

SB134\_L.002

SENATE COMMITTEE OF REFERENCE AMENDMENT

Committee on Health & Human Services.

SB19-134 be amended as follows:

1 Amend printed bill, strike everything below the enacting clause and  
2 substitute:

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

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

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

9 **SECTION 2.** In Colorado Revised Statutes, 10-3-1104, **amend**  
10 (1)(qq); and **add** (1)(ss) and (1)(tt) as follows:

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

15 (qq) Failure to pay a final, nonappealable judgment award for  
16 failure to return or repay collateral received to secure a bond; ~~or~~

17 (ss) A VIOLATION OF SECTION 10-16-704 (3)(d) OR (5.5); OR

18 (tt) MISREPRESENTING IN ANY INFORMATION DISSEMINATED BY A  
19 HEALTH INSURANCE CARRIER TO THE PUBLIC THAT A HEALTH CARE  
20 FACILITY IS A PARTICIPATING OR IN-NETWORK HEALTH CARE FACILITY  
21 WITH THE HEALTH INSURANCE CARRIER WHEN PHYSICIAN SPECIALISTS IN  
22 EMERGENCY MEDICINE, PATHOLOGY, RADIOLOGY, OR ANESTHESIOLOGY  
23 PROVIDING SERVICES AT THE FACILITY ARE NOT UNDER CONTRACT WITH  
24 THE HEALTH INSURANCE CARRIER, AND THE HEALTH INSURANCE CARRIER  
25 CANNOT ON A TIMELY BASIS PROVIDE THE SERVICES ON AN IN-NETWORK  
26 BASIS AT THE HEALTH CARE FACILITY.

27 **SECTION 3.** In Colorado Revised Statutes, 10-16-107, **add** (7)  
28 as follows:

29 **10-16-107. Rate filing regulation - benefits ratio - rules.**

30 (7) STARTING IN 2021, AS PART OF THE RATE FILING REQUIRED PURSUANT  
31 TO THIS SECTION, EACH CARRIER SHALL PROVIDE TO THE COMMISSIONER,  
32 IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER,  
33 INFORMATION CONCERNING THE UTILIZATION OF OUT-OF-NETWORK  
34 PROVIDERS AND FACILITIES, THE AGGREGATE COST SAVINGS AS A RESULT  
35 OF THE IMPLEMENTATION OF SECTION 10-16-704 (3)(d) AND (5.5)(b), AND  
36 THE USE OF OUT-OF-NETWORK PROVIDERS AND FACILITIES BY COVERED  
37 PERSONS AND THE IMPACT ON PREMIUM AFFORDABILITY FOR CONSUMERS.

38 **SECTION 4.** In Colorado Revised Statutes, 10-16-704, **amend**  
39 (3)(a)(III), (5.5)(a) introductory portion, (5.5)(a)(V), (5.5)(b), (9)

1 introductory portion, and (9)(h); and **add** (3)(d), (5.5)(c), (5.5)(d),  
2 (5.5)(e), (12), (13), (14), and (15) as follows:  
3 **10-16-704. Network adequacy - rules - legislative declaration**  
4 **- definitions.** (3) (a) (III) The general assembly finds, determines, and  
5 declares that the division ~~of insurance~~ has correctly interpreted ~~the~~  
6 ~~provisions of~~ this section to protect ~~the insured~~ A COVERED PERSON from  
7 the additional expense charged by ~~an assisting~~ A provider who is an  
8 out-of-network provider, and has properly required ~~insurers~~ CARRIERS to  
9 hold the ~~consumer~~ COVERED PERSON harmless. The division ~~of insurance~~  
10 does not have regulatory authority over all health plans. Some consumers  
11 are enrolled in self-funded health insurance programs that are governed  
12 under the federal "Employee Retirement Income Security Act of 1974",  
13 29 U.S.C. SEC. 1001 ET SEQ. Therefore, ~~the general assembly encourages~~  
14 health care facilities, carriers, and providers ~~to~~ MUST provide consumers  
15 ~~disclosure~~ WITH DISCLOSURES about the potential impact of receiving  
16 services from an out-of-network provider OR HEALTH CARE FACILITY AND  
17 THEIR RIGHTS UNDER THIS SECTION. COVERED PERSONS MUST HAVE  
18 ACCESS TO ACCURATE INFORMATION ABOUT THEIR HEALTH CARE BILLS  
19 AND THEIR PAYMENT OBLIGATIONS IN ORDER TO ENABLE THEM TO MAKE  
20 INFORMED DECISIONS ABOUT THEIR HEALTH CARE AND FINANCIAL  
21 OBLIGATIONS.  
22 (d) (I) IF A COVERED PERSON RECEIVES COVERED SERVICES AT AN  
23 IN-NETWORK FACILITY FROM AN OUT-OF-NETWORK PROVIDER, THE  
24 CARRIER SHALL PAY THE OUT-OF-NETWORK PROVIDER DIRECTLY AND IN  
25 ACCORDANCE WITH THIS SUBSECTION (3)(d). AT THE TIME OF THE  
26 DISPOSITION OF THE CLAIM, THE CARRIER SHALL ADVISE THE  
27 OUT-OF-NETWORK PROVIDER AND THE COVERED PERSON OF ANY  
28 REQUIRED COINSURANCE, DEDUCTIBLE, OR COPAYMENT AMOUNT.  
29 (II) WHEN THE REQUIREMENTS OF SUBSECTION (3)(b) OF THIS  
30 SECTION APPLY, THE CARRIER SHALL REIMBURSE THE OUT-OF-NETWORK  
31 PROVIDER DIRECTLY IN ACCORDANCE WITH SECTION 10-16-106.5 THE  
32 GREATER OF:  
33 (A) ONE HUNDRED TEN PERCENT OF THE CARRIER'S MEDIAN  
34 IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE IN THE  
35 SAME GEOGRAPHIC AREA;  
36 (B) TWO HUNDRED SEVENTY-FIVE PERCENT OF THE MEDICARE  
37 REIMBURSEMENT RATE FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC  
38 AREA; OR  
39 (C) ONE HUNDRED TEN PERCENT OF THE SEVENTY-FIFTH  
40 PERCENTILE OF THE IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME  
41 SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY  
42 AND PROVIDED IN THE SAME GEOGRAPHIC AREA AS DETERMINED BASED ON  
43 COMMERCIAL CLAIMS DATA REPORTED IN THE 2018 CALENDAR YEAR FROM  
44 THE ALL-PAYER HEALTH CLAIMS DATABASE DESCRIBED IN SECTION  
45 25.5-1-204.

