First Regular Session
Seventy-second General Assembly
STATE OF COLORADO

ENGROSSED

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

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.

HOUSE
Amended 2nd Reading
March 21, 2019

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) AND (5.5).

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

1 **10-16-107. Rate filing regulation - benefits ratio - rules.** (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 MANNER
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), (14), (15), and (16) as
11 follows:
12 **10-16-704. Network adequacy - rules - legislative declaration**
13 **- definitions.** (3) (a) (III) The general assembly finds, determines, and
14 declares that the division ~~of insurance~~ has correctly interpreted ~~the~~
15 ~~provisions of~~ this section to protect ~~the insured~~ A COVERED PERSON from
16 the additional expense charged by ~~an assisting~~ A provider who is an
17 out-of-network provider, and has properly required ~~insurers~~ CARRIERS to
18 hold the ~~consumer~~ COVERED PERSON harmless. The division ~~of insurance~~
19 does not have regulatory authority over all health plans. Some consumers
20 are enrolled in self-funded health insurance programs that are governed
21 under the federal "Employee Retirement Income Security Act OF 1974",
22 29 U.S.C. SEC. 1001 ET SEQ. Therefore, ~~the general assembly encourages~~
23 health care facilities, carriers, and providers ~~to~~ MUST provide consumers
24 ~~disclosure~~ WITH DISCLOSURES about the potential impact of receiving
25 services from an out-of-network provider OR HEALTH CARE FACILITY AND
26 THEIR RIGHTS UNDER THIS SECTION. COVERED PERSONS MUST HAVE
27 ACCESS TO ACCURATE INFORMATION ABOUT THEIR HEALTH CARE BILLS

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

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

(b) (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 FACILITY AND OUT-OF-NETWORK PROVIDER 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

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

1 (c) THIS SUBSECTION (5.5) DOES NOT PRECLUDE THE CARRIER AND
2 THE OUT-OF-NETWORK FACILITY AND THE CARRIER AND THE PROVIDER
3 FROM VOLUNTARILY NEGOTIATING AN INDEPENDENT REIMBURSEMENT
4 RATE. IF THE NEGOTIATIONS FAIL, THE REIMBURSEMENT RATE REQUIRED
5 BY SUBSECTION (5.5)(b) OF THIS SECTION APPLIES.
6 (d) (I) SUBSECTIONS (5.5)(a), (5.5)(b), AND (5.5)(c) OF THIS
7 SECTION DO NOT APPLY TO SERVICE AGENCIES, AS DEFINED IN SECTION
8 25-3.5-103 (11.5), PROVIDING AMBULANCE SERVICES, AS DEFINED IN
9 SECTION 25-3.5-103 (3).
10 (II) (A) THE COMMISSIONER SHALL PROMULGATE RULES TO
11 IDENTIFY AND IMPLEMENT A PAYMENT METHODOLOGY THAT APPLIES TO
12 SERVICE AGENCIES DESCRIBED IN SUBSECTION (5.5)(d)(I) OF THIS SECTION,
13 EXCEPT FOR SERVICE AGENCIES THAT ARE PUBLICLY FUNDED FIRE
14 AGENCIES.
15 (B) THE COMMISSIONER SHALL MAKE THE PAYMENT
16 METHODOLOGY AVAILABLE TO THE PUBLIC ON THE DIVISION'S WEBSITE.
17 THE RULES MUST BE EQUITABLE TO PROVIDERS AND CARRIERS; HOLD
18 CONSUMERS HARMLESS EXCEPT FOR ANY APPLICABLE COPAYMENT,
19 COINSURANCE, OR DEDUCTIBLE AMOUNTS; AND BE BASED ON A
20 COST-BASED MODEL THAT INCLUDES DIRECT PAYMENT TO SERVICE
21 AGENCIES AS DESCRIBED IN SUBSECTION (5.5)(d)(I) OF THIS SECTION.
22 (C) THE DIVISION MAY CONTRACT WITH A NEUTRAL THIRD-PARTY
23 THAT HAS NO FINANCIAL INTEREST IN PROVIDERS, EMERGENCY SERVICE
24 PROVIDERS, OR CARRIERS TO CONDUCT THE ANALYSIS TO IDENTIFY AND
25 IMPLEMENT THE PAYMENT METHODOLOGY.
26 (e) FOR PURPOSES OF THIS SUBSECTION (5.5):
27 (I) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL

1 CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT
2 SEVERITY, INCLUDING SEVERE PAIN, THAT A PRUDENT LAYPERSON WITH AN
3 AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY
4 EXPECT, IN THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION, TO RESULT
5 IN:
6 (A) SERIOUS JEOPARDY TO THE HEALTH OF THE INDIVIDUAL OR,
7 WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR
8 HER UNBORN CHILD;
9 (B) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR
10 (C) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.
11 (II) "EMERGENCY SERVICES", WITH RESPECT TO AN EMERGENCY
12 MEDICAL CONDITION, MEANS:
13 (A) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE
14 CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING
15 ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY
16 DEPARTMENT TO EVALUATE THE EMERGENCY MEDICAL CONDITION; AND
17 (B) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES
18 AVAILABLE AT THE HOSPITAL, FURTHER MEDICAL EXAMINATION AND
19 TREATMENT AS REQUIRED TO STABILIZE THE PATIENT TO ASSURE, WITHIN
20 REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION
21 OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE
22 TRANSFER OF THE INDIVIDUAL FROM A FACILITY.
23 (III) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
24 SUBSECTION (3)(d)(V)(A) OF THIS SECTION.
25 (IV) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING
26 AS DEFINED IN SUBSECTION (3)(d)(V)(B) OF THIS SECTION.
27 (12) (a) ON AND AFTER JANUARY 1, 2020, CARRIERS SHALL

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

1 TO REQUEST AN IN-NETWORK PROVIDER TO PROVIDE SERVICES; AND
2 (V) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN
3 THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT
4 CARRIERS, HEALTH CARE FACILITIES, AND PROVIDERS USE LANGUAGE THAT
5 IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY THIS SUBSECTION
6 (12) AND SECTIONS 24-34-113 (2) AND 25-3-120 AND THE RULES ADOPTED
7 PURSUANT TO THIS SUBSECTION (12)(b) AND SECTIONS 24-34-113 (3) AND
8 25-3-120 (2).
9 (c) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SUBSECTION
10 (12) DOES NOT WAIVE A COVERED PERSON'S PROTECTIONS UNDER
11 SUBSECTION (3) OR (5.5) OF THIS SECTION OR THE RIGHT TO BENEFITS
12 UNDER THE HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL
13 FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.
14 (13) WHEN A CARRIER MAKES A PAYMENT TO A PROVIDER OR A
15 FACILITY PURSUANT TO SUBSECTION (3)(d)(II) OR (5.5)(b)(I) OF THIS
16 SECTION, THE PROVIDER OR THE FACILITY MAY REQUEST AND THE
17 COMMISSIONER SHALL COLLECT DATA FROM THE CARRIER TO EVALUATE
18 THE CARRIER'S COMPLIANCE IN PAYING THE HIGHEST RATE REQUIRED. THE
19 INFORMATION REQUESTED MAY INCLUDE THE METHODOLOGY FOR
20 DETERMINING THE CARRIER'S MEDIAN IN-NETWORK RATE OR
21 REIMBURSEMENT FOR EACH SERVICE IN THE SAME GEOGRAPHIC AREA.
22 (14) ON OR BEFORE JANUARY 1 OF EACH YEAR, EACH CARRIER
23 SHALL SUBMIT INFORMATION TO THE COMMISSIONER, IN A FORM AND
24 MANNER DETERMINED BY THE COMMISSIONER, CONCERNING THE USE OF
25 OUT-OF-NETWORK PROVIDERS AND FACILITIES BY COVERED PERSONS AND
26 THE IMPACT ON PREMIUM AFFORDABILITY FOR CONSUMERS.
27 (15) (a) (I) IF A PROVIDER BELIEVES THAT A PAYMENT MADE

