COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Elaine McManis, Deputy Division Director, Health Facilities and Emergency Medical Services Division

Through: Randy Kuykendall, Director, Health Facilities and Emergency Medical Services Division, DRK

Date: February 19, 2020

Subject: Rulemaking Hearing 6 CCR 1011-1, Standards for Hospitals and Health Facilities Chapter 02—General Licensure Standards

The Colorado legislature passed House Bill 19-1174 "Concerning Out-of-Network Health Care Services Provided to Covered Persons" during the 2019 legislative session. This new law requires the Board of Health, in consultation and coordination with two divisions of the Department of Regulatory Agencies (DORA), the Division of Insurance (DOI) and the Division of Professions and Occupations (DPO), to promulgate rules that specify requirements for health care facilities to provide consumer disclosures in certain circumstances, starting Jan. 1, 2020.

This legislation addresses the issue of "surprise billing," something that can occur when a person who has health insurance is treated at an out-of-network facility or agency or is treated by an out-of-network provider at an in-network facility or agency. To prevent surprise bills for clients of facilities and agencies, this new statute ensures that bills for services covered by health insurance will be handled directly by health insurers, regardless of where or by whom the services are provided; and it holds clients harmless for the balance of the bill.

Due to the statutory deadline, the Department requested an emergency rule making in December 2019. The Board of Health adopted the emergency rules on Dec. 18, 2019; and they will remain in effect until April 15, 2020. The Department is now requesting a hearing for consideration of the permanent rules. The proposed regulations will replace emergency rules in 6 CCR 1011-1, Chapter 2 - General Licensure Standards.

The rules attached here are very similar to the emergency rules. The Department received comments from stakeholders throughout December 2019 and January 2020. On Jan. 24, 2020, the Department hosted a well-attended stakeholder meeting to receive public feedback on the emergency rules as promulgated and proposed changes to the permanent rules. In addition, the Department has continued to coordinate with DORA regarding the language of both the regulations and the consumer disclosure. The disclosure is substantively unchanged from the emergency rulemaking; however it been rearranged and reformatted based on a request from a stakeholder group that the disclosure be reviewed for readability. A signature line has been added along with a clarifying statement that signature by the client does not waive any rights under Colorado law, as the Department heard support from consumer advocates that the form should be signed, but wanted protections in place for clients.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1011-1, Standards for Hospitals and Health Facilities
Chapter 2—General Licensure Standards

Basis and Purpose.

The Department is proposing permanent rules to address mandates created by the passage of House Bill 19-1174, which became effective on Aug. 3, 2019. The law seeks to protect clients of licensed healthcare facilities from unexpected costs in certain healthcare settings.

House Bill 19-1174 required the Board of Health to promulgate rules for healthcare facilities that would be effective Jan. 1, 2020. In addition, it required the Department to work in collaboration with two divisions within the Department of Regulatory Agencies (DORA), the Division of Insurance (DOI) and the Division of Professions and Occupations (DPO), who are also required to promulgate similar rules for health professionals and for insurers.

The emergency rules, which were adopted by the Board of Health in December, have now been vetted through a public stakeholder meeting and through feedback from other internal partners. The Department is now requesting a hearing for permanent rulemaking. Changes to the emergency rules are minimal and the changes to the disclosure, which can be found in Appendix A, are primarily in regards to reordering of information and formatting for ease of client reading. The substantive changes to the disclosure are minimal.

Specific Statutory Authority.

Section 25-3-121(2), C.R.S.

Statutes that informed the rule are: Sections 24-34-113 and 10-16-704, C.R.S.

Is this rulemaking due to a change in state statute?

XX Yes, the bill number is HB 19-1174. Rules are ___ authorized XX required.

Does this rulemaking include proposed rule language that incorporate materials by reference?

_____ Yes ___ URL

XX No

Does this rulemaking include proposed rule language to create or modify fines or fees?

_____ Yes

XX No

Does the proposed rule language create (or increase) a state mandate on local government?

XX No.

- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed;

- The proposed rule requires a local government to perform or increase a specific activity because the local government has opted to perform an activity, or;
- The proposed rule reduces or eliminates a state mandate on local government.

REGULATORY ANALYSIS
for Amendments to
6 CCR 1011-1, Standards for Hospitals and Health Facilities
Chapter 2—General Licensure Standards

1. A description of the classes of persons affected by the proposed rule, including the classes that will bear the costs and the classes that will benefit from the proposed rule.

Group of Persons/Entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule Select category: C/CLG/S/B
All facilities or agencies licensed by the Department: hospitals, nursing care facilities, acute treatment units, home care agencies, dialysis treatment clinics, ambulatory surgical centers, hospice, community mental health centers, community clinics, convalescent centers, assisted living residences, birth centers, acute treatment units, home care placement agencies, and facilities for persons with intellectual and developmental disabilities.	3,500+ (the number changes almost daily)	C
Health Insurance Carriers (that offer individual, small group, and large group managed care plans in the state. Estimate provided by Division of Insurance.)	22	S
Health Care Providers (those with an independent scope of practice that may bill separately)	Unknown	S
Consumer Advocates, Colorado Hospital Association, Health Care Provider Associations	Various	S
Coloradans with Insurance Covered by This Statute (Estimate provided by Division of Insurance)	About 30% of the health-care market in Colorado	B

While all are stakeholders, groups of persons/entities connect to the rule and the problem being solved by the rule in different ways. To better understand those different relationships, please use this relationship categorization key:

C = individuals/entities that implement or apply the rule.
S = individuals/entities that do not implement or apply the rule but are interested in others applying the rule.
B = the individuals that are ultimately served, including the customers of our customers. These individuals may benefit, be harmed by or be at-risk because of the standard communicated in the rule or the manner in which the rule is implemented.

