First Regular Session
Seventy-second General Assembly
STATE OF COLORADO

PREAMENDED

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

LLS NO. 19-0709.01 Kristen Forrestal x4217

HOUSE BILL 19-1174

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A BILL FOR AN ACT

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

HOUSE
3rd Reading Unamended
March 22, 2019

HOUSE
Amended 2nd Reading
March 21, 2019

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

in-network and out-of-network facilities;

- Outlines the disclosure requirements and the claims and payment process for the provision of out-of-network services;
- Requires the commissioner of insurance, the state board of health, and the director of the division of professions and occupations in the department of regulatory agencies to promulgate rules that specify the requirements for disclosures to consumers, including the timing, the format, and the contents and language in the disclosures;
- Establishes the reimbursement amount for out-of-network providers that provide health care services to covered persons at an in-network facility and for out-of-network providers or facilities that provide emergency services to covered persons; and
- Creates a penalty for failure to comply with the payment requirements for out-of-network health care services.

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

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

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

(lll) VIOLATES SECTION 24-34-114.

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

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

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

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

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

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

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

ACCESS TO ACCURATE INFORMATION ABOUT THEIR HEALTH CARE BILLS AND THEIR PAYMENT OBLIGATIONS IN ORDER TO ENABLE THEM TO MAKE INFORMED DECISIONS ABOUT THEIR HEALTH CARE AND FINANCIAL OBLIGATIONS.

(d) (I) IF A COVERED PERSON RECEIVES COVERED SERVICES AT AN IN-NETWORK FACILITY FROM AN OUT-OF-NETWORK PROVIDER, THE CARRIER SHALL PAY THE OUT-OF-NETWORK PROVIDER DIRECTLY AND IN ACCORDANCE WITH THIS SUBSECTION (3)(d). AT THE TIME OF THE DISPOSITION OF THE CLAIM, THE CARRIER SHALL ADVISE THE OUT-OF-NETWORK PROVIDER AND THE COVERED PERSON OF ANY REQUIRED COINSURANCE, DEDUCTIBLE, OR COPAYMENT.

(II) WHEN THE REQUIREMENTS OF SUBSECTION (3)(b) OF THIS SECTION APPLY, THE CARRIER SHALL REIMBURSE THE OUT-OF-NETWORK PROVIDER DIRECTLY IN ACCORDANCE WITH SECTION 10-16-106.5 THE GREATER OF:

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

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

(III) PAYMENT MADE BY A CARRIER IN COMPLIANCE WITH THIS SUBSECTION (3)(d) IS PRESUMED TO BE PAYMENT IN FULL FOR THE SERVICES PROVIDED, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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 PROVIDER IN ACCORDANCE WITH SUBSECTION (3)(d)(II) OF THIS SECTION AND REIMBURSE THE OUT-OF-NETWORK FACILITY DIRECTLY IN ACCORDANCE WITH SECTION 10-16-106.5 THE GREATER OF:

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

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

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

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

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

(C) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR BASED ON CLAIMS DATA FROM

THE COLORADO ALL-PAYER HEALTH CLAIMS DATABASE DESCRIBED IN SECTION 25.5-1-204.

(III) PAYMENT MADE BY A CARRIER IN COMPLIANCE WITH THIS SUBSECTION (5.5)(b) IS PRESUMED TO BE PAYMENT IN FULL FOR THE SERVICES PROVIDED, EXCEPT FOR ANY COINSURANCE, DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED TO BE PAID BY THE COVERED PERSON.

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

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

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

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

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

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

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

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

(B) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

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

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

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

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

TRANSFER OF THE INDIVIDUAL FROM A FACILITY.

