First Regular Session
Seventy-third General Assembly
STATE OF COLORADO

ENGROSSED

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

LLS NO. 21-0634.01 Shelby Ross x4510

HOUSE BILL 21-1198

HOUSE SPONSORSHIP

Jodeh,

SENATE SPONSORSHIP

Buckner and Kolker,

House Committees
Health & Insurance
Appropriations

Senate Committees

A BILL FOR AN ACT

CONCERNING HEALTH-CARE BILLING REQUIREMENTS FOR INDIGENT PATIENTS RECEIVING SERVICES NOT REIMBURSED THROUGH THE COLORADO INDIGENT CARE PROGRAM, AND, IN CONNECTION THEREWITH, ESTABLISHING PROCEDURES BEFORE INITIATING COLLECTIONS PROCEEDINGS AGAINST A PATIENT AND MAKING AND REDUCING APPROPRIATIONS.

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.)

No later than June 1, 2022, a health-care facility shall screen each

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
May 11, 2021

uninsured patient for eligibility for public health insurance programs, discounted care through the Colorado indigent care program (CICP), and discounted care as described in the bill. Health-care facilities shall use a single uniform application developed by the department of health care policy and financing (department) when screening a patient. If a health-care facility determines a patient is ineligible for discounted care, the facility shall provide the patient notice of the determination and an opportunity for the patient to appeal the determination.

For emergency and other non-CICP health-care services provided to qualified patients, a health-care facility and licensed health-care professional shall limit the amounts charged to not more than 80% of the medicare rate if the patient is uninsured; collect amounts charged in monthly installments such that a patient is not paying more than 5% of the patient's household income; and after a cumulative 36 months of payments, consider the patient's bill paid in full and permanently cease any and all collection activities on any balance that remains unpaid.

A health-care facility shall make information about patient's rights and the uniform application for discounted care available to the public and to each patient.

Beginning June 1, 2023, and each June 1 thereafter, each health-care facility shall collect and report to the department data that the department determines is necessary to evaluate compliance across patient groups based on race, ethnicity, and primary language spoken with the required screening, discounted care, payment plan, and collections practices.

No later than April 1, 2022, the department shall develop a written explanation of a patient's rights, make the explanation available to the public and each patient, and establish a process for patients to submit a complaint relating to noncompliance with the requirements. The department shall periodically review health-care facilities and licensed health-care professionals (hospital providers) to ensure compliance, and the department shall notify the hospital provider if the hospital provider is not in compliance that the hospital provider has 90 days to file a corrective action plan with the department. A hospital provider may request up to 120 days to submit a corrective action plan. The department may require a hospital provider that is not in compliance to develop and operate under a corrective action plan until the department determines the hospital provider is in compliance. The bill implements fines for hospital providers if the department determines the hospital provider's noncompliance is knowing or willful.

The bill imposes requirements on hospital providers before assigning or selling patient debt to a medical creditor or before pursuing any permissible extraordinary collection action and imposes fines for any hospital provider that fails to comply with the requirements.

The bill prohibits a medical creditor from using impermissible

extraordinary collection action to collect debts owed for health-care services provided by a hospital provider. A medical creditor may engage in permissible extraordinary collection actions 180 days after the first bill for a medical debt is sent to the patient. At least 30 days before taking any permissible extraordinary collection action, a medical creditor shall provide the patient with a notice about the discounted care policy, the permissible extraordinary collection actions that will be initiated, and a deadline after which such permissible extraordinary collection actions will be initiated. If a patient is later found eligible for discounted care, the medical creditor shall reverse any permissible extraordinary collection actions.

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

SECTION 1. In Colorado Revised Statutes, **add** part 5 to article 3 of title 25.5 as follows:

PART 5

HEALTH-CARE BILLING FOR INDIGENT PATIENTS RECEIVING SERVICES NOT REIMBURSED THROUGH THE COLORADO INDIGENT CARE PROGRAM

25.5-3-501. Definitions. AS USED IN THIS PART 5, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "HEALTH-CARE FACILITY" MEANS:

(a) A HOSPITAL LICENSED AS A GENERAL HOSPITAL PURSUANT TO PART 1 OF ARTICLE 3 OF TITLE 25;

(b) A HOSPITAL ESTABLISHED PURSUANT TO SECTION 23-21-503 OR 25-29-103;

(c) ANY FREESTANDING EMERGENCY DEPARTMENT LICENSED PURSUANT TO SECTION 25-1.5-114; OR

(d) ANY OUTPATIENT HEALTH-CARE FACILITY THAT IS LICENSED AS AN ON-CAMPUS DEPARTMENT OR SERVICE OF A HOSPITAL OR THAT IS LISTED AS AN OFF-CAMPUS LOCATION UNDER A HOSPITAL'S LICENSE,

EXCEPT A FEDERALLY QUALIFIED HEALTH CENTER, AS DEFINED IN THE FEDERAL "SOCIAL SECURITY ACT", 42 U.S.C. SEC. 1395x (aa)(4).

(2) "HEALTH-CARE SERVICES" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (33).

(3) "LICENSED HEALTH-CARE PROFESSIONAL" MEANS ANY HEALTH-CARE PROFESSIONAL WHO IS REGISTERED, CERTIFIED, OR LICENSED PURSUANT TO TITLE 12 OR WHO PROVIDES SERVICES UNDER THE SUPERVISION OF A HEALTH-CARE PROFESSIONAL WHO IS REGISTERED, CERTIFIED, OR LICENSED PURSUANT TO TITLE 12, AND WHO PROVIDES HEALTH-CARE SERVICES IN A HEALTH-CARE FACILITY.

(4) "NON-CICP HEALTH-CARE SERVICES" MEANS HEALTH-CARE SERVICES PROVIDED IN A HEALTH-CARE FACILITY FOR WHICH REIMBURSEMENT UNDER THE COLORADO INDIGENT CARE PROGRAM, ESTABLISHED IN PART 1 OF THIS ARTICLE 3, IS NOT AVAILABLE.

