

Second Regular Session  
Seventy-third General Assembly  
STATE OF COLORADO

**REREVISED**

*This Version Includes All Amendments  
Adopted in the Second House*

LLS NO. 22-0503.01 Kristen Forrestal x4217

**HOUSE BILL 22-1284**

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**House Committees**

Health & Insurance  
Appropriations

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**A BILL FOR AN ACT**

101 **CONCERNING UPDATES TO STATE SURPRISE BILLING LAWS TO**  
102 **FACILITATE THE IMPLEMENTATION OF SURPRISE BILLING**  
103 **PROTECTIONS, AND, IN CONNECTION THEREWITH, ALIGNING**  
104 **STATE LAW WITH THE FEDERAL "NO SURPRISES ACT" AND**  
105 **MAKING AN APPROPRIATION.**

**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 changes current state law to align with the federal "No Surprises Act" (act) by:

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.*

SENATE  
3rd Reading Unamended  
May 4, 2022

SENATE  
Amended 2nd Reading  
May 3, 2022

HOUSE  
3rd Reading Unamended  
April 25, 2022

HOUSE  
Amended 2nd Reading  
April 22, 2022

- Allowing a covered person who requests an independent external review of a health-care coverage decision to request a review to determine if the services that were provided or may be provided by an out-of-network provider or facility are subject to an in-network benefit level of coverage;
- Requiring that payments made for health-care services provided at an in-network facility or by an out-of-network provider be applied to the covered person's in-network deductible and any out-of-pocket maximum amounts as if the services were provided by an in-network provider;
- Requiring that emergency health-care services, regardless of the facility at which they are provided, be covered at the in-network benefit level;
- Requiring each health insurance carrier (carrier) to cover post-stabilization services to stabilize a patient after a medical emergency at the in-network benefit level unless specific criteria are met;
- Requiring carriers to develop disclosures to provide to covered persons that comply with the act;
- Requiring the commissioner of insurance (commissioner) and certain regulators of health-care occupations to adopt rules concerning disclosure requirements, including a list of ancillary services for which a provider or facility cannot charge a balance bill;
- Requiring the commissioner to convene a work group to facilitate and streamline the implementation of the payment of claims for services provided by an out-of-network provider at an in-network facility and for services surrounding a medical emergency;
- Prohibiting a carrier from recalculating a covered person's cost-sharing amount based on an additional payment made as a result of arbitration;
- Requiring the parties to an arbitration over health-care coverage to split the costs of the arbitrator if the parties reach an agreement before the final decision of the arbitrator;
- Allowing administrators of self-funded health benefit plans to elect to be subject to state law concerning coverage for health-care services from out-of-network providers and facilities;
- Authorizing the commissioner to promulgate rules to implement the requirements of the act;
- Changing the amount of time that a managed care plan must allow a person to continue to receive care from a

- provider from 60 to 90 days after the date an in-network provider is terminated from a plan without cause;
- Implementing specific requirements for health-care coverage and services for covered persons who are continuing care patients of a provider or facility whose contract with the patient's health insurer is terminated; and
- Allowing an out-of-network provider and an out-of-network facility to charge a covered person a balance bill for health-care services other than ancillary services if the out-of-network provider complies with specific notice requirements and obtains the covered person's signed consent.

The bill changes from January 1 to March 1 the date by which a carrier is required to submit information to the commissioner concerning the use of out-of-network providers and out-of-network facilities and the impact on health insurance premiums for consumers.

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

2 **SECTION 1.** In Colorado Revised Statutes, 10-16-113.5, **add**  
 3 (8.5) as follows:

4 **10-16-113.5. Independent external review of adverse**  
 5 **determinations - legislative declaration - definitions - rules.** (8.5) AN  
 6 INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW MAY  
 7 REQUEST THE REVIEW OR AN EXPEDITED REVIEW TO DETERMINE IF SECTION  
 8 10-16-704 (3) OR (5.5) APPLIES TO THE ITEMS OR SERVICES THAT WERE  
 9 PROVIDED OR MAY BE PROVIDED TO A COVERED PERSON BY AN  
 10 OUT-OF-NETWORK PROVIDER OR AT AN OUT-OF-NETWORK FACILITY.

11 **SECTION 2.** In Colorado Revised Statutes, 10-16-704, **amend**  
 12 (3)(b), (3)(d)(V), (5.5)(a)(V), (12)(a), (12)(b), (13), (14), (15)(d), and  
 13 (15)(e); **repeal** (2)(f), (3)(a)(IV), (3)(d)(VI), and (5.5)(e); and **add**  
 14 (5.5)(a.5), (17), (18), and (19) as follows:

15 **10-16-704. Network adequacy - required disclosures - balance**  
 16 **billing - rules - legislative declaration - definitions - repeal.** (2) (f) For

1 the purposes of this subsection (2):

2 (I) ~~"Balance bill" means the amount that a nonparticipating~~  
3 ~~provider may charge the covered person. Such amount charged equals the~~  
4 ~~difference between the amount paid by the carrier and the amount of the~~  
5 ~~nonparticipating provider's bill charge.~~

6 (II) ~~"Negotiated rate" means the rate mutually agreed upon~~  
7 ~~between the carrier and the provider in a specific instance.~~

8 (III) ~~"Usual, customary, and reasonable rate" means a rate~~  
9 ~~established pursuant to an appropriate methodology that is based on~~  
10 ~~generally accepted industry standards and practices.~~

11 (3) (a) (IV) ~~The general assembly finds, determines, and declares~~  
12 ~~that some consumers intentionally use out-of-network providers, which~~  
13 ~~is the consumers' prerogative under certain health benefit plans. When~~  
14 ~~consumers intentionally use an out-of-network provider, the consumer is~~  
15 ~~only entitled to benefits at the out-of-network rate and may be subject to~~  
16 ~~balance billing by the out-of-network provider.~~

17 (b) When a covered person receives services or treatment in  
18 accordance with plan provisions at ~~a network~~ AN IN-NETWORK facility, the  
19 benefit level for all covered services and treatment received through the  
20 facility shall be the in-network benefit. Covered services or treatment  
21 rendered at ~~a network~~ AN IN-NETWORK facility, including covered  
22 ancillary services or treatment rendered by an out-of-network provider  
23 performing the services or treatment at ~~a network~~ AN IN-NETWORK  
24 facility, shall be covered at no greater cost to the covered person than if  
25 the services or treatment were obtained from an in-network provider. A  
26 PAYMENT MADE BY A COVERED PERSON PURSUANT TO THIS SUBSECTION  
27 (3)(b) MUST BE APPLIED TO THE COVERED PERSON'S IN-NETWORK

1 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUM AMOUNTS AND IN THE SAME  
2 MANNER AS IF THE COST-SHARING PAYMENTS WERE MADE TO AN  
3 IN-NETWORK PROVIDER AT AN IN-NETWORK FACILITY.

4 (d) (V) This subsection (3)(d) does not apply when a covered  
5 person ~~voluntarily uses~~ HAS RECEIVED NOTICE AND GIVEN CONSENT AS  
6 REQUIRED BY SECTION 12-30-112 OR 25-3-121, AS APPLICABLE, TO USE an  
7 out-of-network provider IN COMPLIANCE WITH THE FEDERAL "NO  
8 SURPRISES ACT".

