

Health Insurance Balance Billing

This Act requires health insurers to cover services that are provided at an in-network facility, including services provided by an out-of-network provider, at no greater cost to the covered person than if the services were from an in-network provider.

Submitted as:

Colorado

SB 213

Status: Enacted into law in 2006.

Suggested State Legislation

(Title, enacting clause, etc.)

1 Section 1. [*Short Title.*] This Act shall be cited as “An Act to Address Payments from
2 Health Insurance Companies for Out-of-Network Providers Who Provide Services at In-Network
3 Health Care Facilities.”

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Section 2. [*Legislative Findings.*]

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(1) The [general assembly] hereby finds, determines, and declares that there are situations
7 in which insured consumers receive health care services, including procedures approved by their
8 insurance carrier, in a network facility, with a primary provider that is a network provider, but in
9 which other health care professionals assisting with such procedures may not be in-network
10 providers. In such situations, the consumer is not aware that the assisting providers are out-of-
11 network providers. Further, the consumer may have little or no direct contact with the assisting
12 health care professionals. The state [division of insurance] has interpreted the relationship
13 between an insurer and a health care provider as defined in [insert citation], to mean holding the
14 consumer harmless for additional charges from out-of-network providers for care rendered in a
15 network facility.

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(2) The [general assembly] finds, determines, and declares that the [division of insurance]
17 has correctly interpreted the provisions of [insert citation] to protect the insured from the
18 additional expense charged by an assisting provider who is an out-of-network provider, and has
19 properly required insurers to hold the consumer harmless. The [division of insurance] does not
20 have regulatory authority over all health plans. Some consumers are enrolled in self-funded health
21 insurance programs that are governed under the federal “Employee Retirement Income Security
22 Act.” Therefore, the [general assembly] encourages health care facilities, carriers, and providers
23 to provide consumers disclosure about the potential impact of receiving services from an out-of-
24 network provider.

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(3) The [general assembly] finds, determines, and declares that some consumers
26 intentionally use out-of-network providers, which is the consumers’ prerogative under certain
27 health benefit plans. When consumers intentionally use an out-of-network provider, the consumer
28 is only entitled to benefits at the out-of-network rate and may be subject to balance billing by the
29 out-of-network provider.

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(4) Therefore, the [general assembly] finds, determines, and declares that the purpose of
31 this Act is to codify the interpretation of the [division of insurance] that holds consumers
32 harmless for charges over and above the in-network rates for services rendered in a network
33 facility.

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35 Section 3. [*Reconciling Health Insurance Coverage for Services and Treatment at In-*
36 *Network Facilities Which are Performed by Out-of-Network Providers.*]

37 (1) When a covered person receives services or treatment in accordance with plan
38 provisions at a network facility, the benefit level for all covered services and treatment received
39 through the facility shall be the in-network benefit. Covered services or treatment rendered at a
40 network facility, including covered ancillary services or treatment rendered by an out-of-network
41 provider performing the services or treatment at a network facility, shall be covered at no greater
42 cost to the covered person than if the services or treatment were obtained from an in-network
43 provider.

44 (2) This [Section 3] of this Act is repealed, effective [July 1, 2010].

45 (3) Prior to such repeal, the [division of insurance] shall conduct an evaluation to include,
46 but not be limited to, the following:

47 (a) the effects of this [Section 3] of this Act on network adequacy;

48 (b) the frequency that nonparticipating providers submit more than network
49 reimbursement rates for services rendered in an in-network facility compared to the carrier's book
50 of business for that line of insurance;

51 (c) the amounts paid by carriers to nonparticipating providers; and

52 (d) the impact of this [Section 3] of this Act on consumers.

53 (4) The [division of insurance] shall complete the evaluation on or before [January 15,
54 2010], and shall report its findings to the [senate health and human services committee and the
55 house of representatives business affairs and labor committee, or any successor committees]. The
56 legislative staff for such committees shall notify the [committee chairs] of the expectation of the
57 evaluation and the repeal of this [Section 3] of this Act on or before [July 1, 2009].

58
59 Section 4. [*Severability.*] [Insert severability clause.]

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61 Section 5. [*Repealer.*] [Insert repealer clause.]

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63 Section 6. [*Effective Date.*] [Insert effective date.]