First Regular Session
Seventy-second General Assembly
STATE OF COLORADO

REREVISED

This Version Includes All Amendments Adopted in the Second House

LLS NO. 19-0709.01 Kristen Forrestal x4217

HOUSE BILL 19-1174

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SENATE
3rd Reading Unamended
April 30, 2019

SENATE
Amended 2nd Reading
April 27, 2019

HOUSE
3rd Reading Unamended
March 22, 2019

HOUSE
Amended 2nd Reading
March 21, 2019

A BILL FOR AN ACT

101 CONCERNING OUT-OF-NETWORK HEALTH CARE SERVICES PROVIDED
102 TO COVERED PERSONS, AND, IN CONNECTION THEREWITH,
103 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:

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

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

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

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

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

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

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

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

14 (ss) A VIOLATION OF SECTION 10-16-704 (3)(d) OR (5.5).

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

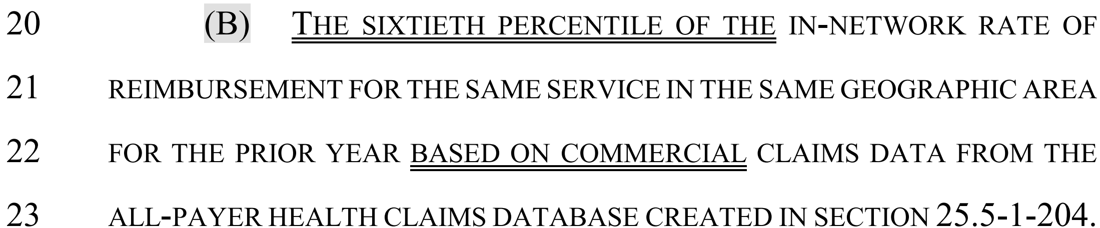
1 **10-16-107. Rate filing regulation - benefits ratio - rules.**
2 (7) STARTING IN 2021, AS PART OF THE RATE FILING REQUIRED PURSUANT
3 TO THIS SECTION, EACH CARRIER SHALL PROVIDE TO THE COMMISSIONER,
4 IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER,
5 INFORMATION CONCERNING THE UTILIZATION OF OUT-OF-NETWORK
6 PROVIDERS AND FACILITIES AND THE AGGREGATE COST SAVINGS AS A
7 RESULT OF THE IMPLEMENTATION OF SECTION 10-16-704 (3)(d)(I) AND
8 (5.5)(b)(I).
9 **SECTION 4.** In Colorado Revised Statutes, 10-16-704, **amend**
10 (3)(a)(III), (5.5)(a) introductory portion, (5.5)(a)(V), and (5.5)(b); and
11 **add** (3)(d), (5.5)(c), (5.5)(d), (5.5)(e), (12), (13), (14), (15), and (16) as
12 follows:
13 **10-16-704. Network adequacy - rules - legislative declaration**
14 **- definitions.** (3) (a) (III) The general assembly finds, determines, and
15 declares that the division ~~of insurance~~ has correctly interpreted ~~the~~
16 ~~provisions of~~ this section to protect ~~the insured~~ A COVERED PERSON from
17 the additional expense charged by ~~an assisting~~ A provider who is an
18 out-of-network provider, and has properly required ~~insurers~~ CARRIERS to
19 hold the ~~consumer~~ COVERED PERSON harmless. The division ~~of insurance~~
20 does not have regulatory authority over all health plans. Some consumers
21 are enrolled in self-funded health insurance programs that are governed
22 under the federal "Employee Retirement Income Security Act OF 1974",
23 29 U.S.C. SEC. 1001 ET SEQ. Therefore, ~~the general assembly encourages~~
24 health care facilities, carriers, and providers ~~to~~ MUST provide consumers
25 ~~disclosure~~ WITH DISCLOSURES about the potential impact of receiving
26 services from an out-of-network provider OR HEALTH CARE FACILITY AND
27 THEIR RIGHTS UNDER THIS SECTION. COVERED PERSONS MUST HAVE

ACCESS TO ACCURATE INFORMATION ABOUT THEIR HEALTH CARE BILLS AND THEIR PAYMENT OBLIGATIONS IN ORDER TO ENABLE THEM TO MAKE INFORMED DECISIONS ABOUT THEIR HEALTH CARE AND FINANCIAL OBLIGATIONS.

