

**First Regular Session
Seventy-second General Assembly
STATE OF COLORADO**

INTRODUCED

LLS NO. 19-0709.01 Kristen Forrestal x4217

HOUSE BILL 19-1174

HOUSE SPONSORSHIP

Esgar and Catlin,

SENATE SPONSORSHIP

Gardner and Pettersen,

House Committees
Health & Insurance

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING OUT-OF-NETWORK HEALTH CARE SERVICES PROVIDED**
102 **TO COVERED PERSONS.**

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:

- ! Requires health insurance carriers, health care providers, and health care facilities to provide patients covered by health benefit plans with information concerning the provision of services by out-of-network providers and in-network and out-of-network facilities;

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

- ! Outlines the disclosure requirements and the claims and payment process for the provision of out-of-network services;
- ! Requires the commissioner of insurance, the state board of health, and the director of the division of professions and occupations in the department of regulatory agencies to promulgate rules that specify the requirements for disclosures to consumers, including the timing, the format, and the contents and language in the disclosures;
- ! Establishes the reimbursement amount for out-of-network providers that provide health care services to covered persons at an in-network facility and for out-of-network providers or facilities that provide emergency services to covered persons; and
- ! Creates a penalty for failure to comply with the payment requirements for out-of-network health care services.

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

2 **SECTION 1.** In Colorado Revised Statutes, 6-1-105, **add** (1)(III)
3 as follows:

4 **6-1-105. Deceptive trade practices.** (1) A person engages in a
5 deceptive trade practice, when, in the course of the person's business,
6 vocation, or occupation, the person:

7 (III) VIOLATES SECTION 24-34-114.

8 **SECTION 2.** In Colorado Revised Statutes, 10-3-1104, **add**
9 (1)(ss) as follows:

10 **10-3-1104. Unfair methods of competition - unfair or deceptive**
11 **practices.** (1) The following are defined as unfair methods of
12 competition and unfair or deceptive acts or practices in the business of
13 insurance:

14 (ss) A VIOLATION OF SECTION 10-16-704 (3)(d).

15 **SECTION 3.** In Colorado Revised Statutes, 10-16-704, **amend**
16 (3)(a)(III), (5.5)(a) introductory portion, (5.5)(a)(V), and (5.5)(b); and

1 **add** (3)(d), (5.5)(c), (5.5)(d), and (12) as follows:

2 **10-16-704. Network adequacy - rules - legislative declaration**

3 **- definitions.** (3) (a) (III) The general assembly finds, determines, and
4 declares that the division ~~of insurance~~ has correctly interpreted the
5 ~~provisions of this section to protect the insured~~ A COVERED PERSON from
6 the additional expense charged by ~~an assisting~~ A provider who is an
7 out-of-network provider, and has properly required ~~insurers~~ CARRIERS to
8 hold the ~~consumer~~ COVERED PERSON harmless. The division ~~of insurance~~
9 does not have regulatory authority over all health plans. Some consumers
10 are enrolled in self-funded health insurance programs that are governed
11 under the federal "Employee Retirement Income Security Act OF 1974",
12 29 U.S.C. SEC. 1001 ET SEQ. Therefore, ~~the general assembly encourages~~
13 health care facilities, carriers, and providers ~~to~~ MUST provide consumers
14 ~~disclosure~~ WITH DISCLOSURES about the potential impact of receiving
15 services from an out-of-network provider OR HEALTH CARE FACILITY AND
16 THEIR RIGHTS UNDER THIS SECTION. COVERED PERSONS MUST HAVE
17 ACCESS TO ACCURATE INFORMATION ABOUT THEIR HEALTH CARE BILLS
18 AND THEIR PAYMENT OBLIGATIONS IN ORDER TO ENABLE THEM TO MAKE
19 INFORMED DECISIONS ABOUT THEIR HEALTH CARE AND FINANCIAL
20 OBLIGATIONS.

