First Regular Session
Seventy-third General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 21-0008.01 Christy Chase x2008 **HOUSE BILL 21-1135**

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A BILL FOR AN ACT

CONCERNING PROTECTIONS FOR CONSUMERS WHO PARTICIPATE IN HEALTH-CARE COST-SHARING ARRANGEMENTS.

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 defines a "health-care cost-sharing arrangement" as a health care sharing ministry or medical cost-sharing community that collects money from its members on a regular basis, at levels established by the arrangement, for purposes of sharing, covering, or defraying the medical costs of its members. A health-care cost-sharing arrangement is required to:

- Report specified information to the commissioner of insurance (commissioner) regarding its operations, financial statements, membership, and medical bills submitted, paid, and denied in Colorado;
- Provide certain written disclosures to potential and renewing members, post the disclosures on its website, if the arrangement has a website, and include the disclosures in its marketing materials;
- Provide specified written statements about arrangement finances and guidelines about arrangement procedures to members; and
- Respond to requests for payment of medical expenses from members or health-care providers within a period specified by the commissioner by rule.

An insurance broker that offers a health-care cost-sharing arrangement in this state is required to provide written or electronic disclosures about the product to prospective members before selling the arrangement to the person.

The commissioner is authorized to:

- Adopt rules to implement the data reporting, disclosure, and response time requirements;
- Impose fines for failure to comply with the requirements and prohibitions specified in the bill;
- Issue an emergency, ex parte cease-and-desist order against a person the commissioner believes to be violating the bill if it appears to the commissioner that the alleged conduct is fraudulent, creates an immediate danger to public safety, or is causing or is reasonably expected to cause significant, imminent, and irreparable public injury; and
- Impose a civil penalty, order restitution, or both, against a person that violates an ex parte cease-and-desist order.

A person is prohibited from making, issuing, circulating, or causing to be made, issued, or circulated any statement or publication that misrepresents the medical cost-sharing benefits, advantages, conditions, or terms of any health-care cost-sharing arrangement.

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

SECTION 1. In Colorado Revised Statutes, **add** 10-3-903.7 as follows:

10-3-903.7. Health-care cost-sharing arrangements - reporting requirements - disclosures - timely response to provider bills - rules

- fines - prohibited acts - enforcement - definitions. (1) **Definitions.** AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "HEALTH-CARE COST-SHARING ARRANGEMENT" OR "ARRANGEMENT" MEANS:

(I) A HEALTH CARE SHARING MINISTRY, AS DEFINED IN 26 U.S.C. SEC. 5000A (d)(2)(B); OR

(II) A MEDICAL COST-SHARING COMMUNITY OR OTHER ARRANGEMENT OR ENTITY THROUGH WHICH MEMBERS OF THE COMMUNITY OR ARRANGEMENT CONTRIBUTE MONEY ON A REGULAR BASIS, AT LEVELS ESTABLISHED BY THE COMMUNITY OR ARRANGEMENT, THAT MAY BE USED TO SHARE, COVER, OR OTHERWISE DEFRAY THE MEDICAL COSTS OF MEMBERS OF THE COMMUNITY OR ARRANGEMENT.

(b) "PRODUCER" HAS THE SAME MEANING SET FORTH IN SECTION 10-2-103 (6).

(2) **Reporting requirements.** BY MARCH 1, 2022, AND BY EACH MARCH 1 THEREAFTER, A PERSON, OTHER THAN A PRODUCER, THAT OFFERS, OPERATES, MANAGES, OR ADMINISTERS A HEALTH-CARE COST-SHARING ARRANGEMENT IN THIS STATE SHALL FILE WITH THE COMMISSIONER, IN THE FORM AND MANNER REQUIRED BY THE COMMISSIONER BY RULE, THE FOLLOWING INFORMATION AND DOCUMENTATION:

(a) ANNUAL AUDITED FINANCIAL STATEMENTS FOR THE PREVIOUS FISCAL YEAR;

(b) A DETAILED LIST OF ANY COMMISSIONS OR OTHER FEES PAID TO THIRD PARTIES FOR MARKETING, PROMOTING, OR ENROLLING MEMBERS IN THE HEALTH-CARE COST-SHARING ARRANGEMENT OR FOR OPERATING, MANAGING, OR ADMINISTERING AN ARRANGEMENT IN THIS STATE;

(c) A LIST AND DESCRIPTION OF MEMBERSHIP BENEFITS, LIMITATIONS, AND EXCLUSIONS APPLICABLE TO THE HEALTH-CARE COST-SHARING ARRANGEMENT IN THIS STATE;

