NOTE: This bill has been prepared for the signatures of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.

An Act

SENATE BILL 26-017

BY SENATOR(S) Daugherty and Bright, Cutter, Exum, Hinrichsen, Kipp, Marchman, Roberts, Snyder, Wallace, Coleman;
also REPRESENTATIVE(S) Stewart R. and Gonzalez R., Bacon, Duran, Lieder, Lindsay, Rutinel, Stewart K.

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

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

SECTION 1. In Colorado Revised Statutes, 10-16-704, **amend** (13) 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, FOR SOME PROVIDERS WITH SMALLER REIMBURSEMENT AMOUNTS BEING DISPUTED, IS PROHIBITIVELY

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

EXPENSIVE AND ADMINISTRATIVELY BURDENSOME;

(B) BECAUSE THE COST OF ARBITRATION EXCEEDS THE AMOUNT OF THE UNDERPAID CLAIM, THIS PROCESS 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; AND

(E) CARRIERS ARE NOT REQUIRED TO DISCLOSE WHEN A PATIENT'S HEALTH BENEFIT PLAN IS GOVERNED BY STATE LAW, SO THE PROVIDER IS UNABLE TO DETERMINE IN WHICH JURISDICTION THE PROVIDER MAY APPEAL.

(II) THE GENERAL ASSEMBLY THEREFORE INTENDS FOR THIS SUBSECTION (13) 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 WHEN A HEALTH

BENEFIT PLAN IS REGULATED BY STATE LAW; AND

(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.

~~(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. DATA SUBMITTED BY A CARRIER PURSUANT TO THIS SUBSECTION (13)(b) IS PROPRIETARY, A TRADE SECRET, AND CONFIDENTIAL PURSUANT TO SECTION 24-72-204 (3)(a)(IV).

~~(b) Repealed.~~

(c) BEGINNING JANUARY 1, 2027, 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 WHEN THE HEALTH BENEFIT PLAN THE CARRIER IS MAKING THE PAYMENT PURSUANT TO IS REGULATED BY THE STATE AND THAT THE PAYMENT WAS MADE PURSUANT TO SUBSECTION (3)(d) OR (5.5)(b) OF THIS SECTION.

(d) A CARRIER SHALL PROVIDE THE CARRIER'S MEDIAN IN-NETWORK REIMBURSEMENT RATE FOR OUT-OF-NETWORK CLAIMS ON EACH REMITTANCE ADVICE.

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.

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James Rashad Coleman, Sr. Julie McCluskie
PRESIDENT OF SPEAKER OF THE HOUSE
THE SENATE OF REPRESENTATIVES

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Esther van Mourik Vanessa Reilly
SECRETARY OF CHIEF CLERK OF THE HOUSE
THE SENATE OF REPRESENTATIVES

APPROVED____
(Date and Time)

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Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO