Second Regular Session
Seventy-third General Assembly
STATE OF COLORADO

INTRODUCTED

LLS NO. 22-0503.01 Kristen Forrestal x4217

HOUSE BILL 22-1284

HOUSE SPONSORSHIP

Esgar and Catlin,

SENATE SPONSORSHIP

Gardner and Pettersen,

House Committees
Health & Insurance

Senate Committees

A BILL FOR AN ACT

101 CONCERNING UPDATES TO STATE SURPRISE BILLING LAWS TO
102 FACILITATE THE IMPLEMENTATION OF SURPRISE BILLING
103 PROTECTIONS, AND, IN CONNECTION THEREWITH, ALIGNING
104 STATE LAW WITH THE FEDERAL "NO SURPRISES ACT".

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

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.

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.

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

2 **SECTION 1.** In Colorado Revised Statutes, 10-16-113.5, **add**
3 (8.5) as follows:

4 **10-16-113.5. Independent external review of adverse**
5 **determinations - legislative declaration - definitions - rules.** (8.5) AN
6 INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW MAY
7 REQUEST THE REVIEW OR AN EXPEDITED REVIEW TO DETERMINE IF SECTION
8 10-16-704 (3) OR (5.5) APPLIES TO THE ITEMS OR SERVICES THAT WERE
9 PROVIDED OR MAY BE PROVIDED TO A COVERED PERSON BY AN
10 OUT-OF-NETWORK PROVIDER OR AT AN OUT-OF-NETWORK FACILITY.

11 **SECTION 2.** In Colorado Revised Statutes, 10-16-704, **amend**
12 (3)(b), (3)(d)(V), (5.5)(a)(V), (12)(a), (12)(b) introductory portion,
13 (12)(b)(IV), (12)(b)(V), (13), (14), (15)(d), and (15)(e); **repeal** (2)(f),
14 (3)(a)(IV), (3)(d)(VI), and (5.5)(e); and **add** (5.5)(a.5), (12)(b)(VI), (17),
15 (18), (19), and (20) as follows:

16 **10-16-704. Network adequacy - required disclosures - balance**
17 **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

1 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUM AMOUNTS AND IN THE SAME
2 MANNER AS IF THE COST-SHARING PAYMENTS WERE MADE TO AN
3 IN-NETWORK PROVIDER AT AN IN-NETWORK FACILITY.
4 (d) (V) This subsection (3)(d) does not apply when a covered
5 person ~~voluntarily uses~~ HAS RECEIVED NOTICE AND GIVEN CONSENT AS
6 REQUIRED BY SECTION 12-30-112 OR 25-3-121, AS APPLICABLE, TO USE an
7 out-of-network provider IN COMPLIANCE WITH THE FEDERAL "NO
8 SURPRISES ACT".
9 (VI) ~~For purposes of this subsection (3):~~
10 ~~(A) "Geographic area" means a specific area in this state as~~
11 ~~established by the commissioner by rule.~~
12 ~~(B) "Medicare reimbursement rate" means the reimbursement rate~~
13 ~~for a particular health-care service provided under the "Health Insurance~~
14 ~~for the Aged Act", Title XVIII of the federal "Social Security Act", as~~
15 ~~amended, 42 U.S.C. sec. 1395 et seq.~~
16 (5.5) (a) Notwithstanding any provision of law, a carrier that
17 provides any benefits with respect to emergency services shall cover the
18 emergency services:
19 (V) At the in-network benefit level, with the same coinsurance,
20 deductible, or copayment requirements as would apply if the emergency
21 services were provided by an in-network provider or AT AN IN-NETWORK
22 facility, and at no greater cost to the covered person than if the emergency
23 services were obtained from an in-network provider at an in-network
24 facility. Any payment made by a covered person pursuant to this
25 subsection (5.5)(a)(V) must be applied to the covered person's in-network
26 ~~cost-sharing limit~~ DEDUCTIBLES AND IN-NETWORK OUT-OF-POCKET
27 MAXIMUM AMOUNTS AND IN THE SAME MANNER AS IF THE COST-SHARING

1 PAYMENTS WERE MADE TO AN IN-NETWORK PROVIDER OR IN-NETWORK
2 FACILITY.
3 (a.5) (I) EXCEPT AS PROVIDED IN SUBSECTION (5.5)(a.5)(II) OF THIS
4 SECTION, A CARRIER SHALL:
5 (A) COVER POST-STABILIZATION SERVICES PROVIDED BY AN
6 OUT-OF-NETWORK PROVIDER OR AT AN OUT-OF-NETWORK FACILITY AT NO
7 GREATER COST TO THE COVERED PERSON THAN THE COST THAT WOULD
8 APPLY, AND WITH THE SAME COINSURANCE, DEDUCTIBLE, OR COPAYMENT
9 REQUIREMENTS AS THE REQUIREMENTS THAT WOULD APPLY, IF THE
10 POST-STABILIZATION SERVICES WERE OBTAINED FROM AN IN-NETWORK
11 PROVIDER OR AT AN IN-NETWORK FACILITY; AND
12 (B) REIMBURSE THE OUT-OF-NETWORK PROVIDER FOR
13 POST-STABILIZATION SERVICES IN ACCORDANCE WITH SUBSECTION
14 (3)(d)(II) OF THIS SECTION AND THE OUT-OF-NETWORK FACILITY IN
15 ACCORDANCE WITH SUBSECTION (5.5)(b) OF THIS SECTION.
16 (II) THE REQUIREMENTS OF SUBSECTION (5.5)(a.5)(I) OF THIS
17 SECTION DO NOT APPLY IF THE FOLLOWING CONDITIONS ARE MET:
18 (A) THE OUT-OF-NETWORK PROVIDER OR OUT-OF-NETWORK
19 FACILITY DETERMINES THE COVERED PERSON IS ABLE TO TRAVEL USING
20 NONMEDICAL TRANSPORTATION OR NONEMERGENCY MEDICAL
21 TRANSPORTATION;
22 (B) THE OUT-OF-NETWORK PROVIDER OR OUT-OF-NETWORK
23 FACILITY HAS PROVIDED THE COVERED PERSON WITH NOTICE AND
24 OBTAINED CONSENT AS REQUIRED BY SECTION 12-30-112 OR 25-3-121, AS
25 APPLICABLE;
26 (C) THE COVERED PERSON IS IN A CONDITION TO RECEIVE THE
27 INFORMATION DESCRIBED IN SUBSECTION (5.5)(a.5)(II)(B) OF THIS

1 SECTION; AND

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

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

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

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

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

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

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

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

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

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

1 ~~the hospital, further medical examination and treatment as required to~~
2 ~~stabilize the patient to assure, within reasonable medical probability, that~~
3 ~~no material deterioration of the condition is likely to result from or occur~~
4 ~~during the transfer of the individual from a facility.~~
5 ~~(III) "Geographic area" has the same meaning as defined in~~
6 ~~subsection (3)(d)(VI)(A) of this section.~~
7 ~~(IV) "Medicare reimbursement rate" has the same meaning as~~
8 ~~defined in subsection (3)(d)(VI)(B) of this section.~~
9 (12) (a) On and after January 1, 2020, carriers shall develop and
10 provide disclosures to covered persons about the potential effects of
11 receiving emergency or nonemergency services from an out-of-network
12 provider or at an out-of-network facility. The disclosures must, AT A
13 MINIMUM, comply with THE FEDERAL "NO SURPRISES ACT" AND the rules
14 adopted under subsection (12)(b) of this section.
15 (b) The commissioner, in consultation with the state board of
16 health created in section 25-1-103 and the ~~director of the division of~~
17 ~~professions and occupations in the department of regulatory agencies~~
18 APPLICABLE REGULATORS OF HEALTH-CARE OCCUPATIONS AND
19 PROFESSIONS, shall adopt rules to specify the disclosure requirements
20 under this subsection (12), which rules must specify, at a minimum, the
21 following:
22 (IV) Disclosure requirements specific to carriers, including the
23 possibility of being treated by an out-of-network provider, whether a
24 provider is out of network, the types of services an out-of-network
25 provider may provide, and the right to request an in-network provider to
26 provide services; ~~and~~
27 (V) Requirements concerning the language to be used in the

1 disclosures, including use of plain language, to ensure that carriers,
2 health-care facilities, and providers use language that is consistent with
3 the disclosures required by this subsection (12) and ~~sections~~ SECTION
4 12-30-112 ~~and~~ OR 25-3-121, AS APPLICABLE, and the rules adopted
5 pursuant to this subsection (12)(b) and ~~sections~~ SECTION 12-30-112 (3)
6 ~~and~~ OR 25-3-121 (2), AS APPLICABLE; AND

7 (VI) A LIST OF THE ANCILLARY SERVICES FOR WHICH AN
8 OUT-OF-NETWORK PROVIDER OR OUT-OF-NETWORK FACILITY SHALL NOT
9 BALANCE BILL A COVERED PERSON.

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

17 (b) (I) THE COMMISSIONER SHALL CONVENE A WORK GROUP TO
18 DISCUSS WAYS TO FACILITATE AND STREAMLINE IMPLEMENTATION OF THIS
19 SUBSECTION (13). THE WORK GROUP MUST INCLUDE, AT A MINIMUM,
20 REPRESENTATIVES OF HOSPITALS, CARRIERS, HEALTH-CARE
21 PROFESSIONALS, AND CONSUMERS. THE WORK GROUP SHALL:

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

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

1 (C) SUBMIT A WRITTEN REPORT WITH PRELIMINARY
2 RECOMMENDATIONS TO THE COMMISSIONER BY MARCH 15, 2023; AND
3 (D) ON OR BEFORE JULY 1, 2023, SUBMIT A WRITTEN REPORT WITH
4 FINAL RECOMMENDATIONS TO THE COMMISSIONER.
5 (II) THIS SUBSECTION (13)(b) IS REPEALED, EFFECTIVE JULY 31,
6 2023.
7 (14) On or before ~~January 1~~ MARCH 1 of each year, each carrier
8 shall submit information to the commissioner, in a form and manner
9 determined by the commissioner, concerning the use of out-of-network
10 providers and OUT-OF-NETWORK facilities by covered persons and the
11 impact on premium affordability for consumers.
12 (15) (d) If the arbitrator's decision MADE PURSUANT TO
13 SUBSECTION (15)(c) OF THIS SECTION requires additional payment by the
14 carrier above the amount paid, the carrier shall pay the provider in
15 accordance with section 10-16-106.5. A CARRIER SHALL NOT
16 RECALCULATE A COVERED PERSON'S COST-SHARING AMOUNT BASED ON AN
17 ADDITIONAL PAYMENT REQUIRED OR MADE AS A RESULT OF AN
18 ARBITRATION DECISION.
19 (e) The party whose final offer amount was not selected by the
20 arbitrator shall pay the arbitrator's expenses and fees. IF THE PARTIES
21 REACH A SETTLEMENT AFTER AN ARBITRATOR IS APPOINTED BUT BEFORE
22 THE ARBITRATOR MAKES A FINAL DECISION, THE PARTIES SHALL SPLIT THE
23 COSTS OF THE ARBITRATION EQUALLY UNLESS OTHERWISE AGREED BY THE
24 PARTIES.
25 (17) THE COMMISSIONER SHALL POST ON THE DIVISION'S WEBSITE
26 INFORMATION ON THE STATE AND FEDERAL AGENCIES THAT A COVERED
27 PERSON MAY CONTACT IF A PROVIDER, FACILITY, OR CARRIER VIOLATES

