summary

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

(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.)

Under current law, when a health care provider who is not under a contract with a health insurer, and is therefore an out-of-network provider, renders health care services to a person covered under a health benefit plan at a facility that is part of the provider network under the plan (in-network facility), the health insurer is required to cover the services of the out-of-network provider at the in-network benefit level and at no greater cost to the covered person than if the services were provided by an in-network provider.

The bill specifies that the in-network benefit level also applies to emergency services provided to a covered person by an out-of-network provider or at an out-of-network facility.

The bill also requires health care facilities, providers, and health insurers to provide disclosures to consumers about the potential effects of receiving nonemergency services from an out-of-network provider or emergency services at an out-of-network facility. The commissioner of insurance, the director of the division of professions and occupations, and the state board of health are directed to adopt rules detailing the disclosure requirements imposed on carriers, providers, and health facilities.

Additionally, if a covered person receives nonemergency services provided by an out-of-network provider at an in-network facility or emergency services provided by an out-of-network provider or at an out-of-network facility and pays the out-of-network provider or facility an amount in excess of the required cost-sharing amount, the out-of-network provider or facility must refund the overpayment and must pay interest on the overpayment if the provider or facility fails to timely refund the overpayment.

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

SECTION 1. In Colorado Revised Statutes, 10-16-704, **amend** (3)(a)(III), (5.5)(a) introductory portion, and (5.5)(a)(V); and **add** (12) and (13) as follows:

10-16-704. Network adequacy - rules - required disclosures - out-of-network providers - limitations on balance billing -

independent dispute resolution process - legislative declaration. (3) (a) (III) 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~~ A provider who is an out-of-network provider and has properly required insurers to hold the consumer harmless. The division of insurance does not have regulatory authority over all health plans. Some consumers are enrolled in self-funded health insurance programs that are governed under the federal "Employee Retirement Income Security Act". Therefore, ~~the general assembly encourages~~ health care facilities, carriers, and providers NEED to provide consumers ~~disclosure~~ WITH DISCLOSURES about the potential impact of receiving services from an out-of-network provider AND THEIR RIGHTS UNDER THIS SECTION. CONSUMERS MUST HAVE ACCESS TO ACCURATE INFORMATION ABOUT THEIR HEALTH CARE BILLS TO ENABLE THEM TO MAKE INFORMED DECISIONS ABOUT THEIR HEALTH CARE AND FINANCIAL OBLIGATIONS.

(5.5) (a) Notwithstanding any provision of law, a carrier ~~that provides any benefits with respect to services in an emergency department of a hospital~~ shall cover emergency services:

(V) AT THE IN-NETWORK BENEFIT LEVEL, with the same cost-sharing requirements as would apply if THE emergency services were provided in-network, AND AT NO GREATER COST TO THE COVERED PERSON THAN IF THE EMERGENCY SERVICES WERE OBTAINED AT OR FROM AN IN-NETWORK PROVIDER AT AN IN-NETWORK FACILITY.

(12) (a) ON AND AFTER JANUARY 1, 2019, HEALTH CARE FACILITIES, CARRIERS, AND PROVIDERS SHALL DEVELOP AND PROVIDE CONSUMERS DISCLOSURES ABOUT THE POTENTIAL EFFECTS OF RECEIVING

NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER OR EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE RULES ADOPTED UNDER SUBSECTION (12)(b) OF THIS SECTION AND SECTIONS 24-34-113 AND 25-1-108 (1)(i).

(b) THE COMMISSIONER, IN CONSULTATION WITH THE STATE BOARD OF HEALTH AND THE DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF REGULATORY AGENCIES, SHALL ADOPT RULES TO SPECIFY THE DISCLOSURE REQUIREMENTS UNDER THIS SUBSECTION (12), WHICH RULES MUST ADDRESS, AT A MINIMUM, THE FOLLOWING:

(I) THE TIMING FOR PROVIDING THE DISCLOSURES FOR BOTH EMERGENCY AND NONEMERGENCY SERVICES;

(II) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON BILLING STATEMENTS, BILLING NOTICES, PRIOR AUTHORIZATIONS, AND OTHER FORMS OR COMMUNICATIONS WITH COVERED PERSONS;