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

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

(A) ONE HUNDRED TEN PERCENT OF THE CARRIER'S MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE IN THE SAME GEOGRAPHIC AREA; OR



(B) THE SIXTIETH PERCENTILE OF THE IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR BASED ON COMMERCIAL CLAIMS DATA FROM THE ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

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

1 (IV) THIS SUBSECTION (3)(d) DOES NOT PRECLUDE THE CARRIER
2 AND THE OUT-OF-NETWORK PROVIDER FROM VOLUNTARILY NEGOTIATING
3 AN INDEPENDENT REIMBURSEMENT RATE. IF THE NEGOTIATIONS FAIL, THE
4 REIMBURSEMENT RATE REQUIRED BY SUBSECTION (3)(d)(II) OF THIS
5 SECTION APPLIES.
6 (V) THIS SUBSECTION (3)(d) DOES NOT APPLY WHEN A COVERED
7 PERSON VOLUNTARILY USES AN OUT-OF-NETWORK PROVIDER.
8 (VI) FOR PURPOSES OF THIS SUBSECTION (3):
9 (A) "GEOGRAPHIC AREA" MEANS A SPECIFIC AREA IN THIS STATE
10 AS ESTABLISHED BY THE COMMISSIONER BY RULE.
11 (B) "MEDICARE REIMBURSEMENT RATE" MEANS THE
12 REIMBURSEMENT RATE FOR A PARTICULAR HEALTH CARE SERVICE
13 PROVIDED UNDER THE "HEALTH INSURANCE FOR THE AGED ACT", TITLE
14 XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, 42 U.S.C.
15 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 ~~in an~~
18 ~~emergency department of a hospital~~ shall cover THE emergency services:
19 (V) AT THE IN-NETWORK BENEFIT LEVEL, with the same
20 ~~cost-sharing~~ COINSURANCE, DEDUCTIBLE, OR COPAYMENT requirements
21 as would apply if THE emergency services were provided BY AN
22 in-network PROVIDER OR FACILITY, AND AT NO GREATER COST TO THE
23 COVERED PERSON THAN IF THE EMERGENCY SERVICES WERE OBTAINED
24 FROM AN IN-NETWORK PROVIDER AT AN IN-NETWORK FACILITY. ANY
25 PAYMENT MADE BY A COVERED PERSON PURSUANT TO THIS SUBSECTION
26 (5.5)(a)(V) MUST BE APPLIED TO THE COVERED PERSON'S IN-NETWORK
27 COST-SHARING LIMIT.

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

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

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

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

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

12 ~~(II) "Emergency services", with respect to an emergency medical~~
13 ~~condition, means:~~

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

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

24 (b) (I) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT
25 AN OUT-OF-NETWORK FACILITY, OTHER THAN ANY OUT-OF-NETWORK
26 FACILITY OPERATED BY THE DENVER HEALTH AND HOSPITAL AUTHORITY
27 PURSUANT TO ARTICLE 29 OF TITLE 25, THE CARRIER SHALL REIMBURSE

1 THE OUT-OF-NETWORK PROVIDER IN ACCORDANCE WITH SUBSECTION
2 (3)(d)(II) OF THIS SECTION AND REIMBURSE THE OUT-OF-NETWORK
3 FACILITY DIRECTLY IN ACCORDANCE WITH SECTION 10-16-106.5 THE
4 GREATER OF:
5 (A) ONE HUNDRED FIVE PERCENT OF THE CARRIER'S MEDIAN
6 IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN
7 A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR
8
9 (B) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE
10 SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME
11 GEOGRAPHIC AREA FOR THE PRIOR YEAR __ BASED ON CLAIMS DATA FROM
12 THE COLORADO ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN
13 SECTION 25.5-1-204.
14 (II) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT ANY
15 OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER HEALTH AND
16 HOSPITAL AUTHORITY CREATED IN SECTION 25-29-103, THE CARRIER
17 SHALL REIMBURSE THE OUT-OF-NETWORK FACILITY DIRECTLY IN
18 ACCORDANCE WITH SECTION 10-16-106.5 THE GREATER OF:
19 (A) THE CARRIER'S MEDIAN IN-NETWORK RATE OF
20 REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY
21 OR SETTING IN THE SAME GEOGRAPHIC AREA;
22 (B) TWO HUNDRED FIFTY PERCENT OF THE MEDICARE
23 REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR
24 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR
25 (C) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE
26 SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME
27 GEOGRAPHIC AREA FOR THE PRIOR YEAR __ BASED ON CLAIMS DATA FROM