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

Impact on Customers (C):
Economic: The rules promulgated by the Board of Health will require that an additional disclosure be provided to clients. The cost of the reproduction of the disclosure will be relatively minimal; however, the facilities may incur additional costs in the development of procedures to ensure that disclosures are provided at the correct time, under the correct circumstances, and that the provision is documented. The proposed rules are concise and provide a template for the required disclosure, thereby reducing the administrative burden on the health care facilities regulated under this rule.

As with any new requirement, there will be a time cost as facilities and agencies develop, implement, and train staff on providing the disclosure to clients. Comments provided by customers indicate that the process of adding this to patient records is more complicated (and thus more costly) than it might initially seem to outsiders. However, there is no way for the Department to quantify these costs.

Non-economic: NA

Impact on Stakeholders (S):
Economic: Health insurance carriers and health care providers are covered by rules promulgated by other agencies. The rules promulgated by the Board of Health should not have a direct economic impact on these stakeholders, other than that the disclosures across entities have been coordinated to provide consistency to clients. The Colorado Hospital Association and any Healthcare Provider Associations will likewise be indirectly affected in that their members are affected, but the associations are not directly impacted. The Colorado Hospital Association provided input on both process and substance of the draft regulations and now the redrafted regulations.

There will be an indirect economic impact on healthcare trade associations, as the Colorado Hospital Association and similar organizations will field questions from members.

Non-economic: The associations are often conduits for members to determine the practical steps to implementation of new regulations, as well as best practices.

Impact on Beneficiaries (B):
Economic: Disclosure will assist clients in making informed choices regarding health care options that can result in significant cost savings to the client. In addition, this law benefits all clients receiving emergency care ensuring that any covered person should not be surprise billed for emergency services and should have no costs above what they would have paid at in-network facilities with in-network providers.

Non-economic: Because the law requires multiple disclosures to the patient (from insurers, from healthcare providers, and from facilities) at multiple points in time (with billing notices, after stabilization of emergency conditions, before providing service, and in “other communications,” the paperwork may add to the confusion experienced by many clients who already encounter a myriad of paperwork.

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   A. Anticipated CDPHE personal services, operating costs, or other expenditures:

Once in place, the proposed amendments are cost neutral. The Department did receive general funds to implement.

Expenditure Impact	FY 2019-20	FY 2020-21
General Fund	$43,283	$18,389
Personal Services	$29,181	$14,007
Operating Expenses	$4,703	$0
Centrally Appropriated	$9,399	$4,382
TOTAL	**$43,283**	**$18,389**

Anticipated CDPHE Revenues:
$33,884 for state fiscal year 2019-20 from general fund to implement Act. (Personal services and Operating expenses noted above).

B. Anticipated personal services, operating costs or other expenditures by another state agency:
The other state agency involved in implementing portions of the statute is the Department of Regulatory Agencies' Division of Insurance and Division of Professions and Occupations. These divisions will incur their own costs related to rulemaking, coordination with other agencies, and implementation of HB 19-1174.

Anticipated Revenues for another state agency:
The Department of Regulatory Agencies received an appropriation of $63,924 for SFY 2019-20 for use by the Division of Insurance for implementation.

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Along with the costs and benefits discussed above, the proposed revisions:

_XX Comply with a statutory mandate to promulgate rules.
___ Comply with federal or state statutory mandates, federal or state regulations, and Department funding obligations.
___ Maintain alignment with other states or national standards.
___ Implement a Regulatory Efficiency Review (rule review) result
___ Improve public and environmental health practice.
___ Implement stakeholder feedback.

Advance the following CDPHE Strategic Plan priorities (select all that apply):

1. Reduce Greenhouse Gas (GHG) emissions economy-wide from 125.716 million metric tons of CO2e (carbon dioxide equivalent) per year to 119.430 million metric tons of CO2e per year by June 30, 2020 and to 113.144 million metric tons of CO2e by June 30, 2023.

___ Contributes to the blueprint for pollution reduction

___ Reduces carbon dioxide from transportation
___ Reduces methane emissions from oil and gas industry
___ Reduces carbon dioxide emissions from electricity sector

2. Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020 and 75 ppb by June 30, 2023.

___ Reduces volatile organic compounds (VOC) and oxides of nitrogen (NOx) from the oil and gas industry.
___ Supports local agencies and COGCC in oil and gas regulations.
___ Reduces VOC and NOx emissions from non-oil and gas contributors

3. Decrease the number of Colorado adults who have obesity by 2,838 by June 30, 2020 and by 12,207 by June 30, 2023.

___ Increases the consumption of healthy food and beverages through education, policy, practice and environmental changes.
___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation.
___ Increases the reach of the National Diabetes Prevention Program and Diabetes Self-Management Education and Support by collaborating with the Department of Health Care Policy and Financing.