(III) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE COVERED PERSON'S RIGHTS AND PAYMENT OBLIGATIONS IF THE COVERED PERSON'S HEALTH BENEFIT PLAN IS UNDER THE JURISDICTION OF THE DIVISION;

(IV) DISCLOSURE REQUIREMENTS SPECIFIC TO FACILITIES, OUT-OF-NETWORK PROVIDERS, AND CARRIERS, INCLUDING THE POSSIBILITY OF BEING TREATED BY AN OUT-OF-NETWORK PROVIDER, WHETHER A PROVIDER IS OUT OF NETWORK, THE TYPES OF SERVICES AN OUT-OF-NETWORK PROVIDER MAY RENDER, AND THE RIGHT TO REQUEST AN IN-NETWORK PROVIDER TO RENDER SERVICES; AND

(V) REQUIREMENTS ABOUT THE WORDING TO BE USED IN THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT CARRIERS, FACILITIES, AND PROVIDERS USE CONSISTENT WORDING IN THE DISCLOSURES REQUIRED BY THIS SUBSECTION (12) AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (12) AND SECTIONS 24-34-113 AND 25-1-108 (1)(i).

(13) (a) WITH REGARD TO NONEMERGENCY SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY OR EMERGENCY SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER OR AT AN OUT-OF-NETWORK FACILITY, IF THE OUT-OF-NETWORK PROVIDER OR FACILITY RECEIVES MORE THAN THE IN-NETWORK COST-SHARING AMOUNT FROM THE COVERED PERSON FOR THE SERVICES PROVIDED, THE OUT-OF-NETWORK PROVIDER SHALL REFUND ANY OVERPAYMENT TO THE COVERED PERSON WITHIN FORTY-FIVE CALENDAR DAYS AFTER RECEIVING NOTICE OF THE OVERPAYMENT.

(b) IF THE OUT-OF-NETWORK PROVIDER OR FACILITY DOES NOT REFUND ANY OVERPAYMENT TO THE COVERED PERSON WITHIN FORTY-FIVE CALENDAR DAYS AFTER RECEIVING NOTICE OF THE OVERPAYMENT, INTEREST ACCRUES ON THE OVERPAYMENT AMOUNT AT THE RATE OF TEN PERCENT PER ANNUM, STARTING ON THE DATE NOTICE OF OVERPAYMENT WAS RECEIVED.

(c) AN OUT-OF-NETWORK PROVIDER OR FACILITY SHALL AUTOMATICALLY INCLUDE IN THE REFUND TO THE COVERED PERSON ALL ACCRUED INTEREST PURSUANT TO THIS SUBSECTION (13) WITHOUT REQUIRING THE COVERED PERSON TO SUBMIT A REQUEST FOR THE INTEREST AMOUNT.

SECTION 2. In Colorado Revised Statutes, **add** 24-34-113 as

follows:

24-34-113. Health care providers - required disclosures - rules. THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE AND THE STATE BOARD OF HEALTH, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR HEALTH CARE PROVIDERS REGULATED UNDER TITLE 12 TO DEVELOP AND PROVIDE CONSUMER DISCLOSURES IN ACCORDANCE WITH SECTION 10-16-704 (12). THE DIRECTOR SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTION 10-16-704 (12) AND RULES ADOPTED BY THE COMMISSIONER UNDER THAT SECTION AND BY THE STATE BOARD OF HEALTH UNDER SECTION 25-1-108 (1)(i).

SECTION 3. In Colorado Revised Statutes, 25-1-108, **add** (1)(i) as follows:

25-1-108. Powers and duties of state board of health. (1) In addition to all other powers and duties conferred and imposed upon the state board of health by the provisions of this part 1, the board has the following specific powers and duties:

(i) TO ADOPT RULES, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE AND THE DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF REGULATORY AGENCIES, THAT SPECIFY THE REQUIREMENTS FOR HEALTH CARE FACILITIES TO DEVELOP AND PROVIDE CONSUMER DISCLOSURES IN ACCORDANCE WITH SECTION 10-16-704 (12). THE STATE BOARD SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTION 10-16-704 (12) AND RULES ADOPTED BY THE COMMISSIONER UNDER THAT SECTION AND BY THE DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS UNDER SECTION 24-34-113.

SECTION 4. 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.