

**First Regular Session  
Seventy-third General Assembly  
STATE OF COLORADO**

**REVISED**

*This Version Includes All Amendments Adopted  
on Second Reading in the Second House*

LLS NO. 21-0634.01 Shelby Ross x4510

**HOUSE BILL 21-1198**

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Appropriations

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**A BILL FOR AN ACT**

101      **CONCERNING HEALTH-CARE BILLING REQUIREMENTS FOR INDIGENT**  
102                    **PATIENTS RECEIVING SERVICES NOT REIMBURSED THROUGH THE**  
103                    **COLORADO INDIGENT CARE PROGRAM, AND, IN CONNECTION**  
104                    **THEREWITH, ESTABLISHING PROCEDURES BEFORE INITIATING**  
105                    **COLLECTIONS PROCEEDINGS AGAINST A PATIENT AND MAKING**  
106                    **AND REDUCING APPROPRIATIONS.**

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**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>.)*

No later than June 1, 2022, a health-care facility shall screen each

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.*

SENATE  
Amended 2nd Reading  
June 3, 2021

HOUSE  
3rd Reading Unamended  
May 12, 2021

HOUSE  
Amended 2nd Reading  
May 11, 2021

uninsured patient for eligibility for public health insurance programs, discounted care through the Colorado indigent care program (CICP), and discounted care as described in the bill. Health-care facilities shall use a single uniform application developed by the department of health care policy and financing (department) when screening a patient. If a health-care facility determines a patient is ineligible for discounted care, the facility shall provide the patient notice of the determination and an opportunity for the patient to appeal the determination.

For emergency and other non-CICP health-care services provided to qualified patients, a health-care facility and licensed health-care professional shall limit the amounts charged to not more than 80% of the medicare rate if the patient is uninsured; collect amounts charged in monthly installments such that a patient is not paying more than 5% of the patient's household income; and after a cumulative 36 months of payments, consider the patient's bill paid in full and permanently cease any and all collection activities on any balance that remains unpaid.

A health-care facility shall make information about patient's rights and the uniform application for discounted care available to the public and to each patient.

Beginning June 1, 2023, and each June 1 thereafter, each health-care facility shall collect and report to the department data that the department determines is necessary to evaluate compliance across patient groups based on race, ethnicity, and primary language spoken with the required screening, discounted care, payment plan, and collections practices.

No later than April 1, 2022, the department shall develop a written explanation of a patient's rights, make the explanation available to the public and each patient, and establish a process for patients to submit a complaint relating to noncompliance with the requirements. The department shall periodically review health-care facilities and licensed health-care professionals (hospital providers) to ensure compliance, and the department shall notify the hospital provider if the hospital provider is not in compliance that the hospital provider has 90 days to file a corrective action plan with the department. A hospital provider may request up to 120 days to submit a corrective action plan. The department may require a hospital provider that is not in compliance to develop and operate under a corrective action plan until the department determines the hospital provider is in compliance. The bill implements fines for hospital providers if the department determines the hospital provider's noncompliance is knowing or willful.

The bill imposes requirements on hospital providers before assigning or selling patient debt to a medical creditor or before pursuing any permissible extraordinary collection action and imposes fines for any hospital provider that fails to comply with the requirements.

The bill prohibits a medical creditor from using impermissible

extraordinary collection action to collect debts owed for health-care services provided by a hospital provider. A medical creditor may engage in permissible extraordinary collection actions 180 days after the first bill for a medical debt is sent to the patient. At least 30 days before taking any permissible extraordinary collection action, a medical creditor shall provide the patient with a notice about the discounted care policy, the permissible extraordinary collection actions that will be initiated, and a deadline after which such permissible extraordinary collection actions will be initiated. If a patient is later found eligible for discounted care, the medical creditor shall reverse any permissible extraordinary collection actions.

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

2 **SECTION 1.** In Colorado Revised Statutes, **add** part 5 to article  
3 of title 25.5 as follows:

4 **PART 5**

5 **HEALTH-CARE BILLING FOR INDIGENT PATIENTS**  
6 **RECEIVING SERVICES NOT REIMBURSED THROUGH**  
7 **THE COLORADO INDIGENT CARE PROGRAM**

8 **25.5-3-501. Definitions.** AS USED IN THIS PART 5, UNLESS THE  
9 CONTEXT OTHERWISE REQUIRES:

10 (1) "HEALTH-CARE FACILITY" MEANS:

11 (a) A HOSPITAL LICENSED AS A GENERAL HOSPITAL PURSUANT TO  
12 PART 1 OF ARTICLE 3 OF TITLE 25;

13 (b) A HOSPITAL ESTABLISHED PURSUANT TO SECTION 23-21-503 OR  
14 25-29-103;

15 (c) ANY FREESTANDING EMERGENCY DEPARTMENT LICENSED  
16 PURSUANT TO SECTION 25-1.5-114; OR

17 (d) ANY OUTPATIENT HEALTH-CARE FACILITY THAT IS LICENSED AS  
18 AN ON-CAMPUS DEPARTMENT OR SERVICE OF A HOSPITAL OR THAT IS  
19 LISTED AS AN OFF-CAMPUS LOCATION UNDER A HOSPITAL'S LICENSE,

1     EXCEPT:

2             (I) A FEDERALLY QUALIFIED HEALTH CENTER, AS DEFINED IN THE  
3     FEDERAL "SOCIAL SECURITY ACT", 42 U.S.C. SEC. 1395x (aa)(4); OR

4             (II) A STUDENT-LEARNING MEDICAL AND DENTAL CLINIC THAT IS  
5     ESTABLISHED FOR THE PURPOSE OF STUDENT LEARNING, OFFERING  
6     DISCOUNTED PATIENT CARE AS PART OF A PROGRAM OF STUDENT  
7     LEARNING, AND IS PHYSICALLY SITUATED WITHIN A HEALTH SCIENCES  
8     SCHOOL.

9             (2) "HEALTH-CARE SERVICES" HAS THE SAME MEANING AS SET  
10     FORTH IN SECTION 10-16-102 (33).

11            (3) "LICENSED HEALTH-CARE PROFESSIONAL" MEANS ANY  
12     HEALTH-CARE PROFESSIONAL WHO IS REGISTERED, CERTIFIED, OR  
13     LICENSED PURSUANT TO TITLE 12 OR WHO PROVIDES SERVICES UNDER THE  
14     SUPERVISION OF A HEALTH-CARE PROFESSIONAL WHO IS REGISTERED,  
15     CERTIFIED, OR LICENSED PURSUANT TO TITLE 12, AND WHO PROVIDES  
16     HEALTH-CARE SERVICES IN A HEALTH-CARE FACILITY.

