Second Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO

ENGROSSED
This Version Includes All Amendments Adopted on Second Reading in the House of Introduction

LLS NO. 24-0514.02 Kristen Forrestal x4217 **SENATE BILL 24-093**

SENATE SPONSORSHIP

Michaelson Jenet,

HOUSE SPONSORSHIP

Amabile,

Senate Committees
Health & Human Services

House Committees

A BILL FOR AN ACT

CONCERNING THE CONTINUITY OF HEALTH-CARE BENEFITS DURING THE TRANSITION TO A NEW HEALTH BENEFIT PLAN WHEN THE ENROLLEES'S HEALTH-CARE PROVIDER DOES NOT HAVE A CONTRACT WITH THE NEW HEALTH INSURANCE CARRIER.

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 allows an enrollee in the state medicaid program or with a private health insurance carrier whose coverage has been terminated or not renewed to receive continued care with the enrollee's same health-care

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing law.
Dashes through the words or numbers indicate deletions from existing law.

SENATE
Amended 2nd Reading
February 21, 2024

provider or health-care facility under the enrollee's new health benefit plan at the in-network level under the enrollee's new health benefit plan for specified time periods if certain conditions exist.

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

SECTION 1. In Colorado Revised Statutes, 10-16-705, **add** (4.5) as follows:

10-16-705. Requirements for carriers and participating providers - definitions - rules. (4.5) (a) AS USED IN THIS SUBSECTION (4.5):

(I) "FACILITY" MEANS A HEALTH-CARE FACILITY LICENSED OR CERTIFIED PURSUANT TO SECTION 25-1.5-103.

(II) "MEDICAID" MEANS A MEDICAL ASSISTANCE PROGRAM ESTABLISHED PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5.

(III) "SERIOUS AND COMPLEX MEDICAL CONDITION" HAS THE SAME MEANING AS SET FORTH IN SUBSECTION (4)(d)(III)(B) OF THIS SECTION.

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(IV) "TRANSFERRING ENROLLEE" MEANS AN INDIVIDUAL WHO:

(A) WAS ENROLLED IN MEDICAID OR THE CHILDREN'S BASIC HEALTH PLAN, BUT IS NO LONGER ELIGIBLE FOR BENEFITS THROUGH THE PROGRAM IN WHICH THE INDIVIDUAL WAS ENROLLED; OR

(B) WAS COVERED UNDER A HEALTH BENEFIT PLAN WHOSE COVERAGE HAS NOT BEEN RENEWED BECAUSE THE CARRIER IS NO LONGER OFFERING ANY HEALTH BENEFIT PLANS THAT THE INDIVIDUAL IS ELIGIBLE FOR AND IS THEREFORE ENROLLED IN A NEW HEALTH BENEFIT PLAN AND WHO: IS UNDERGOING A COURSE OF TREATMENT FOR A SERIOUS AND COMPLEX MEDICAL CONDITION THAT IS TREATED BY THE PROVIDER OR

FACILITY; IS UNDERGOING A COURSE OF INPATIENT CARE PROVIDED BY THE PROVIDER OR FACILITY; IS PREGNANT AND UNDERGOING A COURSE OF TREATMENT FOR THE PREGNANCY PROVIDED BY THE PROVIDER OR FACILITY; IS TERMINALLY ILL AS DETERMINED UNDER SECTION 1861 (dd)(3)(A) OF THE FEDERAL "SOCIAL SECURITY ACT", 42 U.S.C. SEC. 1395x, AS AMENDED, AND IS RECEIVING TREATMENT FOR THE ILLNESS FROM THE PROVIDER OR FACILITY; OR IS SCHEDULED TO UNDERGO NONELECTIVE SURGERY FROM THE PROVIDER OR FACILITY, INCLUDING THE RECEIPT OF POSTOPERATIVE CARE FROM THE PROVIDER OR FACILITY WITH RESPECT TO THE SURGERY.