4. Decrease the number of Colorado children (age 2-4 years) who participate in the WIC Program and have obesity from 2120 to 2115 by June 30, 2020 and to 2100 by June 30, 2023.

___ Ensures access to breastfeeding-friendly environments.

5. Reverse the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.

___ Reverses the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.
___ Performs targeted programming to increase immunization rates.
___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).

6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023.

___ Creates a roadmap to address suicide in Colorado.
___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate.
___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries.
___ Saves health care costs by reducing reliance on emergency Departments and connects to responsive community-based resources.

7. The Office of Emergency Preparedness and Response (OEPR) will identify 100% of jurisdictional gaps to inform the required work of the Operational Readiness Review by June 30, 2020. ___ Conducts a gap assessment. ___ Updates existing plans to address identified gaps. ___ Develops and conducts various exercises to close gaps.
8. For each identified threat, increase the competency rating from 0% to 54% for outbreak/incident investigation steps by June 30, 2020 and increase to 92% competency rating by June 30, 2023. ___ Uses an assessment tool to measure competency for CDPHE's response to an outbreak or environmental incident. ___ Works cross-Departmentally to update and draft plans to address identified gaps noted in the assessment. ___ Conducts exercises to measure and increase performance related to identified gaps in the outbreak or incident response plan.
9. 100% of new technology applications will be virtually available to customers, anytime and anywhere, by June 20, 2020 and 90 of the existing applications by June 30, 2023. ___ Implements the CDPHE Digital Transformation Plan. ___ Optimizes processes prior to digitizing them. ___ Improves data dissemination and interoperability methods and timeliness.
10. Reduce CDPHE's Scope 1 & 2 Greenhouse Gas emissions (GHG) from 6,561 metric tons (in FY2015) to 5,249 metric tons (20% reduction) by June 30, 2020 and 4,593 tons (30% reduction) by June 30, 2023. ___ Reduces emissions from employee commuting ___ Reduces emissions from CDPHE operations
11. Fully implement the roadmap to create and pilot using a budget equity assessment by June 30, 2020 and increase the percent of selected budgets using the equity assessment from 0% to 50% by June 30, 2023. ___ Used a budget equity assessment

___ Advance CDPHE Division-level strategic priorities.

The costs and benefits of the proposed rule will not be incurred if inaction was chosen. Costs and benefits of inaction not previously discussed include:

Inaction is not as option. House Bill 19-1174 mandates that facilities and agencies begin to provide the disclosure, with content approved by the Board of Health, starting Jan. 1, 2020.

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   Rulemaking is proposed when it is the least costly method or the only statutorily allowable method for achieving the purpose of the statute. The specific revisions proposed in this rulemaking were developed in coordination with DORA and with some input from stakeholders, as detailed below. The December 2019 additions to regulation were the minimum necessary to achieve compliance with statute by Jan. 1, 2020, as required. The edited rules, attached, improve on the clarity and respond to stakeholder requests for improvement.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

   The new law requires rulemaking on this topic, thus, there were no alternatives considered. In addition, HB 19-1174 was clear in its directions regarding what topics must be addressed in the rules. The draft rules presented cover the requirements, provide several definitions, and provide the disclosure. Edits since the emergency rulemaking respond to some suggestions from stakeholders and provide a somewhat streamlined disclosure. The disclosure word count was reduced by 10 percent even with the addition of language regarding the signature.

   Staff received preliminary stakeholder comment from several sources and incorporated those ideas that were beneficial and appropriate. The Department held one, widely-attended public meeting on January 24 and used the feedback to further refine the state's draft. Please see the stakeholder engagement section for additional detail.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

   This rulemaking is the result of a new state law requiring rulemaking and setting strict parameters for the topics that were to be covered in the rules. The Division of Insurance assisted in researching disclosure notices from other states. The disclosure that is being proposed borrowed heavily from a well-written Washington State disclosure. There was no need for additional research to meet the limited parameters of this project.

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1011-1, Standards for Hospitals and Health Facilities
Chapter 2—General Licensure Standards

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
Prior to Emergency Rulemaking:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:
On October 24, 2019, DORA coordinated a multi-stakeholder meeting with the Department and interested affected parties. The following attended:

Organization	Representative Name and Title (if known)
Colorado Hospital Association	Amber Burkhart
Falck Rocky Mountain	William Mitch
Colorado Consumer Health Initiative	Emma Sargent
Colorado Consumer Health Initiative	Caitlin Westerson
Bright Health	Julie Uhl
Colorado Association of Health Plans	Julie Mowing
Colorado Association of Health Plans	Karlee Tebbutt
SCL Health Org	Jeani Frickey Saito

The Department also held multiple conversations with DORA to ensure that the disclosures were consistent with each other. On November 1, 2019, the Department sent a message through the Health Facilities Web Portal (Portal) to all licensed facilities and agencies seeking feedback to the proposed rule language and disclosure by November 15, 2019, for consideration prior to the requested emergency rulemaking hearing.

