Colorado Chiropractic Association
2017 Legislative Update
As of May 11, 2017

Bill:	HB17-1057
Title:	Interstate Physical Therapy Licensure Compact
Status	Sent to the Governor
Summary	The bill enacts the Interstate Physical Therapy Licensure Compact Act (compact) and requires the Governor to enter into the compact on behalf of Colorado. Under the compact, physical therapists and physical therapy assistants licensed or certified in a compact member state (home state) may obtain an expedited license or certificate allowing them to practice in another compact member state (remote state). The compact will be administered by the Physical Therapy Compact Commission (commission) which will process applications for compact participation. Licensed physical therapists and certified physical therapy assistants in Colorado and other member states are granted "compact privileges," which allows them to practice as a physical therapist or work as a physical therapy assistant in another member state under the laws and rules of the remote state. To exercise the compact privilege, a licensee or certificate holder, must: • hold a license or certificate in the home state with no encumbrances; • be eligible for a compact privilege in any member state; • have no adverse actions within the previous two years; • notify the commission that compact privilege is being sought in a member state; • pay applicable fees; • be aware of the laws and rules governing the practice of physical therapy in the remote state; and • report adverse action taken by any non-member state within 30 days. The bill authorizes the Physical Therapy Board to: • appoint a qualified delegate to serve on the commission; • participate fully in the commission's data system; • implement a criminal background check requirement upon initial licensure or certification; • notify the commission about adverse action taken by the board; and • approve payment of assessments levied by the commission to cover its cost of operations. Physical therapists and physical therapy assistants licensed or certified under the compact are required to disclose detailed background information under the Michael Skolnik Medical Transparency Act of 2010.

Bill: HB17-1119

Title:	Payment Of Workers' Compensation Benefits
Status	Sent to the Governor
Summary	This bill creates the Uninsured Employer Board (board) and the Colorado Uninsured Employer Fund (fund) in the Division of Workers' Compensation (division) of the Colorado Department of Labor and Employment (CDLE). The board oversees the fund, which is designed to pay benefits to injured workers whose employers do not have workers' compensation insurance beginning January 1, 2020. This provision of statute is subject to a sunset review before July 1, 2022.

Bill: HB17-1121

Title:	Patient Safety Act
Status	Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely (05/04/2017)
Summary	The bill required current licensees and certificate holders and future applicants for initial licensure or certification to submit to a criminal history record check in the following professions: • podiatrists; • dentists and dental hygienists; • medical doctors, physician assistants, and anesthesiologists; • nurses; • certified nurse aides; • optometrists; and • veterinarians.

Bill: HB17-1173

Title:	Health Care Providers And Carriers Contracts
Status	Governor Signed (04/06/2017)
Summary	This bill expands the required protections for health care providers in contracts with health insurance carriers by prohibiting a carrier from taking any adverse action against a provider for expressing his or her disagreement with a carrier's decision. The bill defines adverse action to include limiting, restricting, denying, terminating or otherwise conditioning a provider's participation in one or more provider networks, including participation in a narrow network or location within a tiered network. In addition, the bill states that the contract between carriers and providers must prohibit a carrier from taking any adverse action against a provider due to the provider: • communicating with public officials or others about public policy issues relating to health care items or services; • filing a complaint or making a report to a governmental agency about policies or practices of a carrier that negatively impact the quality of, or access to, patient care; • providing testimony, evidence, opinion, or other public activity in any forum

	concerning a violation or possible violation of the required contractual provisions; • reporting violations or possible violation of the law to an appropriate authority; or • participating in any investigation into a violation or possible violation of the required contractual provisions. A covered person or provider who is aggrieved by a violation of the required contractual protections by the carrier may seek injunctive relief in court and seek recovery of reasonable court costs and attorney fees.

Bill: HB17-1231

Title:	Market Conduct Examinations Insurance Companies
Status	Sent to the Governor
Summary	This bill reorganizes and relocates statutes related to financial examinations and market conduct examinations of insurance companies into separate parts of Title 10 of the Colorado Revised Statutes and makes conforming amendments.

