Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0124.02 Renee Leone x2695 **SENATE BILL 26-017**

SENATE SPONSORSHIP

Daugherty and Bright,

HOUSE SPONSORSHIP

(None),

Senate Committees
Health & Human Services

House Committees

A BILL FOR AN ACT

CONCERNING CHANGES TO OUT-OF-NETWORK HEALTH-CARE SERVICES DISPUTE RESOLUTION PROCESSES FOR HEALTH INSURANCE CARRIERS.

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 makes changes to the dispute resolution process between health insurance carriers (carriers) and out-of-network health-care providers (providers) by:

- Mandating that a carrier provide a remittance advice with each payment made to a provider;

- Establishing penalties that the division of insurance (division) may assess against a carrier that fails to properly reimburse a provider for services provided to a patient;
- Requiring a carrier to annually submit information to the division concerning patient use of out-of-network providers; and
- Requiring the division to produce an annual report regarding patient use of out-of-network providers and relevant arbitration data and statistics.

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

SECTION 1. In Colorado Revised Statutes, 10-16-704, **amend** (13); and **recreate and reenact, with amendments,** (14) and (16) as follows:

10-16-704. Network adequacy - required disclosures - balance billing - rules - legislative declaration - definitions.

(13) (a) (I) THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

(A) UNDER CURRENT STATE LAW, PROVIDERS RESOLVE OUT-OF-NETWORK REIMBURSEMENT DISPUTES THROUGH AN INDIVIDUAL, CLAIM-BY-CLAIM ARBITRATION PROCESS THAT IS PROHIBITIVELY EXPENSIVE AND ADMINISTRATIVELY BURDENSOME;

(B) THE CURRENT FRAGMENTED PROCESS CREATES DE FACTO IMMUNITY FOR CARRIERS TO SYSTEMICALLY UNDERPAY CLAIMS BECAUSE THE COST OF A SINGLE ARBITRATION OFTEN EXCEEDS THE AMOUNT OF THE DISPUTED REIMBURSEMENT, WHICH PRACTICE PARTICULARLY IMPACTS SMALLER PROVIDER GROUPS;

(C) THE DIVISION HAS AN ESTABLISHED COMPLAINT PROCESS THAT ALLOWS PROVIDERS TO SUBMIT COMPLAINTS TO ENSURE THAT PAYMENT REQUIREMENTS ARE MET BY CARRIERS. THIS ESTABLISHED COMPLAINT PROCESS REQUIRES THE RESOLUTION OF CLAIMS WITHIN THIRTY DAYS

AFTER THE COMPLAINT CONTAINING THE CLAIMS HAS BEEN FILED IF THERE ARE ONE HUNDRED OR FEWER CLAIMS SUBMITTED ON THE COMPLAINT FORM AND ALLOWS FOR ADDITIONAL TIME WHEN THERE ARE MORE THAN ONE HUNDRED CLAIMS SUBMITTED ON THE COMPLAINT FORM. HOWEVER, THE COMPLAINT PROCESS DOES NOT ENSURE PROMPT PAYMENT TO PROVIDERS OF MONEY OWED WHEN CARRIERS ARE DEEMED TO HAVE VIOLATED PAYMENT REQUIREMENTS.

(D) TO IMPROVE FAIRNESS IN THE HEALTH-INSURANCE MARKET, THE DIVISION'S EXISTING OVERSIGHT AND ENFORCEMENT AUTHORITY OF CARRIER PAYMENTS TO PROVIDERS SHOULD BE AUGMENTED TO COMPEL PROMPT PAYMENT FROM CARRIERS WHEN UNDERPAYMENT IS IDENTIFIED IN THE COMPLAINT PROCESS, THEREBY PROVIDING A MORE EFFECTIVE PATHWAY FOR PROVIDERS TO CHALLENGE UNDERPAYMENT;

(E) EFFECTIVE DISPUTE RESOLUTION IS FURTHER HINDERED BECAUSE CARRIERS FREQUENTLY FAIL TO DISCLOSE WHETHER A PATIENT'S HEALTH BENEFIT PLAN IS GOVERNED BY STATE LAW OR THE "EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974", 29 U.S.C. SEC. 1001 ET SEQ., LEAVING PROVIDERS UNABLE TO DETERMINE IN WHICH JURISDICTION THE PROVIDER MAY APPEAL; AND

(F) THE DIVISION REQUIRES A CLEAR STATUTORY MANDATE TO COLLECT SPECIFIC REIMBURSEMENT METHODOLOGY DATA AND TO REINSTATE FORMAL REPORTING OF OUT-OF-NETWORK UTILIZATION IN ORDER TO ENSURE THAT THE TRANSPARENCY GOALS OF THIS SECTION ARE FULLY REALIZED.