(5) "QUALIFIED PATIENT" MEANS AN INDIVIDUAL WHOSE HOUSEHOLD INCOME IS NOT MORE THAN TWO HUNDRED FIFTY PERCENT OF THE FEDERAL POVERTY LEVEL AND WHO RECEIVED A HEALTH-CARE SERVICE AT A HEALTH-CARE FACILITY.

(6) "SCREEN" OR "SCREENING" MEANS A PROCESS IDENTIFIED IN RULE BY THE STATE DEPARTMENT WHEREBY HEALTH-CARE FACILITIES ASSESS A PATIENT'S CIRCUMSTANCES RELATED TO ELIGIBILITY CRITERIA AND DETERMINE WHETHER THE PATIENT IS LIKELY TO QUALIFY FOR PUBLIC HEALTH-CARE COVERAGE OR DISCOUNTED CARE, INFORM THE PATIENT OF THE HEALTH-CARE FACILITY'S DETERMINATION, AND PROVIDE INFORMATION TO THE PATIENT ABOUT HOW THE PATIENT CAN ENROLL IN PUBLIC HEALTH-CARE COVERAGE.

(7) "UNINSURED" MEANS AN UNINSURED INDIVIDUAL, AS DEFINED

IN SECTION 10-22-113 (5)(d).

25.5-3-502. Requirement to screen patients for eligibility for public health-care programs and discounted care - rules. (1) BEGINNING JUNE 1, 2022, A HEALTH-CARE FACILITY SHALL SCREEN, UNLESS A PATIENT DECLINES, EACH UNINSURED PATIENT FOR ELIGIBILITY FOR:

(a) PUBLIC HEALTH INSURANCE PROGRAMS INCLUDING BUT NOT LIMITED TO MEDICARE; THE STATE MEDICAL ASSISTANCE PROGRAM, ARTICLES 4, 5, AND 6 OF THIS TITLE 25.5; EMERGENCY MEDICAID; AND THE CHILDREN'S BASIC HEALTH PLAN, ARTICLE 8 OF THIS TITLE 25.5;

(b) DISCOUNTED CARE THROUGH THE COLORADO INDIGENT CARE PROGRAM, ESTABLISHED IN PART 1 OF THIS ARTICLE 3, IF THE PATIENT RECEIVES A SERVICE ELIGIBLE FOR REIMBURSEMENT THROUGH THE PROGRAM; AND

(c) DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-503.

(2) HEALTH-CARE FACILITIES SHALL USE A SINGLE UNIFORM APPLICATION DEVELOPED BY THE STATE DEPARTMENT WHEN SCREENING A PATIENT PURSUANT TO SUBSECTION (1) OF THIS SECTION.

(3) IF A HEALTH-CARE FACILITY DETERMINES THAT A PATIENT IS INELIGIBLE FOR DISCOUNTED CARE, THE FACILITY SHALL PROVIDE THE PATIENT NOTICE OF THE DETERMINATION AND AN OPPORTUNITY FOR THE PATIENT TO APPEAL THE DETERMINATION IN ACCORDANCE WITH STATE DEPARTMENT RULES.

(4) IF THE PATIENT DECLINES THE SCREENING DESCRIBED IN SUBSECTION (1) OF THIS SECTION, THE HEALTH-CARE FACILITY SHALL DOCUMENT THE PATIENT'S DECISION IN ACCORDANCE WITH STATE DEPARTMENT RULES. A PATIENT'S DECISION TO DECLINE THE SCREENING

THAT IS DOCUMENTED AND COMPLIES WITH STATE DEPARTMENT RULES IS A COMPLETE DEFENSE TO A CLAIM BROUGHT BY A PATIENT UNDER SECTION 25.5-3-506 (2) FOR A VIOLATION OF SECTION 25.5-3-506 (1)(a) OR (1)(b).

(5) IF REQUESTED BY THE PATIENT, A HEALTH-CARE FACILITY SHALL SCREEN AN INSURED PATIENT FOR DISCOUNTED CARE PURSUANT TO SUBSECTIONS (1)(b) AND (1)(c) OF THIS SECTION.

25.5-3-503. Health-care discounts on services not eligible for Colorado indigent care program reimbursement. (1) BEGINNING JUNE 1, 2022, IF A PATIENT IS SCREENED PURSUANT TO SECTION 25.5-3-502 AND IS DETERMINED TO BE A QUALIFIED PATIENT, A HEALTH-CARE FACILITY AND A LICENSED HEALTH-CARE PROFESSIONAL SHALL, FOR EMERGENCY AND OTHER NON-CICP HEALTH-CARE SERVICES:

(a) LIMIT THE AMOUNTS CHARGED TO NOT MORE THAN THE DISCOUNTED RATE ESTABLISHED IN STATE DEPARTMENT RULE PURSUANT TO SECTION 25.5-3-505 (2)(j);

(b) COLLECT AMOUNTS CHARGED, NOT INCLUDING AMOUNTS OWED BY THIRD-PARTY PAYERS, IN MONTHLY INSTALLMENTS SUCH THAT THE PATIENT IS NOT PAYING MORE THAN FOUR PERCENT OF THE PATIENT'S MONTHLY HOUSEHOLD INCOME ON A BILL FROM A HEALTH-CARE FACILITY AND NOT PAYING MORE THAN TWO PERCENT OF THE PATIENT'S MONTHLY HOUSEHOLD INCOME ON A BILL FROM A LICENSED HEALTH-CARE PROFESSIONAL; AND

(c) AFTER A CUMULATIVE THIRTY-SIX MONTHS OF PAYMENTS, CONSIDER THE PATIENT'S BILL PAID IN FULL AND PERMANENTLY CEASE ANY AND ALL COLLECTION ACTIVITIES ON ANY BALANCE THAT REMAINS UNPAID.