9 (VI) ~~For purposes of this subsection (3):~~

10 (A) ~~"Geographic area" means a specific area in this state as~~  
11 ~~established by the commissioner by rule.~~

12 (B) ~~"Medicare reimbursement rate" means the reimbursement rate~~  
13 ~~for a particular health-care service provided under the "Health Insurance~~  
14 ~~for the Aged Act", Title XVIII of the federal "Social Security Act", as~~  
15 ~~amended, 42 U.S.C. sec. 1395 et seq.~~

16 (5.5) (a) Notwithstanding any provision of law, a carrier that  
17 provides any benefits with respect to emergency services shall cover the  
18 emergency services:

19 (V) At the in-network benefit level, with the same coinsurance,  
20 deductible, or copayment requirements as would apply if the emergency  
21 services were provided by an in-network provider or AT AN IN-NETWORK  
22 facility, and at no greater cost to the covered person than if the emergency  
23 services were obtained from an in-network provider at an in-network  
24 facility. Any payment made by a covered person pursuant to this  
25 subsection (5.5)(a)(V) must be applied to the covered person's in-network  
26 ~~cost-sharing limit~~ DEDUCTIBLES AND IN-NETWORK OUT-OF-POCKET  
27 MAXIMUM AMOUNTS AND IN THE SAME MANNER AS IF THE COST-SHARING

1 PAYMENTS WERE MADE TO AN IN-NETWORK PROVIDER OR IN-NETWORK  
2 FACILITY.

3 (a.5) (I) A CARRIER SHALL:

4 (A) COVER POST-STABILIZATION SERVICES PROVIDED BY AN  
5 OUT-OF-NETWORK PROVIDER OR AT AN OUT-OF-NETWORK FACILITY AT NO  
6 GREATER COST TO THE COVERED PERSON THAN THE COST THAT WOULD  
7 APPLY, AND WITH THE SAME COINSURANCE, DEDUCTIBLE, OR COPAYMENT  
8 REQUIREMENTS AS THE REQUIREMENTS THAT WOULD APPLY, IF THE  
9 POST-STABILIZATION SERVICES WERE OBTAINED FROM AN IN-NETWORK  
10 PROVIDER OR AT AN IN-NETWORK FACILITY; AND

11 (B) REIMBURSE THE OUT-OF-NETWORK PROVIDER FOR  
12 POST-STABILIZATION SERVICES IN ACCORDANCE WITH SUBSECTION  
13 (3)(d)(II) OF THIS SECTION AND THE OUT-OF-NETWORK FACILITY IN  
14 ACCORDANCE WITH SUBSECTION (5.5)(b) OF THIS SECTION.

15 [REDACTED]

16 (II) ANY PAYMENT MADE BY A COVERED PERSON PURSUANT TO  
17 SUBSECTION (5.5)(a.5)(I) OF THIS SECTION MUST BE APPLIED TO THE  
18 COVERED PERSON'S IN-NETWORK DEDUCTIBLES AND IN-NETWORK  
19 OUT-OF-POCKET MAXIMUM AMOUNTS.

20 (e) For purposes of this subsection (5.5):

21 (f) ~~"Emergency medical condition" means a medical condition that~~  
22 ~~manifests itself by acute symptoms of sufficient severity, including severe~~  
23 ~~pain, that a prudent layperson with an average knowledge of health and~~  
24 ~~medicine could reasonably expect, in the absence of immediate medical~~  
25 ~~attention, to result in:~~

26 (A) ~~Serious jeopardy to the health of the individual or, with~~  
27 ~~respect to a pregnant woman, the health of the woman or her unborn~~

1 child;

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

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

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

6 ~~(A) A medical screening examination that is within the capability~~  
7 ~~of the emergency department of a hospital, including ancillary services~~  
8 ~~routinely available to the emergency department to evaluate the~~  
9 ~~emergency medical condition; and~~

10 ~~(B) Within the capabilities of the staff and facilities available at~~  
11 ~~the hospital, further medical examination and treatment as required to~~  
12 ~~stabilize the patient to assure, within reasonable medical probability, that~~  
13 ~~no material deterioration of the condition is likely to result from or occur~~  
14 ~~during the transfer of the individual from a facility.~~

15 ~~(H) "Geographic area" has the same meaning as defined in~~  
16 ~~subsection (3)(d)(VI)(A) of this section.~~

17 ~~(IV) "Medicare reimbursement rate" has the same meaning as~~  
18 ~~defined in subsection (3)(d)(VI)(B) of this section.~~

19 (12) (a) On and after January 1, 2020, carriers shall develop and  
20 provide disclosures to covered persons about the potential effects of  
21 receiving emergency or nonemergency services from an out-of-network  
22 provider or at an out-of-network facility. The disclosures must, AT A  
23 MINIMUM, comply with THE FEDERAL "NO SURPRISES ACT" AND the rules  
24 adopted under subsection (12)(b) of this section.

25 (b) The commissioner, in consultation with the state board of  
26 health created in section 25-1-103 and the ~~director of the division of~~  
27 ~~professions and occupations in the department of regulatory agencies~~

1 APPLICABLE REGULATORS OF HEALTH-CARE OCCUPATIONS AND  
2 PROFESSIONS, shall adopt rules to specify THE LIST OF THE ANCILLARY  
3 SERVICES FOR WHICH AN OUT-OF-NETWORK PROVIDER OR  
4 OUT-OF-NETWORK FACILITY MUST NOT BALANCE BILL A COVERED PERSON  
5 AND the disclosure requirements under this subsection 12. which rules  
6 must specify, at a minimum, the following:

7 (I) The timing for providing the disclosures for emergency and  
8 nonemergency services with consideration given to potential limitations  
9 relating to the federal "Emergency Medical Treatment and Labor Act", 42  
10 U.S.C. sec. 1395dd;

11 (II) Requirements regarding how the disclosures must be made,  
12 including requirements to include the disclosures on billing statements,  
13 billing notices, prior authorizations, or other forms or communications  
14 with covered persons;

15 (III) The contents of the disclosures, including the covered  
16 person's rights and payment obligations if the covered person's health  
17 benefit plan is under the jurisdiction of the division;

18 (IV) Disclosure requirements specific to carriers, including the  
19 possibility of being treated by an out-of-network provider, whether a  
20 provider is out of network, the types of services an out-of-network  
21 provider may provide, and the right to request an in-network provider to  
22 provide services; and

23 (V) Requirements concerning the language to be used in the  
24 disclosures, including use of plain language, to ensure that carriers,  
25 health-care facilities, and providers use language that is consistent with  
26 the disclosures required by this subsection (12) and sections 12-30-112  
27 and 25-3-121 and the rules adopted pursuant to this subsection (12)(b)



1 ~~and sections 12-30-112 (3) and 25-3-121 (2).~~

2 (13) (a) When a carrier makes a payment to a provider or a  
3 health-care facility pursuant to subsection (3)(d) or (5.5)(b) of this  
4 section, the provider or the facility may request, and the commissioner  
5 shall collect, data from the carrier to evaluate the carrier's compliance in  
6 paying the highest rate required. The information requested may include  
7 the methodology for determining the carrier's median in-network rate or  
8 reimbursement for each service in the same geographic area.

9 (b) (I) THE COMMISSIONER SHALL CONVENE A WORK GROUP TO  
10 DISCUSS WAYS TO FACILITATE AND STREAMLINE IMPLEMENTATION OF THIS  
11 SUBSECTION (13). THE WORK GROUP MUST INCLUDE, ~~TO THE EXTENT~~  
12 ~~PRACTICABLE, EQUAL NUMBERS OF REPRESENTATIVES OF HOSPITALS,~~  
13 ~~CARRIERS, HEALTH-CARE PROVIDERS DIRECTLY AFFECTED BY THIS~~  
14 ~~SECTION,~~ AND CONSUMERS. THE WORK GROUP SHALL:

15 (A) IDENTIFY BARRIERS TO VERIFYING THE ACCURACY OF  
16 STATUTORILY SPECIFIED PAYMENT AMOUNTS AND MANAGING  
17 PAYER-PROVIDER DISPUTES REGARDING PAYMENT AMOUNTS FOR  
18 OUT-OF-NETWORK HEALTH-CARE SERVICES SUBJECT TO THIS SECTION;

19 (B) DEVELOP RECOMMENDATIONS TO STREAMLINE THE  
20 IMPLEMENTATION OF THIS SUBSECTION (13);

21 (C) SUBMIT A WRITTEN REPORT WITH PRELIMINARY  
22 RECOMMENDATIONS TO THE COMMISSIONER BY MARCH 15, 2023; AND

23 (D) ON OR BEFORE JULY 1, 2023, SUBMIT A WRITTEN REPORT WITH  
24 FINAL RECOMMENDATIONS TO THE COMMISSIONER.

25 (II) ~~THE COMMISSIONER MAY ENTER INTO A CONTRACT WITH A~~  
26 ~~QUALIFIED INDEPENDENT THIRD PARTY FOR ANY SERVICES NECESSARY TO~~  
27 ~~FACILITATE THE ACTIVITIES OF THE WORK GROUP.~~

1           (III) THIS SUBSECTION (13)(b) IS REPEALED, EFFECTIVE JULY 31,  
2    2023.