1 (III) THE REIMBURSEMENT CALCULATED IN ACCORDANCE WITH  
2 SUBSECTIONS (3)(d)(II)(B) AND (3)(d)(II)(C) OF THIS SECTION MUST BE  
3 ADJUSTED ON JANUARY 1 OF EACH YEAR BASED ON THE PREVIOUS YEAR'S  
4 DENVER-AURORA-LAKWOOD CONSUMER PRICE INDEX OR ITS SUCCESSOR  
5 INDEX.

6 (IV) PAYMENT MADE BY A CARRIER IN COMPLIANCE WITH THIS  
7 SUBSECTION (3)(d) IS PRESUMED TO BE PAYMENT IN FULL FOR THE  
8 SERVICES PROVIDED, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR  
9 COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON,  
10 UNLESS THE OUT-OF-NETWORK PROVIDER INITIATES ARBITRATION IN  
11 ACCORDANCE WITH SUBSECTION (14) OF THIS SECTION.

12 (V) THIS SUBSECTION (3)(d) DOES NOT PRECLUDE THE CARRIER  
13 AND THE OUT-OF-NETWORK PROVIDER FROM VOLUNTARILY NEGOTIATING  
14 AN INDEPENDENT REIMBURSEMENT RATE. IF THE NEGOTIATIONS FAIL, THE  
15 REIMBURSEMENT RATE REQUIRED BY SUBSECTION (3)(d)(II) OF THIS  
16 SECTION APPLIES.

17 (VI) THIS SUBSECTION (3)(d) DOES NOT APPLY WHEN A COVERED  
18 PERSON INTENTIONALLY USES AN OUT-OF-NETWORK PROVIDER.

19 (VII) FOR PURPOSES OF THIS SUBSECTION (3):

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

22 (B) "MEDICARE REIMBURSEMENT RATE" MEANS THE  
23 REIMBURSEMENT RATE FOR A PARTICULAR HEALTH CARE SERVICE  
24 PROVIDED UNDER THE "HEALTH INSURANCE FOR THE AGED ACT", TITLE  
25 XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, 42 U.S.C.  
26 SEC. 1395 ET SEQ.

27 (VIII) FOR PURPOSES OF THIS SUBSECTION (3)(d) AND  
28 SUBSECTIONS (12), (13), (14), AND (15) OF THIS SECTION, "PROVIDER"  
29 MEANS A PERSON OR ENTITY THAT PROVIDES HEALTH CARE SERVICES TO  
30 A COVERED PERSON AND BILLS INDEPENDENTLY FOR THE SERVICES  
31 PROVIDED.

32 (5.5) (a) Notwithstanding any provision of law, a carrier that  
33 provides any benefits with respect to EMERGENCY services ~~in an~~  
34 ~~emergency department of a hospital~~ shall cover THE emergency services:

35 (V) AT THE IN-NETWORK BENEFIT LEVEL, with the same  
36 ~~cost-sharing~~ COINSURANCE, DEDUCTIBLE, OR COPAYMENT requirements  
37 as would apply if THE emergency services were provided BY AN  
38 in-network PROVIDER OR AT AN IN-NETWORK FACILITY, AND AT NO  
39 GREATER COST TO THE COVERED PERSON THAN IF THE EMERGENCY  
40 SERVICES WERE OBTAINED FROM AN IN-NETWORK PROVIDER AT AN  
41 IN-NETWORK FACILITY. ANY PAYMENT MADE BY A COVERED PERSON  
42 PURSUANT TO THIS SUBSECTION (5.5)(a)(V) MUST BE APPLIED TO THE  
43 COVERED PERSON'S IN-NETWORK ANNUAL COST-SHARING LIMIT.

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

45 (f) ~~"Emergency medical condition" means a medical condition that~~

1 manifests itself by acute symptoms of sufficient severity, including severe  
2 pain, that a prudent layperson with an average knowledge of health and  
3 medicine could reasonably expect, in the absence of immediate medical  
4 attention, to result in:

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

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

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

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

12 (A) ~~A medical screening examination that is within the capability~~  
13 ~~of the emergency department of a hospital, including ancillary services~~  
14 ~~routinely available to the emergency department to evaluate the~~  
15 ~~emergency medical condition; and~~

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

22 (b) (I) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT  
23 AN OUT-OF-NETWORK FACILITY, OTHER THAN ANY OUT-OF-NETWORK  
24 FACILITY OPERATED BY THE DENVER HEALTH AND HOSPITAL AUTHORITY  
25 PURSUANT TO ARTICLE 29 OF TITLE 25, THE CARRIER SHALL REIMBURSE  
26 THE OUT-OF-NETWORK PROVIDER IN ACCORDANCE WITH SUBSECTION  
27 (3)(d)(II) OF THIS SECTION AND REIMBURSE THE OUT-OF-NETWORK  
28 FACILITY DIRECTLY IN ACCORDANCE WITH SECTION 10-16-106.5 THE  
29 GREATER OF:

30 (A) ONE HUNDRED TEN PERCENT OF THE CARRIER'S MEDIAN  
31 IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE PROVIDED  
32 IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR

33 (B) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE  
34 SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME  
35 GEOGRAPHIC AREA FOR THE PRIOR YEAR AS DETERMINED BASED ON  
36 CLAIMS DATA FROM THE COLORADO ALL-PAYER HEALTH CLAIMS  
37 DATABASE DESCRIBED IN SECTION 25.5-1-204.

38 (II) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT ANY  
39 OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER HEALTH AND  
40 HOSPITAL AUTHORITY CREATED IN SECTION 25-29-103, THE CARRIER  
41 SHALL REIMBURSE THE OUT-OF-NETWORK FACILITY DIRECTLY IN  
42 ACCORDANCE WITH SECTION 10-16-106.5 THE GREATER OF:

43 (A) THE CARRIER'S MEDIAN IN-NETWORK RATE OF  
44 REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY  
45 OR SETTING IN THE SAME GEOGRAPHIC AREA;

1 (B) TWO HUNDRED FIFTY PERCENT OF THE MEDICARE  
2 REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR  
3 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR

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

9 (III) PAYMENT MADE BY A CARRIER IN COMPLIANCE WITH THIS  
10 SUBSECTION (5.5)(b) IS PRESUMED TO BE PAYMENT IN FULL FOR THE  
11 SERVICES PROVIDED, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR  
12 COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON,  
13 UNLESS THE OUT-OF-NETWORK PROVIDER INITIATES ARBITRATION IN  
14 ACCORDANCE WITH SUBSECTION (14) OF THIS SECTION.

15 (c) THIS SUBSECTION (5.5) DOES NOT PRECLUDE THE CARRIER AND  
16 THE OUT-OF-NETWORK FACILITY OR THE CARRIER AND THE  
17 OUT-OF-NETWORK PROVIDER FROM VOLUNTARILY NEGOTIATING AN  
18 INDEPENDENT REIMBURSEMENT RATE. IF THE NEGOTIATIONS FAIL, THE  
19 REIMBURSEMENT RATE REQUIRED BY SUBSECTION (5.5)(b) OF THIS  
20 SECTION APPLIES.