1 PURSUANT TO SUBSECTION (3) OR (5.5) OF THIS SECTION OR SECTION
2 24-34-114 OR A HEALTH CARE FACILITY BELIEVES THAT A PAYMENT MADE
3 PURSUANT TO SUBSECTION (5.5) OF THIS SECTION OR SECTION 25-3-121 (3)
4 WAS NOT SUFFICIENT GIVEN THE COMPLEXITY AND CIRCUMSTANCES OF
5 THE SERVICES PROVIDED, THE PROVIDER OR THE HEALTH CARE FACILITY
6 MAY INITIATE ARBITRATION BY FILING A REQUEST FOR ARBITRATION WITH
7 THE COMMISSIONER AND THE CARRIER. THE REQUEST MUST BE FILED
8 WITHIN NINETY DAYS AFTER THE RECEIPT OF THE PAYMENT.
9 (II) PRIOR TO ARBITRATION UNDER SUBSECTION (15)(a)(I) OF THIS
10 SECTION, THE CARRIER AND PROVIDER OR HEALTH CARE FACILITY MAY
11 CONDUCT AN INFORMAL SETTLEMENT TELECONFERENCE WITHIN THIRTY
12 DAYS AFTER THE REQUEST FOR ARBITRATION. THE PARTIES SHALL NOTIFY
13 THE COMMISSIONER OF THE RESULTS OF THE SETTLEMENT CONFERENCE.
14 (III) UPON RECEIPT OF NOTICE THAT THE SETTLEMENT
15 TELECONFERENCE WAS UNSUCCESSFUL, THE COMMISSIONER SHALL
16 APPOINT AN ARBITRATOR AND NOTIFY THE PARTIES OF THE ARBITRATION.
17 (b) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT
18 AN ARBITRATION PROCESS THAT INCLUDES THE SELECTION OF AN
19 ARBITRATOR FROM A LIST OF QUALIFIED ARBITRATORS DEVELOPED
20 PURSUANT TO THE RULES. QUALIFIED ARBITRATORS MUST BE
21 INDEPENDENT; NOT BE AFFILIATED WITH A CARRIER, HEALTH CARE
22 FACILITY, OR PROVIDER, OR ANY PROFESSIONAL ASSOCIATION OF
23 CARRIERS, HEALTH CARE FACILITIES, OR PROVIDERS; NOT HAVE A
24 PERSONAL, PROFESSIONAL, OR FINANCIAL CONFLICT WITH ANY PARTIES TO
25 THE ARBITRATION; AND HAVE EXPERIENCE IN HEALTH CARE BILLING AND
26 REIMBURSEMENT RATES.
27 (c) (I) THE ARBITRATOR SHALL PERFORM THE REVIEW OF THE

1 WRITTEN SUBMISSION BY THE PROVIDER OR HEALTH CARE FACILITY. THE
2 ARBITRATOR SHALL DETERMINE WHETHER THE DISPUTED PAYMENT WAS
3 NOT SUFFICIENT GIVEN THE COMPLEXITY AND CIRCUMSTANCES.
4 (II) IF THE ARBITRATOR DETERMINES ADDITIONAL PAYMENT IS
5 WARRANTED, THEN BOTH PARTIES SHALL SUBMIT, IN WRITING, EACH
6 PARTY'S FINAL OFFER. THE ARBITRATOR SHALL PICK ONE OF THE TWO
7 AMOUNTS SUBMITTED BY THE PARTIES AS THE ARBITRATOR'S FINAL AND
8 BINDING DECISION. THE DECISION MUST BE IN WRITING AND MADE WITHIN
9 FORTY-FIVE DAYS AFTER THE ARBITRATOR'S APPOINTMENT. IN MAKING
10 THE DECISION, THE ARBITRATOR MAY CONSIDER THE CIRCUMSTANCES AND
11 COMPLEXITY OF THE PARTICULAR CASE, INCLUDING THE TIME AND PLACE
12 OF SERVICES, AND AVAILABILITY OF PROVIDERS IN THE SAME GEOGRAPHIC
13 REGION.
14 (d) IF THE ARBITRATOR'S DECISION REQUIRES ADDITIONAL
15 PAYMENT BY THE CARRIER ABOVE THE AMOUNT PAID, THE CARRIER SHALL
16 PAY THE PROVIDER IN ACCORDANCE WITH SECTION 10-16-106.5.
17 (e) THE ARBITRATOR'S EXPENSES AND FEES SHALL BE SPLIT
18 EQUALLY AMONG THE PARTIES.
19 (16) NOT WITHSTANDING SECTION 24-1-136 (11)(a)(I), ON OR
20 BEFORE JULY 1, 2020, AND EACH JULY 1 THEREAFTER, THE COMMISSIONER
21 SHALL PROVIDE A WRITTEN REPORT TO THE HEALTH AND HUMAN SERVICES
22 COMMITTEE OF THE SENATE AND THE HEALTH AND INSURANCE COMMITTEE
23 OF THE HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES,
24 AND SHALL POST THE REPORT ON THE DIVISION'S WEBSITE SUMMARIZING:
25 (a) THE INFORMATION SUBMITTED TO THE COMMISSIONER IN
26 SUBSECTION (14) OF THIS SECTION; AND
27 (b) THE NUMBER OF ARBITRATIONS FILED; THE NUMBER OF