3           (14) On or before ~~January~~ MARCH 1 of each year, each carrier  
4    shall submit information to the commissioner, in a form and manner  
5    determined by the commissioner, concerning the use of out-of-network  
6    providers and OUT-OF-NETWORK facilities by covered persons and the  
7    impact on premium affordability for consumers.

8           (15) (d) If the arbitrator's decision MADE PURSUANT TO  
9    SUBSECTION (15)(c) OF THIS SECTION requires additional payment by the  
10   carrier above the amount paid, the carrier shall pay the provider in  
11   accordance with section 10-16-106.5. A CARRIER SHALL NOT  
12   RECALCULATE A COVERED PERSON'S COST-SHARING AMOUNT BASED ON AN  
13   ADDITIONAL PAYMENT REQUIRED OR MADE AS A RESULT OF AN  
14   ARBITRATION DECISION.

15          (e) The party whose final offer amount was not selected by the  
16   arbitrator shall pay the arbitrator's expenses and fees. IF THE PARTIES  
17   REACH A SETTLEMENT AFTER AN ARBITRATOR IS APPOINTED BUT BEFORE  
18   THE ARBITRATOR MAKES A FINAL DECISION, THE PARTIES SHALL SPLIT THE  
19   COSTS OF THE ARBITRATION EQUALLY UNLESS OTHERWISE AGREED BY THE  
20   PARTIES.

21          (17) THE COMMISSIONER SHALL POST ON THE DIVISION'S WEBSITE  
22   INFORMATION ON THE STATE AND FEDERAL AGENCIES THAT A COVERED  
23   PERSON MAY CONTACT IF A PROVIDER, FACILITY, OR CARRIER VIOLATES  
24   THIS SECTION.

25          (18) THE COMMISSIONER MAY ADOPT RULES TO IMPLEMENT THIS  
26   SECTION, INCLUDING RULES NECESSARY TO IMPLEMENT THE  
27   REQUIREMENTS OF THE FEDERAL "NO SURPRISES ACT".

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(19) AS USED IN THIS SECTION:

(a) "ANCILLARY SERVICES" MEANS:

(I) DIAGNOSTIC SERVICES, INCLUDING RADIOLOGY AND LABORATORY SERVICES, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO 42 U.S.C. SEC. 300gg-132 (b)(3);

(II) ITEMS AND SERVICES RELATED TO EMERGENCY MEDICINE, ANESTHESIOLOGY, PATHOLOGY, RADIOLOGY, AND NEONATOLOGY, WHETHER OR NOT PROVIDED BY A PHYSICIAN OR NONPHYSICIAN PROVIDER, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

(III) ITEMS AND SERVICES PROVIDED BY ASSISTANT SURGEONS, HOSPITALISTS, AND INTENSIVISTS, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

(IV) ITEMS AND SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER IF THERE IS NO IN-NETWORK PROVIDER WHO CAN FURNISH THE NEEDED SERVICES AT THE FACILITY; AND

(V) ANY OTHER ITEMS AND SERVICES PROVIDED BY SPECIALTY PROVIDERS AS ESTABLISHED BY RULE OF THE COMMISSIONER.

(b) "APPLICABLE REGULATORS OF HEALTH-CARE OCCUPATIONS AND PROFESSIONS" MEANS THE:

(I) COLORADO STATE BOARD OF CHIROPRACTIC EXAMINERS CREATED IN SECTION 12-215-104;

- 1 (II) COLORADO DENTAL BOARD CREATED IN SECTION 12-220-105;
- 2 (III) COLORADO MEDICAL BOARD CREATED IN SECTION
- 3 12-240-105;
- 4 (IV) STATE BOARD OF PSYCHOLOGIST EXAMINERS CREATED IN
- 5 SECTION 12-245-302;
- 6 (V) STATE BOARD OF SOCIAL WORK EXAMINERS CREATED IN
- 7 SECTION 12-245-402;
- 8 (VI) STATE BOARD OF MARRIAGE AND FAMILY THERAPIST
- 9 EXAMINERS CREATED IN SECTION 12-245-502;
- 10 (VII) STATE BOARD OF LICENSED PROFESSIONAL COUNSELOR
- 11 EXAMINERS CREATED IN SECTION 12-245-602;
- 12 (VIII) STATE BOARD OF UNLICENSED PSYCHOTHERAPISTS CREATED
- 13 IN SECTION 12-245-702;
- 14 (IX) STATE BOARD OF ADDICTION COUNSELOR EXAMINERS
- 15 CREATED IN SECTION 12-245-802;
- 16 (X) STATE BOARD OF NURSING CREATED IN SECTION 12-255-105;
- 17 (XI) BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS
- 18 CREATED IN SECTION 12-265-106;
- 19 (XII) STATE BOARD OF OPTOMETRY CREATED IN SECTION
- 20 12-275-107;
- 21 (XIII) STATE BOARD OF PHARMACY CREATED IN SECTION
- 22 12-280-104;
- 23 (XIV) STATE PHYSICAL THERAPY BOARD CREATED IN SECTION
- 24 12-285-105; ■■■
- 25 (XV) COLORADO PODIATRY BOARD CREATED IN SECTION
- 26 12-290-105; AND
- 27 (XVI) THE DIRECTOR OF THE DIVISION OF PROFESSIONS AND

1 OCCUPATIONS IN THE DEPARTMENT OF REGULATORY AGENCIES.

2 (c) "BALANCE BILL" MEANS:

3 (I) THE AMOUNT THAT AN OUT-OF-NETWORK PROVIDER MAY  
4 CHARGE A COVERED PERSON FOR THE PROVISION OF HEALTH-CARE  
5 SERVICES, WHICH AMOUNT EQUALS THE DIFFERENCE BETWEEN THE  
6 AMOUNT PAID BY THE CARRIER FOR THE HEALTH-CARE SERVICES AND THE  
7 AMOUNT OF THE OUT-OF-NETWORK PROVIDER'S BILLED CHARGE FOR THE  
8 HEALTH-CARE SERVICES; AND

9 (II) THE ACT OF A NONPARTICIPATING PROVIDER CHARGING A  
10 COVERED PERSON THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND  
11 THE AMOUNT THE CARRIER PAID THE PROVIDER.

12 (d) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL  
13 CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT  
14 SEVERITY, INCLUDING SEVERE PAIN, THAT A PRUDENT LAYPERSON WITH AN  
15 AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY  
16 EXPECT, IN THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION, TO RESULT  
17 IN:

18 (I) SERIOUS JEOPARDY TO THE HEALTH OF THE INDIVIDUAL OR,  
19 WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR  
20 UNBORN CHILD;

21 (II) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

22 (III) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

23 (e) (I) "EMERGENCY SERVICES", WITH RESPECT TO AN EMERGENCY  
24 MEDICAL CONDITION, MEANS:

25 (A) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE  
26 CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL OR A  
27 FREESTANDING EMERGENCY DEPARTMENT, AS APPLICABLE, INCLUDING

1 ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY  
2 DEPARTMENT TO EVALUATE THE EMERGENCY MEDICAL CONDITION; AND

3 (B) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES  
4 AVAILABLE AT THE HOSPITAL, REGARDLESS OF THE DEPARTMENT IN WHICH  
5 FURTHER EXAMINATION OR TREATMENT IS FURNISHED, OR THE  
6 FREESTANDING EMERGENCY DEPARTMENT, AS APPLICABLE, FURTHER  
7 MEDICAL EXAMINATION AND TREATMENT AS ARE REQUIRED TO STABILIZE  
8 THE PATIENT TO ENSURE, WITHIN REASONABLE MEDICAL PROBABILITY,  
9 THAT NO MATERIAL DETERIORATION OF THE CONDITION IS LIKELY TO  
10 RESULT FROM OR OCCUR DURING THE TRANSFER OF THE PATIENT FROM A  
11 FACILITY.