17            (4) "NON-CICP HEALTH-CARE SERVICES" MEANS HEALTH-CARE  
18     SERVICES PROVIDED IN A HEALTH-CARE FACILITY FOR WHICH  
19     REIMBURSEMENT UNDER THE COLORADO INDIGENT CARE PROGRAM,  
20     ESTABLISHED IN PART 1 OF THIS ARTICLE 3, IS NOT AVAILABLE.

21            (5) "QUALIFIED PATIENT" MEANS AN INDIVIDUAL WHOSE  
22     HOUSEHOLD INCOME IS NOT MORE THAN TWO HUNDRED FIFTY PERCENT OF  
23     THE FEDERAL POVERTY LEVEL AND WHO RECEIVED A HEALTH-CARE  
24     SERVICE AT A HEALTH-CARE FACILITY.

25            (6) "SCREEN" OR "SCREENING" MEANS A PROCESS IDENTIFIED IN  
26     RULE BY THE STATE DEPARTMENT WHEREBY HEALTH-CARE FACILITIES  
27     ASSESS A PATIENT'S CIRCUMSTANCES RELATED TO ELIGIBILITY CRITERIA

1 AND DETERMINE WHETHER THE PATIENT IS LIKELY TO QUALIFY FOR PUBLIC  
2 HEALTH-CARE COVERAGE OR DISCOUNTED CARE, INFORM THE PATIENT OF  
3 THE HEALTH-CARE FACILITY'S DETERMINATION, AND PROVIDE  
4 INFORMATION TO THE PATIENT ABOUT HOW THE PATIENT CAN ENROLL IN  
5 PUBLIC HEALTH-CARE COVERAGE.

6 (7) "UNINSURED" MEANS AN UNINSURED INDIVIDUAL, AS DEFINED  
7 IN SECTION 10-22-113 (5)(d).

8 **25.5-3-502. Requirement to screen patients for eligibility for**  
9 **public health-care programs and discounted care - rules.**

10 (1) BEGINNING JUNE 1, 2022, A HEALTH-CARE FACILITY SHALL SCREEN,  
11 UNLESS A PATIENT DECLINES, EACH UNINSURED PATIENT FOR ELIGIBILITY  
12 FOR:

13 (a) PUBLIC HEALTH INSURANCE PROGRAMS INCLUDING BUT NOT  
14 LIMITED TO MEDICARE; THE STATE MEDICAL ASSISTANCE PROGRAM,  
15 ARTICLES 4, 5, AND 6 OF THIS TITLE 25.5; EMERGENCY MEDICAID; AND THE  
16 CHILDREN'S BASIC HEALTH PLAN, ARTICLE 8 OF THIS TITLE 25.5;

17 (b) DISCOUNTED CARE THROUGH THE COLORADO INDIGENT CARE  
18 PROGRAM, ESTABLISHED IN PART 1 OF THIS ARTICLE 3, IF THE PATIENT  
19 RECEIVES A SERVICE ELIGIBLE FOR REIMBURSEMENT THROUGH THE  
20 PROGRAM; AND

21 (c) DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-503.

22 (2) HEALTH-CARE FACILITIES SHALL USE A SINGLE UNIFORM  
23 APPLICATION DEVELOPED BY THE STATE DEPARTMENT WHEN SCREENING  
24 A PATIENT PURSUANT TO SUBSECTION (1) OF THIS SECTION.

25 (3) IF A HEALTH-CARE FACILITY DETERMINES THAT A PATIENT IS  
26 INELIGIBLE FOR DISCOUNTED CARE, THE FACILITY SHALL PROVIDE THE  
27 PATIENT NOTICE OF THE DETERMINATION AND AN OPPORTUNITY FOR THE

1 PATIENT TO APPEAL THE DETERMINATION IN ACCORDANCE WITH STATE  
2 DEPARTMENT RULES.

3 (4) IF THE PATIENT DECLINES THE SCREENING DESCRIBED IN  
4 SUBSECTION (1) OF THIS SECTION, THE HEALTH-CARE FACILITY SHALL  
5 DOCUMENT THE PATIENT'S DECISION IN ACCORDANCE WITH STATE  
6 DEPARTMENT RULES. A PATIENT'S DECISION TO DECLINE THE SCREENING  
7 THAT IS DOCUMENTED AND COMPLIES WITH STATE DEPARTMENT RULES IS  
8 A COMPLETE DEFENSE TO A CLAIM BROUGHT BY A PATIENT UNDER SECTION  
9 25.5-3-506 (2) FOR A VIOLATION OF SECTION 25.5-3-506 (1)(a) OR (1)(b).

10 (5) IF REQUESTED BY THE PATIENT, A HEALTH-CARE FACILITY  
11 SHALL SCREEN AN INSURED PATIENT FOR DISCOUNTED CARE PURSUANT TO  
12 SUBSECTIONS (1)(b) AND (1)(c) OF THIS SECTION.

13 **25.5-3-503. Health-care discounts on services not eligible for**  
14 **Colorado indigent care program reimbursement.** (1) BEGINNING  
15 JUNE 1, 2022, IF A PATIENT IS SCREENED PURSUANT TO SECTION  
16 25.5-3-502 AND IS DETERMINED TO BE A QUALIFIED PATIENT, A  
17 HEALTH-CARE FACILITY AND A LICENSED HEALTH-CARE PROFESSIONAL  
18 SHALL, FOR EMERGENCY AND OTHER NON-CICP HEALTH-CARE SERVICES:

19 (a) LIMIT THE AMOUNTS CHARGED TO NOT MORE THAN THE  
20 DISCOUNTED RATE ESTABLISHED IN STATE DEPARTMENT RULE PURSUANT  
21 TO SECTION 25.5-3-505 (2)(j);

22 (b) COLLECT AMOUNTS CHARGED, NOT INCLUDING AMOUNTS  
23 OWED BY THIRD-PARTY PAYERS, IN MONTHLY INSTALLMENTS SUCH THAT  
24 THE PATIENT IS NOT PAYING MORE THAN FOUR PERCENT OF THE PATIENT'S  
25 MONTHLY HOUSEHOLD INCOME ON A BILL FROM A HEALTH-CARE FACILITY  
26 AND NOT PAYING MORE THAN TWO PERCENT OF THE PATIENT'S MONTHLY  
27 HOUSEHOLD INCOME ON A BILL FROM EACH LICENSED HEALTH-CARE

1     PROFESSIONAL; AND

2           (c) AFTER A CUMULATIVE THIRTY-SIX MONTHS OF PAYMENTS,  
3     CONSIDER THE PATIENT'S BILL PAID IN FULL AND PERMANENTLY CEASE  
4     ANY AND ALL COLLECTION ACTIVITIES ON ANY BALANCE THAT REMAINS  
5     UNPAID.