(2) A HEALTH-CARE FACILITY SHALL NOT:

(a) DENY DISCOUNTED CARE ON THE BASIS THAT THE PATIENT HAS NOT APPLIED FOR ANY PUBLIC BENEFITS PROGRAM; OR

(b) ADOPT OR MAINTAIN ANY POLICIES THAT RESULT IN THE DENIAL OF ADMISSION OR TREATMENT OF A PATIENT BECAUSE THE PATIENT LACKS HEALTH INSURANCE COVERAGE, MAY QUALIFY FOR DISCOUNTED CARE, REQUIRES EXTENDED OR LONG-TERM TREATMENT, OR HAS AN UNPAID MEDICAL BILL.

25.5-3-504. Notification of patient's rights. (1) BEGINNING JUNE 1, 2022, A HEALTH-CARE FACILITY SHALL MAKE INFORMATION DEVELOPED BY THE STATE DEPARTMENT ABOUT PATIENT'S RIGHTS UNDER THIS PART 5 AND THE UNIFORM APPLICATION DEVELOPED BY THE STATE DEPARTMENT PURSUANT TO SECTION 25.5-3-505 (2)(i) AVAILABLE TO THE PUBLIC AND TO EACH PATIENT. AT A MINIMUM, THE HEALTH-CARE FACILITY SHALL:

(a) POST THE INFORMATION IN ALL REQUIRED LANGUAGES PURSUANT TO THIS SUBSECTION (1) CONSPICUOUSLY ON THE HEALTH-CARE FACILITY'S WEBSITE, INCLUDING A LINK TO THE INFORMATION ON THE HEALTH-CARE FACILITY'S MAIN LANDING PAGE;

(b) MAKE THE INFORMATION AVAILABLE IN PATIENT WAITING AREAS;

(c) MAKE THE INFORMATION AVAILABLE TO EACH PATIENT, OR THE PATIENT'S LEGAL GUARDIAN, VERBALLY, WHICH MAY INCLUDE USING A PROFESSIONAL INTERPRETATION SERVICE, OR IN WRITING IN THE PATIENT'S OR LEGAL GUARDIAN'S PRIMARY LANGUAGE BEFORE THE PATIENT IS DISCHARGED FROM THE HEALTH-CARE FACILITY; AND

(d) INFORM EACH PATIENT ON THE PATIENT'S BILLING STATEMENT OF THE PATIENT'S RIGHTS PURSUANT TO THIS PART 5, INCLUDING THE RIGHT TO APPLY FOR DISCOUNTED CARE, AND PROVIDE THE WEBSITE,

E-MAIL ADDRESS, AND TELEPHONE NUMBER WHERE THE INFORMATION MAY BE OBTAINED IN THE PATIENT'S PRIMARY LANGUAGE.

25.5-3-505. Health-care facility reporting requirements - agency enforcement - rules. (1) BEGINNING JUNE 1, 2023, AND EACH JUNE 1 THEREAFTER, EACH HEALTH-CARE FACILITY SHALL REPORT TO THE STATE DEPARTMENT DATA THAT THE STATE DEPARTMENT DETERMINES IS NECESSARY TO EVALUATE COMPLIANCE ACROSS RACE, ETHNICITY, AND PRIMARY-LANGUAGE-SPOKEN PATIENT GROUPS WITH THE SCREENING, DISCOUNTED CARE, PAYMENT PLAN, AND COLLECTIONS PRACTICES REQUIRED PURSUANT TO THIS PART 5. IF A HEALTH-CARE FACILITY IS NOT CAPABLE OF DISAGGREGATING THE DATA REQUIRED PURSUANT TO THIS SUBSECTION (1) BY RACE, ETHNICITY, AND PRIMARY LANGUAGE SPOKEN, THE HEALTH-CARE FACILITY SHALL REPORT TO THE STATE DEPARTMENT THE STEPS THE FACILITY IS TAKING TO IMPROVE RACE, ETHNICITY, AND PRIMARY-LANGUAGE-SPOKEN DATA COLLECTION AND THE DATE BY WHICH THE FACILITY WILL BE ABLE TO DISAGGREGATE THE REPORTED DATA.

(2) NO LATER THAN APRIL 1, 2022, THE STATE BOARD SHALL PROMULGATE RULES NECESSARY FOR THE ADMINISTRATION AND IMPLEMENTATION OF THIS PART 5. AT A MINIMUM, THE RULES MUST:

(a) OUTLINE A PROCESS FOR AN INSURED PATIENT TO REQUEST A SCREENING PURSUANT TO SECTION 25.5-3-502 (5);

(b) OUTLINE A PROCESS FOR DOCUMENTING, PURSUANT TO SECTION 25.5-3-502 (4), THAT A PATIENT HAS MADE AN INFORMED DECISION TO DECLINE THE SCREENING, INCLUDING PROCEDURES FOR RETAINING SUCH DOCUMENTATION;

(c) ESTABLISH THE PROCESS FOR AND THE MAXIMUM NUMBER OF

DAYS THAT A HEALTH-CARE FACILITY HAS TO:

(I) INITIATE A SCREENING AFTER A PATIENT RECEIVES SERVICES;

(II) REQUEST INFORMATION FROM THE PATIENT NEEDED FOR THE SCREENING PROCESS; AND

(III) COMPLETE THE SCREENING PROCESS;

(d) OUTLINE THE REQUIREMENTS FOR NOTIFYING THE PATIENT OF THE RESULTS OF THE SCREENING, INCLUDING AN EXPLANATION OF THE BASIS FOR A DENIAL OF DISCOUNTED CARE AND THE PROCESS FOR APPEALING A DENIAL;

(e) ESTABLISH GUIDELINES FOR PATIENT APPEALS REGARDING ELIGIBILITY FOR DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503;

(f) ESTABLISH A METHODOLOGY THAT ALL HEALTH-CARE FACILITIES MUST USE TO DETERMINE MONTHLY HOUSEHOLD INCOME. THE METHODOLOGY MUST NOT CONSIDER A PATIENT'S ASSETS.

