First Regular Session
Seventy-first General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 17-0931.01 Christy Chase x2008 **SENATE BILL 17-206**

SENATE SPONSORSHIP

Gardner,

HOUSE SPONSORSHIP

Singer,

Senate Committees
Business, Labor, & Technology

House Committees

A BILL FOR AN ACT

CONCERNING HEALTH CARE SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER THAT ARE COVERED BENEFITS UNDER A COVERED PERSON'S HEALTH BENEFIT PLAN, AND, IN CONNECTION THEREWITH, SPECIFYING THE METHOD FOR DETERMINING THE AMOUNT A CARRIER MUST PAY THE OUT-OF-NETWORK PROVIDER FOR PROVIDING HEALTH CARE SERVICES COVERED UNDER THE HEALTH BENEFIT PLAN; REQUIRING HEALTH CARE FACILITIES, OUT-OF-NETWORK PROVIDERS, AND CARRIERS TO DISCLOSE SPECIFIED INFORMATION TO A COVERED PERSON REGARDING SERVICES PROVIDED AT AN IN-NETWORK FACILITY BY AN OUT-OF-NETWORK PROVIDER; AND ESTABLISHING AN INDEPENDENT DISPUTE RESOLUTION PROCESS FOR RESOLVING

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

PAYMENT DISPUTES BETWEEN OUT-OF-NETWORK PROVIDERS AND 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.)

Under current law, when a health care provider who is not under a contract with a health insurer (out-of-network provider) renders health care services to a person covered under a health benefit plan at a facility that is part of the provider network under the plan (in-network facility), the health insurer is required to cover the services of the out-of-network provider at the in-network benefit level and at no greater cost to the covered person than if the services were provided by an in-network provider.

The bill outlines the method for a health insurer to use in determining the amount it must pay an out-of-network provider that rendered covered services to a covered person at an in-network facility and requires the health insurer to pay the out-of-network provider directly. The bill also establishes an independent dispute resolution process by which an out-of-network provider may obtain review of a payment from a health insurer.

Additionally, the bill requires an in-network facility where a covered person will receive a health care procedure or treatment, the health insurer, and an out-of-network provider who provides health care services to a covered person at an in-network facility to provide specified disclosures to the covered person, explaining that:

- An out-of-network provider may provide health care services to the covered person as part of the procedure or treatment provided at the in-network facility;
- If the covered person's plan is governed by state law, the services rendered by an out-of-network provider are covered under the plan at the in-network benefit level;
- The out-of-network provider will submit a bill to the covered person's health insurer, and if the covered person receives a bill from the out-of-network provider, he or she should contact the health insurer's customer service to resolve the bill; and
- The covered person is only responsible for paying the applicable in-network cost-sharing amount, and the carrier

is responsible for paying any remaining balance owed the out-of-network provider.

A health insurer that fails to reimburse out-of-network providers as required by the bill and under current law or fails to provide the required notice to the covered person engages in an unfair or deceptive act or practice in the business of insurance and is subject to monetary penalties and other penalties authorized by law.

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

SECTION 1. In Colorado Revised Statutes, 10-16-704, **amend** (3)(a)(III) and (5.5)(a)(V); and **add** (3)(d) and (3.5) as follows:

10-16-704. Network adequacy - rules - legislative declaration.

(3) (a) (III) The general assembly finds, determines, and declares that the division of insurance has correctly interpreted the provisions of this section to protect the insured from the additional expense charged by an assisting provider who is an out-of-network provider, and has properly required insurers to hold the consumer harmless. The division of insurance does not have regulatory authority over all health plans. Some consumers are enrolled in self-funded health insurance programs that are governed under the federal "Employee Retirement Income Security Act". Therefore, ~~the general assembly encourages~~ health care facilities, carriers, and providers NEED to provide consumers ~~disclosure~~ DISCLOSURES IN ACCORDANCE WITH SUBSECTION (3.5) OF THIS SECTION about the potential impact of receiving services from an out-of-network provider.

