COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Elaine McManis, Deputy Division Director, Health Facilities and Emergency Medical Services Division

Through: Randy Kuykendall, Director, Health Facilities and Emergency Medical Services Division, DRK

Date: December 18, 2019

Subject: Emergency Rulemaking Hearing concerning 6 CCR 1011-1, Standards for Hospitals and Health Facilities Chapter 02—General Licensure Standards

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The Colorado legislature passed HB 19-1174 "Concerning out-of-Network Health Care Services Provided to Covered Persons" during the 2019 legislative session. This new law requires the Board of Health, in consultation and coordination with two divisions of the Department of Regulatory Agencies (DORA), the Division of Insurance (DOI) and the Division of Professions and Occupations (DPO), to promulgate rules that specify requirements for health care facilities to provide consumer disclosures in certain circumstances, starting January 1, 2020.

This legislation addresses the issue of "surprise" or "balance billing," something that can occur when a person who has health insurance is treated at an out-of-network facility or is treated by an out-of-network provider at an in-network facility. To prevent surprise bills for consumers, this new statute ensures that bills for covered services will be handled directly by health insurance carriers, regardless of where or by whom the services are provided and holds consumers harmless for the balance of the bill.

Due to the statutory deadline that facilities and agencies subject to Department licensure begin providing disclosures by January 1, 2020, the Department is requesting an emergency rule making so that the proposed regulatory language and disclosure may be effective by January 1, 2020. The Department is proposing the legislatively required regulations be placed in 6 CCR 1011-1, Chapter 2 - General Licensure Standards, as the requirements will apply to all facility types that do or could have in-network and out-of-network services.

The Department has met with staff members at DORA regarding the language of regulations and the consumer disclosure and has been involved in a joint stakeholder meeting hosted by DOI. DOI will conduct an emergency rule making hearing in December for its regulations and disclosure. The DPO will be conducting an emergency rulemaking in regards to some of the healthcare providers that will be impacted by this statutory change; however there needs to be additional statutory authority prior to undertaking a rule making hearing for others, which will be pursued during the 2020 legislative session.

House Bill 19-1174 mandates that the Board of Health "adopt rules that specify the requirements for health care facilities to develop and provide consumer disclosures…The rules must specify…the timing for providing the disclosures…the contents of the disclosures…the right to request an in-network health care provider." The disclosure being proposed as Appendix A to 6 CCR 1011-1, Chapter 2 mirrors, as much as appropriate, disclosures that have been proposed by DOI. Facilities and agencies will be expected to

provide this disclosure, as stated in the proposed rules, without significant changes and at the appropriate times, when interacting with clients.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1011-1, Standards for Hospitals and Health Facilities
Chapter 2—General Licensure Standards

Basis and Purpose.

The Department is proposing emergency rules to address mandates created by the passage of House Bill 19-1174, which became effective on August 3, 2019. The new law seeks to protect clients of licensed health facilities, agencies covered by health insurance plans regulated by the Department of Regulatory (DORA) Division of Insurance, and licensed health care professionals licensed by DORA from unexpected costs in certain healthcare settings.

House Bill 19-1174 requires Department-licensed health facilities to develop and provide consumer disclosures beginning January 1, 2020. For health facilities to meet the statutory directive, department rules need to be in place on or before January 1, 2020. HB 19-1174 requires similar rules are to be promulgated by the Department of Regulatory Agencies Division of Professions and Occupations (emergency rulemaking hearings scheduled for December 16, 17 and 20, 2019) and the Commissioner of Insurance (emergency rulemaking date to be determined). The Department has spent several months working with staff at the Department of Regulatory Agencies (DORA) to coordinate rule language and consumer disclosures, as required by House Bill 19-1174.

The proposed rules create several relevant definitions; require that client rights policies include the client's right to request an in-network provider; require facilities and agencies to provide the required disclosure; and direct facilities regarding the timing of providing the disclosure. The proposed rule was crafted so it can be used as the disclosure health facilities need to provide to satisfy the statutory mandate.