21 (d) (I) SUBSECTIONS (5.5)(a), (5.5)(b), AND (5.5)(c) OF THIS  
22 SECTION DO NOT APPLY TO SERVICE AGENCIES, AS DEFINED IN SECTION  
23 25-3.5-103 (11.5), PROVIDING AMBULANCE SERVICES, AS DEFINED IN  
24 SECTION 25-3.5-103 (3).

25 (II) (A) THE COMMISSIONER SHALL PROMULGATE RULES TO  
26 IDENTIFY AND IMPLEMENT A PAYMENT METHODOLOGY THAT APPLIES TO  
27 SERVICE AGENCIES DESCRIBED IN SUBSECTION (5.5)(d)(I) OF THIS SECTION,  
28 EXCEPT FOR SERVICE AGENCIES THAT ARE PUBLICLY FUNDED FIRE  
29 AGENCIES.

30 (B) THE COMMISSIONER SHALL MAKE THE PAYMENT  
31 METHODOLOGY AVAILABLE TO THE PUBLIC ON THE DIVISION'S WEBSITE.  
32 THE RULES MUST BE EQUITABLE TO SERVICE AGENCIES AND CARRIERS;  
33 HOLD CONSUMERS HARMLESS EXCEPT FOR ANY APPLICABLE COINSURANCE,  
34 DEDUCTIBLE, OR COPAYMENT AMOUNTS; AND BE BASED ON A COST-BASED  
35 MODEL THAT INCLUDES DIRECT PAYMENT TO SERVICE AGENCIES  
36 DESCRIBED IN SUBSECTION (5.5)(d)(I) OF THIS SECTION.

37 (C) THE DIVISION MAY CONTRACT WITH A NEUTRAL THIRD PARTY  
38 THAT HAS NO FINANCIAL INTEREST IN PROVIDERS, EMERGENCY SERVICE  
39 PROVIDERS, OR CARRIERS TO CONDUCT THE ANALYSIS TO IDENTIFY AND  
40 IMPLEMENT THE PAYMENT METHODOLOGY.

41 (e) FOR PURPOSES OF THIS SUBSECTION (5.5):

42 (I) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL  
43 CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT  
44 SEVERITY, INCLUDING SEVERE PAIN, THAT A PRUDENT LAYPERSON WITH AN  
45 AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY

1 EXPECT, IN THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION, TO RESULT  
2 IN:

3 (A) SERIOUS JEOPARDY TO THE HEALTH OF THE INDIVIDUAL OR,  
4 WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR  
5 HER UNBORN CHILD;

6 (B) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR  
7 (C) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

8 (II) "EMERGENCY SERVICES", WITH RESPECT TO AN EMERGENCY  
9 MEDICAL CONDITION, MEANS:

10 (A) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE  
11 CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING  
12 ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY  
13 DEPARTMENT TO EVALUATE THE EMERGENCY MEDICAL CONDITION; AND  
14 (B) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES  
15 AVAILABLE AT THE HOSPITAL, FURTHER MEDICAL EXAMINATION AND  
16 TREATMENT AS REQUIRED TO STABILIZE THE PATIENT TO ASSURE, WITHIN  
17 REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION  
18 OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE  
19 TRANSFER OF THE INDIVIDUAL FROM A FACILITY.

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

22 (IV) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING  
23 AS DEFINED IN SUBSECTION (3)(d)(VII)(B) OF THIS SECTION.

24 (V) "PROVIDER" HAS THE SAME MEANING AS DEFINED IN  
25 SUBSECTION (3)(d)(VIII) OF THIS SECTION.

26 (9) ~~Beginning January 1, 1998,~~ A carrier shall maintain and make  
27 available upon request of the commissioner, the executive director of the  
28 department of public health and environment, or the executive director of  
29 the department of health care policy and financing, in a manner and form  
30 that reflects the requirements specified in ~~paragraphs (a) to (k) of this~~  
31 ~~subsection (9)~~ SUBSECTIONS (9)(a) TO (9)(k) OF THIS SECTION, an access  
32 plan for each managed care network that the carrier offers in this state.  
33 The carrier shall make the access plans, absent confidential information  
34 as specified in section 24-72-204 (3), ~~C.R.S.~~, available on its business  
35 premises and shall provide them to any interested party upon request. In  
36 addition, all health benefit plans and marketing materials shall clearly  
37 disclose the existence and availability of the access plan. All rights and  
38 responsibilities of the covered person under the health benefit plan,  
39 however, shall be included in the contract provisions, regardless of  
40 whether ~~or not~~ such provisions are also specified in the access plan. The  
41 carrier shall prepare an access plan prior to offering a new managed care  
42 network and shall update an existing access plan whenever the carrier  
43 makes any material change to an existing managed care network, but not  
44 less than annually. The access plan of a carrier offering a managed care  
45 plan shall demonstrate the following:

1 (h) The carrier's system for ensuring the coordination and  
2 continuity of care for covered persons referred to specialty providers,  
3 INCLUDING DOCUMENTATION THAT THE CARRIER HAS A SUFFICIENT  
4 NUMBER OF CONTRACTED PROVIDERS PRACTICING AT THE SAME FACILITIES  
5 WITH WHICH THE CARRIER HAS CONTRACTED TO REASONABLY ENSURE  
6 COVERED PERSONS HAVE TIMELY, IN-NETWORK ACCESS FOR COVERED  
7 SERVICES, INCLUDING PHYSICIAN SPECIALISTS IN EMERGENCY MEDICINE,  
8 PATHOLOGY, RADIOLOGY, AND ANESTHESIOLOGY SERVICES DELIVERED AT  
9 THOSE IN-NETWORK FACILITIES;

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

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

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

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

30 (III) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE  
31 COVERED PERSON'S RIGHTS AND PAYMENT OBLIGATIONS IF THE COVERED  
32 PERSON'S HEALTH BENEFIT PLAN IS UNDER THE JURISDICTION OF THE  
33 DIVISION;

34 (IV) DISCLOSURE REQUIREMENTS SPECIFIC TO CARRIERS,  
35 INCLUDING THE POSSIBILITY OF BEING TREATED BY AN OUT-OF-NETWORK  
36 PROVIDER, WHETHER A PROVIDER IS OUT OF NETWORK, THE TYPES OF  
37 SERVICES AN OUT-OF-NETWORK PROVIDER MAY PROVIDE, AND THE RIGHT  
38 TO REQUEST AN IN-NETWORK PROVIDER TO PROVIDE SERVICES; AND

39 (V) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN  
40 THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT  
41 CARRIERS, HEALTH CARE FACILITIES, AND PROVIDERS USE LANGUAGE THAT  
42 IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY THIS SUBSECTION  
43 (12) AND SECTIONS 24-34-113 AND 25-3-120 AND THE RULES ADOPTED  
44 PURSUANT TO THIS SUBSECTION (12)(b) AND SECTIONS 24-34-113 (3) AND  
45 25-3-120 (2).