(d) (I) IF A COVERED PERSON'S HEALTH BENEFIT PLAN IS UNDER THE JURISDICTION OF THE COMMISSIONER AND DIVISION OF INSURANCE AND THE COVERED PERSON RECEIVES COVERED NONEMERGENCY HEALTH CARE SERVICES AT AN IN-NETWORK FACILITY FROM AN OUT-OF-NETWORK PROVIDER AS DESCRIBED IN SUBSECTION (3)(b) OF THIS SECTION, THE CARRIER SHALL PAY THE OUT-OF-NETWORK PROVIDER DIRECTLY AND IN

ACCORDANCE WITH THIS SUBSECTION (3)(d). THE CARRIER SHALL ADVISE THE OUT-OF-NETWORK PROVIDER AND THE COVERED PERSON OF ANY APPLICABLE IN-NETWORK COST-SHARING AMOUNT.

(II) (A) WHEN THE REQUIREMENTS OF SUBSECTION (3)(b) OF THIS SECTION APPLY, THE CARRIER SHALL PAY THE OUT-OF-NETWORK PROVIDER AN AMOUNT EQUAL TO THE LESSER OF THE OUT-OF-NETWORK PROVIDER'S BILLED CHARGE OR THE EIGHTIETH PERCENTILE OF ALL CURRENT CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY HEALTH CARE PROVIDERS IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHIC AREA, AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY AN INDEPENDENT, NONPROFIT ORGANIZATION AS SPECIFIED BY THE COMMISSIONER, MINUS ANY APPLICABLE IN-NETWORK COST-SHARING AMOUNT.

(B) THE CARRIER SHALL PAY THE OUT-OF-NETWORK PROVIDER IN ACCORDANCE WITH THE REQUIREMENTS OF SECTION 10-16-106.5.

(C) THE CARRIER SHALL DISCLOSE TO THE OUT-OF-NETWORK PROVIDER WHETHER THE AMOUNT REIMBURSED TO THE OUT-OF-NETWORK PROVIDER WAS THE PROVIDER'S BILLED CHARGE OR WAS BASED ON THE EIGHTIETH PERCENTILE OF CURRENT CHARGES FOR THE SAME HEALTH CARE SERVICE, AS DESCRIBED IN SUBSECTION (3)(d)(II)(A) OF THIS SECTION.

(D) THE COMMISSIONER SHALL WORK WITH PROVIDERS, CARRIERS, AND CONSUMERS TO PROMULGATE RULES TO IDENTIFY WHICH INDEPENDENT, NONPROFIT ORGANIZATION'S BENCHMARKING DATABASE AND PROCESS CARRIERS ARE TO USE WHEN CALCULATING REIMBURSEMENT RATES FOR OUT-OF-NETWORK PROVIDERS UNDER THIS SUBSECTION (3)(d).

(III) IF AN OUT-OF-NETWORK PROVIDER BELIEVES THAT THE

CARRIER DID NOT PAY THE CLAIM IN ACCORDANCE WITH SUBSECTION (3)(d)(II) OF THIS SECTION OR THAT THE SERVICE OR PROCEDURE WARRANTS ADDITIONAL PAYMENT CONSIDERATION BASED ON ITS COMPLEXITY, THE OUT-OF-NETWORK PROVIDER MAY SEEK REVIEW OF THE CARRIER'S DETERMINATION THROUGH THE CARRIER'S INTERNAL REVIEW PROCESS AND, IF THE OUT-OF-NETWORK PROVIDER IS STILL AGGRIEVED, MAY SEEK REVIEW THROUGH THE EXTERNAL DISPUTE RESOLUTION PROCESS ESTABLISHED UNDER SECTION 10-16-710.

(IV) IF THE CARRIER ROUTINELY FAILS TO REIMBURSE THE OUT-OF-NETWORK PROVIDER IN ACCORDANCE WITH THIS SUBSECTION (3)(d), THE CARRIER ENGAGES IN A DECEPTIVE TRADE PRACTICE AND THEREFORE FORFEITS ANY RIGHT TO DISCOUNT THE OUT-OF-NETWORK PROVIDER'S BILLED CHARGE AND MUST PAY THE OUT-OF-NETWORK PROVIDER'S FULL BILLED CHARGE. ROUTINELY FAILING TO REIMBURSE OUT-OF-NETWORK PROVIDERS IN ACCORDANCE WITH THIS SUBSECTION (3) CONSTITUTES A VIOLATION OF THIS PART 7 BY THE CARRIER AND AN UNFAIR OR DECEPTIVE ACT OR PRACTICE IN THE BUSINESS OF INSURANCE UNDER PART 11 OF ARTICLE 3 OF THIS TITLE 10.

