THE 2017 LEGISLATIVE SESSION . . . PROVIDERS, LIEUTENANT GOVERNOR, AND DRUG MANUFACTURERS SEEK CHANGES TO HEALTH INSURANCE INDUSTRY

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OVERVIEW

The 2017 legislative session adjourned on Wednesday, May 10, 2017. The 2017 legislative session marked the third consecutive year where one party controlled one legislative chamber and the other party controlled the other legislative chamber. Additionally, for the third year, Republicans controlled the Senate by one, razor-thin vote. Meanwhile, Democrats controlled the House by five votes, an increase of three votes from the previous two years.

Notwithstanding this split legislature, House and Senate leadership convened the 2017 legislative session by committing to work in a bipartisan manner to resolve several significant issues confronting the State of Colorado, including construction defect litigation reform, transportation funding, funding for rural hospitals, and equitable funding for all public schools. Unfortunately, towards the end of the legislative session, the Legislature had yet to pass any bills addressing these issues and the commitment to work in a bipartisan manner seemed like an empty promise. All that changed, however, in the last few days of the legislative session. With just days remaining, the Legislature reached bipartisan compromises on construction defect litigation reform; funding for rural hospitals; equitable funding for all public schools, including charter schools; the state budget; and the school finance act.

The legislative session saw the introduction of several bills impacting the health insurance industry. Most of these bills were sought by providers, the Lieutenant Governor, and drug manufacturers. The following is a sample of the health insurance bills the Legislature introduced during the 2017 legislative session, along with their final dispositions.

COLO. MEDICAL SOCIETY BILLS

After failing to introduce a "late bill" during the 2016 legislative session to address concerns with acquisitions of health insurance carriers and the narrowing of provider networks by health insurance carriers, the Colorado Medical Society ("CMS") introduced six bills during the 2017 legislative session. Each bill was aimed at the health insurance industry.

PARTICIPATION IN PROVIDER NETWORKS

As introduced, SB 88 would have (1) required health insurance carriers to develop and disclose standards for selecting providers to participate in a provider network; (2) prohibited health insurance carriers from making decisions on whether to allow providers to participate in a provider network based on cost; (3) required health insurance carriers to afford providers with numerous, restrictive, and cumbersome "appeal rights" when health insurance carriers deny a prospective provider from participating in a provider network or terminate an existing provider from continuing to participate in a provider network; and (4) imposed severe penalties on health insurance carriers for violating the provisions of the bill.

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Hall & Evans, LLC ("H&E"), along with the business community and health insurance industry, worked with Senator Neville (R) and Senator Aguilar (D) on an amendment to SB 88 that was aligned with current practices by health insurance carriers and the NAIC Network Adequacy Model Act. In general, the amendment continued to require health insurance carriers to develop and disclose standards for selecting providers to participate in a provider network. However, the amendment no longer prohibited health insurance carriers from making decisions on whether to allow providers to participate in a provider network based on cost. In addition, the amendment no longer required health insurance carriers to afford providers with "appeal rights" when health insurance carriers deny a *prospective* provider from participating in a provider network. Instead, the amendment required health insurance carriers to afford providers with less cumbersome "appeal rights" when health insurance carriers terminate an *existing* provider from continuing to participate in a provider network. Finally, the amendment no longer imposed severe penalties on health insurance carriers for violating the provisions of SB 88.

The amendment gained considerable traction in the Senate and, as a result, compelled CMS to negotiate, in good faith, with the health insurance industry on a compromise. The parties ultimately reached a compromise that essentially mirrors the provisions of the amendment. The Governor signed SB 88, as amended, into law on April 18, 2017.

Acquisitions of Health Insurance Carriers

As introduced, SB 198 would have required the Commissioner of Insurance to publicly disclose the pre-acquisition notice ("Form E") filed in connection with the acquisition of either a *domestic* or *foreign* health insurance carrier. The Form E contains certain marketing information that is generally considered to be proprietary in nature. The introduced version of SB 198 would also have required the Commissioner of Insurance to notify the public of, and allow the public to comment on, the proposed acquisition of a *foreign* health insurance carrier. Presently, the public receives notice of, and may comment on, the proposed acquisition of a *domestic* health insurance carrier. CMS sought passage of SB 198 due to its ongoing concerns with proposed acquisitions of health insurance carriers, including Aetna's proposal to acquire Humana.

