First Regular Session
Seventy-third General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 21-0634.01 Shelby Ross x4510 **HOUSE BILL 21-1198**

HOUSE SPONSORSHIP

Jodeh,

SENATE SPONSORSHIP

Buckner and Kolker,

House Committees
Health & Insurance

Senate Committees

A BILL FOR AN ACT

CONCERNING HEALTH-CARE BILLING REQUIREMENTS FOR INDIGENT PATIENTS RECEIVING SERVICES NOT REIMBURSED THROUGH THE COLORADO INDIGENT CARE PROGRAM, AND, IN CONNECTION THEREWITH, ESTABLISHING PROCEDURES BEFORE INITIATING COLLECTIONS PROCEEDINGS AGAINST A PATIENT.

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.)

No later than June 1, 2022, a health-care facility shall screen each uninsured patient for eligibility for public health insurance programs,

discounted care through the Colorado indigent care program (CICP), and discounted care as described in the bill. Health-care facilities shall use a single uniform application developed by the department of health care policy and financing (department) when screening a patient. If a health-care facility determines a patient is ineligible for discounted care, the facility shall provide the patient notice of the determination and an opportunity for the patient to appeal the determination.

For emergency and other non-CICP health-care services provided to qualified patients, a health-care facility and licensed health-care professional shall limit the amounts charged to not more than 80% of the medicare rate if the patient is uninsured; collect amounts charged in monthly installments such that a patient is not paying more than 5% of the patient's household income; and after a cumulative 36 months of payments, consider the patient's bill paid in full and permanently cease any and all collection activities on any balance that remains unpaid.

A health-care facility shall make information about patient's rights and the uniform application for discounted care available to the public and to each patient.

Beginning June 1, 2023, and each June 1 thereafter, each health-care facility shall collect and report to the department data that the department determines is necessary to evaluate compliance across patient groups based on race, ethnicity, and primary language spoken with the required screening, discounted care, payment plan, and collections practices.

No later than April 1, 2022, the department shall develop a written explanation of a patient's rights, make the explanation available to the public and each patient, and establish a process for patients to submit a complaint relating to noncompliance with the requirements. The department shall periodically review health-care facilities and licensed health-care professionals (hospital providers) to ensure compliance, and the department shall notify the hospital provider if the hospital provider is not in compliance that the hospital provider has 90 days to file a corrective action plan with the department. A hospital provider may request up to 120 days to submit a corrective action plan. The department may require a hospital provider that is not in compliance to develop and operate under a corrective action plan until the department determines the hospital provider is in compliance. The bill implements fines for hospital providers if the department determines the hospital provider's noncompliance is knowing or willful.

The bill imposes requirements on hospital providers before assigning or selling patient debt to a medical creditor or before pursuing any permissible extraordinary collection action and imposes fines for any hospital provider that fails to comply with the requirements.

The bill prohibits a medical creditor from using impermissible extraordinary collection action to collect debts owed for health-care

services provided by a hospital provider. A medical creditor may engage in permissible extraordinary collection actions 180 days after the first bill for a medical debt is sent to the patient. At least 30 days before taking any permissible extraordinary collection action, a medical creditor shall provide the patient with a notice about the discounted care policy, the permissible extraordinary collection actions that will be initiated, and a deadline after which such permissible extraordinary collection actions will be initiated. If a patient is later found eligible for discounted care, the medical creditor shall reverse any permissible extraordinary collection actions.

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

SECTION 1. In Colorado Revised Statutes, **add** part 5 to article 3 of title 25.5 as follows:

PART 5

HEALTH-CARE BILLING FOR INDIGENT PATIENTS RECEIVING SERVICES NOT REIMBURSED THROUGH THE COLORADO INDIGENT CARE PROGRAM

25.5-3-501. Definitions. AS USED IN THIS PART 5, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "HEALTH-CARE FACILITY" MEANS:

(a) A HOSPITAL LICENSED AS A GENERAL HOSPITAL PURSUANT TO PART 1 OF ARTICLE 3 OF TITLE 25;

(b) A HOSPITAL ESTABLISHED PURSUANT TO SECTION 23-21-503 OR 25-29-103;

(c) ANY FREESTANDING EMERGENCY DEPARTMENT LICENSED PURSUANT TO SECTION 25-1.5-114; OR

(d) ANY OUTPATIENT HEALTH-CARE FACILITY AFFILIATED WITH OR OPERATING UNDER THE LICENSE OR CERTIFICATE OF A FACILITY DESCRIBED IN SUBSECTIONS (1)(a) TO (1)(c) OF THIS SECTION.

(2) "HEALTH-CARE SERVICES" HAS THE SAME MEANING AS SET

FORTH IN SECTION 10-16-102 (33).