(b) A CARRIER SHALL ALLOW A TRANSFERRING ENROLLEE TO CONTINUE TO RECEIVE TREATMENT AS AN IN-NETWORK BENEFIT FROM AN OUT-OF-NETWORK PROVIDER OR FACILITY AS FOLLOWS:

(I) A TRANSFERRING ENROLLEE BEING TREATED BY AN OUT-OF-NETWORK PROVIDER OR FACILITY MAY CONTINUE TO RECEIVE TREATMENT FROM THAT PROVIDER OR FACILITY UNTIL THE CURRENT EPISODE OF TREATMENT ENDS OR UNTIL NINETY DAYS AFTER THE ENROLLEE IS COVERED BY A NEW HEALTH BENEFIT PLAN, WHICHEVER OCCURS FIRST.

(II) A TRANSFERRING ENROLLEE WHO IS PREGNANT AND BEING TREATED BY AN OUT-OF-NETWORK PROVIDER OR FACILITY MAY CONTINUE TO RECEIVE TREATMENT THROUGH THE COMPLETION OF POSTPARTUM CARE, BEGINNING ON THE DATE OF THE ENROLLEE'S FIRST DAY AS A COVERED PERSON UNDER A NEW HEALTH BENEFIT PLAN.

(c) (I) DURING THE TIME PERIODS COVERED UNDER SUBSECTION (4.5)(b) OF THIS SECTION:

(A) A CARRIER SHALL REIMBURSE THE OUT-OF-NETWORK

PROVIDER OR FACILITY AT THE CARRIER'S STANDARD IN-NETWORK REIMBURSEMENT RATE; AND

(B) THE CARRIER MAY REQUIRE THE OUT-OF-NETWORK PROVIDER OR FACILITY TO ADHERE TO THE CARRIER'S TERMS AND CONDITIONS, QUALITY OF CARE STANDARDS AND PROTOCOLS, REFERRAL PROCESS, AND REPORTING STANDARDS THAT APPLY TO COMPARABLE IN-NETWORK PROVIDERS OR FACILITIES IN ORDER FOR THE OUT-OF-NETWORK PROVIDER OR FACILITY TO BE ELIGIBLE FOR REIMBURSEMENT UNDER SUBSECTION (4.5)(c)(I)(A) OF THIS SECTION.

(II) IF AN OUT-OF-NETWORK PROVIDER OR FACILITY HAS BEEN REIMBURSED PURSUANT TO SUBSECTION (4.5)(c)(I)(A) OF THIS SECTION, THE TRANSFERRING ENROLLEE SHALL NOT BE BALANCE BILLED.

(d) THIS SUBSECTION (4.5) DOES NOT REQUIRE A PROVIDER OR FACILITY TO CONTINUE TO PROVIDE CARE FOR A TRANSFERRING ENROLLEE AFTER THE APPLICABLE TIME PERIOD IN SUBSECTION (4)(b) OF THIS SECTION.

(e) A CARRIER SUBJECT TO THIS SUBSECTION (4.5) SHALL:

(I) NOTIFY THE TRANSFERRING ENROLLEE, IN PLAIN LANGUAGE, AT THE TIME OF ENROLLMENT THAT THE ENROLLEE HAS THE RIGHT TO ELECT CONTINUED TRANSITIONAL CARE FROM AN OUT-OF-NETWORK PROVIDER OR FACILITY IF THE ENROLLEE IS A TRANSFERRING ENROLLEE; AND

(II) AT THE REQUEST OF THE TRANSFERRING ENROLLEE OR THE ENROLLEE'S PROVIDER, GRANT THE TRANSFERRING ENROLLEE AN OPPORTUNITY TO NOTIFY THE CARRIER OF THE NEED FOR CONTINUED TRANSITIONAL CARE WITHIN ONE MONTH AFTER THE TRANSFERRING ENROLLEE'S EFFECTIVE DATE OF COVERAGE.