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

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

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

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

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

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

(III) THE CONTENTS OF THE DISCLOSURES, INCLUDING THE COVERED PERSON'S RIGHTS AND PAYMENT OBLIGATIONS IF THE COVERED

PERSON'S HEALTH BENEFIT PLAN IS UNDER THE JURISDICTION OF THE DIVISION;

(IV) DISCLOSURE REQUIREMENTS SPECIFIC TO CARRIERS, INCLUDING THE POSSIBILITY OF BEING TREATED BY AN OUT-OF-NETWORK PROVIDER, WHETHER A PROVIDER IS OUT OF NETWORK, THE TYPES OF SERVICES AN OUT-OF-NETWORK PROVIDER MAY PROVIDE, AND THE RIGHT TO REQUEST AN IN-NETWORK PROVIDER TO PROVIDE SERVICES; AND

(V) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT CARRIERS, HEALTH CARE FACILITIES, AND PROVIDERS USE LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY THIS SUBSECTION (12) AND SECTIONS 24-34-113 AND 25-3-120 AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (12)(b) AND SECTIONS 24-34-113 (3) AND 25-3-120 (2).

(c) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SUBSECTION (12) DOES NOT WAIVE A COVERED PERSON'S PROTECTIONS UNDER SUBSECTION (3) OR (5.5) OF THIS SECTION OR THE RIGHT TO BENEFITS UNDER THE HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.

(13) WHEN A CARRIER MAKES A PAYMENT TO A PROVIDER OR A HEALTH CARE FACILITY PURSUANT TO SUBSECTION (3)(d) OR (5.5)(b) OF THIS SECTION, THE PROVIDER OR THE FACILITY MAY REQUEST AND THE COMMISSIONER SHALL COLLECT DATA FROM THE CARRIER TO EVALUATE THE CARRIER'S COMPLIANCE IN PAYING THE HIGHEST RATE REQUIRED. THE INFORMATION REQUESTED MAY INCLUDE THE METHODOLOGY FOR DETERMINING THE CARRIER'S MEDIAN IN-NETWORK RATE OR REIMBURSEMENT FOR EACH SERVICE IN THE SAME GEOGRAPHIC AREA.

(14) ON OR BEFORE JANUARY 1 OF EACH YEAR, EACH CARRIER SHALL SUBMIT INFORMATION TO THE COMMISSIONER, IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER, CONCERNING THE USE OF OUT-OF-NETWORK PROVIDERS AND FACILITIES BY COVERED PERSONS AND THE IMPACT ON PREMIUM AFFORDABILITY FOR CONSUMERS.

(15) (a) (I) IF A PROVIDER OR A HEALTH CARE FACILITY BELIEVES THAT A PAYMENT MADE PURSUANT TO SUBSECTION (3) OR (5.5) OF THIS SECTION OR SECTION 24-34-114 OR A HEALTH CARE FACILITY BELIEVES THAT A PAYMENT MADE PURSUANT TO SUBSECTION (5.5) OF THIS SECTION OR SECTION 25-3-121 (3) WAS NOT SUFFICIENT GIVEN THE COMPLEXITY AND CIRCUMSTANCES OF THE SERVICES PROVIDED, THE PROVIDER OR THE HEALTH CARE FACILITY MAY INITIATE ARBITRATION BY FILING A REQUEST FOR ARBITRATION WITH THE COMMISSIONER AND THE CARRIER. A PROVIDER OR HEALTH CARE FACILITY MUST SUBMIT A REQUEST FOR THE ARBITRATION OF A CLAIM WITHIN NINETY DAYS AFTER THE RECEIPT OF PAYMENT FOR THAT CLAIM.

(II) PRIOR TO ARBITRATION UNDER SUBSECTION (15)(a)(I) OF THIS SECTION, IF REQUESTED BY THE CARRIER AND THE PROVIDER OR HEALTH CARE FACILITY, THE COMMISSIONER MAY ARRANGE AN INFORMAL SETTLEMENT TELECONFERENCE TO BE HELD WITHIN THIRTY DAYS AFTER THE REQUEST FOR ARBITRATION. THE PARTIES SHALL NOTIFY THE COMMISSIONER OF THE RESULTS OF THE SETTLEMENT CONFERENCE.

(III) UPON RECEIPT OF NOTICE THAT THE SETTLEMENT TELECONFERENCE WAS UNSUCCESSFUL, THE COMMISSIONER SHALL APPOINT AN ARBITRATOR AND NOTIFY THE PARTIES OF THE ARBITRATION.

(b) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT AN ARBITRATION PROCESS THAT ESTABLISHES A STANDARD ARBITRATION

FORM AND INCLUDES THE SELECTION OF AN ARBITRATOR FROM A LIST OF QUALIFIED ARBITRATORS DEVELOPED PURSUANT TO THE RULES. QUALIFIED ARBITRATORS MUST BE INDEPENDENT; NOT BE AFFILIATED WITH A CARRIER, HEALTH CARE FACILITY, OR PROVIDER, OR ANY PROFESSIONAL ASSOCIATION OF CARRIERS, HEALTH CARE FACILITIES, OR PROVIDERS; NOT HAVE A PERSONAL, PROFESSIONAL, OR FINANCIAL CONFLICT WITH ANY PARTIES TO THE ARBITRATION; AND HAVE EXPERIENCE IN HEALTH CARE BILLING AND REIMBURSEMENT RATES.

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

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

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

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

(e) THE PARTY WHOSE FINAL OFFER AMOUNT WAS NOT SELECTED

BY THE ARBITRATOR SHALL PAY THE ARBITRATOR'S EXPENSES AND FEES.

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

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

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

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

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

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

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

(c) "EMERGENCY SERVICES" HAS THE SAME MEANING AS DEFINED

IN SECTION 10-16-704 (5.5)(e)(II).

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

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

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

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

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

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

(3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR HEALTH CARE PROVIDERS ____ TO DEVELOP AND PROVIDE CONSUMER DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE DIRECTOR SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTION 10-16-704 (12) AND 25-3-120 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE STATE BOARD OF HEALTH PURSUANT TO SECTION 25-3-120 (2). THE RULES MUST SPECIFY, AT A

MINIMUM, THE FOLLOWING:

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

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

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

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

(e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY THIS SECTION AND SECTIONS 10-16-704 (12) AND 25-3-120 AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (3) AND SECTIONS 10-16-704 (12)(b) AND 25-3-120 (2).

(4) RECEIPT OF THE DISCLOSURES REQUIRED BY THIS SECTION DOES NOT WAIVE A CONSUMER'S PROTECTIONS UNDER SECTION 10-16-704 (3) OR (5.5) OR THE CONSUMER'S RIGHT TO BENEFITS UNDER THE

CONSUMER'S HEALTH BENEFIT PLAN AT THE IN-NETWORK BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED.

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

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

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

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

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

(b) AN OUT-OF-NETWORK HEALTH CARE PROVIDER THAT FAILS TO

REIMBURSE A COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF THIS SECTION FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE OVERPAYMENT AT THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON THE DATE THE PROVIDER RECEIVED THE NOTICE OF THE OVERPAYMENT. THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED INTEREST FROM THE OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.

(3) AN OUT-OF-NETWORK HEALTH CARE PROVIDER SHALL PROVIDE A COVERED PERSON A WRITTEN ESTIMATE OF THE AMOUNT FOR WHICH THE COVERED PERSON MAY BE RESPONSIBLE FOR COVERED NONEMERGENCY SERVICES WITHIN THREE BUSINESS DAYS AFTER A REQUEST FROM THE COVERED PERSON.

(4) (a) AN OUT-OF-NETWORK HEALTH CARE PROVIDER MUST SEND A CLAIM FOR A COVERED SERVICE TO THE CARRIER WITHIN ONE HUNDRED EIGHTY DAYS AFTER THE RECEIPT OF INSURANCE INFORMATION IN ORDER TO RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (4)(a). THE REIMBURSEMENT RATE IS THE GREATER OF:

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

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

(b) IF THE OUT-OF-NETWORK HEALTH CARE PROVIDER SUBMITS A CLAIM FOR COVERED SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY

PERIOD SPECIFIED IN SUBSECTION (4)(a) OF THIS SECTION, THE CARRIER SHALL REIMBURSE THE HEALTH CARE PROVIDER ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME SERVICES IN THE SAME GEOGRAPHIC AREA.