(3) "LICENSED HEALTH-CARE PROFESSIONAL" MEANS ANY HEALTH-CARE PROFESSIONAL WHO IS REGISTERED, CERTIFIED, OR LICENSED PURSUANT TO TITLE 12 OR WHO PROVIDES SERVICES UNDER THE SUPERVISION OF A HEALTH-CARE PROFESSIONAL WHO IS REGISTERED, CERTIFIED, OR LICENSED PURSUANT TO TITLE 12, AND WHO PROVIDES HEALTH-CARE SERVICES IN A HEALTH-CARE FACILITY.

(4) "NON-CICP HEALTH-CARE SERVICES" MEANS HEALTH-CARE SERVICES PROVIDED IN A HEALTH-CARE FACILITY FOR WHICH REIMBURSEMENT UNDER THE COLORADO INDIGENT CARE PROGRAM, ESTABLISHED IN PART 1 OF THIS ARTICLE 3, IS NOT AVAILABLE.

(5) "QUALIFIED PATIENT" MEANS AN INDIVIDUAL WHOSE HOUSEHOLD INCOME IS NOT MORE THAN TWO HUNDRED FIFTY PERCENT OF THE FEDERAL POVERTY LEVEL AND WHO RECEIVED A HEALTH-CARE SERVICE AT A HEALTH-CARE FACILITY.

(6) "SCREEN" OR "SCREENING" MEANS A PROCESS IDENTIFIED IN RULE BY THE STATE DEPARTMENT WHEREBY HEALTH-CARE FACILITIES ASSESS A PATIENT'S CIRCUMSTANCES RELATED TO ELIGIBILITY CRITERIA AND DETERMINE WHETHER THE PATIENT IS LIKELY TO QUALIFY FOR PUBLIC HEALTH-CARE COVERAGE OR DISCOUNTED CARE, INFORM THE PATIENT OF THE HEALTH-CARE FACILITY'S DETERMINATION, AND PROVIDE INFORMATION TO THE PATIENT ABOUT HOW THE PATIENT CAN ENROLL IN PUBLIC HEALTH-CARE COVERAGE.

25.5-3-502. Requirement to screen patients for eligibility for public health-care programs and discounted care - rules. (1) BEGINNING JUNE 1, 2022, A HEALTH-CARE FACILITY SHALL SCREEN, UNLESS A PATIENT DECLINES, EACH UNINSURED PATIENT FOR ELIGIBILITY

FOR:

(a) PUBLIC HEALTH INSURANCE PROGRAMS INCLUDING BUT NOT LIMITED TO MEDICARE; THE STATE MEDICAL ASSISTANCE PROGRAM, ARTICLES 4, 5, AND 6 OF THIS TITLE 25.5; EMERGENCY MEDICAID; AND THE CHILDREN'S BASIC HEALTH PLAN, ARTICLE 8 OF THIS TITLE 25.5;

(b) DISCOUNTED CARE THROUGH THE COLORADO INDIGENT CARE PROGRAM, ESTABLISHED IN PART 1 OF THIS ARTICLE 3, IF THE PATIENT RECEIVES A SERVICE ELIGIBLE FOR REIMBURSEMENT THROUGH THE PROGRAM; AND

(c) DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-503.

(2) HEALTH-CARE FACILITIES SHALL USE A SINGLE UNIFORM APPLICATION DEVELOPED BY THE STATE DEPARTMENT WHEN SCREENING A PATIENT PURSUANT TO SUBSECTION (1) OF THIS SECTION.

(3) IF A HEALTH-CARE FACILITY DETERMINES THAT A PATIENT IS INELIGIBLE FOR DISCOUNTED CARE, THE FACILITY SHALL PROVIDE THE PATIENT NOTICE OF THE DETERMINATION AND AN OPPORTUNITY FOR THE PATIENT TO APPEAL THE DETERMINATION IN ACCORDANCE WITH STATE DEPARTMENT RULES.

(4) IF THE PATIENT DECLINES THE SCREENING DESCRIBED IN SUBSECTION (1) OF THIS SECTION, THE HEALTH-CARE FACILITY SHALL DOCUMENT THE PATIENT'S DECISION IN ACCORDANCE WITH STATE DEPARTMENT RULES.

(5) IF REQUESTED BY THE PATIENT, A HEALTH-CARE FACILITY SHALL SCREEN AN INSURED PATIENT FOR DISCOUNTED CARE PURSUANT TO SUBSECTIONS (1)(b) AND (1)(c) OF THIS SECTION.

