Second Regular Session
Seventy-third General Assembly
STATE OF COLORADO

PREAMENDED

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

LLS NO. 22-0503.01 Kristen Forrestal x4217 **HOUSE BILL 22-1284**

HOUSE SPONSORSHIP

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House Committees
Health & Insurance
Appropriations

Senate Committees

A BILL FOR AN ACT

CONCERNING UPDATES TO STATE SURPRISE BILLING LAWS TO FACILITATE THE IMPLEMENTATION OF SURPRISE BILLING PROTECTIONS, AND, IN CONNECTION THEREWITH, ALIGNING STATE LAW WITH THE FEDERAL "NO SURPRISES ACT", AND 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 changes current state law to align with the federal "No Surprises Act" (act) by:

- Allowing a covered person who requests an independent external review of a health-care coverage decision to request a review to determine if the services that were provided or may be provided by an out-of-network provider or facility are subject to an in-network benefit level of coverage;
- Requiring that payments made for health-care services provided at an in-network facility or by an out-of-network provider be applied to the covered person's in-network deductible and any out-of-pocket maximum amounts as if the services were provided by an in-network provider;
- Requiring that emergency health-care services, regardless of the facility at which they are provided, be covered at the in-network benefit level;
- Requiring each health insurance carrier (carrier) to cover post-stabilization services to stabilize a patient after a medical emergency at the in-network benefit level unless specific criteria are met;
- Requiring carriers to develop disclosures to provide to covered persons that comply with the act;
- Requiring the commissioner of insurance (commissioner) and certain regulators of health-care occupations to adopt rules concerning disclosure requirements, including a list of ancillary services for which a provider or facility cannot charge a balance bill;
- Requiring the commissioner to convene a work group to facilitate and streamline the implementation of the payment of claims for services provided by an out-of-network provider at an in-network facility and for services surrounding a medical emergency;
- Prohibiting a carrier from recalculating a covered person's cost-sharing amount based on an additional payment made as a result of arbitration;
- Requiring the parties to an arbitration over health-care coverage to split the costs of the arbitrator if the parties reach an agreement before the final decision of the arbitrator;
- Allowing administrators of self-funded health benefit plans to elect to be subject to state law concerning coverage for health-care services from out-of-network providers and facilities;
- Authorizing the commissioner to promulgate rules to implement the requirements of the act;
- Changing the amount of time that a managed care plan must allow a person to continue to receive care from a

provider from 60 to 90 days after the date an in-network provider is terminated from a plan without cause;

- Implementing specific requirements for health-care coverage and services for covered persons who are continuing care patients of a provider or facility whose contract with the patient's health insurer is terminated; and
- Allowing an out-of-network provider and an out-of-network facility to charge a covered person a balance bill for health-care services other than ancillary services if the out-of-network provider complies with specific notice requirements and obtains the covered person's signed consent.

The bill changes from January 1 to March 1 the date by which a carrier is required to submit information to the commissioner concerning the use of out-of-network providers and out-of-network facilities and the impact on health insurance premiums for consumers.

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

SECTION 1. In Colorado Revised Statutes, 10-16-113.5, **add** (8.5) as follows:

10-16-113.5. Independent external review of adverse determinations - legislative declaration - definitions - rules. (8.5) AN INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW MAY REQUEST THE REVIEW OR AN EXPEDITED REVIEW TO DETERMINE IF SECTION 10-16-704 (3) OR (5.5) APPLIES TO THE ITEMS OR SERVICES THAT WERE PROVIDED OR MAY BE PROVIDED TO A COVERED PERSON BY AN OUT-OF-NETWORK PROVIDER OR AT AN OUT-OF-NETWORK FACILITY.

SECTION 2. In Colorado Revised Statutes, 10-16-704, **amend** (3)(b), (3)(d)(V), (5.5)(a)(V), (12)(a), (12)(b), (13), (14), (15)(d), and (15)(e); **repeal** (2)(f), (3)(a)(IV), (3)(d)(VI), and (5.5)(e); and **add** (5.5)(a.5), (17), (18), and (19) as follows:

10-16-704. Network adequacy - required disclosures - balance billing - rules - legislative declaration - definitions - repeal. (2) (f) ~~For~~

~~the purposes of this subsection (2).~~

~~(I) "Balance bill" means the amount that a nonparticipating provider may charge the covered person. Such amount charged equals the difference between the amount paid by the carrier and the amount of the nonparticipating provider's bill charge.~~

~~(II) "Negotiated rate" means the rate mutually agreed upon between the carrier and the provider in a specific instance.~~

~~(III) "Usual, customary, and reasonable rate" means a rate established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices.~~

(3) (a) (IV) ~~The general assembly finds, determines, and declares that some consumers intentionally use out-of-network providers, which is the consumers' prerogative under certain health benefit plans. When consumers intentionally use an out-of-network provider, the consumer is only entitled to benefits at the out-of-network rate and may be subject to balance billing by the out-of-network provider.~~

(b) When a covered person receives services or treatment in accordance with plan provisions at ~~a network~~ AN IN-NETWORK facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit. Covered services or treatment rendered at ~~a network~~ AN IN-NETWORK facility, including covered ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at ~~a network~~ AN IN-NETWORK facility, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider. A PAYMENT MADE BY A COVERED PERSON PURSUANT TO THIS SUBSECTION (3)(b) MUST BE APPLIED TO THE COVERED PERSON'S IN-NETWORK

DEDUCTIBLES AND OUT-OF-POCKET MAXIMUM AMOUNTS AND IN THE SAME MANNER AS IF THE COST-SHARING PAYMENTS WERE MADE TO AN IN-NETWORK PROVIDER AT AN IN-NETWORK FACILITY.

(d) (V) This subsection (3)(d) does not apply when a covered person ~~voluntarily uses~~ HAS RECEIVED NOTICE AND GIVEN CONSENT AS REQUIRED BY SECTION 12-30-112 OR 25-3-121, AS APPLICABLE, TO USE an out-of-network provider IN COMPLIANCE WITH THE FEDERAL "NO SURPRISES ACT".

