Colorado Legislative Council Staff

SB17-088

REVISED FISCAL NOTE

(replaces fiscal note dated February 9, 2017)

FISCAL IMPACT: ☒ State ☐ Local ☐ Statutory Public Entity ☐ Conditional ☐ No Fiscal Impact

Drafting Number:	LLS 17-0503	**Date:**	March 28, 2017
Prime Sponsor(s):	Sen. Holbert; Williams A. Rep. Hooton; Van Winkle	**Bill Status:**	House Health Insurance, and Environment
		Fiscal Analyst:	Clare Pramuk (303-866-2677)

BILL TOPIC: PARTICIPATING PROVIDER NETWORK SELECTION CRITERIA

Fiscal Impact Summary	FY 2017-2018	FY 2018-2019
State Revenue		
State Expenditures	Workload increase.	
Appropriation Required: None.		
Future Year Impacts: Ongoing workload increase.		

Summary of Legislation

If a health insurer offers a tiered network, the ***reengrossed*** bill requires the health insurer to develop and use standards for selecting and tiering participating providers. The insurer is required to make the standards available to the Commissioner of Insurance, participating healthcare providers, and the public. Selection and tiering standards cannot:

- allow the insurer to discriminate against high-risk populations by excluding or tiering providers based on their location in a geographic area that contains high-risk populations; or
- exclude providers because they treat or specialize in treating high-risk patients.

The bill requires that at least 60 days prior to implementing a decision to terminate or place a provider in a tiered network, that an insurer provide written notice to the provider with an explanation of the reasons for the decision, and to inform the provider of the right to request the insurer to reconsider the decision. The bill requires insurers to establish a reconsideration process with specific deadlines.

The commissioner and Division of Insurance staff are prohibited from arbitrating, mediating, or settling disputes regarding a decision not to include a provider in a network or tiered network or regarding any dispute between an insurer, the insurer's intermediary, or providers. However, if the commissioner determines that an insurer has violated the provisions of this bill, the commissioner must require the insurer to follow a corrective action plan and may use enforcement powers available under current insurance law.

Background

Health insurers contract with healthcare providers and facilities to provide care to their policyholders at an agreed upon rate. These are "in-network" providers. An insurer can create a a "tiered network" where providers are placed in different benefit tiers. The tier determines how much a policyholder pays for service from a provider through a copay and coinsurance.

State Expenditures

This bill increases workload in the Division of Insurance in the Department of Regulatory Agencies (DORA). The division will update its rules to incorporate the provisions of the bill in FY 2017-18. The Department of Law will provide legal services to support the rulemaking process with hours included in DORA's annual appropriation of legal services hours. If an insurer fails to comply with the bill, the division will have an increase in workload to develop and monitor a corrective action plan or to take other enforcement action. The fiscal note assumes that insurers will provide documentation on their standards only upon request and that the division will not routinely review and evaluate insurer standards. This increase is workload can be accomplished within existing appropriations.

State Appropriations

The bill includes an appropriation for $42,006 to the Department of Regulatory Agencies and an allocation of 0.5 FTE. The reengrossed bill does not require this appropriation.

Effective Date

The bill takes effect January 1, 2018, unless a referendum petition is filed, and applies to contracts issued or renewed on or after that date.

State and Local Government Contacts

Information Technology Judicial Regulatory Agencies