(g) IDENTIFY THE DOCUMENTS THAT MAY BE REQUIRED TO ESTABLISH INCOME ELIGIBILITY FOR DISCOUNTED CARE USING THE MINIMUM AMOUNT OF INFORMATION NEEDED TO DETERMINE ELIGIBILITY;

(h) IDENTIFY THE STEPS A HEALTH-CARE FACILITY AND LICENSED HEALTH-CARE PROFESSIONAL MUST TAKE BEFORE SENDING PATIENT DEBT TO COLLECTIONS;

(i) CREATE A SINGLE UNIFORM APPLICATION THAT A HEALTH-CARE FACILITY SHALL USE WHEN SCREENING A PATIENT FOR ELIGIBILITY FOR THE COLORADO INDIGENT CARE PROGRAM AND DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-502; AND

(j) ANNUALLY ESTABLISH RATES FOR DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503 (1)(a). THE RATES SHOULD APPROXIMATE AND NOT BE LESS THAN EIGHTY PERCENT OF THE MEDICARE

RATE OR, IF A MEDICARE RATE IS NOT AVAILABLE, ONE HUNDRED PERCENT OF THE MEDICAID BASE RATE. THE STATE DEPARTMENT SHALL PUBLICLY POST THE ESTABLISHED RATES ON THE STATE DEPARTMENT'S WEBSITE.

(3) IN PROMULGATING RULES PURSUANT TO THIS SECTION, THE STATE DEPARTMENT SHALL:

(a) ALIGN THE PROCESSES OF QUALIFYING FOR AND APPEALING DENIALS OF ELIGIBILITY FOR THE COLORADO INDIGENT CARE PROGRAM WITH DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-502; AND

(b) CONSIDER POTENTIAL LIMITATIONS RELATING TO THE FEDERAL "EMERGENCY MEDICAL TREATMENT AND LABOR ACT", 42 U.S.C. SEC. 1395dd.

(4) PRIOR TO PROMULGATING RULES PURSUANT TO THIS SECTION, THE STATE DEPARTMENT SHALL HOLD AT LEAST ONE STAKEHOLDER MEETING WITH HOSPITAL REPRESENTATIVES, HEALTH-CARE CONSUMERS, AND HEALTH-CARE CONSUMER ADVOCATES THAT IS ACCESSIBLE TO INDIVIDUALS WHOSE PRIMARY LANGUAGE IS NOT ENGLISH, IF REQUESTED.

(5) NO LATER THAN APRIL 1, 2022, THE STATE DEPARTMENT SHALL:

(a) USING FEEDBACK FROM HOSPITAL HEALTH-CARE CONSUMERS AND HEALTH-CARE CONSUMER ADVOCATE STAKEHOLDERS, DEVELOP A WRITTEN EXPLANATION OF A PATIENT'S RIGHTS UNDER THIS SECTION THAT IS WRITTEN IN PLAIN LANGUAGE AT A SIXTH- GRADE READING LEVEL AND TRANSLATED INTO ALL LANGUAGES SPOKEN BY TEN PERCENT OR MORE OF THE POPULATION IN EACH COUNTY OF THE STATE AND POST THE WRITTEN EXPLANATION IN ALL REQUIRED LANGUAGES ON THE STATE DEPARTMENT'S WEBSITE. EACH HEALTH-CARE FACILITY SHALL MAKE THE EXPLANATION AVAILABLE TO THE PUBLIC AND EACH PATIENT AS PROVIDED IN SECTION

25.5-3-504.

(b) (I) ESTABLISH A PROCESS FOR PATIENTS TO SUBMIT A COMPLAINT RELATING TO NONCOMPLIANCE WITH THIS PART 5 TO THE STATE DEPARTMENT BY PHONE, MAIL, OR ONLINE. THE STATE DEPARTMENT SHALL CONDUCT A REVIEW WITHIN THIRTY DAYS AFTER RECEIVING A COMPLAINT.

(II) THE STATE DEPARTMENT SHALL PERIODICALLY REVIEW HEALTH-CARE FACILITIES AND LICENSED HEALTH-CARE PROFESSIONALS TO ENSURE COMPLIANCE WITH THIS SECTION. IF THE STATE DEPARTMENT FINDS THAT A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL IS NOT IN COMPLIANCE WITH THIS SECTION, THE STATE DEPARTMENT SHALL NOTIFY THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL AND THE FACILITY OR PROFESSIONAL HAS NINETY DAYS TO FILE A CORRECTIVE ACTION PLAN WITH THE STATE DEPARTMENT THAT MUST INCLUDE MEASURES TO INFORM THE PATIENT ABOUT THE NONCOMPLIANCE AND PROVIDE A FINANCIAL CORRECTION CONSISTENT WITH THIS PART 5. A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL MAY REQUEST UP TO ONE HUNDRED TWENTY DAYS TO SUBMIT A CORRECTIVE ACTION PLAN. THE STATE DEPARTMENT MAY REQUIRE A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL THAT IS NOT IN COMPLIANCE WITH THIS PART 5 OR ANY STATE BOARD RULES ADOPTED PURSUANT TO THIS PART 5 TO DEVELOP AND OPERATE UNDER A CORRECTIVE ACTION PLAN UNTIL THE STATE DEPARTMENT DETERMINES THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL IS IN COMPLIANCE.