(VI) ~~For purposes of this subsection (3):~~

~~(A) "Geographic area" means a specific area in this state as established by the commissioner by rule.~~

~~(B) "Medicare reimbursement rate" means the reimbursement rate for a particular health-care service provided under the "Health Insurance for the Aged Act", Title XVIII of the federal "Social Security Act", as amended, 42 U.S.C. sec. 1395 et seq.~~

(5.5) (a) Notwithstanding any provision of law, a carrier that provides any benefits with respect to emergency services shall cover the emergency services:

(V) At the in-network benefit level, with the same coinsurance, deductible, or copayment requirements as would apply if the emergency services were provided by an in-network provider or AT AN IN-NETWORK facility, and at no greater cost to the covered person than if the emergency services were obtained from an in-network provider at an in-network facility. Any payment made by a covered person pursuant to this subsection (5.5)(a)(V) must be applied to the covered person's in-network ~~cost-sharing limit~~ DEDUCTIBLES AND IN-NETWORK OUT-OF-POCKET MAXIMUM AMOUNTS AND IN THE SAME MANNER AS IF THE COST-SHARING

PAYMENTS WERE MADE TO AN IN-NETWORK PROVIDER OR IN-NETWORK FACILITY.

(a.5) (I) EXCEPT AS PROVIDED IN SUBSECTION (5.5)(a.5)(II) OF THIS SECTION, A CARRIER SHALL:

(A) COVER POST-STABILIZATION SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER OR AT AN OUT-OF-NETWORK FACILITY AT NO GREATER COST TO THE COVERED PERSON THAN THE COST THAT WOULD APPLY, AND WITH THE SAME COINSURANCE, DEDUCTIBLE, OR COPAYMENT REQUIREMENTS AS THE REQUIREMENTS THAT WOULD APPLY, IF THE POST-STABILIZATION SERVICES WERE OBTAINED FROM AN IN-NETWORK PROVIDER OR AT AN IN-NETWORK FACILITY; AND

(B) REIMBURSE THE OUT-OF-NETWORK PROVIDER FOR POST-STABILIZATION SERVICES IN ACCORDANCE WITH SUBSECTION (3)(d)(II) OF THIS SECTION AND THE OUT-OF-NETWORK FACILITY IN ACCORDANCE WITH SUBSECTION (5.5)(b) OF THIS SECTION.

(II) THE REQUIREMENTS OF SUBSECTION (5.5)(a.5)(I) OF THIS SECTION DO NOT APPLY IF THE FOLLOWING CONDITIONS ARE MET:

(A) THE OUT-OF-NETWORK PROVIDER OR OUT-OF-NETWORK FACILITY DETERMINES THE COVERED PERSON IS ABLE TO TRAVEL USING NONMEDICAL TRANSPORTATION OR NONEMERGENCY MEDICAL TRANSPORTATION;

(B) THE OUT-OF-NETWORK PROVIDER OR OUT-OF-NETWORK FACILITY HAS PROVIDED THE COVERED PERSON WITH NOTICE AND OBTAINED CONSENT AS REQUIRED BY SECTION 12-30-112 OR 25-3-121, AS APPLICABLE;

(C) THE COVERED PERSON IS IN A CONDITION TO RECEIVE THE INFORMATION DESCRIBED IN SUBSECTION (5.5)(a.5)(II)(B) OF THIS

SECTION; AND

(D) THE OUT-OF-NETWORK PROVIDER OR OUT-OF-NETWORK FACILITY IS IN COMPLIANCE WITH, AT A MINIMUM, OTHER REQUIREMENTS ESTABLISHED IN 42 U.S.C. SEC. 300gg-111 AND ANY FEDERAL REGULATIONS ADOPTED PURSUANT TO 42 U.S.C. SEC. 300gg-111.

(III) ANY PAYMENT MADE BY A COVERED PERSON PURSUANT TO SUBSECTION (5.5)(a.5)(I) OF THIS SECTION MUST BE APPLIED TO THE COVERED PERSON'S IN-NETWORK DEDUCTIBLES AND IN-NETWORK OUT-OF-POCKET MAXIMUM AMOUNTS.

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

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

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

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

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

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

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

~~(B) Within the capabilities of the staff and facilities available at~~

~~the hospital, further medical examination and treatment as required to stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.~~

~~(III) "Geographic area" has the same meaning as defined in subsection (3)(d)(VI)(A) of this section.~~

~~(IV) "Medicare reimbursement rate" has the same meaning as defined in subsection (3)(d)(VI)(B) of this section.~~

(12) (a) On and after January 1, 2020, carriers shall develop and provide disclosures to covered persons about the potential effects of receiving emergency or nonemergency services from an out-of-network provider or at an out-of-network facility. The disclosures must, AT A MINIMUM, comply with THE FEDERAL "NO SURPRISES ACT" AND the rules adopted under subsection (12)(b) of this section.

(b) The commissioner, in consultation with the state board of health created in section 25-1-103 and the ~~director of the division of professions and occupations in the department of regulatory agencies~~ APPLICABLE REGULATORS OF HEALTH-CARE OCCUPATIONS AND PROFESSIONS, shall adopt rules to specify the disclosure requirements under this subsection 12. ~~which rules must specify, at a minimum, the following:~~

~~(I) The timing for providing the disclosures for emergency and nonemergency services with consideration given to potential limitations relating to the federal "Emergency Medical Treatment and Labor Act", 42 U.S.C. sec. 1395dd;~~

~~(II) Requirements regarding how the disclosures must be made, including requirements to include the disclosures on billing statements,~~

~~billing notices, prior authorizations, or other forms or communications with covered persons;~~

~~(III) The contents of the disclosures, including the covered person's rights and payment obligations if the covered person's health benefit plan is under the jurisdiction of the division;~~

~~(IV) Disclosure requirements specific to carriers, including the possibility of being treated by an out-of-network provider, whether a provider is out of network, the types of services an out-of-network provider may provide, and the right to request an in-network provider to provide services; and~~

~~(V) Requirements concerning the language to be used in the disclosures, including use of plain language, to ensure that carriers, health-care facilities, and providers use language that is consistent with the disclosures required by this subsection (12) and sections 12-30-112 and 25-3-121 and the rules adopted pursuant to this subsection (12)(b) and sections 12-30-112 (3) and 25-3-121 (2).~~

(13) (a) When a carrier makes a payment to a provider or a health-care facility pursuant to subsection (3)(d) or (5.5)(b) of this section, the provider or the facility may request, and the commissioner shall collect, data from the carrier to evaluate the carrier's compliance in paying the highest rate required. The information requested may include the methodology for determining the carrier's median in-network rate or reimbursement for each service in the same geographic area.

(b) (I) THE COMMISSIONER SHALL CONVENE A WORK GROUP TO DISCUSS WAYS TO FACILITATE AND STREAMLINE IMPLEMENTATION OF THIS SUBSECTION (13). THE WORK GROUP MUST INCLUDE, TO THE EXTENT PRACTICABLE, EQUAL NUMBERS OF REPRESENTATIVES OF HOSPITALS,

CARRIERS, HEALTH-CARE PROVIDERS DIRECTLY AFFECTED BY THIS SECTION, AND CONSUMERS. THE WORK GROUP SHALL:

(A) IDENTIFY BARRIERS TO VERIFYING THE ACCURACY OF STATUTORILY SPECIFIED PAYMENT AMOUNTS AND MANAGING PAYER-PROVIDER DISPUTES REGARDING PAYMENT AMOUNTS FOR OUT-OF-NETWORK HEALTH-CARE SERVICES SUBJECT TO THIS SECTION;

(B) DEVELOP RECOMMENDATIONS TO STREAMLINE THE IMPLEMENTATION OF THIS SUBSECTION (13);

(C) SUBMIT A WRITTEN REPORT WITH PRELIMINARY RECOMMENDATIONS TO THE COMMISSIONER BY MARCH 15, 2023; AND

(D) ON OR BEFORE JULY 1, 2023, SUBMIT A WRITTEN REPORT WITH FINAL RECOMMENDATIONS TO THE COMMISSIONER.

(II) THE COMMISSIONER MAY ENTER INTO A CONTRACT WITH A QUALIFIED INDEPENDENT THIRD PARTY FOR ANY SERVICES NECESSARY TO FACILITATE THE ACTIVITIES OF THE WORK GROUP.

(III) THIS SUBSECTION (13)(b) IS REPEALED, EFFECTIVE JULY 31, 2023.

(14) On or before ~~January 1~~ MARCH 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 OUT-OF-NETWORK facilities by covered persons and the impact on premium affordability for consumers.

(15) (d) If the arbitrator's decision MADE PURSUANT TO SUBSECTION (15)(c) OF THIS SECTION requires additional payment by the carrier above the amount paid, the carrier shall pay the provider in accordance with section 10-16-106.5. A CARRIER SHALL NOT RECALCULATE A COVERED PERSON'S COST-SHARING AMOUNT BASED ON AN

ADDITIONAL PAYMENT REQUIRED OR MADE AS A RESULT OF AN ARBITRATION DECISION.

(e) The party whose final offer amount was not selected by the arbitrator shall pay the arbitrator's expenses and fees. IF THE PARTIES REACH A SETTLEMENT AFTER AN ARBITRATOR IS APPOINTED BUT BEFORE THE ARBITRATOR MAKES A FINAL DECISION, THE PARTIES SHALL SPLIT THE COSTS OF THE ARBITRATION EQUALLY UNLESS OTHERWISE AGREED BY THE PARTIES.

(17) THE COMMISSIONER SHALL POST ON THE DIVISION'S WEBSITE INFORMATION ON THE STATE AND FEDERAL AGENCIES THAT A COVERED PERSON MAY CONTACT IF A PROVIDER, FACILITY, OR CARRIER VIOLATES THIS SECTION.

(18) THE COMMISSIONER MAY ADOPT RULES TO IMPLEMENT THIS SECTION, INCLUDING RULES NECESSARY TO IMPLEMENT THE REQUIREMENTS OF THE FEDERAL"NO SURPRISES ACT".

(19) AS USED IN THIS SECTION:

(a) "ANCILLARY SERVICES" MEANS:

(I) DIAGNOSTIC SERVICES, INCLUDING RADIOLOGY AND LABORATORY SERVICES, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO 42 U.S.C. SEC. 300gg-132 (b)(3);

(II) ITEMS AND SERVICES RELATED TO EMERGENCY MEDICINE, ANESTHESIOLOGY, PATHOLOGY, RADIOLOGY, AND NEONATOLOGY, WHETHER OR NOT PROVIDED BY A PHYSICIAN OR NONPHYSICIAN PROVIDER, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION

2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

(III) ITEMS AND SERVICES PROVIDED BY ASSISTANT SURGEONS, HOSPITALISTS, AND INTENSIVISTS, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

(IV) ITEMS AND SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER IF THERE IS NO IN-NETWORK PROVIDER WHO CAN FURNISH THE NEEDED SERVICES AT THE FACILITY; AND

(V) ANY OTHER ITEMS AND SERVICES PROVIDED BY SPECIALTY PROVIDERS AS ESTABLISHED BY RULE OF THE COMMISSIONER.

(b) "APPLICABLE REGULATORS OF HEALTH-CARE OCCUPATIONS AND PROFESSIONS" MEANS THE:

(I) COLORADO STATE BOARD OF CHIROPRACTIC EXAMINERS CREATED IN SECTION 12-215-104;

(II) COLORADO DENTAL BOARD CREATED IN SECTION 12-220-105;

(III) COLORADO MEDICAL BOARD CREATED IN SECTION 12-240-105;

(IV) STATE BOARD OF PSYCHOLOGIST EXAMINERS CREATED IN SECTION 12-245-302;

(V) STATE BOARD OF SOCIAL WORK EXAMINERS CREATED IN SECTION 12-245-402;

(VI) STATE BOARD OF MARRIAGE AND FAMILY THERAPIST EXAMINERS CREATED IN SECTION 12-245-502;

(VII) STATE BOARD OF LICENSED PROFESSIONAL COUNSELOR EXAMINERS CREATED IN SECTION 12-245-602;

(VIII) STATE BOARD OF UNLICENSED PSYCHOTHERAPISTS CREATED

IN SECTION 12-245-702;

(IX) STATE BOARD OF ADDICTION COUNSELOR EXAMINERS CREATED IN SECTION 12-245-802;

(X) STATE BOARD OF NURSING CREATED IN SECTION 12-255-105;

(XI) BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS CREATED IN SECTION 12-265-106;

(XII) STATE BOARD OF OPTOMETRY CREATED IN SECTION 12-275-107;

(XIII) STATE BOARD OF PHARMACY CREATED IN SECTION 12-280-104;

(XIV) STATE PHYSICAL THERAPY BOARD CREATED IN SECTION 12-285-105;

(XV) COLORADO PODIATRY BOARD CREATED IN SECTION 12-290-105; AND

(XVI) THE DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF REGULATORY AGENCIES.

