First Regular Session
Seventy-second General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 19-0709.01 Kristen Forrestal x4217 **HOUSE BILL 19-1174**

HOUSE SPONSORSHIP

Esgar and Catlin,

SENATE SPONSORSHIP

Gardner and Pettersen,

House Committees
Health & Insurance
Appropriations

Senate Committees

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

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

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).

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

1 INFORMED DECISIONS ABOUT THEIR HEALTH CARE AND FINANCIAL
2 OBLIGATIONS.
3 (d) (I) IF A COVERED PERSON RECEIVES COVERED SERVICES AT AN
4 IN-NETWORK FACILITY FROM AN OUT-OF-NETWORK PROVIDER, THE
5 CARRIER SHALL PAY THE OUT-OF-NETWORK PROVIDER DIRECTLY AND IN
6 ACCORDANCE WITH THIS SUBSECTION (3)(d). AT THE TIME OF THE
7 DISPOSITION OF THE CLAIM, THE CARRIER SHALL ADVISE THE
8 OUT-OF-NETWORK PROVIDER AND THE COVERED PERSON OF ANY
9 REQUIRED COINSURANCE, DEDUCTIBLE, OR COPAYMENT.
10 (II) WHEN THE REQUIREMENTS OF SUBSECTION (3)(b) OF THIS
11 SECTION APPLY, THE CARRIER SHALL REIMBURSE THE OUT-OF-NETWORK
12 PROVIDER DIRECTLY IN ACCORDANCE WITH SECTION 10-16-106.5 THE
13 GREATER OF:
14 (A) THE CARRIER'S MEDIAN IN-NETWORK RATE OF
15 REIMBURSEMENT FOR THAT SERVICE IN THE SAME GEOGRAPHIC AREA;
16 (B) ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE
17 REIMBURSEMENT RATE FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC
18 AREA; OR
19 (C) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF
20 REIMBURSEMENT FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA
21 FOR THE PRIOR YEAR AS DETERMINED BASED ON CLAIMS DATA FROM THE
22 ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.
23 (III) PAYMENT MADE BY A CARRIER IN COMPLIANCE WITH THIS
24 SUBSECTION (3)(d) IS PRESUMED TO BE PAYMENT IN FULL FOR THE
25 SERVICES PROVIDED, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR
26 COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.
27 (IV) THIS SUBSECTION (3)(d) DOES NOT PRECLUDE THE CARRIER

1 AND THE OUT-OF-NETWORK PROVIDER FROM VOLUNTARILY NEGOTIATING
2 AN INDEPENDENT REIMBURSEMENT RATE. IF THE NEGOTIATIONS FAIL, THE
3 REIMBURSEMENT RATE REQUIRED BY SUBSECTION (3)(d)(II) OF THIS
4 SECTION APPLIES.
5 (V) FOR PURPOSES OF THIS SUBSECTION (3):
6 (A) "GEOGRAPHIC AREA" MEANS A SPECIFIC AREA IN THIS STATE
7 AS ESTABLISHED BY THE COMMISSIONER BY RULE.
8 (B) "MEDICARE REIMBURSEMENT RATE" MEANS THE
9 REIMBURSEMENT RATE FOR A PARTICULAR HEALTH CARE SERVICE
10 PROVIDED UNDER THE "HEALTH INSURANCE FOR THE AGED ACT", TITLE
11 XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, 42 U.S.C.
12 SEC. 1395 ET SEQ.
13 (5.5) (a) Notwithstanding any provision of law, a carrier that
14 provides any benefits with respect to EMERGENCY services ~~in an~~
15 ~~emergency department of a hospital~~ shall cover THE emergency services:
16 (V) AT THE IN-NETWORK BENEFIT LEVEL, with the same
17 ~~cost-sharing~~ COINSURANCE, DEDUCTIBLE, OR COPAYMENT requirements
18 as would apply if THE emergency services were provided BY AN
19 in-network PROVIDER OR FACILITY, AND AT NO GREATER COST TO THE
20 COVERED PERSON THAN IF THE EMERGENCY SERVICES WERE OBTAINED AT
21 OR FROM AN IN-NETWORK PROVIDER AT AN IN-NETWORK FACILITY. ANY
22 PAYMENT MADE BY A COVERED PERSON PURSUANT TO THIS SUBSECTION
23 (5.5)(a)(V) MUST BE APPLIED TO THE COVERED PERSON'S IN-NETWORK
24 OUT-OF-POCKET MAXIMUM.
25 ~~(b) For purposes of this subsection (5.5):~~
26 ~~(I) "Emergency medical condition" means a medical condition that~~
27 ~~manifests itself by acute symptoms of sufficient severity, including severe~~