Bill: HB17-1247

Title:	Patient Choice Health Care Provider
Status	House Committee on Health, Insurance, & Environment Postpone Indefinitely (04/13/2017)
Summary	The bill required a health benefit plan or third-party administrator plan covering services provided by a licensed chiropractor, optometrist, or pharmacist, the bill prohibits the carrier or administrator from limiting a patient's ability to choose such a provider in the following ways: • limiting or restricting a covered person's ability to select the provider of his or her choice, as long as the selected provider has agreed to the terms of the contract of the health benefit plan; • imposing a copayment, fee, or other cost-sharing requirement on a covered person or health care provider unless the health benefit plan imposes the same copayment, fee, or cost-sharing requirement on all covered persons or health care providers in the state; • imposing any other conditions on a covered person or provider that limit or restrict a covered person's ability to use the provider or his or her choice; or • denying a selected provider the right to participate in any of its provider network contracts in this state if the provider agrees to the contractual terms and provides appropriate services under all applicable state and federal laws and regulations.

Bill: SB17-003

Title:	Repeal Colorado Health Benefit Exchange
Status	Lost on the Senate Calendar (05/10/2017)

Summary	Colorado created a Health Benefit Exchange pursuant to the enactment of federal law that allowed each state to establish a health benefit exchange option through state law or opt to participate in a national exchange. The act created the state exchange, a board of directors (board) to implement the exchange, and a legislative health benefits exchange implementation review committee to make recommendations to the board. The bill repealed the act, effective January 1, 2018, and allowed the exchange to continue for one year for the purpose of winding up its affairs. The bill also required the board, on the last day of the wind-up period, to transfer any unencumbered money that remains in the exchange to the state treasurer.

Bill: SB17-065

Title:	Transparency In Direct Pay Health Care Prices
Status	Governor Signed (04/06/2017)
Category	The act creates the "Transparency in Health Care Prices Act", which requires health care professional and health care facilities to make available to the public, either electronically or by posting conspicuously on their websites, the health care prices they charge, before negotiating any discounts, for common health care services they provide to patients who will be paying directly for the services. For a health care professional in solo or small practice setting, the professional may comply with the requirements by making the health care price information available in the patient waiting area. Health care professionals and facilities are not required to submit their health care prices to any government agency for review or approval. Additionally, the act prohibits health insurers, government agencies, or other persons or entities from penalizing a health care recipient, provider, facility, employer, or other person or entity who pays directly for health care services or otherwise exercises rights under or complies with the act.

Bill: SB17-088

Title:	Participating Provider Network Selection Criteria
Status	Governor Signed (04/18/2017)
Summary	If a health insurer offers a tiered network, the bill requires the health insurer to develop and use standards for selecting and tiering participating providers. The insurer is required to make the standards available to the Commissioner of Insurance, participating healthcare providers, and the public. Selection and tiering standards cannot: • allow the insurer to discriminate against high-risk populations by excluding or

	tiering providers based on their location in a geographic area that contains high-risk populations; or • exclude providers because they treat or specialize in treating high-risk patients. The bill requires that at least 60 days prior to implementing a decision to terminate or place a provider in a tiered network, that an insurer provide written notice to the provider with an explanation of the reasons for the decision, and to inform the provider of the right to request the insurer to reconsider the decision. The bill requires insurers to establish a reconsideration process with specific deadlines. The commissioner and Division of Insurance staff are prohibited from arbitrating, mediating, or settling disputes regarding a decision not to include a provider in a network or tiered network or regarding any dispute between an insurer, the insurer's intermediary, or providers. However, if the commissioner determines that an insurer has violated the provisions of this bill, the commissioner must require the insurer to follow a corrective action plan and may use enforcement powers available under current insurance law.