Since Emergency Rulemaking:
The Department convened a stakeholder meeting on Jan. 24, 2020. More than 3500 facilities were notified of the meeting via a portal message sent on Dec. 31, 3019. In addition, the message was posted to the division's blog, which is available to the general public. The message contained details regarding the onsite meeting as well as instructions for how to login to the zoom connection and call in.

The following representatives attended in person. In addition 80+ stakeholders attended the meeting remotely via Zoom. All participants were invited to comment verbally, via chat, and via email. Participants were also invited to provide email comments between the date of the meeting and the date of the Board of Health meeting.

Organization	Representative Name and Title (if known)
Colorado Hospital Association	Amber Burkhart
Colorado Consumer Health Initiative	Emma Sargent
Colorado Consumer Health Initiative	Bob Connelly
Children's Hospital	Kevin J.D. Wilson
SCL Health	Bill Klossner

Children's Hospital	Micah Brock
SCL Health	Jeani Frickey Saito
Estes Park Health	Julie Glasgow, Dir. of HIM
Estes Park Health	Laurie Johnson, Dir. Of PFS
SCL Health	Beth Broadway, Sr. Dir. of Pat. Access
Colorado Center on Law and Policy	Sara Lipowitz, Public Benefits Atty
Axiom Politics/HealthOne	Lisa LaBriola, Legislative Director
Paragon Infusion Care	Lori Palmisano, Administrator
Gordon Rees Scully Mansukhani	Peggy Kozal, Atty
Colorado Legal Services	Kate Russell, Staff Atty

In addition to the formal meeting, since Nov. 1, the department has handled 10 written comments/questions from the public and has considered all comments and used information from some of these interactions to further refine the language in both the rule and the disclosure.

Stakeholder Group Notification

The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was provided prior to the date the notice of rulemaking was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

___ Not applicable. This is an Emergency Rulemaking Packet. Notification will occur if the Board of Health sets this matter for final rulemaking.

_xx_ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

The following major issues were discussed in the stakeholder meeting or in written comments from stakeholders. The discussion points are included as well as the rationale for final decisions.

"Surprise" vs. "Balance" Billing

In the disclosure included in the emergency rules, the terms "balance billing" and "surprise billing" were used interchangeably. There was extensive discussion at the stakeholder meeting regarding the fact that neither term is used in the legislation. One stakeholder pointed out that balance billing is defined in Colorado statute, while surprise billing is not. A comment from one internal reviewer suggested that using only one of the terms would be less confusing for the public. After significant debate, stakeholders during the January 24th meeting agreed with the Department to consistently use the term surprise billing. Language was added to the disclosure to clarify that Colorado law defines balance billing similarly to the term surprise billing as being used in the disclosure. The Department and several stakeholders believe that surprise billing is a more consumer-friendly term and, thus, should be the term used in the consumer-oriented notice.

Who Receives the Disclosure?

The Department received extensive feedback from some stakeholders who were not in favor of providing the disclosure to all clients. They suggested that this would create confusion for many clients to whom the law does not apply. Many insurance plans, including all federal payer sources as well as self-funded plans, are not covered under HB 19-1174. These facilities suggested that they would prefer to only provide the disclosure to persons whose insurance plans are covered. Other stakeholders disagreed and thought that it would be easier to just provide it to everyone. In addition, the law discusses giving the disclosure to "consumers," a term that is used very broadly. Furthermore, the Department's long-standing practice is to develop regulations that are not based on payment type.

As the issue was discussed during the January 24th meeting, it became clear that it is not always easy, or even possible at the time of service, to determine whether clients are receiving in-network services from in-network providers. Clients cannot determine this independently as they do not know about the facility or agency's contractual arrangements. Moreover, often the exact nature of the agreement between insurance plans and a facility or agency makes it difficult for even a facility or agency to be sure until services are completed and billed. The employees who process admissions may not know if all of the providers accept any given insurance. The Department believes that it is less confusing to give the disclosure to all clients and has maintained this language in the permanent rule.

Should the Disclosure Indicate Which Insurance Types Are Not Covered?

The wording in the disclosure in regards to the applicability of the protections offered by HB 19-1174 is "THIS LAW ONLY APPLIES IF YOU HAVE A "CO-DOI" ON YOUR HEALTH INSURANCE ID CARD…" This wording was recommended by the Division of Insurance and focuses on the consumer who is covered. The Department believes it would be potentially confusing to try to define plans that do not qualify.

It was discussed during the January 24th stakeholder meeting if the disclosure could also contain language regarding what plans are not covered by HB 19-1174; specifically federal payment plans and self-funded plans. The Department is not the expert on which insurance plans are subject to this law and which are not. Furthermore, people change insurance plans regularly and may be covered by a Colorado-regulated plan one month and covered by one that is not the next. After consideration of all the information, the Department decided that language stating what plans are not covered would be more confusing to facility and agency clients, and would be difficult for the Department to determine its accuracy in the future.

Is a Signature Mandatory?

The short answer is "no." The draft emergency rules were amended by the Board of Health in December making obtaining a signature from the patient permissive instead of mandatory as originally proposed by the Department. The Department indicated to stakeholders that it would move back to a mandatory signature in the permanent rulemaking.