21 (d) (I) IF A COVERED PERSON RECEIVES SERVICES AT AN
22 IN-NETWORK FACILITY FROM AN OUT-OF-NETWORK PROVIDER, THE
23 CARRIER SHALL PAY THE OUT-OF-NETWORK PROVIDER DIRECTLY AND IN
24 ACCORDANCE WITH THIS SUBSECTION (3)(d). AT THE TIME OF THE
25 DISPOSITION OF THE CLAIM, THE CARRIER SHALL ADVISE THE
26 OUT-OF-NETWORK PROVIDER AND THE COVERED PERSON OF ANY
27 REQUIRED COINSURANCE, DEDUCTIBLE, OR COPAYMENT.

1 (II) WHEN THE REQUIREMENTS OF SUBSECTION (3)(b) OF THIS
2 SECTION APPLY, THE CARRIER SHALL REIMBURSE THE OUT-OF-NETWORK
3 PROVIDER DIRECTLY IN ACCORDANCE WITH SECTION 10-16-106.5 THE
4 GREATER OF:

5 (A) THE CARRIER'S AVERAGE IN-NETWORK RATE OF
6 REIMBURSEMENT FOR THAT SERVICE IN THE SAME GEOGRAPHIC AREA;

7 (B) ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE
8 REIMBURSEMENT RATE FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC
9 AREA; OR

10 (C) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF
11 REIMBURSEMENT FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA
12 FOR THE PRIOR YEAR AS DETERMINED BASED ON CLAIMS DATA FROM THE
13 ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

14 (III) PAYMENT MADE BY A CARRIER IN COMPLIANCE WITH THIS
15 SUBSECTION (3)(d) IS PRESUMED TO BE PAYMENT IN FULL FOR THE
16 SERVICES PROVIDED, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR
17 COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.

18 (IV) THIS SUBSECTION (3)(d) DOES NOT PRECLUDE THE CARRIER
19 AND THE OUT-OF-NETWORK PROVIDER FROM VOLUNTARILY NEGOTIATING
20 AN INDEPENDENT REIMBURSEMENT RATE. IF THE NEGOTIATIONS FAIL, THE
21 REIMBURSEMENT RATE REQUIRED BY SUBSECTION (3)(d)(II) OF THIS
22 SECTION APPLIES.

23 (V) FOR PURPOSES OF THIS SUBSECTION (3):

24 (A) "GEOGRAPHIC AREA" MEANS A SPECIFIC AREA IN THIS STATE
25 AS ESTABLISHED BY THE COMMISSIONER BY RULE.

26 (B) "MEDICARE REIMBURSEMENT RATE" MEANS THE
27 REIMBURSEMENT RATE FOR A PARTICULAR HEALTH CARE SERVICE

1 PROVIDED UNDER THE "HEALTH INSURANCE FOR THE AGED ACT", TITLE
2 XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, 42 U.S.C.
3 SEC. 1395 ET SEQ.

4 (5.5) (a) Notwithstanding any provision of law, a carrier that
5 provides any benefits with respect to EMERGENCY services ~~in an~~
6 ~~emergency department of a hospital~~ shall cover THE emergency services:

7 (V) AT THE IN-NETWORK BENEFIT LEVEL, with the same
8 ~~cost-sharing~~ COINSURANCE, DEDUCTIBLE, OR COPAYMENT requirements
9 as would apply if THE emergency services were provided BY AN
10 in-network PROVIDER OR FACILITY, AND AT NO GREATER COST TO THE
11 COVERED PERSON THAN IF THE EMERGENCY SERVICES WERE OBTAINED AT
12 OR FROM AN IN-NETWORK PROVIDER AT AN IN-NETWORK FACILITY.

