Second Regular Session
Seventy-second General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 20-1083.01 Duane Gall x4335 **SENATE BILL 20-188**

SENATE SPONSORSHIP

Fields,

HOUSE SPONSORSHIP

(None),

Senate Committees
Health & Human Services

House Committees

A BILL FOR AN ACT

CONCERNING A REQUIREMENT FOR THE USE OF PLAIN LANGUAGE IN BILLS FOR MEDICAL SERVICES.

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 a health care facility to provide an itemized statement or bill to a patient within 30 days after discharge from the facility or within 7 days after the patient's written request. The statement or bill must list all medical services provided in understandable language, without using procedure codes or drug codes exclusively and with a breakdown of the charges for which payment is expected from the patient.

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

SECTION 1. In Colorado Revised Statutes, 25-3-121, **amend** (4) as follows:

25-3-121. Health care facilities - emergency and nonemergency services - required disclosures - rules - definitions.

(4) ~~For the purposes of~~ AS USED IN this section and ~~section~~ SECTIONS 25-3-121.5 AND 25-3-122:

(a) "Carrier" has the same meaning as defined in section 10-16-102 (8).

(b) "Covered person" has the same meaning as defined in section 10-16-102 (15).

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

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

(e) "Health benefit plan" has the same meaning as defined in section 10-16-102 (32).

(f) "HEALTH CARE FACILITY" OR "FACILITY" MEANS ANY FACILITY SUBJECT TO LICENSURE UNDER SECTION 25-3-101.

(g) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS ANY PERSON WHO:

(I) IS SUBJECT TO LICENSURE, REGISTRATION, OR CERTIFICATION UNDER ARTICLES 200 TO 310 OF TITLE 12; AND

(II) PROVIDES PROFESSIONAL SERVICES IN, OR UNDER CONTRACT WITH, A HEALTH CARE FACILITY.

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

defined in section 10-16-704 (3)(d)(VI)(B).

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

SECTION 2. In Colorado Revised Statutes, **add** 25-3-121.5 as follows:

25-3-121.5. Health care facilities - plain-language billing statements - rules. (1) (a) ON AND AFTER JANUARY 1, 2021, HEALTH CARE FACILITIES SHALL, WITHIN THIRTY DAYS AFTER A PATIENT'S DISCHARGE OR RELEASE OR WITHIN SEVEN DAYS AFTER RECEIVING A WRITTEN REQUEST, PROVIDE TO THE PATIENT OR TO THE PATIENT'S SURVIVOR OR LEGAL GUARDIAN, AS APPROPRIATE, A CONSOLIDATED, ITEMIZED STATEMENT OR BILL DETAILING, IN PLAIN LANGUAGE THAT IS COMPREHENSIBLE TO AN ORDINARY LAYPERSON, THE SPECIFIC NATURE OF THE CHARGES OR EXPENSES FOR THE HEALTH CARE SERVICES AND GOODS THE PATIENT RECEIVED AT THE FACILITY. THE DESCRIPTION OF BILLED CHARGES MAY INCLUDE TECHNICAL TERMS TO DESCRIBE THE HEALTH CARE SERVICES IF THE TECHNICAL TERMS ARE DEFINED USING LIMITED MEDICAL NOMENCLATURE AS PERMITTED UNDER THE RULES ADOPTED PURSUANT TO SUBSECTION (3) OF THIS SECTION.

(b) THE ITEMIZED STATEMENT OR BILL REQUIRED BY THIS SECTION MUST:

(I) NOT DESCRIBE A BILLED CHARGE USING ONLY A MEDICAL BILLING CODE OR A GENERAL TERM SUCH AS "MISCELLANEOUS CHARGES", "SUPPLY CHARGES", OR "OTHER CHARGES";

(II) LIST THE SPECIFIC SERVICES RECEIVED AND EXPENSES INCURRED BY DATE AND PROVIDER, ENUMERATING IN DETAIL THE CONSTITUENT COMPONENTS OF THE SERVICES RECEIVED WITHIN EACH

DEPARTMENT OF THE FACILITY AND INCLUDING UNIT PRICE DATA ON RATES CHARGED BY THE FACILITY;

(III) IDENTIFY EACH ITEM AS PAID, ASSIGNED TO A THIRD-PARTY PAYER, OR CHARGEABLE DIRECTLY TO THE PATIENT, INCLUDING THE AMOUNT DUE AND THE DUE DATE FOR ANY AMOUNT EXPECTED FROM THE PATIENT;