6           (2) A HEALTH-CARE FACILITY SHALL NOT:

7           (a) DENY DISCOUNTED CARE ON THE BASIS THAT THE PATIENT HAS  
8     NOT APPLIED FOR ANY PUBLIC BENEFITS PROGRAM; OR

9           (b) ADOPT OR MAINTAIN ANY POLICIES THAT RESULT IN THE  
10    DENIAL OF ADMISSION OR TREATMENT OF A PATIENT BECAUSE THE  
11    PATIENT LACKS HEALTH INSURANCE COVERAGE, MAY QUALIFY FOR  
12    DISCOUNTED CARE, REQUIRES EXTENDED OR LONG-TERM TREATMENT, OR  
13    HAS AN UNPAID MEDICAL BILL.

14           **25.5-3-504. Notification of patient's rights.** (1) BEGINNING JUNE  
15    1, 2022, A HEALTH-CARE FACILITY SHALL MAKE INFORMATION DEVELOPED  
16    BY THE STATE DEPARTMENT ABOUT PATIENT'S RIGHTS UNDER THIS PART  
17    5 AND THE UNIFORM APPLICATION DEVELOPED BY THE STATE DEPARTMENT  
18    PURSUANT TO SECTION 25.5-3-505 (2)(i) AVAILABLE TO THE PUBLIC AND  
19    TO EACH PATIENT. AT A MINIMUM, THE HEALTH-CARE FACILITY SHALL:

20           (a) POST THE INFORMATION IN ALL REQUIRED LANGUAGES  
21    PURSUANT TO THIS SUBSECTION (1) CONSPICUOUSLY ON THE HEALTH-CARE  
22    FACILITY'S WEBSITE, INCLUDING A LINK TO THE INFORMATION ON THE  
23    HEALTH-CARE FACILITY'S MAIN LANDING PAGE;

24           (b) MAKE THE INFORMATION AVAILABLE IN PATIENT WAITING  
25    AREAS;

26           (c) MAKE THE INFORMATION AVAILABLE TO EACH PATIENT, OR THE  
27    PATIENT'S LEGAL GUARDIAN, VERBALLY, WHICH MAY INCLUDE USING A

1     PROFESSIONAL INTERPRETATION SERVICE, OR IN WRITING IN THE PATIENT'S  
2     OR LEGAL GUARDIAN'S PRIMARY LANGUAGE BEFORE THE PATIENT IS  
3     DISCHARGED FROM THE HEALTH-CARE FACILITY; AND

4             (d) INFORM EACH PATIENT ON THE PATIENT'S BILLING STATEMENT  
5     OF THE PATIENT'S RIGHTS PURSUANT TO THIS PART 5, INCLUDING THE  
6     RIGHT TO APPLY FOR DISCOUNTED CARE, AND PROVIDE THE WEBSITE,  
7     E-MAIL ADDRESS, AND TELEPHONE NUMBER WHERE THE INFORMATION  
8     MAY BE OBTAINED IN THE PATIENT'S PRIMARY LANGUAGE.

9             **25.5-3-505. Health-care facility reporting requirements -**  
10    **agency enforcement - report - rules.** (1) BEGINNING JUNE 1, 2023, AND  
11    EACH JUNE 1 THEREAFTER, EACH HEALTH-CARE FACILITY SHALL   
12    REPORT TO THE STATE DEPARTMENT DATA THAT THE STATE DEPARTMENT  
13    DETERMINES IS NECESSARY TO EVALUATE COMPLIANCE ACROSS RACE,  
14    ETHNICITY, AGE, AND PRIMARY-LANGUAGE-SPOKEN PATIENT GROUPS WITH  
15    THE SCREENING, DISCOUNTED CARE, PAYMENT PLAN, AND COLLECTIONS  
16    PRACTICES REQUIRED PURSUANT TO THIS PART 5. IF A HEALTH-CARE  
17    FACILITY IS NOT CAPABLE OF DISAGGREGATING THE DATA REQUIRED  
18    PURSUANT TO THIS SUBSECTION (1) BY RACE, ETHNICITY, AGE, AND  
19    PRIMARY LANGUAGE SPOKEN, THE HEALTH-CARE FACILITY SHALL REPORT  
20    TO THE STATE DEPARTMENT THE STEPS THE FACILITY IS TAKING TO  
21    IMPROVE RACE, ETHNICITY, AGE, AND PRIMARY-LANGUAGE-SPOKEN DATA  
22    COLLECTION AND THE DATE BY WHICH THE FACILITY WILL BE ABLE TO  
23    DISAGGREGATE THE REPORTED DATA.

24             (2) NO LATER THAN APRIL 1, 2022, THE STATE BOARD SHALL  
25    PROMULGATE RULES NECESSARY FOR THE ADMINISTRATION AND  
26    IMPLEMENTATION OF THIS PART 5. AT A MINIMUM, THE RULES MUST:

27             (a) OUTLINE A PROCESS FOR AN INSURED PATIENT TO REQUEST A



- 1 SCREENING PURSUANT TO SECTION 25.5-3-502 (5);
- 2 (b) OUTLINE A PROCESS FOR DOCUMENTING, PURSUANT TO  
3 SECTION 25.5-3-502 (4), THAT A PATIENT HAS MADE AN INFORMED  
4 DECISION TO DECLINE THE SCREENING, INCLUDING PROCEDURES FOR  
5 RETAINING SUCH DOCUMENTATION;
- 6 (c) ESTABLISH THE PROCESS FOR AND THE MAXIMUM NUMBER OF  
7 DAYS THAT A HEALTH-CARE FACILITY HAS TO:
- 8 (I) INITIATE A SCREENING AFTER A PATIENT RECEIVES SERVICES;  
9 (II) REQUEST INFORMATION FROM THE PATIENT NEEDED FOR THE  
10 SCREENING PROCESS; AND
- 11 (III) COMPLETE THE SCREENING PROCESS;
- 12 (d) OUTLINE THE REQUIREMENTS FOR NOTIFYING THE PATIENT OF  
13 THE RESULTS OF THE SCREENING, INCLUDING AN EXPLANATION OF THE  
14 BASIS FOR A DENIAL OF DISCOUNTED CARE AND THE PROCESS FOR  
15 APPEALING A DENIAL;
- 16 (e) ESTABLISH GUIDELINES FOR PATIENT APPEALS REGARDING  
17 ELIGIBILITY FOR DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503;
- 18 (f) ESTABLISH A METHODOLOGY THAT ALL HEALTH-CARE  
19 FACILITIES MUST USE TO DETERMINE MONTHLY HOUSEHOLD INCOME. THE  
20 METHODOLOGY MUST NOT CONSIDER A PATIENT'S ASSETS.
- 21 (g) IDENTIFY THE DOCUMENTS THAT MAY BE REQUIRED TO  
22 ESTABLISH INCOME ELIGIBILITY FOR DISCOUNTED CARE USING THE  
23 MINIMUM AMOUNT OF INFORMATION NEEDED TO DETERMINE ELIGIBILITY;
- 24 (h) IDENTIFY THE STEPS A HEALTH-CARE FACILITY AND LICENSED  
25 HEALTH-CARE PROFESSIONAL MUST TAKE BEFORE SENDING PATIENT DEBT  
26 TO COLLECTIONS; ■
- 27 (i) CREATE A SINGLE UNIFORM APPLICATION THAT A HEALTH-CARE