(d) A LIST OF PROVIDERS WITH WHOM THE HEALTH-CARE COST-SHARING ARRANGEMENT HAS A PROVIDER AGREEMENT, CONTRACT, OR OTHER ARRANGEMENT IN THIS STATE;

(e) THE TOTAL NUMBER OF MEMBERS AND HOUSEHOLDS IN THE HEALTH-CARE COST-SHARING ARRANGEMENT IN THIS STATE IN THE PREVIOUS CALENDAR YEAR;

(f) IF APPLICABLE, THE TOTAL NUMBER OF EMPLOYER GROUPS, AND THE TOTAL NUMBER OF EMPLOYEES IN EACH EMPLOYER GROUP, THAT PARTICIPATED IN THE HEALTH-CARE COST-SHARING ARRANGEMENT IN THIS STATE IN THE PREVIOUS CALENDAR YEAR;

(g) THE NUMBER OF APPLICATIONS OR OTHER REQUESTS TO PARTICIPATE IN THE HEALTH-CARE COST-SHARING ARRANGEMENT THAT WERE SUBMITTED, ACCEPTED, AND DENIED IN THIS STATE IN THE PREVIOUS CALENDAR YEAR;

(h) THE TOTAL NUMBER, IN THE PREVIOUS CALENDAR YEAR, OF:

(I) BILLS OR MEDICAL EXPENSES SUBMITTED TO THE HEALTH-CARE COST-SHARING ARRANGEMENT BY OR ON BEHALF OF MEMBERS IN THIS STATE, INCLUDING THE TOTAL AMOUNT OF ALL BILLS OR MEDICAL EXPENSES THAT WERE SUBMITTED IN THIS STATE;

(II) BILLS OR MEDICAL EXPENSES PAID, SHARED, COVERED, REIMBURSED, OR OTHERWISE DEFRAYED WITH THE MONEY COLLECTED, MANAGED, OR FACILITATED BY THE HEALTH-CARE COST-SHARING ARRANGEMENT FOR ITS MEMBERS IN THIS STATE, INCLUDING THE TOTAL AMOUNT OF ALL BILLS OR MEDICAL EXPENSES THAT WERE PAID, SHARED,

COVERED, REIMBURSED, OR OTHERWISE DEFRAYED IN THIS STATE;

(III) BILLS OR MEDICAL EXPENSES SUBMITTED IN THIS STATE THAT THE HEALTH-CARE COST-SHARING ARRANGEMENT, IN WHOLE OR IN PART, DENIED OR DETERMINED TO BE INELIGIBLE FOR COST SHARING, INCLUDING THE TOTAL AMOUNT OF ALL BILLS AND MEDICAL EXPENSES SUBMITTED IN THIS STATE THAT WERE DENIED OR DETERMINED TO BE INELIGIBLE;

(IV) RETROACTIVE MEMBERSHIP DENIALS IN THIS STATE; AND

(V) MEMBER APPEALS OR GRIEVANCES SUBMITTED TO THE HEALTH-CARE COST-SHARING ARRANGEMENT IN THIS STATE, INCLUDING THE NUMBER OF APPEALS IN THIS STATE APPROVED IN WHOLE OR IN PART AND THE DOLLAR AMOUNT APPROVED IN THE APPEAL;

(i) THE TOTAL AMOUNT PAID OR CONTRIBUTED TO THE HEALTH-CARE COST-SHARING ARRANGEMENT IN THE PREVIOUS CALENDAR YEAR BY MEMBERS WHO ARE RESIDENTS OF THIS STATE; AND

(j) THE NAME, MAILING ADDRESS, E-MAIL ADDRESS, AND TELEPHONE NUMBER OF AN INDIVIDUAL SERVING AS A CONTACT PERSON FOR THE HEALTH-CARE COST-SHARING ARRANGEMENT IN THIS STATE. THE COMMISSIONER SHALL NOT MAKE THE ARRANGEMENT'S CONTACT PERSON'S INFORMATION AVAILABLE TO THE PUBLIC.