H&E, along with the Division of Insurance and health insurance industry, participated in a series of meetings with CMS to address concerns with SB 198. The health insurance industry was primarily concerned with the provision in SB 198 requiring public disclosure of the Form E. The parties ultimately agreed to an amendment requiring the Commissioner of Insurance to only disclose the product, geographic market, and market shares at issue when the Commissioner of Insurance determines the Form E, filed in connection with the acquisition of a *foreign* health insurance carrier, presents *prima facie* evidence of a violation of competitive standards outlined in current law. The amendment also requires the Commissioner of Insurance to (1) notify the public of the proposed acquisition of a *foreign* health insurance carrier and (2) allow the public to comment on the proposed acquisition of a *foreign* health insurance carrier if the Commissioner of Insurance determines the proposed acquisition presents *prima facie* evidence of a violation of competitive standards outlined in current law. The Governor signed SB 198, as amended, into law on June 2, 2017.

Out-of-Network Provider Charges

During the summer and fall of 2015, health insurance carriers and CMS participated in numerous meetings, which were presided over by a professional facilitator, to address concerns by health insurance carriers regarding unreasonable and egregious charges billed by certain out-of-network providers for

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medical services rendered to insureds/patients. Although H&E actively participated in those meetings, a resolution to the foregoing concerns was never ascertained.

This year, the Legislature introduced SB 206 at the request of CMS. SB 206 would have required a health insurance carrier to pay an out-of-network provider who renders medical services to an insured at an in-network facility the lesser of the provider's billed charges or the 80th percentile of charges billed for the same medical services rendered by all providers in the same medical specialty and in the same geographic area. SB 206, therefore, did nothing to dissuade out-of-network providers from continuing to submit unreasonable and egregious charges to health insurance carriers. In fact, by tying the amount a health insurance carrier must pay an out-of-network provider to either the provider's billed charges or the 80th percentile of charges billed by all providers, SB 206 would have simply encouraged out-of-network providers to charge and seek even more from health insurance carriers for medical services rendered to insureds. H&E worked closely with the health insurance industry to educate the sponsor of the bill on the ramifications of SB 206. These efforts proved to be worthwhile as the sponsor of the bill ultimately asked the Senate Business Committee to kill SB 206. On April 10, 2017, at the sponsor's request, the Senate Business Committee killed SB 206.

Provider Complaints Against Health Insurance Carriers

SB 133 would have required the Commissioner of Insurance to investigate complaints, filed by providers, against health insurance carriers alleging the improper handling of claims or denial of benefits. Presently, the Commissioner of Insurance is authorized, but not required, to investigate such complaints. On April 12, 2017, the Senate Business Committee killed SB 133 in light of the fact the Division of Insurance plans to implement a pilot program where it will begin to collect provider complaints against health insurance carriers.

Adverse Actions Against Providers

As introduced, HB 1173 would have prohibited a health insurance carrier from taking certain types of adverse actions against a provider who disagrees with the carrier's decision to limit or deny benefits to an insured, communicates with public officials about health care policy, or alleges violations of law by the carrier. The bill would also have allowed an insured or a provider, who believed a health insurance carrier violated the provisions of HB 1173, to file an action for injunctive relief and seek the recovery of legal fees and costs.

H&E, along with the health insurance industry, worked with the sponsor of the bill on several amendments to address certain concerns. As amended, HB 1173 does not protect a provider from an adverse action if the provider does not act in good faith. The amended version of HB 1173 no longer allows an insured to file an action for injunctive relief. In addition, HB 1173, as amended, no longer allows a provider, who files an action for injunctive relief, to seek the recovery of legal fees. The provider may still seek the recovery of costs. Similarly, a health insurance carrier may seek the recovery of costs if a court deems a provider's action for injunctive relief to be frivolous. Finally, HB 1173, as amended, in no way changes the standard for obtaining injunctive relief. The Governor signed HB 1173, as amended, into law on April 6, 2017.