1 THE COLORADO ALL-PAYER HEALTH CLAIMS DATABASE DESCRIBED IN
2 SECTION 25.5-1-204.
3 (III) PAYMENT MADE BY A CARRIER IN COMPLIANCE WITH THIS
4 SUBSECTION (5.5)(b) IS PRESUMED TO BE PAYMENT IN FULL FOR THE
5 SERVICES PROVIDED, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR
6 COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.
7 (c) THIS SUBSECTION (5.5) DOES NOT PRECLUDE THE CARRIER AND
8 THE OUT-OF-NETWORK FACILITY AND THE CARRIER AND THE PROVIDER
9 FROM VOLUNTARILY NEGOTIATING AN INDEPENDENT REIMBURSEMENT
10 RATE. IF THE NEGOTIATIONS FAIL, THE REIMBURSEMENT RATE REQUIRED
11 BY SUBSECTION (5.5)(b) OF THIS SECTION APPLIES.
12 (d) (I) SUBSECTIONS (5.5)(a), (5.5)(b), AND (5.5)(c) OF THIS
13 SECTION DO NOT APPLY TO SERVICE AGENCIES, AS DEFINED IN SECTION
14 25-3.5-103 (11.5), PROVIDING AMBULANCE SERVICES, AS DEFINED IN
15 SECTION 25-3.5-103 (3).
16 (II) (A) THE COMMISSIONER SHALL PROMULGATE RULES TO
17 IDENTIFY AND IMPLEMENT A PAYMENT METHODOLOGY THAT APPLIES TO
18 SERVICE AGENCIES DESCRIBED IN SUBSECTION (5.5)(d)(I) OF THIS SECTION,
19 EXCEPT FOR SERVICE AGENCIES THAT ARE PUBLICLY FUNDED FIRE
20 AGENCIES.
21 (B) THE COMMISSIONER SHALL MAKE THE PAYMENT
22 METHODOLOGY AVAILABLE TO THE PUBLIC ON THE DIVISION'S WEBSITE.
23 THE RULES MUST BE EQUITABLE TO SERVICE AGENCIES AND CARRIERS;
24 HOLD CONSUMERS HARMLESS EXCEPT FOR ANY APPLICABLE COINSURANCE,
25 DEDUCTIBLE, OR COPAYMENT AMOUNTS; AND BE BASED ON A COST-BASED
26 MODEL THAT INCLUDES DIRECT PAYMENT TO SERVICE AGENCIES AS
27 DESCRIBED IN SUBSECTION (5.5)(d)(I) OF THIS SECTION.

1 (C) THE DIVISION MAY CONTRACT WITH A NEUTRAL THIRD-PARTY
2 THAT HAS NO FINANCIAL INTEREST IN PROVIDERS, EMERGENCY SERVICE
3 PROVIDERS, OR CARRIERS TO CONDUCT THE ANALYSIS TO IDENTIFY AND
4 IMPLEMENT THE PAYMENT METHODOLOGY.
5 (e) FOR PURPOSES OF THIS SUBSECTION (5.5):
6 (I) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL
7 CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT
8 SEVERITY, INCLUDING SEVERE PAIN, THAT A PRUDENT LAYPERSON WITH AN
9 AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY
10 EXPECT, IN THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION, TO RESULT
11 IN:
12 (A) SERIOUS JEOPARDY TO THE HEALTH OF THE INDIVIDUAL OR,
13 WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR
14 HER UNBORN CHILD;
15 (B) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR
16 (C) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.
17 (II) "EMERGENCY SERVICES", WITH RESPECT TO AN EMERGENCY
18 MEDICAL CONDITION, MEANS:
19 (A) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE
20 CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING
21 ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY
22 DEPARTMENT TO EVALUATE THE EMERGENCY MEDICAL CONDITION; AND
23 (B) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES
24 AVAILABLE AT THE HOSPITAL, FURTHER MEDICAL EXAMINATION AND
25 TREATMENT AS REQUIRED TO STABILIZE THE PATIENT TO ASSURE, WITHIN
26 REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION
27 OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE

1 TRANSFER OF THE INDIVIDUAL FROM A FACILITY.
2 (III) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
3 SUBSECTION (3)(d)(V)(A) OF THIS SECTION.
4 (IV) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING
5 AS DEFINED IN SUBSECTION (3)(d)(V)(B) OF THIS SECTION.
6 (12) (a) ON AND AFTER JANUARY 1, 2020, CARRIERS SHALL
7 DEVELOP AND PROVIDE DISCLOSURES TO COVERED PERSONS ABOUT THE
8 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
9 SERVICES FROM AN OUT-OF-NETWORK PROVIDER OR AT AN
10 OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE
11 RULES ADOPTED UNDER SUBSECTION (12)(b) OF THIS SECTION.
12 (b) THE COMMISSIONER, IN CONSULTATION WITH THE STATE
13 BOARD OF HEALTH CREATED IN SECTION 25-1-103 AND THE DIRECTOR OF
14 THE DIVISION OF PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF
15 REGULATORY AGENCIES, SHALL ADOPT RULES TO SPECIFY THE DISCLOSURE
16 REQUIREMENTS UNDER THIS SUBSECTION (12), WHICH RULES MUST
17 SPECIFY, AT A MINIMUM, THE FOLLOWING:
18 (I) THE TIMING FOR PROVIDING THE DISCLOSURES FOR EMERGENCY
19 AND NONEMERGENCY SERVICES WITH CONSIDERATION GIVEN TO
20 POTENTIAL LIMITATIONS RELATING TO THE FEDERAL "EMERGENCY
21 MEDICAL TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd;
22 (II) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
23 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
24 BILLING STATEMENTS, BILLING NOTICES, PRIOR AUTHORIZATIONS, OR
25 OTHER FORMS OR COMMUNICATIONS WITH COVERED PERSONS;
26 (III) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
27 COVERED PERSON'S RIGHTS AND PAYMENT OBLIGATIONS IF THE COVERED

PERSON'S HEALTH BENEFIT PLAN IS UNDER THE JURISDICTION OF THE DIVISION;

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

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

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

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

(14) ON OR BEFORE JANUARY 1 OF EACH YEAR, EACH CARRIER SHALL SUBMIT INFORMATION TO THE COMMISSIONER, IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER, CONCERNING THE USE OF OUT-OF-NETWORK PROVIDERS AND FACILITIES BY COVERED PERSONS AND THE IMPACT ON PREMIUM AFFORDABILITY FOR CONSUMERS.