(3.5) (a) HEALTH CARE FACILITIES, CARRIERS, AND PROVIDERS SHALL DEVELOP AND PROVIDE CONSUMERS DISCLOSURES IN ACCORDANCE WITH THIS SUBSECTION (3.5) AND RULES ADOPTED UNDER THIS SUBSECTION (3.5) ABOUT THE POTENTIAL EFFECTS OF RECEIVING NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER.

(b) (I) AT THE TIME AN IN-NETWORK FACILITY SCHEDULES A PROCEDURE OR SEEKS PRIOR AUTHORIZATION FROM A CARRIER FOR THE PROVISION OF NONEMERGENCY SERVICES TO A COVERED PERSON, THE IN-NETWORK FACILITY SHALL PROVIDE THE COVERED PERSON WITH A

WRITTEN DISCLOSURE INFORMING THE COVERED PERSON:

(A) THAT, AS PART OF THE COURSE OF TREATMENT, THE COVERED PERSON MAY RECEIVE CARE FROM SEVERAL PROVIDERS AT THE FACILITY, SOME OF WHICH MAY BE OUT-OF-NETWORK PROVIDERS THAT DO NOT HAVE A CONTRACT WITH THE COVERED PERSON'S CARRIER;

(B) THAT IF THE COVERED PERSON'S HEALTH BENEFIT PLAN IS UNDER THE JURISDICTION OF THE COMMISSIONER AND THE DIVISION OF INSURANCE, THE CARRIER MUST ENSURE THAT WHEN THE COVERED PERSON RECEIVES SERVICES OR TREATMENT IN ACCORDANCE WITH THE PLAN PROVISIONS AT AN IN-NETWORK FACILITY, THE BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED AT THE IN-NETWORK FACILITY IS THE IN-NETWORK BENEFIT LEVEL, REGARDLESS OF WHETHER AN OUT-OF-NETWORK PROVIDER RENDERED THE COVERED SERVICE OR TREATMENT;

(C) OF THE SPECIFIC TYPES OF ANCILLARY SERVICES THE COVERED PERSON MAY RECEIVE WITHIN THE IN-NETWORK FACILITY; AND

(D) THAT THE COVERED PERSON MAY OBTAIN A LIST OF IN-NETWORK PROVIDERS FROM HIS OR HER CARRIER AND MAY REQUEST THAT AN IN-NETWORK PROVIDER RENDER SERVICES OR TREATMENT AT THAT FACILITY IF AVAILABLE.

(II) AT THE TIME A COVERED PERSON IS ADMITTED TO AN IN-NETWORK FACILITY TO RECEIVE NONEMERGENCY SERVICES, THE FACILITY SHALL PROVIDE THE COVERED PERSON WITH THE WRITTEN DISCLOSURE DESCRIBED IN SUBSECTION (3.5)(b)(I) OF THIS SECTION AND OBTAIN THE SIGNATURE OF THE COVERED PERSON OR HIS OR HER AUTHORIZED REPRESENTATIVE ON THE DISCLOSURE TO ACKNOWLEDGE RECEIPT OF THE DISCLOSURE AT THE TIME OF ADMISSION TO THE

IN-NETWORK FACILITY.

(III) RECEIPT OF THE DISCLOSURE UNDER THIS SUBSECTION (3.5)(b) DOES NOT WAIVE THE COVERED PERSON'S PROTECTIONS UNDER SUBSECTION (3)(b) OF THIS SECTION OR THE RIGHT TO BENEFITS UNDER THE HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED AT THE IN-NETWORK FACILITY.