(3) **Consumer disclosures and rights.** (a) ON AND AFTER JANUARY 1, 2022, PRIOR TO ENROLLING, ACCEPTING, OR RENEWING AN INDIVIDUAL OR GROUP IN A HEALTH-CARE COST-SHARING ARRANGEMENT IN THIS STATE, A PERSON, OTHER THAN A PRODUCER, OFFERING, OPERATING, MANAGING, OR ADMINISTERING THE ARRANGEMENT SHALL PROVIDE A WRITTEN DISCLOSURE, EITHER IN HARD COPY OR ELECTRONIC FORMAT, TO BE SIGNED BY THE PROSPECTIVE OR RENEWING MEMBER OR GROUP, CONTAINING THE FOLLOWING INFORMATION:

(I) PARTICIPATION OR MEMBERSHIP IN AN ARRANGEMENT DOES NOT GUARANTEE PAYMENT OF BILLS OR MEDICAL EXPENSES;

(II) A MEMBER OF AN ARRANGEMENT REMAINS PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL BILLS OR MEDICAL EXPENSES;

(III) A MEMBER OF AN ARRANGEMENT MAY BE SUBJECT TO CERTAIN PREEXISTING CONDITION EXCLUSIONS OR OTHER LIMITATIONS; AND

(IV) ANY OTHER DISCLOSURES DETERMINED BY THE COMMISSIONER BY RULE TO ADDRESS CONSUMER CONFUSION OR TO ENSURE CONSUMERS HAVE NECESSARY INFORMATION TO MAKE INFORMED DECISIONS.

(b) ON AND AFTER JANUARY 1, 2022, A PERSON, OTHER THAN A PRODUCER, OFFERING, OPERATING, MANAGING, OR ADMINISTERING A HEALTH-CARE COST-SHARING ARRANGEMENT SHALL DISPLAY PROMINENTLY ON ITS WEBSITE, IF THE PERSON HAS A WEBSITE, AND IN ITS WRITTEN MARKETING MATERIALS THE INFORMATION SPECIFIED IN SUBSECTION (3)(a) OF THIS SECTION.

(c) ON AND AFTER JANUARY 1, 2022, A PRODUCER OFFERING A HEALTH-CARE COST-SHARING ARRANGEMENT IN THIS STATE SHALL PROVIDE A WRITTEN OR ELECTRONIC DISCLOSURE TO A PROSPECTIVE MEMBER BEFORE SELLING THE ARRANGEMENT TO THE PERSON. THE DISCLOSURE MUST INCLUDE THE FOLLOWING INFORMATION:

(I) PARTICIPATION OR MEMBERSHIP IN AN ARRANGEMENT DOES NOT GUARANTEE PAYMENT OF BILLS OR MEDICAL EXPENSES;

(II) A MEMBER OF AN ARRANGEMENT REMAINS PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL BILLS OR MEDICAL EXPENSES;

(III) A MEMBER OF AN ARRANGEMENT MAY BE SUBJECT TO

CERTAIN PREEXISTING CONDITION EXCLUSIONS OR OTHER LIMITATIONS; AND

(IV) ANY OTHER DISCLOSURES DETERMINED BY THE COMMISSIONER BY RULE TO ADDRESS CONSUMER CONFUSION OR TO ENSURE CONSUMERS HAVE NECESSARY INFORMATION TO MAKE INFORMED DECISIONS.

(d) ON AND AFTER JANUARY 1, 2022, A HEALTH-CARE COST-SHARING ARRANGEMENT SHALL PROVIDE THE FOLLOWING TO EACH MEMBER OF THE ARRANGEMENT IN THIS STATE:

(I) ON ANY CARD THE ARRANGEMENT ISSUES TO A MEMBER FOR THE PURPOSE OF PRESENTING TO A HEALTH-CARE PROVIDER, A STATEMENT CLEARLY INDICATING THAT THE PERSON IS A MEMBER OF AN ARRANGEMENT THAT PROVIDES NO ASSUMPTION OF RISK OR PROMISE TO PAY FOR HEALTH-CARE SERVICES PROVIDED TO THE MEMBER;

(II) ON A MONTHLY BASIS, A WRITTEN OR ELECTRONIC STATEMENT LISTING THE TOTAL DOLLAR AMOUNT:

(A) OF THE ELIGIBLE MEDICAL EXPENSES SUBMITTED BY THE MEMBER IN THE IMMEDIATELY PRECEDING MONTH; AND

(B) PAID, SHARED, COVERED, REIMBURSED, OR OTHERWISE DEFRAYED ON BEHALF OF THE MEMBER IN THE IMMEDIATELY PRECEDING MONTH WITH MONEY COLLECTED, MANAGED, OR FACILITATED BY THE ARRANGEMENT;