1 ARBITRATIONS SETTLED, ARBITRATED, AND DISMISSED IN THE PREVIOUS
2 CALENDAR YEAR; AND A SUMMARY OF WHETHER THE ARBITRATIONS WERE
3 IN FAVOR OF THE CARRIER OR THE OUT-OF-NETWORK PROVIDER OR
4 HEALTH CARE FACILITY. THE LIST OF ARBITRATION DECISIONS MUST NOT
5 INCLUDE ANY INFORMATION THAT SPECIFICALLY IDENTIFIES THE
6 PROVIDER, HEALTH CARE FACILITY, CARRIER, OR COVERED PERSON
7 INVOLVED IN EACH ARBITRATION DECISION.
8 **SECTION 5.** In Colorado Revised Statutes, **add** 24-34-113 and
9 24-34-114 as follows:
10 **24-34-113. Health care providers - required disclosures - rules**
11 **- definitions.** (1) FOR THE PURPOSES OF THIS SECTION AND SECTION
12 24-34-114:
13 (a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION
14 10-16-102 (8).
15 (b) "COVERED PERSON" HAS THE SAME MEANING AS DEFINED IN
16 SECTION 10-16-102 (15).
17 (c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED
18 IN SECTION 10-16-704 (5.5)(e)(II).
19 (d) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
20 SECTION 10-16-704 (3)(d)(V)(A).
21 (e) "HEALTH BENEFIT PLAN" HAS THE SAME MEANING AS DEFINED
22 IN SECTION 10-16-102 (32).
23 (f) "HEALTH CARE PROVIDER" HAS THE SAME MEANING AS
24 "PROVIDER" AS DEFINED IN SECTION 10-16-102 (56).
25 (g) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING
26 AS DEFINED IN SECTION 10-16-704 (3)(d)(V)(B).
27 (h) "OUT-OF-NETWORK PROVIDER" MEANS A HEALTH CARE

1 PROVIDER THAT IS NOT A PARTICIPATING PROVIDER, AS DEFINED IN
2 SECTION 10-16-102 (46).
3 (2) ON AND AFTER JANUARY 1, 2020, HEALTH CARE PROVIDERS
4 SHALL DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE
5 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
6 SERVICES FROM AN OUT-OF-NETWORK PROVIDER. THE DISCLOSURES MUST
7 COMPLY WITH THE RULES ADOPTED PURSUANT TO SUBSECTION (3) OF THIS
8 SECTION.
9 (3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF
10 INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION
11 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR
12 HEALTH CARE PROVIDERS REGULATED UNDER TITLE 12 TO DEVELOP AND
13 PROVIDE CONSUMER DISCLOSURES IN ACCORDANCE WITH THIS SECTION.
14 THE DIRECTOR SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH
15 SECTION 10-16-704 (12) AND 25-3-120 AND RULES ADOPTED BY THE
16 COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE
17 STATE BOARD OF HEALTH PURSUANT TO SECTION 25-3-120 (2). THE RULES
18 MUST SPECIFY, AT A MINIMUM, THE FOLLOWING:
19 (a) THE TIMING FOR PROVIDING THE DISCLOSURES FOR EMERGENCY
20 AND NONEMERGENCY SERVICES WITH CONSIDERATION GIVEN TO
21 POTENTIAL LIMITATIONS RELATING TO THE FEDERAL "EMERGENCY
22 MEDICAL TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd;
23 (b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
24 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
25 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR
26 COMMUNICATIONS WITH CONSUMERS;
27 (c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE

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

1 (a) SUBMIT A CLAIM FOR THE ENTIRE COST OF THE SERVICES TO
2 THE COVERED PERSON'S CARRIER; AND
3 (b) NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR
4 ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE
5 CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,
6 DEDUCTIBLE, OR COPAYMENT REQUIRED TO BE PAID BY THE COVERED
7 PERSON.
8 (2) (a) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES
9 NONEMERGENCY SERVICES AT AN IN-NETWORK FACILITY OR EMERGENCY
10 SERVICES AT AN OUT-OF-NETWORK OR IN-NETWORK FACILITY AND THE
11 HEALTH CARE PROVIDER RECEIVES PAYMENT FROM THE COVERED PERSON
12 FOR SERVICES FOR WHICH THE COVERED PERSON IS NOT RESPONSIBLE
13 PURSUANT TO SECTION 10-16-704 (3)(b) OR (5.5), THE HEALTH CARE
14 PROVIDER SHALL REIMBURSE THE COVERED PERSON WITHIN SIXTY
15 CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS
16 REPORTED TO THE PROVIDER.
17 (b) AN OUT-OF-NETWORK HEALTH CARE PROVIDER THAT FAILS TO
18 REIMBURSE A COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF
19 THIS SECTION FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE
20 OVERPAYMENT AT THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON
21 THE DATE THE PROVIDER RECEIVED THE NOTICE OF THE OVERPAYMENT.
22 THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED
23 INTEREST FROM THE OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER
24 TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.
25 (3) AN OUT-OF-NETWORK HEALTH CARE PROVIDER SHALL PROVIDE
26 A COVERED PERSON A WRITTEN ESTIMATE OF THE AMOUNT FOR WHICH THE
27 COVERED PERSON MAY BE RESPONSIBLE FOR NONEMERGENCY SERVICES

1 WITHIN THREE BUSINESS DAYS AFTER A REQUEST FROM THE COVERED
2 PERSON.
3 (4) (a) AN OUT-OF-NETWORK HEALTH CARE PROVIDER MUST SEND
4 A CLAIM FOR A COVERED SERVICE TO THE CARRIER WITHIN ONE HUNDRED
5 EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO RECEIVE
6 REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (4)(a). THE
7 REIMBURSEMENT RATE IS THE GREATER OF:
8 (I) ONE HUNDRED FIVE PERCENT OF THE CARRIER'S MEDIAN
9 IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN
10 THE SAME GEOGRAPHIC AREA; OR
11
12 (II) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF
13 REIMBURSEMENT FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA
14 FOR THE PRIOR YEAR AS DETERMINED BASED ON CLAIMS DATA FROM THE
15 ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.
16 (b) IF THE OUT-OF-NETWORK HEALTH CARE PROVIDER SUBMITS A
17 CLAIM FOR SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY PERIOD
18 SPECIFIED IN SUBSECTION (4)(a) OF THIS SECTION, THE CARRIER SHALL
19 REIMBURSE THE HEALTH CARE PROVIDER ONE HUNDRED TWENTY-FIVE
20 PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME
21 SERVICES IN THE SAME GEOGRAPHIC AREA.
22 (c) THE HEALTH CARE PROVIDER SHALL NOT BILL A COVERED
23 PERSON ANY OUTSTANDING BALANCE FOR A COVERED SERVICE NOT PAID
24 FOR BY THE CARRIER, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR
25 COPAYMENT REQUIRED TO BE PAID BY THE COVERED PERSON.
26 (5) A HEALTH CARE PROVIDER MAY INITIATE ARBITRATION
27 PURSUANT TO SECTION 10-16-704 (15) IF THE HEALTH CARE PROVIDER

1 BELIEVES THE PAYMENT MADE PURSUANT TO SUBSECTION (4) OF THIS
2 SECTION IS NOT SUFFICIENT.
3 **SECTION 6.** In Colorado Revised Statutes, **add** 25-3-120 and
4 25-3-121 as follows:
5 **25-3-120. Health care facilities - emergency and**
6 **nonemergency services - required disclosures - rules - definitions.**
7 (1) ON AND AFTER JANUARY 1, 2020, HEALTH CARE FACILITIES SHALL
8 DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE
9 POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY
10 SERVICES FROM AN OUT-OF-NETWORK PROVIDER PROVIDING SERVICES AT
11 AN IN-NETWORK FACILITY OR EMERGENCY SERVICES AT AN
12 OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE
13 RULES ADOPTED UNDER SUBSECTION (2) OF THIS SECTION.
14 (2) THE STATE BOARD OF HEALTH, IN CONSULTATION WITH THE
15 COMMISSIONER OF INSURANCE AND THE DIRECTOR OF THE DIVISION OF
16 PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF REGULATORY
17 AGENCIES, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR
18 HEALTH CARE FACILITIES TO DEVELOP AND PROVIDE CONSUMER
19 DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE STATE BOARD OF
20 HEALTH SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTION
21 10-16-704 (12) AND 24-34-113 (2) AND RULES ADOPTED BY THE
22 COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE
23 DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS PURSUANT
24 TO SECTION 24-34-113 (3). THE RULES MUST SPECIFY, AT A MINIMUM, THE
25 FOLLOWING:
26 (a) THE TIMING FOR PROVIDING THE DISCLOSURES FOR EMERGENCY
27 AND NONEMERGENCY SERVICES WITH CONSIDERATION GIVEN TO

