CHAPTER 120

HEALTH AND ENVIRONMENT

HOUSE BILL 17-1173

BY REPRESENTATIVE(S) Hansen, Arndt, Becker K., Garnett, Ginal, Kennedy, Mitsch Bush, Young;
also SENATOR(S) Neville T., Aguilar, Cooke, Court, Crowder, Fields, Hill, Holbert, Jahn, Kefalas, Martinez Humenik, Merrifield, Moreno, Priola, Scott, Tate, Todd, Grantham.

AN ACT

CONCERNING REQUIRED PROVISIONS IN A CONTRACT BETWEEN A HEALTH INSURANCE CARRIER AND A HEALTH CARE PROVIDER CONCERNING MEDICAL COMMUNICATIONS REGARDING DISAGREEMENTS IN HEALTH CARE DECISIONS.

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

SECTION 1. In Colorado Revised Statutes, 10-16-121, **amend** (1); and **add** (7) and (8) as follows:

10-16-121. Required contract provisions in contracts between carriers and providers - definitions. (1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan ~~shall~~ MUST make provisions for the following requirements:

(a) The contract ~~shall~~ MUST contain a provision stating that neither the provider nor the carrier ~~shall be~~ IS prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of the carrier or provider.

(b) (I) The contract ~~shall~~ MUST contain a provision that states the carrier ~~shall not terminate the contract with~~ MAY NOT TAKE AN ADVERSE ACTION AGAINST a provider because the provider expresses disagreement with a carrier's decision to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the carrier's decision or because a provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients.

(II) THE CONTRACT BETWEEN A CARRIER AND THE PROVIDER MUST STATE THAT THE CARRIER MAY NOT TAKE AN ADVERSE ACTION AGAINST A PROVIDER BECAUSE THE PROVIDER, ACTING IN GOOD FAITH:

(A) COMMUNICATES WITH A PUBLIC OFFICIAL OR OTHER PERSON CONCERNING PUBLIC POLICY ISSUES RELATED TO HEALTH CARE ITEMS OR SERVICES;

(B) FILES A COMPLAINT, MAKES A REPORT, OR COMMENTS TO AN APPROPRIATE GOVERNMENTAL BODY REGARDING ACTIONS, POLICIES, OR PRACTICES OF THE CARRIER THE PROVIDER BELIEVES MIGHT NEGATIVELY AFFECT THE QUALITY OF, OR ACCESS TO, PATIENT CARE;

(C) PROVIDES TESTIMONY, EVIDENCE, OPINION, OR ANY OTHER PUBLIC ACTIVITY IN ANY FORUM CONCERNING A VIOLATION OR POSSIBLE VIOLATION OF ANY PROVISION OF THIS SECTION;

(D) REPORTS WHAT THE PROVIDER BELIEVES TO BE A VIOLATION OF LAW TO AN APPROPRIATE AUTHORITY; OR

(E) PARTICIPATES IN ANY INVESTIGATION INTO A VIOLATION OR POSSIBLE VIOLATION OF ANY PROVISION OF THIS SECTION.

(c) Any contract providing for the performance of claims processing functions by an entity with which the carrier contracts ~~shall~~ MUST require such entity to comply with section 10-16-106.5 (3), (4), and (5).

(d) The contract ~~shall~~ MUST contain a provision that the provider shall not be subjected to financial disincentives based on the number of referrals made to participating providers in the health plan for covered benefits so long as the provider making the referral adheres to the carrier's or the carrier's intermediary's utilization review policies and procedures.

(7) (a) A PROVIDER WHO IS AGGRIEVED BY A VIOLATION OF THIS SECTION MAY BRING AN ACTION FOR INJUNCTIVE RELIEF IN A COURT OF COMPETENT JURISDICTION AND MAY SEEK RECOVERY OF REASONABLE COURT COSTS. THIS SECTION DOES NOT CHANGE THE STANDARDS FOR OBTAINING INJUNCTIVE RELIEF.

(b) IF A COURT DEEMS AN ACTION FRIVOLOUS, THE COURT MAY AWARD COSTS TO THE DEFENDANT.

(8) AS USED IN THIS SECTION:

(a) "ADVERSE ACTION" MEANS A DECISION BY A CARRIER TO TERMINATE, DENY, OR OTHERWISE CONDITION A PROVIDER'S PARTICIPATION IN ONE OR MORE PROVIDER NETWORKS, INCLUDING A DECISION PERTAINING TO PARTICIPATION IN A NARROW NETWORK OR ALLOCATION WITHIN A TIERED NETWORK.

(b) "NARROW NETWORK" MEANS A REDUCED OR SELECTIVE PROVIDER NETWORK

THAT IS A SUBGROUP OR SUBDIVISION OF A LARGER PROVIDER NETWORK AND FROM WHICH PROVIDERS WHO PARTICIPATE IN THE LARGER NETWORK MAY BE EXCLUDED.

(c) "TIERED NETWORK" MEANS A PROVIDER NETWORK IN WHICH:

(I) PROVIDERS ARE ASSIGNED TO, OR PLACED IN, DIFFERENT BENEFIT TIERS, AS DETERMINED BY TIERING; AND

(II) PATIENTS RECEIVE BENEFITS AND PAY THE COPAYMENT, COINSURANCE, OR DEDUCTIBLE AMOUNTS THAT ARE ASSOCIATED WITH THE BENEFIT TIER TO WHICH THE PROVIDER FROM WHOM SERVICES WERE RECEIVED IS ASSIGNED.

(d) "TIERING" MEANS A SYSTEM THAT COMPARES, RATES, RANKS, TIERS, OR CLASSIFIES A PROVIDER'S PERFORMANCE, QUALITY OF CARE, OR COST OF CARE AGAINST OBJECTIVE STANDARDS OR AGAINST THE PRACTICE OR PERFORMANCE OF OTHER HEALTH CARE PROVIDERS. "TIERING" INCLUDES QUALITY IMPROVEMENT PROGRAMS, PAY-FOR-PERFORMANCE PROGRAMS, PUBLIC REPORTING ON HEALTH CARE PROVIDER PERFORMANCE OR RATINGS, AND THE USE OF TIERED OR NARROWED NETWORKS.

SECTION 2. Effective date - applicability. This act takes effect July 1, 2017, and applies to contracts entered or renewed on or after said date.

SECTION 3. 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.

Approved: April 6, 2017