(III) ON A QUARTERLY BASIS, A WRITTEN OR ELECTRONIC STATEMENT LISTING THE PERCENTAGE OF THE ENTIRE MEMBERSHIP'S CONTRIBUTIONS THAT WERE USED FOR EACH OF THE FOLLOWING:

(A) TO MEET MEMBERS' MEDICAL EXPENSES; AND

(B) TO COVER THE ADMINISTRATIVE COSTS OF THE ARRANGEMENT;

(IV) WITHIN THIRTY DAYS AFTER JOINING THE ARRANGEMENT, A COMPLETE SET OF GUIDELINES FOR:

(A) PAYING FOR MEDICAL EXPENSES USING MONEY COLLECTED, MANAGED, OR FACILITATED BY THE ARRANGEMENT;

(B) APPEALING DECISIONS MADE BY THE ARRANGEMENT OR ITS MEMBERS; AND

(C) FILING COMPLAINTS WITH THE ARRANGEMENT AND WITH THE DIVISION.

(e) A HEALTH-CARE COST-SHARING ARRANGEMENT SHALL ALLOW ITS MEMBERS TO CONTINUE PARTICIPATION IN THE ARRANGEMENT AFTER DEVELOPING OR BEING DIAGNOSED WITH A MEDICAL CONDITION.

(f) A HEALTH-CARE COST-SHARING ARRANGEMENT SHALL SUBMIT TO THE COMMISSIONER, AS PART OF THE REPORT REQUIRED BY SUBSECTION (2) OF THIS SECTION AND IN THE FORM AND MANNER REQUIRED BY THE COMMISSIONER BY RULE, INFORMATION DEMONSTRATING COMPLIANCE WITH THIS SUBSECTION (3).

(4) **Notice of decision on bills.** (a) A HEALTH-CARE COST-SHARING ARRANGEMENT THAT RECEIVES A BILL OR REQUEST FOR PAYMENT OF MEDICAL EXPENSES FROM A MEMBER OF THE ARRANGEMENT OR FROM A HEALTH-CARE PROVIDER THAT PROVIDED HEALTH CARE TO A MEMBER OF THE ARRANGEMENT SHALL PROVIDE A RESPONSE TO THE BILL OR REQUEST FOR PAYMENT WITHIN A SPECIFIED NUMBER OF DAYS, AS DETERMINED BY THE COMMISSIONER BY RULE, AFTER THE DATE THE BILL IS SUBMITTED OR THE REQUEST FOR PAYMENT IS MADE TO THE ARRANGEMENT.

(b) IF THE HEALTH-CARE COST-SHARING ARRANGEMENT:

(I) FAILS TO PAY OR FACILITATE THE PAYMENT OF THE MEDICAL

EXPENSES IN ACCORDANCE WITH THE ARRANGEMENT GUIDELINES OR FAILS TO RESPOND TO THE BILL OR REQUEST FOR PAYMENT WITHIN THE TIME SPECIFIED BY THE COMMISSIONER BY RULE, THE FAILURE CONSTITUTES A DENIAL OF THE BILL OR REQUEST OR A DETERMINATION THAT THE MEDICAL EXPENSES ARE INELIGIBLE FOR COST SHARING; AND

(II) PAYS OR FACILITATES THE PAYMENT OF AN AMOUNT OR PORTION OF THE MEDICAL EXPENSES THAT IS LESS THAN WHAT THE ARRANGEMENT GUIDELINES SPECIFY, THE FAILURE TO PAY THE REMAINING BALANCE OF THE MEDICAL EXPENSES WITHIN THE SPECIFIED PERIOD CONSTITUTES A DENIAL OF THE REMAINING PORTION OF THE MEDICAL EXPENSES OR A DETERMINATION THAT THE REMAINING PORTION OF THE MEDICAL EXPENSES IS INELIGIBLE FOR COST SHARING.

(c) IF THE HEALTH-CARE COST-SHARING ARRANGEMENT DENIES THE MEDICAL EXPENSE OR DETERMINES THAT THE MEDICAL EXPENSE IS INELIGIBLE FOR COST SHARING AND THE MEMBER OF THE ARRANGEMENT ALSO HAS COVERAGE UNDER A QUALIFIED HEALTH PLAN, A MEDICAL ASSISTANCE PROGRAM ADMINISTERED PURSUANT TO ARTICLES 4, 5, AND 6 OF TITLE 25.5, OR OTHER COVERAGE FOR WHICH A THIRD-PARTY PAYER MAY BE RESPONSIBLE FOR PAYING FOR THE MEMBER'S MEDICAL EXPENSES, THE PROVIDER MAY BILL APPROPRIATE THIRD-PARTY PAYERS FOR ANY UNPAID BALANCE OWED FOR HEALTH CARE THE PROVIDER PROVIDED TO THE MEMBER.