(c) "BALANCE BILL" MEANS:

(I) THE AMOUNT THAT AN OUT-OF-NETWORK PROVIDER MAY CHARGE A COVERED PERSON FOR THE PROVISION OF HEALTH-CARE SERVICES, WHICH AMOUNT EQUALS THE DIFFERENCE BETWEEN THE AMOUNT PAID BY THE CARRIER FOR THE HEALTH-CARE SERVICES AND THE AMOUNT OF THE OUT-OF-NETWORK PROVIDER'S BILLED CHARGE FOR THE HEALTH-CARE SERVICES; AND

(II) THE ACT OF A NONPARTICIPATING PROVIDER CHARGING A COVERED PERSON THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND THE AMOUNT THE CARRIER PAID THE PROVIDER.

(d) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL

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

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

(II) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

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

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

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

(II) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, REGARDLESS OF THE DEPARTMENT IN WHICH FURTHER EXAMINATION OR TREATMENT IS FURNISHED, OR THE FREESTANDING EMERGENCY DEPARTMENT, AS APPLICABLE, FURTHER MEDICAL EXAMINATION AND TREATMENT AS ARE REQUIRED TO STABILIZE THE PATIENT TO ENSURE, WITHIN REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE TRANSFER OF THE PATIENT FROM A FACILITY; AND

(III) ANCILLARY SERVICES.

(f) "FEDERAL 'NO SURPRISES ACT'" MEANS THE FEDERAL "NO SURPRISES ACT", PUB.L. 116-260, AS AMENDED.

(g) "FREESTANDING EMERGENCY DEPARTMENT" HAS THE SAME MEANING AS SET FORTH IN SECTION 25-1.5-114 (5).

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

(i) "IN-NETWORK FACILITY" MEANS A PARTICIPATING PROVIDER THAT IS A HEALTH-CARE FACILITY.

(j) "IN-NETWORK PROVIDER" MEANS A PARTICIPATING PROVIDER WHO IS AN INDIVIDUAL.

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

(l) "NEGOTIATED RATE" MEANS THE RATE MUTUALLY AGREED UPON BETWEEN THE CARRIER AND THE PROVIDER IN A SPECIFIC INSTANCE.

(m) "POST-STABILIZATION SERVICES" MEANS MEDICALLY NECESSARY HEALTH-CARE SERVICES RELATED TO AN EMERGENCY MEDICAL CONDITION THAT ARE PROVIDED AFTER A COVERED PERSON IS STABILIZED IN ORDER TO MAINTAIN THE STABILIZED CONDITION, REGARDLESS OF THE DEPARTMENT OF THE HOSPITAL OR FACILITY IN WHICH THE FURTHER EXAMINATION OR TREATMENT IS PROVIDED.

(n) "STABILIZED" MEANS THE CONDITION OF A PATIENT IN WHICH, WITHIN REASONABLE MEDICAL PROBABILITY, NO MATERIAL DETERIORATION OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE TRANSFER OF THE PATIENT FROM ONE FACILITY OR

DEPARTMENT TO ANOTHER.

(o) "USUAL, CUSTOMARY, AND REASONABLE RATE" MEANS A RATE ESTABLISHED PURSUANT TO AN APPROPRIATE METHODOLOGY THAT IS BASED ON GENERALLY ACCEPTED INDUSTRY STANDARDS AND PRACTICES.

SECTION 3. In Colorado Revised Statutes, 10-16-705, **amend** (4)(b); and **add** (4)(d) as follows:

10-16-705. Requirements for carriers and participating providers - definitions. (4) (b) Each CARRIER THAT ISSUES A managed care plan shall allow covered persons to continue receiving care for ~~sixty~~ UP TO NINETY days ~~from~~ AFTER the date a ~~participating provider is terminated by the plan without cause, when proper notice as specified in subsection (7) of this section has not been provided to the covered person~~ CARRIER HAS PROVIDED NOTICE TO AN INDIVIDUAL ENROLLED IN SUCH PLAN PURSUANT TO SUBSECTION (4)(d)(II)(A) OF THIS SECTION THAT THE CONTRACT IS TERMINATED. THE CARRIER SHALL PROVIDE THE REQUISITE COVERAGE OR CONTINUING CARE TO THE COVERED PERSON AT THE COVERED PERSON'S IN-NETWORK BENEFIT LEVEL COST-SHARING AMOUNT DURING THE PERIOD BEGINNING ON THE DATE ON WHICH THE NOTICE OF TERMINATION IS GIVEN PURSUANT TO SUBSECTION (4)(d)(II)(A) OF THIS SECTION AND ENDING ON THE EARLIER OF THE NINETY-DAY PERIOD BEGINNING ON SUCH DATE OR THE DATE ON WHICH THE COVERED PERSON IS NO LONGER A CONTINUING CARE PATIENT WITH THE PROVIDER OR HEALTH-CARE FACILITY.

(d) (I) A CARRIER SHALL COMPLY WITH THE REQUIREMENTS OF SUBSECTION (4)(d)(II) OF THIS SECTION IF A PARTICIPATING PROVIDER, WHETHER AN INDIVIDUAL PROVIDER OR A FACILITY, IS TREATING A CONTINUING CARE PATIENT WHO IS A COVERED PERSON UNDER THE PLAN

AND IF:

(A) THE CONTRACT BETWEEN THE CARRIER AND THE PARTICIPATING PROVIDER IS TERMINATED DUE TO THE EXPIRATION OR NONRENEWAL OF THE CONTRACT;

(B) THE BENEFITS PROVIDED UNDER THE MANAGED CARE PLAN OR THE HEALTH INSURANCE COVERAGE, WITH RESPECT TO THE PROVIDER OR FACILITY, ARE TERMINATED DUE TO THE EXPIRATION OR NONRENEWAL OF THE CONTRACT BETWEEN THE CARRIER AND THE PROVIDER OR FACILITY BECAUSE OF A CHANGE IN THE TERMS OF THE PARTICIPATION IN THE PLAN OR COVERAGE; OR

(C) A CONTRACT BETWEEN THE GROUP HEALTH PLAN AND THE CARRIER OFFERING COVERAGE IN CONNECTION WITH THE GROUP HEALTH PLAN IS TERMINATED DUE TO THE EXPIRATION OR NONRENEWAL OF THE CONTRACT, RESULTING IN THE LOSS OF BENEFITS UNDER THE PLAN WITH RESPECT TO THE PARTICIPATING PROVIDER THAT IS PROVIDING TREATMENT OR SERVICES TO THE COVERED PERSON IN COMPLIANCE WITH THE FEDERAL "NO SURPRISES ACT".