1 ~~pain, that a prudent layperson with an average knowledge of health and~~
2 ~~medicine could reasonably expect, in the absence of immediate medical~~
3 ~~attention, to result in:~~
4 ~~(A) Placing the health of the individual or, with respect to a~~
5 ~~pregnant woman, the health of the woman or her unborn child, in serious~~
6 ~~jeopardy;~~
7 ~~(B) Serious impairment to bodily functions; or~~
8 ~~(C) Serious dysfunction of any bodily organ or part.~~
9 ~~(II) "Emergency services", with respect to an emergency medical~~
10 ~~condition, means:~~
11 ~~(A) A medical screening examination that is within the capability~~
12 ~~of the emergency department of a hospital, including ancillary services~~
13 ~~routinely available to the emergency department to evaluate the~~
14 ~~emergency medical condition; and~~
15 ~~(B) Within the capabilities of the staff and facilities available at~~
16 ~~the hospital, further medical examination and treatment as required to~~
17 ~~stabilize the patient to assure, within reasonable medical probability, that~~
18 ~~no material deterioration of the condition is likely to result from or occur~~
19 ~~during the transfer of the individual from a facility, or with respect to an~~
20 ~~emergency medical condition.~~
21 (b) (I) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT
22 AN OUT-OF-NETWORK FACILITY OTHER THAN ANY OUT-OF-NETWORK
23 FACILITY OPERATED BY THE DENVER HEALTH AND HOSPITAL AUTHORITY
24 PURSUANT TO ARTICLE 29 OF TITLE 25, THE CARRIER SHALL REIMBURSE
25 THE OUT-OF-NETWORK FACILITY AND OUT-OF-NETWORK PROVIDER
26 DIRECTLY IN ACCORDANCE WITH SECTION 10-16-106.5 THE GREATER OF:
27 (A) ONE HUNDRED FIVE PERCENT OF THE CARRIER'S MEDIAN

1 IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN
2 A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR
3
4 (B) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF
5 REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY
6 OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR AS
7 DETERMINED BASED ON CLAIMS DATA FROM THE COLORADO ALL-PAYER
8 HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.
9 (II) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT ANY
10 OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER HEALTH AND
11 HOSPITAL AUTHORITY CREATED IN SECTION 25-29-103, THE CARRIER
12 SHALL REIMBURSE THE OUT-OF-NETWORK FACILITY DIRECTLY IN
13 ACCORDANCE WITH SECTION 10-16-106.5 THE GREATER OF:
14 (A) THE CARRIER'S MEDIAN IN-NETWORK RATE OF
15 REIMBURSEMENT FOR THAT SERVICE PROVIDED IN A SIMILAR FACILITY OR
16 SETTING IN THE SAME GEOGRAPHIC AREA;
17 (B) TWO HUNDRED FIFTY PERCENT OF THE MEDICARE
18 REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR
19 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR
20 (C) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF
21 REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY
22 OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR AS
23 DETERMINED BASED ON CLAIMS DATA FROM THE COLORADO ALL-PAYER
24 HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.
25 (III) PAYMENT MADE BY A CARRIER IN COMPLIANCE WITH THIS
26 SUBSECTION (5.5)(b) IS PRESUMED TO BE PAYMENT IN FULL FOR THE
27 SERVICES PROVIDED, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR

1 COPAYMENT REQUIRED TO BE PAID BY THE COVERED PERSON.

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

7 (d) (I) SUBSECTIONS (5.5)(a), (5.5)(b), AND (5.5)(c) OF THIS
8 SECTION DO NOT APPLY TO SERVICE AGENCIES, AS DEFINED IN SECTION
9 25-3.5-103 (11.5), PROVIDING AMBULANCE SERVICES, AS DEFINED IN
10 SECTION 25-3.5-103 (3).