12 (II) FOR A COVERED PERSON WHO IS PROVIDED SERVICES  
13 DESCRIBED IN SUBSECTIONS (19)(e)(I)(A) AND (19)(e)(I)(B) WITH RESPECT  
14 TO AN EMERGENCY MEDICAL CONDITION, UNLESS EACH OF THE  
15 CONDITIONS IN SUBSECTION (19)(e)(III) OF THIS SECTION ARE MET, THE  
16 TERM "EMERGENCY SERVICES" INCLUDES SERVICES THAT ARE:

17 (A) COVERED UNDER THE HEALTH BENEFIT PLAN; AND

18 (B) PROVIDED BY A NONPARTICIPATING PROVIDERS OR  
19 NONPARTICIPATING EMERGENCY FACILITY, REGARDLESS OF THE  
20 DEPARTMENT OR THE FACILITY IN WHICH THE ITEMS OR SERVICES ARE  
21 PROVIDED AFTER THE COVERED PERSON IS STABILIZED AND AS PART OF  
22 THE OUTPATIENT OBSERVATION OR INPATIENT OR OUTPATIENT STAY, WITH  
23 RESPECT TO THE EMERGENCY VISIT IN WHICH THE SERVICES DESCRIBED IN  
24 SUBSECTION (19)(e)(I) OF THIS SECTION ARE PROVIDED.

25 (III) FOR THE PURPOSES OF SUBSECTION (19)(e)(II) OF THIS  
26 SECTION, THE CONDITIONS DESCRIBED IN THIS SUBSECTION (19)(e)(III),  
27 WITH RESPECT TO A COVERED INDIVIDUAL WHO IS STABILIZED AND

1 FURNISHED ADDITIONAL ITEMS AND SERVICES DESCRIBED IN SUBSECTION  
2 (19)(e)(II) OF THIS SECTION AFTER THE STABILIZATION BY A PROVIDER OR  
3 FACILITY ARE THE FOLLOWING:

4 (A) THE OUT-OF-NETWORK PROVIDER OR OUT-OF-NETWORK  
5 FACILITY DETERMINES THE COVERED PERSON IS ABLE TO TRAVEL USING  
6 NONMEDICAL TRANSPORTATION OR NONEMERGENCY MEDICAL  
7 TRANSPORTATION;

8 (B) THE OUT-OF-NETWORK PROVIDER OR OUT-OF-NETWORK  
9 FACILITY HAS PROVIDED THE COVERED PERSON WITH NOTICE AND  
10 OBTAINED CONSENT AS REQUIRED BY SECTION 12-30-112 OR 25-3-121, AS  
11 APPLICABLE;

12 (C) THE COVERED PERSON IS IN A CONDITION TO RECEIVE THE  
13 NOTICE AND CONSENT DESCRIBED IN SECTION 12-30-112 OR 25-3-121 AND  
14 TO PROVIDE INFORMED CONSENT; AND

15 (D) THE OUT-OF-NETWORK PROVIDER OR OUT-OF-NETWORK  
16 FACILITY IS IN COMPLIANCE WITH, AT A MINIMUM, OTHER REQUIREMENTS  
17 ESTABLISHED IN 42 U.S.C. SEC. 300gg-111 AND ANY FEDERAL  
18 REGULATIONS ADOPTED PURSUANT TO 42 U.S.C. SEC. 300gg-111.

19 (f) "FEDERAL 'NO SURPRISES ACT'" MEANS THE FEDERAL "NO  
20 SURPRISES ACT", PUB.L. 116-260, AS AMENDED.

21 (g) "FREESTANDING EMERGENCY DEPARTMENT" HAS THE SAME  
22 MEANING AS SET FORTH IN SECTION 25-1.5-114 (5).

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

25 (i) "IN-NETWORK FACILITY" MEANS A PARTICIPATING PROVIDER  
26 THAT IS A HEALTH-CARE FACILITY.

27 (j) "IN-NETWORK PROVIDER" MEANS A PARTICIPATING PROVIDER

1 WHO IS AN INDIVIDUAL.

2 (k) "MEDICARE REIMBURSEMENT RATE" MEANS THE  
3 REIMBURSEMENT RATE FOR A PARTICULAR HEALTH-CARE SERVICE  
4 PROVIDED UNDER THE "HEALTH INSURANCE FOR THE AGED ACT", TITLE  
5 XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", 42 U.S.C. SEC. 1395 ET  
6 SEQ., AS AMENDED.

7 (l) "NEGOTIATED RATE" MEANS THE RATE MUTUALLY AGREED UPON  
8 BETWEEN THE CARRIER AND THE PROVIDER IN A SPECIFIC INSTANCE.

9

10 (m) "STABILIZED" MEANS THE CONDITION OF A PATIENT IN WHICH,  
11 WITHIN REASONABLE MEDICAL PROBABILITY, NO MATERIAL  
12 DETERIORATION OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR  
13 DURING THE TRANSFER OF THE PATIENT FROM ONE FACILITY OR  
14 DEPARTMENT TO ANOTHER.

15 (n) "USUAL, CUSTOMARY, AND REASONABLE RATE" MEANS A RATE  
16 ESTABLISHED PURSUANT TO AN APPROPRIATE METHODOLOGY THAT IS  
17 BASED ON GENERALLY ACCEPTED INDUSTRY STANDARDS AND PRACTICES.

18 **SECTION 3.** In Colorado Revised Statutes, 10-16-705, **amend**  
19 (4)(b); and **add** (4)(d) as follows:

20 **10-16-705. Requirements for carriers and participating**  
21 **providers - definitions.** (4) (b) Each CARRIER THAT ISSUES A managed  
22 care plan shall allow covered persons to continue receiving care for sixty  
23 UP TO NINETY days from AFTER the date a participating provider is  
24 terminated by the plan without cause, when proper notice as specified in  
25 subsection (7) of this section has not been provided to the covered person  
26 CARRIER HAS PROVIDED NOTICE TO AN INDIVIDUAL ENROLLED IN SUCH  
27 PLAN PURSUANT TO SUBSECTION (4)(d)(II)(A) OF THIS SECTION THAT THE



1 CONTRACT IS TERMINATED. THE CARRIER SHALL PROVIDE THE REQUISITE  
2 COVERAGE OR CONTINUING CARE TO THE COVERED PERSON AT THE  
3 COVERED PERSON'S IN-NETWORK BENEFIT LEVEL COST-SHARING AMOUNT  
4 DURING THE PERIOD BEGINNING ON THE DATE ON WHICH THE NOTICE OF  
5 TERMINATION IS GIVEN PURSUANT TO SUBSECTION (4)(d)(II)(A) OF THIS  
6 SECTION AND ENDING ON THE EARLIER OF THE NINETY-DAY PERIOD  
7 BEGINNING ON SUCH DATE OR THE DATE ON WHICH THE COVERED PERSON  
8 IS NO LONGER A CONTINUING CARE PATIENT WITH THE PROVIDER OR  
9 HEALTH-CARE FACILITY.

10 (d) (I) A CARRIER SHALL COMPLY WITH THE REQUIREMENTS OF  
11 SUBSECTION (4)(d)(II) OF THIS SECTION IF A PARTICIPATING PROVIDER,  
12 WHETHER AN INDIVIDUAL PROVIDER OR A FACILITY, IS TREATING A  
13 CONTINUING CARE PATIENT WHO IS A COVERED PERSON UNDER THE PLAN  
14 AND IF:

15 (A) THE CONTRACT BETWEEN THE CARRIER AND THE  
16 PARTICIPATING PROVIDER IS TERMINATED DUE TO THE EXPIRATION OR  
17 NONRENEWAL OF THE CONTRACT;

18 (B) THE BENEFITS PROVIDED UNDER THE MANAGED CARE PLAN OR  
19 THE HEALTH INSURANCE COVERAGE, WITH RESPECT TO THE PROVIDER OR  
20 FACILITY, ARE TERMINATED DUE TO THE EXPIRATION OR NONRENEWAL OF  
21 THE CONTRACT BETWEEN THE CARRIER AND THE PROVIDER OR FACILITY  
22 BECAUSE OF A CHANGE IN THE TERMS OF THE PARTICIPATION IN THE PLAN  
23 OR COVERAGE; OR

24 (C) A CONTRACT BETWEEN THE GROUP HEALTH PLAN AND THE  
25 CARRIER OFFERING COVERAGE IN CONNECTION WITH THE GROUP HEALTH  
26 PLAN IS TERMINATED DUE TO THE EXPIRATION OR NONRENEWAL OF THE  
27 CONTRACT, RESULTING IN THE LOSS OF BENEFITS UNDER THE PLAN WITH

1 RESPECT TO THE PARTICIPATING PROVIDER THAT IS PROVIDING TREATMENT  
2 OR SERVICES TO THE COVERED PERSON IN COMPLIANCE WITH THE FEDERAL  
3 "NO SURPRISES ACT".