1 POTENTIAL LIMITATIONS RELATING TO THE "EMERGENCY MEDICAL
2 TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd;
3 (b) REQUIREMENTS REGARDING HOW THE DISCLOSURES MUST BE
4 MADE, INCLUDING REQUIREMENTS TO INCLUDE THE DISCLOSURES ON
5 BILLING STATEMENTS, BILLING NOTICES, OR OTHER FORMS OR
6 COMMUNICATIONS WITH COVERED PERSONS;
7 (c) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE
8 CONSUMER'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE
9 CONSUMER'S HEALTH BENEFIT PLAN;
10 (d) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE
11 FACILITIES, WHETHER A HEALTH CARE PROVIDER DELIVERING SERVICES AT
12 THE FACILITY IS OUT OF NETWORK, THE TYPES OF SERVICES AN
13 OUT-OF-NETWORK HEALTH CARE PROVIDER MAY PROVIDE, AND THE RIGHT
14 TO REQUEST AN IN-NETWORK HEALTH CARE PROVIDER TO PROVIDE
15 SERVICES; AND
16 (e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN
17 THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT
18 CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE
19 LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY
20 THIS SECTION AND SECTIONS 10-16-704 (12) AND 24-34-113 (2) AND THE
21 RULES ADOPTED PURSUANT TO THIS SUBSECTION (2) AND SECTIONS
22 10-16-704 (12) AND 24-34-113 (3).
23 (3) RECEIPT OF THE DISCLOSURE REQUIRED BY SUBSECTION (1) OF
24 THIS SECTION DOES NOT WAIVE A CONSUMER'S PROTECTIONS UNDER
25 SECTION 10-16-704 (3) OR (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS
26 UNDER THE CONSUMER'S HEALTH BENEFIT PLAN AT THE IN-NETWORK
27 BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.

1 (4) FOR THE PURPOSES OF THIS SECTION AND SECTION 25-3-121:
2 (a) "CARRIER" HAS THE SAME MEANING AS DEFINED IN SECTION
3 10-16-102 (8).
4 (b) "COVERED PERSON" HAS THE SAME MEANING AS DEFINED IN
5 SECTION 10-16-102 (15).
6 (c) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN
7 SECTION 10-16-704 (3)(d)(V)(A).
8 (d) "HEALTH BENEFIT PLAN" HAS THE SAME MEANING AS DEFINED
9 IN SECTION 10-16-102 (32).
10 (e) "MEDICARE REIMBURSEMENT RATE" HAS THE SAME MEANING
11 AS DEFINED IN SECTION 10-16-704 (3)(d)(V)(B).
12 (f) "OUT-OF-NETWORK FACILITY" MEANS A HEALTH CARE FACILITY
13 THAT IS NOT A PARTICIPATING PROVIDER, AS DEFINED IN SECTION
14 10-16-102 (46).
15 **25-3-121. Out-of-network facilities - emergency medical**
16 **services - billing - payment.** (1) IF A COVERED PERSON RECEIVES
17 EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE
18 OUT-OF-NETWORK FACILITY SHALL:
19 (a) SUBMIT A CLAIM FOR THE ENTIRE COST OF THE SERVICES TO
20 THE COVERED PERSON'S CARRIER; AND
21 (b) NOT BILL OR COLLECT PAYMENT FROM THE COVERED PERSON
22 FOR ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY
23 THE CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,
24 DEDUCTIBLE, OR COPAYMENT REQUIRED TO BE PAID BY THE COVERED
25 PERSON.
26 (2) (a) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT
27 AN OUT-OF-NETWORK FACILITY, AND THE FACILITY RECEIVES PAYMENT