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

16 (B) THE COMMISSIONER SHALL MAKE THE PAYMENT
17 METHODOLOGY AVAILABLE TO THE PUBLIC ON THE DIVISION'S WEBSITE.
18 THE RULES MUST BE EQUITABLE TO PROVIDERS AND CARRIERS; HOLD
19 CONSUMERS HARMLESS EXCEPT FOR ANY APPLICABLE COPAYMENT,
20 COINSURANCE, OR DEDUCTIBLE AMOUNTS; AND BASED ON A COST-BASED
21 MODEL THAT INCLUDES DIRECT PAYMENT TO SERVICE AGENCIES AS
22 DESCRIBED IN SUBSECTION (5.5)(d)(I) OF THIS SECTION.

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

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

1 (I) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL
2 CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT
3 SEVERITY, INCLUDING SEVERE PAIN, THAT A PRUDENT LAYPERSON WITH AN
4 AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY
5 EXPECT, IN THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION, TO RESULT
6 IN:
7 (A) SERIOUS JEOPARDY TO THE HEALTH OF THE INDIVIDUAL OR,
8 WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR
9 HER UNBORN CHILD;
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
13 MEDICAL CONDITION, MEANS:
14 (A) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE
15 CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING
16 ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY
17 DEPARTMENT TO EVALUATE THE EMERGENCY MEDICAL CONDITION; AND
18 (B) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES
19 AVAILABLE AT THE HOSPITAL, FURTHER MEDICAL EXAMINATION AND
20 TREATMENT AS REQUIRED TO STABILIZE THE PATIENT TO ASSURE, WITHIN
21 REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION
22 OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE
23 TRANSFER OF THE INDIVIDUAL FROM A FACILITY.
24 (III) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
25 SUBSECTION (3)(d)(V)(A) OF THIS SECTION.
26 (IV) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING
27 AS DEFINED IN SUBSECTION (3)(d)(V)(B) OF THIS SECTION.

1 (12) (a) ON AND AFTER JANUARY 1, 2020, CARRIERS SHALL
2 DEVELOP AND PROVIDE DISCLOSURES TO COVERED PERSONS ABOUT THE
3 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
4 SERVICES FROM AN OUT-OF-NETWORK PROVIDER OR AT AN
5 OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE
6 RULES ADOPTED UNDER SUBSECTION (12)(b) OF THIS SECTION.
7 (b) THE COMMISSIONER, IN CONSULTATION WITH THE STATE
8 BOARD OF HEALTH CREATED IN SECTION 25-1-103 AND THE DIRECTOR OF
9 THE DIVISION OF PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF
10 REGULATORY AGENCIES, SHALL ADOPT RULES TO SPECIFY THE DISCLOSURE
11 REQUIREMENTS UNDER THIS SUBSECTION (12), WHICH RULES MUST
12 SPECIFY, AT A MINIMUM, THE FOLLOWING:
13 (I) 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 (II) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
18 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
19 BILLING STATEMENTS, BILLING NOTICES, PRIOR AUTHORIZATIONS, OR
20 OTHER FORMS OR COMMUNICATIONS WITH COVERED PERSONS;
21 (III) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
22 COVERED PERSON'S RIGHTS AND PAYMENT OBLIGATIONS IF THE COVERED
23 PERSON'S HEALTH BENEFIT PLAN IS UNDER THE JURISDICTION OF THE
24 DIVISION;
25 (IV) DISCLOSURE REQUIREMENTS SPECIFIC TO CARRIERS,
26 INCLUDING THE POSSIBILITY OF BEING TREATED BY AN OUT-OF-NETWORK
27 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 (2) 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 FACILITY PURSUANT TO SUBSECTION (3)(d)(II) OR (5.5)(b)(I) 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.

