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.)

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

Section 2. [*Legislative Findings*.]

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

(2) The [general assembly] finds, determines, and declares that the [division of insurance] has correctly interpreted the provisions of [insert citation] 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 to provide consumers disclosure about the potential impact of receiving services from an out-of-network provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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