1 FACILITY SHALL USE WHEN SCREENING A PATIENT FOR ELIGIBILITY FOR THE  
2 COLORADO INDIGENT CARE PROGRAM AND DISCOUNTED CARE, AS  
3 DESCRIBED IN SECTION 25.5-3-502; AND

4 (j) ANNUALLY ESTABLISH RATES FOR DISCOUNTED CARE  
5 PURSUANT TO SECTION 25.5-3-503 (1)(a). THE RATES SHOULD  
6 APPROXIMATE AND NOT BE LESS THAN ONE HUNDRED PERCENT OF THE  
7 MEDICARE RATE OR ONE HUNDRED PERCENT OF THE MEDICAID BASE RATE,  
8 WHICHEVER IS GREATER. THE STATE DEPARTMENT SHALL PUBLICLY POST  
9 THE ESTABLISHED RATES ON THE STATE DEPARTMENT'S WEBSITE.

10 (3) IN PROMULGATING RULES PURSUANT TO THIS SECTION, THE  
11 STATE DEPARTMENT SHALL:

12 (a) ALIGN THE PROCESSES OF QUALIFYING FOR AND APPEALING  
13 DENIALS OF ELIGIBILITY FOR THE COLORADO INDIGENT CARE PROGRAM  
14 WITH DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-502; AND

15 (b) CONSIDER POTENTIAL LIMITATIONS RELATING TO THE FEDERAL  
16 "EMERGENCY MEDICAL TREATMENT AND LABOR ACT", 42 U.S.C. SEC.  
17 1395dd.

18 (4) PRIOR TO PROMULGATING RULES PURSUANT TO THIS SECTION,  
19 THE STATE DEPARTMENT SHALL HOLD AT LEAST ONE STAKEHOLDER  
20 MEETING WITH HOSPITAL REPRESENTATIVES, HEALTH-CARE CONSUMERS,  
21 AND HEALTH-CARE CONSUMER ADVOCATES THAT IS ACCESSIBLE TO  
22 INDIVIDUALS WHOSE PRIMARY LANGUAGE IS NOT ENGLISH, IF REQUESTED.

23 (5) NO LATER THAN APRIL 1, 2022, THE STATE DEPARTMENT  
24 SHALL:

25 (a) USING FEEDBACK FROM HOSPITAL HEALTH-CARE CONSUMERS  
26 AND HEALTH-CARE CONSUMER ADVOCATE STAKEHOLDERS, DEVELOP A  
27 WRITTEN EXPLANATION OF A PATIENT'S RIGHTS UNDER THIS SECTION THAT

1 IS WRITTEN IN PLAIN LANGUAGE AT A SIXTH- GRADE READING LEVEL AND  
2 TRANSLATED INTO ALL LANGUAGES SPOKEN BY TEN PERCENT OR MORE OF  
3 THE POPULATION IN EACH COUNTY OF THE STATE AND POST THE WRITTEN  
4 EXPLANATION IN ALL REQUIRED LANGUAGES ON THE STATE DEPARTMENT'S  
5 WEBSITE. EACH HEALTH-CARE FACILITY SHALL MAKE THE EXPLANATION  
6 AVAILABLE TO THE PUBLIC AND EACH PATIENT AS PROVIDED IN SECTION  
7 25.5-3-504.

8 (b) (I) ESTABLISH A PROCESS FOR PATIENTS TO SUBMIT A  
9 COMPLAINT RELATING TO NONCOMPLIANCE WITH THIS PART 5 TO THE  
10 STATE DEPARTMENT BY PHONE, MAIL, OR ONLINE. THE STATE  
11 DEPARTMENT SHALL CONDUCT A REVIEW WITHIN THIRTY DAYS AFTER  
12 RECEIVING A COMPLAINT.

13 (II) THE STATE DEPARTMENT SHALL PERIODICALLY REVIEW  
14 HEALTH-CARE FACILITIES AND LICENSED HEALTH-CARE PROFESSIONALS TO  
15 ENSURE COMPLIANCE WITH THIS SECTION. IF THE STATE DEPARTMENT  
16 FINDS THAT A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE  
17 PROFESSIONAL IS NOT IN COMPLIANCE WITH THIS SECTION, THE STATE  
18 DEPARTMENT SHALL NOTIFY THE HEALTH-CARE FACILITY OR LICENSED  
19 HEALTH-CARE PROFESSIONAL AND THE FACILITY OR PROFESSIONAL HAS  
20 NINETY DAYS TO FILE A CORRECTIVE ACTION PLAN WITH THE STATE  
21 DEPARTMENT THAT MUST INCLUDE MEASURES TO INFORM THE PATIENT  
22 ABOUT THE NONCOMPLIANCE AND PROVIDE A FINANCIAL CORRECTION  
23 CONSISTENT WITH THIS PART 5. A HEALTH-CARE FACILITY OR LICENSED  
24 HEALTH-CARE PROFESSIONAL MAY REQUEST UP TO ONE HUNDRED TWENTY  
25 DAYS TO SUBMIT A CORRECTIVE ACTION PLAN. THE STATE DEPARTMENT  
26 MAY REQUIRE A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE  
27 PROFESSIONAL THAT IS NOT IN COMPLIANCE WITH THIS PART 5 OR ANY

1 STATE BOARD RULES ADOPTED PURSUANT TO THIS PART 5 TO DEVELOP AND  
2 OPERATE UNDER A CORRECTIVE ACTION PLAN UNTIL THE STATE  
3 DEPARTMENT DETERMINES THE HEALTH-CARE FACILITY OR LICENSED  
4 HEALTH-CARE PROFESSIONAL IS IN COMPLIANCE.

5 (III) IF A HEALTH-CARE FACILITY'S OR LICENSED HEALTH-CARE  
6 PROFESSIONAL'S NONCOMPLIANCE WITH THIS SECTION IS DETERMINED BY  
7 THE STATE DEPARTMENT TO BE KNOWING OR WILLFUL OR THERE IS A  
8 REPEATED PATTERN OF NONCOMPLIANCE, THE STATE DEPARTMENT MAY  
9 FINE THE FACILITY OR PROFESSIONAL NO MORE THAN FIVE THOUSAND  
10 DOLLARS. IF THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE  
11 PROFESSIONAL FAILS TO TAKE CORRECTIVE ACTION OR FAILS TO FILE A  
12 CORRECTIVE ACTION PLAN WITH THE STATE DEPARTMENT PURSUANT TO  
13 SUBSECTION (5)(b)(II) OF THIS SECTION, THE STATE DEPARTMENT MAY  
14 FINE THE FACILITY OR PROFESSIONAL NO MORE THAN FIVE THOUSAND  
15 DOLLARS A WEEK UNTIL THE FACILITY OR PROFESSIONAL TAKES  
16 CORRECTIVE ACTION. THE STATE DEPARTMENT SHALL CONSIDER THE SIZE  
17 OF THE HEALTH-CARE FACILITY AND THE SERIOUSNESS OF THE VIOLATION  
18 IN SETTING THE FINE AMOUNT.