(15) (a) (I) IF A PROVIDER OR A HEALTH CARE FACILITY BELIEVES THAT A PAYMENT MADE PURSUANT TO SUBSECTION (3) OR (5.5) OF THIS SECTION OR SECTION 24-34-114 OR A HEALTH CARE FACILITY BELIEVES THAT A PAYMENT MADE PURSUANT TO SUBSECTION (5.5) OF THIS SECTION OR SECTION 25-3-121 (3) WAS NOT SUFFICIENT GIVEN THE COMPLEXITY AND CIRCUMSTANCES OF THE SERVICES PROVIDED, THE PROVIDER OR THE HEALTH CARE FACILITY MAY INITIATE ARBITRATION BY FILING A REQUEST FOR ARBITRATION WITH THE COMMISSIONER AND THE CARRIER. A PROVIDER OR HEALTH CARE FACILITY MUST SUBMIT A REQUEST FOR THE ARBITRATION OF A CLAIM WITHIN NINETY DAYS AFTER THE RECEIPT OF PAYMENT FOR THAT CLAIM.

(II) PRIOR TO ARBITRATION UNDER SUBSECTION (15)(a)(I) OF THIS SECTION, IF REQUESTED BY THE CARRIER AND THE PROVIDER OR HEALTH CARE FACILITY, THE COMMISSIONER MAY ARRANGE AN INFORMAL SETTLEMENT TELECONFERENCE TO BE HELD WITHIN THIRTY DAYS AFTER THE REQUEST FOR ARBITRATION. THE PARTIES SHALL NOTIFY THE COMMISSIONER OF THE RESULTS OF THE SETTLEMENT CONFERENCE.

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

(b) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT AN ARBITRATION PROCESS THAT ESTABLISHES A STANDARD ARBITRATION

1 FORM AND INCLUDES THE SELECTION OF AN ARBITRATOR FROM A LIST OF
2 QUALIFIED ARBITRATORS DEVELOPED PURSUANT TO THE RULES.
3 QUALIFIED ARBITRATORS MUST BE INDEPENDENT; NOT BE AFFILIATED
4 WITH A CARRIER, HEALTH CARE FACILITY, OR PROVIDER, OR ANY
5 PROFESSIONAL ASSOCIATION OF CARRIERS, HEALTH CARE FACILITIES, OR
6 PROVIDERS; NOT HAVE A PERSONAL, PROFESSIONAL, OR FINANCIAL
7 CONFLICT WITH ANY PARTIES TO THE ARBITRATION; AND HAVE
8 EXPERIENCE IN HEALTH CARE BILLING AND REIMBURSEMENT RATES.
9 (c) WITHIN THIRTY DAYS AFTER THE COMMISSIONER APPOINTS
10 AN ARBITRATOR AND NOTIFIES THE PARTIES OF THE ARBITRATION, BOTH
11 PARTIES SHALL SUBMIT TO THE ARBITRATOR, IN WRITING, EACH PARTY'S
12 FINAL OFFER AND EACH PARTY'S ARGUMENT. THE ARBITRATOR SHALL PICK
13 ONE OF THE TWO AMOUNTS SUBMITTED BY THE PARTIES AS THE
14 ARBITRATOR'S FINAL AND BINDING DECISION. THE DECISION MUST BE IN
15 WRITING AND MADE WITHIN FORTY-FIVE DAYS AFTER THE ARBITRATOR'S
16 APPOINTMENT. IN MAKING THE DECISION, THE ARBITRATOR SHALL
17 CONSIDER THE CIRCUMSTANCES AND COMPLEXITY OF THE PARTICULAR
18 CASE, INCLUDING THE FOLLOWING AREAS:
19 (I) THE PROVIDER'S LEVEL OF TRAINING, EDUCATION, EXPERIENCE,
20 AND SPECIALIZATION OR SUBSPECIALIZATION; AND
21 (II) THE PREVIOUSLY CONTRACTED RATE, IF THE PROVIDER HAD A
22 CONTRACT WITH THE CARRIER THAT WAS TERMINATED OR EXPIRED WITHIN
23 ONE YEAR PRIOR TO THE DISPUTE.
24 (d) IF THE ARBITRATOR'S DECISION REQUIRES ADDITIONAL
25 PAYMENT BY THE CARRIER ABOVE THE AMOUNT PAID, THE CARRIER SHALL
26 PAY THE PROVIDER IN ACCORDANCE WITH SECTION 10-16-106.5.
27 (e) THE PARTY WHOSE FINAL OFFER AMOUNT WAS NOT SELECTED