(II) A CARRIER SUBJECT TO THIS SUBSECTION (4)(d) SHALL:

(A) NOTIFY EACH COVERED PERSON WHO IS RECEIVING CARE FROM A PROVIDER OR FACILITY WITH WHOM A CONTRACT IS TERMINATED AS DESCRIBED IN SUBSECTION (4)(d)(I) OF THIS SECTION, AT THE TIME OF THE TERMINATION OF THE CONTRACT, THAT THE PATIENT HAS THE RIGHT TO ELECT CONTINUED TRANSITIONAL CARE FROM THE TREATING PROVIDER OR FACILITY IF THE TERMINATION OF THE CONTRACT AFFECTS THE STATUS OF THE PROVIDER OR FACILITY AS A PARTICIPATING PROVIDER;

(B) PROVIDE THE COVERED PERSON WITH AN OPPORTUNITY TO NOTIFY THE MANAGED CARE PLAN OR CARRIER OF THE NEED FOR

TRANSITIONAL CARE; AND

(C) PERMIT THE COVERED PERSON TO ELECT TO CONTINUE TO HAVE BENEFITS PROVIDED UNDER THE COVERED PERSON'S CURRENT PLAN OR COVERAGE UNDER THE SAME TERMS AND CONDITIONS AS WOULD HAVE APPLIED AND WITH RESPECT TO THE SAME ITEMS AND SERVICES AS WOULD HAVE BEEN COVERED HAD A TERMINATION DESCRIBED IN SUBSECTION (4)(d)(I) OF THIS SECTION NOT OCCURRED, WITH RESPECT TO THE COURSE OF TREATMENT FURNISHED BY THE PROVIDER OR FACILITY RELATING TO THE COVERED PERSON'S STATUS AS A CONTINUING CARE PATIENT DURING THE PERIOD BEGINNING ON THE DATE ON WHICH THE NOTICE UNDER SUBSECTION (4)(d)(II)(A) OF THIS SECTION IS PROVIDED AND ENDING ON THE NINETY-FIRST DAY AFTER THAT DATE OR THE DATE ON WHICH THE COVERED PERSON IS NO LONGER A CONTINUING CARE PATIENT WITH RESPECT TO THE PROVIDER OR FACILITY, WHICHEVER IS EARLIER.

(III) AS USED IN THIS SUBSECTION (4)(d);

(A) "CONTINUING CARE PATIENT" MEANS A COVERED PERSON WHO, WITH RESPECT TO A PROVIDER OR FACILITY WHOSE CONTRACT WITH THE COVERED PERSON'S CARRIER IS TERMINATED: IS UNDERGOING A COURSE OF TREATMENT FOR A SERIOUS AND COMPLEX MEDICAL CONDITION, WHICH COURSE OF TREATMENT IS PROVIDED BY THE PROVIDER OR FACILITY; IS UNDERGOING A COURSE OF INPATIENT CARE PROVIDED BY THE PROVIDER OR FACILITY; IS PREGNANT AND UNDERGOING A COURSE OF TREATMENT FOR THE PREGNANCY PROVIDED BY THE PROVIDER OR FACILITY; IS TERMINALLY ILL AS DETERMINED UNDER SECTION 1861 (dd)(3)(A) OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, AND IS RECEIVING TREATMENT FOR THE ILLNESS FROM THE PROVIDER OR FACILITY; OR IS SCHEDULED TO UNDERGO NONELECTIVE SURGERY FROM

THE PROVIDER OR FACILITY, INCLUDING THE RECEIPT OF POSTOPERATIVE CARE FROM THE PROVIDER OR FACILITY WITH RESPECT TO THE SURGERY.

(B) "SERIOUS AND COMPLEX MEDICAL CONDITION" MEANS, IN THE CASE OF ACUTE ILLNESS, A CONDITION THAT IS SERIOUS ENOUGH TO REQUIRE SPECIALIZED MEDICAL TREATMENT TO AVOID THE REASONABLE POSSIBILITY OF DEATH OR PERMANENT HARM OR, IN THE CASE OF A CHRONIC ILLNESS OR CONDITION, A CONDITION THAT IS LIFE-THREATENING, DEGENERATIVE, POTENTIALLY DISABLING, OR CONGENITAL AND REQUIRES SPECIALIZED MEDICAL CARE OVER A PROLONGED PERIOD OF TIME.

(C) "TERMINATED", WITH RESPECT TO A CONTRACT, MEANS THE EXPIRATION OR NONRENEWAL OF THE CONTRACT; EXCEPT THAT "TERMINATED" DOES NOT INCLUDE A CONTRACT TERMINATED FOR FAILURE TO MEET APPLICABLE QUALITY STANDARDS OR FOR FRAUD.

SECTION 4. In Colorado Revised Statutes, 12-30-112, **amend** (1) introductory portion, (1)(a), (1)(c), (1)(d), (1)(f), (1)(g), and (3); and **add** (1)(a.3), (1)(a.5), (1)(c.5), (1)(h), and (3.5) as follows:

12-30-112. Health-care providers - required disclosures - balance billing - rules - definitions. (1) ~~For the purposes of~~ AS USED IN this section and section 12-30-113:

(a) ~~"Carrier" has the same meaning as defined in section 10-16-102 (8).~~ "ANCILLARY SERVICES" MEANS:

(I) DIAGNOSTIC SERVICES, INCLUDING RADIOLOGY AND LABORATORY SERVICES, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO 42 U.S.C. SEC. 300gg-132 (b)(3);

(II) ITEMS AND SERVICES RELATED TO EMERGENCY MEDICINE,

ANESTHESIOLOGY, PATHOLOGY, RADIOLOGY, AND NEONATOLOGY, WHETHER OR NOT PROVIDED BY A PHYSICIAN OR NONPHYSICIAN PROVIDER, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

(III) ITEMS AND SERVICES PROVIDED BY ASSISTANT SURGEONS, HOSPITALISTS, AND INTENSIVISTS, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

(IV) ITEMS AND SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER IF THERE IS NO IN-NETWORK PROVIDER WHO CAN FURNISH THE NEEDED SERVICES AT THE FACILITY; AND

(V) ANY OTHER ITEMS AND SERVICES PROVIDED BY SPECIALTY PROVIDERS AS ESTABLISHED BY RULE OF THE COMMISSIONER.

(a.3) "BALANCE BILL" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-704 (20)(c).

(a.5) "CARRIER" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (8).

(c) "Emergency services" has the same meaning as ~~defined~~ SET FORTH in section 10-16-704 ~~(5.5)(c)(II)~~ (19)(e).