19 (6) THE STATE DEPARTMENT SHALL MAKE THE INFORMATION  
20 REPORTED PURSUANT TO SUBSECTION (1) OF THIS SECTION AND ANY  
21 CORRECTIVE ACTION PLANS FOR WHICH FINES WERE IMPOSED PURSUANT  
22 TO SUBSECTION (5)(b) OF THIS SECTION AVAILABLE TO THE PUBLIC AND  
23 SHALL ANNUALLY REPORT THE INFORMATION AS A PART OF ITS  
24 PRESENTATION TO ITS COMMITTEES OF REFERENCE AT A HEARING HELD  
25 PURSUANT TO SECTION 2-7-203 (2)(a) OF THE "STATE MEASUREMENT FOR  
26 ACCOUNTABLE, RESPONSIVE, AND TRANSPARENT (SMART)  
27 GOVERNMENT ACT.

1           **25.5-3-506. Limitations on collection actions - private**

2 **enforcement.** (1) BEGINNING JUNE 1, 2022, BEFORE ASSIGNING OR  
3 SELLING PATIENT DEBT TO A COLLECTION AGENCY, AS DEFINED IN SECTION  
4 5-16-103 (3)(a), OR A DEBT BUYER, AS DEFINED IN SECTION 5-16-103 (8.5),  
5 OR BEFORE PURSUING, EITHER DIRECTLY OR INDIRECTLY, ANY PERMISSIBLE  
6 EXTRAORDINARY COLLECTION ACTION, AS DEFINED IN SECTION 6-20-201  
7 (7):

8           (a) A HEALTH-CARE FACILITY SHALL MEET THE SCREENING  
9 REQUIREMENTS IN SECTION 25.5-3-502;

10           (b) A HEALTH-CARE FACILITY AND LICENSED HEALTH-CARE  
11 PROFESSIONAL SHALL PROVIDE DISCOUNTED CARE TO A PATIENT  
12 PURSUANT TO SECTION 25.5-3-503; ■

13           (c) A HEALTH-CARE FACILITY AND LICENSED HEALTH-CARE  
14 PROFESSIONAL SHALL PROVIDE A PLAIN LANGUAGE EXPLANATION OF THE  
15 HEALTH-CARE SERVICES AND FEES BEING BILLED AND NOTIFY THE PATIENT  
16 OF POTENTIAL COLLECTION ACTIONS; AND

17           (d) A HEALTH-CARE FACILITY AND HEALTH-CARE PROFESSIONAL  
18 SHALL BILL ANY THIRD-PARTY PAYER THAT IS RESPONSIBLE FOR  
19 PROVIDING HEALTH-CARE COVERAGE TO THE PATIENT. IF A HEALTH-CARE  
20 PROFESSIONAL IS AN OUT-OF-NETWORK PROVIDER UNDER A QUALIFIED  
21 PATIENT'S HEALTH INSURANCE PLAN, THE HEALTH-CARE PROFESSIONAL  
22 AND HEALTH INSURANCE CARRIER SHALL COMPLY WITH THE  
23 OUT-OF-NETWORK BILLING REQUIREMENTS DESCRIBED IN SECTIONS  
24 10-16-704 (3) AND 12-30-113.

25           (2) A HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE  
26 PROFESSIONAL THAT FAILS TO COMPLY WITH THE REQUIREMENTS OF THIS  
27 SECTION IS LIABLE TO THE PATIENT IN AN AMOUNT EQUAL TO THE SUM OF:

1 (a) ANY ACTUAL DAMAGES SUSTAINED BY THE PATIENT AS A  
2 RESULT OF SUCH FAILURE;

3 (b) IN THE CASE OF SUCH ACTION BROUGHT BY AN INDIVIDUAL,  
4 ANY ADDITIONAL DAMAGES THAT THE COURT MAY ALLOW, NOT TO  
5 EXCEED ONE THOUSAND DOLLARS;

6 (c) IN THE CASE OF A CLASS ACTION, SUCH AMOUNT FOR EACH  
7 NAMED PLAINTIFF THAT MAY RECOVER DAMAGES UNDER SUBSECTION  
8 (2)(b) OF THIS SECTION, AND SUCH AMOUNT THAT THE COURT MAY ALLOW  
9 FOR ALL OTHER CLASS MEMBERS WITHOUT REGARD TO A MINIMUM  
10 INDIVIDUAL RECOVERY, NOT TO EXCEED THE LESSER OF FIVE HUNDRED  
11 THOUSAND DOLLARS OR ONE PERCENT OF THE NET WORTH OF THE  
12 HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE PROFESSIONAL; AND

13 (d) IN THE CASE OF ANY SUCCESSFUL ACTION TO ENFORCE THE  
14 FOREGOING LIABILITY, THE COSTS OF THE ACTION TOGETHER WITH  
15 REASONABLE ATTORNEY FEES AS DETERMINED BY THE COURT. ON A  
16 FINDING BY THE COURT THAT THE ACTION WAS BROUGHT IN BAD FAITH,  
17 THE COURT MAY AWARD REASONABLE ATTORNEY FEES TO THE  
18 DEFENDANT THAT ARE RELATED TO THE WORK EXPENDED AND COSTS.

19 (3) IN DETERMINING THE AMOUNT OF LIABILITY IN ANY ACTION  
20 PURSUANT TO SUBSECTION (2) OF THIS SECTION, THE COURT SHALL  
21 CONSIDER, AMONG OTHER RELEVANT FACTORS:

22 (a) IN ANY INDIVIDUAL ACTION BROUGHT PURSUANT TO  
23 SUBSECTION (2)(a) OF THIS SECTION, THE FREQUENCY AND PERSISTENCE  
24 OF NONCOMPLIANCE BY THE HEALTH-CARE FACILITY OR LICENSED  
25 HEALTH-CARE PROFESSIONAL, THE NATURE OF SUCH NONCOMPLIANCE,  
26 AND THE EXTENT TO WHICH SUCH NONCOMPLIANCE WAS INTENTIONAL; OR

27 (b) IN ANY INDIVIDUAL ACTION BROUGHT PURSUANT TO

1 SUBSECTION (2)(b) OF THIS SECTION, THE FREQUENCY AND PERSISTENCE  
2 OF NONCOMPLIANCE BY THE HEALTH-CARE FACILITY OR LICENSED  
3 HEALTH-CARE PROFESSIONAL, THE NATURE OF SUCH NONCOMPLIANCE, THE  
4 RESOURCES OF THE HEALTH-CARE FACILITY OR LICENSED HEALTH-CARE  
5 PROFESSIONAL, THE NUMBER OF INDIVIDUALS ADVERSELY AFFECTED, AND  
6 THE EXTENT TO WHICH THE HEALTH-CARE FACILITY'S OR LICENSED  
7 HEALTH-CARE PROFESSIONAL'S NONCOMPLIANCE WAS INTENTIONAL.