(c) AN OUT-OF-NETWORK PROVIDER WHO RENDERS NONEMERGENCY SERVICES TO A COVERED PERSON AT AN IN-NETWORK FACILITY SHALL INCLUDE A STATEMENT ON A SURPRISE BILL OR ANY OTHER BILLING NOTICE SENT TO THE COVERED PERSON FOR THE SERVICES RENDERED TO THE COVERED PERSON, INFORMING THE COVERED PERSON THAT:

(I) BASED ON THE HEALTH BENEFIT PLAN INFORMATION MADE AVAILABLE TO THE PROVIDER, HE OR SHE IS NOT A PARTICIPATING PROVIDER UNDER THE COVERED PERSON'S HEALTH BENEFIT PLAN;

(II) THE OUT-OF-NETWORK PROVIDER WILL SUBMIT A BILL FOR SERVICES RENDERED TO THE COVERED PERSON DIRECTLY TO THE COVERED PERSON'S CARRIER AND WILL ACCEPT ASSIGNMENT OF THE BENEFIT; AND

(III) UNDER SUBSECTION (3)(b) OF THIS SECTION, THE COVERED PERSON IS ONLY RESPONSIBLE FOR PAYING THE APPLICABLE IN-NETWORK COST-SHARING AMOUNT, AND THE CARRIER IS RESPONSIBLE FOR PAYING ANY REMAINING BALANCE.

(d) (I) A CARRIER SHALL PROVIDE A WRITTEN DISCLOSURE TO A COVERED PERSON AT THE TIME OF PRIOR AUTHORIZATION, IF APPLICABLE, FOR A COVERED NONEMERGENCY SERVICE THAT IS TO BE PROVIDED TO THE COVERED PERSON AT AN IN-NETWORK FACILITY, NOTIFYING THE COVERED

PERSON:

(A) OF THE POSSIBILITY OF BEING TREATED BY A PROVIDER WHO IS NOT A PARTICIPATING PROVIDER UNDER THE COVERED PERSON'S HEALTH BENEFIT PLAN;

(B) WHETHER THE COVERED PERSON'S HEALTH BENEFIT PLAN IS UNDER THE JURISDICTION OF THE COMMISSIONER AND DIVISION OF INSURANCE AND, IF SO, THAT THE COVERED PERSON IS ONLY RESPONSIBLE FOR PAYING THE APPLICABLE IN-NETWORK COST-SHARING AMOUNT, INCLUDING THE DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT REQUIRED UNDER THE PLAN, ON THE IN-NETWORK ALLOWANCE FOR A COVERED SERVICE PROVIDED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY, AND THAT THE CARRIER IS OBLIGATED TO PAY ANY REMAINING BALANCE BILLED BY THE OUT-OF-NETWORK PROVIDER; AND

(C) THAT IF THE COVERED PERSON RECEIVES A SURPRISE BILL FROM THE OUT-OF-NETWORK PROVIDER FOR THE REMAINING BALANCE, THE COVERED PERSON SHOULD CONTACT THE CARRIER'S CUSTOMER SERVICE DIVISION FOR RESOLUTION OF THE BILL.

(II) A CARRIER SHALL INCLUDE THE INFORMATION SPECIFIED IN SUBSECTION (3.5)(d)(I) OF THIS SECTION ON THE COVERED PERSON'S EXPLANATION OF BENEFITS FOR THE SERVICES RENDERED BY AN OUT-OF-NETWORK PROVIDER.

(III) RECEIPT OF THE DISCLOSURE UNDER THIS SUBSECTION (3.5)(d) DOES NOT WAIVE THE COVERED PERSON'S PROTECTIONS UNDER SUBSECTION (3)(b) OF THIS SECTION OR THE RIGHT TO BENEFITS UNDER THE HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED AT THE IN-NETWORK FACILITY.

(IV) A CARRIER SHALL DOCUMENT THE SPECIFIC DETAILS OF ALL INSTANCES WHEN A COVERED PERSON RECEIVES A COVERED SERVICE FROM AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY AND THE REQUIREMENTS OF SUBSECTION (3)(b) OR (5.5)(a)(V) OF THIS SECTION APPLY. A CARRIER SHALL PROVIDE THE INFORMATION REQUIRED BY THIS SUBSECTION (3.5)(d)(IV) TO THE COMMISSIONER UPON REQUEST.

