SENATE COMMITTEE OF REFERENCE REPORT

_____ April 15, 2019
Chair of Committee Date

Committee on Judiciary.

After consideration on the merits, the Committee recommends the following:

HB19-1174 be amended as follows, and as so amended, be referred to the Committee on Finance with favorable recommendation:

Amend reengrossed bill, page 2, line 14, strike "AND" and substitute "OR".

Page 3, line 1, strike "AS" and substitute "STARTING IN 2021, AS".

Page 4, line 15, strike "THE" and substitute "ONE HUNDRED TEN PERCENT OF THE".

Page 4, line 18, strike "ONE HUNDRED PERCENT" and substitute "THE SIXTIETH PERCENTILE".

Page 4, line 20, strike "AS DETERMINED".

Page 5, after line 3 insert:

"(V) THIS SUBSECTION (3)(d) DOES NOT APPLY WHEN A COVERED PERSON VOLUNTARILY USES AN OUT-OF-NETWORK PROVIDER.".

Renumber succeeding subparagraph accordingly.

Page 5, lines 19 and 20, strike "AT OR".

Page 5, strike line 23, and substitute "COST-SHARING LIMIT.".

Page 6, strike line 24 and substitute "THE OUT-OF-NETWORK PROVIDER IN ACCORDANCE WITH SUBSECTION (3)(d)(II) OF THIS SECTION AND

REIMBURSE THE OUT-OF-NETWORK FACILITY".

Page 7, line 3, strike "ONE HUNDRED PERCENT OF THE" and substitute "THE".

Page 7, lines 5 and 6, strike "AS DETERMINED".

Page 7, line 14, strike "THAT" and substitute "THE SAME".

Page 7, line 19, strike "ONE HUNDRED PERCENT OF THE" and substitute "THE".

Page 7, lines 21 and 22, strike "AS DETERMINED".

Page 7, line 23, strike "CREATED" and substitute "DESCRIBED".

Page 7, line 27, after "COPAYMENT" insert "AMOUNT".

Page 8, line 17, strike "PROVIDERS" and substitute "SERVICE AGENCIES".

Page 8, lines 18 and 19, strike "COPAYMENT, COINSURANCE, OR DEDUCTIBLE" and substitute "COINSURANCE, DEDUCTIBLE, OR COPAYMENT".

Page 11, line 6, strike "24-34-113 (2)" and substitute "24-34-113".

Page 11, strike line 15 and substitute "HEALTH CARE FACILITY PURSUANT TO SUBSECTION (3)(d) OR (5.5)(b) OF THIS".

Page 11, line 27, after "PROVIDER" insert "OR A HEALTH CARE FACILITY".

Page 12, strike lines 7 and 8 and substitute "THE COMMISSIONER AND THE CARRIER. A PROVIDER OR HEALTH CARE FACILITY MUST SUBMIT A REQUEST FOR THE ARBITRATION OF A CLAIM WITHIN NINETY DAYS AFTER THE RECEIPT OF PAYMENT FOR THAT CLAIM.".

Page 12, strike lines 10 and 11 and substitute "SECTION, IF REQUESTED BY THE CARRIER AND THE PROVIDER OR HEALTH CARE FACILITY, THE COMMISSIONER MAY ARRANGE AN INFORMAL SETTLEMENT TELECONFERENCE TO BE HELD WITHIN THIRTY".

Page 12, line 18, after "THAT" insert "ESTABLISHES A STANDARD ARBITRATION FORM AND".

Page 12, strike line 27.