13 (b) ~~For purposes of this subsection (5.5):~~

14 (I) ~~"Emergency medical condition" means a medical condition that~~
15 ~~manifests itself by acute symptoms of sufficient severity, including severe~~
16 ~~pain, that a prudent layperson with an average knowledge of health and~~
17 ~~medicine could reasonably expect, in the absence of immediate medical~~
18 ~~attention, to result in:~~

19 (A) ~~Placing the health of the individual or, with respect to a~~
20 ~~pregnant woman, the health of the woman or her unborn child, in serious~~
21 ~~jeopardy;~~

22 (B) ~~Serious impairment to bodily functions; or~~

23 (C) ~~Serious dysfunction of any bodily organ or part.~~

24 (H) ~~"Emergency services", with respect to an emergency medical~~
25 ~~condition, means:~~

26 (A) ~~A medical screening examination that is within the capability~~
27 ~~of the emergency department of a hospital, including ancillary services~~

1 ~~routinely available to the emergency department to evaluate the~~
2 ~~emergency medical condition; and~~

3 ~~(B) Within the capabilities of the staff and facilities available at~~
4 ~~the hospital, further medical examination and treatment as required to~~
5 ~~stabilize the patient to assure, within reasonable medical probability, that~~
6 ~~no material deterioration of the condition is likely to result from or occur~~
7 ~~during the transfer of the individual from a facility, or with respect to an~~
8 ~~emergency medical condition.~~

9 (b) (I) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT
10 AN OUT-OF-NETWORK FACILITY, THE CARRIER SHALL REIMBURSE THE
11 OUT-OF-NETWORK FACILITY DIRECTLY IN ACCORDANCE WITH SECTION
12 10-16-106.5 THE GREATER OF:

13 (A) THE CARRIER'S AVERAGE IN-NETWORK RATE OF
14 REIMBURSEMENT FOR THAT SERVICE PROVIDED IN A SIMILAR FACILITY OR
15 SETTING IN THE SAME GEOGRAPHIC AREA;

16 (B) ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE
17 REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR
18 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR

19 (C) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF
20 REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY
21 OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR AS
22 DETERMINED BASED ON CLAIMS DATA FROM THE COLORADO ALL-PAYER
23 HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

24 (II) PAYMENT MADE BY A CARRIER IN COMPLIANCE WITH THIS
25 SUBSECTION (5.5)(b) IS PRESUMED TO BE PAYMENT IN FULL FOR THE
26 SERVICES PROVIDED, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR
27 COPAYMENT REQUIRED TO BE PAID BY THE COVERED PERSON.

1 (c) THIS SUBSECTION (5.5) DOES NOT PRECLUDE THE CARRIER AND
2 THE OUT-OF-NETWORK FACILITY FROM VOLUNTARILY NEGOTIATING AN
3 INDEPENDENT REIMBURSEMENT RATE. IF THE NEGOTIATIONS FAIL, THE
4 REIMBURSEMENT RATE REQUIRED BY SUBSECTION (5.5)(b) OF THIS
5 SECTION APPLIES.

6 (d) FOR PURPOSES OF THIS SUBSECTION (5.5):

7 (I) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL
8 CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT
9 SEVERITY, INCLUDING SEVERE PAIN, THAT A PRUDENT LAYPERSON WITH AN
10 AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY
11 EXPECT, IN THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION, TO RESULT
12 IN:

13 (A) SERIOUS JEOPARDY TO THE HEALTH OF THE INDIVIDUAL OR,
14 WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR
15 HER UNBORN CHILD;

16 (B) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

17 (C) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

18 (II) "EMERGENCY SERVICES", WITH RESPECT TO AN EMERGENCY
19 MEDICAL CONDITION, MEANS:

20 (A) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE
21 CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING
22 ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY
23 DEPARTMENT TO EVALUATE THE EMERGENCY MEDICAL CONDITION; AND

24 (B) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES
25 AVAILABLE AT THE HOSPITAL, FURTHER MEDICAL EXAMINATION AND
26 TREATMENT AS REQUIRED TO STABILIZE THE PATIENT TO ASSURE, WITHIN
27 REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION

1 OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE
2 TRANSFER OF THE INDIVIDUAL FROM A FACILITY.

3 (III) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
4 SUBSECTION (3)(d)(V)(A) OF THIS SECTION.