1 **SECTION 5.** In Colorado Revised Statutes, **add** 24-34-113 and
2 24-34-114 as follows:
3 **24-34-113. Health care providers - required disclosures - rules**
4 **- definitions.** (1) FOR THE PURPOSES OF THIS SECTION AND SECTION
5 24-34-114:
6 (a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION
7 10-16-102 (8).
8 (b) "COVERED PERSON" HAS THE SAME MEANING AS DEFINED IN
9 SECTION 10-16-102 (15).
10 (c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED
11 IN SECTION 10-16-704 (5.5)(e)(II).
12 (d) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
13 SECTION 10-16-704 (3)(d)(V)(A).
14 (e) "HEALTH BENEFIT PLAN" HAS THE SAME MEANING AS DEFINED
15 IN SECTION 10-16-102 (32).
16 (f) "HEALTH CARE PROVIDER" HAS THE SAME MEANING AS
17 "PROVIDER" AS DEFINED IN SECTION 10-16-102 (56).
18 (g) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING
19 AS DEFINED IN SECTION 10-16-704 (3)(d)(V)(B).
20 (h) "OUT-OF-NETWORK PROVIDER" MEANS A HEALTH CARE
21 PROVIDER THAT IS NOT A PARTICIPATING PROVIDER, AS DEFINED IN
22 SECTION 10-16-102 (46).
23 (2) ON AND AFTER JANUARY 1, 2020, HEALTH CARE PROVIDERS
24 SHALL DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE
25 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
26 SERVICES FROM AN OUT-OF-NETWORK PROVIDER. THE DISCLOSURES MUST
27 COMPLY WITH THE RULES ADOPTED PURSUANT TO SUBSECTION (3) OF THIS

1 SECTION.

2 (3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF
3 INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION
4 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR
5 HEALTH CARE PROVIDERS REGULATED UNDER TITLE 12 TO DEVELOP AND
6 PROVIDE CONSUMER DISCLOSURES IN ACCORDANCE WITH THIS SECTION.
7 THE DIRECTOR SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH
8 SECTION 10-16-704 (12) AND 25-3-120 AND RULES ADOPTED BY THE
9 COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE
10 STATE BOARD OF HEALTH PURSUANT TO SECTION 25-3-120 (2). THE RULES
11 MUST SPECIFY, AT A MINIMUM, THE FOLLOWING:

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

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

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

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

1 (e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN
2 THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT
3 CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE
4 LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY
5 THIS SECTION AND SECTIONS 10-16-704 (12) AND 25-3-120 AND THE RULES
6 ADOPTED PURSUANT TO THIS SUBSECTION (3) AND SECTIONS 10-16-704
7 (12)(b) AND 25-3-120 (2).
8 (4) RECEIPT OF THE DISCLOSURES REQUIRED BY SUBSECTION (2) OF
9 THIS SECTION DOES NOT WAIVE A CONSUMER'S PROTECTIONS UNDER
10 SECTION 10-16-704 (3) OR (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS
11 UNDER THE CONSUMER'S HEALTH BENEFIT PLAN AT THE IN-NETWORK
12 BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.
13 (5) THIS SECTION DOES NOT APPLY TO SERVICE AGENCIES, AS
14 DEFINED IN SECTION 25-3.5-103 (11.5), THAT ARE PUBLICLY FUNDED FIRE
15 AGENCIES.
16 **24-34-114. Out-of-network health care providers -**
17 **out-of-network services - billing - payment.** (1) IF AN
18 OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES EMERGENCY
19 SERVICES OR COVERED NONEMERGENCY SERVICES TO A COVERED PERSON
20 AT AN IN-NETWORK FACILITY, THE OUT-OF-NETWORK PROVIDER SHALL:
21 (a) SUBMIT A CLAIM FOR THE ENTIRE COST OF THE SERVICES TO
22 THE COVERED PERSON'S CARRIER; AND
23 (b) NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR
24 ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE
25 CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,
26 DEDUCTIBLE, OR COPAYMENT REQUIRED TO BE PAID BY THE COVERED
27 PERSON.