(5) **Rules.** THE COMMISSIONER:

(a) SHALL ADOPT RULES TO IMPLEMENT THE DISCLOSURE AND REPORTING REQUIREMENTS SPECIFIED IN THIS SECTION AND THE TIME BY WHICH A HEALTH-CARE COST-SHARING ARRANGEMENT IS REQUIRED TO RESPOND TO A BILL OR REQUEST FOR PAYMENT OF MEDICAL EXPENSES;

AND

(b) MAY ESTABLISH A SCHEDULE FOR THE ASSESSMENT OF PENALTIES AS AUTHORIZED IN SUBSECTION (6) OF THIS SECTION BASED ON THE FREQUENCY AND SEVERITY OF NONCOMPLIANCE.

(6) **Civil penalties.** (a) (I) THE COMMISSIONER MAY ASSESS A PENALTY AGAINST A HEALTH-CARE COST-SHARING ARRANGEMENT FOR FAILING TO:

(A) FILE THE INFORMATION REQUIRED BY SUBSECTION (2) OF THIS SECTION;

(B) POST OR PROVIDE THE DISCLOSURES REQUIRED BY SUBSECTION (3) OF THIS SECTION; OR

(C) PAY OR RESPOND TO A BILL OR REQUEST FOR PAYMENT WITHIN THE TIME SPECIFIED BY RULE PURSUANT TO SUBSECTION (4) OF THIS SECTION.

(II) THE COMMISSIONER MAY ASSESS A PENALTY OF UP TO FIVE HUNDRED DOLLARS FOR AN INITIAL VIOLATION OF A REQUIREMENT SPECIFIED IN THIS SUBSECTION (6)(a) AND UP TO FIVE THOUSAND DOLLARS FOR ANY SUBSEQUENT FAILURE TO COMPLY WITH A REQUIREMENT SPECIFIED IN THIS SUBSECTION (6)(a).

(b) IF A PRODUCER FAILS TO POST OR PROVIDE THE DISCLOSURES REQUIRED BY SUBSECTION (3) OF THIS SECTION, THE COMMISSIONER MAY ALSO ASSESS A CIVIL PENALTY IN ACCORDANCE WITH SECTION 10-2-804.

(7) **Prohibited acts - enforcement.** A PERSON SHALL NOT MAKE, ISSUE, CIRCULATE, OR CAUSE TO BE MADE, ISSUED, OR CIRCULATED ANY STATEMENT OR PUBLICATION THAT MISREPRESENTS THE MEDICAL COST-SHARING BENEFITS, ADVANTAGES, CONDITIONS, OR TERMS OF ANY HEALTH-CARE COST-SHARING ARRANGEMENT. THE COMMISSIONER MAY

ENFORCE THIS SUBSECTION (7) IN ACCORDANCE WITH SECTIONS 10-3-904.5, 10-3-904.6, AND 10-3-904.7.

(8) NOTHING IN THIS SECTION LIMITS THE AUTHORITY OF THE COMMISSIONER TO TAKE ACTION AGAINST A HEALTH-CARE COST-SHARING ARRANGEMENT FOR DECEPTIVE TRADE PRACTICES, THE UNAUTHORIZED SALE OF INSURANCE, OR ENGAGING IN THE UNAUTHORIZED BUSINESS OF INSURANCE.

SECTION 2. In Colorado Revised Statutes, 10-3-904.5, **amend** (1)(a) as follows:

10-3-904.5. Emergency cease-and-desist orders - issuance. (1) The commissioner may issue an emergency cease-and-desist order ex parte if:

(a) The commissioner believes that:

(I) An unauthorized person is engaging in the business of insurance in violation of ~~the provisions of~~ section 10-3-105 or 10-3-903 or is in violation of a rule promulgated by the commissioner; ~~and~~ OR

(II) A PERSON, INCLUDING AN UNAUTHORIZED PERSON, IS VIOLATING SECTION 10-3-903.7; AND

SECTION 3. Act subject to petition - effective date - applicability. (1) 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; 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 2022 and, in such case, will take effect on the date of the official declaration of the vote thereon by the

governor.

(2) This act applies to conduct occurring on or after the applicable effective date of this act.