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

6 (13) WHEN A CARRIER MAKES A PAYMENT TO A PROVIDER OR A  
7 HEALTH CARE FACILITY PURSUANT TO SUBSECTION (3)(d) OR (5.5)(b) OF  
8 THIS SECTION, THE PROVIDER OR THE FACILITY MAY REQUEST AND THE  
9 COMMISSIONER SHALL COLLECT DATA FROM THE CARRIER TO EVALUATE  
10 THE CARRIER'S COMPLIANCE IN PAYING THE HIGHEST RATE REQUIRED. THE  
11 INFORMATION REQUESTED MAY INCLUDE THE METHODOLOGY FOR  
12 DETERMINING THE CARRIER'S MEDIAN IN-NETWORK RATE OR  
13 REIMBURSEMENT FOR EACH SERVICE IN THE SAME GEOGRAPHIC AREA.

14 (14) (a) (I) IF A PROVIDER OR HEALTH CARE FACILITY BELIEVES  
15 THAT A PAYMENT MADE PURSUANT TO SUBSECTION (3) OR (5.5) OF THIS  
16 SECTION OR SECTION 24-34-114 OR A HEALTH CARE FACILITY BELIEVES  
17 THAT A PAYMENT MADE PURSUANT TO SUBSECTION (5.5) OF THIS SECTION  
18 OR SECTION 25-3-121 (3) WAS NOT SUFFICIENT GIVEN THE COMPLEXITY  
19 AND CIRCUMSTANCES OF THE SERVICES PROVIDED, THE PROVIDER OR THE  
20 HEALTH CARE FACILITY MAY INITIATE ARBITRATION BY FILING A REQUEST  
21 FOR ARBITRATION WITH THE COMMISSIONER AND THE CARRIER. A  
22 PROVIDER OR HEALTH CARE FACILITY MUST SUBMIT A REQUEST FOR THE  
23 ARBITRATION OF A CLAIM WITHIN NINETY DAYS AFTER THE RECEIPT OF  
24 PAYMENT FOR THAT CLAIM. THE PROVIDER MAY INCLUDE MULTIPLE  
25 CLAIMS TO BE ARBITRATED IN A SINGLE ARBITRATION PROCESS.

26 (II) PRIOR TO ARBITRATION UNDER SUBSECTION (14)(a)(I) OF THIS  
27 SECTION, IF REQUESTED BY THE CARRIER AND THE PROVIDER OR HEALTH  
28 CARE FACILITY, THE COMMISSIONER MAY ARRANGE AN INFORMAL  
29 SETTLEMENT TELECONFERENCE TO BE HELD WITHIN THIRTY DAYS AFTER  
30 THE REQUEST FOR ARBITRATION. THE PARTIES SHALL NOTIFY THE  
31 COMMISSIONER OF THE RESULTS OF THE SETTLEMENT CONFERENCE.

32 (III) UPON RECEIPT OF NOTICE THAT THE SETTLEMENT  
33 TELECONFERENCE WAS UNSUCCESSFUL, THE COMMISSIONER SHALL  
34 APPOINT AN ARBITRATOR AND NOTIFY THE PARTIES OF THE ARBITRATION.

35 (b) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT  
36 AN ARBITRATION PROCESS THAT ESTABLISHES A STANDARD ARBITRATION  
37 FORM AND INCLUDES THE SELECTION OF AN ARBITRATOR FROM A LIST OF  
38 QUALIFIED ARBITRATORS DEVELOPED PURSUANT TO THE RULES.  
39 QUALIFIED ARBITRATORS MUST BE INDEPENDENT; NOT BE AFFILIATED  
40 WITH A CARRIER, HEALTH CARE FACILITY, OR PROVIDER, OR ANY  
41 PROFESSIONAL ASSOCIATION OF CARRIERS, HEALTH CARE FACILITIES, OR  
42 PROVIDERS; NOT HAVE A PERSONAL, PROFESSIONAL, OR FINANCIAL  
43 CONFLICT WITH ANY PARTIES TO THE ARBITRATION; AND HAVE  
44 EXPERIENCE IN HEALTH CARE BILLING AND REIMBURSEMENT RATES.

45 (c) (I) THE ARBITRATOR SHALL PERFORM THE REVIEW OF THE

1 WRITTEN SUBMISSION BY THE PROVIDER OR HEALTH CARE FACILITY. THE  
2 ARBITRATOR SHALL DETERMINE WHETHER THE DISPUTED PAYMENT WAS  
3 INSUFFICIENT GIVEN THE COMPLEXITY AND CIRCUMSTANCES.

4 (II) IF THE ARBITRATOR DETERMINES ADDITIONAL PAYMENT IS  
5 WARRANTED, BOTH PARTIES SHALL SUBMIT, IN WRITING, EACH PARTY'S  
6 FINAL OFFER. THE ARBITRATOR SHALL PICK ONE OF THE TWO AMOUNTS  
7 SUBMITTED BY THE PARTIES AS THE ARBITRATOR'S FINAL AND BINDING  
8 DECISION. THE DECISION MUST BE IN WRITING AND MADE WITHIN  
9 FORTY-FIVE DAYS AFTER THE ARBITRATOR'S APPOINTMENT. IN MAKING  
10 THE DECISION, THE ARBITRATOR MAY CONSIDER THE CIRCUMSTANCES AND  
11 COMPLEXITY OF THE PARTICULAR CASE, INCLUDING THE TIME AND PLACE  
12 OF SERVICES, AND THE AVAILABILITY OF PROVIDERS IN THE SAME  
13 GEOGRAPHIC REGION.

14 (d) IF THE ARBITRATOR'S DECISION REQUIRES ADDITIONAL  
15 PAYMENT BY THE CARRIER ABOVE THE AMOUNT PAID, THE CARRIER SHALL  
16 PAY THE PROVIDER IN ACCORDANCE WITH SECTION 10-16-106.5.

17 (e) THE ARBITRATOR'S EXPENSES AND FEES SHALL BE SPLIT  
18 EQUALLY AMONG THE PARTIES.