5 (IV) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING
6 AS DEFINED IN SUBSECTION (3)(d)(V)(B) OF THIS SECTION.

7 (12) (a) ON AND AFTER JANUARY 1, 2020, CARRIERS SHALL
8 DEVELOP AND PROVIDE DISCLOSURES TO COVERED PERSONS ABOUT THE
9 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
10 SERVICES FROM AN OUT-OF-NETWORK PROVIDER OR AT AN
11 OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE
12 RULES ADOPTED UNDER SUBSECTION (12)(b) OF THIS SECTION.

13 (b) THE COMMISSIONER, IN CONSULTATION WITH THE STATE
14 BOARD OF HEALTH CREATED IN SECTION 25-1-103 AND THE DIRECTOR OF
15 THE DIVISION OF PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF
16 REGULATORY AGENCIES, SHALL ADOPT RULES TO SPECIFY THE DISCLOSURE
17 REQUIREMENTS UNDER THIS SUBSECTION (12), WHICH RULES MUST
18 SPECIFY, AT A MINIMUM, THE FOLLOWING:

19 (I) THE TIMING FOR PROVIDING THE DISCLOSURES FOR EMERGENCY
20 AND NONEMERGENCY SERVICES WITH CONSIDERATION GIVEN TO
21 POTENTIAL LIMITATIONS RELATING TO THE FEDERAL "EMERGENCY
22 MEDICAL TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd;

23 (II) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
24 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
25 BILLING STATEMENTS, BILLING NOTICES, PRIOR AUTHORIZATIONS, OR
26 OTHER FORMS OR COMMUNICATIONS WITH COVERED PERSONS;

27 (III) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE

1 COVERED PERSON'S RIGHTS AND PAYMENT OBLIGATIONS IF THE COVERED
2 PERSON'S HEALTH BENEFIT PLAN IS UNDER THE JURISDICTION OF THE
3 DIVISION;

4 (IV) DISCLOSURE REQUIREMENTS SPECIFIC TO CARRIERS,
5 INCLUDING THE POSSIBILITY OF BEING TREATED BY AN OUT-OF-NETWORK
6 PROVIDER, WHETHER A PROVIDER IS OUT OF NETWORK, THE TYPES OF
7 SERVICES AN OUT-OF-NETWORK PROVIDER MAY PROVIDE, AND THE RIGHT
8 TO REQUEST AN IN-NETWORK PROVIDER TO PROVIDE SERVICES; AND

9 (V) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN
10 THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT
11 CARRIERS, HEALTH CARE FACILITIES, AND PROVIDERS USE LANGUAGE THAT
12 IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY THIS SUBSECTION
13 (12) AND SECTIONS 24-34-113 (2) AND 25-3-120 AND THE RULES ADOPTED
14 PURSUANT TO THIS SUBSECTION (12)(b) AND SECTIONS 24-34-113 (3) AND
15 25-3-120 (2).

16 (c) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SUBSECTION
17 (12) DOES NOT WAIVE A COVERED PERSON'S PROTECTIONS UNDER
18 SUBSECTION (3) OR (5.5) OF THIS SECTION OR THE RIGHT TO BENEFITS
19 UNDER THE HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL
20 FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.

21 **SECTION 4.** In Colorado Revised Statutes, **add** 24-34-113 and
22 24-34-114 as follows:

23 **24-34-113. Health care providers - required disclosures - rules**
24 **- definitions.** (1) FOR THE PURPOSES OF THIS SECTION AND SECTION
25 24-34-114:

26 (a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION
27 10-16-102 (8).

1 (b) "COVERED PERSON" HAS THE SAME MEANING AS DEFINED IN
2 SECTION 10-16-102 (15).

3 (c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED
4 IN SECTION 10-16-704 (5.5)(d)(II).