1 THIS SECTION.

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

5 (19) AN ENTITY THAT PROVIDES OR ADMINISTERS A SELF-FUNDED
6 HEALTH BENEFIT PLAN MAY ELECT TO BE SUBJECT TO THE REQUIREMENTS
7 IN SUBSECTIONS (3)(d), (5.5), (12), (13), AND (15) OF THIS SECTION.

8 (20) AS USED IN THIS SECTION:

9 (a) "ANCILLARY SERVICES" MEANS:

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

14 (II) ITEMS AND SERVICES RELATED TO EMERGENCY MEDICINE,
15 ANESTHESIOLOGY, PATHOLOGY, RADIOLOGY, AND NEONATOLOGY,
16 WHETHER OR NOT PROVIDED BY A PHYSICIAN OR NONPHYSICIAN PROVIDER,
17 UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES
18 DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION
19 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

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

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

1 (V) ANY OTHER ITEMS AND SERVICES PROVIDED BY SPECIALTY
2 PROVIDERS AS ESTABLISHED BY RULE OF THE COMMISSIONER.
3 (b) "APPLICABLE REGULATORS OF HEALTH-CARE OCCUPATIONS
4 AND PROFESSIONS" MEANS THE:
5 (I) COLORADO STATE BOARD OF CHIROPRACTIC EXAMINERS
6 CREATED IN SECTION 12-215-104;
7 (II) COLORADO DENTAL BOARD CREATED IN SECTION 12-220-105;
8 (III) COLORADO MEDICAL BOARD CREATED IN SECTION
9 12-240-105;
10 (IV) STATE BOARD OF PSYCHOLOGIST EXAMINERS CREATED IN
11 SECTION 12-245-302;
12 (V) STATE BOARD OF SOCIAL WORK EXAMINERS CREATED IN
13 SECTION 12-245-402;
14 (VI) STATE BOARD OF MARRIAGE AND FAMILY THERAPIST
15 EXAMINERS CREATED IN SECTION 12-245-502;
16 (VII) STATE BOARD OF LICENSED PROFESSIONAL COUNSELOR
17 EXAMINERS CREATED IN SECTION 12-245-602;
18 (VIII) STATE BOARD OF UNLICENSED PSYCHOTHERAPISTS CREATED
19 IN SECTION 12-245-702;
20 (IX) STATE BOARD OF ADDICTION COUNSELOR EXAMINERS
21 CREATED IN SECTION 12-245-802;
22 (X) STATE BOARD OF NURSING CREATED IN SECTION 12-255-105;
23 (XI) BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS
24 CREATED IN SECTION 12-265-106;
25 (XII) STATE BOARD OF OPTOMETRY CREATED IN SECTION
26 12-275-107;
27 (XIII) STATE BOARD OF PHARMACY CREATED IN SECTION

1 12-280-104;

2 (XIV) STATE PHYSICAL THERAPY BOARD CREATED IN SECTION
3 12-285-105; AND

4 (XV) COLORADO PODIATRY BOARD CREATED IN SECTION
5 12-290-105.

6 (c) "BALANCE BILL" MEANS:

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

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

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

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

25 (II) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

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

27 (e) "EMERGENCY SERVICES", WITH RESPECT TO AN EMERGENCY

1 MEDICAL CONDITION, MEANS:
2 (I) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE
3 CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL OR A
4 FREESTANDING EMERGENCY DEPARTMENT, AS APPLICABLE, INCLUDING
5 ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY
6 DEPARTMENT TO EVALUATE THE EMERGENCY MEDICAL CONDITION;
7 (II) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES
8 AVAILABLE AT THE HOSPITAL, REGARDLESS OF THE DEPARTMENT IN WHICH
9 FURTHER EXAMINATION OR TREATMENT IS FURNISHED, OR THE
10 FREESTANDING EMERGENCY DEPARTMENT, AS APPLICABLE, FURTHER
11 MEDICAL EXAMINATION AND TREATMENT AS ARE REQUIRED TO STABILIZE
12 THE PATIENT TO ENSURE, WITHIN REASONABLE MEDICAL PROBABILITY,
13 THAT NO MATERIAL DETERIORATION OF THE CONDITION IS LIKELY TO
14 RESULT FROM OR OCCUR DURING THE TRANSFER OF THE PATIENT FROM A
15 FACILITY; AND
16 (III) ANCILLARY SERVICES.
17 (f) "FEDERAL 'NO SURPRISES ACT'" MEANS THE FEDERAL "NO
18 SURPRISES ACT", PUB.L. 116-260, AS AMENDED.
19 (g) "FREESTANDING EMERGENCY DEPARTMENT" HAS THE SAME
20 MEANING AS SET FORTH IN SECTION 25-1.5-114 (5).
21 (h) "GEOGRAPHIC AREA" MEANS A SPECIFIC AREA IN THIS STATE AS
22 ESTABLISHED BY THE COMMISSIONER BY RULE.
23 (i) "IN-NETWORK FACILITY" MEANS A PARTICIPATING PROVIDER
24 THAT IS A HEALTH-CARE FACILITY.
25 (j) "IN-NETWORK PROVIDER" MEANS A PARTICIPATING PROVIDER
26 WHO IS AN INDIVIDUAL.
27 (k) "MEDICARE REIMBURSEMENT RATE" MEANS THE