During the additional stakeholder process, a stakeholder representing consumers correctly pointed out that the wording in the proposed rule placed the responsibility for signing on the client as a condition to move forward with care. The Department

regulates facilities and agencies, not clients, and the wording was changed to reflect that the facility or agency must provide the form to the client for signature. If the client declines to sign, the facility or agency is not penalized. Nonetheless, facilities and agencies would be wise to institute some means of tracking that the disclosure was provided to the client, and the client refused to sign.

During the emergency rulemaking hearing, the Board of Health requested that the Department speak to facilities and agencies about how the giving of the disclosures to clients would be operationalized and to consider if delayed implementation of signature requirements would ease the burden, particularly on small and rural facilities. During the January 24th meeting, stakeholders expressed that they were encountering technical difficulties as well as staff education hurdles in providing the disclosure, but that the signature requirement was not the cause of these difficulties. Rather, the statutory deadline of January 1, 2020 and not knowing whether or not a client was covered by the law seemed to be at the root. The changes made in the rule related to signature, as discussed above, as well as the reminder that the permanent rules will not take effect until mid-April, which provides another eight weeks to work through some of the technical issues regarding the implementation of a disclosure with a signature requested, gives facilities and agencies more latitude and time to work through the operationalizing of the disclosure.

During the January 24th stakeholder meeting, a discussion ensued about whether the disclosure could be altered in any way. The Department believes, based on the statutory language, that the disclosure as set in rule will be the minimum. The law does not require that the exact form be used, but that "the contents of the disclosures," be set in rule. A regulated facility or agency must use at least the content of the required disclosure. It may be that some regulated facilities add a letterhead or even add other information to the disclosure, as long as the required minimum disclosure is not altered or removed from its context, this would be appropriate.

The Department was also asked if it would be providing translation of the disclosure. While the Department recognizes that translation of the disclosure for non-English speakers is necessary for the disclosure to be meaningful, it was decided that the Department will not provide translations in any language. However, the facility or agency may seek translation into any language that it feels is appropriate for its client population. As mentioned above, the law does not require that the disclosure be provided exactly on the form provided by the Department, just that the contents be set in rule. As long as an appropriate translation is provided, we believe this would be consistent with the intent of "the contents of the disclosures."

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking.

Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.	X	Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
	Improves access to food and healthy food options.		Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
X	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.		Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.		Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____ _____		Other:_____ _____

HOUSE BILL 19-1174

BY REPRESENTATIVE(S) Esgar and Catlin, Bird, Buckner, Buentello, Caraveo, Coleman, Cutter, Exum, Galindo, Garnett, Gray, Hooton, Jackson, Jaquez Lewis, Kennedy, Kipp, Kraft-Tharp, Lontine, McCluskie, McLachlan, Michaelson Jenet, Mullica, Roberts, Singer, Sirota, Snyder, Sullivan, Tipper, Titone, Valdez A., Valdez D., Weissman, Becker, Duran, Gonzales-Gutierrez, Melton, Soper, Will;
also SENATOR(S) Gardner and Pettersen, Bridges, Crowder, Danielson, Donovan, Fenberg, Lee, Moreno, Priola, Story, Tate, Winter, Garcia.

CONCERNING OUT-OF-NETWORK HEALTH CARE SERVICES PROVIDED TO COVERED PERSONS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

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

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

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

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(mmm) VIOLATES SECTION 24-34-114.

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

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

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

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

10-16-107. Rate filing regulation - benefits ratio - rules. (7) STARTING IN 2021, AS PART OF THE RATE FILING REQUIRED PURSUANT TO THIS SECTION, EACH CARRIER SHALL PROVIDE TO THE COMMISSIONER, IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER, INFORMATION CONCERNING THE UTILIZATION OF OUT-OF-NETWORK PROVIDERS AND FACILITIES AND THE AGGREGATE COST SAVINGS AS A RESULT OF THE IMPLEMENTATION OF SECTION 10-16-704 (3)(d)(I) AND (5.5)(b)(I).

SECTION 4. In Colorado Revised Statutes, 10-16-704, **amend** (3)(a)(III), (5.5)(a) introductory portion, (5.5)(a)(V), and (5.5)(b); and **add** (3)(d), (5.5)(c), (5.5)(d), (5.5)(e), (12), (13), (14), (15), and (16) as follows:

10-16-704. Network adequacy - rules - legislative declaration - definitions. (3) (a) (III) The general assembly finds, determines, and declares that the division ~~of insurance~~ has correctly interpreted ~~the provisions of~~ this section to protect ~~the insured~~ A COVERED PERSON from the additional expense charged by ~~an assisting~~ A provider who is an out-of-network provider, and has properly required ~~insurers~~ CARRIERS to hold the ~~consumer~~ COVERED PERSON harmless. The division ~~of insurance~~ does not have regulatory authority over all health plans. Some consumers are enrolled in self-funded health insurance programs that are governed under the federal "Employee Retirement Income Security Act OF 1974", 29 U.S.C. SEC. 1001 ET SEQ. Therefore, ~~the general assembly encourages~~ health care facilities, carriers, and providers ~~to~~ MUST provide consumers ~~disclosure~~ WITH DISCLOSURES about the potential impact of receiving services from an out-of-network provider OR HEALTH CARE FACILITY AND 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.