Bill: SB17-106

Title:	Sunset Registration Of Naturopathic Doctors
Status	Sent to the Governor
Summary	Continues the regulation of naturopathic doctors by the director of the division of professions and occupations for 5 years, until September 1, 2022; Requires insurance carriers to report to the director any malpractice judgments against or settlements entered into by a naturopathic doctor; Adds naturopathic doctors to the list of persons required to report child abuse or neglect and mistreatment of at-risk elders and at-risk adults with intellectual and developmental disabilities. The bill clarifies that the naturopathic formulary that lists the medicines naturopathic doctors may use in the practice of naturopathic medicine includes prescription substances and devices authorized under the "Naturopathic Doctor Act".

Bill: SB17-133

Title:	Insurance Commissioner Investigation Of Provider Complaints
Status	Senate Committee on Business, Labor, & Technology Postpone Indefinitely (04/12/2017)
Summary	This bill required the Commissioner of Insurance to investigate complaints against health insurance carriers filed by health care providers alleging improper handling of claims or denial of benefits. Under current law, such investigations may be conducted at the discretion of the Commissioner. In addition, the bill required the Commissioner to notify the provider when the investigation is complete

	and to inform the provider of the facts and conclusions determined by the investigation. The Commissioner was also required to evaluate complaints filed against insurance carriers to determine if there is a pattern or practice by an insurance carrier of improper handling of claims or denial of benefits.

Bill: SB17-135

Title:	Remove Medical Release Requirement For Animal Chiropractic
Status	House Committee on Agriculture, Livestock, & Natural Resources Postpone Indefinitely (03/13/2017)
Summary	This bill removed the requirement that a registered animal chiropractor receive medical clearance by a licensed veterinarian to perform animal chiropractic treatment. If the animal patient was also under the care of a licensed veterinarian, the animal chiropractor was encouraged to collaborate with the veterinarian. The bill also allowed a chiropractor who is not registered as an animal chiropractor to perform animal chiropractic treatment if a licensed veterinarian provides medical clearance. In this situation, the chiropractor is required to maintain professional collaboration with the veterinarian who provided the medical clearance.

Bill: SB17-151

Title:	Consumer Access To Health Care
Status	Senate Committee on Business, Labor, & Technology Postpone Indefinitely (02/15/2017)
Summary	The bill required health insurance carriers that conduct credentialing of providers, utilization management, and utilization review to do the following: 1. base health care coverage authorizations and medical necessity determinations on generally accepted and evidence-based standards and criteria of clinical practice; 2. disclose evidence-based standards and criteria of clinical practice and processes to policyholders and providers that the carrier uses for coverage authorizations and medical necessity determinations; 3. ensure that coverage authorizations and medical necessity determinations are performed by a health care provider who is licensed in a similar health field as the requesting provider; 4. categorize a condition as a new episode of care if the same provider has not treated the policyholder for the condition within the previous 30 days; and 5. ensure that tiered prior authorization criteria are based on generally accepted evidence-based standards and criteria. In addition, the bill prohibited an intermediary from requiring a coverage authorization or medical necessity determination prior to evaluation and management services provided at an initial visit. In

	addition, a carrier could not create payment or other incentives for an intermediary to reduce or deny coverage authorizations or medical necessity determinations. Insurance carriers and intermediaries were also prohibited from requiring that a provider participate or be credentialed by a specific carrier or intermediary as a condition of health insurance network participation. The Division of Insurance was required to develop rules for dispute resolution processes for policyholders and providers who have a dispute with an intermediary.

Bill: SB17-181

Title:	Collateral-Source Rule Evidence Of Insurance
Status	House Committee on State, Veterans, & Military Affairs Postpone Indefinitely (04/19/2017)
Summary	Currently in a civil action for damages, the jury is not told about insurance coverage or other sources (collateral-source) from which the plaintiff has or may receive compensation. This bill allowed the presentation of collateral-source evidence, unless the plaintiff agrees to a reduced jury award.