1 REIMBURSEMENT RATE FOR A PARTICULAR HEALTH-CARE SERVICE
2 PROVIDED UNDER THE "HEALTH INSURANCE FOR THE AGED ACT", TITLE
3 XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", 42 U.S.C. SEC. 1395 ET
4 SEQ., AS AMENDED.
5 (l) "NEGOTIATED RATE" MEANS THE RATE MUTUALLY AGREED
6 UPON BETWEEN THE CARRIER AND THE PROVIDER IN A SPECIFIC INSTANCE.
7 (m) "POST-STABILIZATION SERVICES" MEANS MEDICALLY
8 NECESSARY HEALTH-CARE SERVICES RELATED TO AN EMERGENCY
9 MEDICAL CONDITION THAT ARE PROVIDED AFTER A COVERED PERSON IS
10 STABILIZED IN ORDER TO MAINTAIN THE STABILIZED CONDITION,
11 REGARDLESS OF THE DEPARTMENT OF THE HOSPITAL OR FACILITY IN WHICH
12 THE FURTHER EXAMINATION OR TREATMENT IS PROVIDED.
13 (n) "STABILIZED" MEANS THE CONDITION OF A PATIENT IN WHICH,
14 WITHIN REASONABLE MEDICAL PROBABILITY, NO MATERIAL
15 DETERIORATION OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR
16 DURING THE TRANSFER OF THE PATIENT FROM ONE FACILITY OR
17 DEPARTMENT TO ANOTHER.
18 (o) "USUAL, CUSTOMARY, AND REASONABLE RATE" MEANS A RATE
19 ESTABLISHED PURSUANT TO AN APPROPRIATE METHODOLOGY THAT IS
20 BASED ON GENERALLY ACCEPTED INDUSTRY STANDARDS AND PRACTICES.
21 **SECTION 3.** In Colorado Revised Statutes, 10-16-705, **amend**
22 (4)(b); and **add** (4)(d) as follows:
23 **10-16-705. Requirements for carriers and participating**
24 **providers - definitions.** (4) (b) Each CARRIER THAT ISSUES A managed
25 care plan shall allow covered persons to continue receiving care for ~~sixty~~
26 A MAXIMUM OF NINETY days ~~from~~ AFTER the date a participating provider
27 is terminated by the plan without cause. ~~when proper notice as specified~~

1 ~~in subsection (7) of this section has not been provided to the covered~~
2 ~~person~~ THE CARRIER SHALL PROVIDE THE REQUISITE COVERAGE OR
3 CONTINUING CARE TO THE COVERED PERSON AT THE COVERED PERSON'S
4 IN-NETWORK BENEFIT LEVEL COST-SHARING AMOUNT DURING THE
5 NINETY-DAY PERIOD OR UNTIL THE COVERED PERSON SWITCHES TO A NEW
6 PARTICIPATING PROVIDER.

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

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

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

21 (C) A CONTRACT BETWEEN THE MANAGED CARE PLAN AND THE
22 CARRIER OFFERING COVERAGE IN CONNECTION WITH THE MANAGED CARE
23 PLAN IS TERMINATED DUE TO THE EXPIRATION OR NONRENEWAL OF THE
24 CONTRACT, RESULTING IN THE LOSS OF BENEFITS UNDER THE PLAN WITH
25 RESPECT TO THE PARTICIPATING PROVIDER THAT IS PROVIDING TREATMENT
26 OR SERVICES TO THE COVERED PERSON.

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

1 (A) NOTIFY EACH COVERED PERSON WHO IS RECEIVING CARE FROM
2 A PROVIDER OR FACILITY WITH WHOM A CONTRACT IS TERMINATED AS
3 DESCRIBED IN SUBSECTION (4)(d)(I) OF THIS SECTION, AT THE TIME OF THE
4 TERMINATION OF THE CONTRACT, THAT THE PATIENT HAS THE RIGHT TO
5 ELECT CONTINUED TRANSITIONAL CARE FROM THE TREATING PROVIDER OR
6 FACILITY IF THE TERMINATION OF THE CONTRACT AFFECTS THE STATUS OF
7 THE PROVIDER OR FACILITY AS A PARTICIPATING PROVIDER;
8 (B) PROVIDE THE COVERED PERSON WITH AN OPPORTUNITY TO
9 NOTIFY THE MANAGED CARE PLAN OR CARRIER OF THE NEED FOR
10 TRANSITIONAL CARE; AND
11 (C) PERMIT THE COVERED PERSON TO ELECT TO CONTINUE TO
12 HAVE BENEFITS PROVIDED UNDER THE COVERED PERSON'S CURRENT PLAN
13 OR COVERAGE UNDER THE SAME TERMS AND CONDITIONS AS WOULD HAVE
14 APPLIED AND WITH RESPECT TO THE SAME ITEMS AND SERVICES AS WOULD
15 HAVE BEEN COVERED HAD A TERMINATION DESCRIBED IN SUBSECTION
16 (4)(d)(I) OF THIS SECTION NOT OCCURRED, WITH RESPECT TO THE COURSE
17 OF TREATMENT FURNISHED BY THE PROVIDER OR FACILITY RELATING TO
18 THE COVERED PERSON'S STATUS AS A CONTINUING CARE PATIENT DURING
19 THE PERIOD BEGINNING ON THE DATE ON WHICH THE NOTICE UNDER
20 SUBSECTION (4)(d)(II)(A) OF THIS SECTION IS PROVIDED AND ENDING ON
21 THE NINETY-FIRST DAY AFTER THAT DATE OR THE DATE ON WHICH THE
22 COVERED PERSON IS NO LONGER A CONTINUING CARE PATIENT WITH
23 RESPECT TO THE PROVIDER OR FACILITY, WHICHEVER IS EARLIER.
24 (III) AS USED IN THIS SUBSECTION (4)(d);
25 (A) "CONTINUING CARE PATIENT" MEANS A COVERED PERSON
26 WHO, WITH RESPECT TO A PROVIDER OR FACILITY WHOSE CONTRACT WITH
27 THE COVERED PERSON'S CARRIER IS TERMINATED: IS UNDERGOING A

1 COURSE OF TREATMENT FOR A SERIOUS AND COMPLEX MEDICAL
2 CONDITION, WHICH COURSE OF TREATMENT IS PROVIDED BY THE PROVIDER
3 OR FACILITY; IS UNDERGOING A COURSE OF INPATIENT CARE PROVIDED BY
4 THE PROVIDER OR FACILITY; IS PREGNANT AND UNDERGOING A COURSE OF
5 TREATMENT FOR THE PREGNANCY PROVIDED BY THE PROVIDER OR
6 FACILITY; IS TERMINALLY ILL AS DETERMINED UNDER SECTION 1861
7 (dd)(3)(A) OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, AND
8 IS RECEIVING TREATMENT FOR THE ILLNESS FROM THE PROVIDER OR
9 FACILITY; OR IS SCHEDULED TO UNDERGO NONELECTIVE SURGERY FROM
10 THE PROVIDER OR FACILITY, INCLUDING THE RECEIPT OF POSTOPERATIVE
11 CARE FROM THE PROVIDER OR FACILITY WITH RESPECT TO THE SURGERY.
12 (B) "SERIOUS AND COMPLEX MEDICAL CONDITION" MEANS, IN THE
13 CASE OF ACUTE ILLNESS, A CONDITION THAT IS SERIOUS ENOUGH TO
14 REQUIRE SPECIALIZED MEDICAL TREATMENT TO AVOID THE REASONABLE
15 POSSIBILITY OF DEATH OR PERMANENT HARM OR, IN THE CASE OF A
16 CHRONIC ILLNESS OR CONDITION, A CONDITION THAT IS
17 LIFE-THREATENING, DEGENERATIVE, POTENTIALLY DISABLING, OR
18 CONGENITAL AND REQUIRES SPECIALIZED MEDICAL CARE OVER A
19 PROLONGED PERIOD OF TIME.
20 **SECTION 4.** In Colorado Revised Statutes, 12-30-112, **amend**
21 (1) introductory portion, (1)(a), (1)(c), (1)(d), (1)(f), (1)(g), and (3)
22 introductory portion; and **add** (1)(a.3), (1)(a.5), (1)(c.5), (1)(h), and (3.5)
23 as follows:
24 **12-30-112. Health-care providers - required disclosures -**
25 **balance billing - rules - definitions.** (1) ~~For the purposes of~~ AS USED IN
26 this section and section 12-30-113:
27 (a) ~~"Carrier" has the same meaning as defined in section~~

1 ~~10-16-102 (8).~~ "ANCILLARY SERVICES" MEANS:

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

6 (II) ITEMS AND SERVICES RELATED TO EMERGENCY MEDICINE,
7 ANESTHESIOLOGY, PATHOLOGY, RADIOLOGY, AND NEONATOLOGY,
8 WHETHER OR NOT PROVIDED BY A PHYSICIAN OR NONPHYSICIAN PROVIDER,
9 UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES
10 DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION
11 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

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

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

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

22 (a.3) "BALANCE BILL" MEANS:

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

1 HEALTH-CARE SERVICES; AND

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

5 (a.5) "CARRIER" HAS THE SAME MEANING AS SET FORTH IN SECTION
6 10-16-102 (8).

7 (c) "Emergency services" has the same meaning as ~~defined~~ SET
8 FORTH in section 10-16-704 ~~(5.5)(e)(II)~~ (20)(e).

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

11 (d) "Geographic area" has the same meaning as ~~defined~~ SET FORTH
12 in section 10-16-704 ~~(3)(d)(VI)(A)~~ (20)(h).

13 (f) "Medicare reimbursement rate" has the same meaning as
14 ~~defined~~ SET FORTH in section 10-16-704 ~~(3)(d)(VI)(B)~~ (20)(k).