(IV) NOT REFER TO DRUG CODE NUMBERS WITHOUT ALSO USING THE APPROPRIATE BRAND NAME OR GENERIC NAME FOR EACH DRUG;

(V) INCLUDE THE SERVICES PROVIDED BY HOSPITAL-BASED PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO MAY NOT BILL SEPARATELY;

(VI) SPECIFICALLY IDENTIFY PHYSICAL, REHABILITATIVE, OCCUPATIONAL, OR SPEECH THERAPY TREATMENT BY DATE, TYPE, AND LENGTH OF TREATMENT; AND

(VII) CONSPICUOUSLY DISPLAY THE TELEPHONE NUMBER OF THE FACILITY'S PATIENT LIAISON RESPONSIBLE FOR EXPEDITING THE RESOLUTION OF ANY BILLING DISPUTE BETWEEN THE PATIENT, OR THE PATIENT'S SURVIVOR OR LEGAL GUARDIAN, IN ACCORDANCE WITH SUBSECTION (2) OF THIS SECTION.

(c) AFTER DELIVERY OF THE INITIAL STATEMENT OR BILL, ANY SUBSEQUENT STATEMENT OR BILL PROVIDED TO A PATIENT OR TO THE PATIENT'S SURVIVOR OR LEGAL GUARDIAN, AS APPROPRIATE, RELATING TO THE SAME EPISODE OF CARE MUST INCLUDE ALL OF THE INFORMATION REQUIRED BY SUBSECTION (1)(b) OF THIS SECTION, WITH ANY REVISIONS CLEARLY DELINEATED.

(d) A HEALTH CARE FACILITY SHALL:

(I) NOT BILL OR OTHERWISE CHARGE A PATIENT FOR PREPARATION

OF AN ITEMIZED STATEMENT OR BILL REQUIRED BY THIS SECTION; AND

(II) TRANSMIT THE ITEMIZED STATEMENT OR BILL BY SECURE E-MAIL, VIA A SECURE ONLINE PORTAL, OR, UPON REQUEST, BY MAIL.

(2) EACH HEALTH CARE FACILITY SHALL ESTABLISH POLICIES AND PROCEDURES FOR REVIEWING AND RESPONDING TO QUESTIONS FROM A PATIENT CONCERNING THE PATIENT'S CONSOLIDATED ITEMIZED STATEMENT OR BILL. THE RESPONSE MUST BE PROVIDED NO MORE THAN SEVEN BUSINESS DAYS AFTER THE DATE A QUESTION IS RECEIVED.

(3) 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 PLAIN-LANGUAGE BILLING STATEMENTS IN ACCORDANCE WITH THIS SECTION. THE STATE BOARD OF HEALTH SHALL ENSURE THAT THE RULES ARE CONSISTENT WITH SECTIONS 10-16-704 (12) AND 12-30-112 AND RULES ADOPTED BY THE COMMISSIONER PURSUANT TO SECTION 10-16-704 (12)(b) AND BY THE DIRECTOR OF THE DIVISION OF PROFESSIONS AND OCCUPATIONS PURSUANT TO SECTION 12-30-112 (3)(e). THE RULES MUST SPECIFY, AT A MINIMUM, THE FOLLOWING:

(a) THE CONTENTS OF THE STATEMENTS, INCLUDING THE PATIENT'S RIGHTS AND PAYMENT OBLIGATIONS PURSUANT TO THE PATIENT'S HEALTH BENEFIT PLAN;

(b) DISCLOSURE REQUIREMENTS SPECIFIC TO HEALTH CARE FACILITIES, INCLUDING THE TERMS USED TO DIFFERENTIATE IN-NETWORK AND OUT-OF-NETWORK SERVICES AND HEALTH CARE PROVIDERS; AND

(c) REQUIREMENTS TO ENSURE THAT CARRIERS, HEALTH CARE

FACILITIES, AND HEALTH CARE PROVIDERS USE LANGUAGE THAT IS CONSISTENT WITH THE DISCLOSURES REQUIRED BY SECTIONS 10-16-704 (12), 12-30-112, AND 25-3-121 AND THE RULES ADOPTED PURSUANT TO SECTIONS 25-3-121 (2)(e), 10-16-704 (12)(b), AND 12-30-112 (3)(e).

(4) THIS SECTION DOES NOT APPLY TO PATIENTS COVERED 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., OR ENROLLED IN A PROGRAM PURSUANT TO ARTICLE 4, 5, OR 6 OF TITLE 25.5.

SECTION 3. 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 5, 2020, if adjournment sine die is on May 6, 2020); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within 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.