5 (d) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
6 SECTION 10-16-704 (3)(d)(V)(A).

7 (e) "HEALTH BENEFIT PLAN" HAS THE SAME MEANING AS DEFINED
8 IN SECTION 10-16-102 (32).

9 (f) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING
10 AS DEFINED IN SECTION 10-16-704 (3)(d)(V)(B).

11 (g) "OUT-OF-NETWORK PROVIDER" MEANS A HEALTH CARE
12 PROVIDER THAT IS NOT A PARTICIPATING PROVIDER, AS DEFINED IN
13 SECTION 10-16-102 (46).

14 (2) ON AND AFTER JANUARY 1, 2020, HEALTH CARE PROVIDERS
15 SHALL DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE
16 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
17 SERVICES FROM AN OUT-OF-NETWORK PROVIDER. THE DISCLOSURES MUST
18 COMPLY WITH THE RULES ADOPTED PURSUANT TO SUBSECTION (3) OF THIS
19 SECTION.

20 (3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF
21 INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION
22 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR
23 HEALTH CARE PROVIDERS REGULATED UNDER TITLE 12 TO DEVELOP AND
24 PROVIDE CONSUMER DISCLOSURES IN ACCORDANCE WITH THIS SECTION.
25 THE DIRECTOR SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH
26 SECTION 10-16-704 (12) AND 25-3-120 AND RULES ADOPTED BY THE
27 COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE

1 STATE BOARD OF HEALTH PURSUANT TO SECTION 25-3-120(2). THE RULES
2 MUST SPECIFY, AT A MINIMUM, THE FOLLOWING:

3 (a) THE TIMING FOR PROVIDING THE DISCLOSURES FOR EMERGENCY
4 AND NONEMERGENCY SERVICES WITH CONSIDERATION GIVEN TO
5 POTENTIAL LIMITATIONS RELATING TO THE FEDERAL "EMERGENCY
6 MEDICAL TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd;

7 (b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
8 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
9 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR
10 COMMUNICATIONS WITH CONSUMERS;

11 (c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
12 CONSUMER'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE
13 CONSUMER'S HEALTH BENEFIT PLAN;

14 (d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE
15 PROVIDERS, INCLUDING WHETHER A PROVIDER IS OUT OF NETWORK, THE
16 TYPES OF SERVICES AN OUT-OF-NETWORK PROVIDER MAY PROVIDE, AND
17 THE RIGHT TO REQUEST AN IN-NETWORK PROVIDER TO PROVIDE SERVICES;
18 AND

19 (e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN
20 THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT
21 CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE
22 LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY
23 THIS SECTION AND SECTIONS 10-16-704(12) AND 25-3-120 AND THE RULES
24 ADOPTED PURSUANT TO THIS SUBSECTION (3) AND SECTIONS 10-16-704
25 (12)(b) AND 25-3-120 (2).

26 (4) RECEIPT OF THE DISCLOSURES REQUIRED BY SUBSECTION (2) OF
27 THIS SECTION DOES NOT WAIVE A CONSUMER'S PROTECTIONS UNDER

1 SECTION 10-16-704 (3) OR (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS
2 UNDER THE CONSUMER'S HEALTH BENEFIT PLAN AT THE IN-NETWORK
3 BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.

4 **24-34-114. Out-of-network health care providers -**
5 **out-of-network services - billing - payment.** (1) IF AN
6 OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES EMERGENCY
7 SERVICES OR COVERED NONEMERGENCY SERVICES TO A COVERED PERSON
8 AT AN IN-NETWORK FACILITY, THE OUT-OF-NETWORK PROVIDER SHALL:

9 (a) SUBMIT A CLAIM FOR THE ENTIRE COST OF THE SERVICES TO
10 THE COVERED PERSON'S CARRIER; AND

11 (b) NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR
12 ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE
13 CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,
14 DEDUCTIBLE, OR COPAYMENT REQUIRED TO BE PAID BY THE COVERED
15 PERSON.