25.5-3-503. Health-care discounts on services not eligible for Colorado indigent care program reimbursement. (1) IF A PATIENT IS

SCREENED PURSUANT TO SECTION 25.5-3-502 AND IS DETERMINED TO BE A QUALIFIED PATIENT, A HEALTH-CARE FACILITY AND A LICENSED HEALTH-CARE PROFESSIONAL SHALL, FOR EMERGENCY AND OTHER NON-CICP HEALTH-CARE SERVICES:

(a) LIMIT THE AMOUNTS CHARGED TO NOT MORE THAN EIGHTY PERCENT OF THE MEDICARE RATE IF THE PATIENT IS UNINSURED;

(b) COLLECT AMOUNTS CHARGED, NOT INCLUDING AMOUNTS OWED BY THIRD-PARTY PAYERS, IN MONTHLY INSTALLMENTS SUCH THAT THE PATIENT IS NOT PAYING MORE THAN FIVE PERCENT OF THE PATIENT'S MONTHLY HOUSEHOLD INCOME FOR ALL HEALTH-CARE SERVICES AND FEES INCURRED DURING A VISIT; AND

(c) AFTER A CUMULATIVE THIRTY-SIX MONTHS OF PAYMENTS, CONSIDER THE PATIENT'S BILL PAID IN FULL AND PERMANENTLY CEASE ANY AND ALL COLLECTION ACTIVITIES ON ANY BALANCE THAT REMAINS UNPAID.

(2) A HEALTH-CARE FACILITY SHALL NOT:

(a) DENY DISCOUNTED CARE ON THE BASIS THAT THE PATIENT HAS NOT APPLIED FOR ANY PUBLIC BENEFITS PROGRAM; OR

(b) ADOPT OR MAINTAIN ANY POLICIES THAT RESULT IN THE DENIAL OF ADMISSION OR TREATMENT OF A PATIENT BECAUSE THE PATIENT LACKS HEALTH INSURANCE COVERAGE, MAY QUALIFY FOR DISCOUNTED CARE, REQUIRES EXTENDED OR LONG-TERM TREATMENT, OR HAS AN UNPAID MEDICAL BILL.

25.5-3-504. Notification of patient's rights. (1) A HEALTH-CARE FACILITY SHALL MAKE INFORMATION DEVELOPED BY THE STATE DEPARTMENT ABOUT PATIENT'S RIGHTS UNDER THIS PART 5 AND THE UNIFORM APPLICATION DEVELOPED BY THE STATE DEPARTMENT PURSUANT

TO SECTION 25.5-3-505 (2)(i) AVAILABLE TO THE PUBLIC AND TO EACH PATIENT. AT A MINIMUM, THE HEALTH-CARE FACILITY SHALL:

(a) POST THE INFORMATION IN ALL REQUIRED LANGUAGES PURSUANT TO THIS SUBSECTION (1) CONSPICUOUSLY ON THE HEALTH-CARE FACILITY'S WEBSITE, INCLUDING A LINK TO THE INFORMATION ON THE HEALTH-CARE FACILITY'S MAIN LANDING PAGE;

(b) MAKE THE INFORMATION AVAILABLE IN PATIENT WAITING AREAS;

(c) MAKE THE INFORMATION AVAILABLE TO EACH PATIENT, OR THE PATIENT'S LEGAL GUARDIAN, VERBALLY OR IN WRITING IN THE PATIENT'S OR LEGAL GUARDIAN'S PRIMARY LANGUAGE BEFORE THE PATIENT IS DISCHARGED FROM THE HEALTH-CARE FACILITY; AND

(d) INFORM EACH PATIENT ON THE PATIENT'S BILLING STATEMENT OF THE PATIENT'S RIGHTS PURSUANT TO THIS PART 5, INCLUDING THE RIGHT TO APPLY FOR DISCOUNTED CARE, AND PROVIDE THE WEBSITE, E-MAIL ADDRESS, AND TELEPHONE NUMBER WHERE THE INFORMATION MAY BE OBTAINED IN THE PATIENT'S PRIMARY LANGUAGE.

25.5-3-505. Health-care facility reporting requirements - agency enforcement - rules. (1) BEGINNING JUNE 1, 2023, AND EACH JUNE 1 THEREAFTER, EACH HEALTH-CARE FACILITY SHALL COLLECT AND REPORT TO THE STATE DEPARTMENT DATA THAT THE STATE DEPARTMENT DETERMINES IS NECESSARY TO EVALUATE COMPLIANCE ACROSS RACE, ETHNICITY, AND PRIMARY-LANGUAGE-SPOKEN PATIENT GROUPS WITH THE SCREENING, DISCOUNTED CARE, PAYMENT PLAN, AND COLLECTIONS PRACTICES REQUIRED PURSUANT TO THIS PART 5. IF A HEALTH-CARE FACILITY IS NOT CAPABLE OF DISAGGREGATING THE DATA REQUIRED PURSUANT TO THIS SUBSECTION (1) BY RACE, ETHNICITY, AND PRIMARY

LANGUAGE SPOKEN, THE HEALTH-CARE FACILITY SHALL REPORT TO THE STATE DEPARTMENT THE STEPS THE FACILITY IS TAKING TO IMPROVE RACE, ETHNICITY, AND PRIMARY-LANGUAGE-SPOKEN DATA COLLECTION AND THE DATE BY WHICH THE FACILITY WILL BE ABLE TO DISAGGREGATE THE REPORTED DATA.