(e) THE COMMISSIONER SHALL ADOPT RULES AS NECESSARY TO IMPLEMENT THIS SUBSECTION (3.5), INCLUDING RULES TO ENSURE THAT CARRIERS, FACILITIES, AND OUT-OF-NETWORK PROVIDERS USE CONSISTENT WORDING IN THE DISCLOSURES REQUIRED BY THIS SUBSECTION (3.5).

(f) (I) AS USED IN THIS SUBSECTION (3.5), "SURPRISE BILL" MEANS A BILL RECEIVED BY A COVERED PERSON FOR HEALTH CARE SERVICES, OTHER THAN EMERGENCY SERVICES AS DEFINED IN SUBSECTION (5.5)(b)(II) OF THIS SECTION, THAT:

(A) WERE RENDERED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY DURING A SERVICE OR PROCEDURE THAT WAS PERFORMED BY AN IN-NETWORK PROVIDER OR WAS PREVIOUSLY APPROVED OR AUTHORIZED BY THE CARRIER; AND

(B) THE COVERED PERSON DID NOT KNOWINGLY ELECT TO OBTAIN FROM AN OUT-OF-NETWORK PROVIDER.

(II) "SURPRISE BILL" DOES NOT INCLUDE A BILL FOR HEALTH CARE SERVICES RECEIVED BY A COVERED PERSON WHEN AN IN-NETWORK PROVIDER WAS AVAILABLE TO RENDER THE SERVICES AND THE COVERED PERSON KNOWINGLY ELECTED TO OBTAIN THE SERVICES FROM AN OUT-OF-NETWORK PROVIDER.

(5.5) (a) Notwithstanding any provision of law, a carrier that provides any benefits with respect to services in an emergency department

of a hospital shall cover emergency services:

(V) With the same cost-sharing requirements as would apply if emergency services were provided in-network AND AT NO GREATER COST TO THE COVERED PERSON THAN IF THE EMERGENCY SERVICES WERE OBTAINED FROM AN IN-NETWORK PROVIDER.

SECTION 2. In Colorado Revised Statutes, **add** 10-16-710 as follows:

10-16-710. Independent dispute resolution process - rules - definitions. (1) AS USED IN THIS SECTION:

(a) "INDEPENDENT DISPUTE RESOLUTION ENTITY" OR "IDRE" MEANS AN ENTITY THAT MEETS THE REQUIREMENTS OF THIS SECTION AND RULES ADOPTED UNDER THIS SECTION AND IS CERTIFIED BY THE COMMISSIONER TO CONDUCT AN INDEPENDENT DISPUTE RESOLUTION REVIEW.

(b) "INDEPENDENT DISPUTE RESOLUTION PROCESS" OR "IDRP" MEANS A PROCESS TO RESOLVE A DISPUTE BETWEEN A CARRIER AND AN OUT-OF-NETWORK PROVIDER REGARDING A CLAIM FOR PAYMENT UNDER SECTION 10-16-704 (3)(d).

(c) "REQUESTING PARTY" MEANS THE OUT-OF-NETWORK PROVIDER REQUESTING REVIEW THROUGH AN IDRP OR THE REQUESTING PROVIDER'S DESIGNATED REPRESENTATIVE.

(d) "REVIEWER" MEANS A PERSON WITH TRAINING AND EXPERIENCE IN HEALTH CARE BILLING, REIMBURSEMENT, AND PROVIDER CHARGES WHO IS SELECTED BY THE IDRE TO REVIEW A CLAIM FOR PAYMENT DISPUTE BETWEEN A CARRIER AND AN OUT-OF-NETWORK PROVIDER.

(2) (a) THE COMMISSIONER SHALL PROMULGATE RULES TO

IMPLEMENT AND ADMINISTER AN INDEPENDENT DISPUTE RESOLUTION PROCESS AS SPECIFIED IN THIS SECTION FOR THE PURPOSE OF RESOLVING DISPUTES BETWEEN A CARRIER AND AN OUT-OF-NETWORK PROVIDER REGARDING A CLAIM FOR PAYMENT UNDER SECTION 10-16-704 (3)(d).

