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Seventy-fourth General Assembly
STATE OF COLORADO

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LLS NO. 23-0528.01 Brita Darling x2241 **SENATE BILL**

SENATE SPONSORSHIP

Cutter,

HOUSE SPONSORSHIP

Weissman,

BILL TOPIC: "Protections For Consumers For Medical Debt"
DEADLINES: Finalize by: JAN 23, 2023 File by: JAN 25, 2023

A BILL FOR AN ACT

CONCERNING PROTECTIONS FOR CONSUMERS RELATING TO MEDICAL DEBT. <{***placeholder title***}>

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:

- Caps the rate of interest on medical debt at 3% per annum.
- For purposes of a statutory cap on interest rates and fair debt collection practices, defines "medical debt" to include debt arising from the receipt of health-care services or medical products or devices.

- Requires a debt collector or collection agency collecting on a medical debt to provide to the consumer, upon written request, an itemized statement concerning the debt. Requires disclosures of medical records to be compliant with federal privacy laws relating to medical records and information.
- Establishes requirements relating to payment plans for medical debt, including written documentation of the payment plan between the consumer and the creditor, debt collector or debt collection agency; notice to the consumer if the payment plan will become inoperative and the opportunity to renegotiate the payment plan.
- Prohibits collection on the debt during an appeal or reporting to a consumer reporting agency until a certain amount of time after the payment plan becomes inoperative.
- Requires a debt collector or collection agency that files a legal action to collect medical debt to include an itemization of the charges and prior to the entry of a default judgment against the creditor, provide evidence of the debt
- Makes it a deceptive trade practice for violation of surprise or balance billing laws whether in or out of network.
- Upon request of a prospective patient, the bill requires a health care provider or health care facility to provide a estimate of the total cost of a health-care service (service) to a person who intends to self-pay for the service (self-pay estimate). The bill includes requirements for the self-pay estimate and caps the amount that the final, total cost of the service may exceed the self-pay estimate, unless emergency, or unforseen, medically necessary services required during the health-care service. The bill make it a deceptive trade practice to violate provisions relating to the self-pay estimate.

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

SECTION 1. In Colorado Revised Statutes, 5-12-102, **add** (5) as follows:

5-12-102. Statutory interest. (5) (a) THE MAXIMUM RATE OF INTEREST ON MEDICAL DEBT IS THREE PERCENT PER ANNUM.

(b) AS USED IN THIS SUBSECTION (5), "MEDICAL DEBT" MEANS A

LOAN, OTHER THAN A HEALTH CARE LOAN, <{***How to describe? Do we need this here?***}>INDEBTEDNESS, OR OTHER OBLIGATION ARISING DIRECTLY FROM THE RECEIPT OF HEALTH-CARE SERVICES OR OF MEDICAL PRODUCTS OR DEVICES. <{***Do we need definitions of any of these things?***}>

SECTION 2. In Colorado Revised Statutes, 5-16-103, **add** (10.5) as follows:

5-16-103. Definitions. As used in this article 16, unless the context otherwise requires:

(10.5) "MEDICAL DEBT" MEANS A LOAN, OTHER THAN A HEALTH-CARE LOAN, <{***Same question as above***}>INDEBTEDNESS, OR OTHER OBLIGATION ARISING DIRECTLY FROM THE RECEIPT OF HEALTH-CARE SERVICES OR OF MEDICAL PRODUCTS OR DEVICES.

SECTION 3. In Colorado Revised Statutes, 5-16-109, **add** (5) as follows:

5-16-109. Validation of debts. (5) (a) UPON WRITTEN OR ORAL REQUEST AND WITHOUT FEE, A DEBT COLLECTOR OR COLLECTION AGENCY COLLECTING ON MEDICAL DEBT SHALL PROVIDE AN ITEMIZED STATEMENT TO THE CONSUMER WITHIN THIRTY DAYS OF THE REQUEST. THE ITEMIZED STATEMENT MUST INCLUDE:

(I) THE NAME AND ADDRESS OF THE MEDICAL CREDITOR;

(II) THE DATE OR DATES OF SERVICE;

(III) THE DATE OR DATES THE MEDICAL DEBT WAS INCURRED, IF DIFFERENT FROM THE DATE OF SERVICE;

(IV) A DETAILED LIST OF THE SPECIFIC HEALTH-CARE SERVICES PROVIDED TO THE CONSUMER;

(V) A LIST OF ALL HEALTH-CARE PROFESSIONALS WHO TREATED

THE PATIENT;