Emergency Rulemaking Finding and Justification:
An emergency rule-making, which waives the initial Administrative Procedure Act noticing requirements, is necessary to comply with state law. Emergency rulemaking is authorized pursuant to Section 24-4-103(6), C.R.S. as House Bill 19-1174 mandates that facilities and agencies begin to provide the disclosure, with content approved by the Board of Health, starting January 1, 2020.

This emergency rule shall become effective on adoption. It will be effective for no more than 120 days after its adoption unless made permanent through a rulemaking that satisfies the Administrative Procedure Act noticing requirements.

Specific Statutory Authority.

Section 25-3-121(2), C.R.S.

Statutes that informed the rule are: Sections 24-34-113 and 10-16-704, C.R.S.

Is this rulemaking due to a change in state statute?

XX Yes, the bill number is HB 19-1174. Rules are ___ authorized XX required.

Does this rulemaking include proposed rule language that incorporate materials by reference?

_____ Yes ___ URL

XX No

Does this rulemaking include proposed rule language to create or modify fines or fees?

_____ Yes

XX No

Does the proposed rule language create (or increase) a state mandate on local government?

XX No.

- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed;
- The proposed rule requires a local government to perform or increase a specific activity because the local government has opted to perform an activity, or;
- The proposed rule reduces or eliminates a state mandate on local government.

REGULATORY ANALYSIS
for Amendments to
6 CCR 1011-1, Standards for Hospitals and Health Facilities
Chapter 2—General Licensure Standards

1. A description of the classes of persons affected by the proposed rule, including the classes that will bear the costs and the classes that will benefit from the proposed rule.

Group of Persons/Entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule Select category: C/CLG/S/B
All facilities or agencies licensed by the Department: hospitals, nursing care facilities, acute treatment units, home care agencies, dialysis treatment clinics, ambulatory surgical centers, hospice, community mental health centers, community clinics, convalescent centers, assisted living residences, birth centers, acute treatment units, home care placement agencies, and facilities for persons with intellectual and developmental disabilities.	3,563	C
Health Insurance Carriers (that offer individual, small group, and large group managed care plans in the state)	22	S
Health Care Providers (those with an independent scope of practice that may bill separately)	Unknown	S
Consumer Advocates, Colorado Hospital Association, Health Care Provider Associations	Various	S
Coloradans with Insurance Covered by This Statute	About 30% of the healthcare market in Colorado	B

While all are stakeholders, groups of persons/entities connect to the rule and the problem being solved by the rule in different ways. To better understand those different relationships, please use this relationship categorization key:

C = individuals/entities that implement or apply the rule.
S = individuals/entities that do not implement or apply the rule but are interested in others applying the rule.
B = the individuals that are ultimately served, including the customers of our customers. These individuals may benefit, be harmed by or be at-risk because of the standard communicated in the rule or the manner in which the rule is implemented.

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

Impact on Customers (C):
Economic: The rules promulgated by the Board of Health will require that an additional

disclosure be provided to patients. The cost of the reproduction of the disclosure will be relatively minimal; however, the facilities may incur additional costs in the development procedures to ensure that disclosures are provided at the correct time, to the correct patients, under the correct circumstances, and that the provision is documented. The proposed rules are concise and provide a template for the required notice, thereby reducing the administrative burden on the health care facilities regulated under this rule.

As with any new requirement, there will be a time cost as facilities and agencies develop, implement, and train staff on providing the disclosure to clients.

Non-economic: NA

Impact on Stakeholders (S):
Economic: Health insurance carriers and health care providers are covered by rules promulgated by other agencies. The rules promulgated by the Board of Health should not have a direct economic impact on these stakeholders, other than that the disclosures across entities have been coordinated to provide consistency to clients. The Colorado Hospital Association and any Healthcare Provider Associations will likewise be indirectly affected in that their members are affected, but not the associations themselves. The Colorado Hospital Association has provided input on both process and substance of the draft regulations.

Non-economic: The associations are often conduits for members to determine the practical steps to implementation of new regulations, as well as best practices.