(f) (I) AT THE REQUEST OF THE TRANSFERRING ENROLLEE OR

PROVIDER, A NEW CARRIER SHALL ACCEPT A PREAUTHORIZATION FOR TREATMENT FROM THE PREVIOUS CARRIER FOR COVERAGE BY THE NEW CARRIER FOR:

(A) THE PROCEDURES, TREATMENT, MEDICATIONS, OR SERVICES THAT ARE COVERED BENEFITS UNDER THE NEW HEALTH BENEFIT PLAN; AND

(B) A PERIOD OF NINETY DAYS OR FOR THE COURSE OF TREATMENT, WHICHEVER IS LESS, OR UNTIL THE COMPLETION OF POSTPARTUM CARE.

(II) SUBJECT TO STATE AND FEDERAL LAWS RELATING TO THE CONFIDENTIALITY OF MEDICAL RECORDS, AT THE REQUEST AND WITH THE CONSENT OF AN ENROLLEE, A CARRIER SHALL PROVIDE A COPY OF THE ENROLLEE'S PREAUTHORIZATION FOR TREATMENT TO THE ENROLLEE'S NEW CARRIER WITHIN TEN DAYS AFTER RECEIPT OF THE REQUEST.

(III) AFTER THE APPLICABLE TIME PERIOD UNDER SUBSECTION (4.5)(b) OF THIS SECTION HAS LAPSED, THE NEW CARRIER MAY ELECT TO PERFORM ITS OWN UTILIZATION REVIEW IN ORDER TO:

(A) REASSESS AND MAKE ITS OWN DETERMINATION REGARDING THE NEED FOR CONTINUED TREATMENT; AND

(B) AUTHORIZE ANY CONTINUED PROCEDURE, TREATMENT, MEDICATION, OR SERVICE DEEMED TO BE MEDICALLY NECESSARY.

(g) THIS SUBSECTION (4.5) DOES NOT REQUIRE A CARRIER TO PROVIDE BENEFITS TO AN ENROLLEE THAT ARE NOT OTHERWISE COVERED BENEFITS UNDER THE HEALTH BENEFIT PLAN.

(h) THE COMMISSIONER MAY ADOPT RULES TO IMPLEMENT THIS SUBSECTION (4.5).

SECTION 2. In Colorado Revised Statutes, 12-30-112, **add** (3.7)

as follows:

12-30-112. Health-care providers - required disclosures - balance billing - deceptive trade practice - rules - definitions. (3.7) AN OUT-OF-NETWORK PROVIDER SHALL NOT BALANCE BILL A COVERED PERSON FOR SERVICES IF THE PROVISIONS OF SECTION 10-16-705 (4.5)(c)(II) APPLY.

SECTION 3. In Colorado Revised Statutes, 25-3-121, **add** (3.5)(d) as follows:

25-3-121. Health-care facilities - emergency and nonemergency services - required disclosures - balance billing - deceptive trade practice - rules - definitions. (3.5) (d) AN OUT-OF-NETWORK FACILITY SHALL NOT BALANCE BILL A COVERED PERSON, AS DEFINED IN SECTION 10-16-102 (15), FOR SERVICES IF THE PROVISIONS OF SECTION 10-16-705 (4.5)(c)(II) APPLY.

SECTION 4. In Colorado Revised Statutes, **add** 25.5-4-431 as follows:

25.5-4-431. Preauthorization for treatment - request to share with insurance carrier. SUBJECT TO STATE AND FEDERAL LAWS RELATING TO THE CONFIDENTIALITY OF MEDICAL RECORDS, AT THE REQUEST AND WITH THE CONSENT OF AN ENROLLEE IN THE MEDICAL ASSISTANCE PROGRAM, THE STATE DEPARTMENT SHALL PROVIDE A COPY OF THE ENROLLEE'S PREAUTHORIZATION FOR TREATMENT TO THE ENROLLEE'S NEW INSURANCE CARRIER WITHIN TEN DAYS AFTER RECEIPT OF THE REQUEST IF THE ENROLLEE IS NO LONGER ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM.

SECTION 5. Act subject to petition - effective date - applicability. (1) This act takes effect January 1, 2025; 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 the ninety-day period after final adjournment of the general assembly, 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 2024 and, in such case, will take effect January 1, 2025, or on the date of the official declaration of the vote thereon by the governor, whichever is later.

(2) This act applies to health benefit plans issued on or after the applicable effective date of this act.