4 (II) A CARRIER SUBJECT TO THIS SUBSECTION (4)(d) SHALL:

5 (A) NOTIFY EACH COVERED PERSON WHO IS RECEIVING CARE FROM  
6 A PROVIDER OR FACILITY WITH WHOM A CONTRACT IS TERMINATED AS  
7 DESCRIBED IN SUBSECTION (4)(d)(I) OF THIS SECTION, AT THE TIME OF THE  
8 TERMINATION OF THE CONTRACT, THAT THE PATIENT HAS THE RIGHT TO  
9 ELECT CONTINUED TRANSITIONAL CARE FROM THE TREATING PROVIDER OR  
10 FACILITY IF THE TERMINATION OF THE CONTRACT AFFECTS THE STATUS OF  
11 THE PROVIDER OR FACILITY AS A PARTICIPATING PROVIDER;

12 (B) PROVIDE THE COVERED PERSON WITH AN OPPORTUNITY TO  
13 NOTIFY THE MANAGED CARE PLAN OR CARRIER OF THE NEED FOR  
14 TRANSITIONAL CARE; AND

15 (C) PERMIT THE COVERED PERSON TO ELECT TO CONTINUE TO HAVE  
16 BENEFITS PROVIDED UNDER THE COVERED PERSON'S CURRENT PLAN OR  
17 COVERAGE UNDER THE SAME TERMS AND CONDITIONS AS WOULD HAVE  
18 APPLIED AND WITH RESPECT TO THE SAME ITEMS AND SERVICES AS WOULD  
19 HAVE BEEN COVERED HAD A TERMINATION DESCRIBED IN SUBSECTION  
20 (4)(d)(I) OF THIS SECTION NOT OCCURRED, WITH RESPECT TO THE COURSE  
21 OF TREATMENT FURNISHED BY THE PROVIDER OR FACILITY RELATING TO  
22 THE COVERED PERSON'S STATUS AS A CONTINUING CARE PATIENT DURING  
23 THE PERIOD BEGINNING ON THE DATE ON WHICH THE NOTICE UNDER  
24 SUBSECTION (4)(d)(II)(A) OF THIS SECTION IS PROVIDED AND ENDING ON  
25 THE NINETY-FIRST DAY AFTER THAT DATE OR THE DATE ON WHICH THE  
26 COVERED PERSON IS NO LONGER A CONTINUING CARE PATIENT WITH  
27 RESPECT TO THE PROVIDER OR FACILITY, WHICHEVER IS EARLIER.

1 (III) AS USED IN THIS SUBSECTION (4)(d);

2 (A) "CONTINUING CARE PATIENT" MEANS A COVERED PERSON WHO,  
3 WITH RESPECT TO A PROVIDER OR FACILITY WHOSE CONTRACT WITH THE  
4 COVERED PERSON'S CARRIER IS TERMINATED; IS UNDERGOING A COURSE OF  
5 TREATMENT FOR A SERIOUS AND COMPLEX MEDICAL CONDITION, WHICH  
6 COURSE OF TREATMENT IS PROVIDED BY THE PROVIDER OR FACILITY; IS  
7 UNDERGOING A COURSE OF INPATIENT CARE PROVIDED BY THE PROVIDER  
8 OR FACILITY; IS PREGNANT AND UNDERGOING A COURSE OF TREATMENT  
9 FOR THE PREGNANCY PROVIDED BY THE PROVIDER OR FACILITY; IS  
10 TERMINALLY ILL AS DETERMINED UNDER SECTION 1861 (dd)(3)(A) OF THE  
11 FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, AND IS RECEIVING  
12 TREATMENT FOR THE ILLNESS FROM THE PROVIDER OR FACILITY; OR IS  
13 SCHEDULED TO UNDERGO NONELECTIVE SURGERY FROM THE PROVIDER OR  
14 FACILITY, INCLUDING THE RECEIPT OF POSTOPERATIVE CARE FROM THE  
15 PROVIDER OR FACILITY WITH RESPECT TO THE SURGERY.

16 (B) "SERIOUS AND COMPLEX MEDICAL CONDITION" MEANS, IN THE  
17 CASE OF ACUTE ILLNESS, A CONDITION THAT IS SERIOUS ENOUGH TO  
18 REQUIRE SPECIALIZED MEDICAL TREATMENT TO AVOID THE REASONABLE  
19 POSSIBILITY OF DEATH OR PERMANENT HARM OR, IN THE CASE OF A  
20 CHRONIC ILLNESS OR CONDITION, A CONDITION THAT IS LIFE-THREATENING,  
21 DEGENERATIVE, POTENTIALLY DISABLING, OR CONGENITAL AND REQUIRES  
22 SPECIALIZED MEDICAL CARE OVER A PROLONGED PERIOD OF TIME.

23 (C) "TERMINATED", WITH RESPECT TO A CONTRACT, MEANS THE  
24 EXPIRATION OR NONRENEWAL OF THE CONTRACT; EXCEPT THAT  
25 "TERMINATED" DOES NOT INCLUDE A CONTRACT TERMINATED FOR FAILURE  
26 TO MEET APPLICABLE QUALITY STANDARDS OR FOR FRAUD.

27 **SECTION 4.** In Colorado Revised Statutes, 12-30-112, **amend** (1)

1 introductory portion, (1)(a), (1)(c), (1)(d), (1)(f), (1)(g), and (3); and add  
2 (1)(a.3), (1)(a.5), (1)(c.5), (1)(h), and (3.5) as follows:

3 **12-30-112. Health-care providers - required disclosures -**  
4 **balance billing - rules - definitions.** (1) ~~For the purposes of~~ AS USED IN  
5 this section and section 12-30-113:

6 (a) ~~"Carrier" has the same meaning as defined in section 10-16-102~~  
7 ~~(8)~~: "ANCILLARY SERVICES" MEANS:

8 (I) DIAGNOSTIC SERVICES, INCLUDING RADIOLOGY AND  
9 LABORATORY SERVICES, UNLESS EXCLUDED BY RULE OF THE SECRETARY  
10 OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES  
11 PURSUANT TO 42 U.S.C. SEC. 300gg-132 (b)(3);

12 (II) ITEMS AND SERVICES RELATED TO EMERGENCY MEDICINE,  
13 ANESTHESIOLOGY, PATHOLOGY, RADIOLOGY, AND NEONATOLOGY,  
14 WHETHER OR NOT PROVIDED BY A PHYSICIAN OR NONPHYSICIAN PROVIDER,  
15 UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES  
16 DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION  
17 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

18 (III) ITEMS AND SERVICES PROVIDED BY ASSISTANT SURGEONS,  
19 HOSPITALISTS, AND INTENSIVISTS, UNLESS EXCLUDED BY RULE OF THE  
20 SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN  
21 SERVICES PURSUANT TO SECTION 2799B-2 (b)(3) OF THE FEDERAL "NO  
22 SURPRISES ACT";

23 (IV) ITEMS AND SERVICES PROVIDED BY AN OUT-OF-NETWORK  
24 PROVIDER IF THERE IS NO IN-NETWORK PROVIDER WHO CAN FURNISH THE  
25 NEEDED SERVICES AT THE FACILITY; AND

26 (V) ANY OTHER ITEMS AND SERVICES PROVIDED BY SPECIALTY  
27 PROVIDERS AS ESTABLISHED BY RULE OF THE COMMISSIONER.

1            (a.3) "BALANCE BILL" HAS THE SAME MEANING AS SET FORTH  
2 IN SECTION 10-16-704 (20)(c).

