SB 19-134

Legislative Council Staff
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FINAL FISCAL NOTE

Drafting Number:	LLS 19-0777	**Date:**	June 26, 2019
Prime Sponsors:	Sen. Fields; Tate Rep. Soper	**Bill Status:**	Postponed Indefinitely
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Bill Topic: OUT-OF-NETWORK HEALTH CARE DISCLOSURES & CHARGES

Summary of Fiscal Impact:

- ☐ State Revenue
- ☒ State Expenditure
- ☒ State Diversion
- ☐ TABOR Refund
- ☐ Local Government
- ☐ Statutory Public Entity

The bill would have established disclosure requirements and payment schedules for out-of-network health care services, and created an arbitration process for insurance carriers and health care providers to settle billing disputes. It would have increased state expenditures on an ongoing basis and created a diversion from the General Fund.

Appropriation Summary: For FY 2019-20, the bill would have required an appropriation of $50,560 to the Department of Regulatory Agencies.

Fiscal Note Status: The fiscal note reflects the introduced bill. The bill was not enacted into law; therefore, the impacts identified in this analysis do not take effect.

Table 1
State Fiscal Impacts Under SB 19-134

		FY 2019-20	FY 2020-21
Revenue		-	-
Expenditures	Cash Funds	$50,560	$75,375
	Centrally Appropriated	$9,603	$15,908
	Total	**$60,163**	**$91,283**
	Total FTE	**0.6 FTE**	**1.0 FTE**
Diversions	General Fund	($60,163)	($91,283)
	Cash Funds	$60,163	$91,283
	Total	**$0**	**$0**
TABOR Refund		-	-

Summary of Legislation

Beginning January 1, 2020, the bill establishes disclosure requirements and payment schedules for out-of-network health care services, and creates an arbitration process for insurance carriers and health care providers to settle billing disputes.

Disclosures. The bill requires in-network health care facilities to provide disclosures to patients concerning the provision of services by out-of-network providers under certain circumstances defined by the bill. An out-of-network provider that provides services to a covered person must include with any billing notice a statement notifying them that they may be entitled to certain out-of-network protections under Colorado law.

Payment for unanticipated out-of-network services. The bill sets rates that insurance carriers must reimburse providers for unanticipated out-of-network services, which are defined as emergency services provided to a covered person by an out-of-network provider; or nonemergency services provided to a covered person at an in-network facility by an out-of-network provider, where the person did not have the ability to select an in-network provider.

When unanticipated out-of-network services are provided, the covered person is responsible for paying only the applicable in-network cost-sharing amount. Insurance carriers will reimburse providers of unanticipated out-of-network services the lesser of the full amount billed or the minimum benefit standard, which for non-rural areas is defined as the greater of the following, for the service performed by a provider in the same or similar specialty and provided in the same geographic area:

- 150 percent of an amount equal to the 75th percentile of all in-network amounts; or
- the average in-network and out-of-network amounts paid, excluding payments by Medicaid, Medicare, and plans purchased through the Colorado Health Benefit Exchange (exchange).

For rural areas, as defined Commissioner of Insurance in the Department of Regulatory Agencies (DORA), the minimum benefit standard is defined as the greater of:

- 200 percent of the highest in-network amount; or
- 200 percent of the average in-network and out-of-network amounts paid, excluding payments by Medicaid, Medicare, and plans purchased through the exchange.

If a covered person receives emergency services at an out-of-network facility, the carrier must reimburse the facility the greater of the following, for the same service provided in a similar facility or setting in the same geographic area:

- the carrier's average in-network rate of reimbursement;
- 125 percent of the Medicare reimbursement rate; or
- 100 percent of the average in-network rate of reimbursement, based on claims data from the all-payer health claims database.

Arbitration. The bill creates an arbitration process to settle disputed claims. The commissioner will establish a process to create a list of arbitrators that may be selected to arbitrate disputes and the Division of Insurance will monitor and evaluate arbitrators. An out-of-network provider that was reimbursed in accordance with this bill may request arbitration for a disputed amount over $50 if the provider believes the payment does not properly recognize the value of the services. Specific criteria for dispute are listed in the bill.

Beginning February 1, 2021, insurance carriers will report annually to the commissioner on unanticipated out-of-network services, including the total number of minimum benefit standard payments received. Beginning January 1, 2022, the commissioner will submit an annual report to the General Assembly compiling the data submitted by carriers and summarizing the utilization and results of arbitration. The provisions of the bill concerning billing for nonemergency services and arbitration are repealed on January 1, 2025.

State Diversions

The bill diverts up to $60,163 from the General Fund in FY 2019-20 and up to $91,283 in FY 2020-21. This revenue diversion occurs because the bill increases costs in the Division of Insurance in DORA, which is funded with premium tax revenue that would otherwise be credited to the General Fund.

State Expenditures

The bill increases state expenditures in DORA by $60,163 and 0.6 FTE in FY 2019-20 and $91,283 and 1.0 FTE in FY 2020-21 and future years through FY 2024-25. Expenditures by other agencies may be affected. These impacts are shown in Table 2 and described below.

Table 2
Expenditures Under SB 19-134

	FY 2019-20	FY 2020-21
Department of Regulatory Agencies		
Personal Services	$45,287	$74,425
Operating Expenses and Capital Outlay Costs	$5,273	$950
Centrally Appropriated Costs*	$9,603	$15,908
Total Cost	**$60,163**	**$91,283**
Total FTE	**0.6 FTE**	**1.0 FTE**

** Centrally appropriated costs are not included in the bill's appropriation.*

Regulatory Agencies. DORA will require 1.0 FTE to support the arbitration process established by the bill, prorated to reflect a half year of implementation in FY 2019-20. This work will include arranging settlement teleconferences, appointing arbitrators when disputes are not settled, monitoring and evaluating arbitrators, and reporting to the General Assembly each year. An additional 0.1 FTE is required in FY 2019-20 only to support rulemaking to establish the arbitration process and define areas that are considered rural for the purposes of out-of-network reimbursements.

Health Care Policy and Financing. Insurance carriers that offer Child Health Plan Plus (CHP+) plans will be required to adhere to the disclosure, payment, and arbitration requirements in the bill. Any impact to these carriers may require the department to adjust the CHP+ capitation rate paid to carriers accordingly, which will be addressed through the annual budget process.

State employee insurance. Insurance carriers that offer health benefit plans to state employees will likewise be affected by the disclosure, payment, and arbitration requirements in the bill. Any change to insurer costs be reflected in future insurance premiums, which may affect costs for state agencies. Because insurance rates are influenced by a number of variables, the impact of this bill on premiums cannot be determined. Any impact will be addressed through the total compensation analysis included in the annual budget process.

Centrally appropriated costs. Pursuant to a Joint Budget Committee policy, certain costs associated with this bill are addressed through the annual budget process and centrally appropriated in the Long Bill or supplemental appropriations bills, rather than in this bill. These costs, which include employee insurance and supplemental employee retirement payments, are estimated to be $9,603 in FY 2019-20 and $15,908 in FY 2020-21.

Effective Date

This bill was postponed indefinitely by the Senate Health and Human Services Committee on April 25, 2019.

State Appropriations

For FY 2019-20, the bill would have required an appropriation of $50,560 to the Department of Regulatory Agencies from the Division of Insurance Cash Fund, and an allocation of 0.6 FTE.

State and Local Government Contacts

Colorado Health Benefit Exchange
Health Care Policy and Financing
Information Technology
Public Health and Environment
Law
Regulatory Agencies
Personnel
Higher Education
Municipalities