(III) IF A HEALTH-CARE FACILITY'S OR LICENSED HEALTH-CARE PROFESSIONAL'S NONCOMPLIANCE WITH THIS SECTION IS DETERMINED BY

THE STATE DEPARTMENT TO BE KNOWING OR WILLFUL OR THERE IS A REPEATED PATTERN OF NONCOMPLIANCE, THE STATE DEPARTMENT MAY FINE THE FACILITY OR PROFESSIONAL NO MORE THAN FIVE THOUSAND DOLLARS. IF THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL FAILS TO TAKE CORRECTIVE ACTION OR FAILS TO FILE A CORRECTIVE ACTION PLAN WITH THE STATE DEPARTMENT PURSUANT TO SUBSECTION (5)(b)(II) OF THIS SECTION, THE STATE DEPARTMENT MAY FINE THE FACILITY OR PROFESSIONAL NO MORE THAN FIVE THOUSAND DOLLARS A WEEK UNTIL THE FACILITY OR PROFESSIONAL TAKES CORRECTIVE ACTION. THE STATE DEPARTMENT SHALL CONSIDER THE SIZE OF THE HEALTH-CARE FACILITY AND THE SERIOUSNESS OF THE VIOLATION IN SETTING THE FINE AMOUNT.

(6) THE STATE DEPARTMENT SHALL MAKE THE INFORMATION REPORTED PURSUANT TO SUBSECTION (1) OF THIS SECTION AND ANY CORRECTIVE ACTION PLANS FOR WHICH FINES WERE IMPOSED PURSUANT TO SUBSECTION (5)(b) OF THIS SECTION AVAILABLE TO THE PUBLIC.

25.5-3-506. Limitations on collection actions - private enforcement. (1) BEGINNING JUNE 1, 2022, BEFORE ASSIGNING OR SELLING PATIENT DEBT TO A COLLECTION AGENCY, AS DEFINED IN SECTION 5-16-103 (3)(a), OR A DEBT BUYER, AS DEFINED IN SECTION 5-16-103 (8.5), OR BEFORE PURSUING, EITHER DIRECTLY OR INDIRECTLY, ANY PERMISSIBLE EXTRAORDINARY COLLECTION ACTION, AS DEFINED IN SECTION 6-20-201 (7):

(a) A HEALTH-CARE FACILITY SHALL MEET THE SCREENING REQUIREMENTS IN SECTION 25.5-3-502;

(b) A HEALTH-CARE FACILITY AND LICENSED HEALTH-CARE PROFESSIONAL SHALL PROVIDE DISCOUNTED CARE TO A PATIENT

PURSUANT TO SECTION 25.5-3-503;

(c) A HEALTH-CARE FACILITY AND LICENSED HEALTH-CARE PROFESSIONAL SHALL PROVIDE A PLAIN LANGUAGE EXPLANATION OF THE HEALTH-CARE SERVICES AND FEES BEING BILLED AND NOTIFY THE PATIENT OF POTENTIAL COLLECTION ACTIONS; AND

(d) A HEALTH-CARE FACILITY AND HEALTH-CARE PROFESSIONAL SHALL BILL ANY THIRD-PARTY PAYER THAT IS RESPONSIBLE FOR PROVIDING HEALTH-CARE COVERAGE TO THE PATIENT.

(2) A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL THAT FAILS TO COMPLY WITH THE REQUIREMENTS OF THIS SECTION IS LIABLE TO THE PATIENT IN AN AMOUNT EQUAL TO THE SUM OF:

(a) ANY ACTUAL DAMAGES SUSTAINED BY THE PATIENT AS A RESULT OF SUCH FAILURE;

(b) IN THE CASE OF SUCH ACTION BROUGHT BY AN INDIVIDUAL, ANY ADDITIONAL DAMAGES THAT THE COURT MAY ALLOW, NOT TO EXCEED ONE THOUSAND DOLLARS;

(c) IN THE CASE OF A CLASS ACTION, SUCH AMOUNT FOR EACH NAMED PLAINTIFF THAT MAY RECOVER DAMAGES UNDER SUBSECTION (2)(b) OF THIS SECTION, AND SUCH AMOUNT THAT THE COURT MAY ALLOW FOR ALL OTHER CLASS MEMBERS WITHOUT REGARD TO A MINIMUM INDIVIDUAL RECOVERY, NOT TO EXCEED THE LESSER OF FIVE HUNDRED THOUSAND DOLLARS OR ONE PERCENT OF THE NET WORTH OF THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL; AND

(d) IN THE CASE OF ANY SUCCESSFUL ACTION TO ENFORCE THE FOREGOING LIABILITY, THE COSTS OF THE ACTION TOGETHER WITH REASONABLE ATTORNEY FEES AS DETERMINED BY THE COURT. ON A FINDING BY THE COURT THAT THE ACTION WAS BROUGHT IN BAD FAITH,

THE COURT MAY AWARD REASONABLE ATTORNEY FEES TO THE DEFENDANT THAT ARE RELATED TO THE WORK EXPENDED AND COSTS.

(3) IN DETERMINING THE AMOUNT OF LIABILITY IN ANY ACTION PURSUANT TO SUBSECTION (2) OF THIS SECTION, THE COURT SHALL CONSIDER, AMONG OTHER RELEVANT FACTORS:

(a) IN ANY INDIVIDUAL ACTION BROUGHT PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION, THE FREQUENCY AND PERSISTENCE OF NONCOMPLIANCE BY THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL, THE NATURE OF SUCH NONCOMPLIANCE, AND THE EXTENT TO WHICH SUCH NONCOMPLIANCE WAS INTENTIONAL; OR

(b) IN ANY INDIVIDUAL ACTION BROUGHT PURSUANT TO SUBSECTION (2)(b) OF THIS SECTION, THE FREQUENCY AND PERSISTENCE OF NONCOMPLIANCE BY THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL, THE NATURE OF SUCH NONCOMPLIANCE, THE RESOURCES OF THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL, THE NUMBER OF INDIVIDUALS ADVERSELY AFFECTED, AND THE EXTENT TO WHICH THE HEALTH-CARE FACILITY'S OR LICENSED HEALTH-CARE PROFESSIONAL'S NONCOMPLIANCE WAS INTENTIONAL.