(b) (I) THE COMMISSIONER SHALL PROMULGATE RULES AS NECESSARY FOR THE CERTIFICATION OF INDEPENDENT DISPUTE RESOLUTION ENTITIES UNDER THIS SECTION. THE COMMISSIONER MAY CONTRACT WITH ANY PERSON OR ENTITY TO DEVELOP THE CERTIFICATION RULES AND FOR ADMINISTRATION OF THE CERTIFICATION PROGRAM. THE COMMISSIONER SHALL CONSULT WITH AND UTILIZE PUBLIC AND PRIVATE RESOURCES, INCLUDING HEALTH CARE PROVIDERS, IN THE DEVELOPMENT OF THE RULES.

(II) THE COMMISSIONER MAY DENY, SUSPEND, OR REVOKE THE CERTIFICATION OF AN IDRE THAT DOES NOT COMPLY WITH THE REQUIREMENTS OF THIS SECTION OR RULES ADOPTED UNDER THIS SECTION.

(3) (a) CARRIERS SHALL MAKE AVAILABLE AN INDEPENDENT DISPUTE RESOLUTION PROCESS THAT MEETS THE REQUIREMENTS OF THIS SECTION AND RULES ADOPTED UNDER THIS SECTION. IN ALL WRITTEN COMMUNICATIONS WITH AN OUT-OF-NETWORK PROVIDER, THE CARRIER SHALL ADVISE THE OUT-OF-NETWORK PROVIDER OF THE ABILITY TO REQUEST REVIEW OF A CLAIM UNDER THE IDRP, THE PROCEDURES FOR REQUESTING A REVIEW UNDER THE IDRP, AND THE DEADLINES ASSOCIATED WITH THE IDRP.

(b) (I) IF AN OUT-OF-NETWORK PROVIDER HAS SOUGHT REVIEW OF A CARRIER'S PAYMENT DETERMINATION UNDER SECTION 10-16-704 (3)(d) THROUGH A CARRIER'S INTERNAL REVIEW PROCESS AND THE CARRIER UPHELD ITS INITIAL PAYMENT DETERMINATION, THE OUT-OF-NETWORK

PROVIDER MAY REQUEST A REVIEW OF THE CARRIER'S PAYMENT DETERMINATION UNDER THE IDRP IN THE TIME AND MANNER SPECIFIED IN THIS SECTION, REGARDLESS OF THE AMOUNT OF THE CLAIM FOR PAYMENT.

(II) THE REQUESTING PARTY MAY REQUEST REVIEW OF MULTIPLE CLAIMS FOR THE SAME SERVICE OR PROCEDURE, PROCESSED BY THE SAME CARRIER, FOR THE SAME OR DIFFERENT COVERED PERSONS, AND THE IDRE MAY HANDLE THE REVIEW AS ONE REQUEST FOR THE PURPOSES OF DETERMINING THE AMOUNT PAYABLE TO THE IDRE FOR COMPLETING THE REVIEW.

(c) AN OUT-OF-NETWORK PROVIDER REQUESTING REVIEW UNDER THE IDRP SHALL SUBMIT THE REQUEST WITHIN SIXTY CALENDAR DAYS AFTER RECEIVING NOTIFICATION THAT THE CARRIER'S INTERNAL REVIEW DETERMINATION IS TO UPHOLD THE ORIGINAL PAYMENT. THE CARRIER SHALL INFORM THE OUT-OF-NETWORK PROVIDER, IN THE NOTIFICATION OF THE OUTCOME OF THE INTERNAL REVIEW, OF THE OUT-OF-NETWORK PROVIDER'S RIGHT TO REQUEST A REVIEW UNDER THE IDRP.

(d) UPON RECEIPT OF A REQUEST FROM AN OUT-OF-NETWORK PROVIDER FOR REVIEW OF A PAYMENT DETERMINATION UNDER THE IDRP, THE CARRIER SHALL NOTIFY THE DIVISION OF INSURANCE OF THE REQUEST. THE DIVISION OF INSURANCE OR ITS CONTRACTOR SHALL INFORM THE CARRIER OF THE NAME OF THE IDRE TO WHICH THE CARRIER SHOULD SEND THE REQUEST.