Impact on Beneficiaries (B):
Economic: Facility disclosures will assist clients in making informed choices regarding health care options that can result in significant cost savings to the client. In addition, this law benefits all clients receiving emergency care ensuring that any covered person should not be balanced billed for emergency services and should have no costs above what they would have paid at in-network facilities with in-network providers.

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   A. Anticipated CDPHE personal services, operating costs, or other expenditures:

Once in place, the proposed amendments are cost neutral. The Department did receive general funds to implement.

Expenditure Impact	FY 2019-20	FY 2020-21
General Fund	$43,283	$18,389
Personal Services	$29,181	$14,007
Operating Expenses	$4,703	$0
Centrally Appropriated	$9,399	$4,382
TOTAL	**$43,283**	**$18,389**

Anticipated CDPHE Revenues:
$33,884 for state fiscal year 2019-20 from general fund to implement Act. (Personal services and Operating expenses noted above).

B. Anticipated personal services, operating costs or other expenditures by another state agency:
The other state agency involved in implementing portions of the statute is the Department of Regulatory Agencies' Divisions of Insurance and Division of Professions and Occupations Department. These divisions will incur their own costs related to rulemaking, coordination with other agencies, and implementation of HB 19-1174.

Anticipated Revenues for another state agency:
The Department of Regulatory Agencies received an appropriation of $63,924 for SFY 2019-20 for use by the Division of Insurance for implementation.

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Along with the costs and benefits discussed above, the proposed revisions:

_XX Comply with a statutory mandate to promulgate rules.
___ Comply with federal or state statutory mandates, federal or state regulations, and Department funding obligations.
___ Maintain alignment with other states or national standards.
___ Implement a Regulatory Efficiency Review (rule review) result
___ Improve public and environmental health practice.
___ Implement stakeholder feedback.

Advance the following CDPHE Strategic Plan priorities (select all that apply):

1. Reduce Greenhouse Gas (GHG) emissions economy-wide from 125.716 million metric tons of CO2e (carbon dioxide equivalent) per year to 119.430 million metric tons of CO2e per year by June 30, 2020 and to 113.144 million metric tons of CO2e by June 30, 2023. ___ Contributes to the blueprint for pollution reduction ___ Reduces carbon dioxide from transportation ___ Reduces methane emissions from oil and gas industry ___ Reduces carbon dioxide emissions from electricity sector
2. Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020 and 75 ppb by June 30, 2023. ___ Reduces volatile organic compounds (VOC) and oxides of nitrogen (NOx) from the oil and gas industry. ___ Supports local agencies and COGCC in oil and gas regulations. ___ Reduces VOC and NOx emissions from non-oil and gas contributors
3. Decrease the number of Colorado adults who have obesity by 2,838 by June 30, 2020 and by 12,207 by June 30, 2023.

___ Increases the consumption of healthy food and beverages through education, policy, practice and environmental changes.
___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation.
___ Increases the reach of the National Diabetes Prevention Program and Diabetes Self-Management Education and Support by collaborating with the Department of Health Care Policy and Financing.

4. Decrease the number of Colorado children (age 2-4 years) who participate in the WIC Program and have obesity from 2120 to 2115 by June 30, 2020 and to 2100 by June 30, 2023.

___ Ensures access to breastfeeding-friendly environments.

5. Reverse the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.

___ Reverses the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.
___ Performs targeted programming to increase immunization rates.
___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).

6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023.

___ Creates a roadmap to address suicide in Colorado.
___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate.
___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries.
___ Saves health care costs by reducing reliance on emergency Departments and connects to responsive community-based resources.

7. The Office of Emergency Preparedness and Response (OEPR) will identify 100% of jurisdictional gaps to inform the required work of the Operational Readiness Review by June 30, 2020.

___ Conducts a gap assessment.
___ Updates existing plans to address identified gaps.
___ Develops and conducts various exercises to close gaps.

8. For each identified threat, increase the competency rating from 0% to 54% for outbreak/incident investigation steps by June 30, 2020 and increase to 92% competency rating by June 30, 2023.