Page 13, strike lines 1 through 13 and substitute:

"(c) WITHIN THIRTY DAYS AFTER THE COMMISSIONER APPOINTS AN ARBITRATOR AND NOTIFIES THE PARTIES OF THE ARBITRATION, BOTH PARTIES SHALL SUBMIT TO THE ARBITRATOR, IN WRITING, EACH PARTY'S FINAL OFFER AND EACH PARTY'S ARGUMENT. THE ARBITRATOR SHALL PICK ONE OF THE TWO AMOUNTS SUBMITTED BY THE PARTIES AS THE ARBITRATOR'S FINAL AND BINDING DECISION. THE DECISION MUST BE IN WRITING AND MADE WITHIN FORTY-FIVE DAYS AFTER THE ARBITRATOR'S APPOINTMENT. IN MAKING THE DECISION, THE ARBITRATOR SHALL CONSIDER THE CIRCUMSTANCES AND COMPLEXITY OF THE PARTICULAR CASE, INCLUDING THE FOLLOWING AREAS:

(I) THE PROVIDER'S LEVEL OF TRAINING, EDUCATION, EXPERIENCE, AND SPECIALIZATION OR SUBSPECIALIZATION; AND

(II) THE PREVIOUSLY CONTRACTED RATE, IF THE PROVIDER HAD A CONTRACT WITH THE CARRIER THAT WAS TERMINATED OR EXPIRED WITHIN ONE YEAR PRIOR TO THE DISPUTE.".

Page 13, strike lines 17 and 18 and substitute:

"(e) THE PARTY WHOSE FINAL OFFER AMOUNT WAS NOT SELECTED BY THE ARBITRATOR SHALL PAY THE ARBITRATOR'S EXPENSES AND FEES.".

Page 13, line 20, strike "2020," and substitute "2021,".

Page 15, line 12, strike "REGULATED UNDER TITLE 12".

Page 16, line 4, after "A" insert "HEALTH CARE".

Page 16, line 5, after "OUT-OF-NETWORK" insert "HEALTH CARE".

Page 16, line 6, after "IN-NETWORK" insert "HEALTH CARE".

Page 16, line 15, strike "SUBSECTION (2) OF".

Page 17, line 6, after "COPAYMENT" insert "AMOUNT".

Page 17, line 9, before "NONEMERGENCY" insert "COVERED".

Page 17, line 27, after "FOR" insert "COVERED".

Page 18, line 5, strike "DELIVERY OF SERVICES" and substitute "RECEIPT OF INSURANCE INFORMATION".

Page 18, line 8, strike "FIVE" and substitute "TEN".

Page 18, line 12, strike "ONE HUNDRED PERCENT" and substitute "THE SIXTIETH PERCENTILE".

Page 18, line 14, strike "AS DETERMINED".

Page 18, line 17, after "FOR" insert "COVERED".

Page 18, line 25, after "COPAYMENT" insert "AMOUNT".

Page 19, line 13, strike "UNDER" and substitute "PURSUANT TO".

Page 19, line 21, strike "24-34-113 (2)" and substitute "24-34-113".

Page 20, line 1, after "THE" insert "FEDERAL".

Page 20, line 11, after "FACILITIES," insert "INCLUDING".

Page 20, line 20, strike "24-34-113 (2)" and substitute "24-34-113".

Page 20, line 22 strike "(12)" and substitute "(12)(b)".

Page 20, line 23, strike "SUBSECTION (1) OF".

Page 21, after line 5 insert:

"(c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED IN SECTION 10-16-704 (5.5)(e)(II).".

Reletter succeeding paragraphs accordingly.

Page 21, line 21, strike "THE" and substitute "A".

Page 21, line 24, after "COPAYMENT" insert "AMOUNT".

Page 22, line 2, strike "10-16-704 (5.5)," and substitute "10-16-704 (3)(b) OR (5.5),".

Page 22, line 12, strike "PROVIDER" and substitute "FACILITY".

Page 22, line 18, strike "DELIVERY OF SERVICES" and substitute "RECEIPT OF INSURANCE INFORMATION".

Page 22, line 25, strike "ONE HUNDRED PERCENT OF THE" and substitute "THE".

Page 22, line 27, strike "AS".

Page 23, line 1, strike "DETERMINED".

Page 23, line 10, strike "THAT" and substitute "THE SAME".