1 FROM THE COVERED PERSON FOR SERVICES FOR WHICH THE COVERED
2 PERSON IS NOT RESPONSIBLE PURSUANT TO SECTION 10-16-704 (5.5), THE
3 FACILITY SHALL REIMBURSE THE COVERED PERSON WITHIN SIXTY
4 CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS
5 REPORTED TO THE FACILITY.
6 (b) AN OUT-OF-NETWORK FACILITY THAT FAILS TO REIMBURSE A
7 COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF THIS SECTION
8 FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE OVERPAYMENT AT
9 THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON THE DATE THE
10 FACILITY RECEIVED THE NOTICE OF THE OVERPAYMENT. THE COVERED
11 PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED INTEREST FROM THE
12 OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER TO RECEIVE
13 INTEREST WITH THE REIMBURSEMENT AMOUNT.
14 (3) (a) AN OUT-OF-NETWORK FACILITY, OTHER THAN ANY
15 OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER HEALTH AND
16 HOSPITAL AUTHORITY PURSUANT TO ARTICLE 29 OF TITLE 25, MUST SEND
17 A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE
18 HUNDRED EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO
19 RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (3)(a). THE
20 REIMBURSEMENT RATE IS THE GREATER OF:
21 (I) ONE HUNDRED FIVE PERCENT OF THE CARRIER'S MEDIAN
22 IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN
23 A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR
24
25 (II) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF
26 REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY
27 OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR AS

1 DETERMINED BASED ON CLAIMS DATA FROM THE ALL-PAYER HEALTH
2 CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.
3 (b) AN OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER
4 HEALTH AND HOSPITAL AUTHORITY CREATED IN SECTION 25-29-103 MUST
5 SEND A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE
6 HUNDRED EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO
7 RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (3)(b). THE
8 REIMBURSEMENT RATE IS THE GREATER OF:
9 (I) THE CARRIER'S MEDIAN IN-NETWORK RATE OF REIMBURSEMENT
10 FOR THAT SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE
11 SAME GEOGRAPHIC AREA;
12 (II) TWO HUNDRED FIFTY PERCENT OF THE MEDICARE
13 REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR
14 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR
15 (III) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE
16 OF REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR
17 FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR
18 YEAR AS DETERMINED BASED ON CLAIMS DATA FROM THE COLORADO
19 ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.
20 (c) IF THE OUT-OF-NETWORK FACILITY SUBMITS A CLAIM FOR
21 EMERGENCY SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY PERIOD
22 SPECIFIED IN SUBSECTION (3)(a) OF THIS SECTION, THE CARRIER SHALL
23 REIMBURSE THE FACILITY ONE HUNDRED TWENTY-FIVE PERCENT OF THE
24 MEDICARE REIMBURSEMENT RATE FOR THE SAME SERVICES IN A SIMILAR
25 SETTING OR FACILITY IN THE SAME GEOGRAPHIC AREA.
26 (d) THE OUT-OF-NETWORK FACILITY SHALL NOT BILL A COVERED
27 PERSON ANY OUTSTANDING BALANCE FOR A COVERED SERVICE NOT PAID

1 FOR BY THE CARRIER, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR
2 COPAYMENT REQUIRED TO BE PAID BY THE COVERED PERSON.
3 (4) AN OUT-OF-NETWORK FACILITY MAY INITIATE ARBITRATION
4 PURSUANT TO SECTION 10-16-704 (15) IF THE FACILITY BELIEVES THE
5 PAYMENT MADE PURSUANT TO SUBSECTION (3) OF THIS SECTION IS NOT
6 SUFFICIENT.
7 **SECTION 7.** In Colorado Revised Statutes, 25-1-114, **add** (1)(j)
8 as follows:
9 **25-1-114. Unlawful acts - penalties.** (1) It is unlawful for any
10 person, association, or corporation, and the officers thereof:
11 (j) TO VIOLATE SECTION 25-3-121.
12 **SECTION 8. Appropriation.** (1) For the 2019-20 state fiscal
13 year, $33,884 is appropriated to the department of public health and
14 environment for use by the health facilities and emergency medical
15 services division. This appropriation is from the general fund and is based
16 on an assumption that the division will require an additional 0.4 FTE. To
17 implement this act, the division may use this appropriation for
18 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.