___ Uses an assessment tool to measure competency for CDPHE's response to an outbreak or environmental incident.

___ Works cross-Departmentally to update and draft plans to address identified gaps noted in the assessment. ___ Conducts exercises to measure and increase performance related to identified gaps in the outbreak or incident response plan.
9. 100% of new technology applications will be virtually available to customers, anytime and anywhere, by June 20, 2020 and 90 of the existing applications by June 30, 2023. ___ Implements the CDPHE Digital Transformation Plan. ___ Optimizes processes prior to digitizing them. ___ Improves data dissemination and interoperability methods and timeliness.
10. Reduce CDPHE's Scope 1 & 2 Greenhouse Gas emissions (GHG) from 6,561 metric tons (in FY2015) to 5,249 metric tons (20% reduction) by June 30, 2020 and 4,593 tons (30% reduction) by June 30, 2023. ___ Reduces emissions from employee commuting ___ Reduces emissions from CDPHE operations
11. Fully implement the roadmap to create and pilot using a budget equity assessment by June 30, 2020 and increase the percent of selected budgets using the equity assessment from 0% to 50% by June 30, 2023. ___ Used a budget equity assessment

___ Advance CDPHE Division-level strategic priorities.

The costs and benefits of the proposed rule will not be incurred if inaction was chosen. Costs and benefits of inaction not previously discussed include:

Inaction is not as option. House Bill 19-1174 mandates that facilities and agencies begin to provide the disclosure, with content approved by the Board of Health, starting January 1, 2020.

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Rulemaking is proposed when it is the least costly method or the only statutorily allowable method for achieving the purpose of the statute. The specific revisions proposed in this rulemaking were developed in coordination with DORA and with some input from stakeholders, as time allowed. The proposed additions to regulation are the minimum necessary to achieve compliance with statute by January 1, 2020, as required.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

The new law requires rulemaking on this topic, thus, there were no alternatives considered. In addition, HB 19-1174 was clear in its directions regarding what topics must be addressed in the rules. The draft rules presented cover the requirements,

provide several definitions, and provide the disclosure.

Staff received preliminary stakeholder comment from several sources and incorporated those ideas that were beneficial and appropriate. The Department will continue this process after the emergency rules are adopted and plans to hold at least one public meeting prior to appearing before the Board to present the permanent proposed rule changes.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

This rulemaking is the result of a new state law requiring rulemaking and setting strict parameters for the topics that were to be covered in the rules. The Division of Insurance assisted in researching disclosure notices from other states. The disclosure that is being proposed borrowed heavily from a well-written Washington State disclosure. There was no need for additional research to meet the limited parameters of this project.

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1011-1, Standards for Hospitals and Health Facilities
Chapter 2—General Licensure Standards

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:
On October 24, 2019, DORA coordinated a multi-stakeholder meeting with the Department and interested affected parties. The following attended:

Organization	Representative Name and Title (if known)
Colorado Hospital Association	Amber Burkhart
Falck Rocky Mountain	William Mitch
Colorado Consumer Health Initiative	Emma Sargent
Colorado Consumer Health Initiative	Caitlin Westerson
Bright Health	Julie Uhl
Colorado Association of Health Plans	Julie Mowing
Colorado Association of Health Plans	Karlee Tebbutt
SCL Health Org	Jeani Frickey Saito

The Department also held multiple conversations with DORA to ensure that the disclosures were consistent with each other. On November 1, 2019, the Department sent a message through the Health Facilities Web Portal (Portal) to all licensed facilities and agencies seeking feedback to the proposed rule language and disclosure by November 15, 2019 for consideration prior to the requested emergency rulemaking hearing.

Stakeholder Group Notification
The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was provided prior to the date the notice of rulemaking was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

XX Not applicable. This is an Emergency Rulemaking Packet. Notification will occur if the Board of Health sets this matter for final rulemaking.

____ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

At this time, the Department has not received significant comment on the proposed rules and disclosure. Stakeholders have voiced concern that the disclosure may be too long and hard to read for the average health care client, and have requested that it be reviewed by a

professional in medical literacy. The Department is committed to exploring this prior to the final rulemaking.

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking.

Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.	X	Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
	Improves access to food and healthy food options.		Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
X	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.		Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.		Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____ _____		Other:_____ _____

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES CHAPTER 2 – GENERAL LICENSURE STANDARDS

6 CCR 1011-1 Chapter 2

Emergency rules adopted by the Board of Health _____, 2019. Effective _____.

Editor's note: This note will not appear in the adopted rule.
Revisions to 6 CCR 1011-2 were adopted by the Board of Health on November 20, 2019 (Tracking number ("TN") 2019-00557; based upon the Secretary of State's publishing schedule, any revision adopted under this emergency rulemaking, will be published on January 14, 2020, contemporaneous with the TN 2019-00557 changes. For this reason, the numbering that appears in this rule aligns with the rule as it will appear on January 14, 2019 rather than providing the rule number as it would appear in the rule until January 14, 2020. For example, under the rule in effect until January 14, the proposed 1.16 definition below would be 2.2.3.5 (between 2.2.3 and 2.2.4), the proposed 7.1.1(Q) client rights policy requirement would appear at 6.104(1).

PART 1. DEFINITIONS

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1.16 COST SHARING – THE SHARE OF COST COVERED BY A CLIENT'S INSURANCE THAT THE CLIENT PAYS OUT OF POCKET. THIS TERM INCLUDES, BUT IS NOT LIMITED TO DEDUCTIBLES, COINSURANCE, COPAYMENTS, OR OTHER SIMILAR CHARGES.

Editor's note: This note will not appear in the adopted rule.
Re-number TN 2019-00557 Rule 1.16 through 1.20 to 1.17 through 1.21.

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1.22 "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: SERIOUS JEOPARDY TO THE HEALTH OF THE INDIVIDUAL OR, WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR HER UNBORN CHILD; OR SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

1.23 "EMERGENCY SERVICES," WITH RESPECT TO AN EMERGENCY MEDICAL CONDITION, MEANS: 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 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.

Editor's note: This note will not appear in the adopted rule.
Re-number TN 2019-00557 Rule 1.21 through 1.31 to 1.24 through 1.33.

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1.34 "IN-NETWORK " MEANS A FACILITY OR AGENCY THAT IS A PARTICIPATING PROVIDER, AS DEFINED AT SECTION 10-16-102(46), C.R.S., IN AN INDIVIDUAL'S HEALTH INSURANCE PLAN OR AS DEFINED BELOW.

Editor's note: This note will not appear in the adopted rule.
Re-number TN 2019-00557 Rule 1.32 through 1.41 to 1.35 through 1.44.

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1.45 "OUT-OF-NETWORK" MEANS A FACILITY OR AGENCY THAT IS NOT A PARTICIPATING PROVIDER, AS DEFINED AT SECTION 10-16-102(46), C.R.S.

Editor's note: This note will not appear in the adopted rule.
Re-number TN 2019-00557 Rule 1.42 through 1.55 to 1.46 through 1.59.

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PART 7. CLIENT RIGHTS

7.1 Client Rights Policy

7.1.1 The facility or agency shall develop and implement a policy regarding client rights. The policy shall ensure that each client or, where appropriate, the client's designated representative, has the right to:

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(Q) REQUEST THAT AN IN-NETWORK HEALTHCARE PROVIDER PROVIDE SERVICES AT AN IN-NETWORK FACILITY OR AGENCY IF AVAILABLE.

7.1.2 The facility or agency shall disclose the policy regarding rights to the client or the client's designated representative prior to treatment or upon admission, where possible. For any services requiring multiple client encounters, disclosure provided at the beginning of such care or treatment course shall meet the intent of the regulations.

7.1.3 PURSUANT TO SECTION 25-3-121, C.R.S. FACILITIES AND AGENCIES SHALL PROVIDE THE DISCLOSURE CONTAINED IN APPENDIX A TO ALL CLIENTS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK FACILITY OR AGENCY OR AN OUT-OF-NETWORK PROVIDER WHO PROVIDES SERVICES AT AN IN-NETWORK FACILITY OR AGENCY.