SECTION 2. In Colorado Revised Statutes, 5-16-108, **add** (1)(l) as follows:

5-16-108. Unfair practices. (1) A debt collector or collection agency shall not use unfair or unconscionable means to collect or attempt to collect any debt, including, but not limited to, the following conduct:

(l) AN ATTEMPT TO COLLECT A DEBT THAT VIOLATES THE PROVISIONS OF SECTION 6-20-203 (1), (2), (3)(b), (4)(a), (4)(b)(I), (4)(d), (4)(e), OR (5)(a) TO (5)(c).

SECTION 3. In Colorado Revised Statutes, 6-20-201, **add**

(4), (5), and (6) as follows:

6-20-201. Definitions. For the purposes of this part 2, unless the context otherwise requires:

(4) "HOSPITAL SERVICES" MEANS HEALTH-CARE SERVICES, AS DEFINED IN SECTION 10-16-102 (33), PROVIDED BY A HEALTH-CARE FACILITY, AS DEFINED IN SECTION 25.5-3-501 (1), OR A LICENSED HEALTH-CARE PROFESSIONAL, AS DEFINED IN SECTION 25.5-3-501 (3).

(5) "IMPERMISSIBLE EXTRAORDINARY COLLECTION ACTION" MEANS INITIATING FORECLOSURE ON AN INDIVIDUAL'S PRIMARY RESIDENCE OR HOMESTEAD, INCLUDING A MOBILE HOME, AS DEFINED IN SECTION 38-12-201.5 (5).

(6) "MEDICAL CREDITOR" MEANS AN ENTITY THAT ATTEMPTS TO COLLECT ON A MEDICAL DEBT, INCLUDING:

(a) A HEALTH-CARE PROVIDER OR HEALTH-CARE PROVIDER'S BILLING OFFICE;

(b) A COLLECTION AGENCY, AS DEFINED IN SECTION 5-16-103 (3);

(c) A DEBT BUYER, AS DEFINED IN SECTION 5-16-103 (8.5); AND

(d) A DEBT COLLECTOR, AS DEFINED IN 15 U.S.C. SEC. 1692a (6).

(7) "PERMISSIBLE EXTRAORDINARY COLLECTION ACTION" MEANS AN ACTION OTHER THAN AN IMPERMISSIBLE EXTRAORDINARY COLLECTION ACTION THAT REQUIRES A LEGAL OR JUDICIAL PROCESS, INCLUDING BUT NOT LIMITED TO PLACING A LIEN ON AN INDIVIDUAL'S REAL PROPERTY, ATTACHING OR SEIZING AN INDIVIDUAL'S BANK ACCOUNT OR ANY OTHER PERSONAL PROPERTY, OR GARNISHING AN INDIVIDUAL'S WAGES. A PERMISSIBLE EXTRAORDINARY COLLECTION ACTION DOES NOT INCLUDE THE ASSERTION OF A HOSPITAL LIEN PURSUANT TO SECTION 38-27-101.

SECTION 4. In Colorado Revised Statutes, **add** 6-20-203 as follows:

6-20-203. Limitations on collection actions - definition.

(1) BEGINNING JUNE 1, 2022, IMPERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS MAY NOT BE USED BY ANY MEDICAL CREDITOR TO COLLECT DEBTS OWED FOR HOSPITAL SERVICES.

(2) BEGINNING JUNE 1, 2022, NO MEDICAL CREDITOR COLLECTING ON A DEBT FOR HOSPITAL SERVICES SHALL ENGAGE IN ANY PERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS UNTIL ONE HUNDRED EIGHTY-TWO DAYS AFTER THE DATE THE PATIENT RECEIVES HOSPITAL SERVICES.

(3) (a) BEGINNING JUNE 1, 2022, AT LEAST THIRTY DAYS BEFORE TAKING ANY PERMISSIBLE EXTRAORDINARY COLLECTION ACTION, A MEDICAL CREDITOR, AS DEFINED IN SECTION 6-20-201 (6)(a), COLLECTING ON A DEBT FOR HOSPITAL SERVICES SHALL NOTIFY THE PATIENT OF POTENTIAL COLLECTION ACTIONS AND SHALL INCLUDE WITH THE NOTICE A STATEMENT DEVELOPED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING THAT EXPLAINS THE AVAILABILITY OF DISCOUNTED CARE FOR QUALIFIED INDIVIDUALS AND HOW TO APPLY FOR SUCH CARE.

(b) (I) A MEDICAL CREDITOR, AS DEFINED IN SECTION 6-20-201 (6)(b), (6)(c), OR (6)(d), COLLECTING ON A DEBT FOR HOSPITAL SERVICES SHALL INCLUDE THE FOLLOWING STATEMENT IN THE NOTICES THE MEDICAL CREDITOR PROVIDES TO THE PATIENT PURSUANT TO SECTION 5-16-109 (1) AND 15 U.S.C. SEC. 1692g (a): "PURSUANT TO COLORADO LAW, DISCOUNTS FOR HOSPITAL SERVICES ARE AVAILABLE FOR QUALIFIED INDIVIDUALS." THE STATEMENT MUST INCLUDE A LINK TO THE WRITTEN EXPLANATION OF THE PATIENT'S RIGHTS THAT IS POSTED TO THE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING'S WEBSITE PURSUANT TO SECTION 25.5-3-505 (4)(a).

(II) A MEDICAL CREDITOR, AS DEFINED SECTION 6-20-201 (6)(b), (6)(c), OR (6)(d), SHALL NOT TAKE ANY PERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS UNTIL THE LATER OF THIRTY DAYS FROM THE DATE OF SENDING THE NOTICE REQUIRED PURSUANT TO SUBSECTION (3)(b)(I) OF THIS SECTION OR THE COMPLETION OF THE VALIDATION REQUIREMENTS DESCRIBED IN SECTION 5-16-109 (2) AND 15 U.S.C. SEC. 1692g (b).