(2) NO LATER THAN APRIL 1, 2022, THE STATE BOARD SHALL PROMULGATE RULES NECESSARY FOR THE ADMINISTRATION AND IMPLEMENTATION OF THIS PART 5. AT A MINIMUM, THE RULES MUST:

(a) OUTLINE A PROCESS FOR AN INSURED PATIENT TO REQUEST A SCREENING PURSUANT TO SECTION 25.5-3-502 (5);

(b) OUTLINE A PROCESS FOR DOCUMENTING THAT A PATIENT HAS DECLINED A SCREENING PURSUANT TO SECTION 25.5-3-502;

(c) ESTABLISH THE PROCESS FOR AND THE MAXIMUM NUMBER OF DAYS THAT A HEALTH-CARE FACILITY HAS TO:

(I) INITIATE A SCREENING AFTER A PATIENT RECEIVES SERVICES;

(II) REQUEST INFORMATION FROM THE PATIENT NEEDED FOR THE SCREENING PROCESS; AND

(III) COMPLETE THE SCREENING PROCESS;

(d) OUTLINE THE REQUIREMENTS FOR NOTIFYING THE PATIENT OF THE RESULTS OF THE SCREENING, INCLUDING AN EXPLANATION OF THE BASIS FOR A DENIAL OF DISCOUNTED CARE AND THE PROCESS FOR APPEALING A DENIAL;

(e) ESTABLISH GUIDELINES FOR PATIENT APPEALS REGARDING ELIGIBILITY FOR DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503;

(f) ESTABLISH A METHODOLOGY THAT ALL HEALTH-CARE FACILITIES MUST USE TO DETERMINE MONTHLY HOUSEHOLD INCOME. THE METHODOLOGY MUST NOT CONSIDER A PATIENT'S ASSETS.

(g) IDENTIFY THE DOCUMENTS THAT MAY BE REQUIRED TO ESTABLISH INCOME ELIGIBILITY FOR DISCOUNTED CARE USING THE MINIMUM AMOUNT OF INFORMATION NEEDED TO DETERMINE ELIGIBILITY;

(h) IDENTIFY THE STEPS A HEALTH-CARE FACILITY AND LICENSED HEALTH-CARE PROFESSIONAL MUST TAKE BEFORE SENDING PATIENT DEBT TO COLLECTIONS; AND

(i) CREATE A SINGLE UNIFORM APPLICATION THAT A HEALTH-CARE FACILITY SHALL USE WHEN SCREENING A PATIENT FOR ELIGIBILITY FOR THE COLORADO INDIGENT CARE PROGRAM AND DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-502.

(3) IN PROMULGATING RULES PURSUANT TO THIS SECTION, THE STATE DEPARTMENT SHALL:

(a) ALIGN THE PROCESSES OF QUALIFYING FOR AND APPEALING DENIALS OF ELIGIBILITY FOR THE COLORADO INDIGENT CARE PROGRAM WITH DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-502; AND

(b) CONSIDER POTENTIAL LIMITATIONS RELATING TO THE FEDERAL "EMERGENCY MEDICAL TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd.

(4) NO LATER THAN APRIL 1, 2022, THE STATE DEPARTMENT SHALL:

(a) DEVELOP A WRITTEN EXPLANATION OF A PATIENT'S RIGHTS UNDER THIS SECTION THAT IS WRITTEN IN PLAIN LANGUAGE AT A SIXTH-GRADE READING LEVEL AND TRANSLATED INTO ALL LANGUAGES SPOKEN BY TEN PERCENT OR MORE OF THE POPULATION IN EACH COUNTY OF THE STATE. EACH HEALTH-CARE FACILITY SHALL MAKE THE EXPLANATION AVAILABLE TO THE PUBLIC AND EACH PATIENT AS PROVIDED IN SECTION 25.5-3-504.

(b) (I) ESTABLISH A PROCESS FOR PATIENTS TO SUBMIT A COMPLAINT RELATING TO NONCOMPLIANCE WITH THIS PART 5 TO THE STATE DEPARTMENT BY PHONE, MAIL, OR ONLINE. THE STATE DEPARTMENT SHALL CONDUCT A REVIEW WITHIN THIRTY DAYS AFTER RECEIVING A COMPLAINT.

