

**Second Regular Session
Seventy-third General Assembly
STATE OF COLORADO**

REVISED

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

LLS NO. 22-0503.01 Kristen Forrestal x4217

HOUSE BILL 22-1284

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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
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.

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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; [REDACTED]

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.