(c.5) "FEDERAL 'NO SURPRISES ACT'" MEANS THE FEDERAL "NO SURPRISES ACT", PUB.L. 116-260, AS AMENDED.

(d) "Geographic area" has the same meaning as ~~defined~~ SET FORTH in section 10-16-704 ~~(3)(d)(VI)(A)~~ (19)(h).

(f) "Medicare reimbursement rate" has the same meaning as

~~defined~~ SET FORTH in section 10-16-704 ~~(3)(d)(VI)(B)~~ (19)(k).

(g) "Out-of-network provider" means a health-care provider that is not a ~~"participating provider" as defined in section 10-16-102 (46)~~ PARTICIPATING PROVIDER.

(h) "PARTICIPATING PROVIDER" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (46).

(3) The ~~director~~ REGULATOR, in consultation with the commissioner of insurance and the state board of health created in section 25-1-103, shall adopt rules that specify the requirements for health-care providers to develop and provide consumer disclosures in accordance with this section. The ~~director~~ REGULATOR shall ensure that the rules, AT A MINIMUM, COMPLY WITH THE NOTICE AND CONSENT REQUIREMENTS IN SUBSECTION (3.5) OF ~~are consistent with sections 10-16-704 (12) and 25-3-121 and rules adopted by the commissioner pursuant to section 10-16-704 (12)(b) and by the state board of health pursuant to section 25-3-121 (2). The rules must specify, at a minimum, the following:~~

~~(a) The timing for providing the disclosures for emergency and nonemergency services with consideration given to potential limitations relating to the federal "Emergency Medical Treatment and Labor Act", 42 U.S.C. sec. 1395dd;~~

~~(b) Requirements regarding how the disclosures must be made, including requirements to include the disclosures on billing statements, billing notices, or other forms or communications with consumers;~~

~~(c) The contents of the disclosures, including the consumer's rights and payment obligations pursuant to the consumer's health benefit plan;~~

~~(d) Disclosure requirements specific to health-care providers,~~

~~including whether a health-care provider is out of network, the types of services an out-of-network health-care provider may provide, and the right to request an in-network health-care provider to provide services; and~~

~~(c) Requirements concerning the language to be used in the disclosures, including use of plain language, to ensure that carriers, health-care facilities, and health-care providers use language that is consistent with the disclosures required by this section and sections 10-16-704 (12) and 25-3-121 and the rules adopted pursuant to this subsection (3) and sections 10-16-704 (12)(b) and 25-3-121 (2)~~ THIS SECTION AND THE FEDERAL "NO SURPRISES ACT".

(3.5) (a) AN OUT-OF-NETWORK PROVIDER MAY BALANCE BILL A COVERED PERSON FOR SERVICES OTHER THAN ANCILLARY SERVICES IF:

(I) THE OUT-OF-NETWORK PROVIDER PROVIDES WRITTEN NOTICE THAT THE PROVIDER WILL BALANCE BILL A COVERED PERSON AT LEAST SEVEN DAYS IN ADVANCE OF THE DATE OF SERVICE, IF THE APPOINTMENT WAS SCHEDULED AT LEAST SEVEN DAYS IN ADVANCE, OR AT LEAST FORTY-EIGHT HOURS BEFORE THE SCHEDULED APPOINTMENT, IF THE APPOINTMENT WAS MADE LESS THAN SEVEN DAYS IN ADVANCE, IN EITHER PAPER OR ELECTRONIC FORMAT, AS SELECTED BY THE COVERED PERSON. THE NOTICE MUST BE AVAILABLE IN THE FIFTEEN MOST COMMON LANGUAGES IN THE GEOGRAPHIC REGION IN WHICH THE OUT-OF-NETWORK PROVIDER IS LOCATED. THE NOTICE MUST STATE:

(A) IF APPLICABLE, THAT THE HEALTH-CARE PROVIDER IS OUT OF NETWORK WITH RESPECT TO THE COVERED PERSON'S HEALTH BENEFIT PLAN;

(B) EFFECTIVE UPON THE IMPLEMENTATION DATE OF THE

APPLICABLE FEDERAL RULES, A GOOD-FAITH ESTIMATE OF THE AMOUNT OF THE CHARGES FOR WHICH THE COVERED PERSON MAY BE RESPONSIBLE;

(C) THAT THE ESTIMATE OR CONSENT TO TREATMENT DOES NOT CONSTITUTE A CONTRACT FOR SERVICES;

(D) IF THE FACILITY IS A PARTICIPATING PROVIDER AND THE HEALTH-CARE PROVIDER IS AN OUT-OF-NETWORK PROVIDER, A LIST OF PARTICIPATING PROVIDERS AT THE FACILITY WHO ARE ABLE TO PROVIDE THE SAME SERVICES AND, IF THE SERVICE IS SCHEDULED AT LEAST TEN DAYS BEFORE THE DATE THE NOTICE IN THIS SUBSECTION (3.5)(a)(I) WAS RECEIVED, THAT THE COVERED PERSON MAY USE THE OUT-OF-NETWORK PROVIDER SERVICES AT THE IN-NETWORK BENEFIT LEVEL;

(E) INFORMATION ABOUT WHETHER PRIOR AUTHORIZATION OR OTHER CARE MANAGEMENT LIMITATIONS MAY BE REQUIRED IN ADVANCE OF RECEIVING THE REQUESTED SERVICES; AND

(F) THAT CONSENT TO RECEIVE THE SERVICES FROM AN OUT-OF-NETWORK PROVIDER IS OPTIONAL AND THAT THE COVERED PERSON MAY SEEK SERVICES FROM A PARTICIPATING PROVIDER, IN WHICH CASE THE COST-SHARING RESPONSIBILITY OF THE COVERED PERSON WOULD NOT EXCEED THE RESPONSIBILITY FOR IN-NETWORK BENEFITS UNDER THE COVERED PERSON'S HEALTH BENEFIT PLAN; AND

(II) THE OUT-OF-NETWORK PROVIDER OBTAINS SIGNED CONSENT FROM THE COVERED PERSON THAT ACKNOWLEDGES THAT THE COVERED PERSON HAS BEEN:

(A) PROVIDED WITH WRITTEN NOTICE OF THE COVERED PERSON'S FINANCIAL RESPONSIBILITY, IN THE FORMAT AND LANGUAGE SELECTED BY THE COVERED PERSON AND WITHIN THE APPLICABLE PERIODS SPECIFIED IN SUBSECTION (3.5)(a)(I) OF THIS SECTION; AND

(B) PROVIDED WRITTEN NOTICE THAT THE PAYMENT BY THE COVERED PERSON FOR HEALTH-CARE SERVICES PROVIDED BY THE OUT-OF-NETWORK PROVIDER MAY NOT ACCRUE TOWARD MEETING ANY LIMITATION THAT THE HEALTH BENEFIT PLAN PLACES ON COST SHARING, INCLUDING AN EXPLANATION THAT THE PAYMENT MAY NOT APPLY TO AN IN-NETWORK DEDUCTIBLE.