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TELEHEALTH SERVICES

HB 1094 clarifies how telehealth services are provided and how health insurance carriers must pay or reimburse for such services. In addition, at the request of H&E and the health insurance industry, HB 1094 clarifies that a health insurance carrier may impose a cost-sharing amount on an insured for health care services delivered by telehealth that is less than the cost-sharing amount for the same health care services delivered by an in-person office visit. The Governor signed HB 1094 into law on March 16, 2017.

OTHER PROVIDER BILLS

This legislative session also saw a familiar group of providers, including independent pharmacists, optometrists, physical therapists, occupational therapists, chiropractors, family physicians, and dentists seek passage of legislation aimed at the health insurance industry.

ANY WILLING PROVIDER

In 2015, the independent pharmacists introduced SB 15-123, which would have allowed any willing pharmacist to dispense high-cost, complex, specialty drugs or biological products under certain conditions. The Senate ultimately killed SB 15-123 on Second Reading. In 2016, the independent pharmacists tried again and introduced HB 16-1361. HB 16-1361 would have prohibited a health insurance carrier or pharmacy benefit manager ("PBM") from (1) limiting an insured's ability to select a pharmacy of the insured's choice; (2) imposing conditions on a pharmacy that limit or restrict an insured's ability to use a pharmacy chosen by the insured; and (3) imposing fees on a pharmacy chosen by the insured if such fees are not also imposed on other in-network pharmacies. Ultimately, the Senate Finance Committee killed HB 16-1361.

This year, the independent pharmacists partnered with the optometrists and chiropractors and introduced HB 1247. HB 1247 would have prohibited health insurance carriers and third-party administrators that cover services rendered by a pharmacist, optometrist, or chiropractor (a "Provider") from (1) limiting an insured's ability to select a Provider of the insured's choice; (2) imposing conditions on a Provider that limit or restrict an insured's ability to use a Provider chosen by the insured; (3) imposing fees on a Provider chosen by the insured if such fees are not imposed on other in-network providers; and (4) denying a Provider from participating in any provider networks if the Provider is selected by an insured.

H&E, along with the health insurance industry, the PBM community, the vision plans, and the business community, actively lobbied against HB 1247. These efforts paid off as HB 1247 died in the House Health Insurance Committee, the bill's first committee of reference.

REQUIREMENTS ON CARRIERS AND INTERMEDIARIES

In 2014 (HB 14-1108) and 2015 (HB 15-1083), the Legislature introduced bills that would have limited the cost-sharing amount a health insurance carrier can charge an insured for physical therapy services, occupational therapy services, and chiropractic services. The bill in 2014 was vetoed by the Governor, while the bill in 2015, in an effort to avoid the Governor's veto pen, was amended to only require the Colorado Commission on Affordable Health Care to study the costs associated with physical rehabilitation services. In 2016, the Legislature introduced HB 16-1326, which would have imposed certain requirements on health insurance carriers covering physical therapy services, occupational

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therapy services, and chiropractic services, and on intermediaries who contract with such health insurance carriers. Many of these requirements would have centered on how coverage authorizations and medical necessity determinations are made and how utilization reviews are conducted. This bill ultimately died in the Senate State Affairs Committee.

This year, the Legislature introduced SB 151 on behalf of the physical therapists, occupational therapists, and chiropractors. SB 151 was similar to last year's HB 16-1326. However, SB 151 applied to *all* types of medical services and prohibited health insurance carriers from offering incentives to intermediaries to reduce or deny coverage authorizations or medical necessity determinations. The health insurance industry and the intermediary community lobbied against SB 151. These efforts proved to be worthwhile as SB 151 died in the Senate Business Committee, the bill's first committee of reference.

Direct Primary Care Agreements

HB 1115 establishes the parameters under which a direct primary care agreement may be implemented. H&E, along with the health insurance industry, worked with the family physicians to secure amendments to HB 1115 that require direct primary care providers to disclose to consumers that a direct primary care agreement is not health insurance and does not afford patients with the same protections afforded to insureds under Colorado's insurance code. The Governor signed HB 1115, as amended, into law on April 24, 2017.