19 (15) (a) NOTWITHSTANDING SECTION 24-1-136 (11)(a)(I), ON OR  
20 BEFORE JULY 1, 2021, AND EACH JULY 1 THEREAFTER, THE COMMISSIONER  
21 SHALL PROVIDE A WRITTEN REPORT TO THE HEALTH AND HUMAN SERVICES  
22 COMMITTEE OF THE SENATE AND THE HEALTH AND INSURANCE COMMITTEE  
23 OF THE HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES,  
24 AND SHALL POST THE REPORT ON THE DIVISION'S WEBSITE SUMMARIZING:

25 (I) FOR THE PREVIOUS CALENDAR YEAR:

26 (A) THE INFORMATION SUBMITTED TO THE COMMISSIONER IN  
27 ACCORDANCE WITH SECTION 10-16-107 (7) AND THE NUMBER OF  
28 ARBITRATIONS FILED;

29 (B) THE NUMBER OF ARBITRATIONS SETTLED, ARBITRATED, AND  
30 DISMISSED; AND

31 (C) WHETHER THE ARBITRATIONS WERE IN FAVOR OF THE CARRIER  
32 OR THE OUT-OF-NETWORK PROVIDER OR HEALTH CARE FACILITY.

33 (b) THE LIST OF ARBITRATION DECISIONS MUST NOT INCLUDE ANY  
34 INFORMATION THAT SPECIFICALLY IDENTIFIES THE PROVIDER, HEALTH  
35 CARE FACILITY, CARRIER, OR COVERED PERSON INVOLVED IN EACH  
36 ARBITRATION DECISION.

37 **SECTION 5.** In Colorado Revised Statutes, **add** 24-34-113 and  
38 24-34-114 as follows:

39 **24-34-113. Health care providers - required disclosures - rules**  
40 **- definitions.** (1) FOR THE PURPOSES OF THIS SECTION AND SECTION  
41 24-34-114:

42 (a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION  
43 10-16-102 (8).

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

1 (c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED  
2 IN SECTION 10-16-704 (5.5)(e)(II).  
3 (d) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN  
4 SECTION 10-16-704 (3)(d)(VII)(A).  
5 (e) "HEALTH BENEFIT PLAN" HAS THE SAME MEANING AS DEFINED  
6 IN SECTION 10-16-102 (32).  
7 (f) "HEALTH CARE PROVIDER" MEANS A PERSON OR ENTITY THAT  
8 PROVIDES HEALTH CARE SERVICES TO A COVERED PERSON AND BILLS  
9 INDEPENDENTLY FOR THE SERVICES PROVIDED.  
10 (g) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING  
11 AS DEFINED IN SECTION 10-16-704 (3)(d)(VII)(B).  
12 (h) "OUT-OF-NETWORK PROVIDER" MEANS A HEALTH CARE  
13 PROVIDER THAT IS NOT A "PARTICIPATING PROVIDER" AS DEFINED IN  
14 SECTION 10-16-102 (46).  
15 (2) ON AND AFTER JANUARY 1, 2020, HEALTH CARE PROVIDERS  
16 SHALL DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE  
17 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY  
18 SERVICES FROM AN OUT-OF-NETWORK PROVIDER. THE DISCLOSURES MUST  
19 COMPLY WITH THE RULES ADOPTED PURSUANT TO SUBSECTION (3) OF THIS  
20 SECTION.  
21 (3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF  
22 INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION  
23 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR  
24 HEALTH CARE PROVIDERS TO DEVELOP AND PROVIDE CONSUMER  
25 DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE DIRECTOR SHALL  
26 ENSURE THAT THE RULES ARE CONSISTENT WITH SECTIONS 10-16-704 (12)  
27 AND 25-3-120 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO  
28 SECTION 10-16-704 (12)(b) AND BY THE STATE BOARD OF HEALTH  
29 PURSUANT TO SECTION 25-3-120 (2). THE RULES MUST SPECIFY, AT A  
30 MINIMUM, THE FOLLOWING:  
31 (a) THE TIMING FOR PROVIDING THE DISCLOSURES FOR EMERGENCY  
32 AND NONEMERGENCY SERVICES WITH CONSIDERATION GIVEN TO  
33 POTENTIAL LIMITATIONS RELATING TO THE FEDERAL "EMERGENCY  
34 MEDICAL TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd;  
35 (b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE  
36 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON  
37 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR  
38 COMMUNICATIONS WITH CONSUMERS;  
39 (c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE  
40 CONSUMER'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE  
41 CONSUMER'S HEALTH BENEFIT PLAN;  
42 (d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE  
43 PROVIDERS, INCLUDING WHETHER A HEALTH CARE PROVIDER IS OUT OF  
44 NETWORK, THE TYPES OF SERVICES AN OUT-OF-NETWORK HEALTH CARE  
45 PROVIDER MAY PROVIDE, AND THE RIGHT TO REQUEST AN IN-NETWORK

1 HEALTH CARE PROVIDER TO PROVIDE SERVICES; AND

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

9 (4) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SECTION DOES  
10 NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTION 10-16-704(3) OR  
11 (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS UNDER THE CONSUMER'S  
12 HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL FOR ALL  
13 COVERED SERVICES AND TREATMENT RECEIVED.

14 (5) THIS SECTION DOES NOT APPLY TO SERVICE AGENCIES, AS  
15 DEFINED IN SECTION 25-3.5-103 (11.5), THAT ARE PUBLICLY FUNDED FIRE  
16 AGENCIES.

17 **24-34-114. Out-of-network health care providers -**  
18 **out-of-network services - billing - payment.** (1) IF AN  
19 OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES EMERGENCY  
20 SERVICES OR COVERED NONEMERGENCY SERVICES TO A COVERED PERSON  
21 AT AN IN-NETWORK FACILITY, THE OUT-OF-NETWORK PROVIDER SHALL:

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

24 (b) NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR  
25 ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE  
26 CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,  
27 DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE  
28 COVERED PERSON.

29 (2)(a) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES  
30 COVERED NONEMERGENCY SERVICES AT AN IN-NETWORK FACILITY OR  
31 EMERGENCY SERVICES AT AN OUT-OF-NETWORK OR IN-NETWORK FACILITY  
32 AND THE HEALTH CARE PROVIDER RECEIVES PAYMENT FROM THE COVERED  
33 PERSON FOR SERVICES FOR WHICH THE COVERED PERSON IS NOT  
34 RESPONSIBLE PURSUANT TO SECTION 10-16-704 (3)(b) OR (5.5), THE  
35 HEALTH CARE PROVIDER SHALL REIMBURSE THE COVERED PERSON WITHIN  
36 SIXTY CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS  
37 REPORTED TO THE PROVIDER.

38 (b) AN OUT-OF-NETWORK HEALTH CARE PROVIDER THAT FAILS TO  
39 REIMBURSE A COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF  
40 THIS SECTION FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE  
41 OVERPAYMENT AT THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON  
42 THE DATE THE PROVIDER RECEIVED THE NOTICE OF THE OVERPAYMENT.  
43 THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED  
44 INTEREST FROM THE OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER  
45 TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.