Page 23, line 15, strike "ONE HUNDRED PERCENT OF THE" and substitute "THE".

Page 23, line 18, strike "AS DETERMINED".

Page 23, line 19, strike "CREATED" and substitute "DESCRIBED".

Page 23, strike line 22 and substitute "SPECIFIED IN THIS SUBSECTION (3), THE CARRIER SHALL".

Page 24, line 2, after "COPAYMENT" insert "AMOUNT".

Page 24, after line 6 insert:

"(5) THIS SECTION DOES NOT APPLY WHEN A COVERED PERSON VOLUNTARILY USES AN OUT-OF-NETWORK PROVIDER.".

Page 24, after line 11 insert:

"**SECTION 8.** In Colorado Revised Statutes, **add to article 30 as relocated by House Bill 19-1172** 12-30-111 and 12-30-112 as follows:

12-30-111. Health care providers - required disclosures - rules - definitions. (1) FOR THE PURPOSES OF THIS SECTION AND SECTION

12-30-112:

(a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION 10-16-102 (8).

(b) "COVERED PERSON" HAS THE SAME MEANING AS DEFINED IN SECTION 10-16-102 (15).

(c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED IN SECTION 10-16-704 (5.5)(e)(II).

(d) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN SECTION 10-16-704 (3)(d)(V)(A).

(e) "HEALTH BENEFIT PLAN" HAS THE SAME MEANING AS DEFINED IN SECTION 10-16-102 (32).

(f) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING AS DEFINED IN SECTION 10-16-704 (3)(d)(V)(B).

(g) "OUT-OF-NETWORK PROVIDER" MEANS A HEALTH CARE PROVIDER THAT IS NOT A "PARTICIPATING PROVIDER" AS DEFINED IN SECTION 10-16-102 (46).

(2) ON AND AFTER JANUARY 1, 2020, HEALTH CARE PROVIDERS SHALL DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER. THE DISCLOSURES MUST COMPLY WITH THE RULES ADOPTED PURSUANT TO SUBSECTION (3) OF THIS SECTION.

(3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR HEALTH CARE PROVIDERS TO DEVELOP AND PROVIDE CONSUMER DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE DIRECTOR SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTIONS 10-16-704 (12) AND 25-3-120 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE STATE BOARD OF HEALTH PURSUANT TO SECTION 25-3-120 (2). THE RULES MUST SPECIFY, AT A MINIMUM, THE FOLLOWING:

(a) THE TIMING FOR PROVIDING THE DISCLOSURES FOR EMERGENCY AND NONEMERGENCY SERVICES WITH CONSIDERATION GIVEN TO POTENTIAL LIMITATIONS RELATING TO THE FEDERAL "EMERGENCY MEDICAL TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd;

(b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR COMMUNICATIONS WITH CONSUMERS;

(c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE

CONSUMER'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE CONSUMER'S HEALTH BENEFIT PLAN;

(d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE PROVIDERS, INCLUDING WHETHER A HEALTH CARE PROVIDER IS OUT OF NETWORK, THE TYPES OF SERVICES AN OUT-OF-NETWORK HEALTH CARE PROVIDER MAY PROVIDE, AND THE RIGHT TO REQUEST AN IN-NETWORK HEALTH CARE PROVIDER TO PROVIDE SERVICES; AND

(e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY THIS SECTION AND SECTIONS 10-16-704 (12) AND 25-3-120 AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (3) AND SECTIONS 10-16-704 (12)(b) AND 25-3-120 (2).

(4) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SECTION DOES NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTION 10-16-704 (3) OR (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS UNDER THE CONSUMER'S HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.

(5) THIS SECTION DOES NOT APPLY TO SERVICE AGENCIES, AS DEFINED IN SECTION 25-3.5-103 (11.5), THAT ARE PUBLICLY FUNDED FIRE AGENCIES.