Charges for Non-Covered Dental Items or Services

SB 190 authorizes a dentist to charge an insured for non-covered items or services any amount determined by the dentist that is no more than the usual and customary amount the dentist charges individuals who do not have coverage for such items and services. The health insurance industry did not oppose SB 190. As such, the Legislature passed SB 190 in a bi-partisan manner, and the Governor signed SB 190 into law on April 24, 2017.

LIEUTENANT GOVERNOR BILLS

The new Lieutenant Governor, Donna Lynne, a former Kaiser Permanente executive, introduced a package of bills intended to reform the health care industry. Many of the bills were aimed at the health insurance industry. However, the Legislature failed to pass any of the bills.

HB 1235 would have provided financial support to certain low-income insureds who (1) purchase health insurance through the state health insurance exchange; (2) spend more than 15% of their household income on health insurance premiums; and (3) reside in certain high-cost areas in Colorado. On April 24, 2017, the Senate State Affairs Committee killed HB 1235 on a party-line vote.

HB 1237 would have permitted the State of Colorado to contract with a local government to provide health benefits to employees of the local government through the state employee group benefit plans. Several health insurance carriers, particularly those who insure local government employees, were concerned HB 1237 would drive healthy and less costly local government employees to the state employee group benefit plans, which would leave these health insurance carriers with only insuring sick and costlier local government employees. H&E, along with certain health insurance carriers and rural hospitals, actively opposed HB 1237. These efforts paid off as the Senate State Affairs Committee killed HB 1237 on May 3, 2017.

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HB 1286 would have required health insurance carriers that contract with the State of Colorado to provide state employee group benefits to (1) offer individual insurance plans through the state health insurance exchange; (2) offer health insurance plans in certain high-cost counties; and (3) participate in Medicaid, the Children's Basic Health Plan, and certain other programs. Presently, many health insurance carriers do not meet all of the requirements outlined in HB 1286. Some of these health insurance carriers, however, would like to bid on the contract to provide state employee group benefits. H&E, along with certain health insurance carriers and the business community, actively opposed HB 1286. These efforts paid off as the Senate State Affairs Committee killed HB 1286 on May 3, 2017.

HB 1318 would have required health insurance carriers to report to the Commissioner of Insurance certain information regarding prescription drug costs, including cost-sharing amounts paid by insureds for prescription drugs, the net cost of prescription drugs after all negotiated discounts and rebates, and a list of the drug classes of the 10 prescription drugs that have the highest dispense rate and aggregate cost. H&E, along with the health insurance industry, opposed HB 1318 because it did nothing to incentivize drug manufacturers to reduce their prescription drug prices. The Senate State Affairs Committee killed HB 1318 on May 3, 2017.

DRUG MANUFACTURER BILLS

This year, the drug manufacturers partnered with certain consumer groups to introduce legislation that would have limited the use of certain cost-saving mechanisms employed by health insurance carriers to combat the rising costs of prescription drugs.

SB 84 would have placed limitations and restrictions on how health insurance carriers manage their prescription drug formularies and removed incentives for drug manufacturers to control the costs of their prescription drugs. H&E, along with the health insurance industry and the PBM community, actively opposed SB 84. These efforts convinced the Senate Health Committee, the bill's first committee of reference, to kill the bill.

As introduced, SB 203 would have prohibited health insurance carriers from requiring an insured to undergo step therapy when the insured is being treated for a terminal condition or the insured has previously tried a step therapy prescription drug under his or her current or previous health insurance plan. SB 203, as introduced, would also have allowed providers to override step therapy requirements imposed by health insurance carriers.

H&E, along with the health insurance industry and the PBM community, actively opposed the introduced version of SB 203. As a result, the Senate Business Committee adopted an amendment to SB 203 that simply prohibits health insurance carriers from requiring an insured to undergo step therapy when the insured has previously tried a step therapy prescription drug under his or her current or previous health insurance plan. Against the wishes of the drug manufacturers, the Legislature ultimately passed the amended version of SB 203. The Governor signed SB 203, as amended, into law on June 2, 2017.

MISCELLANEOUS BILLS

The Legislature also introduced several other bills on a wide array of topics impacting the health insurance industry. These bills covered topics relating to coverage for high-risk individuals, freestanding

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emergency rooms, contraception coverage, market conduct examinations and financial examinations, and provider directories.