1 (2) (a) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES
2 NONEMERGENCY SERVICES AT AN IN-NETWORK FACILITY OR EMERGENCY
3 SERVICES AT AN OUT-OF-NETWORK OR IN-NETWORK FACILITY AND THE
4 HEALTH CARE PROVIDER RECEIVES PAYMENT FROM THE COVERED PERSON
5 FOR SERVICES FOR WHICH THE COVERED PERSON IS NOT RESPONSIBLE
6 PURSUANT TO SECTION 10-16-704 (3)(b) OR (5.5), THE HEALTH CARE
7 PROVIDER SHALL REIMBURSE THE COVERED PERSON WITHIN SIXTY
8 CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS
9 REPORTED TO THE PROVIDER.
10 (b) AN OUT-OF-NETWORK HEALTH CARE PROVIDER THAT FAILS TO
11 REIMBURSE A COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF
12 THIS SECTION FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE
13 OVERPAYMENT AT THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON
14 THE DATE THE PROVIDER RECEIVED THE NOTICE OF THE OVERPAYMENT.
15 THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED
16 INTEREST FROM THE OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER
17 TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.
18 (3) AN OUT-OF-NETWORK HEALTH CARE PROVIDER SHALL PROVIDE
19 A COVERED PERSON A WRITTEN ESTIMATE OF THE AMOUNT FOR WHICH THE
20 COVERED PERSON MAY BE RESPONSIBLE FOR NONEMERGENCY SERVICES
21 WITHIN THREE BUSINESS DAYS AFTER A REQUEST FROM THE COVERED
22 PERSON.
23 (4) (a) AN OUT-OF-NETWORK HEALTH CARE PROVIDER MUST SEND
24 A CLAIM FOR A COVERED SERVICE TO THE CARRIER WITHIN ONE HUNDRED
25 EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO RECEIVE
26 REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (4)(a). THE
27 REIMBURSEMENT RATE IS THE GREATER OF:

1 (I) ONE HUNDRED FIVE PERCENT OF THE CARRIER'S MEDIAN
2 IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN
3 THE SAME GEOGRAPHIC AREA; OR
4
5 (II) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF
6 REIMBURSEMENT FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA
7 FOR THE PRIOR YEAR AS DETERMINED BASED ON CLAIMS DATA FROM THE
8 ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.
9 (b) IF THE OUT-OF-NETWORK HEALTH CARE PROVIDER SUBMITS A
10 CLAIM FOR SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY PERIOD
11 SPECIFIED IN SUBSECTION (4)(a) OF THIS SECTION, THE CARRIER SHALL
12 REIMBURSE THE HEALTH CARE PROVIDER ONE HUNDRED TWENTY-FIVE
13 PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME
14 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 REQUIRED TO BE PAID BY THE COVERED PERSON.
19 **SECTION 6.** In Colorado Revised Statutes, **add** 25-3-120 and
20 25-3-121 as follows:
21 **25-3-120. Health care facilities - emergency and**
22 **nonemergency services - required disclosures - rules - definitions.**
23 (1) ON AND AFTER JANUARY 1, 2020, HEALTH CARE FACILITIES SHALL
24 DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE
25 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
26 SERVICES FROM AN OUT-OF-NETWORK PROVIDER PROVIDING SERVICES AT
27 AN IN-NETWORK FACILITY OR EMERGENCY SERVICES AT AN

1 OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE
2 RULES ADOPTED UNDER SUBSECTION (2) OF THIS SECTION.
3 (2) THE STATE BOARD OF HEALTH, IN CONSULTATION WITH THE
4 COMMISSIONER OF INSURANCE AND THE DIRECTOR OF THE DIVISION OF
5 PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF REGULATORY
6 AGENCIES, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR
7 HEALTH CARE FACILITIES TO DEVELOP AND PROVIDE CONSUMER
8 DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE STATE BOARD OF
9 HEALTH SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTION
10 10-16-704 (12) AND 24-34-113 (2) AND RULES ADOPTED BY THE
11 COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE
12 DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS PURSUANT
13 TO SECTION 24-34-113 (3). THE RULES MUST SPECIFY, AT A MINIMUM, THE
14 FOLLOWING:
15 (a) THE TIMING FOR PROVIDING THE DISCLOSURES FOR EMERGENCY
16 AND NONEMERGENCY SERVICES WITH CONSIDERATION GIVEN TO
17 POTENTIAL LIMITATIONS RELATING TO THE "EMERGENCY MEDICAL
18 TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd;
19 (b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
20 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
21 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR
22 COMMUNICATIONS WITH COVERED PERSONS;
23 (c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
24 CONSUMER'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE
25 CONSUMER'S HEALTH BENEFIT PLAN;
26 (d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE
27 FACILITIES, WHETHER A HEALTH CARE PROVIDER DELIVERING SERVICES AT

