

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

ENGROSSED

*This Version Includes All Amendments Adopted
on Second Reading in the House of Introduction*

LLS NO. 26-0124.02 Renee Leone x2695

SENATE BILL 26-017

SENATE SPONSORSHIP

Daugherty and Bright,

HOUSE SPONSORSHIP

Stewart R.,

Senate Committees

Health & Human Services
Appropriations

House Committees

A BILL FOR AN ACT

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

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 dispute resolution process between health insurance carriers (carriers) and out-of-network health-care providers (providers) by:

- Mandating that a carrier provide a remittance advice with each payment made to a provider;

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing law.
Dashes through the words or numbers indicate deletions from existing law.

SENATE
Amended 2nd Reading
April 28, 2026

- Establishing penalties that the division of insurance (division) may assess against a carrier that fails to properly reimburse a provider for services provided to a patient;
- Requiring a carrier to annually submit information to the division concerning patient use of out-of-network providers; and
- Requiring the division to produce an annual report regarding patient use of out-of-network providers and relevant arbitration data and statistics.

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

2 **SECTION 1.** In Colorado Revised Statutes, 10-16-704, **amend**
3 (13) as follows:

4 **10-16-704. Network adequacy - required disclosures - balance**
5 **billing - rules - legislative declaration - definitions.**

6 (13) (a) (I) THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

7 (A) UNDER CURRENT STATE LAW, PROVIDERS RESOLVE
8 OUT-OF-NETWORK REIMBURSEMENT DISPUTES THROUGH AN INDIVIDUAL,
9 CLAIM-BY-CLAIM ARBITRATION PROCESS THAT, FOR SOME PROVIDERS WITH
10 SMALLER REIMBURSEMENT AMOUNTS BEING DISPUTED, IS PROHIBITIVELY
11 EXPENSIVE AND ADMINISTRATIVELY BURDENSOME;

12 (B) BECAUSE THE COST OF ARBITRATION EXCEEDS THE AMOUNT
13 OF THE UNDERPAID CLAIM, THIS PROCESS PARTICULARLY IMPACTS
14 SMALLER PROVIDER GROUPS;

15 (C) THE DIVISION HAS AN ESTABLISHED COMPLAINT PROCESS THAT
16 ALLOWS PROVIDERS TO SUBMIT COMPLAINTS TO ENSURE THAT PAYMENT
17 REQUIREMENTS ARE MET BY CARRIERS. THIS ESTABLISHED COMPLAINT
18 PROCESS REQUIRES THE RESOLUTION OF CLAIMS WITHIN THIRTY DAYS
19 AFTER THE COMPLAINT CONTAINING THE CLAIMS HAS BEEN FILED IF THERE
20 ARE ONE HUNDRED OR FEWER CLAIMS SUBMITTED ON THE COMPLAINT

1 FORM AND ALLOWS FOR ADDITIONAL TIME WHEN THERE ARE MORE THAN
2 ONE HUNDRED CLAIMS SUBMITTED ON THE COMPLAINT FORM. HOWEVER,
3 THE COMPLAINT PROCESS DOES NOT ENSURE PROMPT PAYMENT TO
4 PROVIDERS OF MONEY OWED WHEN CARRIERS ARE DEEMED TO HAVE
5 VIOLATED PAYMENT REQUIREMENTS.

6 (D) TO IMPROVE FAIRNESS IN THE HEALTH-INSURANCE MARKET,
7 THE DIVISION'S EXISTING OVERSIGHT AND ENFORCEMENT AUTHORITY OF
8 CARRIER PAYMENTS TO PROVIDERS SHOULD BE AUGMENTED TO COMPEL
9 PROMPT PAYMENT FROM CARRIERS WHEN UNDERPAYMENT IS IDENTIFIED
10 IN THE COMPLAINT PROCESS, THEREBY PROVIDING A MORE EFFECTIVE
11 PATHWAY FOR PROVIDERS TO CHALLENGE UNDERPAYMENT; AND

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

16 (II) THE GENERAL ASSEMBLY THEREFORE INTENDS FOR THIS
17 SUBSECTION (13) TO:

18 (A) STREAMLINE OUT-OF-NETWORK DISPUTE RESOLUTIONS BY
19 GRANTING THE DIVISION ADDITIONAL ENFORCEMENT AUTHORITY WITHIN
20 ITS OUT-OF-NETWORK COMPLAINT PROCESS, INCLUDING A REQUIREMENT
21 TO COMPEL PROMPT PAYMENT FROM CARRIERS WHEN UNDERPAYMENT IS
22 IDENTIFIED;

23 (B) REQUIRE JURISDICTIONAL TRANSPARENCY BY MANDATING
24 THAT CARRIERS CLEARLY STATE ON A REMITTANCE ADVICE WHEN A
25 HEALTH BENEFIT PLAN IS REGULATED BY STATE LAW; AND

26 (C) EMPOWER DATA-DRIVEN ENFORCEMENT BY REQUIRING
27 CARRIERS TO DISCLOSE THE SPECIFIC METHODOLOGIES USED TO

1 DETERMINE OUT-OF-NETWORK REIMBURSEMENT AND BY GRANTING THE
2 COMMISSIONER AUTHORITY TO ORDER CORRECTIVE PAYMENTS AND
3 IMPOSE FINES FOR NONCOMPLIANCE.

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5 (a) (b) When a carrier makes a payment to a provider or a
6 health-care facility pursuant to subsection (3)(d) or (5.5)(b) of this
7 section, the provider or the facility may request, and the commissioner
8 shall collect, data from the carrier to evaluate the carrier's compliance in
9 paying the highest rate required. The information ~~requested may~~
10 PROVIDED MUST include the methodology for determining the carrier's
11 median in-network rate ~~or~~ AND reimbursement for each service in the
12 same geographic area. DATA SUBMITTED BY A CARRIER PURSUANT TO THIS
13 SUBSECTION (13)(b) IS PROPRIETARY, A TRADE SECRET, AND
14 CONFIDENTIAL PURSUANT TO SECTION 24-72-204 (3)(a)(IV).

15 (b) ~~Repeated.~~

16 (c) BEGINNING JANUARY 1, 2027, WHEN A CARRIER MAKES A
17 PAYMENT TO A PROVIDER OR A HEALTH-CARE FACILITY PURSUANT TO
18 SUBSECTION (3)(d) OR (5.5)(b) OF THIS SECTION, THE CARRIER SHALL
19 PROVIDE A REMITTANCE ADVICE THAT IDENTIFIES WHEN THE HEALTH
20 BENEFIT PLAN THE CARRIER IS MAKING THE PAYMENT PURSUANT TO IS
21 REGULATED BY THE STATE AND THAT THE PAYMENT WAS MADE PURSUANT
22 TO SUBSECTION (3)(d) OR (5.5)(b) OF THIS SECTION.

23

24 (d) A CARRIER SHALL PUBLICLY POST THE CARRIER'S MEDIAN
25 IN-NETWORK REIMBURSEMENT RATE FOR OUT-OF-NETWORK CLAIMS OR
26 PROVIDE THE CARRIER'S MEDIAN IN-NETWORK REIMBURSEMENT RATE FOR
27 OUT-OF-NETWORK CLAIMS ON EACH REMITTANCE ADVICE.

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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.