First Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 25-0517.01 Kristen Forrestal x4217 **HOUSE BILL 25-1151**

HOUSE SPONSORSHIP

Hartsook and Stewart R.,

SENATE SPONSORSHIP

(None),

House Committees
Health & Human Services

Senate Committees

A BILL FOR AN ACT

CONCERNING THE ARBITRATION REQUIREMENT FOR BATCHING OUT-OF-NETWORK HEALTH INSURANCE CLAIMS.

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.)

The bill makes changes to the arbitration requirements for out-of-network health insurance claims by requiring the arbitration process to include a batching process, by which multiple claims may be considered jointly and under the same arbitration fee as part of one payment determination in alignment with federal law. The commissioner of insurance is required to adopt rules that specify the information each

insurance carrier is required to submit to a provider with the initial payment of a claim.

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

SECTION 1. In Colorado Revised Statutes, 10-16-704, **amend** (15)(b) and (15)(d) as follows:

10-16-704. Network adequacy - required disclosures - balance billing - arbitration - rules - legislative declaration - definitions. (15) (b) The commissioner shall ~~promulgate~~ ADOPT rules to implement an arbitration process that establishes a standard arbitration form and includes the selection of an arbitrator from a list of qualified arbitrators developed pursuant to the rules. Qualified arbitrators must be independent; not be affiliated with a carrier, health-care facility, or provider or ~~any~~ professional association of carriers, health-care facilities, or providers; not have a personal, professional, or financial conflict with ~~any~~ THE parties to the arbitration; and have experience in health-care billing and reimbursement rates. THE ARBITRATION PROCESS MUST INCLUDE A BATCHING PROCESS, BY WHICH MULTIPLE CLAIMS MAY BE CONSIDERED JOINTLY AND UNDER THE SAME ARBITRATION FEE AS PART OF ONE PAYMENT DETERMINATION, THAT ALIGNS WITH THE BATCHING PROCESS IN THE FEDERAL ACT; THE FEDERAL "INTERNAL REVENUE CODE OF 1986", 26 U.S.C. SEC. 9816 (c)(3); THE FEDERAL "EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974", 29 U.S.C. SEC. 1001 ET SEQ.; AND THE FEDERAL "PUBLIC HEALTH SERVICE ACT", 42 U.S.C. SEC. 201 ET SEQ. THE COMMISSIONER SHALL ADOPT RULES TO IMPLEMENT THIS SUBSECTION (15).

(d) (I) If the arbitrator's decision made pursuant to subsection (15)(c) of this section requires additional payment by the carrier above the

amount paid, the carrier shall pay the provider in accordance with section 10-16-106.5. A carrier shall not recalculate a covered person's cost-sharing amount based on an additional payment required or made as a result of an arbitration decision.

(II) FOR THE PURPOSE OF BATCHING CLAIMS, THE COMMISSIONER SHALL ADOPT RULES SPECIFYING THE INFORMATION EACH CARRIER IS REQUIRED TO SUBMIT TO A PROVIDER WITH THE INITIAL PAYMENT OF A CLAIM, INCLUDING BUT NOT LIMITED TO THE INFORMATION SPECIFIED IN SUBSECTION (1) OF THIS SECTION USED BY THE CARRIER TO ESTABLISH NETWORK ADEQUACY. EACH CARRIER MUST PROVIDE ALL INFORMATION SPECIFIED BY THE COMMISSIONER SO THAT A PROVIDER MAY CORRECTLY BATCH CLAIMS IN TANDEM WITH THE DELIVERY OF THE INITIAL PAYMENT. AT THE TIME EACH INITIAL PAYMENT IS MADE, EACH CARRIER MUST CONSPICUOUSLY DISCLOSE IN WRITING TO THE ENTITY RECEIVING THE INITIAL PAYMENT THE CLAIMS ADJUSTMENT REASON CODES AND REMITTANCE ADVICE REMARK CODES AS DESCRIBED IN THE FEDERAL EDI 835 ELECTRONIC HEALTH CARE CLAIM PAYMENT/ADVICE, WHICH SERVES AS A NOTICE OF PAYMENTS AND ADJUSTMENTS SENT TO PROVIDERS, BILLING ENTITIES, AND SUPPLIERS, AND MUST USE THE AVAILABLE FIELDS IN THE FEDERAL EDI 835 ELECTRONIC HEALTH CARE CLAIM PAYMENT/ADVICE TO DESCRIBE IF THE SERVICES PROVIDED WERE IN NETWORK OR OUT OF NETWORK.

(III) EACH GROUP HEALTH BENEFIT PLAN AND EACH CARRIER, AND ANY OTHER ISSUER OF HEALTH INSURANCE SUBJECT TO THIS SECTION, SHALL USE EXACTLY ONE OF THE FOLLOWING TWO MUTUALLY EXCLUSIVE REMITTANCE ADVICE REMARK CODES WITH THE INITIAL PAYMENT OR NOTICE OF DENIAL TO CLEARLY IDENTIFY WHETHER STATE OR FEDERAL

RULES OR REGULATIONS APPLY:

(A) AN N871 ALERT: THIS INITIAL PAYMENT WAS CALCULATED BASED ON A STATE-SPECIFIED LAW IN ACCORDANCE WITH THE FEDERAL "NO SURPRISES ACT"; OR

(B) AN N859 ALERT: THE FEDERAL "NO SURPRISES ACT" WAS APPLIED TO THE PROCESSING OF THIS CLAIM. PAYMENT AMOUNTS MAY BE DISPUTED PURSUANT TO A FEDERAL DOCUMENTED APPEAL, GRIEVANCE, OR DISPUTE RESOLUTION PROCESS.

SECTION 2. Act subject to petition - effective date. 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; 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.