(e) AFTER RECEIPT OF THE NAME OF THE IDRE FROM THE DIVISION OF INSURANCE, THE CARRIER SHALL:

(I) NOTIFY THE REQUESTING PARTY IN WRITING OF THE NAME OF THE IDRE SELECTED TO CONDUCT THE REVIEW AND INCLUDE DESCRIPTIVE

INFORMATION ON THE IDRE;

(II) PROVIDE THE FOLLOWING DOCUMENTS TO THE IDRE:

(A) ANY INFORMATION SUBMITTED TO THE CARRIER BY THE REQUESTING PARTY IN SUPPORT OF THE REQUEST FOR RECONSIDERATION OF THE AMOUNT ALLOWED FOR THE SERVICE OR PROCEDURE UNDER DISPUTE; AND

(B) A COPY OF ANY RELEVANT DOCUMENTS USED BY THE CARRIER TO MAKE ITS DETERMINATION; AND

(III) UPON REQUEST, PROVIDE COPIES OF ALL DOCUMENTS PROVIDED TO THE IDRE UNDER SUBSECTION (3)(e)(II) OF THIS SECTION TO THE REQUESTING PARTY.

(4) (a) (I) THE IDRE SHALL SELECT A REVIEWER TO CONDUCT THE REVIEW OF THE PAYMENT DISPUTE WHO:

(A) HAS NOT BEEN INVOLVED IN THE CARE OF THE COVERED PERSON TO WHOM THE REQUESTING PARTY PROVIDED HEALTH CARE SERVICES AND FOR WHICH THE REQUESTING PARTY IS DISPUTING THE CARRIER'S PAYMENT;

(B) IS NOT A MEMBER OF THE CARRIER'S BOARD OF DIRECTORS;

(C) HAS NOT BEEN INVOLVED PREVIOUSLY IN THE REVIEW PROCESS FOR THE REQUESTING PARTY;

(D) DOES NOT HAVE A DIRECT FINANCIAL INTEREST IN THE OUTCOME OF THE MATTER UNDER REVIEW; AND

(E) IS NOT EMPLOYED BY THE CARRIER.

(II) IF THE REQUESTING PARTY IS REQUESTING THE REVIEW BASED ON THE COMPLEXITY OF THE SERVICE OR PROCEDURE PROVIDED TO A COVERED PERSON, THE REVIEWER SELECTED BY THE IDRE SHALL CONSULT WITH A PHYSICIAN OR OTHER PROVIDER WHO HAS THE SAME OR SIMILAR

SPECIALTY AS THE OUT-OF-NETWORK PROVIDER TO ASSIST IN MAKING A DETERMINATION.

(b) THE IDRE SHALL NOTIFY THE REQUESTING PARTY AND THE CARRIER OF ANY ADDITIONAL INFORMATION REQUIRED TO CONDUCT THE REVIEW AFTER RECEIPT OF THE DOCUMENTATION REQUIRED BY SUBSECTION (3)(e)(II) OF THIS SECTION. THE REQUESTING PARTY SHALL SUBMIT THE ADDITIONAL INFORMATION, OR AN EXPLANATION OF WHY THE ADDITIONAL INFORMATION IS NOT BEING SUBMITTED, TO THE IDRE AND THE CARRIER AFTER RECEIPT OF THE REQUEST.

(c) THE IDRE SHALL MAINTAIN THE CONFIDENTIALITY OF ANY MEDICAL RECORDS SUBMITTED BY THE CARRIER OR THE REQUESTING PARTY UNDER THIS SECTION.

(d) THE CARRIER MAY DETERMINE THAT THE ADDITIONAL INFORMATION PROVIDED BY THE REQUESTING PARTY JUSTIFIES A RECONSIDERATION OF ITS INITIAL PAYMENT DETERMINATION, AND A SUBSEQUENT DECISION BY THE CARRIER TO PROVIDE ADDITIONAL PAYMENT AS REQUESTED BY THE REQUESTING PARTY TERMINATES THE IDRP UPON NOTIFICATION IN WRITING TO THE IDRE AND THE REQUESTING PARTY.