16 (2)(a) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES
17 NONEMERGENCY SERVICES AT AN IN-NETWORK FACILITY OR EMERGENCY
18 SERVICES AT AN OUT-OF-NETWORK OR IN-NETWORK FACILITY AND THE
19 HEALTH CARE PROVIDER RECEIVES PAYMENT FROM THE COVERED PERSON
20 FOR SERVICES FOR WHICH THE COVERED PERSON IS NOT RESPONSIBLE
21 PURSUANT TO SECTION 10-16-704 (3)(b) OR (5.5), THE HEALTH CARE
22 PROVIDER SHALL REIMBURSE THE COVERED PERSON WITHIN SIXTY
23 CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS
24 REPORTED TO THE PROVIDER.

25 (b) AN OUT-OF-NETWORK HEALTH CARE PROVIDER THAT FAILS TO
26 REIMBURSE A COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF
27 THIS SECTION FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE

1 OVERPAYMENT AT THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON
2 THE DATE THE PROVIDER RECEIVED THE NOTICE OF THE OVERPAYMENT.
3 THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED
4 INTEREST FROM THE OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER
5 TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.

6 (3) AN OUT-OF-NETWORK HEALTH CARE PROVIDER SHALL PROVIDE
7 A COVERED PERSON A WRITTEN ESTIMATE OF THE AMOUNT FOR WHICH THE
8 COVERED PERSON MAY BE RESPONSIBLE FOR NONEMERGENCY SERVICES
9 WITHIN THREE BUSINESS DAYS AFTER A REQUEST FROM THE COVERED
10 PERSON.

11 (4) (a) AN OUT-OF-NETWORK HEALTH CARE PROVIDER MUST SEND
12 A CLAIM FOR A COVERED SERVICE TO THE CARRIER WITHIN ONE HUNDRED
13 EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO RECEIVE
14 REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (4)(a). THE
15 REIMBURSEMENT RATE IS THE GREATER OF:

16 (I) THE CARRIER'S AVERAGE IN-NETWORK RATE OF
17 REIMBURSEMENT FOR THAT SERVICE PROVIDED IN THE SAME GEOGRAPHIC
18 AREA;

19 (II) ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE
20 REIMBURSEMENT RATE FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC
21 AREA; OR

22 (III) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE
23 OF REIMBURSEMENT FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC
24 AREA FOR THE PRIOR YEAR AS DETERMINED BASED ON CLAIMS DATA FROM
25 THE ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION
26 25.5-1-204.

27 (b) IF THE OUT-OF-NETWORK HEALTH CARE PROVIDER SUBMITS A

1 CLAIM FOR SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY PERIOD
2 SPECIFIED IN SUBSECTION (4)(a) OF THIS SECTION, THE CARRIER SHALL
3 REIMBURSE THE HEALTH CARE PROVIDER ONE HUNDRED TWENTY-FIVE
4 PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME
5 SERVICES IN THE SAME GEOGRAPHIC AREA.

6 (c) THE HEALTH CARE PROVIDER SHALL NOT BILL A COVERED
7 PERSON ANY OUTSTANDING BALANCE FOR A COVERED SERVICE NOT PAID
8 FOR BY THE CARRIER, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR
9 COPAYMENT REQUIRED TO BE PAID BY THE COVERED PERSON.

10 **SECTION 5.** In Colorado Revised Statutes, **add 25-3-120 and**
11 **25-3-121 as follows:**

12 **25-3-120. Health care facilities - emergency and**
13 **nonemergency services - required disclosures - rules - definitions.**

14 (1) ON AND AFTER JANUARY 1, 2020, HEALTH CARE FACILITIES SHALL
15 DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE
16 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
17 SERVICES FROM AN OUT-OF-NETWORK PROVIDER PROVIDING SERVICES AT
18 AN IN-NETWORK FACILITY OR EMERGENCY SERVICES AT AN
19 OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE
20 RULES ADOPTED UNDER SUBSECTION (2) OF THIS SECTION.