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

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

4 **25-3-121. Out-of-network facilities - emergency medical**
5 **services - billing - payment.** (1) IF A COVERED PERSON RECEIVES
6 EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE
7 OUT-OF-NETWORK FACILITY SHALL:

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

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

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

22 (b) AN OUT-OF-NETWORK FACILITY THAT FAILS TO REIMBURSE A
23 COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF THIS SECTION
24 FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE OVERPAYMENT AT
25 THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON THE DATE THE
26 FACILITY RECEIVED THE NOTICE OF THE OVERPAYMENT. THE COVERED
27 PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED INTEREST FROM THE

1 OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER TO RECEIVE
2 INTEREST WITH THE REIMBURSEMENT AMOUNT.
3 (3) (a) AN OUT-OF-NETWORK FACILITY, OTHER THAN ANY
4 OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER HEALTH AND
5 HOSPITAL AUTHORITY PURSUANT TO ARTICLE 29 OF TITLE 25, MUST SEND
6 A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE
7 HUNDRED EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO
8 RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (3)(a). THE
9 REIMBURSEMENT RATE IS THE GREATER OF:
10 (I) ONE HUNDRED FIVE PERCENT OF THE CARRIER'S MEDIAN
11 IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN
12 A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR
13
14 (II) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF
15 REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY
16 OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR AS
17 DETERMINED BASED ON CLAIMS DATA FROM THE ALL-PAYER HEALTH
18 CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.
19 (b) AN OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER
20 HEALTH AND HOSPITAL AUTHORITY CREATED IN SECTION 25-29-103 MUST
21 SEND A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE
22 HUNDRED EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO
23 RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (3)(b). THE
24 REIMBURSEMENT RATE IS THE GREATER OF:
25 (I) THE CARRIER'S MEDIAN IN-NETWORK RATE OF REIMBURSEMENT
26 FOR THAT SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE
27 SAME GEOGRAPHIC AREA;

1 (II) TWO HUNDRED FIFTY PERCENT OF THE MEDICARE
2 REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR
3 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR
4 (III) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE
5 OF REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR
6 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR
7 YEAR AS DETERMINED BASED ON CLAIMS DATA FROM THE COLORADO
8 ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.
9 (c) IF THE OUT-OF-NETWORK FACILITY SUBMITS A CLAIM FOR
10 EMERGENCY SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY PERIOD
11 SPECIFIED IN SUBSECTION (3)(a) OF THIS SECTION, THE CARRIER SHALL
12 REIMBURSE THE FACILITY ONE HUNDRED TWENTY-FIVE PERCENT OF THE
13 MEDICARE REIMBURSEMENT RATE FOR THE SAME SERVICES IN A SIMILAR
14 SETTING OR FACILITY IN THE SAME GEOGRAPHIC AREA.
15 (d) THE OUT-OF-NETWORK FACILITY 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 REQUIRED TO BE PAID BY THE COVERED PERSON.
19 **SECTION 7.** In Colorado Revised Statutes, 25-1-114, **add** (1)(j)
20 as follows:
21 **25-1-114. Unlawful acts - penalties.** (1) It is unlawful for any
22 person, association, or corporation, and the officers thereof:
23 (j) TO VIOLATE SECTION 25-3-121.
24 **SECTION 8. Appropriation.** (1) For the 2019-20 state fiscal
25 year, $33,884 is appropriated to the department of public health and
26 environment for use by the health facilities and emergency medical
27 services division. This appropriation is from the general fund and is based

1 on an assumption that the division will require an additional 0.4 FTE. To
2 implement this act, the division may use this appropriation for
3 administration and operations.

1 (2) For the 2019-20 state fiscal year, $16,340 is appropriated to the
2 department of regulatory agencies for use by the division of insurance.
3 This appropriation is from the division of insurance cash fund created in
4 section 10-1-103 (3), C.R.S. To implement this act, the division may use
5 this appropriation as follows:

6 (a) $16,150 for personal services, which amount is based on an
7 assumption that the division will require an additional 0.2 FTE; and

(b) $190 for operating expenses.

SECTION 9. Act subject to petition - effective date - applicability. (1) 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) This act applies to health benefit plans issued or renewed on or after the applicable effective date of this act.