Colorado Legislative Council Staff

SB17-088

FISCAL NOTE

FISCAL IMPACT: ☒ State ☐ Local ☐ Statutory Public Entity ☐ Conditional ☐ No Fiscal Impact

Drafting Number:	LLS 17-0503	**Date:**	February 9, 2017
Prime Sponsor(s):	Sen. Holbert; Williams A. Rep. Hooton; Van Winkle	**Bill Status:**	Senate Business
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BILL TOPIC: PARTICIPATING PROVIDER NETWORK SELECTION CRITERIA

Fiscal Impact Summary	FY 2017-2018	FY 2018-2019
State Revenue		
General Fund	Minimal increase See State Revenue section.	
State Diversions		
General Fund	(49,255)	(51,875)
Cash Funds	49,255	51,875
State Expenditures	**$49,255**	**$51,875**
Cash Funds	42,006	43,309
Centrally Appropriated Costs	7,249	8,566
TABOR Impact	Minimal increase.	
FTE Position Change	0.5 FTE	0.6 FTE
Appropriation Required: $42,006 - Department of Regulatory Agencies (FY 2017-18).		
Future Year Impacts: Ongoing revenue and expenditure increase.		

Summary of Legislation

If a health insurer offers a narrow network or a tiered network, this bill requires the health insurer to develop, use, and disclose to participating and prospective healthcare providers, consumers, and the Commissioner of Insurance, the standards it uses for selecting providers to participate in its network. Selection, narrowing, and tiering standards cannot:

- allow the insurer to discriminate against high-risk populations;
- exclude providers because they treat or specialize in treating high-risk patients;
- allow an insurer to utilize economic criteria to credential a provider; or
- discriminate against any provider who is acting within the scope of the provider's license or certification under applicable state laws or rule.

For networks that an insurer markets as representing quality or value, the insurer must include a quality component in its standards that carries an equal or greater weight than other components of the standards. Quality criteria must be based on specialty-appropriate, nationally recognized, evidence-based medical guidelines or nationally recognized, consensus-based guidelines. An insurer may use professional certification or accreditation in determining provider quality of care but not as the sole factor in determining provider quality.

The bill requires that at least 45 days prior to taking an adverse action against a provider, that an insurer provide written notice to the provider with an explanation of the proposed adverse action, reference to the evidence or documentation behind the decision, and to inform the provider of the right to request the insurer to reconsider the adverse action. The bill requires insurers to establish a reconsideration process with specific deadlines.

An insurer that violates the provisions of this bill engages in an unfair or deceptive act or practice in the business of insurance. Under current law, an insurer found to have committed an unfair or deceptive practice by the Commissioner of Insurance may face a range of potential disciplinary actions, including a fine of up to $30,000 per act and up to $750,000 in aggregate per year for knowingly committing such violation as well as suspension or revocation of an insurer's license.

Background

Health insurers contract with healthcare providers and facilities to provide care to their policyholders at an agreed upon rate. These are "in-network" providers. An insurer can create a "narrow network" which is a reduced or selective provider network that is a subgroup of its larger network. An insurer can also create a "tiered network" where providers are placed in different benefit tiers. The tier determines how much a policyholder pays for service from a provider through a copay and coinsurance.

State Revenue

This bill potentially increases General Fund revenue by a minimal amount and diverts funds from the General Fund, as described below.

Fine Revenue. The Division of Insurance in the Department of Regulatory Agencies (DORA) may assess and receive fine revenue for violations of the practices prohibited by the bill, which is deposited into the General Fund. However, the fiscal note assumes a high level of compliance by insurance carriers and that any violations that occur will likely be addressed and resolved prior to the issuance of a penalty. Therefore, the potential increase in fine revenue is assumed to be minimal.

State diversions. This bill diverts $49,255 from the General Fund in FY 2017-18 and $51,875 in FY 2018-19. This revenue diversion occurs because the bill increases costs in the Division of Insurance, which is funded with premium tax revenue that would otherwise be credited to the General Fund.

TABOR Impact

This bill potentially increases state General Fund revenue from fines, which will increase the amount of money required to be refunded under TABOR for FY 2017-18 and FY 2018-19. TABOR refunds are paid out of the General Fund. Since the bill increases both revenue to the General Fund and the refund obligation by equal amounts, there is no net impact on the amount of money available in the General Fund for the budget. However, the bill will increase money available for the General Fund budget in the future during years when the state does not collect money above the TABOR limit.

State Expenditures

This bill increases state cash fund expenditures by $49,255 and 0.5 FTE in FY 2017-18 and $51,875 and 0.6 FTE in FY 2018-19 from the Division of Insurance Cash Fund. These costs are listed in Table 1 and explained below. It may also minimally increase workload in the Judicial Department.

Assumptions. The fiscal note assumes that insurers will provide documentation on their standards to the division in response to investigation of complaints, rather than as a matter of course. Therefore the division will not routinely review and evaluate insurer standards.

Table 1. Expenditures Under SB17-088

Cost Components	**FY 2017-18**	**FY 2018-19**
Personal Services	$36,828	$42,739
FTE	0.5 FTE	0.6 FTE
Operating Expenses and Capital Outlay Costs	5,178	570
Centrally Appropriated Costs*	7,249	8,566
TOTAL	**$49,255**	**$51,875**

** Centrally appropriated costs are not included in the bill's appropriation.*

Division of Insurance, DORA. The division will convene a stakeholder group to develop revisions to four regulations and to promulgate a new regulation. For rulemaking, the division requires 0.2 FTE of a Rate Financial Analyst IV for FY 2017-18 only. To handle insurer, provider, and consumer inquiries and complaints, the division requires a Rate Financial Analyst III prorated in FY 2017-18 to 0.3 FTE and 0.6 FTE thereafter. The Department of Law will provide legal services to support the ratemaking process and enforcement actions but these hours are included in DORA's annual appropriation of legal services hours.

Judicial Department. This bill may create a minimal increase in workload associated with unfair and deceptive practice cases. This increase can be addressed within existing appropriations.

Centrally appropriated costs. Pursuant to a Joint Budget Committee policy, certain costs associated with this bill are addressed through the annual budget process and centrally appropriated in the Long Bill or supplemental appropriations bills, rather than in this bill. The centrally appropriated costs subject to this policy are estimated in the fiscal note for informational purposes and summarized in Table 2.

Table 2. Centrally Appropriated Costs Under SB17-088

Cost Components	**FY 2017-18**	**FY 2018-19**
Employee Insurance (Health, Life, Dental, and Short-term Disability)	$3,949	$4,736
Supplemental Employee Retirement Payments	3,300	3,830
TOTAL	**$7,249**	**$8,566**

Effective Date

The bill takes effect January 1, 2018, unless a referendum petition is filed.

State Appropriations

For FY 2017-18, the Department of Regulatory Agencies requires an appropriation of $42,006 from the Division of Insurance Cash Fund.

State and Local Government Contacts

Health Care Policy And Financing
Information Technology
Judicial
Regulatory Agencies