(II) THE GENERAL ASSEMBLY THEREFORE INTENDS FOR THIS SUBSECTION (13) AND SUBSECTIONS (14) AND (16) OF THIS SECTION TO:

(A) STREAMLINE OUT-OF-NETWORK DISPUTE RESOLUTIONS BY

GRANTING THE DIVISION ADDITIONAL ENFORCEMENT AUTHORITY WITHIN ITS OUT-OF-NETWORK COMPLAINT PROCESS, INCLUDING A REQUIREMENT TO COMPEL PROMPT PAYMENT FROM CARRIERS WHEN UNDERPAYMENT IS IDENTIFIED;

(B) REQUIRE JURISDICTIONAL TRANSPARENCY BY MANDATING THAT CARRIERS CLEARLY STATE ON A REMITTANCE ADVICE WHETHER A HEALTH BENEFIT PLAN IS REGULATED BY STATE LAW OR FEDERAL LAW;

(C) EMPOWER DATA-DRIVEN ENFORCEMENT BY REQUIRING CARRIERS TO DISCLOSE THE SPECIFIC METHODOLOGIES USED TO DETERMINE OUT-OF-NETWORK REIMBURSEMENT AND BY GRANTING THE COMMISSIONER AUTHORITY TO ORDER CORRECTIVE PAYMENTS AND IMPOSE FINES FOR NONCOMPLIANCE; AND

(D) RESTORE PUBLIC ACCOUNTABILITY BY REINSTATING THE REQUIREMENT THAT THE DIVISION PUBLISH AN ANNUAL REPORT ON THE IMPLEMENTATION AND IMPACT OF THE STATE'S OUT-OF-NETWORK PAYMENT LAWS.

~~(a)~~ (b) When a carrier makes a payment to a provider or a health-care facility pursuant to subsection (3)(d) or (5.5)(b) of this section, the provider or the facility may request, and the commissioner shall collect, data from the carrier to evaluate the carrier's compliance in paying the highest rate required. The information ~~requested may~~ PROVIDED MUST include the methodology for determining the carrier's median in-network rate ~~or~~ AND reimbursement for each service in the same geographic area.

~~(b) Repealed.~~

(c) WHEN A CARRIER MAKES A PAYMENT TO A PROVIDER OR A HEALTH-CARE FACILITY PURSUANT TO SUBSECTION (3)(d) OR (5.5)(b) OF

THIS SECTION, THE CARRIER SHALL PROVIDE A REMITTANCE ADVICE THAT IDENTIFIES WHETHER THE HEALTH BENEFIT PLAN THE CARRIER IS MAKING THE PAYMENT PURSUANT TO IS REGULATED BY THE STATE OR THE FEDERAL GOVERNMENT.

(d) IF THE COMMISSIONER FINDS, BASED ON THE INFORMATION PROVIDED BY THE CARRIER PURSUANT TO SUBSECTION (13)(b) OF THIS SECTION, THAT THE CARRIER DID NOT PROPERLY REIMBURSE A PROVIDER FOR SERVICES PROVIDED TO A COVERED PERSON WHO HAS A HEALTH BENEFIT PLAN ISSUED AND DELIVERED IN THE STATE PURSUANT TO SUBSECTION (3)(d) OR (5.5)(b) OF THIS SECTION, THE COMMISSIONER SHALL ORDER THE CARRIER TO PAY:

(I) THE PROVIDER IN COMPLIANCE WITH SUBSECTION (3)(d) OR (5.5)(b) OF THIS SECTION;

(II) ANY ADDITIONAL AMOUNTS THAT MAY BE DUE UNDER SECTION 10-16-106.5; AND

(III) A FINE THAT THE COMMISSIONER ASSESSES AND IN AN AMOUNT THAT THE COMMISSIONER DEEMS APPROPRIATE BASED ON THE FACTS.

(14) BEGINNING ON JANUARY 1, 2027, AND ON OR BEFORE JANUARY 1 OF EACH YEAR THEREAFTER, EACH CARRIER SHALL SUBMIT INFORMATION TO THE COMMISSIONER, IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER, CONCERNING THE USE OF OUT-OF-NETWORK PROVIDERS AND HEALTH-CARE FACILITIES BY COVERED PERSONS AND THE IMPACT ON PREMIUM AFFORDABILITY FOR CONSUMERS.

(16) NOTWITHSTANDING SECTION 24-1-136 (11)(a)(I), ON OR BEFORE JULY 1, 2027, AND ON OR BEFORE EACH JULY 1 THEREAFTER, THE COMMISSIONER SHALL PRODUCE A REPORT THAT THE COMMISSIONER

POSTS ON THE DIVISION'S WEBSITE AND SUBMITS TO THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE AND THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES. THE REPORT MUST SUMMARIZE:

(a) THE INFORMATION SUBMITTED TO THE COMMISSIONER PURSUANT TO SUBSECTION (14) OF THIS SECTION; AND

(b) THE NUMBER OF COMPLAINTS FILED IN THE PREVIOUS CALENDAR YEAR; THE NUMBER OF COMPLAINTS SETTLED, ARBITRATED, AND DISMISSED IN THE PREVIOUS CALENDAR YEAR; AND A SUMMARY REFLECTING THE NUMBER OF COMPLAINTS RESOLVED IN FAVOR OF THE CARRIER OR IN FAVOR OF THE PROVIDER OR HEALTH-CARE FACILITY. THE REPORT SUBMITTED PURSUANT TO THIS SUBSECTION (16) MUST NOT INCLUDE ANY INFORMATION THAT SPECIFICALLY IDENTIFIES THE PROVIDER, HEALTH-CARE FACILITY, CARRIER, OR COVERED PERSON INVOLVED IN EACH DECISION.

SECTION 2. Act subject to petition - effective date - applicability. (1) 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 12, 2026, if adjournment sine die is on May 13, 2026); 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 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

(2) This act applies to payments owed by health insurance carriers on or after the applicable effective date of this act.