1 BY THE ARBITRATOR SHALL PAY THE ARBITRATOR'S EXPENSES AND FEES.

2 (16) NOT WITHSTANDING SECTION 24-1-136 (11)(a)(I), ON OR
3 BEFORE JULY 1, 2021, AND EACH JULY 1 THEREAFTER, THE COMMISSIONER
4 SHALL PROVIDE A WRITTEN REPORT TO THE HEALTH AND HUMAN SERVICES
5 COMMITTEE OF THE SENATE AND THE HEALTH AND INSURANCE COMMITTEE
6 OF THE HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES,
7 AND SHALL POST THE REPORT ON THE DIVISION'S WEBSITE SUMMARIZING:

8 (a) THE INFORMATION SUBMITTED TO THE COMMISSIONER IN
9 SUBSECTION (14) OF THIS SECTION; AND

10 (b) THE NUMBER OF ARBITRATIONS FILED; THE NUMBER OF
11 ARBITRATIONS SETTLED, ARBITRATED, AND DISMISSED IN THE PREVIOUS
12 CALENDAR YEAR; AND A SUMMARY OF WHETHER THE ARBITRATIONS WERE
13 IN FAVOR OF THE CARRIER OR THE OUT-OF-NETWORK PROVIDER OR
14 HEALTH CARE FACILITY. THE LIST OF ARBITRATION DECISIONS MUST NOT
15 INCLUDE ANY INFORMATION THAT SPECIFICALLY IDENTIFIES THE
16 PROVIDER, HEALTH CARE FACILITY, CARRIER, OR COVERED PERSON
17 INVOLVED IN EACH ARBITRATION DECISION.

18 **SECTION 5.** In Colorado Revised Statutes, **add** 24-34-113 and
19 24-34-114 as follows:

20 **24-34-113. Health care providers - required disclosures - rules**
21 **- definitions.** (1) FOR THE PURPOSES OF THIS SECTION AND SECTION
22 24-34-114:

23 (a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION
24 10-16-102 (8).

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

27 (c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED

1 IN SECTION 10-16-704 (5.5)(e)(II).

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

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

6 (f) "HEALTH CARE PROVIDER" HAS THE SAME MEANING AS
7 "PROVIDER" AS DEFINED IN SECTION 10-16-102 (56).

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

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

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

19 (3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF
20 INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION
21 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR
22 HEALTH CARE PROVIDERS ____ TO DEVELOP AND PROVIDE CONSUMER
23 DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE DIRECTOR SHALL
24 ENSURE THAT THE RULES ARE CONSISTENT WITH SECTION 10-16-704 (12)
25 AND 25-3-120 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO
26 SECTION 10-16-704 (12)(b) AND BY THE STATE BOARD OF HEALTH
27 PURSUANT TO SECTION 25-3-120 (2). THE RULES MUST SPECIFY, AT A

1 MINIMUM, THE FOLLOWING:

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

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

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

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

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

25 (4) RECEIPT OF THE DISCLOSURES REQUIRED BY __ THIS SECTION
26 DOES NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTION 10-16-704
27 (3) OR (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS UNDER THE

1 CONSUMER'S HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL
2 FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.
3 (5) THIS SECTION DOES NOT APPLY TO SERVICE AGENCIES, AS
4 DEFINED IN SECTION 25-3.5-103 (11.5), THAT ARE PUBLICLY FUNDED FIRE
5 AGENCIES.
6 **24-34-114. Out-of-network health care providers -**
7 **out-of-network services - billing - payment.** (1) IF AN
8 OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES EMERGENCY
9 SERVICES OR COVERED NONEMERGENCY SERVICES TO A COVERED PERSON
10 AT AN IN-NETWORK FACILITY, THE OUT-OF-NETWORK PROVIDER SHALL:
11 (a) SUBMIT A CLAIM FOR THE ENTIRE COST OF THE SERVICES TO
12 THE COVERED PERSON'S CARRIER; AND
13 (b) NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR
14 ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE
15 CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,
16 DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE
17 COVERED PERSON.
18 (2) (a) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES
19 COVERED NONEMERGENCY SERVICES AT AN IN-NETWORK FACILITY OR
20 EMERGENCY SERVICES AT AN OUT-OF-NETWORK OR IN-NETWORK FACILITY
21 AND THE HEALTH CARE PROVIDER RECEIVES PAYMENT FROM THE COVERED
22 PERSON FOR SERVICES FOR WHICH THE COVERED PERSON IS NOT
23 RESPONSIBLE PURSUANT TO SECTION 10-16-704 (3)(b) OR (5.5), THE
24 HEALTH CARE PROVIDER SHALL REIMBURSE THE COVERED PERSON WITHIN
25 SIXTY CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS
26 REPORTED TO THE PROVIDER.
27 (b) AN OUT-OF-NETWORK HEALTH CARE PROVIDER THAT FAILS TO