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

(V) THIS SUBSECTION (3)(d) DOES NOT APPLY WHEN A COVERED PERSON VOLUNTARILY USES AN OUT-OF-NETWORK PROVIDER.

(VI) FOR PURPOSES OF THIS SUBSECTION (3):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) THE CARRIER'S MEDIAN IN-NETWORK RATE OF REIMBURSEMENT

FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA;

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

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

(III) PAYMENT MADE BY A CARRIER IN COMPLIANCE WITH THIS SUBSECTION (5.5)(b) 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.

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

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

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

(B) THE COMMISSIONER SHALL MAKE THE PAYMENT METHODOLOGY AVAILABLE TO THE PUBLIC ON THE DIVISION'S WEBSITE. THE RULES MUST BE EQUITABLE TO SERVICE AGENCIES AND CARRIERS; HOLD CONSUMERS HARMLESS EXCEPT FOR ANY APPLICABLE COINSURANCE, DEDUCTIBLE, OR COPAYMENT AMOUNTS; AND BE BASED ON A COST-BASED MODEL THAT INCLUDES DIRECT PAYMENT TO SERVICE AGENCIES AS DESCRIBED IN

SUBSECTION (5.5)(d)(I) OF THIS SECTION.

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

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

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

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

(B) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

(C) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

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

(A) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE THE EMERGENCY MEDICAL CONDITION; AND

(B) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, FURTHER MEDICAL EXAMINATION AND TREATMENT AS REQUIRED TO STABILIZE THE PATIENT TO ASSURE, WITHIN REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE TRANSFER OF THE INDIVIDUAL FROM A FACILITY.

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

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

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

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

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

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

(III) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE 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 25-3-121 AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (12)(b) AND SECTIONS 24-34-113 (3) AND 25-3-121 (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 25-3-122 (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 FORM AND INCLUDES THE SELECTION OF AN ARBITRATOR FROM A LIST OF QUALIFIED ARBITRATORS DEVELOPED PURSUANT TO THE RULES. QUALIFIED ARBITRATORS MUST BE INDEPENDENT; NOT BE AFFILIATED WITH A CARRIER, HEALTH CARE FACILITY, OR PROVIDER, OR ANY PROFESSIONAL ASSOCIATION OF CARRIERS, HEALTH CARE FACILITIES, OR PROVIDERS; NOT HAVE A PERSONAL, PROFESSIONAL, OR FINANCIAL CONFLICT WITH ANY PARTIES TO THE ARBITRATION; AND HAVE EXPERIENCE IN HEALTH CARE BILLING AND REIMBURSEMENT RATES.

(c) WITHIN THIRTY DAYS AFTER THE COMMISSIONER APPOINTS AN ARBITRATOR AND NOTIFIES THE PARTIES OF THE ARBITRATION, BOTH PARTIES SHALL SUBMIT TO THE ARBITRATOR, IN WRITING, EACH PARTY'S FINAL OFFER AND EACH PARTY'S ARGUMENT. THE ARBITRATOR SHALL PICK ONE OF THE TWO AMOUNTS SUBMITTED BY THE PARTIES AS THE ARBITRATOR'S FINAL AND BINDING DECISION. THE DECISION MUST BE IN WRITING AND MADE WITHIN FORTY-FIVE DAYS AFTER THE ARBITRATOR'S APPOINTMENT. IN MAKING THE DECISION, THE ARBITRATOR SHALL CONSIDER THE CIRCUMSTANCES AND COMPLEXITY OF THE PARTICULAR CASE, INCLUDING THE FOLLOWING AREAS:

(I) THE PROVIDER'S LEVEL OF TRAINING, EDUCATION, EXPERIENCE, AND SPECIALIZATION OR SUBSPECIALIZATION; AND

(II) THE PREVIOUSLY CONTRACTED RATE, IF THE PROVIDER HAD A CONTRACT WITH THE CARRIER THAT WAS TERMINATED OR EXPIRED WITHIN ONE YEAR PRIOR TO THE DISPUTE.

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

(e) THE PARTY WHOSE FINAL OFFER AMOUNT WAS NOT SELECTED BY THE ARBITRATOR SHALL PAY THE ARBITRATOR'S EXPENSES AND FEES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR HEALTH CARE PROVIDERS TO DEVELOP AND PROVIDE CONSUMER DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE DIRECTOR SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTION 10-16-704 (12) AND 25-3-121 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE STATE BOARD OF HEALTH PURSUANT TO SECTION 25-3-121 (2). THE RULES MUST SPECIFY, AT A MINIMUM, THE FOLLOWING:

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

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

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

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

(e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY THIS SECTION AND SECTIONS 10-16-704 (12) AND 25-3-121 AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (3) AND SECTIONS 10-16-704 (12)(b) AND 25-3-121 (2).

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

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

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

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

(b) NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,

DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.

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

(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 ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

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

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

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

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

SECTION 6. In Colorado Revised Statutes, **add** 25-3-121 and 25-3-122 as follows:

25-3-121. Health care facilities - emergency and nonemergency services - required disclosures - rules - definitions. (1) ON AND AFTER JANUARY 1, 2020, HEALTH CARE FACILITIES SHALL DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER PROVIDING SERVICES AT AN IN-NETWORK FACILITY OR EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE RULES ADOPTED PURSUANT TO SUBSECTION (2) OF THIS SECTION.