(II) THE STATE DEPARTMENT SHALL PERIODICALLY REVIEW HEALTH-CARE FACILITIES AND LICENSED HEALTH-CARE PROFESSIONALS TO ENSURE COMPLIANCE WITH THIS SECTION. IF THE STATE DEPARTMENT FINDS THAT A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL IS NOT IN COMPLIANCE WITH THIS SECTION, THE STATE DEPARTMENT SHALL NOTIFY THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL AND THE FACILITY OR PROFESSIONAL HAS NINETY DAYS TO FILE A CORRECTIVE ACTION PLAN WITH THE STATE DEPARTMENT THAT MUST INCLUDE MEASURES TO INFORM THE PATIENT ABOUT THE NONCOMPLIANCE AND PROVIDE A FINANCIAL CORRECTION CONSISTENT WITH THIS PART 5. A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL MAY REQUEST UP TO ONE HUNDRED TWENTY DAYS TO SUBMIT A CORRECTIVE ACTION PLAN. THE STATE DEPARTMENT MAY REQUIRE A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL THAT IS NOT IN COMPLIANCE WITH THIS PART 5 OR ANY STATE BOARD RULES ADOPTED PURSUANT TO THIS PART 5 TO DEVELOP AND OPERATE UNDER A CORRECTIVE ACTION PLAN UNTIL THE STATE DEPARTMENT DETERMINES THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL IS IN COMPLIANCE.

(III) IF A HEALTH-CARE FACILITY'S OR LICENSED HEALTH-CARE PROFESSIONAL'S NONCOMPLIANCE WITH THIS SECTION IS DETERMINED BY THE STATE DEPARTMENT TO BE KNOWING OR WILLFUL OR THERE IS A

REPEATED PATTERN OF NONCOMPLIANCE, THE STATE DEPARTMENT MAY FINE THE FACILITY OR PROFESSIONAL NO MORE THAN FIVE THOUSAND DOLLARS. IF THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL FAILS TO TAKE CORRECTIVE ACTION OR FAILS TO FILE A CORRECTIVE ACTION PLAN WITH THE STATE DEPARTMENT PURSUANT TO SUBSECTION (4)(b)(II) OF THIS SECTION, THE STATE DEPARTMENT MAY FINE THE FACILITY OR PROFESSIONAL NO MORE THAN FIVE THOUSAND DOLLARS A WEEK UNTIL THE FACILITY OR PROFESSIONAL TAKES CORRECTIVE ACTION. THE STATE DEPARTMENT SHALL CONSIDER THE SIZE OF THE HEALTH-CARE FACILITY AND THE SERIOUSNESS OF THE VIOLATION IN SETTING THE FINE AMOUNT.

(5) THE STATE DEPARTMENT SHALL MAKE THE INFORMATION REPORTED PURSUANT TO SUBSECTION (1) OF THIS SECTION AND ANY CORRECTIVE ACTION PLANS FOR WHICH FINES WERE IMPOSED PURSUANT TO SUBSECTION (4)(b) OF THIS SECTION AVAILABLE TO THE PUBLIC.

25.5-3-506. Limitations on collection actions - private enforcement. (1) BEFORE ASSIGNING OR SELLING PATIENT DEBT TO A COLLECTION AGENCY, AS DEFINED IN SECTION 5-16-103 (3)(a), OR A DEBT BUYER, AS DEFINED IN SECTION 5-16-103 (8.5), OR BEFORE PURSUING, EITHER DIRECTLY OR INDIRECTLY, ANY PERMISSIBLE EXTRAORDINARY COLLECTION ACTION, AS DEFINED IN SECTION 6-20-201 (6):

(a) A HEALTH-CARE FACILITY SHALL MEET THE SCREENING REQUIREMENTS IN SECTION 25.5-3-502;

(b) A HEALTH-CARE FACILITY AND LICENSED HEALTH-CARE PROFESSIONAL SHALL PROVIDE DISCOUNTED CARE TO A PATIENT PURSUANT TO SECTION 25.5-3-503, OR, IF THE PATIENT IS NOT A QUALIFIED PATIENT, OFFER THE PATIENT A PAYMENT PLAN THAT DOES NOT EXCEED

FIVE PERCENT OF THE PATIENT'S MONTHLY HOUSEHOLD INCOME; AND

(c) PROVIDE A PLAIN LANGUAGE EXPLANATION OF THE HEALTH-CARE SERVICES AND FEES BEING BILLED AND NOTIFY THE PATIENT OF POTENTIAL COLLECTION ACTIONS.