1 (3) AN OUT-OF-NETWORK HEALTH CARE PROVIDER SHALL PROVIDE  
2 A COVERED PERSON A WRITTEN ESTIMATE OF THE AMOUNT FOR WHICH THE  
3 COVERED PERSON MAY BE RESPONSIBLE FOR COVERED NONEMERGENCY  
4 SERVICES WITHIN THREE BUSINESS DAYS AFTER A REQUEST FROM THE  
5 COVERED PERSON.

6 (4) (a) AN OUT-OF-NETWORK HEALTH CARE PROVIDER MUST SEND  
7 A CLAIM FOR A COVERED SERVICE TO THE CARRIER WITHIN ONE HUNDRED  
8 EIGHTY DAYS AFTER RECEIPT OF INSURANCE INFORMATION IN ORDER TO  
9 RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (4)(a). THE  
10 REIMBURSEMENT RATE IS THE GREATER OF:

11 (I) ONE HUNDRED TEN PERCENT OF THE CARRIER'S MEDIAN  
12 IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE IN THE  
13 SAME GEOGRAPHIC AREA;

14 (II) TWO HUNDRED SEVENTY-FIVE PERCENT OF THE MEDICARE  
15 REIMBURSEMENT RATE FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC  
16 AREA; OR

17 (III) ONE HUNDRED TEN PERCENT OF THE SEVENTY-FIFTH  
18 PERCENTILE OF THE IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME  
19 SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY  
20 AND PROVIDED IN THE SAME GEOGRAPHIC AREA AS DETERMINED BASED ON  
21 COMMERCIAL CLAIMS DATA REPORTED IN THE 2018 CALENDAR YEAR FROM  
22 THE ALL-PAYER HEALTH CLAIMS DATABASE DESCRIBED IN SECTION  
23 25.5-1-204.

24 (IV) THE REIMBURSEMENT CALCULATED IN ACCORDANCE WITH  
25 SUBSECTIONS (4)(a)(II) AND (4)(a)(III) OF THIS SECTION MUST BE  
26 ADJUSTED ON JANUARY 1 OF EACH YEAR BASED ON THE PREVIOUS YEAR'S  
27 DENVER-AURORA-LAKEWOOD CONSUMER PRICE INDEX OR ITS SUCCESSOR  
28 INDEX.

29 (b) IF THE OUT-OF-NETWORK HEALTH CARE PROVIDER SUBMITS A  
30 CLAIM FOR COVERED SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY  
31 PERIOD SPECIFIED IN SUBSECTION (4)(a) OF THIS SECTION, THE CARRIER  
32 SHALL REIMBURSE THE HEALTH CARE PROVIDER ONE HUNDRED  
33 TWENTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE  
34 SAME SERVICES IN THE SAME GEOGRAPHIC AREA.

35 (c) THE HEALTH CARE PROVIDER SHALL NOT BILL A COVERED  
36 PERSON ANY OUTSTANDING BALANCE FOR A COVERED SERVICE NOT PAID  
37 FOR BY THE CARRIER, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR  
38 COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.

39 (5) A HEALTH CARE PROVIDER MAY INITIATE ARBITRATION  
40 PURSUANT TO SECTION 10-16-704 (14) IF THE HEALTH CARE PROVIDER  
41 BELIEVES THE PAYMENT MADE PURSUANT TO SUBSECTION (4) OF THIS  
42 SECTION IS NOT SUFFICIENT.

43 (6) THIS SECTION DOES NOT APPLY WHEN A COVERED PERSON  
44 INTENTIONALLY USES AN OUT-OF-NETWORK PROVIDER.

45 **SECTION 6.** In Colorado Revised Statutes, **add** 25-3-120 and

1 25-3-121 as follows:

2 **25-3-120. Health care facilities - emergency and**  
3 **nonemergency services - required disclosures - rules - definitions.**

4 (1) ON AND AFTER JANUARY 1, 2020, HEALTH CARE FACILITIES SHALL  
5 DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE  
6 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY  
7 SERVICES FROM AN OUT-OF-NETWORK PROVIDER PROVIDING SERVICES AT  
8 AN IN-NETWORK FACILITY OR EMERGENCY SERVICES AT AN  
9 OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE  
10 RULES ADOPTED PURSUANT TO SUBSECTION (2) OF THIS SECTION.

11 (2) THE STATE BOARD OF HEALTH, IN CONSULTATION WITH THE  
12 COMMISSIONER OF INSURANCE AND THE DIRECTOR OF THE DIVISION OF  
13 PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF REGULATORY  
14 AGENCIES, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR  
15 HEALTH CARE FACILITIES TO DEVELOP AND PROVIDE CONSUMER  
16 DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE STATE BOARD OF  
17 HEALTH SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTIONS  
18 10-16-704 (12) AND 24-34-113 AND RULES ADOPTED BY THE  
19 COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE  
20 DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS PURSUANT  
21 TO SECTION 24-34-113 (3). THE RULES MUST SPECIFY, AT A MINIMUM, THE  
22 FOLLOWING:

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

27 (b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE  
28 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON  
29 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR  
30 COMMUNICATIONS WITH CONSUMERS;

31 (c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE  
32 CONSUMER'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE  
33 CONSUMER'S HEALTH BENEFIT PLAN;

34 (d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE  
35 FACILITIES, INCLUDING WHETHER A HEALTH CARE PROVIDER DELIVERING  
36 SERVICES AT THE FACILITY IS OUT OF NETWORK, THE TYPES OF SERVICES  
37 AN OUT-OF-NETWORK HEALTH CARE PROVIDER MAY PROVIDE, AND THE  
38 RIGHT TO REQUEST AN IN-NETWORK HEALTH CARE PROVIDER TO PROVIDE  
39 SERVICES; AND

40 (e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN  
41 THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT  
42 CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE  
43 LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY  
44 THIS SECTION AND SECTIONS 10-16-704 (12) AND 24-34-113 AND THE  
45 RULES ADOPTED PURSUANT TO THIS SUBSECTION (2) AND SECTIONS

1 10-16-704 (12)(b) AND 24-34-113 (3).

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

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

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

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

12 (c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED  
13 IN SECTION 10-16-704 (5.5)(e)(II).

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

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

18 (f) "HEALTH CARE PROVIDER" MEANS A PERSON OR ENTITY THAT  
19 PROVIDES HEALTH CARE SERVICES TO A COVERED PERSON AND BILLS  
20 INDEPENDENTLY FOR THE SERVICES PROVIDED.

21 (g) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING  
22 AS DEFINED IN SECTION 10-16-704 (3)(d)(VII)(B).

23 (h) "OUT-OF-NETWORK FACILITY" MEANS A HEALTH CARE  
24 FACILITY THAT IS NOT A PARTICIPATING PROVIDER, AS DEFINED IN SECTION  
25 10-16-102 (46).