(5) (a) THE IDRE SHALL SUBMIT ITS DETERMINATION TO THE CARRIER, THE REQUESTING PARTY, AND THE COMMISSIONER WITHIN THIRTY BUSINESS DAYS AFTER THE IDRE RECEIVED THE REQUEST TO REVIEW THE PAYMENT DISPUTE; EXCEPT THAT, AT THE REQUEST OF THE REVIEWER, THE DEADLINE SHALL BE EXTENDED BY UP TO TEN BUSINESS DAYS FOR THE CONSIDERATION OF ADDITIONAL INFORMATION REQUIRED PURSUANT TO THIS SECTION.

(b) THE REVIEWER'S DETERMINATION MUST:

(I) BE IN WRITING AND STATE THE REASONS THE CARRIER'S ORIGINAL PAYMENT DETERMINATION FOR THE TREATMENT OR SERVICE SHOULD OR SHOULD NOT BE CHANGED;

(II) SPECIFICALLY CITE THE EIGHTIETH PERCENTILE OF CURRENT CHARGES FROM AN INDEPENDENT, NONPROFIT BENCHMARKING DATABASE, AS SPECIFIED BY THE COMMISSIONER UNDER SECTION 10-16-704 (3)(d)(II), OR THE SPECIFIC MEDICAL CONDITION OR ADDITIONAL CONSIDERATIONS THAT WARRANTED ANY ADDITIONAL PAYMENT;

(III) BE BASED ON AN OBJECTIVE REVIEW OF RELEVANT BENCHMARKING CHARGE DATA OR MEDICAL EVIDENCE; AND

(IV) INCLUDE:

(A) THE TITLES AND QUALIFYING CREDENTIALS OF THE REVIEWER AND ANY OTHER PERSONS INVOLVED IN CONDUCTING THE REVIEW;

(B) A STATEMENT OF THE UNDERSTANDING OF THE REVIEWER OF THE NATURE OF THE GRIEVANCE AND ALL PERTINENT FACTS; AND

(C) THE RATIONALE FOR THE DECISION.

(c) THE REVIEWER'S DETERMINATION IS BINDING ON THE CARRIER AND THE REQUESTING PARTY.

(d) IF THE DETERMINATION IS MADE IN FAVOR OF THE REQUESTING PARTY, THE CARRIER SHALL PAY THE OUT-OF-NETWORK PROVIDER PURSUANT TO THE DETERMINATION WITHIN FIFTEEN BUSINESS DAYS AFTER RECEIVING NOTIFICATION OF THE DETERMINATION.

(e) IF THE IDRE OVERTURNS THE CARRIER'S ORIGINAL PAYMENT DETERMINATION, THE CARRIER SHALL PAY THE COSTS OF THE IDRP. IF THE IDRE UPHOLDS THE CARRIER'S ORIGINAL PAYMENT DETERMINATION, THE REQUESTING PARTY SHALL PAY THE COSTS OF THE IDRP.

(6) (a) AN IDRE AND THE REVIEWER ASSIGNED BY THE IDRE TO

CONDUCT A REVIEW PURSUANT TO THIS SECTION ARE IMMUNE FROM CIVIL LIABILITY IN ANY ACTION BROUGHT BY ANY PERSON BASED UPON THE DETERMINATIONS MADE PURSUANT TO THIS SECTION. THIS SUBSECTION (6) DOES NOT APPLY TO AN ACT OR OMISSION OF THE IDRE OR REVIEWER THAT IS MADE IN BAD FAITH OR INVOLVES GROSS NEGLIGENCE.

(b) A CARRIER IS NOT LIABLE FOR DAMAGES ARISING FROM ANY ACT OR OMISSION OF THE IDRE OR REVIEWER THAT CONDUCTED A REVIEW UNDER THIS SECTION.

(7) A CARRIER MAY REQUIRE A SURETY BOND TO INDEMNIFY THE CARRIER FOR THE IDRE'S NONCOMPLIANCE WITH THIS SECTION.

SECTION 3. In Colorado Revised Statutes, 10-3-1104, **add** (1)(ss) as follows:

10-3-1104. Unfair methods of competition - unfair or deceptive acts or practices. (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(ss) VIOLATING SECTION 10-16-704 (3)(b), (3)(d), (3.5)(d), OR (5.5)(a)(V).

SECTION 4. 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.