8 **SECTION 2.** In Colorado Revised Statutes, 5-16-108, **add** (1)(l)  
9 as follows:

10 **5-16-108. Unfair practices.** (1) A debt collector or collection  
11 agency shall not use unfair or unconscionable means to collect or attempt  
12 to collect any debt, including, but not limited to, the following conduct:

13 (1) AN ATTEMPT TO COLLECT A DEBT THAT VIOLATES THE  
14 PROVISIONS OF SECTION 6-20-203 (1), (2), (3)(b), (4)(a), (4)(b)(I), (4)(d),  
15 (4)(e), OR (5)(a) TO (5)(c).

16 **SECTION 3.** In Colorado Revised Statutes, 6-20-201, **add**  
17 (4), (5), and (6) as follows:

18 **6-20-201. Definitions.** For the purposes of this part 2, unless the  
19 context otherwise requires:

20 **(4) "HOSPITAL SERVICES"** MEANS HEALTH-CARE SERVICES, AS  
21 DEFINED IN SECTION 10-16-102 (33), PROVIDED BY A HEALTH-CARE  
22 FACILITY, AS DEFINED IN SECTION 25.5-3-501 (1), OR A LICENSED  
23 HEALTH-CARE PROFESSIONAL, AS DEFINED IN SECTION 25.5-3-501 (3).

24 **(5) "IMPERMISSIBLE EXTRAORDINARY COLLECTION ACTION"**  
25 MEANS INITIATING FORECLOSURE ON AN INDIVIDUAL'S PRIMARY  
26 RESIDENCE OR HOMESTEAD, INCLUDING A MOBILE HOME, AS DEFINED IN  
27

1 SECTION 38-12-201.5 (5).

2 (6) "MEDICAL CREDITOR" MEANS AN ENTITY THAT ATTEMPTS TO  
3 COLLECT ON A MEDICAL DEBT, INCLUDING:

4 (a) A HEALTH-CARE PROVIDER OR HEALTH-CARE PROVIDER'S  
5 BILLING OFFICE;

6 (b) A COLLECTION AGENCY, AS DEFINED IN SECTION 5-16-103 (3);

7 (c) A DEBT BUYER, AS DEFINED IN SECTION 5-16-103 (8.5); AND

8 (d) A DEBT COLLECTOR, AS DEFINED IN 15 U.S.C. SEC. 1692a (6).

9 (7) "PERMISSIBLE EXTRAORDINARY COLLECTION ACTION" MEANS  
10 AN ACTION OTHER THAN AN IMPERMISSIBLE EXTRAORDINARY COLLECTION  
11 ACTION THAT REQUIRES A LEGAL OR JUDICIAL PROCESS, INCLUDING BUT  
12 NOT LIMITED TO PLACING A LIEN ON AN INDIVIDUAL'S REAL PROPERTY,  
13 ATTACHING OR SEIZING AN INDIVIDUAL'S BANK ACCOUNT OR ANY OTHER  
14 PERSONAL PROPERTY, OR GARNISHING AN INDIVIDUAL'S WAGES. A  
15 PERMISSIBLE EXTRAORDINARY COLLECTION ACTION DOES NOT INCLUDE  
16 THE ASSERTION OF A HOSPITAL LIEN PURSUANT TO SECTION 38-27-101.

17 SECTION 4. In Colorado Revised Statutes, add 6-20-203 as  
18 follows:

19 6-20-203. Limitations on collection actions - definition. ■ ■

20 (1) BEGINNING JUNE 1, 2022, IMPERMISSIBLE EXTRAORDINARY  
21 COLLECTION ACTIONS MAY NOT BE USED BY ANY MEDICAL CREDITOR TO  
22 COLLECT DEBTS OWED FOR HOSPITAL SERVICES.

23 (2) BEGINNING JUNE 1, 2022, NO MEDICAL CREDITOR ■  
24 COLLECTING ON A DEBT FOR HOSPITAL SERVICES SHALL ENGAGE IN ANY  
25 PERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS UNTIL ONE HUNDRED  
26 EIGHTY-TWO DAYS AFTER THE DATE THE PATIENT RECEIVES HOSPITAL  
27 SERVICES.



1 (3) (a) BEGINNING JUNE 1, 2022, AT LEAST THIRTY DAYS BEFORE  
2 TAKING ANY PERMISSIBLE EXTRAORDINARY COLLECTION ACTION, A  
3 MEDICAL CREDITOR, AS DEFINED IN SECTION 6-20-201 (6)(a), COLLECTING  
4 ON A DEBT FOR HOSPITAL SERVICES SHALL NOTIFY THE PATIENT OF  
5 POTENTIAL COLLECTION ACTIONS AND SHALL INCLUDE WITH THE NOTICE  
6 A STATEMENT DEVELOPED BY THE DEPARTMENT OF HEALTH CARE POLICY  
7 AND FINANCING THAT EXPLAINS THE AVAILABILITY OF DISCOUNTED CARE  
8 FOR QUALIFIED INDIVIDUALS AND HOW TO APPLY FOR SUCH CARE.

9 (b) (I) A MEDICAL CREDITOR, AS DEFINED IN SECTION 6-20-201  
10 (6)(b), (6)(c), OR (6)(d), COLLECTING ON A DEBT FOR HOSPITAL SERVICES  
11 SHALL INCLUDE THE FOLLOWING STATEMENT IN THE NOTICES THE  
12 MEDICAL CREDITOR PROVIDES TO THE PATIENT PURSUANT TO SECTION  
13 5-16-109 (1) AND 15 U.S.C. SEC. 1692g (a): "PURSUANT TO COLORADO  
14 LAW, DISCOUNTS FOR HOSPITAL SERVICES ARE AVAILABLE FOR QUALIFIED  
15 INDIVIDUALS." THE STATEMENT MUST INCLUDE A LINK TO THE WRITTEN  
16 EXPLANATION OF THE PATIENT'S RIGHTS THAT IS POSTED TO THE  
17 DEPARTMENT OF HEALTH CARE POLICY AND FINANCING'S WEBSITE  
18 PURSUANT TO SECTION 25.5-3-505 (4)(a).

19 (II) A MEDICAL CREDITOR, AS DEFINED SECTION 6-20-201 (6)(b),  
20 (6)(c), OR (6)(d), SHALL NOT TAKE ANY PERMISSIBLE EXTRAORDINARY  
21 COLLECTION ACTIONS UNTIL THE LATER OF THIRTY DAYS FROM THE DATE  
22 OF SENDING THE NOTICE REQUIRED PURSUANT TO SUBSECTION (3)(b)(I) OF  
23 THIS SECTION OR THE COMPLETION OF THE VALIDATION REQUIREMENTS  
24 DESCRIBED IN SECTION 5-16-109 (2) AND 15 U.S.C. SEC. 1692g (b).