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

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

SECTION 6. In Colorado Revised Statutes, **add** 25-3-120 and 25-3-121 as follows:

25-3-120. Health care facilities - emergency and nonemergency services - required disclosures - rules - definitions. (1) ON AND AFTER JANUARY 1, 2020, HEALTH CARE FACILITIES SHALL DEVELOP AND PROVIDE DISCLOSURES TO CONSUMERS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER PROVIDING SERVICES AT AN IN-NETWORK FACILITY OR EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY. THE DISCLOSURES MUST COMPLY WITH THE RULES ADOPTED PURSUANT TO SUBSECTION (2) OF THIS SECTION.

(2) THE STATE BOARD OF HEALTH, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE AND THE DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS IN THE DEPARTMENT OF REGULATORY AGENCIES, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR

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

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

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

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

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

(e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT

CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY THIS SECTION AND SECTIONS 10-16-704 (12) AND 24-34-113 AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (2) AND SECTIONS 10-16-704 (12)(b) AND 24-34-113 (3).

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

(4) FOR THE PURPOSES OF THIS SECTION AND SECTION 25-3-121:

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

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

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

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

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

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

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

25-3-121. Out-of-network facilities - emergency medical

services - billing - payment. (1) IF A COVERED PERSON RECEIVES EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE OUT-OF-NETWORK FACILITY SHALL:

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

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

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

(b) AN OUT-OF-NETWORK FACILITY THAT FAILS TO REIMBURSE A COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF THIS SECTION FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE OVERPAYMENT AT THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON THE DATE THE FACILITY RECEIVED THE NOTICE OF THE OVERPAYMENT. THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED INTEREST FROM THE OUT-OF-NETWORK HEALTH CARE FACILITY IN ORDER TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.

(3) (a) AN OUT-OF-NETWORK FACILITY, OTHER THAN ANY OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER HEALTH AND

HOSPITAL AUTHORITY PURSUANT TO ARTICLE 29 OF TITLE 25, MUST SEND A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE HUNDRED EIGHTY DAYS AFTER THE RECEIPT OF INSURANCE INFORMATION IN ORDER TO RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (3)(a). THE REIMBURSEMENT RATE IS THE GREATER OF:

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

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

(b) AN OUT-OF-NETWORK FACILITY OPERATED BY THE DENVER HEALTH AND HOSPITAL AUTHORITY CREATED IN SECTION 25-29-103 MUST SEND A CLAIM FOR EMERGENCY SERVICES TO THE CARRIER WITHIN ONE HUNDRED EIGHTY DAYS AFTER THE DELIVERY OF SERVICES IN ORDER TO RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (3)(b). THE REIMBURSEMENT RATE IS THE GREATER OF:

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

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

(III) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE

SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR __ BASED ON CLAIMS DATA FROM THE COLORADO ALL-PAYER HEALTH CLAIMS DATABASE DESCRIBED IN SECTION 25.5-1-204.

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

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

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

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

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

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

(j) TO VIOLATE SECTION 25-3-121.

SECTION 8. In Colorado Revised Statutes, **add to article 30 as relocated by House Bill 19-1172** 12-30-111 and 12-30-112 as follows:

12-30-111. Health care providers - required disclosures - rules - definitions. (1) FOR THE PURPOSES OF THIS SECTION AND SECTION 12-30-112:

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

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

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

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

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

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

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

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

(3) THE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE AND THE STATE BOARD OF HEALTH CREATED IN SECTION 25-1-103, SHALL ADOPT RULES THAT SPECIFY THE REQUIREMENTS FOR