(2) A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL THAT FAILS TO COMPLY WITH THE REQUIREMENTS OF THIS SECTION IS LIABLE TO THE PATIENT IN AN AMOUNT EQUAL TO THE SUM OF:

(a) ANY ACTUAL DAMAGES SUSTAINED BY THE PATIENT AS A RESULT OF SUCH FAILURE;

(b) IN THE CASE OF SUCH ACTION BROUGHT BY AN INDIVIDUAL, ANY ADDITIONAL DAMAGES THAT THE COURT MAY ALLOW, NOT TO EXCEED ONE THOUSAND DOLLARS;

(c) IN THE CASE OF A CLASS ACTION, SUCH AMOUNT FOR EACH NAMED PLAINTIFF THAT MAY RECOVER DAMAGES UNDER SUBSECTION (2)(b) OF THIS SECTION, AND SUCH AMOUNT THAT THE COURT MAY ALLOW FOR ALL OTHER CLASS MEMBERS WITHOUT REGARD TO A MINIMUM INDIVIDUAL RECOVERY, NOT TO EXCEED THE LESSER OF FIVE HUNDRED THOUSAND DOLLARS OR ONE PERCENT OF THE NET WORTH OF THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL; AND

(d) IN THE CASE OF ANY SUCCESSFUL ACTION TO ENFORCE THE FOREGOING LIABILITY, THE COSTS OF THE ACTION TOGETHER WITH REASONABLE ATTORNEY FEES AS DETERMINED BY THE COURT. ON A FINDING BY THE COURT THAT THE ACTION WAS BROUGHT IN BAD FAITH, THE COURT MAY AWARD REASONABLE ATTORNEY FEES TO THE DEFENDANT THAT ARE RELATED TO THE WORK EXPENDED AND COSTS.

(3) IN DETERMINING THE AMOUNT OF LIABILITY IN ANY ACTION PURSUANT TO SUBSECTION (2) OF THIS SECTION, THE COURT SHALL

CONSIDER, AMONG OTHER RELEVANT FACTORS:

(a) IN ANY INDIVIDUAL ACTION BROUGHT PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION, THE FREQUENCY AND PERSISTENCE OF NONCOMPLIANCE BY THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL, THE NATURE OF SUCH NONCOMPLIANCE, AND THE EXTENT TO WHICH SUCH NONCOMPLIANCE WAS INTENTIONAL; OR

(b) IN ANY INDIVIDUAL ACTION BROUGHT PURSUANT TO SUBSECTION (2)(b) OF THIS SECTION, THE FREQUENCY AND PERSISTENCE OF NONCOMPLIANCE BY THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL, THE NATURE OF SUCH NONCOMPLIANCE, THE RESOURCES OF THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL, THE NUMBER OF INDIVIDUALS ADVERSELY AFFECTED, AND THE EXTENT TO WHICH THE HEALTH-CARE FACILITY'S OR LICENSED HEALTH-CARE PROFESSIONAL'S NONCOMPLIANCE WAS INTENTIONAL.

SECTION 2. In Colorado Revised Statutes, 5-16-108, **add** (1)(l) as follows:

5-16-108. Unfair practices. (1) A debt collector or collection agency shall not use unfair or unconscionable means to collect or attempt to collect any debt, including, but not limited to, the following conduct:

(l) AN ATTEMPT TO COLLECT A DEBT THAT VIOLATES THE PROVISIONS OF SECTION 6-20-203.

SECTION 3. In Colorado Revised Statutes, 6-20-201, **amend** (3); and **add** (4), (5), and (6) as follows:

6-20-201. Definitions. For the purposes of this part 2, unless the context otherwise requires:

(3) EXCEPT AS DEFINED IN SECTION 6-20-203, "health-care provider" includes a health-care facility licensed pursuant to article 3 of

title 25 ~~C.R.S.~~, and any other health-care provider.

(4) "IMPERMISSIBLE EXTRAORDINARY COLLECTION ACTION" MEANS CAUSING AN INDIVIDUAL'S ARREST, CAUSING AN INDIVIDUAL TO BE SUBJECT TO A WRIT OF BODY ATTACHMENT OR SIMILAR PROCESS, FORECLOSING ON AN INDIVIDUAL'S REAL PROPERTY, OR GARNISHING AN INDIVIDUAL'S STATE INCOME TAX REFUND.