Coverage for High-Risk Individuals

SB 300 requires the Commissioner of Insurance to study how to provide health insurance coverage to high-risk individuals and reduce health insurance premiums in the individual market. SB 300 also requires the Commissioner of Insurance to explore the feasibility of implementing a reinsurance program or other high-risk coverage programs. The Governor signed SB 300 into law on June 2, 2017. Since the signing of SB 300, the Division of Insurance has convened two meetings with stakeholders to discuss the parameters of the study.

Freestanding Emergency Rooms

SB 64 would have created a new license for freestanding emergency rooms that provide emergency and urgent care and are either independent of a hospital or operated by a hospital at a location off the hospital's main campus. SB 64 would also have required freestanding emergency rooms to provide claims and billing data to health insurance carriers and to triage patients to determine the level of care patients require. Although the health insurance industry is concerned with the billing practices by freestanding emergency rooms, SB 64 did not contain enough provisions to address the industry's concerns. As a result, the health insurance industry took a neutral position on SB 64. Ultimately, the Senate State Affairs Committee killed SB 64 on a party-line vote.

Contraception Coverage

HB 1186 requires health insurance carriers to reimburse providers and pharmacies for dispensing a prescription contraceptive in a 3-month supply for the first time the prescription contraceptive is dispensed and in a 12-month supply, or for the duration of the insured's plan year (whichever is shorter), for any subsequent dispensing of the same prescription contraceptive. HB 1186 also requires health insurance carriers to reimburse providers and pharmacies for dispensing a vaginal contraceptive ring intended to last for 3 months. The health insurance industry did not oppose HB 1186. As such, the Legislature passed HB 1186 in a bi-partisan manner, and the Governor signed HB 1186 into law on June 5, 2017.

Market Conduct/Financial Examinations

Dating back to 2015, H&E, along with the health insurance industry, actively participated in a series of meetings with the Division of Insurance to discuss legislation that would harmonize existing statutes pertaining to market conduct examinations and financial examinations that are intertwined and, in some cases, overlap and conflict. During these meetings, H&E succeeded in preserving existing provisions allowing an insurance carrier to meet with the Division of Insurance prior to the issuance of a draft market conduct examination report to resolve any outstanding issues. H&E also succeeded in preserving existing provisions affording an insurance carrier the right to appeal to district court any findings issued, and any penalties or fines imposed, by the Division of Insurance as part of either a market conduct examination or a financial examination.

HB 1231, a priority for the Division of Insurance, is the result of the aforementioned meetings. In general, HB 1231 amends existing statutes by separating market conduct examination provisions from financial

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examination provisions. However, HB 1231 and SB 249 amend existing statutes by creating new provisions regarding the imposition of civil penalties. For instance, HB 1231 requires the Commissioner of Insurance to include in the Final Agency Order any civil penalties she seeks to impose as part of a market conduct examination. Moreover, HB 1231 requires the Commissioner of Insurance to consider certain factors when determining the amount of the civil penalty. Finally, SB 249, which continues the functions of the Division of Insurance for 13 years, requires any fine or penalty imposed as part of a market conduct examination to relate to the "general business practices and compliance activities" of the insurance carrier and not to "clearly infrequent or unintentional random errors that do not cause significant consumer harm." The Governor signed HB 1231 and SB 249 into law on June 1, 2017.

PROVIDER DIRECTORIES

The introduced version of HB 1165 was inartfully drafted and would have required health insurance carriers and, inexplicably, producers to update, at least monthly, their provider directories by removing a provider whose license has been revoked or suspended from the provider directories. However, HB 1165, as introduced, did not require the Department of Regulatory Agencies to notify the public when it revoked or suspended a provider's license. H&E, along with the health insurance industry, worked with the sponsors of the bill on an amendment that no longer requires producers to update the provider directories. In addition, H&E and the health insurance industry secured an amendment that requires the Department of Regulatory Agencies to separately list on its website each provider whose license it has revoked or suspended. The Governor signed HB 1165, as amended, into law on June 6, 2017.

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