HEALTH CARE PROVIDERS TO DEVELOP AND PROVIDE CONSUMER DISCLOSURES IN ACCORDANCE WITH THIS SECTION. THE DIRECTOR SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTIONS 10-16-704 (12) AND 25-3-120 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE STATE BOARD OF HEALTH PURSUANT TO SECTION 25-3-120 (2). THE RULES MUST SPECIFY, AT A MINIMUM, THE FOLLOWING:

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

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

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

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

(e) REQUIREMENTS CONCERNING THE LANGUAGE TO BE USED IN THE DISCLOSURES, INCLUDING USE OF PLAIN LANGUAGE, TO ENSURE THAT CARRIERS, HEALTH CARE FACILITIES, AND HEALTH CARE PROVIDERS USE LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY

THIS SECTION AND SECTIONS 10-16-704 (12) AND 25-3-120 AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (3) AND SECTIONS 10-16-704 (12)(b) AND 25-3-120 (2).

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

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

12-30-112. Out-of-network health care providers - out-of-network services - billing - payment. (1) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES EMERGENCY SERVICES OR COVERED NONEMERGENCY SERVICES TO A COVERED PERSON AT AN IN-NETWORK FACILITY, THE OUT-OF-NETWORK PROVIDER SHALL:

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

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

(2) (a) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES COVERED NONEMERGENCY SERVICES AT AN IN-NETWORK FACILITY OR EMERGENCY SERVICES AT AN OUT-OF-NETWORK OR IN-NETWORK FACILITY AND THE HEALTH CARE PROVIDER RECEIVES PAYMENT FROM THE COVERED

PERSON FOR SERVICES FOR WHICH THE COVERED PERSON IS NOT RESPONSIBLE PURSUANT TO SECTION 10-16-704 (3)(b) OR (5.5), THE HEALTH CARE PROVIDER SHALL REIMBURSE THE COVERED PERSON WITHIN SIXTY CALENDAR DAYS AFTER THE DATE THAT THE OVERPAYMENT WAS REPORTED TO THE PROVIDER.

(b) AN OUT-OF-NETWORK HEALTH CARE PROVIDER THAT FAILS TO REIMBURSE A COVERED PERSON AS REQUIRED BY SUBSECTION (2)(a) OF THIS SECTION FOR AN OVERPAYMENT SHALL PAY INTEREST ON THE OVERPAYMENT AT THE RATE OF TEN PERCENT PER ANNUM BEGINNING ON THE DATE THE PROVIDER RECEIVED THE NOTICE OF THE OVERPAYMENT. THE COVERED PERSON IS NOT REQUIRED TO REQUEST THE ACCRUED INTEREST FROM THE OUT-OF-NETWORK HEALTH CARE PROVIDER IN ORDER TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.

(3) AN OUT-OF-NETWORK HEALTH CARE PROVIDER SHALL PROVIDE A COVERED PERSON A WRITTEN ESTIMATE OF THE AMOUNT FOR WHICH THE COVERED PERSON MAY BE RESPONSIBLE FOR COVERED NONEMERGENCY SERVICES WITHIN THREE BUSINESS DAYS AFTER A REQUEST FROM THE COVERED PERSON.

(4) (a) AN OUT-OF-NETWORK HEALTH CARE PROVIDER MUST SEND A CLAIM FOR A COVERED SERVICE TO THE CARRIER WITHIN ONE HUNDRED EIGHTY DAYS AFTER THE RECEIPT OF INSURANCE INFORMATION IN ORDER TO RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (4)(a). THE REIMBURSEMENT RATE IS THE GREATER OF:

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

(II) THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE

SAME SERVICE IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR BASED ON CLAIMS DATA FROM THE ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

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

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

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

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

(2) For the 2019-20 state fiscal year, $16,340 is appropriated to the department of regulatory agencies for use by the division of insurance. This appropriation is from the division of insurance cash fund created in

section 10-1-103 (3), C.R.S. To implement this act, the division may use this appropriation as follows:

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

(b) $190 for operating expenses.

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

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

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

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