(VI) THE AMOUNT OF THE PRINCIPAL FOR ANY MEDICAL DEBT INCURRED;

(VII) ANY ADJUSTMENT TO THE BILL, INCLUDING NEGOTIATED INSURANCE RATES OR OTHER DISCOUNTS;

(VIII) THE AMOUNT OF ANY PAYMENTS RECEIVED, WHETHER FROM THE PATIENT OR ANY OTHER PARTY; <{***person instead of party?***}>

(IX) ANY INTEREST OR FEES;

(X) WHETHER THE PATIENT WAS SCREENED FOR FINANCIAL ASSISTANCE; AND

(XI) WHETHER THE PATIENT WAS FOUND ELIGIBLE FOR FINANCIAL ASSISTANCE, AND IF SO, THE AMOUNT DUE AFTER ALL FINANCIAL ASSISTANCE HAS BEEN APPLIED TO THE ITEMIZED BILL.

(b) THE DEBT COLLECTOR OR COLLECTION AGENCY PROVIDING THE ITEMIZED STATEMENT PURSUANT TO THIS SUBSECTION (5) SHALL COMPLY WITH ALL APPLICABLE PROVISIONS OF THE FEDERAL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", AS AMENDED, PUB.L. 104-191, AND FEDERAL REGULATIONS IMPLEMENTING THE ACT. <{***see 18-4-412 definitions / theft statute. Is this how/where you want to refer to HIPPA?***}>

SECTION 4. In Colorado Revised Statutes, **add** 5-16-109.5 as follows:

5-16-109.5. Requirements related to payment plans for medical debt. (1) A MEDICAL CREDITOR, AS DEFINED IN SECTION 6-20-201 (6), A DEBT COLLECTOR, OR COLLECTION AGENCY COLLECTING ON MEDICAL DEBT THAT AGREES TO A PAYMENT PLAN FOR A MEDICAL DEBT SHALL PROVIDE A WRITTEN COPY OF THE PAYMENT PLAN TO THE CONSUMER WITHIN SEVEN

DAYS OF ENTERING INTO THE PAYMENT PLAN. THE PAYMENT PLAN MUST PROMINENTLY DISCLOSE THE RATE OF INTEREST AND THE DATE BY WHICH TH ACCOUNT WILL BE PAID IN FULL, ASSUMING PAYMENTS SET BY THE SCHEDULE IN THE PAYMENT PLAN ARE MADE WITHOUT INTERRUPTION.

(2) (a) A MEDICAL DEBT PAYMENT PLAN MAY BE ACCELERATED OR DECLARED IN DEFAULT OR NO LONGER OPERATIVE DUE TO NONPAYMENT ONLY AFTER THE CONSUMER FAILS TO MAKE SCHEDULED PAYMENT ON THE PAYMENT PLAN FOR AT LEAST THREE CONSECUTIVE MONTHS.

(b) BEFORE DECLARING THE PAYMENT PLAN NO LONGER OPERATIVE, THE MEDICAL CREDITOR, OR DEBT COLLECTOR OR COLLECTION AGENCY COLLECTING ON MEDICAL DEBT SHALL:

(I) MAKE AT LEAST THREE REASONABLE ATTEMPTS TO CONTACT THE CONSUMER BY TELEPHONE OR OTHER METHOD PREFERRED BY THE CONSUMER; AND

(II) PROVIDE NOTICE TO THE CONSUMER IN WRITING THAT THE PAYMENT PLAN MAY BECOME INOPERATIVE, AND INFORM THE PATIENT OF THE OPPORTUNITY TO RENEGOTIATE THE PAYMENT PLAN.

(3) THE MEDICAL CREDITOR, OR DEBT COLLECTOR OR COLLECTION AGENCY COLLECTING ON MEDICAL DEBT:

(a) IF REQUESTED BY THE CONSUMER, SHALL ATTEMPT TO RENEGOTIATE THE TERMS OF THE DEFAULTED PAYMENT PLAN PRIOR TO THE PAYMENT PLAN BEING DECLARED INOPERATIVE; AND

(b) SHALL NOT REPORT ADVERSE INFORMATION TO A CONSUMER CREDIT REPORTING AGENCY OR COMMENCE A CIVIL ACTION AGAINST THE CONSUMER OR RESPONSIBLE PARTY FOR NONPAYMENT UNTIL AT LEAST SIXTY-THREE DAYS AFTER THE PAYMENT PLAN IS DECLARED TO BE NO LONGER OPERATIVE.