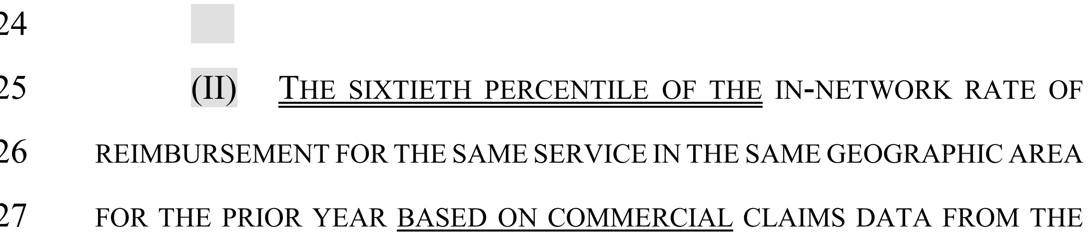
REIMBURSE A COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF THIS SECTION FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE OVERPAYMENT AT THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON THE DATE THE PROVIDER RECEIVED THE NOTICE OF THE OVERPAYMENT. THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED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

(3) IN ACCORDANCE WITH SUBSECTIONS (1) AND (2) OF THIS SECTION, AN OUT-OF-NETWORK HEALTH CARE PROVIDER SHALL PROVIDE A COVERED PERSON A WRITTEN ESTIMATE OF THE AMOUNT FOR WHICH THE COVERED PERSON MAY BE RESPONSIBLE FOR COVERED NONEMERGENCY SERVICES WITHIN THREE BUSINESS DAYS AFTER A REQUEST FROM THE COVERED PERSON.

(4) IN ACCORDANCE WITH SUBSECTIONS (1) AND (2) OF THIS SECTION:

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

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



(II) THE SIXTIETH PERCENTILE OF THE IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR BASED ON COMMERCIAL CLAIMS DATA FROM THE

1 ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.
2 (b) IF THE OUT-OF-NETWORK HEALTH CARE PROVIDER SUBMITS A
3 CLAIM FOR COVERED SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY
4 PERIOD SPECIFIED IN SUBSECTION (4)(a) OF THIS SECTION, THE CARRIER
5 SHALL REIMBURSE THE HEALTH CARE PROVIDER ONE HUNDRED
6 TWENTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE
7 SAME SERVICES IN THE SAME GEOGRAPHIC AREA.
8 (c) THE HEALTH CARE PROVIDER SHALL NOT BILL A COVERED
9 PERSON ANY OUTSTANDING BALANCE FOR A COVERED SERVICE NOT PAID
10 FOR BY THE CARRIER, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR
11 COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.
12 (5) A HEALTH CARE PROVIDER MAY INITIATE ARBITRATION
13 PURSUANT TO SECTION 10-16-704 (15) IF THE HEALTH CARE PROVIDER
14 BELIEVES THE PAYMENT MADE PURSUANT TO SUBSECTION (4) OF THIS
15 SECTION IS NOT SUFFICIENT.
16 (6) THIS SECTION DOES NOT APPLY WHEN A COVERED PERSON
17 VOLUNTARILY USES AN OUT-OF-NETWORK PROVIDER.
18 **SECTION 6.** In Colorado Revised Statutes, **add** 25-3-120 and
19 25-3-121 as follows:
20 **25-3-120. Health care facilities - emergency and**
21 **nonemergency services - required disclosures - rules - definitions.**
22 (1) ON AND AFTER JANUARY 1, 2020, HEALTH CARE FACILITIES SHALL
23 DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE
24 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
25 SERVICES FROM AN OUT-OF-NETWORK PROVIDER PROVIDING SERVICES AT
26 AN IN-NETWORK FACILITY OR EMERGENCY SERVICES AT AN
27 OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE

1 RULES ADOPTED PURSUANT TO SUBSECTION (2) OF THIS SECTION.

2 (2) THE STATE BOARD OF HEALTH, IN CONSULTATION WITH THE
3 COMMISSIONER OF INSURANCE AND THE DIRECTOR OF THE DIVISION OF
4 PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF REGULATORY
5 AGENCIES, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR
6 HEALTH CARE FACILITIES TO DEVELOP AND PROVIDE CONSUMER
7 DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE STATE BOARD OF
8 HEALTH SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTION
9 10-16-704 (12) AND 24-34-113 AND RULES ADOPTED BY THE
10 COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE
11 DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS PURSUANT
12 TO SECTION 24-34-113 (3). THE RULES MUST SPECIFY, AT A MINIMUM, THE
13 FOLLOWING:

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

18 (b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
19 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
20 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR
21 COMMUNICATIONS WITH COVERED PERSONS;

22 (c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
23 CONSUMER'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE
24 CONSUMER'S HEALTH BENEFIT PLAN;

25 (d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE
26 FACILITIES, INCLUDING WHETHER A HEALTH CARE PROVIDER DELIVERING
27 SERVICES AT THE FACILITY IS OUT OF NETWORK, THE TYPES OF SERVICES