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

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

20 (3) The director, in consultation with the commissioner of
21 insurance and the state board of health created in section 25-1-103, shall
22 adopt rules that specify the requirements for health-care providers to
23 develop and provide consumer disclosures in accordance with this
24 section. The director shall ensure that the rules, AT A MINIMUM, COMPLY
25 WITH THE NOTICE AND CONSENT REQUIREMENTS IN SUBSECTION (3.5) OF
26 THIS SECTION AND THE FEDERAL "NO SURPRISES ACT" AND are consistent
27 with ~~sections~~ SECTION 10-16-704 (12) ~~and~~ OR 25-3-121, AS APPLICABLE,

1 and rules adopted by the commissioner pursuant to section 10-16-704
2 (12)(b) and by the state board of health pursuant to section 25-3-121 (2),
3 AS APPLICABLE. The rules must specify, at a minimum, the following:
4 (3.5) (a) AN OUT-OF-NETWORK PROVIDER MAY BALANCE BILL A
5 COVERED PERSON FOR SERVICES OTHER THAN ANCILLARY SERVICES IF:
6 (I) THE OUT-OF-NETWORK PROVIDER PROVIDES WRITTEN NOTICE
7 THAT THE PROVIDER WILL BALANCE BILL A COVERED PERSON AT LEAST
8 SEVEN DAYS IN ADVANCE OF THE DATE OF SERVICE, IF THE APPOINTMENT
9 WAS SCHEDULED AT LEAST SEVEN DAYS IN ADVANCE, OR AT LEAST
10 FORTY-EIGHT HOURS BEFORE THE SCHEDULED APPOINTMENT, IF THE
11 APPOINTMENT WAS MADE LESS THAN SEVEN DAYS IN ADVANCE, IN EITHER
12 PAPER OR ELECTRONIC FORMAT, AS SELECTED BY THE COVERED PERSON.
13 THE NOTICE MUST BE AVAILABLE IN THE FIFTEEN MOST COMMON
14 LANGUAGES IN THE GEOGRAPHIC REGION IN WHICH THE OUT-OF-NETWORK
15 PROVIDER IS LOCATED. THE NOTICE MUST STATE:
16 (A) IF APPLICABLE, THAT THE HEALTH-CARE PROVIDER IS OUT OF
17 NETWORK WITH RESPECT TO THE COVERED PERSON'S HEALTH BENEFIT
18 PLAN;
19 (B) A GOOD-FAITH ESTIMATE OF THE AMOUNT OF THE CHARGES
20 FOR WHICH THE COVERED PERSON MAY BE RESPONSIBLE;
21 (C) THAT THE ESTIMATE OR CONSENT TO TREATMENT DOES NOT
22 CONSTITUTE A CONTRACT FOR SERVICES;
23 (D) IF THE FACILITY IS A PARTICIPATING PROVIDER AND THE
24 HEALTH-CARE PROVIDER IS AN OUT-OF-NETWORK PROVIDER, A LIST OF
25 PARTICIPATING PROVIDERS AT THE FACILITY WHO ARE ABLE TO PROVIDE
26 THE SAME SERVICES AND, IF THE SERVICE IS SCHEDULED AT LEAST TEN
27 DAYS BEFORE THE DATE THE NOTICE IN THIS SUBSECTION (3.5)(a)(I) WAS

1 RECEIVED, THAT THE COVERED PERSON MAY USE THE OUT-OF-NETWORK
2 PROVIDER SERVICES AT THE IN-NETWORK BENEFIT LEVEL;
3 (E) INFORMATION ABOUT WHETHER PRIOR AUTHORIZATION OR
4 OTHER CARE MANAGEMENT LIMITATIONS MAY BE REQUIRED IN ADVANCE
5 OF RECEIVING THE REQUESTED SERVICES; AND
6 (F) THAT CONSENT TO RECEIVE THE SERVICES FROM AN
7 OUT-OF-NETWORK PROVIDER IS OPTIONAL AND THAT THE COVERED
8 PERSON MAY SEEK SERVICES FROM A PARTICIPATING PROVIDER, IN WHICH
9 CASE THE COST-SHARING RESPONSIBILITY OF THE COVERED PERSON
10 WOULD NOT EXCEED THE RESPONSIBILITY FOR IN-NETWORK BENEFITS
11 UNDER THE COVERED PERSON'S HEALTH BENEFIT PLAN; AND
12 (II) THE OUT-OF-NETWORK PROVIDER OBTAINS SIGNED CONSENT
13 FROM THE COVERED PERSON THAT ACKNOWLEDGES THAT THE COVERED
14 PERSON HAS BEEN:
15 (A) PROVIDED WITH WRITTEN NOTICE OF THE COVERED PERSON'S
16 FINANCIAL RESPONSIBILITY, IN THE FORMAT AND LANGUAGE SELECTED BY
17 THE COVERED PERSON AND WITHIN THE APPLICABLE PERIODS SPECIFIED IN
18 SUBSECTION (3.5)(a)(I) OF THIS SECTION; AND
19 (B) PROVIDED WRITTEN NOTICE THAT THE PAYMENT BY THE
20 COVERED PERSON FOR HEALTH-CARE SERVICES PROVIDED BY THE
21 OUT-OF-NETWORK PROVIDER MAY NOT ACCRUE TOWARD MEETING ANY
22 LIMITATION THAT THE HEALTH BENEFIT PLAN PLACES ON COST SHARING,
23 INCLUDING AN EXPLANATION THAT THE PAYMENT MAY NOT APPLY TO AN
24 IN-NETWORK DEDUCTIBLE.
25 (b) THE NOTICE AND CONSENT REQUIRED BY THIS SUBSECTION
26 (3.5) MUST INCLUDE THE DATE ON WHICH THE COVERED PERSON RECEIVED
27 THE WRITTEN NOTICE AND THE DATE ON WHICH THE CONSENT FORM WAS