25 (4) BEGINNING JUNE 1, 2022, IF A MEDICAL CREDITOR COLLECTING  
26 ON A DEBT FOR HOSPITAL SERVICES BILLS OR INITIATES COLLECTION  
27 ACTIVITIES AND IT IS LATER DETERMINED THAT THE PATIENT SHOULD

1 HAVE BEEN SCREENED [REDACTED] PURSUANT TO SECTION 25.5-3-503 AND IS  
2 DETERMINED TO BE A QUALIFIED PATIENT, AS DEFINED IN SECTION  
3 25.5-3-501 (5), OR IT IS DETERMINED THAT THE PATIENT'S BILL IS ELIGIBLE  
4 FOR REIMBURSEMENT THROUGH A PUBLIC HEALTH-CARE COVERAGE  
5 PROGRAM OR THE COLORADO INDIGENT CARE PROGRAM, THE MEDICAL  
6 CREDITOR SHALL: [REDACTED]

7 (a) DELETE ANY NEGATIVE REPORTS TO CONSUMER REPORTING  
8 AGENCIES;

9 (b) (I) UNLESS PROHIBITED BY LAW, IF THE COURT HAS ENTERED  
10 A JUDGMENT ON THE MEDICAL DEBT:

11 (A) REQUEST THE COURT VACATE THE JUDGMENT IN ANY  
12 COLLECTION LAWSUIT OVER THE MEDICAL DEBT AND ENTER INTO A  
13 PAYMENT PLAN WITH THE PATIENT THAT MEETS THE REQUIREMENTS OF  
14 SECTION 25.5-3-503 (1)(b); OR

15 (B) REQUEST THE COURT REDUCE THE AMOUNT OF THE JUDGMENT,  
16 INCLUDING ANY FEES AND COSTS RELATED TO THE COLLECTION LAWSUIT,  
17 TO THE TOTAL AMOUNT THE PATIENT OWES PURSUANT TO THE PUBLIC  
18 HEALTH-CARE COVERAGE PROGRAM OR DISCOUNTED CARE POLICY THAT  
19 THE PATIENT QUALIFIES FOR, ENTER INTO A PAYMENT PLAN WITH THE  
20 PATIENT THAT MEETS THE REQUIREMENTS OF SECTION 25.5-3-503 (1)(b),  
21 AND SUSPEND ALL EXECUTION ON THE JUDGMENT WHILE THE PATIENT IS  
22 COMPLIANT WITH THE TERMS OF THE PAYMENT PLAN; OR

23 (C) FILE A SATISFACTION OF JUDGMENT SUCH THAT THE  
24 REMAINING UNPAID BALANCE OF THE JUDGMENT, INCLUDING ANY FEES  
25 AND COSTS RELATED TO THE COLLECTION LAWSUIT, IS EQUAL TO THE  
26 TOTAL AMOUNT THE PATIENT OWES UNDER THE PUBLIC HEALTH-CARE  
27 COVERAGE PROGRAM OR DISCOUNTED CARE POLICY THAT THE PATIENT

1 QUALIFIES FOR, ENTER INTO A PAYMENT PLAN WITH THE PATIENT THAT  
2 MEETS THE REQUIREMENTS OF SECTION 25.5-3-503 (1)(b), AND SUSPEND  
3 ALL EXECUTION ON THE JUDGMENT WHILE THE PATIENT IS COMPLIANT  
4 WITH THE TERMS OF THE PAYMENT PLAN.

5 (II) FOR THE PURPOSES OF SUBSECTION (4)(b)(I)(B) AND  
6 (4)(b)(I)(C) OF THIS SECTION, THE COURT SHALL REFUND TO THE PARTIES  
7 ANY FEES AND COSTS PAID TO THE COURT IN CONNECTION WITH THE  
8 LITIGATION OF THE MEDICAL DEBT AND THE HEALTH-CARE PROVIDER  
9 SHALL INDEMNIFY THE MEDICAL CREDITOR FOR ANY FEES AWARDED AS  
10 PART OF THE JUDGMENT IN CONNECTION WITH THE MEDICAL DEBT.

11 (c) AS THE TERM "MEDICAL CREDITOR" IS DEFINED IN SECTION  
12 6-20-201 (6)(a), REFUND ANY EXCESS AMOUNT TO THE PATIENT IF THE  
13 PATIENT HAS PAID ANY PART OF THE MEDICAL DEBT OR IF ANY OF THE  
14 PATIENT'S MONEY HAS BEEN SEIZED OR LEVIED IN EXCESS OF THE AMOUNT  
15 THAT THE PATIENT OWES AFTER APPLICATION OF REQUIRED DISCOUNTS;

16 (d) AS THE TERM "MEDICAL CREDITOR" IS DEFINED IN SECTIONS  
17 6-20-201 (6)(b), (6)(c), AND (6)(d), IF THE PATIENT HAS PAID ANY PART OF  
18 THE MEDICAL DEBT OR IF ANY OF THE PATIENT'S MONEY HAS BEEN SEIZED  
19 OR LEVIED IN EXCESS OF THE AMOUNT THAT THE PATIENT OWES AFTER  
20 APPLICATION OF REQUIRED DISCOUNTS, REFUND ANY EXCESS AMOUNT TO  
21 THE PATIENT TO THE EXTENT THE MEDICAL CREDITOR HAS NOT ALREADY  
22 REMITTED SUCH AN AMOUNT TO THE HEALTH-CARE PROVIDER; AND

23 (e) REMEDY ANY OTHER PERMISSIBLE EXTRAORDINARY  
24 COLLECTION ACTION.