1 AN OUT-OF-NETWORK HEALTH CARE PROVIDER MAY PROVIDE, AND THE
2 RIGHT TO REQUEST AN IN-NETWORK HEALTH CARE PROVIDER TO PROVIDE
3 SERVICES; AND
4 (e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN
5 THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT
6 CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE
7 LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY
8 THIS SECTION AND SECTIONS 10-16-704 (12) AND 24-34-113 AND THE
9 RULES ADOPTED PURSUANT TO THIS SUBSECTION (2) AND SECTIONS
10 10-16-704 (12)(b) AND 24-34-113 (3).
11 (3) RECEIPT OF THE DISCLOSURE REQUIRED BY ___ THIS SECTION
12 DOES NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTION 10-16-704
13 (3) OR (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS UNDER THE
14 CONSUMER'S HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL
15 FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.
16 (4) FOR THE PURPOSES OF THIS SECTION AND SECTION 25-3-121:
17 (a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION
18 10-16-102 (8).
19 (b) "COVERED PERSON" HAS THE SAME MEANING AS DEFINED IN
20 SECTION 10-16-102 (15).
21 (c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED
22 IN SECTION 10-16-704 (5.5)(e)(II).
23 (d) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
24 SECTION 10-16-704 (3)(d)(V)(A).
25 (e) "HEALTH BENEFIT PLAN" HAS THE SAME MEANING AS DEFINED
26 IN SECTION 10-16-102 (32).
27 (f) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING

1 AS DEFINED IN SECTION 10-16-704 (3)(d)(V)(B).

2 (g) "OUT-OF-NETWORK FACILITY" MEANS A HEALTH CARE
3 FACILITY THAT IS NOT A PARTICIPATING PROVIDER, AS DEFINED IN SECTION
4 10-16-102 (46).

5 **25-3-121. Out-of-network facilities - emergency medical**
6 **services - billing - payment.** (1) IF A COVERED PERSON RECEIVES
7 EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE
8 OUT-OF-NETWORK FACILITY SHALL:

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

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

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

23 (b) AN OUT-OF-NETWORK FACILITY THAT FAILS TO REIMBURSE A
24 COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF THIS SECTION
25 FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE OVERPAYMENT AT
26 THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON THE DATE THE
27 FACILITY RECEIVED THE NOTICE OF THE OVERPAYMENT. THE COVERED

1 PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED INTEREST FROM THE
2 OUT-OF-NETWORK HEALTH CARE FACILITY IN ORDER TO RECEIVE INTEREST
3 WITH THE REIMBURSEMENT AMOUNT.
4 (3) (a) AN OUT-OF-NETWORK FACILITY, OTHER THAN ANY
5 OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER HEALTH AND
6 HOSPITAL AUTHORITY PURSUANT TO ARTICLE 29 OF TITLE 25, MUST SEND
7 A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE
8 HUNDRED EIGHTY DAYS AFTER THE RECEIPT OF INSURANCE INFORMATION
9 IN ORDER TO RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION
10 (3)(a). THE REIMBURSEMENT RATE IS THE GREATER OF:
11 (I) ONE HUNDRED FIVE PERCENT OF THE CARRIER'S MEDIAN
12 IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN
13 A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR
14
15 (II) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE
16 SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME
17 GEOGRAPHIC AREA FOR THE PRIOR YEAR ___ ___ BASED ON CLAIMS DATA
18 FROM THE ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION
19 25.5-1-204.
20 (b) AN OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER
21 HEALTH AND HOSPITAL AUTHORITY CREATED IN SECTION 25-29-103 MUST
22 SEND A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE
23 HUNDRED EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO
24 RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (3)(b). THE
25 REIMBURSEMENT RATE IS THE GREATER OF:
26 (I) THE CARRIER'S MEDIAN IN-NETWORK RATE OF REIMBURSEMENT
27 FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN

1 THE SAME GEOGRAPHIC AREA;

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

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

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

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

20 (4) AN OUT-OF-NETWORK FACILITY MAY INITIATE ARBITRATION
21 PURSUANT TO SECTION 10-16-704 (15) IF THE FACILITY BELIEVES THE
22 PAYMENT MADE PURSUANT TO SUBSECTION (3) OF THIS SECTION IS NOT
23 SUFFICIENT.

24 (5) THIS SECTION DOES NOT APPLY WHEN A COVERED PERSON
25 VOLUNTARILY USES AN OUT-OF-NETWORK PROVIDER.