(4) BEGINNING JUNE 1, 2022, IF A MEDICAL CREDITOR COLLECTING ON A DEBT FOR HOSPITAL SERVICES BILLS OR INITIATES COLLECTION ACTIVITIES AND IT IS LATER DETERMINED THAT THE PATIENT SHOULD HAVE BEEN SCREENED PURSUANT TO SECTION 25.5-3-503 AND IS DETERMINED TO BE A QUALIFIED PATIENT, AS DEFINED IN SECTION 25.5-3-501 (5), OR IT IS DETERMINED THAT THE PATIENT'S BILL IS ELIGIBLE FOR REIMBURSEMENT THROUGH A PUBLIC HEALTH-CARE COVERAGE PROGRAM OR THE COLORADO INDIGENT CARE PROGRAM, THE MEDICAL CREDITOR SHALL:

(a) DELETE ANY NEGATIVE REPORTS TO CONSUMER REPORTING AGENCIES;

(b) (I) UNLESS PROHIBITED BY LAW, IF THE COURT HAS ENTERED A JUDGMENT ON THE MEDICAL DEBT:

(A) REQUEST THE COURT VACATE THE JUDGMENT IN ANY COLLECTION LAWSUIT OVER THE MEDICAL DEBT AND ENTER INTO A PAYMENT PLAN WITH THE PATIENT THAT MEETS THE REQUIREMENTS OF SECTION 25.5-3-503 (1)(b); OR

(B) REQUEST THE COURT REDUCE THE AMOUNT OF THE JUDGMENT, INCLUDING ANY FEES AND COSTS RELATED TO THE COLLECTION LAWSUIT,

TO THE TOTAL AMOUNT THE PATIENT OWES PURSUANT TO THE PUBLIC HEALTH-CARE COVERAGE PROGRAM OR DISCOUNTED CARE POLICY THAT THE PATIENT QUALIFIES FOR, ENTER INTO A PAYMENT PLAN WITH THE PATIENT THAT MEETS THE REQUIREMENTS OF SECTION 25.5-3-503 (1)(b), AND SUSPEND ALL EXECUTION ON THE JUDGMENT WHILE THE PATIENT IS COMPLIANT WITH THE TERMS OF THE PAYMENT PLAN; OR

(C) FILE A SATISFACTION OF JUDGMENT SUCH THAT THE REMAINING UNPAID BALANCE OF THE JUDGMENT, INCLUDING ANY FEES AND COSTS RELATED TO THE COLLECTION LAWSUIT, IS EQUAL TO THE TOTAL AMOUNT THE PATIENT OWES UNDER THE PUBLIC HEALTH-CARE COVERAGE PROGRAM OR DISCOUNTED CARE POLICY THAT THE PATIENT QUALIFIES FOR, ENTER INTO A PAYMENT PLAN WITH THE PATIENT THAT MEETS THE REQUIREMENTS OF SECTION 25.5-3-503 (1)(b), AND SUSPEND ALL EXECUTION ON THE JUDGMENT WHILE THE PATIENT IS COMPLIANT WITH THE TERMS OF THE PAYMENT PLAN.

(II) FOR THE PURPOSES OF SUBSECTION (4)(b)(I)(B) AND (4)(b)(I)(C) OF THIS SECTION, THE COURT SHALL REFUND TO THE PARTIES ANY FEES AND COSTS PAID TO THE COURT IN CONNECTION WITH THE LITIGATION OF THE MEDICAL DEBT AND THE HEALTH-CARE PROVIDER SHALL INDEMNIFY THE MEDICAL CREDITOR FOR ANY FEES AWARDED AS PART OF THE JUDGMENT IN CONNECTION WITH THE MEDICAL DEBT.

(c) AS THE TERM "MEDICAL CREDITOR" IS DEFINED IN SECTION 6-20-201 (6)(a), REFUND ANY EXCESS AMOUNT TO THE PATIENT IF THE PATIENT HAS PAID ANY PART OF THE MEDICAL DEBT OR IF ANY OF THE PATIENT'S MONEY HAS BEEN SEIZED OR LEVIED IN EXCESS OF THE AMOUNT THAT THE PATIENT OWES AFTER APPLICATION OF REQUIRED DISCOUNTS;

(d) AS THE TERM "MEDICAL CREDITOR" IS DEFINED IN SECTIONS

6-20-201 (6)(b), (6)(c), AND (6)(d), IF THE PATIENT HAS PAID ANY PART OF THE MEDICAL DEBT OR IF ANY OF THE PATIENT'S MONEY HAS BEEN SEIZED OR LEVIED IN EXCESS OF THE AMOUNT THAT THE PATIENT OWES AFTER APPLICATION OF REQUIRED DISCOUNTS, REFUND ANY EXCESS AMOUNT TO THE PATIENT TO THE EXTENT THE MEDICAL CREDITOR HAS NOT ALREADY REMITTED SUCH AN AMOUNT TO THE HEALTH-CARE PROVIDER; AND

(e) REMEDY ANY OTHER PERMISSIBLE EXTRAORDINARY COLLECTION ACTION.