REQUIRED DISCLOSURES BY CARRIERS AND HEALTHCARE PROVIDERS MAY BE FOUND AT 3 CCR 702-4, 4-2-65 AND RULES PROMULGATED THROUGH THE DEPARTMENT OF REGULATORY AGENCIES, DIVISIONS OF OCCUPATIONS AND PROFESSIONS.

(A) THE FACILITY OR AGENCY SHALL PROVIDE THE DISCLOSURE CONTAINED IN APPENDIX A ON THE FOLLOWING OCCASIONS:

(1) FOR EMERGENCY SERVICES: AFTER PERFORMING AN APPROPRIATE MEDICAL SCREENING EXAMINATION AND DETERMINING THAT A CLIENT DOES NOT HAVE AN EMERGENCY MEDICAL CONDITION OR AFTER TREATMENT HAS BEEN PROVIDED TO

STABILIZE AN EMERGENCY MEDICAL CONDITION. THE DISCLOSURE SHALL BE SIGNED BY THE CLIENT OR THEIR DESIGNATED REPRESENTATIVE PRIOR TO DISCHARGE;

(2) AT THE TIME THE CLIENT CONSENTS TO CARE OR TREATMENT BY THE FACILITY OR AGENCY FOR NONEMERGENCY SERVICES. THE DISCLOSURE SHALL BE SIGNED BY THE CLIENT OR THEIR DESIGNATED REPRESENTATIVE BEFORE THE START OF SERVICES;

(3) ON OR WITH BILLING STATEMENTS AND BILLING NOTICES ISSUED BY THE FACILITY OR AGENCY; AND

(4) ON OR WITH OTHER FORMS OR COMMUNICATIONS RELATED TO THE SERVICES BEING PROVIDED PURSUANT TO INSURANCE COVERAGE.

7.1.~~43~~ Each facility or agency shall post a clear and unambiguous notice in a public location in the facility or agency specifying that complaints may be registered with the facility or agency, the Department, and with the appropriate oversight board at the Department of Regulatory Agencies (DORA). Upon request, the facility or agency shall provide the client and any interested person with contact information for registering complaints.

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Editor's note: This note will not appear in the adopted rule.
In the rule as published prior to January 14, 2020, Appendix A appears after Rule 10.12.
As published on or after January 14, 2020, Appendix A will appear after Rule 11.4.2.

Appendix A: Surprise Billing Disclosure

Surprise Billing -- Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado.*

What is surprise/balance billing, and when does it happen?

If you are seen by a provider or use services in a facility or agency that is **NOT** in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network facilities or agencies often bill you the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and /or coinsurance. You cannot be billed for any other amount. This includes both the facility where you receive emergency services and any providers that see you for emergency services.

Please note that not every service provided in an emergency Department is an emergency service.

Non-Emergency Services at an In-Network Facility by an Out-of-Network Provider

The facility or agency must tell you if you are at an out-of-network location or at an in-network location that is using out of network providers. They must also tell you what types of services that you will be using may be provided by an out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within 60 days of being notified.
- No one, including a provider, hospital, or insurer, can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you

INTENTIONALLY RECEIVE NON-EMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER OR FACILITY, YOU MAY ALSO BE BALANCE BILLED.

IF YOU THINK YOU HAVE RECEIVED A BILL FOR AMOUNTS OTHER THAN YOUR COPAYMENTS, DEDUCTIBLE, AND/OR COINSURANCE, PLEASE CONTACT THE BILLING DEPARTMENT, OR THE COLORADO DIVISION OF INSURANCE AT 303-894-7490 OR 1-800-930-3745.

* THIS LAW DOES NOT APPLY TO ALL COLORADO HEALTH PLANS. IT ONLY APPLIES IF:

- YOU HAVE A "**CO-DOI**" ON YOUR HEALTH INSURANCE ID CARD, AND
- YOU ARE RECEIVING CARE AND SERVICES PROVIDED AT A REGULATED FACILITY IN THE STATE OF COLORADO.

PLEASE CONTACT YOUR HEALTH INSURANCE PLAN AT THE NUMBER ON YOUR HEALTH INSURANCE ID CARD OR THE COLORADO DIVISION OF INSURANCE WITH QUESTIONS.