(5) "MEDICAL CREDITOR" MEANS ANY OF THE FOLLOWING:

(a) A HEALTH-CARE PROVIDER TAKING ANY COLLECTION ACTIVITIES OR PERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS ON AN UNPAID MEDICAL ACCOUNT ON ITS OWN BEHALF;

(b) ANY ENTITY OR BUSINESS ASSIGNED AN UNPAID MEDICAL ACCOUNT BY A HEALTH-CARE PROVIDER IN ORDER TO TAKE ANY COLLECTION ACTION OR PERMISSIBLE EXTRAORDINARY COLLECTION ACTION, INCLUDING BUT NOT LIMITED TO:

(I) A HEALTH-CARE PROVIDER'S BILLING DEPARTMENT;

(II) BUSINESS ENTITIES OWNED IN WHOLE OR IN PART BY A HEALTH-CARE PROVIDER; OR

(III) BUSINESS ENTITIES THAT CONTRACT WITH A HEALTH-CARE PROVIDER FOR COLLECTION PURPOSES; AND

(c) ANY ENTITY OR BUSINESS THAT HAS PURCHASED AN UNPAID MEDICAL ACCOUNT AND IS TAKING COLLECTION ACTIONS OR PERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS ON ITS OWN BEHALF.

(6) "PERMISSIBLE EXTRAORDINARY COLLECTION ACTION" MEANS AN ACTION OTHER THAN AN IMPERMISSIBLE EXTRAORDINARY COLLECTION ACTION THAT REQUIRES A LEGAL OR JUDICIAL PROCESS, INCLUDING BUT NOT LIMITED TO PLACING A LIEN ON AN INDIVIDUAL'S REAL PROPERTY, ATTACHING OR SEIZING AN INDIVIDUAL'S BANK ACCOUNT OR ANY OTHER

PERSONAL PROPERTY, COMMENCING A CIVIL ACTION AGAINST AN INDIVIDUAL, OR GARNISHING AN INDIVIDUAL'S WAGES.

SECTION 4. In Colorado Revised Statutes, **add** 6-20-203 as follows:

6-20-203. Limitations on collection actions - definition. (1) AS USED IN THIS SECTION, "HEALTH-CARE PROVIDER" MEANS A LICENSED HEALTH-CARE PROFESSIONAL OR HEALTH-CARE FACILITY, AS DEFINED IN SECTION 25.5-3-501 (1).

(2) IMPERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS MAY NOT BE USED BY ANY MEDICAL CREDITOR TO COLLECT DEBTS OWED FOR HEALTH-CARE SERVICES PROVIDED BY A HEALTH-CARE PROVIDER.

(3) NO MEDICAL CREDITOR OR MEDICAL DEBT COLLECTOR COLLECTING ON A DEBT FOR HEALTH-CARE SERVICES PROVIDED BY A HEALTH-CARE PROVIDER SHALL ENGAGE IN ANY PERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS UNTIL ONE HUNDRED EIGHTY DAYS AFTER THE FIRST BILL FOR A MEDICAL DEBT IS SENT TO THE PATIENT.

(4) AT LEAST THIRTY DAYS BEFORE TAKING ANY PERMISSIBLE EXTRAORDINARY COLLECTION ACTION, A MEDICAL CREDITOR COLLECTING ON A DEBT FOR HEALTH-CARE SERVICES PROVIDED BY A HEALTH-CARE PROVIDER SHALL PROVIDE TO THE PATIENT A NOTICE DEVELOPED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING THAT CONTAINS THE FOLLOWING:

(a) A STATEMENT THAT DISCOUNTED CARE IS AVAILABLE FOR QUALIFIED INDIVIDUALS AND A PLAIN-LANGUAGE SUMMARY OF THE DISCOUNTED CARE POLICY AND HOW TO APPLY;

(b) A STATEMENT OF THE PERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS THAT WILL BE INITIATED IN ORDER TO OBTAIN

PAYMENT; AND

(c) A DEADLINE AFTER WHICH SUCH PERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS WILL BE INITIATED, WHICH DATE IS NOT EARLIER THAN THIRTY DAYS AFTER THE DATE OF THE NOTICE.

(5) IF A MEDICAL CREDITOR COLLECTING ON A DEBT FOR HEALTH-CARE SERVICES PROVIDED BY A HEALTH-CARE PROVIDER BILLS OR INITIATES COLLECTION ACTIVITIES AND IT IS LATER DETERMINED THAT THE PATIENT SHOULD HAVE BEEN SCREENED FOR DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503 AND IS DETERMINED TO BE A QUALIFIED PATIENT, AS DEFINED IN SECTION 25.5-3-501 (5), THE MEDICAL CREDITOR SHALL REVERSE ANY COLLECTION ACTIONS, INCLUDING:

(a) DELETING ANY NEGATIVE REPORTS TO CONSUMER REPORTING AGENCIES;

(b) DISMISSING ANY COLLECTION LAWSUITS OVER THE MEDICAL DEBT AND VACATING ANY JUDGMENT ENTERED THEREIN;

(c) REMOVING ANY WAGE GARNISHMENT ORDERS. IF THE PATIENT HAS PAID ANY PART OF THE MEDICAL DEBT OR ANY OF THE PATIENT'S MONEY HAS BEEN SEIZED OR LEVIED IN EXCESS OF THE AMOUNT THAT THE PATIENT OWES AFTER APPLICATION OF FINANCIAL ASSISTANCE, THE MEDICAL CREDITOR SHALL REFUND ANY EXCESS AMOUNT TO THE PATIENT; AND

(d) ANY OTHER PERMISSIBLE EXTRAORDINARY COLLECTION ACTION.

