

HB1174_L.040

SENATE COMMITTEE OF REFERENCE AMENDMENT

Committee on Judiciary.

HB19-1174 be amended as follows:

- 1 Amend reengrossed bill, page 2, line 14, strike "AND" and substitute "OR".
- 2 Page 3, line 1, strike "AS" and substitute "STARTING IN 2021, AS".
- 3 Page 3, line 5, strike "AND FACILITIES".
- 4 Page 3, line 7, strike "10-16-704 (3)(d)(I) AND (5.5)(b)(I)." and substitute
5 "10-16-704 (3)(d).".
- 6 Page 4, line 18, strike "ONE HUNDRED PERCENT OF THE" and substitute
7 "THE".
- 8 Page 4, line 20, strike "AS DETERMINED".
- 9 Page 5, after line 11 insert:
10 "(VI) FOR THE PURPOSES OF THIS SUBSECTION (3)(d) AND
11 SUBSECTIONS (12), (13), (14), (15), AND (16) OF THIS SECTION, "PROVIDER"
12 MEANS A PERSON OR ENTITY THAT PROVIDES HEALTH CARE SERVICES TO
13 A COVERED PERSON AND BILLS INDEPENDENTLY FOR THE SERVICES
14 PROVIDED."
- 15 Page 5, line 18, after "OR" insert "AT AN IN-NETWORK".
- 16 Page 5, lines 19 and 20, strike "AT OR".
- 17 Page 5, strike line 23, and substitute "COST-SHARING LIMIT."
- 18 Page 6, strike line 24 and substitute "THE OUT-OF-NETWORK PROVIDER IN
19 ACCORDANCE WITH SUBSECTION (3)(d)(II) OF THIS SECTION AND
20 REIMBURSE THE OUT-OF-NETWORK FACILITY".
- 21 Page 7, line 3, strike "ONE HUNDRED PERCENT OF THE" and substitute
22 "THE".
- 23 Page 7, lines 5 and 6, strike "AS DETERMINED".
- 24 Page 7, line 14, strike "THAT" and substitute "THE SAME".
- 25 Page 7, line 19, strike "ONE HUNDRED PERCENT OF THE" and substitute
26 "THE".

- 1 Page 7, lines 21 and 22, strike "AS DETERMINED".
- 2 Page 7, line 23, strike "CREATED" and substitute "DESCRIBED".
- 3 Page 7, line 27, after "COPAYMENT" insert "AMOUNT".
- 4 Page 8, line 17, strike "PROVIDERS" and substitute "SERVICE AGENCIES".
- 5 Page 8, lines 18 and 19, strike "COPAYMENT, COINSURANCE, OR
6 DEDUCTIBLE" and substitute "COINSURANCE, DEDUCTIBLE, OR
7 COPAYMENT".
- 8 Page 9, after line 26 insert:
9 "(V) "PROVIDER" HAS THE SAME MEANING AS DEFINED IN
10 SUBSECTION (3)(d)(VI) OF THIS SECTION."
- 11 Page 11, line 6, strike "24-34-113 (2)" and substitute "24-34-113".
- 12 Page 11, strike line 15 and substitute "HEALTH CARE FACILITY PURSUANT
13 TO SUBSECTION (3)(d) OR (5.5)(b) OF THIS".
- 14 Page 11, line 27, after "PROVIDER" insert "OR A HEALTH CARE FACILITY".
- 15 Page 12, strike lines 7 and 8 and substitute "THE COMMISSIONER AND THE
16 CARRIER. A PROVIDER OR HEALTH CARE FACILITY MUST SUBMIT A
17 REQUEST FOR THE ARBITRATION OF A CLAIM WITHIN NINETY DAYS AFTER
18 THE RECEIPT OF PAYMENT FOR THAT CLAIM."
- 19 Page 12, strike lines 10 and 11 and substitute "SECTION, IF REQUESTED BY
20 THE CARRIER AND THE PROVIDER OR HEALTH CARE FACILITY, THE
21 COMMISSIONER MAY ARRANGE AN INFORMAL SETTLEMENT
22 TELECONFERENCE TO BE HELD WITHIN THIRTY".
- 23 Page 12, line 18, after "THAT" insert "ESTABLISHES A STANDARD
24 ARBITRATION FORM AND".
- 25 Page 13, line 3, strike "NOT SUFFICIENT" and substitute "INSUFFICIENT".
- 26 Page 13, line 5, strike "THEN".
- 27 Page 13, line 12, after "AND" insert "THE".
- 28 Page 13, line 20, strike "2020," and substitute "2021".
- 29 Page 14, strike lines 23 and 24 and substitute:

- 1 (f) "HEALTH CARE PROVIDER" MEANS A PERSON OR ENTITY THAT
2 PROVIDES HEALTH CARE SERVICES TO A COVERED PERSON AND BILLS
3 INDEPENDENTLY FOR THE SERVICES PROVIDED."
- 4 Page 15, line 12, strike "REGULATED UNDER TITLE 12".
- 5 Page 16, line 4, after "A" insert "HEALTH CARE".
- 6 Page 16, line 5, after "OUT-OF-NETWORK" insert "HEALTH CARE".
- 7 Page 16, line 6, after "IN-NETWORK" insert "HEALTH CARE".
- 8 Page 16, line 15, strike "SUBSECTION (2) OF".
- 9 Page 17, line 6, after "COPAYMENT" insert "AMOUNT".
- 10 Page 17, line 9, before "NONEMERGENCY" insert "COVERED".
- 11 Page 17, line 27, after "FOR" insert "COVERED".
- 12 Page 18, line 5, strike "DELIVERY OF SERVICES" and substitute "RECEIPT
13 OF INSURANCE INFORMATION".
- 14 Page 18, line 12, strike "ONE HUNDRED PERCENT OF THE" and substitute
15 "THE".
- 16 Page 18, line 14, strike "AS DETERMINED".
- 17 Page 18, line 17, after "FOR" insert "COVERED".
- 18 Page 18, line 25, after "COPAYMENT" insert "AMOUNT".
- 19 Page 19, line 13, strike "UNDER" and substitute "PURSUANT TO".
- 20 Page 19, line 21, strike "24-34-113 (2)" and substitute "24-34-113".
- 21 Page 20, line 1, after "THE" insert "FEDERAL".
- 22 Page 20, line 6, strike "COVERED PERSONS." and substitute "CONSUMERS."
- 23 Page 20, line 11, after "FACILITIES," insert "INCLUDING".
- 24 Page 20, line 20, strike "24-34-113 (2)" and substitute "24-34-113".
- 25 Page 20, line 22 strike "(12)" and substitute "(12)(b)".

- 1 Page 20, line 23, strike "SUBSECTION (1) OF".
- 2 Page 21, after line 9 insert:
3 "(e) "HEALTH CARE PROVIDER" MEANS A PERSON OR ENTITY THAT
4 PROVIDES HEALTH CARE SERVICES TO A COVERED PERSON AND BILLS
5 INDEPENDENTLY FOR THE SERVICES PROVIDED."
- 6 Reletter succeeding paragraphs accordingly.
- 7 Page 21, line 21, strike "THE" and substitute "A".
- 8 Page 21, line 24, after "COPAYMENT" insert "AMOUNT".
- 9 Page 22, line 2, strike "10-16-704 (5.5)," and substitute "10-16-704 (3)(b)
10 OR (5.5),".
- 11 Page 22, line 12, strike "PROVIDER" and substitute "FACILITY".
- 12 Page 22, line 18, strike "DELIVERY OF SERVICES" and substitute "RECEIPT
13 OF INSURANCE INFORMATION".
- 14 Page 22, line 25, strike "ONE HUNDRED PERCENT OF THE" and substitute
15 "THE".
- 16 Page 22, line 27, strike "AS".
- 17 Page 23, line 1, strike "DETERMINED".
- 18 Page 23, line 10, strike "THAT" and substitute "THE SAME".
- 19 Page 23, line 15, strike "ONE HUNDRED PERCENT OF THE" and substitute
20 "THE".
- 21 Page 23, line 18, strike "AS DETERMINED".
- 22 Page 23, line 19, strike "CREATED" and substitute "DESCRIBED".
- 23 Page 23, strike line 22 and substitute "SPECIFIED IN THIS SUBSECTION (3),
24 THE CARRIER SHALL".
- 25 Page 24, line 2, after "COPAYMENT" insert "AMOUNT".
- 26 Page 24, after line 11 insert:
27 "SECTION 8. In Colorado Revised Statutes, **add to article 30 as**
28 **relocated by House Bill 19-1172 12-30-111 and 12-30-112 as follows:**