1 SIGNED. THE OUT-OF-NETWORK PROVIDER SHALL PROVIDE A SIGNED COPY
2 OF THE CONSENT FORM TO THE COVERED PERSON THROUGH REGULAR OR
3 ELECTRONIC MAIL.
4 (c) AN OUT-OF-NETWORK PROVIDER THAT OBTAINS A SIGNED
5 CONSENT WITH RESPECT TO FURNISHING AN ITEM OR SERVICE SHALL
6 RETAIN THE SIGNED CONSENT FOR AT LEAST A SEVEN-YEAR PERIOD AFTER
7 THE DATE ON WHICH SUCH ITEM OR SERVICE IS FURNISHED.
8 **SECTION 5.** In Colorado Revised Statutes, 25-3-121, **amend** (2)
9 introductory portion, (4) introductory portion, (4)(a), (4)(c), (4)(d), (4)(f),
10 and (4)(g); and **add** (3.5), (4)(a.3), (4)(a.5), (4)(c.5), and (4)(h) as
11 follows:
12 **25-3-121. Health-care facilities - emergency and**
13 **nonemergency services - required disclosures - balance billing - rules**
14 **- definitions.** (2) The state board of health, in consultation with the
15 commissioner of insurance and the director of the division of professions
16 and occupations in the department of regulatory agencies, shall adopt
17 rules that specify the requirements for health-care facilities to develop and
18 provide consumer disclosures in accordance with this section. The state
19 board of health shall ensure that the rules, AT A MINIMUM, COMPLY WITH
20 THE NOTICE AND CONSENT REQUIREMENTS IN SUBSECTION (3.5) OF THIS
21 SECTION AND THE FEDERAL "NO SURPRISES ACT" AND are consistent with
22 ~~sections~~ SECTION 10-16-704 (12) ~~and~~ OR 12-30-112, AS APPLICABLE, and
23 rules adopted by the commissioner pursuant to section 10-16-704 (12)(b)
24 and by the director of the division of professions and occupations
25 pursuant to section 12-30-112 (3), AS APPLICABLE. The rules must specify,
26 at a minimum, the following:
27 (3.5) (a) AN OUT-OF-NETWORK FACILITY MAY BALANCE BILL A

1 COVERED PERSON FOR SERVICES OTHER THAN ANCILLARY SERVICES IF:
2 (I) THE OUT-OF-NETWORK FACILITY PROVIDES WRITTEN NOTICE
3 THAT THE FACILITY WILL BALANCE BILL A COVERED PERSON AT LEAST
4 SEVEN DAYS IN ADVANCE OF THE DATE OF SERVICE, IF THE APPOINTMENT
5 WAS SCHEDULED AT LEAST SEVEN DAYS IN ADVANCE, OR AT LEAST
6 FORTY-EIGHT HOURS BEFORE THE SCHEDULED APPOINTMENT, IF THE
7 APPOINTMENT WAS MADE LESS THAN SEVEN DAYS IN ADVANCE, IN EITHER
8 PAPER OR ELECTRONIC FORMAT, AS SELECTED BY THE COVERED PERSON.
9 THE NOTICE MUST BE AVAILABLE IN THE FIFTEEN MOST COMMON
10 LANGUAGES IN THE GEOGRAPHIC REGION IN WHICH THE OUT-OF-NETWORK
11 FACILITY IS LOCATED. THE NOTICE MUST STATE:
12 (A) IF APPLICABLE, THAT THE FACILITY IS OUT OF NETWORK WITH
13 RESPECT TO THE COVERED PERSON'S HEALTH BENEFIT PLAN;
14 (B) A GOOD-FAITH ESTIMATE OF THE AMOUNT OF THE CHARGES
15 FOR WHICH THE COVERED PERSON MAY BE RESPONSIBLE;
16 (C) THAT THE ESTIMATE OR CONSENT TO TREATMENT DOES NOT
17 CONSTITUTE A CONTRACT FOR SERVICES;
18 (D) IF THE FACILITY IS A PARTICIPATING PROVIDER AND THE
19 HEALTH-CARE PROVIDER IS NOT A PARTICIPATING PROVIDER, A LIST OF
20 PARTICIPATING PROVIDERS AT THE FACILITY WHO ARE ABLE TO PROVIDE
21 THE SAME SERVICES AND, IF THE SERVICE IS SCHEDULED AT LEAST TEN
22 DAYS BEFORE THE DATE THE NOTICE IN THIS SUBSECTION (3.5)(a)(I) WAS
23 RECEIVED, THAT THE COVERED PERSON MAY USE THE OUT-OF-NETWORK
24 PROVIDER SERVICES AT THE IN-NETWORK BENEFIT LEVEL;
25 (E) INFORMATION ABOUT WHETHER PRIOR AUTHORIZATION OR
26 OTHER CARE MANAGEMENT LIMITATIONS MAY BE REQUIRED IN ADVANCE
27 OF RECEIVING THE REQUESTED SERVICES; AND