26 **25-3-121. Out-of-network facilities - emergency medical**  
27 **services - billing - payment.** (1) IF A COVERED PERSON RECEIVES  
28 EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE  
29 OUT-OF-NETWORK FACILITY SHALL:

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

32 (b) NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR  
33 ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE  
34 CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,  
35 DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE  
36 COVERED PERSON.

37 (2) (a) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT  
38 AN OUT-OF-NETWORK FACILITY, AND THE FACILITY RECEIVES PAYMENT  
39 FROM THE COVERED PERSON FOR SERVICES FOR WHICH THE COVERED  
40 PERSON IS NOT RESPONSIBLE PURSUANT TO SECTION 10-16-704 (3)(b) OR  
41 (5.5), THE FACILITY SHALL REIMBURSE THE COVERED PERSON WITHIN  
42 SIXTY CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS  
43 REPORTED TO THE FACILITY.

44 (b) AN OUT-OF-NETWORK FACILITY THAT FAILS TO REIMBURSE A  
45 COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF THIS SECTION

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

7 (3) (a) AN OUT-OF-NETWORK FACILITY, OTHER THAN ANY  
8 OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER HEALTH AND  
9 HOSPITAL AUTHORITY PURSUANT TO ARTICLE 29 OF TITLE 25, MUST SEND  
10 A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE  
11 HUNDRED EIGHTY DAYS AFTER RECEIPT OF INSURANCE INFORMATION IN  
12 ORDER TO RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION  
13 (3)(a). THE REIMBURSEMENT RATE IS THE GREATER OF:

14 (I) ONE HUNDRED TEN PERCENT OF THE CARRIER'S MEDIAN  
15 IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE PROVIDED  
16 IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR

17 (II) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE  
18 SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME  
19 GEOGRAPHIC AREA FOR THE PRIOR YEAR AS DETERMINED BASED ON  
20 CLAIMS DATA FROM THE COLORADO ALL-PAYER HEALTH CLAIMS  
21 DATABASE DESCRIBED IN SECTION 25.5-1-204.

22 (b) AN OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER  
23 HEALTH AND HOSPITAL AUTHORITY CREATED IN SECTION 25-29-103 MUST  
24 SEND A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE  
25 HUNDRED EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO  
26 RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (3)(b). THE  
27 REIMBURSEMENT RATE IS THE GREATER OF:

28 (I) THE CARRIER'S MEDIAN IN-NETWORK RATE OF REIMBURSEMENT  
29 FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN  
30 THE SAME GEOGRAPHIC AREA;

31 (II) TWO HUNDRED FIFTY PERCENT OF THE MEDICARE  
32 REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR  
33 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR

34 (III) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE  
35 SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME  
36 GEOGRAPHIC AREA FOR THE PRIOR YEAR AS DETERMINED BASED ON  
37 CLAIMS DATA FROM THE COLORADO ALL-PAYER HEALTH CLAIMS  
38 DATABASE DESCRIBED IN SECTION 25.5-1-204.

39 (c) IF THE OUT-OF-NETWORK FACILITY SUBMITS A CLAIM FOR  
40 EMERGENCY SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY PERIOD  
41 SPECIFIED IN THIS SUBSECTION (3), THE CARRIER SHALL REIMBURSE THE  
42 FACILITY ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE  
43 REIMBURSEMENT RATE FOR THE SAME SERVICES IN A SIMILAR SETTING OR  
44 FACILITY IN THE SAME GEOGRAPHIC AREA.

45 (d) THE OUT-OF-NETWORK FACILITY SHALL NOT BILL A COVERED

1 PERSON ANY OUTSTANDING BALANCE FOR A COVERED SERVICE NOT PAID  
2 FOR BY THE CARRIER, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR  
3 COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.

4 (4) AN OUT-OF-NETWORK FACILITY MAY INITIATE ARBITRATION  
5 PURSUANT TO SECTION 10-16-704 (14) IF THE FACILITY BELIEVES THE  
6 PAYMENT MADE PURSUANT TO SUBSECTION (3) OF THIS SECTION IS NOT  
7 SUFFICIENT.

8 **SECTION 7.** In Colorado Revised Statutes, 25-1-114, **add** (1)(j)  
9 as follows:

10 **25-1-114. Unlawful acts - penalties.** (1) It is unlawful for any  
11 person, association, or corporation, and the officers thereof:

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

13 **SECTION 8.** In Colorado Revised Statutes, **add to article 30 as**  
14 **relocated by House Bill 19-1172** 12-30-111 and 12-30-112 as follows:

15 **12-30-111. Health care providers - required disclosures - rules**  
16 **- definitions.** (1) FOR THE PURPOSES OF THIS SECTION AND SECTION  
17 12-30-112:

18 (a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION  
19 10-16-102 (8).

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

22 (c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED  
23 IN SECTION 10-16-704 (5.5)(e)(II).

24 (d) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN  
25 SECTION 10-16-704 (3)(d)(VII)(A).

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

28 (f) "HEALTH CARE PROVIDER" MEANS A PERSON OR ENTITY THAT  
29 PROVIDES HEALTH CARE SERVICES TO A COVERED PERSON AND BILLS  
30 INDEPENDENTLY FOR THE SERVICES PROVIDED.

31 (g) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING  
32 AS DEFINED IN SECTION 10-16-704 (3)(d)(VII)(B).

33 (h) "OUT-OF-NETWORK PROVIDER" MEANS A HEALTH CARE  
34 PROVIDER THAT IS NOT A "PARTICIPATING PROVIDER" AS DEFINED IN  
35 SECTION 10-16-102 (46).

36 (2) ON AND AFTER JANUARY 1, 2020, HEALTH CARE PROVIDERS  
37 SHALL DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE  
38 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY  
39 SERVICES FROM AN OUT-OF-NETWORK PROVIDER. THE DISCLOSURES MUST  
40 COMPLY WITH THE RULES ADOPTED PURSUANT TO SUBSECTION (3) OF THIS  
41 SECTION.

42 (3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF  
43 INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION  
44 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR  
45 HEALTH CARE PROVIDERS TO DEVELOP AND PROVIDE CONSUMER

1 DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE DIRECTOR SHALL  
2 ENSURE THAT THE RULES ARE CONSISTENT WITH SECTIONS 10-16-704(12)  
3 AND 25-3-120 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO  
4 SECTION 10-16-704 (12)(b) AND BY THE STATE BOARD OF HEALTH  
5 PURSUANT TO SECTION 25-3-120 (2). THE RULES MUST SPECIFY, AT A  
6 MINIMUM, THE FOLLOWING:

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

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

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

18 (d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE  
19 PROVIDERS, INCLUDING WHETHER A HEALTH CARE PROVIDER IS OUT OF  
20 NETWORK, THE TYPES OF SERVICES AN OUT-OF-NETWORK HEALTH CARE  
21 PROVIDER MAY PROVIDE, AND THE RIGHT TO REQUEST AN IN-NETWORK  
22 HEALTH CARE PROVIDER TO PROVIDE 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 25-3-120 AND THE RULES  
28 ADOPTED PURSUANT TO THIS SUBSECTION (3) AND SECTIONS 10-16-704  
29 (12)(b) AND 25-3-120 (2).