(6) A MEDICAL CREDITOR COLLECTING ON A DEBT FOR HEALTH-CARE SERVICES PROVIDED BY A HEALTH-CARE PROVIDER SHALL NOT SELL A MEDICAL DEBT TO ANOTHER PARTY UNLESS, PRIOR TO THE SALE, THE MEDICAL CREDITOR HAS ENTERED INTO A LEGALLY BINDING

WRITTEN AGREEMENT WITH THE MEDICAL DEBT BUYER OF THE DEBT PURSUANT TO WHICH:

(a) THE MEDICAL DEBT BUYER OR COLLECTOR AGREES NOT TO PURSUE IMPERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS TO OBTAIN PAYMENT FOR THE CARE;

(b) THE MEDICAL DEBT BUYER IS PROHIBITED FROM CHARGING INTEREST ON THE DEBT IN EXCESS OF THAT DESCRIBED IN SECTION 5-12-101;

(c) THE DEBT IS RETURNABLE TO OR RECALLABLE BY THE MEDICAL CREDITOR UPON A DETERMINATION BY THE MEDICAL CREDITOR OR MEDICAL DEBT BUYER THAT THE PATIENT IS ELIGIBLE FOR DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503; AND

(d) IF THE PATIENT IS DETERMINED TO BE ELIGIBLE FOR DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503 AND THE DEBT IS NOT RETURNED TO OR RECALLED BY THE MEDICAL CREDITOR, THE MEDICAL DEBT BUYER SHALL ADHERE TO PROCEDURES THAT MUST BE SPECIFIED IN THE AGREEMENT THAT ENSURES THE PATIENT WILL NOT PAY, AND HAS NO OBLIGATION TO PAY, THE MEDICAL DEBT BUYER AND THE MEDICAL CREDITOR TOGETHER MORE THAN THE PATIENT IS PERSONALLY RESPONSIBLE FOR PAYING.

(7) NOTHING IN THIS SECTION LIMITS OR AFFECTS A HEALTH-CARE PROVIDER'S RIGHT TO PURSUE THE COLLECTION OF PERSONAL INJURY, LIABILITY, UNINSURED, UNDERINSURED, MEDICAL PAYMENT REHABILITATION, DISABILITY, HOMEOWNER'S, BUSINESS OWNER'S, WORKER'S COMPENSATION, OR FAULT-BASED INSURANCE.

SECTION 5. In Colorado Revised Statutes, 25-49-105, **amend** (1) as follows:

25-49-105. No review of health-care prices - no punishment for exercising rights - no impairment of contracts. (1) Nothing in this article 49 requires a health-care facility or health-care provider to report its health-care prices to any agency for review, filing, or other purposes, ~~except as required by section 25-3-112,~~ or for applications for health-care professional loan repayment submitted pursuant to section 25-1.5-503. This article 49 does not grant any agency the authority to approve, disapprove, or limit a health-care facility's or health-care provider's health-care prices or changes to its health-care prices. The department of public health and environment is not authorized to take any action regarding or pursuant to this article 49.

SECTION 6. In Colorado Revised Statutes, 25.5-3-104, **add** (3) as follows:

25.5-3-104. Program for the medically indigent established - eligibility - rules. (3) FOR PROVIDERS DEFINED AS HOSPITAL PROVIDERS IN 10 CCR 2505-10, SEC. 8.901.J, THE STATE DEPARTMENT SHALL PROMULGATE RULES:

(a) PROHIBITING HOSPITALS FROM CONSIDERING ASSETS WHEN DETERMINING WHETHER A PATIENT MEETS THE SPECIFIED PERCENTAGE OF THE FEDERAL POVERTY LINE REQUIRED IN SUBSECTION (2) OF THIS SECTION; AND

(b) ENSURING THE METHOD USED TO DETERMINE WHETHER A PATIENT MEETS THE SPECIFIED PERCENTAGE OF THE FEDERAL POVERTY LINE IS UNIFORM ACROSS HOSPITALS AND ALIGNED WITH THE METHOD FOR COUNTING INCOME FOR THE PURPOSES OF DETERMINING ELIGIBILITY FOR DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-503.

SECTION 7. In Colorado Revised Statutes, **repeal** 25-3-112.

SECTION 8. Act subject to petition - effective date. 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; 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 2022 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.