12-30-112. Out-of-network health care providers - out-of-network services - billing - payment. (1) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES EMERGENCY SERVICES OR COVERED NONEMERGENCY SERVICES TO A COVERED PERSON AT AN IN-NETWORK FACILITY, THE OUT-OF-NETWORK PROVIDER SHALL:

(a) SUBMIT A CLAIM FOR THE ENTIRE COST OF THE SERVICES TO THE COVERED PERSON'S CARRIER; AND

(b) NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE, DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.

(2) (a) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES COVERED NONEMERGENCY SERVICES AT AN IN-NETWORK FACILITY OR EMERGENCY SERVICES AT AN OUT-OF-NETWORK OR IN-NETWORK FACILITY AND THE HEALTH CARE PROVIDER RECEIVES PAYMENT FROM THE COVERED PERSON FOR SERVICES FOR WHICH THE COVERED PERSON IS NOT RESPONSIBLE PURSUANT TO SECTION 10-16-704 (3)(b) OR (5.5), THE HEALTH CARE PROVIDER SHALL REIMBURSE THE COVERED PERSON WITHIN

SIXTY CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS REPORTED TO THE PROVIDER.

(b) AN OUT-OF-NETWORK HEALTH CARE PROVIDER THAT FAILS TO REIMBURSE A COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF THIS SECTION FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE OVERPAYMENT AT THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON THE DATE THE PROVIDER RECEIVED THE NOTICE OF THE OVERPAYMENT. THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED INTEREST FROM THE OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.

(3) AN OUT-OF-NETWORK HEALTH CARE PROVIDER SHALL PROVIDE A COVERED PERSON A WRITTEN ESTIMATE OF THE AMOUNT FOR WHICH THE COVERED PERSON MAY BE RESPONSIBLE FOR COVERED NONEMERGENCY SERVICES WITHIN THREE BUSINESS DAYS AFTER A REQUEST FROM THE COVERED PERSON.

(4) (a) AN OUT-OF-NETWORK HEALTH CARE PROVIDER MUST SEND A CLAIM FOR A COVERED SERVICE TO THE CARRIER WITHIN ONE HUNDRED EIGHTY DAYS AFTER THE RECEIPT OF INSURANCE INFORMATION IN ORDER TO RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (4)(a). THE REIMBURSEMENT RATE IS THE GREATER OF:

(I) ONE HUNDRED FIVE PERCENT OF THE CARRIER'S MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN THE SAME GEOGRAPHIC AREA; OR

(II) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR BASED ON CLAIMS DATA FROM THE ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

(b) IF THE OUT-OF-NETWORK HEALTH CARE PROVIDER SUBMITS A CLAIM FOR COVERED SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY PERIOD SPECIFIED IN SUBSECTION (4)(a) OF THIS SECTION, THE CARRIER SHALL REIMBURSE THE HEALTH CARE PROVIDER ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME SERVICES IN THE SAME GEOGRAPHIC AREA.

(c) THE HEALTH CARE PROVIDER SHALL NOT BILL A COVERED PERSON ANY OUTSTANDING BALANCE FOR A COVERED SERVICE NOT PAID FOR BY THE CARRIER, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.

(5) A HEALTH CARE PROVIDER MAY INITIATE ARBITRATION PURSUANT TO SECTION 10-16-704 (15) IF THE HEALTH CARE PROVIDER BELIEVES THE PAYMENT MADE PURSUANT TO SUBSECTION (4) OF THIS SECTION IS NOT SUFFICIENT.".

Renumber succeeding sections accordingly.

Strike page 25 and substitute:

"**SECTION 10. Act subject to petition - effective date - applicability.** (1) Except as otherwise provided in subsection (2) of this section, this act takes effect January 1, 2020; 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 2020 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

(2) (a) Section 5 of this act takes effect only if House Bill 19-1172 does not become law.

(b) Section 8 of this act takes effect only if House Bill 19-1172 becomes law.

(3) This act applies to health care services provided on or after the applicable effective date of this act.".

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