3            (a.5) "CARRIER" HAS THE SAME MEANING AS SET FORTH IN SECTION  
4 10-16-102 (8).

5            (c) "Emergency services" has the same meaning as ~~defined~~ SET  
6 FORTH in section 10-16-704 ~~(5.5)(e)(H)~~ (19)(e).

7            (c.5) "FEDERAL 'NO SURPRISES ACT'" MEANS THE FEDERAL "NO  
8 SURPRISES ACT", PUB.L. 116-260, AS AMENDED.

9            (d) "Geographic area" has the same meaning as ~~defined~~ SET FORTH  
10 in section 10-16-704 ~~(3)(d)(VI)(A)~~ (19)(h).

11            (f) "Medicare reimbursement rate" has the same meaning as  
12 ~~defined~~ SET FORTH in section 10-16-704 ~~(3)(d)(VI)(B)~~ (19)(k).

13            (g) "Out-of-network provider" means a health-care provider that is  
14 not a ~~"participating provider" as defined in section 10-16-102 (46)~~  
15 PARTICIPATING PROVIDER.

16            (h) "PARTICIPATING PROVIDER" HAS THE SAME MEANING AS SET  
17 FORTH IN SECTION 10-16-102 (46).

18            (3) The ~~director~~ REGULATOR, in consultation with the  
19 commissioner of insurance and the state board of health created in section  
20 25-1-103, shall adopt rules that specify the requirements for health-care  
21 providers to develop and provide consumer disclosures in accordance with  
22 this section. The ~~director~~ REGULATOR shall ensure that the rules, AT A  
23 MINIMUM, COMPLY WITH THE NOTICE AND CONSENT REQUIREMENTS IN  
24 SUBSECTION (3.5) OF ~~are consistent with sections 10-16-704 (12) and~~  
25 ~~25-3-121 and rules adopted by the commissioner pursuant to section~~  
26 ~~10-16-704 (12)(b) and by the state board of health pursuant to section~~  
27 ~~25-3-121 (2). The rules must specify, at a minimum, the following:~~

1           ~~(a) The timing for providing the disclosures for emergency and~~  
2 ~~nonemergency services with consideration given to potential limitations~~  
3 ~~relating to the federal "Emergency Medical Treatment and Labor Act", 42~~  
4 ~~U.S.C. sec. 1395dd;~~

5           ~~(b) Requirements regarding how the disclosures must be made,~~  
6 ~~including requirements to include the disclosures on billing statements,~~  
7 ~~billing notices, or other forms or communications with consumers;~~

8           ~~(c) The contents of the disclosures, including the consumer's rights~~  
9 ~~and payment obligations pursuant to the consumer's health benefit plan;~~

10          ~~(d) Disclosure requirements specific to health-care providers,~~  
11 ~~including whether a health-care provider is out of network, the types of~~  
12 ~~services an out-of-network health-care provider may provide, and the right~~  
13 ~~to request an in-network health-care provider to provide services; and~~

14          ~~(e) Requirements concerning the language to be used in the~~  
15 ~~disclosures, including use of plain language, to ensure that carriers,~~  
16 ~~health-care facilities, and health-care providers use language that is~~  
17 ~~consistent with the disclosures required by this section and sections~~  
18 ~~10-16-704 (12) and 25-3-121 and the rules adopted pursuant to this~~  
19 ~~subsection (3) and sections 10-16-704 (12)(b) and 25-3-121 (2) THIS~~  
20 ~~SECTION AND THE FEDERAL "NO SURPRISES ACT".~~

21           (3.5) (a) AN OUT-OF-NETWORK PROVIDER MAY BALANCE BILL A  
22 COVERED PERSON FOR POST-STABILIZATION SERVICES IN ACCORDANCE  
23 WITH SECTION 10-16-704 AND COVERED NONEMERGENCY SERVICES IN AN  
24 IN-NETWORK FACILITY THAT ARE NOT ANCILLARY SERVICES IF:

25           (I) THE OUT-OF-NETWORK PROVIDER PROVIDES WRITTEN NOTICE  
26 THAT THE PROVIDER WILL BALANCE BILL A COVERED PERSON AT LEAST  
27 SEVENTY-TWO HOURS IN ADVANCE OF THE DATE OF SERVICE, IF THE

1 APPOINTMENT WAS SCHEDULED AT LEAST SEVENTY-TWO HOURS IN  
2 ADVANCE, OR AT LEAST THREE HOURS BEFORE THE SCHEDULED  
3 APPOINTMENT, IF THE APPOINTMENT WAS MADE LESS THAN SEVENTY-TWO  
4 HOURS IN ADVANCE, IN EITHER PAPER OR ELECTRONIC FORMAT, AS  
5 SELECTED BY THE COVERED PERSON. THE NOTICE MUST BE AVAILABLE IN  
6 THE FIFTEEN MOST COMMON LANGUAGES IN THE GEOGRAPHIC REGION IN  
7 WHICH THE OUT-OF-NETWORK PROVIDER IS LOCATED. THE NOTICE MUST  
8 STATE:

9 (A) IF APPLICABLE, THAT THE HEALTH-CARE PROVIDER IS OUT OF  
10 NETWORK WITH RESPECT TO THE COVERED PERSON'S HEALTH BENEFIT  
11 PLAN;

12 (B) EFFECTIVE UPON THE IMPLEMENTATION DATE OF THE  
13 APPLICABLE FEDERAL RULES, A GOOD-FAITH ESTIMATE OF THE AMOUNT OF  
14 THE CHARGES FOR WHICH THE COVERED PERSON MAY BE RESPONSIBLE;

15 (C) THAT THE ESTIMATE OR CONSENT TO TREATMENT DOES NOT  
16 CONSTITUTE A CONTRACT FOR SERVICES;

17 (D) IF THE FACILITY IS A PARTICIPATING PROVIDER AND THE  
18 HEALTH-CARE PROVIDER IS AN OUT-OF-NETWORK PROVIDER, A LIST OF  
19 PARTICIPATING PROVIDERS AT THE FACILITY WHO ARE ABLE TO PROVIDE  
20 THE SAME SERVICES;

21 (E) INFORMATION ABOUT WHETHER PRIOR AUTHORIZATION OR  
22 OTHER CARE MANAGEMENT LIMITATIONS MAY BE REQUIRED IN ADVANCE  
23 OF RECEIVING THE REQUESTED SERVICES; AND

24 (F) THAT CONSENT TO RECEIVE THE SERVICES FROM AN  
25 OUT-OF-NETWORK PROVIDER IS OPTIONAL AND THAT THE COVERED PERSON  
26 MAY SEEK SERVICES FROM A PARTICIPATING PROVIDER, IN WHICH CASE THE  
27 COST-SHARING RESPONSIBILITY OF THE COVERED PERSON WOULD NOT

1 EXCEED THE RESPONSIBILITY FOR IN-NETWORK BENEFITS UNDER THE  
2 COVERED PERSON'S HEALTH BENEFIT PLAN; ■

3 (II) THE OUT-OF-NETWORK PROVIDER OBTAINS SIGNED CONSENT  
4 FROM THE COVERED PERSON THAT ACKNOWLEDGES THAT THE COVERED  
5 PERSON HAS BEEN:

6 (A) PROVIDED WITH WRITTEN NOTICE OF THE COVERED PERSON'S  
7 FINANCIAL RESPONSIBILITY, IN THE FORMAT AND LANGUAGE SELECTED BY  
8 THE COVERED PERSON AND WITHIN THE APPLICABLE PERIODS SPECIFIED IN  
9 SUBSECTION (3.5)(a)(I) OF THIS SECTION; AND

10 (B) PROVIDED WRITTEN NOTICE THAT THE PAYMENT BY THE  
11 COVERED PERSON FOR HEALTH-CARE SERVICES PROVIDED BY THE  
12 OUT-OF-NETWORK PROVIDER MAY NOT ACCRUE TOWARD MEETING ANY  
13 LIMITATION THAT THE HEALTH BENEFIT PLAN PLACES ON COST SHARING,  
14 INCLUDING AN EXPLANATION THAT THE PAYMENT MAY NOT APPLY TO AN  
15 IN-NETWORK DEDUCTIBLE.