25 (5) BEGINNING JUNE 1, 2022, A MEDICAL CREDITOR COLLECTING  
26 ON A DEBT FOR HOSPITAL SERVICES SHALL NOT SELL A MEDICAL DEBT TO  
27 ANOTHER PARTY UNLESS, PRIOR TO THE SALE, THE MEDICAL DEBT SELLER

1 HAS ENTERED INTO A LEGALLY BINDING WRITTEN AGREEMENT WITH THE  
2 MEDICAL DEBT BUYER OF THE DEBT PURSUANT TO WHICH:

3 (a) THE MEDICAL DEBT BUYER [REDACTED] AGREES NOT TO PURSUE  
4 IMPERMISSIBLE EXTRAORDINARY COLLECTION ACTIONS TO OBTAIN  
5 PAYMENT FOR THE CARE;

6 [REDACTED]  
7 (b) THE DEBT IS RETURNABLE TO OR RECALLABLE BY THE MEDICAL  
8 DEBT SELLER UPON A DETERMINATION THAT THE PATIENT SHOULD HAVE  
9 BEEN SCREENED PURSUANT TO SECTION 25.5-3-502 AND IS ELIGIBLE FOR  
10 DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503 OR THAT THE BILL  
11 UNDERLYING THE MEDICAL DEBT IS ELIGIBLE FOR REIMBURSEMENT  
12 THROUGH A PUBLIC HEALTH-CARE COVERAGE PROGRAM OR THE  
13 COLORADO INDIGENT CARE PROGRAM; AND

14 (c) IF IT IS DETERMINED THAT THE PATIENT SHOULD HAVE BEEN  
15 SCREENED PURSUANT TO SECTION 25.5-3-502 AND IS ELIGIBLE FOR  
16 DISCOUNTED CARE PURSUANT TO SECTION 25.5-3-503 OR THAT THE BILL  
17 UNDERLYING THE MEDICAL DEBT IS ELIGIBLE FOR REIMBURSEMENT  
18 THROUGH A PUBLIC HEALTH-CARE COVERAGE PROGRAM OR THE  
19 COLORADO INDIGENT CARE PROGRAM AND THE DEBT IS NOT RETURNED TO  
20 OR RECALLED BY THE MEDICAL DEBT SELLER, THE MEDICAL DEBT BUYER  
21 SHALL ADHERE TO PROCEDURES THAT MUST BE SPECIFIED IN THE  
22 AGREEMENT THAT ENSURES THE PATIENT WILL NOT PAY, AND HAS NO  
23 OBLIGATION TO PAY, THE MEDICAL DEBT BUYER AND THE MEDICAL  
24 CREDITOR TOGETHER MORE THAN THE PATIENT IS PERSONALLY  
25 RESPONSIBLE FOR PAYING.

26 (6) THE MEDICAL DEBT SELLER SHALL INDEMNIFY THE MEDICAL  
27 DEBT BUYER FOR ANY AMOUNT PAID FOR A DEBT THAT IS RETURNED TO OR

1 RECALLED BY THE MEDICAL DEBT SELLER.

2 (7) NOTHING IN THIS SECTION LIMITS OR AFFECTS A HEALTH-CARE  
3 PROVIDER'S RIGHT TO PURSUE AGAINST ANY PARTY OTHER THAN THE  
4 PATIENT THE COLLECTION OF PERSONAL INJURY, LIABILITY, UNINSURED,  
5 UNDERINSURED, MEDICAL PAYMENT REHABILITATION, DISABILITY,  
6 HOMEOWNER'S, BUSINESS OWNER'S, WORKER'S COMPENSATION,  
7 FAULT-BASED INSURANCE, SUBROGATED CLAIMS, OR OTHER CLAIMS NOT  
8 AGAINST THE PATIENT.

9 SECTION 5. In Colorado Revised Statutes, 25-49-105, **amend**  
10 (1) as follows:

11 **25-49-105. No review of health-care prices - no punishment for**  
12 **exercising rights - no impairment of contracts.** (1) Nothing in this  
13 article 49 requires a health-care facility or health-care provider to report  
14 its health-care prices to any agency for review, filing, or other purposes,  
15 ~~except as required by section 25-3-112,~~ or for applications for health-care  
16 professional loan repayment submitted pursuant to section 25-1.5-503.  
17 This article 49 does not grant any agency the authority to approve,  
18 disapprove, or limit a health-care facility's or health-care provider's  
19 health-care prices or changes to its health-care prices. The department of  
20 public health and environment is not authorized to take any action  
21 regarding or pursuant to this article 49.

22 SECTION 6. In Colorado Revised Statutes, 25.5-3-104, **add** (3)  
23 as follows:

24 **25.5-3-104. Program for the medically indigent established -**  
25 **eligibility - rules.** (3) NO LATER THAN JUNE 1, 2022, FOR PROVIDERS  
26 DEFINED AS HOSPITAL PROVIDERS IN 10 CCR 2505-10, SEC. 8.901.J, THE  
27 STATE DEPARTMENT SHALL PROMULGATE RULES:

1 (a) PROHIBITING HOSPITALS FROM CONSIDERING ASSETS WHEN  
2 DETERMINING WHETHER A PATIENT MEETS THE SPECIFIED PERCENTAGE OF  
3 THE FEDERAL POVERTY LINE REQUIRED IN SUBSECTION (2) OF THIS  
4 SECTION; AND

5 (b) ENSURING THE METHOD USED TO DETERMINE WHETHER A  
6 PATIENT MEETS THE SPECIFIED PERCENTAGE OF THE FEDERAL POVERTY  
7 LINE IS UNIFORM ACROSS HOSPITALS AND ALIGNED WITH THE METHOD FOR  
8 COUNTING INCOME FOR THE PURPOSES OF DETERMINING ELIGIBILITY FOR  
9 DISCOUNTED CARE, AS DESCRIBED IN SECTION 25.5-3-503.

10 **SECTION 7.** In Colorado Revised Statutes, **repeal** 25-3-112.

11 **SECTION 8. Appropriation - adjustments to 2021 long bill.**

12 (1) To implement this act, appropriations made in the annual general  
13 appropriation act for the 2021-22 state fiscal year to the department of  
14 public health and environment are adjusted as follows:

15 (a) The general fund appropriation for health, life, and dental  
16 expenses is decreased by \$4,000;

17 (b) The general fund appropriation for short-term disability is  
18 decreased by \$35;

19 (c) The general fund appropriation for S.B. 04-257 amortization  
20 equalization disbursements is decreased by \$1,028;

21 (d) The general fund appropriation for S.B. 06-235 supplemental  
22 amortization equalization disbursements is decreased by \$1,028; and

23 (e) The general fund appropriation for use by the health facilities  
24 and emergency medical services division for nursing and acute care  
25 facility survey is decreased by \$38,113, and the related FTE is decreased  
26 by 0.3 FTE.

27 (2) For the 2021-22 state fiscal year, \$219,295 is appropriated to

1 the department of health care policy and financing for use by the  
2 executive director's office. This appropriation is from the general fund.

3 To implement this act, the office may use this appropriation as follows:

4 (a) \$47,855 for personal services, which amount is based on an  
5 assumption that the office will require an additional 0.7 FTE;

6 (b) \$7,280 for operating expenses; and

7 (c) \$164,160 for general professional services and special  
8 projects.

9 **SECTION 9. Act subject to petition - effective date.** This act  
10 takes effect at 12:01 a.m. on the day following the expiration of the  
11 ninety-day period after final adjournment of the general assembly; except  
12 that, if a referendum petition is filed pursuant to section 1 (3) of article V  
13 of the state constitution against this act or an item, section, or part of this  
14 act within such period, then the act, item, section, or part will not take  
15 effect unless approved by the people at the general election to be held in  
16 November 2022 and, in such case, will take effect on the date of the  
17 official declaration of the vote thereon by the governor.