Bill: SB17-182

Title:	Uninsured Motor Vehicle And Medical Coverage
Status	House Committee on State, Veterans, & Military Affairs Postpone Indefinitely (04/19/2017)
Summary	The bill clarified that an insurer is not required to reimburse a policyholder for an amount that exceeds actual damages caused during a collision covered by an uninsured or under-insured motorist (UM/UIM) coverage policy, and defines UI/UIM vehicles.

Bill: SB17-191

Title:	Market-based Interest Rates On Judgments
Status	House Committee on State, Veterans, & Military Affairs Postpone Indefinitely (04/19/2017)
Summary	Beginning on January 1, 2018, this bill would have eliminated the minimum post-judgment interest rate. It also required the interest rate on damages for personal injuries caused by tort be the same rate in statute as the post-judgment interest rate.

Bill: SB17-193

Title:	Research Center Prevention Substance Abuse Addiction

Status	Sent to the Governor
Summary	This bill creates a research center (center) for substance abuse and addiction prevention strategies and treatment at the University of Colorado Health Sciences Center. The center's mission is to: • establish or expand programs for research concerning abuse and addiction to opioids, other controlled substances, and alcohol; • establish or expand treatments for opioids, other controlled substances, and alcohol; • expand existing partnerships with national organizations with similar missions; and • seek federal and private resources to further the center's activities.

Bill: SB17-206

Title:	Out-of-network Providers Payments Patient Notice
Status	Senate Committee on Business, Labor, & Technology Postpone Indefinitely (04/10/2017)
Summary	The bill outlined the method for a health insurer to use in determining the amount it must pay an out-of-network provider that rendered covered services to a covered person at an in-network facility and requires the health insurer to pay the out-of-network provider directly. The bill also established an independent dispute resolution process by which an out-of-network provider may obtain review of a payment from a health insurer. Additionally, the bill required an in-network facility where a covered person will receive a health care procedure or treatment, the health insurer, and an out-of-network provider who provides health care services to a covered person at an in-network facility to provide specified disclosures to the covered person, explaining that: 1)An out-of-network provider may provide health care services to the covered person as part of the procedure or treatment provided at the in-network facility; 2) If the covered person's plan is governed by state law, the services rendered by an out-of-network provider are covered under the plan at the in-network benefit level; 3) The out-of-network provider will submit a bill to the covered person's health insurer, and if the covered person receives a bill from the out-of-network provider, he or she should contact the health insurer's customer service to resolve the bill; and 4) The covered person was only responsible for paying the applicable in-network cost-sharing amount, and the carrier is responsible for paying any remaining balance owed the out-of-network provider. A health insurer that failed to reimburse out-of-network providers as required by the bill and under current law or fails to provide the required notice to the covered person engages in an unfair or deceptive act or practice in the business of insurance and is subject to monetary penalties

and other penalties authorized by law.

Bill: SB17-249

Title:	Sunset Division Of Insurance
Status	Sent to the Governor
Summary	This bill continues the Division of Insurance in the Department of Regulatory Agencies until September 1, 2030, and implements recommendations from the 2016 sunset report. In addition to various technical changes, the bill repeals the duties assigned to the Department of Public Health and Environment related to health maintenance organizations (HMOs) and reassign them to the Commissioner of Insurance.

Bill: SB17-250

Title:	Student Exemption From Immunization Requirements
Status	Senate Second Reading Lost with Amendments - Floor (04/19/2017)
Summary	Under current law, a student may be exempted from the immunization requirements for school attendance under either a medical or personal belief exemption. This bill specified that a certification of a medical exemption submitted by a physician or advanced practice nurse or a statement of a personal belief exemption submitted by a parent, guardian, or emancipated student can be in letter form and that a form furnished by the Department of Public Health and Environment or the State Board of Health is not required. Correspondingly, the bill clarified the rulemaking authority of the State Board of Health concerning the frequency that exemptions are submitted, rather than the frequency that exemption forms are submitted.