16 (b) IF THE NOTICE IN SUBSECTION (3.5)(a)(I) OF THIS SECTION IS  
17 RECEIVED WITHIN TEN DAYS BEFORE A SCHEDULED SERVICE, THE COVERED  
18 PERSON MAY ELECT TO USE THE OUT-OF-NETWORK PROVIDER AT THE  
19 IN-NETWORK BENEFIT LEVEL, AND THE PROVIDER MUST BE REIMBURSED  
20 FOR THE SERVICES IN ACCORDANCE WITH SECTION 10-16-704 (3)(d)(II).

21 (c) THE NOTICE AND CONSENT REQUIRED BY THIS SUBSECTION (3.5)  
22 MUST INCLUDE THE DATE AND THE TIME AT WHICH THE COVERED PERSON  
23 RECEIVED THE WRITTEN NOTICE AND THE DATE ON WHICH THE CONSENT  
24 FORM WAS SIGNED. THE OUT-OF-NETWORK PROVIDER SHALL PROVIDE A  
25 SIGNED COPY OF THE CONSENT FORM TO THE COVERED PERSON THROUGH  
26 REGULAR OR ELECTRONIC MAIL.

27 (d) AN OUT-OF-NETWORK PROVIDER THAT OBTAINS A SIGNED



1 CONSENT WITH RESPECT TO FURNISHING AN ITEM OR SERVICE SHALL  
2 RETAIN THE SIGNED CONSENT FOR AT LEAST A SEVEN-YEAR PERIOD AFTER  
3 THE DATE ON WHICH SUCH ITEM OR SERVICE IS FURNISHED.

4 **SECTION 5.** In Colorado Revised Statutes, 25-3-121, **amend** (2),  
5 (4) introductory portion, (4)(a), (4)(c), (4)(d), (4)(f), and (4)(g); and **add**  
6 (3.5), (4)(a.3), (4)(a.5), (4)(c.5), and (4)(h) as follows:

7 **25-3-121. Health-care facilities - emergency and nonemergency**  
8 **services - required disclosures - balance billing - rules - definitions.**

9 (2) The state board of health, in consultation with the commissioner of  
10 insurance and the ~~director of~~ APPLICABLE REGULATORS OF HEALTH-CARE  
11 PROVIDERS IN the division of professions and occupations in the  
12 department of regulatory agencies, shall adopt rules that specify the  
13 requirements for health-care facilities to develop and provide consumer  
14 disclosures in accordance with this section. The state board of health shall  
15 ensure that the rules, AT A MINIMUM, COMPLY WITH THE NOTICE AND  
16 CONSENT REQUIREMENTS IN SUBSECTION (3.5) OF THIS ~~are consistent with~~  
17 ~~sections 10-16-704 (12) and 12-30-112 and rules adopted by the~~  
18 ~~commissioner pursuant to section 10-16-704 (12)(b) and by the director~~  
19 ~~of the division of professions and occupations pursuant to section~~  
20 ~~12-30-112 (3). The rules must specify, at a minimum, the following:~~

21 ~~(a) The timing for providing the disclosures for emergency and~~  
22 ~~nonemergency services with consideration given to potential limitations~~  
23 ~~relating to the federal "Emergency Medical Treatment and Labor Act", 42~~  
24 ~~U.S.C. sec. 1395dd;~~

25 ~~(b) Requirements regarding how the disclosures must be made,~~  
26 ~~including requirements to include the disclosures on billing statements,~~  
27 ~~billing notices, or other forms or communications with covered persons;~~

1 ~~(c) The contents of the disclosures, including the consumer's rights~~  
2 ~~and payment obligations pursuant to the consumer's health benefit plan;~~

3 ~~(d) Disclosure requirements specific to health-care facilities,~~  
4 ~~including whether a health-care provider delivering services at the facility~~  
5 ~~is out of network, the types of services an out-of-network health-care~~  
6 ~~provider may provide, and the right to request an in-network health-care~~  
7 ~~provider to provide services; and~~

8 ~~(e) Requirements concerning the language to be used in the~~  
9 ~~disclosures, including use of plain language, to ensure that carriers,~~  
10 ~~health-care facilities, and health-care providers use language that is~~  
11 ~~consistent with the disclosures required by this section and sections~~  
12 ~~10-16-704 (12) and 12-30-112 and the rules adopted pursuant to this~~  
13 ~~subsection (2) and sections 10-16-704 (12)(b) and 12-30-112 (3) SECTION~~  
14 ~~AND THE FEDERAL "NO SURPRISES ACT".~~

15 (3.5) (a) AN OUT-OF-NETWORK FACILITY MAY BALANCE BILL A  
16 COVERED PERSON FOR SERVICES OTHER THAN ANCILLARY SERVICES IF:

17 (I) THE OUT-OF-NETWORK FACILITY PROVIDES WRITTEN NOTICE  
18 THAT THE FACILITY WILL BALANCE BILL A COVERED PERSON AT LEAST  
19 SEVENTY-TWO HOURS IN ADVANCE OF THE DATE OF SERVICE, IF THE  
20 APPOINTMENT WAS SCHEDULED AT LEAST SEVENTY-TWO HOURS IN  
21 ADVANCE, OR AT LEAST THREE HOURS BEFORE THE SCHEDULED  
22 APPOINTMENT, IF THE APPOINTMENT WAS MADE LESS THAN SEVENTY-TWO  
23 HOURS IN ADVANCE, IN EITHER PAPER OR ELECTRONIC FORMAT, AS  
24 SELECTED BY THE COVERED PERSON. THE NOTICE MUST BE AVAILABLE IN  
25 THE FIFTEEN MOST COMMON LANGUAGES IN THE GEOGRAPHIC REGION IN  
26 WHICH THE OUT-OF-NETWORK FACILITY IS LOCATED. THE NOTICE MUST  
27 STATE:

1 (A) IF APPLICABLE, THAT THE FACILITY IS OUT OF NETWORK WITH  
2 RESPECT TO THE COVERED PERSON'S HEALTH BENEFIT PLAN;

3 (B) EFFECTIVE UPON THE IMPLEMENTATION DATE OF THE  
4 APPLICABLE FEDERAL RULES, A GOOD-FAITH ESTIMATE OF THE AMOUNT OF  
5 THE CHARGES FOR WHICH THE COVERED PERSON MAY BE RESPONSIBLE;

6 (C) THAT THE ESTIMATE OR CONSENT TO TREATMENT DOES NOT  
7 CONSTITUTE A CONTRACT FOR SERVICES;

8 (D) IF THE FACILITY IS A PARTICIPATING PROVIDER AND THE  
9 HEALTH-CARE PROVIDER IS NOT A PARTICIPATING PROVIDER, A LIST OF  
10 PARTICIPATING PROVIDERS AT THE FACILITY WHO ARE ABLE TO PROVIDE  
11 THE SAME SERVICES;

12 (E) INFORMATION ABOUT WHETHER PRIOR AUTHORIZATION OR  
13 OTHER CARE MANAGEMENT LIMITATIONS MAY BE REQUIRED IN ADVANCE  
14 OF RECEIVING THE REQUESTED SERVICES; AND

15 (F) THAT CONSENT TO RECEIVE THE SERVICES AT AN  
16 OUT-OF-NETWORK FACILITY IS OPTIONAL AND THAT THE COVERED PERSON  
17 MAY SEEK SERVICES FROM A PARTICIPATING PROVIDER, IN WHICH CASE THE  
18 COST-SHARING RESPONSIBILITY OF THE COVERED PERSON WOULD NOT  
19 EXCEED THE RESPONSIBILITY FOR IN-NETWORK BENEFITS UNDER THE  
20 COVERED PERSON'S HEALTH BENEFIT PLAN;

21 (II) THE OUT-OF-NETWORK FACILITY OBTAINS SIGNED CONSENT  
22 FROM THE COVERED PERSON THAT ACKNOWLEDGES THAT THE COVERED  
23 PERSON HAS BEEN:

24 (A) PROVIDED WITH WRITTEN NOTICE OF THE COVERED PERSON'S  
25 FINANCIAL RESPONSIBILITY, IN THE FORMAT AND LANGUAGE SELECTED BY  
26 THE COVERED PERSON AND WITHIN THE APPLICABLE PERIODS SPECIFIED IN  
27 SUBSECTION (3.5)(a)(I) OF THIS SECTION; AND

1 (B) PROVIDED WRITTEN NOTICE THAT THE PAYMENT BY THE  
2 COVERED PERSON FOR HEALTH-CARE SERVICES PROVIDED AT THE  
3 OUT-OF-NETWORK FACILITY MAY NOT ACCRUE TOWARD MEETING ANY  
4 LIMITATION THAT THE HEALTH BENEFIT PLAN PLACES ON COST SHARING,  
5 INCLUDING AN EXPLANATION THAT THE PAYMENT MAY NOT APPLY TO AN  
6 IN-NETWORK DEDUCTIBLE.