(2) THE STATE BOARD OF HEALTH, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE AND THE DIRECTOR OF THE DIVISION OF

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

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

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

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

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

(e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY THIS SECTION AND SECTIONS 10-16-704 (12) AND 24-34-113 AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (2) AND SECTIONS 10-16-704 (12)(b) AND 24-34-113 (3).

(3) RECEIPT OF THE DISCLOSURE REQUIRED BY THIS SECTION DOES

NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTION 10-16-704 (3) OR (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS UNDER THE CONSUMER'S HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.

(4) FOR THE PURPOSES OF THIS SECTION AND SECTION 25-3-122:

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

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

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

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

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

(f) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING AS DEFINED IN SECTION 10-16-704 (3)(d)(VI)(B).

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

25-3-122. Out-of-network facilities - emergency medical services - billing - payment. (1) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE OUT-OF-NETWORK FACILITY SHALL:

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

(b) NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,

DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.

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

(b) AN OUT-OF-NETWORK FACILITY 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 FACILITY RECEIVED THE NOTICE OF THE OVERPAYMENT. THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED INTEREST FROM THE OUT-OF-NETWORK HEALTH CARE FACILITY IN ORDER TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.

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

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

(II) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR BASED ON CLAIMS DATA FROM THE ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

(b) AN OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER HEALTH AND HOSPITAL AUTHORITY CREATED IN SECTION 25-29-103 MUST SEND A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE

HUNDRED EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (3)(b). THE REIMBURSEMENT RATE IS THE GREATER OF:

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

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

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

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

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

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

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

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

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

(j) TO VIOLATE SECTION 25-3-122.

SECTION 8. In Colorado Revised Statutes, **add to article 30 as relocated by House Bill 19-1172** 12-30-112 and 12-30-113 as follows:

12-30-112. Health care providers - required disclosures - rules - definitions. (1) FOR THE PURPOSES OF THIS SECTION AND SECTION 12-30-113:

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

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

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

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

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

(f) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING AS DEFINED IN SECTION 10-16-704 (3)(d)(VI)(B).

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

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

(3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR HEALTH CARE PROVIDERS TO DEVELOP AND PROVIDE CONSUMER DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE DIRECTOR SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTIONS 10-16-704 (12) AND 25-3-121 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE STATE BOARD OF HEALTH PURSUANT TO SECTION 25-3-121 (2). THE RULES MUST SPECIFY, AT A MINIMUM, THE FOLLOWING:

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

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

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

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

(e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY THIS SECTION AND SECTIONS 10-16-704 (12) AND 25-3-121 AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (3) AND SECTIONS 10-16-704 (12)(b) AND 25-3-121 (2).

(4) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SECTION DOES

NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTION 10-16-704 (3) OR (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS UNDER THE CONSUMER'S HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.

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

12-30-113. Out-of-network health care providers - out-of-network services - billing - payment. (1) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES EMERGENCY SERVICES OR COVERED NONEMERGENCY SERVICES TO A COVERED PERSON AT AN IN-NETWORK FACILITY, THE OUT-OF-NETWORK PROVIDER SHALL:

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

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

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

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

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

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

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

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

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

(2) For the 2019-20 state fiscal year, $63,924 is appropriated to the department of regulatory agencies for use by the division of insurance. This appropriation is from the division of insurance cash fund created in section 10-1-103 (3), C.R.S. To implement this act, the division may use this appropriation as follows:

(a) $58,366 for personal services, which amount is based on an assumption that the division will require an additional 0.9 FTE; and

(b) $5,558 for operating expenses.

SECTION 10. Act subject to petition - effective date - applicability. (1) Except as otherwise provided in subsection (2) of this section, this act takes effect January 1, 2020; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within the ninety-day period after final adjournment of the general assembly, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2020 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

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

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

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

KC Becker
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Leroy M. Garcia
PRESIDENT OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

APPROVED May 14, 2019 at 1:03 p.m.
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES CHAPTER 2 – GENERAL LICENSURE STANDARDS

6 CCR 1011-1 Chapter 2

PART 1. DEFINITIONS

***

1.16 "Cost sharing" MEANS – the share of cost covered by a client's insurance that the client pays out of pocket. This term includes, but is not limited to deductibles, coinsurance, copayments, or other similar charges.

***

1.22 "Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in: serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child; or serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

1.23 "Emergency services," with respect to an emergency medical condition, means: a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility OR AGENCY.

***

1.34 "In-network" means a facility or agency that is a participating provider, as defined at section 10-16-102(46), C.R.S., in an individual's health insurance plan ~~or as defined below~~.

***

1.45 "Out-of-network" means a facility or agency that is not a participating provider, as defined at Section 10-16-102(46), C.R.S.

***

PART 7. CLIENT RIGHTS

7.1 Client Rights Policy

***

(Q) Request that an in-network healthcare provider provide services at an in-network facility or agency if available.

***

7.1.3 Pursuant to section 25-3-121, C.R.S., facilities and agencies shall provide the disclosure contained in Appendix A to all clients about the potential effects of receiving emergency or nonemergency services from an out-of-network facility or agency or an out-of-network provider who provides services at an in-network facility or agency.