(5) BEGINNING JUNE 1, 2022, A MEDICAL CREDITOR COLLECTING ON A DEBT FOR HOSPITAL SERVICES SHALL NOT SELL A MEDICAL DEBT TO ANOTHER PARTY UNLESS, PRIOR TO THE SALE, THE MEDICAL DEBT SELLER HAS ENTERED INTO A LEGALLY BINDING WRITTEN AGREEMENT WITH THE MEDICAL DEBT BUYER OF THE DEBT PURSUANT TO WHICH:

(a) THE MEDICAL DEBT BUYER AGREES NOT TO PURSUE IMPERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS TO OBTAIN PAYMENT FOR THE CARE;

(b) THE DEBT IS RETURNABLE TO OR RECALLABLE BY THE MEDICAL DEBT SELLER UPON A DETERMINATION THAT THE PATIENT SHOULD HAVE BEEN SCREENED PURSUANT TO SECTION 25.5-3-502 AND IS ELIGIBLE FOR DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503 OR THAT THE BILL UNDERLYING THE MEDICAL DEBT IS ELIGIBLE FOR REIMBURSEMENT THROUGH A PUBLIC HEALTH-CARE COVERAGE PROGRAM OR THE COLORADO INDIGENT CARE PROGRAM; AND

(c) IF IT IS DETERMINED THAT THE PATIENT SHOULD HAVE BEEN SCREENED PURSUANT TO SECTION 25.5-3-502 AND IS ELIGIBLE FOR DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503 OR THAT THE BILL

UNDERLYING THE MEDICAL DEBT IS ELIGIBLE FOR REIMBURSEMENT THROUGH A PUBLIC HEALTH-CARE COVERAGE PROGRAM OR THE COLORADO INDIGENT CARE PROGRAM AND THE DEBT IS NOT RETURNED TO OR RECALLED BY THE MEDICAL DEBT SELLER, THE MEDICAL DEBT BUYER SHALL ADHERE TO PROCEDURES THAT MUST BE SPECIFIED IN THE AGREEMENT THAT ENSURES THE PATIENT WILL NOT PAY, AND HAS NO OBLIGATION TO PAY, THE MEDICAL DEBT BUYER AND THE MEDICAL CREDITOR TOGETHER MORE THAN THE PATIENT IS PERSONALLY RESPONSIBLE FOR PAYING.

(6) THE MEDICAL DEBT SELLER SHALL INDEMNIFY THE MEDICAL DEBT BUYER FOR ANY AMOUNT PAID FOR A DEBT THAT IS RETURNED TO OR RECALLED BY THE MEDICAL DEBT SELLER.

(7) NOTHING IN THIS SECTION LIMITS OR AFFECTS A HEALTH-CARE PROVIDER'S RIGHT TO PURSUE AGAINST ANY PARTY OTHER THAN THE PATIENT THE COLLECTION OF PERSONAL INJURY, LIABILITY, UNINSURED, UNDERINSURED, MEDICAL PAYMENT REHABILITATION, DISABILITY, HOMEOWNER'S, BUSINESS OWNER'S, WORKER'S COMPENSATION, FAULT-BASED INSURANCE, SUBROGATED CLAIMS, OR OTHER CLAIMS NOT AGAINST THE PATIENT.

SECTION 5. In Colorado Revised Statutes, 25-49-105, **amend** (1) as follows:

25-49-105. No review of health-care prices - no punishment for exercising rights - no impairment of contracts. (1) Nothing in this article 49 requires a health-care facility or health-care provider to report its health-care prices to any agency for review, filing, or other purposes, ~~except as required by section 25-3-112,~~ or for applications for health-care professional loan repayment submitted pursuant to section 25-1.5-503.

This article 49 does not grant any agency the authority to approve, disapprove, or limit a health-care facility's or health-care provider's health-care prices or changes to its health-care prices. The department of public health and environment is not authorized to take any action regarding or pursuant to this article 49.

SECTION 6. In Colorado Revised Statutes, 25.5-3-104, **add** (3) as follows:

25.5-3-104. Program for the medically indigent established - eligibility - rules. (3) NO LATER THAN JUNE 1, 2022, FOR PROVIDERS DEFINED AS HOSPITAL PROVIDERS IN 10 CCR 2505-10, SEC. 8.901.J, THE STATE DEPARTMENT SHALL PROMULGATE RULES:

(a) PROHIBITING HOSPITALS FROM CONSIDERING ASSETS WHEN DETERMINING WHETHER A PATIENT MEETS THE SPECIFIED PERCENTAGE OF THE FEDERAL POVERTY LINE REQUIRED IN SUBSECTION (2) OF THIS SECTION; AND

(b) ENSURING THE METHOD USED TO DETERMINE WHETHER A PATIENT MEETS THE SPECIFIED PERCENTAGE OF THE FEDERAL POVERTY LINE IS UNIFORM ACROSS HOSPITALS AND ALIGNED WITH THE METHOD FOR COUNTING INCOME FOR THE PURPOSES OF DETERMINING ELIGIBILITY FOR DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-503.

SECTION 7. In Colorado Revised Statutes, **repeal** 25-3-112.

SECTION 8. Appropriation - adjustments to 2021 long bill. (1) To implement this act, appropriations made in the annual general appropriation act for the 2021-22 state fiscal year to the department of public health and environment are adjusted as follows:

(a) The general fund appropriation for health, life, and dental expenses is decreased by $4,000;

(b) The general fund appropriation for short-term disability is decreased by $35;

(c) The general fund appropriation for S.B. 04-257 amortization equalization disbursements is decreased by $1,028;

(d) The general fund appropriation for S.B. 06-235 supplemental amortization equalization disbursements is decreased by $1,028; and

(e) The general fund appropriation for use by the health facilities and emergency medical services division for nursing and acute care facility survey is decreased by $38,113, and the related FTE is decreased by 0.3 FTE.

(2) For the 2021-22 state fiscal year, $219,295 is appropriated to the department of health care policy and financing for use by the executive director's office. This appropriation is from the general fund. To implement this act, the office may use this appropriation as follows:

(a) $47,855 for personal services, which amount is based on an assumption that the office will require an additional 0.7 FTE;

(b) $7,280 for operating expenses; and

(c) $164,160 for general professional services and special projects.

SECTION 9. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly; 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 such period, 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 2022 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.