7 (b) THE NOTICE AND CONSENT REQUIRED BY THIS SUBSECTION (3.5)  
8 MUST INCLUDE THE DATE ON WHICH THE COVERED PERSON RECEIVED THE  
9 WRITTEN NOTICE AND THE DATE AND THE TIME AT WHICH THE CONSENT  
10 FORM WAS SIGNED. THE OUT-OF-NETWORK FACILITY SHALL PROVIDE A  
11 SIGNED COPY OF THE CONSENT FORM TO THE COVERED PERSON THROUGH  
12 REGULAR OR ELECTRONIC MAIL.

13 (c) AN OUT-OF-NETWORK FACILITY THAT OBTAINS A SIGNED  
14 CONSENT WITH RESPECT TO FURNISHING AN ITEM OR SERVICE SHALL  
15 RETAIN THE SIGNED CONSENT FOR AT LEAST A SEVEN-YEAR PERIOD AFTER  
16 THE DATE ON WHICH SUCH ITEM OR SERVICE IS FURNISHED.

17 (4) ~~For the purposes of~~ AS USED IN this section and section  
18 25-3-122:

19 (a) ~~"Carrier" has the same meaning as defined in section 10-16-102~~  
20 (8): "ANCILLARY SERVICES" MEANS:

21 (I) DIAGNOSTIC SERVICES, INCLUDING RADIOLOGY AND  
22 LABORATORY SERVICES, UNLESS EXCLUDED BY RULE OF THE SECRETARY  
23 OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES  
24 PURSUANT TO 42 U.S.C. SEC. 300gg-132 (b)(3);


25 (II) ITEMS AND SERVICES RELATED TO EMERGENCY MEDICINE,  
26 ANESTHESIOLOGY, PATHOLOGY, RADIOLOGY, AND NEONATOLOGY,  
27 WHETHER OR NOT PROVIDED BY A PHYSICIAN OR NONPHYSICIAN PROVIDER,

1 UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES  
2 DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION  
3 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

4 (III) ITEMS AND SERVICES PROVIDED BY ASSISTANT SURGEONS,  
5 HOSPITALISTS, AND INTENSIVISTS, UNLESS EXCLUDED BY RULE OF THE  
6 SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN  
7 SERVICES PURSUANT TO SECTION 2799B-2 (b)(3) OF THE FEDERAL "NO  
8 SURPRISES ACT";

9 (IV) ITEMS AND SERVICES PROVIDED BY AN OUT-OF-NETWORK  
10 PROVIDER IF THERE IS NO IN-NETWORK PROVIDER WHO CAN FURNISH THE  
11 NEEDED SERVICES AT THE FACILITY; AND

12 (V) ANY OTHER ITEMS AND SERVICES PROVIDED BY SPECIALTY  
13 PROVIDERS AS ESTABLISHED BY RULE OF THE COMMISSIONER.

14   
15 (a.3) "BALANCE BILL" HAS THE SAME MEANING AS SET FORTH IN  
16 SECTION 10-16-704 (20)(c).

17 (a.5) "CARRIER" HAS THE SAME MEANING AS SET FORTH IN SECTION  
18 10-16-102 (8).

19 (c) "Emergency services" has the same meaning as ~~defined~~ SET  
20 FORTH in section 10-16-704 ~~(5.5)(e)(H)~~ (19)(e).

21 (c.5) "FEDERAL 'NO SURPRISES ACT'" MEANS THE FEDERAL "NO  
22 SURPRISES ACT", PUB.L. 116-260, AS AMENDED.

23 (d) "Geographic area" has the same meaning as ~~defined~~ SET FORTH  
24 in section 10-16-704 ~~(3)(d)(VI)(A)~~ (19)(h).

25 (f) "Medicare reimbursement rate" has the same meaning as  
26 ~~defined~~ SET FORTH in section 10-16-704 ~~(3)(d)(VI)(B)~~ (19)(k).

27 (g) "Out-of-network facility" means a health-care facility that is not

1 a participating provider. ~~as defined in section 10-16-102 (46).~~

2 (h) "PARTICIPATING PROVIDER" HAS THE SAME MEANING AS SET  
3 FORTH IN SECTION 10-16-102 (46).

4 **SECTION 6.** In Colorado Revised Statutes, 6-1-105, **amend**  
5 (1)(mmm) as follows:

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

9 (mmm) Violates section ~~12-30-113~~ 12-30-112;

10 **SECTION 7.** In Colorado Revised Statutes, 10-16-133, **add** (6)  
11 as follows:

12 **10-16-133. Health insurance carrier information disclosure -**  
13 **website - insurance producer fees and disclosure requirements -**  
14 **legislative declaration - rules.** (6) (a) A CARRIER OFFERING INDIVIDUAL  
15 HEALTH BENEFIT PLANS OR SHORT-TERM LIMITED DURATION HEALTH  
16 INSURANCE POLICIES SHALL DISCLOSE TO THE COVERED PERSON THE  
17 AMOUNT OF COMPENSATION ASSOCIATED WITH PLAN SELECTION AND  
18 ENROLLMENT CONSISTENT WITH, THE FEDERAL "NO SURPRISES ACT",  
19 PUB.L. 116-260, AS AMENDED.

20 (b) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT  
21 THE CARRIER DISCLOSURE REQUIREMENTS UNDER THIS SUBSECTION (6).

22 **SECTION 8. Appropriation.** (1) For the 2022-23 state fiscal  
23 year, \$233,018 is appropriated to the department of regulatory agencies.  
24 This appropriation is from the division of insurance cash fund created in  
25 section 10-1-103 (3), C.R.S. To implement this act, the department may  
26 use this appropriation as follows:

27 (a) \$129,745 for use by the division of insurance for personal

1 services, which amount is based on an assumption that the division will  
2 require an additional 1.6 FTE;

3 (b) \$14,560 for use by the division of insurance for operating  
4 expenses; and

5 (c) \$88,713 for the purchase of legal services.

6 (2) For the 2022-23 state fiscal year, \$88,713 is appropriated to the  
7 department of law. This appropriation is from reappropriated funds  
8 received from the department of regulatory agencies under subsection  
9 (1)(c) of this section and is based on an assumption that the department of  
10 law will require an additional 0.5 FTE. To implement this act, the  
11 department of law may use this appropriation to provide legal services for  
12 the department of regulatory agencies.

13 (3) For the 2022-23 state fiscal year, \$7,506 is appropriated to the  
14 department of public health and environment for use by health  
15 facilities and emergency medical services division. This appropriation is  
16 from the health facilities general licensure cash fund created in section  
17 25-3-103.1 (1), C.R.S., and is based on an assumption that the department  
18 will require an additional 0.1 FTE. To implement this act, the department  
19 may use this appropriation for administration and operations related to  
20 operations management.

21 **SECTION 9. Act subject to petition - effective date.** This act  
22 takes effect at 12:01 a.m. on the day following the expiration of the  
23 ninety-day period after final adjournment of the general assembly; except  
24 that, if a referendum petition is filed pursuant to section 1 (3) of article V  
25 of the state constitution against this act or an item, section, or part of this  
26 act within such period, then the act, item, section, or part will not take  
27 effect unless approved by the people at the general election to be held in

- 1 November 2022 and, in such case, will take effect on the date of the
- 2 official declaration of the vote thereon by the governor.