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

1 **25-1-114. Unlawful acts - penalties.** (1) It is unlawful for any
2 person, association, or corporation, and the officers thereof:
3 (j) TO VIOLATE SECTION 25-3-121.
4 **SECTION 8.** In Colorado Revised Statutes, **add to article 30 as**
5 **relocated by House Bill 19-1172** 12-30-111 and 12-30-112 as follows:
6 **12-30-111. Health care providers - required disclosures - rules**
7 **- definitions.** (1) FOR THE PURPOSES OF THIS SECTION AND SECTION
8 12-30-112:
9 (a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION
10 10-16-102 (8).
11 (b) "COVERED PERSON" HAS THE SAME MEANING AS DEFINED IN
12 SECTION 10-16-102 (15).
13 (c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED
14 IN SECTION 10-16-704 (5.5)(e)(II).
15 (d) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
16 SECTION 10-16-704 (3)(d)(V)(A).
17 (e) "HEALTH BENEFIT PLAN" HAS THE SAME MEANING AS DEFINED
18 IN SECTION 10-16-102 (32).
19 (f) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING
20 AS DEFINED IN SECTION 10-16-704 (3)(d)(V)(B).
21 (g) "OUT-OF-NETWORK PROVIDER" MEANS A HEALTH CARE
22 PROVIDER THAT IS NOT A "PARTICIPATING PROVIDER" AS DEFINED IN
23 SECTION 10-16-102 (46).
24 (2) ON AND AFTER JANUARY 1, 2020, HEALTH CARE PROVIDERS
25 SHALL DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE
26 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
27 SERVICES FROM AN OUT-OF-NETWORK PROVIDER. THE DISCLOSURES MUST

1 COMPLY WITH THE RULES ADOPTED PURSUANT TO SUBSECTION (3) OF THIS
2 SECTION.
3 (3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF
4 INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION
5 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR
6 HEALTH CARE PROVIDERS TO DEVELOP AND PROVIDE CONSUMER
7 DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE DIRECTOR SHALL
8 ENSURE THAT THE RULES ARE CONSISTENT WITH SECTIONS 10-16-704 (12)
9 AND 25-3-120 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO
10 SECTION 10-16-704 (12)(b) AND BY THE STATE BOARD OF HEALTH
11 PURSUANT TO SECTION 25-3-120 (2). THE RULES MUST SPECIFY, AT A
12 MINIMUM, THE FOLLOWING:
13 (a) THE TIMING FOR PROVIDING THE DISCLOSURES FOR EMERGENCY
14 AND NONEMERGENCY SERVICES WITH CONSIDERATION GIVEN TO
15 POTENTIAL LIMITATIONS RELATING TO THE FEDERAL "EMERGENCY
16 MEDICAL TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd;
17 (b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
18 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
19 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR
20 COMMUNICATIONS WITH CONSUMERS;
21 (c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
22 CONSUMER'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE
23 CONSUMER'S HEALTH BENEFIT PLAN;
24 (d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE
25 PROVIDERS, INCLUDING WHETHER A HEALTH CARE PROVIDER IS OUT OF
26 NETWORK, THE TYPES OF SERVICES AN OUT-OF-NETWORK HEALTH CARE
27 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 **12-30-112. 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

1 COVERED PERSON.

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

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

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

24 (4) (a) AN OUT-OF-NETWORK HEALTH CARE PROVIDER MUST SEND
25 A CLAIM FOR A COVERED SERVICE TO THE CARRIER WITHIN ONE HUNDRED
26 EIGHTY DAYS AFTER THE RECEIPT OF INSURANCE INFORMATION IN ORDER
27 TO RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (4)(a).

1 THE REIMBURSEMENT RATE IS THE GREATER OF:

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

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

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

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

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

23 **SECTION 9. Appropriation.** (1) For the 2019-20 state fiscal
24 year, $33,884 is appropriated to the department of public health and
25 environment for use by the health facilities and emergency medical
26 services division. This appropriation is from the general fund and is based
27 on an assumption that the division will require an additional 0.4 FTE. To

1 implement this act, the division may use this appropriation for
2 administration and operations.
3 (2) For the 2019-20 state fiscal year, $63,924 is appropriated to the
4 department of regulatory agencies for use by the division of insurance.
5 This appropriation is from the division of insurance cash fund created in
6 section 10-1-103 (3), C.R.S. To implement this act, the division may use
7 this appropriation as follows:
8 (a) $58,366 for personal services, which amount is based on an
9 assumption that the division will require an additional 0.9 FTE; and
10 (b) $5,558 for operating expenses.
11
12 **SECTION 10. Act subject to petition - effective date -**
13 **applicability.** (1) Except as otherwise provided in subsection (2) of this
14 section, this act takes effect January 1, 2020; except that, if a referendum
15 petition is filed pursuant to section 1 (3) of article V of the state
16 constitution against this act or an item, section, or part of this act within
17 the ninety-day period after final adjournment of the general assembly,
18 then the act, item, section, or part will not take effect unless approved by
19 the people at the general election to be held in November 2020 and, in
20 such case, will take effect on the date of the official declaration of the
21 vote thereon by the governor.
22 (2) (a) Section 5 of this act takes effect only if House Bill 19-1172
23 does not become law.
24 (b) Section 8 of this act takes effect only if House Bill 19-1174
25 becomes law.
26 (3) This act applies to health care services provided on or after the
27 applicable effective date of this act.