1 **12-30-111. Health care providers - required disclosures - rules**
2 **- definitions.** (1) FOR THE PURPOSES OF THIS SECTION AND SECTION
3 12-30-112:

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

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

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

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

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

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

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

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

22 (2) ON AND AFTER JANUARY 1, 2020, HEALTH CARE PROVIDERS
23 SHALL DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE
24 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
25 SERVICES FROM AN OUT-OF-NETWORK PROVIDER. THE DISCLOSURES MUST
26 COMPLY WITH THE RULES ADOPTED PURSUANT TO SUBSECTION (3) OF THIS
27 SECTION.

28 (3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF
29 INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION
30 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR
31 HEALTH CARE PROVIDERS TO DEVELOP AND PROVIDE CONSUMER
32 DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE DIRECTOR SHALL
33 ENSURE THAT THE RULES ARE CONSISTENT WITH SECTIONS 10-16-704 (12)
34 AND 25-3-120 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO
35 SECTION 10-16-704 (12)(b) AND BY THE STATE BOARD OF HEALTH
36 PURSUANT TO SECTION 25-3-120 (2). THE RULES MUST SPECIFY, AT A
37 MINIMUM, THE FOLLOWING:

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

42 (b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
43 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
44 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR
45 COMMUNICATIONS WITH CONSUMERS;

1 (c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
2 CONSUMER'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE
3 CONSUMER'S HEALTH BENEFIT PLAN;

4 (d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE
5 PROVIDERS, INCLUDING WHETHER A HEALTH CARE PROVIDER IS OUT OF
6 NETWORK, THE TYPES OF SERVICES AN OUT-OF-NETWORK HEALTH CARE
7 PROVIDER MAY PROVIDE, AND THE RIGHT TO REQUEST AN IN-NETWORK
8 HEALTH CARE PROVIDER TO PROVIDE SERVICES; AND

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

16 (4) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SECTION DOES
17 NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTION 10-16-704 (3) OR
18 (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS UNDER THE CONSUMER'S
19 HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL FOR ALL
20 COVERED SERVICES AND TREATMENT RECEIVED.

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

24 **12-30-112. Out-of-network health care providers -**
25 **out-of-network services - billing - payment.** (1) IF AN
26 OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES EMERGENCY
27 SERVICES OR COVERED NONEMERGENCY SERVICES TO A COVERED PERSON
28 AT AN IN-NETWORK FACILITY, THE OUT-OF-NETWORK PROVIDER SHALL:

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

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

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

45 (b) AN OUT-OF-NETWORK HEALTH CARE PROVIDER THAT FAILS TO

1 REIMBURSE A COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF
2 THIS SECTION FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE
3 OVERPAYMENT AT THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON
4 THE DATE THE PROVIDER RECEIVED THE NOTICE OF THE OVERPAYMENT.
5 THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED
6 INTEREST FROM THE OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER
7 TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.

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

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

18 (I) ONE HUNDRED FIVE PERCENT OF THE CARRIER'S MEDIAN
19 IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN
20 THE SAME GEOGRAPHIC AREA; OR

21 (II) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE
22 SAME SERVICE IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR
23 BASED ON CLAIMS DATA FROM THE ALL-PAYER HEALTH CLAIMS DATABASE
24 CREATED IN SECTION 25.5-1-204.

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

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

35 (5) A HEALTH CARE PROVIDER MAY INITIATE ARBITRATION
36 PURSUANT TO SECTION 10-16-704 (15) IF THE HEALTH CARE PROVIDER
37 BELIEVES THE PAYMENT MADE PURSUANT TO SUBSECTION (4) OF THIS
38 SECTION IS NOT SUFFICIENT."

39 Renumber succeeding sections accordingly.

40 Strike page 25 and substitute:

41 "SECTION 10. Act subject to petition - effective date -
42 applicability. (1) Except as otherwise provided in subsection (2) of this

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

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

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

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

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