(b) THE NOTICE AND CONSENT REQUIRED BY THIS SUBSECTION (3.5) MUST INCLUDE THE DATE AND THE TIME AT WHICH THE COVERED PERSON RECEIVED THE WRITTEN NOTICE AND THE DATE ON WHICH THE CONSENT FORM WAS SIGNED. THE OUT-OF-NETWORK PROVIDER SHALL PROVIDE A SIGNED COPY OF THE CONSENT FORM TO THE COVERED PERSON THROUGH REGULAR OR ELECTRONIC MAIL.

(c) AN OUT-OF-NETWORK PROVIDER THAT OBTAINS A SIGNED CONSENT WITH RESPECT TO FURNISHING AN ITEM OR SERVICE SHALL RETAIN THE SIGNED CONSENT FOR AT LEAST A SEVEN-YEAR PERIOD AFTER THE DATE ON WHICH SUCH ITEM OR SERVICE IS FURNISHED.

SECTION 5. In Colorado Revised Statutes, 25-3-121, **amend** (2), (4) introductory portion, (4)(a), (4)(c), (4)(d), (4)(f), and (4)(g); and **add** (3.5), (4)(a.3), (4)(a.5), (4)(c.5), and (4)(h) as follows:

25-3-121. Health-care facilities - emergency and nonemergency services - required disclosures - balance billing - rules - definitions. (2) The state board of health, in consultation with the commissioner of insurance and the ~~director of~~ APPLICABLE REGULATORS OF HEALTH-CARE PROVIDERS IN the division of professions and occupations in the department of regulatory agencies, shall adopt rules that specify the requirements for health-care facilities to develop and provide consumer disclosures in accordance with this section. The state

board of health shall ensure that the rules, AT A MINIMUM, COMPLY WITH THE NOTICE AND CONSENT REQUIREMENTS IN SUBSECTION (3.5) OF THIS ~~are consistent with sections 10-16-704 (12) and 12-30-112 and rules adopted by the commissioner pursuant to section 10-16-704 (12)(b) and by the director of the division of professions and occupations pursuant to section 12-30-112 (3). The rules must specify, at a minimum, the following:~~

~~(a) The timing for providing the disclosures for emergency and nonemergency services with consideration given to potential limitations relating to the federal "Emergency Medical Treatment and Labor Act", 42 U.S.C. sec. 1395dd;~~

~~(b) Requirements regarding how the disclosures must be made, including requirements to include the disclosures on billing statements, billing notices, or other forms or communications with covered persons;~~

~~(c) The contents of the disclosures, including the consumer's rights and payment obligations pursuant to the consumer's health benefit plan;~~

~~(d) Disclosure requirements specific to health-care facilities, including whether a health-care provider delivering services at the facility is out of network, the types of services an out-of-network health-care provider may provide, and the right to request an in-network health-care provider to provide services; and~~

~~(e) Requirements concerning the language to be used in the disclosures, including use of plain language, to ensure that carriers, health-care facilities, and health-care providers use language that is consistent with the disclosures required by this section and sections 10-16-704 (12) and 12-30-112 and the rules adopted pursuant to this~~

~~subsection (2) and sections 10-16-704 (12)(b) and 12-30-112 (3)~~ SECTION AND THE FEDERAL "NO SURPRISES ACT".

(3.5) (a) AN OUT-OF-NETWORK FACILITY MAY BALANCE BILL A COVERED PERSON FOR SERVICES OTHER THAN ANCILLARY SERVICES IF:

(I) THE OUT-OF-NETWORK FACILITY PROVIDES WRITTEN NOTICE THAT THE FACILITY WILL BALANCE BILL A COVERED PERSON AT LEAST SEVEN DAYS IN ADVANCE OF THE DATE OF SERVICE, IF THE APPOINTMENT WAS SCHEDULED AT LEAST SEVEN DAYS IN ADVANCE, OR AT LEAST FORTY-EIGHT HOURS BEFORE THE SCHEDULED APPOINTMENT, IF THE APPOINTMENT WAS MADE LESS THAN SEVEN DAYS IN ADVANCE, IN EITHER PAPER OR ELECTRONIC FORMAT, AS SELECTED BY THE COVERED PERSON. THE NOTICE MUST BE AVAILABLE IN THE FIFTEEN MOST COMMON LANGUAGES IN THE GEOGRAPHIC REGION IN WHICH THE OUT-OF-NETWORK FACILITY IS LOCATED. THE NOTICE MUST STATE:

(A) IF APPLICABLE, THAT THE FACILITY IS OUT OF NETWORK WITH RESPECT TO THE COVERED PERSON'S HEALTH BENEFIT PLAN;

(B) EFFECTIVE UPON THE IMPLEMENTATION DATE OF THE APPLICABLE FEDERAL RULES, A GOOD-FAITH ESTIMATE OF THE AMOUNT OF THE CHARGES FOR WHICH THE COVERED PERSON MAY BE RESPONSIBLE;

(C) THAT THE ESTIMATE OR CONSENT TO TREATMENT DOES NOT CONSTITUTE A CONTRACT FOR SERVICES;

(D) INFORMATION ABOUT WHETHER PRIOR AUTHORIZATION OR OTHER CARE MANAGEMENT LIMITATIONS MAY BE REQUIRED IN ADVANCE OF RECEIVING THE REQUESTED SERVICES; AND

(E) THAT CONSENT TO RECEIVE THE SERVICES AT AN OUT-OF-NETWORK FACILITY IS OPTIONAL AND THAT THE COVERED PERSON

MAY SEEK SERVICES FROM A PARTICIPATING PROVIDER, IN WHICH CASE THE COST-SHARING RESPONSIBILITY OF THE COVERED PERSON WOULD NOT EXCEED THE RESPONSIBILITY FOR IN-NETWORK BENEFITS UNDER THE COVERED PERSON'S HEALTH BENEFIT PLAN;