1 (F) THAT CONSENT TO RECEIVE THE SERVICES AT AN
2 OUT-OF-NETWORK FACILITY IS OPTIONAL AND THAT THE COVERED PERSON
3 MAY SEEK SERVICES FROM A PARTICIPATING PROVIDER, IN WHICH CASE
4 THE COST-SHARING RESPONSIBILITY OF THE COVERED PERSON WOULD NOT
5 EXCEED THE RESPONSIBILITY FOR IN-NETWORK BENEFITS UNDER THE
6 COVERED PERSON'S HEALTH BENEFIT PLAN;
7 (II) THE OUT-OF-NETWORK FACILITY OBTAINS SIGNED CONSENT
8 FROM THE COVERED PERSON THAT ACKNOWLEDGES THAT THE COVERED
9 PERSON HAS BEEN:
10 (A) PROVIDED WITH WRITTEN NOTICE OF THE COVERED PERSON'S
11 FINANCIAL RESPONSIBILITY, IN THE FORMAT AND LANGUAGE SELECTED BY
12 THE COVERED PERSON AND WITHIN THE APPLICABLE PERIODS SPECIFIED IN
13 SUBSECTION (3.5)(a)(I) OF THIS SECTION; AND
14 (B) PROVIDED WRITTEN NOTICE THAT THE PAYMENT BY THE
15 COVERED PERSON FOR HEALTH-CARE SERVICES PROVIDED AT THE
16 OUT-OF-NETWORK FACILITY MAY NOT ACCRUE TOWARD MEETING ANY
17 LIMITATION THAT THE HEALTH BENEFIT PLAN PLACES ON COST SHARING,
18 INCLUDING AN EXPLANATION THAT THE PAYMENT MAY NOT APPLY TO AN
19 IN-NETWORK DEDUCTIBLE.
20 (b) THE NOTICE AND CONSENT REQUIRED BY THIS SUBSECTION
21 (3.5) MUST INCLUDE THE DATE ON WHICH THE COVERED PERSON RECEIVED
22 THE WRITTEN NOTICE AND THE DATE ON WHICH THE CONSENT FORM WAS
23 SIGNED. THE OUT-OF-NETWORK FACILITY SHALL PROVIDE A SIGNED COPY
24 OF THE CONSENT FORM TO THE COVERED PERSON THROUGH REGULAR OR
25 ELECTRONIC MAIL.
26 (c) AN OUT-OF-NETWORK FACILITY THAT OBTAINS A SIGNED
27 CONSENT WITH RESPECT TO FURNISHING AN ITEM OR SERVICE SHALL

1 RETAIN THE SIGNED CONSENT FOR AT LEAST A SEVEN-YEAR PERIOD AFTER
2 THE DATE ON WHICH SUCH ITEM OR SERVICE IS FURNISHED.

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

5 (a) ~~"Carrier" has the same meaning as defined in section~~
6 ~~10-16-102 (8).~~ "ANCILLARY SERVICES" MEANS:

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

11 (II) ITEMS AND SERVICES RELATED TO EMERGENCY MEDICINE,
12 ANESTHESIOLOGY, PATHOLOGY, RADIOLOGY, AND NEONATOLOGY,
13 WHETHER OR NOT PROVIDED BY A PHYSICIAN OR NONPHYSICIAN PROVIDER,
14 UNLESS EXCLUDED BY RULE OF THE SECRETARY OF THE UNITED STATES
15 DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION
16 2799B-2 (b)(3) OF THE FEDERAL "NO SURPRISES ACT";

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

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

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

27 (a.3) "BALANCE BILL" MEANS:

1 (I) THE AMOUNT THAT AN OUT-OF-NETWORK PROVIDER MAY
2 CHARGE A COVERED PERSON FOR THE PROVISION OF HEALTH-CARE
3 SERVICES, WHICH AMOUNT EQUALS THE DIFFERENCE BETWEEN THE
4 AMOUNT PAID BY THE CARRIER FOR THE HEALTH-CARE SERVICES AND THE
5 AMOUNT OF THE OUT-OF-NETWORK PROVIDER'S BILLED CHARGE FOR THE
6 HEALTH-CARE SERVICES; AND
7 (II) THE ACT OF A NONPARTICIPATING PROVIDER CHARGING A
8 COVERED PERSON THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND
9 THE AMOUNT THE CARRIER PAID THE PROVIDER.
10 (a.5) "CARRIER" HAS THE SAME MEANING AS SET FORTH IN SECTION
11 10-16-102 (8).
12 (c) "Emergency services" has the same meaning as ~~defined~~ SET
13 FORTH in section 10-16-704 ~~(5.5)(c)(II)~~ (20)(e).
14 (c.5) "FEDERAL 'NO SURPRISES ACT'" MEANS THE FEDERAL "NO
15 SURPRISES ACT", PUB.L. 116-260, AS AMENDED.
16 (d) "Geographic area" has the same meaning as ~~defined~~ SET FORTH
17 in section 10-16-704 ~~(3)(d)(VI)(A)~~ (20)(h).
18 (f) "Medicare reimbursement rate" has the same meaning as
19 ~~defined~~ SET FORTH in section 10-16-704 ~~(3)(d)(VI)(B)~~ (20)(k).
20 (g) "Out-of-network facility" means a health-care facility that is
21 not a participating provider. ~~as defined in section 10-16-102 (46).~~
22 (h) "PARTICIPATING PROVIDER" HAS THE SAME MEANING AS SET
23 FORTH IN SECTION 10-16-102 (46).
24 **SECTION 6. Act subject to petition - effective date.** This act
25 takes effect at 12:01 a.m. on the day following the expiration of the
26 ninety-day period after final adjournment of the general assembly; except
27 that, if a referendum petition is filed pursuant to section 1 (3) of article V

1 of the state constitution against this act or an item, section, or part of this
2 act within such period, then the act, item, section, or part will not take
3 effect unless approved by the people at the general election to be held in
4 November 2022 and, in such case, will take effect on the date of the
5 official declaration of the vote thereon by the governor.