30 (4) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SECTION DOES  
31 NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTION 10-16-704(3) OR  
32 (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS UNDER THE CONSUMER'S  
33 HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL FOR ALL  
34 COVERED SERVICES AND TREATMENT RECEIVED.

35 (5) THIS SECTION DOES NOT APPLY TO SERVICE AGENCIES, AS  
36 DEFINED IN SECTION 25-3.5-103 (11.5), THAT ARE PUBLICLY FUNDED FIRE  
37 AGENCIES.

38 **12-30-112. Out-of-network health care providers -**  
39 **out-of-network services - billing - payment.** (1) IF AN  
40 OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES EMERGENCY  
41 SERVICES OR COVERED NONEMERGENCY SERVICES TO A COVERED PERSON  
42 AT AN IN-NETWORK FACILITY, THE OUT-OF-NETWORK PROVIDER SHALL:

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

45 (b) NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR

1 ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE  
2 CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,  
3 DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE  
4 COVERED PERSON.

5 (2)(a) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES  
6 COVERED NONEMERGENCY SERVICES AT AN IN-NETWORK FACILITY OR  
7 EMERGENCY SERVICES AT AN OUT-OF-NETWORK OR IN-NETWORK FACILITY  
8 AND THE HEALTH CARE PROVIDER RECEIVES PAYMENT FROM THE COVERED  
9 PERSON FOR SERVICES FOR WHICH THE COVERED PERSON IS NOT  
10 RESPONSIBLE PURSUANT TO SECTION 10-16-704 (3)(b) OR (5.5), THE  
11 HEALTH CARE PROVIDER SHALL REIMBURSE THE COVERED PERSON WITHIN  
12 SIXTY CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS  
13 REPORTED TO THE PROVIDER.

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

22 (3) AN OUT-OF-NETWORK HEALTH CARE PROVIDER SHALL PROVIDE  
23 A COVERED PERSON A WRITTEN ESTIMATE OF THE AMOUNT FOR WHICH THE  
24 COVERED PERSON MAY BE RESPONSIBLE FOR COVERED NONEMERGENCY  
25 SERVICES WITHIN THREE BUSINESS DAYS AFTER A REQUEST FROM THE  
26 COVERED PERSON.

27 (4)(a) AN OUT-OF-NETWORK HEALTH CARE PROVIDER MUST SEND  
28 A CLAIM FOR A COVERED SERVICE TO THE CARRIER WITHIN ONE HUNDRED  
29 EIGHTY DAYS AFTER RECEIPT OF INSURANCE INFORMATION IN ORDER TO  
30 RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (4)(a). THE  
31 REIMBURSEMENT RATE IS THE GREATER OF:

32 (I) ONE HUNDRED TEN PERCENT OF THE CARRIER'S MEDIAN  
33 IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE IN THE  
34 SAME GEOGRAPHIC AREA;

35 (II) TWO HUNDRED SEVENTY-FIVE PERCENT OF THE MEDICARE  
36 REIMBURSEMENT RATE FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC  
37 AREA; OR

38 (III) ONE HUNDRED TEN PERCENT OF THE SEVENTY-FIFTH  
39 PERCENTILE OF THE IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME  
40 SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY  
41 AND PROVIDED IN THE SAME GEOGRAPHIC AREA AS DETERMINED BASED ON  
42 COMMERCIAL CLAIMS DATA REPORTED IN THE 2018 CALENDAR YEAR FROM  
43 THE ALL-PAYER HEALTH CLAIMS DATABASE DESCRIBED IN SECTION  
44 25.5-1-204.

45 (IV) THE REIMBURSEMENT CALCULATED IN ACCORDANCE WITH

1 SUBSECTIONS (4)(a)(II) AND (4)(a)(III) OF THIS SECTION MUST BE  
2 ADJUSTED ON JANUARY 1 OF EACH YEAR BASED ON THE PREVIOUS YEAR'S  
3 DENVER-AURORA-LAKEWOOD CONSUMER PRICE INDEX OR ITS SUCCESSOR  
4 INDEX.

5 (b) IF THE OUT-OF-NETWORK HEALTH CARE PROVIDER SUBMITS A  
6 CLAIM FOR COVERED SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY  
7 PERIOD SPECIFIED IN SUBSECTION (4)(a) OF THIS SECTION, THE CARRIER  
8 SHALL REIMBURSE THE HEALTH CARE PROVIDER ONE HUNDRED  
9 TWENTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE  
10 SAME SERVICES IN THE SAME GEOGRAPHIC AREA.

11 (c) THE HEALTH CARE PROVIDER SHALL NOT BILL A COVERED  
12 PERSON ANY OUTSTANDING BALANCE FOR A COVERED SERVICE NOT PAID  
13 FOR BY THE CARRIER, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR  
14 COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.

15 (5) A HEALTH CARE PROVIDER MAY INITIATE ARBITRATION  
16 PURSUANT TO SECTION 10-16-704 (14) IF THE HEALTH CARE PROVIDER  
17 BELIEVES THE PAYMENT MADE PURSUANT TO SUBSECTION (4) OF THIS  
18 SECTION IS NOT SUFFICIENT.

19 (6) THIS SECTION DOES NOT APPLY WHEN A COVERED PERSON  
20 INTENTIONALLY USES AN OUT-OF-NETWORK PROVIDER.

21 **SECTION 9. Act subject to petition - effective date -**  
22 **applicability.** (1) Except as otherwise provided in subsection (2) of this  
23 section, this act takes effect January 1, 2020; except that, if a referendum  
24 petition is filed pursuant to section 1 (3) of article V of the state  
25 constitution against this act or an item, section, or part of this act within  
26 the ninety-day period after final adjournment of the general assembly,  
27 then the act, item, section, or part will not take effect unless approved by  
28 the people at the general election to be held in November 2020 and, in  
29 such case, will take effect on the date of the official declaration of the  
30 vote thereon by the governor.

31 (2) (a) Section 5 of this act takes effect only if House Bill 19-1172  
32 does not become law.

33 (b) Section 8 of this act takes effect only if House Bill 19-1172  
34 becomes law.

35 (3) This act applies to health care services provided on or after the  
36 applicable effective date of this act."

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