(II) THE OUT-OF-NETWORK FACILITY OBTAINS SIGNED CONSENT FROM THE COVERED PERSON THAT ACKNOWLEDGES THAT THE COVERED PERSON HAS BEEN:

(A) PROVIDED WITH WRITTEN NOTICE OF THE COVERED PERSON'S FINANCIAL RESPONSIBILITY, IN THE FORMAT AND LANGUAGE SELECTED BY THE COVERED PERSON AND WITHIN THE APPLICABLE PERIODS SPECIFIED IN SUBSECTION (3.5)(a)(I) OF THIS SECTION; AND

(B) PROVIDED WRITTEN NOTICE THAT THE PAYMENT BY THE COVERED PERSON FOR HEALTH-CARE SERVICES PROVIDED AT THE OUT-OF-NETWORK FACILITY MAY NOT ACCRUE TOWARD MEETING ANY LIMITATION THAT THE HEALTH BENEFIT PLAN PLACES ON COST SHARING, INCLUDING AN EXPLANATION THAT THE PAYMENT MAY NOT APPLY TO AN IN-NETWORK DEDUCTIBLE.

(b) THE NOTICE AND CONSENT REQUIRED BY THIS SUBSECTION (3.5) MUST INCLUDE THE DATE ON WHICH THE COVERED PERSON RECEIVED THE WRITTEN NOTICE AND THE DATE AND THE TIME AT WHICH THE CONSENT FORM WAS SIGNED. THE OUT-OF-NETWORK FACILITY SHALL PROVIDE A SIGNED COPY OF THE CONSENT FORM TO THE COVERED PERSON THROUGH REGULAR OR ELECTRONIC MAIL.

(c) AN OUT-OF-NETWORK FACILITY THAT OBTAINS A SIGNED CONSENT WITH RESPECT TO FURNISHING AN ITEM OR SERVICE SHALL RETAIN THE SIGNED CONSENT FOR AT LEAST A SEVEN-YEAR PERIOD AFTER THE DATE ON WHICH SUCH ITEM OR SERVICE IS FURNISHED.

(4) ~~For the purposes of~~ AS USED IN this section and section 25-3-122:

(a) ~~"Carrier" has the same meaning as defined in section 10-16-102 (8).~~ "ANCILLARY SERVICES" MEANS:

(I) DIAGNOSTIC SERVICES, INCLUDING RADIOLOGY AND LABORATORY SERVICES, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO 42 U.S.C. SEC. 300gg-132 (b)(3);

(II) ITEMS AND SERVICES RELATED TO EMERGENCY MEDICINE, ANESTHESIOLOGY, PATHOLOGY, RADIOLOGY, AND NEONATOLOGY, WHETHER OR NOT PROVIDED BY A PHYSICIAN OR NONPHYSICIAN PROVIDER, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

(III) ITEMS AND SERVICES PROVIDED BY ASSISTANT SURGEONS, HOSPITALISTS, AND INTENSIVISTS, UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

(IV) ITEMS AND SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER IF THERE IS NO IN-NETWORK PROVIDER WHO CAN FURNISH THE NEEDED SERVICES AT THE FACILITY; AND

(V) ANY OTHER ITEMS AND SERVICES PROVIDED BY SPECIALTY PROVIDERS AS ESTABLISHED BY RULE OF THE COMMISSIONER.

(a.3) "BALANCE BILL" HAS THE SAME MEANING AS SET FORTH IN

SECTION 10-16-704 (20)(c).

(a.5) "CARRIER" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (8).

(c) "Emergency services" has the same meaning as ~~defined~~ SET FORTH in section 10-16-704 ~~(5.5)(c)(II)~~ (19)(e).

(c.5) "FEDERAL 'NO SURPRISES ACT'" MEANS THE FEDERAL "NO SURPRISES ACT", PUB.L. 116-260, AS AMENDED.

(d) "Geographic area" has the same meaning as ~~defined~~ SET FORTH in section 10-16-704 ~~(3)(d)(VI)(A)~~ (19)(h).

(f) "Medicare reimbursement rate" has the same meaning as ~~defined~~ SET FORTH in section 10-16-704 ~~(3)(d)(VI)(B)~~ (19)(k).

(g) "Out-of-network facility" means a health-care facility that is not a participating provider. ~~as defined in section 10-16-102 (46).~~

(h) "PARTICIPATING PROVIDER" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (46).

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

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

(mmm) Violates section ~~12-30-113~~ 12-30-112;

SECTION 7. In Colorado Revised Statutes, 10-16-133, **add** (6) as follows:

10-16-133. Health insurance carrier information disclosure - website - insurance producer fees and disclosure requirements - legislative declaration - rules. (6) (a) A CARRIER OFFERING INDIVIDUAL HEALTH BENEFIT PLANS OR SHORT-TERM LIMITED DURATION HEALTH

INSURANCE POLICIES SHALL DISCLOSE TO THE COVERED PERSON THE AMOUNT OF COMPENSATION ASSOCIATED WITH PLAN SELECTION AND ENROLLMENT CONSISTENT WITH, THE FEDERAL "NO SURPRISES ACT", PUB.L. 116-260, AS AMENDED.

(b) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT THE CARRIER DISCLOSURE REQUIREMENTS UNDER THIS SUBSECTION (6).

SECTION 8. Appropriation. (1) For the 2022-23 state fiscal year, $233,018 is appropriated to the department of regulatory agencies. This appropriation is from the division of insurance cash fund created in section 10-1-103 (3), C.R.S. To implement this act, the department may use this appropriation as follows:

(a) $129,745 for use by the division of insurance for personal services, which amount is based on an assumption that the division will require an additional 1.6 FTE;

(b) $14,560 for use by the division of insurance for operating expenses; and

(c) $88,713 for the purchase of legal services.

(2) For the 2022-23 state fiscal year, $88,713 is appropriated to the department of law. This appropriation is from reappropriated funds received from the department of regulatory agencies under subsection (1)(c) of this section and is based on an assumption that the department of law will require an additional 0.5 FTE. To implement this act, the department of law may use this appropriation to provide legal services for the department of regulatory agencies.

(3) For the 2022-23 state fiscal year, $7,506 is appropriated to the department of public health and environment for use by administration

and support. This appropriation is from the health facilities general licensure cash fund created in section 25-3-103.1 (1), C.R.S., and is based on an assumption that the department will require an additional 0.1 FTE. To implement this act, the department may use this appropriation for personal services related to administration.

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.