First Regular Session
Seventy-second General Assembly
STATE OF COLORADO

INTRODUCED

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.

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 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).

SECTION 3. 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), and (12) 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 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) THE CARRIER'S AVERAGE IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE IN THE SAME GEOGRAPHIC AREA;

(B) ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA; OR

(C) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR AS DETERMINED 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) 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 AT OR FROM AN IN-NETWORK PROVIDER AT AN IN-NETWORK FACILITY.

~~(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, 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 AVERAGE IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA;

(B) ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR

(C) ONE HUNDRED PERCENT OF 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 AS DETERMINED BASED ON CLAIMS DATA FROM THE COLORADO ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

(II) 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 REQUIRED TO BE PAID BY THE COVERED PERSON.

(c) THIS SUBSECTION (5.5) DOES NOT PRECLUDE THE CARRIER AND THE OUT-OF-NETWORK FACILITY 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) 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 (2) AND 25-3-120 AND THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (12)(b) AND SECTIONS 24-34-113 (3) AND 25-3-120 (2).

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

SECTION 4. 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)(d)(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 REGULATED UNDER TITLE 12 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 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

(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 SUBSECTION (2) OF 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.

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 REQUIRED TO BE PAID BY THE COVERED PERSON.

(2) (a) IF AN OUT-OF-NETWORK HEALTH CARE PROVIDER PROVIDES 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 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 DELIVERY OF SERVICES IN ORDER TO RECEIVE REIMBURSEMENT AS SPECIFIED IN THIS SUBSECTION (4)(a). THE REIMBURSEMENT RATE IS THE GREATER OF:

(I) THE CARRIER'S AVERAGE IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN THE SAME GEOGRAPHIC AREA;

(II) ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA; OR

(III) ONE HUNDRED PERCENT OF THE MEDIAN IN-NETWORK RATE OF REIMBURSEMENT FOR THE SAME SERVICE IN THE SAME GEOGRAPHIC AREA FOR THE PRIOR YEAR AS DETERMINED 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 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 REQUIRED TO BE PAID BY THE COVERED PERSON.

SECTION 5. 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 UNDER 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 (2) 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 "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, 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 (2) AND THE

RULES ADOPTED PURSUANT TO THIS SUBSECTION (2) AND SECTIONS 10-16-704 (12) AND 24-34-113 (3).

(3) RECEIPT OF THE DISCLOSURE REQUIRED BY SUBSECTION (1) OF 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) "GEOGRAPHIC AREA" HAS THE SAME MEANING AS DEFINED IN SECTION 10-16-704 (3)(d)(V)(A).

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

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

(f) "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 THE COVERED PERSON FOR ANY OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE, DEDUCTIBLE, OR COPAYMENT 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 (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 PROVIDER IN ORDER TO RECEIVE INTEREST WITH THE REIMBURSEMENT AMOUNT.

(3) (a) AN OUT-OF-NETWORK FACILITY 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)(a). THE REIMBURSEMENT RATE IS THE GREATER OF:

(I) THE CARRIER'S AVERAGE IN-NETWORK RATE OF REIMBURSEMENT FOR THAT SERVICE PROVIDED IN A SIMILAR FACILITY OR

SETTING IN THE SAME GEOGRAPHIC AREA;

(II) ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME SERVICE PROVIDED IN A SIMILAR FACILITY OR SETTING IN THE SAME GEOGRAPHIC AREA; OR

(III) ONE HUNDRED PERCENT OF 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 AS DETERMINED BASED ON CLAIMS DATA FROM THE ALL-PAYER HEALTH CLAIMS DATABASE CREATED IN SECTION 25.5-1-204.

(b) IF THE OUT-OF-NETWORK FACILITY SUBMITS A CLAIM FOR EMERGENCY SERVICES AFTER THE ONE-HUNDRED-EIGHTY-DAY PERIOD SPECIFIED IN SUBSECTION (3)(a) OF THIS SECTION, 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.

(c) 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 REQUIRED TO BE PAID BY THE COVERED PERSON.

SECTION 6. 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 7. 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 (August

2, 2019, if adjournment sine die is on May 3, 2019); 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 2020 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.