21 (2) THE STATE BOARD OF HEALTH, IN CONSULTATION WITH THE
22 COMMISSIONER OF INSURANCE AND THE DIRECTOR OF THE DIVISION OF
23 PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF REGULATORY
24 AGENCIES, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR
25 HEALTH CARE FACILITIES TO DEVELOP AND PROVIDE CONSUMER
26 DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE STATE BOARD OF
27 HEALTH SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTION

1 10-16-704 (12) AND 24-34-113 (2) AND RULES ADOPTED BY THE
2 COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE
3 DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS PURSUANT
4 TO SECTION 24-34-113 (3). THE RULES MUST SPECIFY, AT A MINIMUM, THE
5 FOLLOWING:

6 (a) THE TIMING FOR PROVIDING THE DISCLOSURES FOR EMERGENCY
7 AND NONEMERGENCY SERVICES WITH CONSIDERATION GIVEN TO
8 POTENTIAL LIMITATIONS RELATING TO THE "EMERGENCY MEDICAL
9 TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd;

10 (b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
11 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
12 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR
13 COMMUNICATIONS WITH COVERED PERSONS;

14 (c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
15 CONSUMER'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE
16 CONSUMER'S HEALTH BENEFIT PLAN;

17 (d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE
18 FACILITIES, WHETHER A HEALTH CARE PROVIDER DELIVERING SERVICES AT
19 THE FACILITY IS OUT OF NETWORK, THE TYPES OF SERVICES AN
20 OUT-OF-NETWORK HEALTH CARE PROVIDER MAY PROVIDE, AND THE RIGHT
21 TO REQUEST AN IN-NETWORK HEALTH CARE PROVIDER TO PROVIDE
22 SERVICES; AND

23 (e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN
24 THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT
25 CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE
26 LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY
27 THIS SECTION AND SECTIONS 10-16-704 (12) AND 24-34-113 (2) AND THE

1 RULES ADOPTED PURSUANT TO THIS SUBSECTION (2) AND SECTIONS
2 10-16-704 (12) AND 24-34-113 (3).

3 (3) RECEIPT OF THE DISCLOSURE REQUIRED BY SUBSECTION (1) OF
4 THIS SECTION DOES NOT WAIVE A CONSUMER'S PROTECTIONS UNDER
5 SECTION 10-16-704 (3) OR (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS
6 UNDER THE CONSUMER'S HEALTH BENEFIT PLAN AT THE IN-NETWORK
7 BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.

8 (4) FOR THE PURPOSES OF THIS SECTION AND SECTION 25-3-121:

9 (a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION
10 10-16-102 (8).

11 (b) "COVERED PERSON" HAS THE SAME MEANING AS DEFINED IN
12 SECTION 10-16-102 (15).

13 (c) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
14 SECTION 10-16-704 (3)(d)(V)(A).

15 (d) "HEALTH BENEFIT PLAN" HAS THE SAME MEANING AS DEFINED
16 IN SECTION 10-16-102 (32).

17 (e) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING
18 AS DEFINED IN SECTION 10-16-704 (3)(d)(V)(B).

19 (f) "OUT-OF-NETWORK FACILITY" MEANS A HEALTH CARE FACILITY
20 THAT IS NOT A PARTICIPATING PROVIDER, AS DEFINED IN SECTION
21 10-16-102 (46).

22 **25-3-121. Out-of-network facilities - emergency medical**
23 **services - billing - payment.** (1) IF A COVERED PERSON RECEIVES
24 EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE
25 OUT-OF-NETWORK FACILITY SHALL:

26 (a) SUBMIT A CLAIM FOR THE ENTIRE COST OF THE SERVICES TO
27 THE COVERED PERSON'S CARRIER; AND

1 (b) NOT BILL OR COLLECT PAYMENT FROM THE COVERED PERSON
2 FOR ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY
3 THE CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,
4 DEDUCTIBLE, OR COPAYMENT REQUIRED TO BE PAID BY THE COVERED
5 PERSON.