Required disclosures by carriers and healthcare providers may be found ~~at 3 CCR 702-4, 4-2-65 and~~ IN rules promulgated ~~through~~ BY the Department of Regulatory Agencies, DIVISION OF INSURANCE AND Division of Occupations and Professions.

(A) The facility or agency shall provide the disclosure contained in Appendix A on the following occasions:

(1) For emergency services: After performing an appropriate medical screening examination and determining that a client does not have an emergency medical condition or after treatment has been provided to stabilize an emergency medical condition. The disclosure SHALL BE PROVIDED TO~~may be signed by~~ the client or their designated representative FOR SIGNATURE prior to discharge OR AT THE TIME OF ADMISSION FOR CONTINUING NONEMERGENCY SERVICES;

(2) FOR NONEMERGENCY SERVICES: PRIOR TO THE PROVISION OF ANY SERVICES, THE DISCLOSURE SHALL BE PROVIDED TO THE CLIENT OR THEIR DESIGNATED REPRESENTATIVE FOR SIGNATURE. ~~At the time the client consents to care or treatment by the facility or agency for nonemergency services. The disclosure may be signed by the client or their designated representative before the start of services~~;

(3) ~~On or with~~ WITH billing statements and billing notices issued by the facility or agency; and

(4) ~~On or with~~ WITH other forms or communications related to the services being provided pursuant to insurance coverage.

***

~~\Appendix A: Surprise Billing Disclosure~~

Surprise Billing -- Know Your Rights

~~Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:~~

- ~~You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or~~
- ~~You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado.*~~

What is surprise~~/balance~~ billing~~, and when does it happen~~?

If you are seen by a provider or use services in a facility or agency that is not in your health insurance plan's provider network, ~~sometimes~~ referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network facilities or agencies often bill you the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. ~~This~~ UNDER COLORADO LAW THIS is DEFINED AS BALANCED BILLING AND IS COMMONLY called ~~"~~surprise~~" or "balance"~~ billing.

ON JAN. 1, 2020, A NEW STATE LAW WENT INTO EFFECT TO PROTECT YOU FROM SURPRISE BILLING. THESE PROTECTIONS APPLY WHEN:

- YOU RECEIVE COVERED EMERGENCY SERVICES, OTHER THAN AMBULANCE SERVICES, FROM AN OUT-OF-NETWORK PROVIDER IN COLORADO.
- YOU UNINTENTIONALLY RECEIVE COVERED SERVICES FROM AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY OR AGENCY IN COLORADO.

THIS LAW ONLY APPLIES IF YOU HAVE A "CO-DOI" ON YOUR HEALTH INSURANCE ID CARD AND YOU ARE RECEIVING CARE AND SERVICES PROVIDED AT A REGULATED FACILITY OR AGENCY IN COLORADO.

When you ~~**CANNOT**~~ CANNOT be ~~**balance**~~ SURPRISE billed:

Emergency Services

If you are receiving emergency services, ~~the most~~ you can ONLY be billed ~~is~~ FOR your plan's in-network cost-sharing amounts, which are copayments, deductibles, and /or coinsurance. You cannot be billed for ~~any other amount. This includes both the~~ ANYTHING ELSE. ~~facility where you receive emergency services and any providers that~~ WHO ~~see you for emergency services.~~ THIS APPLIES ONLY TO SERVICES RELATED TO AND BILLED AS AN "EMERGENCY SERVICE."

~~Please note that not every service provided in an emergency department is an emergency service.~~

Non-Emergency Services at an In-Network Facility OR AGENCY by an Out-of-Network Provider

~~The facility~~ FACILITY or agency STAFF must tell you if you are at an out-of-network location or ~~at an in-network location that is~~ IF THEY ARE using out-of-network providers~~. They~~, WHEN KNOWN. Staff must also tell you what types of services ~~that~~ you will be using ~~may~~ THAT MIGHT be provided by an out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is ~~not available. In this case,~~ UNAVAILABLE. If your insurer covers the ~~most~~ SERVICE, you can ONLY be billed for ~~**covered** services is~~ your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. ~~These providers cannot balance bill you for additional costs.~~

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services ~~(described above)~~ toward your in-network deductible and out-of-pocket limit.
- ~~Your~~ THE provider OR ~~,~~ facility~~, hospital,~~ or agency must refund any amount you overpay within 60 days of being notified.
- No one, including a provider, hospital, or insurer, can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency in any ~~***OTHER***~~ OTHER situation, you may still be ~~***balance***~~ SURPRISE billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility OR AGENCY, you may also be ~~***balance***~~ SURPRISE billed.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the FACILITY'S OR AGENCY'S billing department~~,~~ or the Colorado Division of Insurance at 303-894-~~7490~~7499 or 1-800-930-3745.

_____DATE _____

MY SIGNATURE ACKNOWLEDGES RECEIVING THIS NOTICE AND DOES NOT WAIVE MY RIGHTS UNDER THE LAW.

~~* This law does NOT apply to ALL Colorado health plans. It only applies if:~~

- ~~You have a "**CO-DOI**" on your health insurance ID card, and~~
- ~~You are receiving care and services provided at a regulated facility state of Colorado.~~

~~Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.~~