6 (2) (a) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT
7 AN OUT-OF-NETWORK FACILITY, AND THE FACILITY RECEIVES PAYMENT
8 FROM THE COVERED PERSON FOR SERVICES FOR WHICH THE COVERED
9 PERSON IS NOT RESPONSIBLE PURSUANT TO SECTION 10-16-704 (5.5), THE
10 FACILITY SHALL REIMBURSE THE COVERED PERSON WITHIN SIXTY
11 CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS
12 REPORTED TO THE FACILITY.

13 (b) AN OUT-OF-NETWORK FACILITY THAT FAILS TO REIMBURSE A
14 COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF THIS SECTION
15 FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE OVERPAYMENT AT
16 THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON THE DATE THE
17 FACILITY RECEIVED THE NOTICE OF THE OVERPAYMENT. THE COVERED
18 PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED INTEREST FROM THE
19 OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER TO RECEIVE
20 INTEREST WITH THE REIMBURSEMENT AMOUNT.

21 (3) (a) AN OUT-OF-NETWORK FACILITY MUST SEND A CLAIM FOR
22 EMERGENCY SERVICES TO THE CARRIER WITHIN ONE HUNDRED EIGHTY
23 DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO RECEIVE
24 REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (3)(a). THE
25 REIMBURSEMENT RATE IS THE GREATER OF:

26 (I) THE CARRIER'S AVERAGE IN-NETWORK RATE OF
27 REIMBURSEMENT FOR THAT SERVICE PROVIDED IN A SIMILAR FACILITY OR

1 SETTING IN THE SAME GEOGRAPHIC AREA;

2 (II) ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE
3 REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR
4 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR

5 (III) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE
6 OF REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR
7 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR
8 YEAR AS DETERMINED BASED ON CLAIMS DATA FROM THE ALL-PAYER
9 HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

10 (b) IF THE OUT-OF-NETWORK FACILITY SUBMITS A CLAIM FOR
11 EMERGENCY SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY PERIOD
12 SPECIFIED IN SUBSECTION (3)(a) OF THIS SECTION, THE CARRIER SHALL
13 REIMBURSE THE FACILITY ONE HUNDRED TWENTY-FIVE PERCENT OF THE
14 MEDICARE REIMBURSEMENT RATE FOR THE SAME SERVICES IN A SIMILAR
15 SETTING OR FACILITY IN THE SAME GEOGRAPHIC AREA.

16 (c) THE OUT-OF-NETWORK FACILITY SHALL NOT BILL A COVERED
17 PERSON ANY OUTSTANDING BALANCE FOR A COVERED SERVICE NOT PAID
18 FOR BY THE CARRIER, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR
19 COPAYMENT REQUIRED TO BE PAID BY THE COVERED PERSON.

20 **SECTION 6.** In Colorado Revised Statutes, 25-1-114, **add** (1)(j)
21 as follows:

22 **25-1-114. Unlawful acts - penalties.** (1) It is unlawful for any
23 person, association, or corporation, and the officers thereof:

24 (j) TO VIOLATE SECTION 25-3-121.

25 **SECTION 7. Act subject to petition - effective date.** This act
26 takes effect at 12:01 a.m. on the day following the expiration of the
27 ninety-day period after final adjournment of the general assembly (August

1 2, 2019, if adjournment sine die is on May 3, 2019); except that, if a
2 referendum petition is filed pursuant to section 1 (3) of article V of the
3 state constitution against this act or an item, section, or part of this act
4 within such period, then the act, item, section, or part will not take effect
5 unless approved by the people at the general election to be held in
6 November 2020 and, in such case, will take effect on the date of the
7 official declaration of the vote thereon by the governor.