(4) FOR PURPOSES OF THIS SECTION, THE NOTICE AND TELEPHONE CALLS TO THE CONSUMER MAY BE TO THE LAST KNOWN TELEPHONE NUMBER AND ADDRESS OF THE CONSUMER.

5-16-109.6. Prohibition on collection of medical debt during health insurance appeals. (1) A MEDICAL CREDITOR, AS DEFINED IN SECTION 6-20-201(6), <{***Your note: Is this the right cross reference?***}> OR A DEBT COLLECTOR OR COLLECTION AGENCY COLLECTING ON MEDICAL DEBT THAT KNOWS OR SHOULD ~~HAVE KNOWN~~ <{***KNOW***}> ABOUT AN INTERNAL REVIEW, EXTERNAL REVIEW, OR OTHER APPEAL <{***Is it section 10-16-113 or section 10-16-113.5? Do you want to reference the appeal/prior auth statutes?***}> CONCERNING A HEALTH INSURANCE PLAN ISSUED BY A CARRIER REGULATED BY THE COMMISSIONER OF INSURANCE PURSUANT TO ARTICLE 16 OF TITLE 10 <{***Added this language to limit appeal provision to state-regulated plans***}> THAT IS PENDING OR WAS PENDING WITHIN THE PREVIOUS SIXTY-THREE DAYS SHALL NOT:

<{***section 10-16-105.6 prompt payment of claims. Need to know the timing of the appeals in order to align the days with Colorado law. 63 days may not be correct.***}>

(a) PROVIDE INFORMATION RELATIVE TO UNPAID CHARGES FOR HEALTH-CARE SERVICES TO A CONSUMER REPORTING AGENCY;

(b) COMMUNICATE WITH THE CONSUMER REGARDING THE UNPAID CHARGES FOR HEALTH-CARE SERVICES IN AN ATTEMPT TO COLLECT ON THE CHARGES; OR

(c) INITIATE A CIVIL ACTION OR ARBITRATION PROCEEDING AGAINST THE CONSUMER RELATIVE TO UNPAID CHARGES FOR HEALTH-CARE SERVICES.

(2) IF A MEDICAL DEBT HAS ALREADY BEEN REPORTED TO A

CONSUMER REPORTING AGENCY AND THE MEDICAL CREDITOR, OR A DEBT COLLECTOR OR COLLECTION AGENCY COLLECTING ON MEDICAL DEBT WHO REPORTED THE INFORMATION LEARNS OF AN INTERNAL REVIEW, EXTERNAL REVIEW, OR OTHER APPEAL OF A HEALTH INSURANCE DECISION THAT IS PENDING OR WAS PENDING WITHIN THE PREVIOUS SIXTY-THREE DAYS, THAT PERSON SHALL INSTRUCT THE CONSUMER REPORTING AGENCY TO DELETE THE INFORMATION ABOUT THE DEBT.

(3) A MEDICAL CREDITOR OR A DEBT COLLECTOR OR COLLECTION AGENCY COLLECTING ON MEDICAL DEBT THAT KNOWS OR SHOULD HAVE KNOWN ABOUT AN INTERNAL REVIEW, EXTERNAL REVIEW, OR OTHER APPEAL OF A HEALTH INSURANCE DECISION THAT IS PENDING OR WAS PENDING WITHIN THE PREVIOUS SIXTY-THREE DAYS SHALL NOT ATTEMPT TO COLLECT ON THE CHARGES OR SELL THE DEBT TO A DEBT BUYER.

SECTION 5. In Colorado Revised Statutes, 5-16-111, **add** (5) and (6) as follows:

5-16-111. Legal actions by collection agencies. (5) (a) A DEBT COLLECTOR OR COLLECTION AGENCY WHO <{***"that" or "who"?--seems to be "who" in some of the existing law.***}> BRINGS A LEGAL ACTION ON A MEDICAL DEBT SHALL ATTACH TO THE COMPLAINT OR FORM A COPY OF A REDACTED ITEMIZATION OF CHARGES INCURRED.

(b) THE PLAINTIFF NAMED IN A LEGAL ACTION ON MEDICAL DEBT MUST BE THE OWNER OF THE DEBT AND NOT A DEBT COLLECTOR OR COLLECTION AGENCY WHO HAS TAKEN ASSIGNMENT ONLY FOR COLLECTION PURPOSES.

(6) (a) PRIOR TO ENTRY OF A DEFAULT JUDGMENT AGAINST A CONSUMER IN A LEGAL ACTION ON A MEDICAL DEBT, THE PLAINTIFF SHALL FILE WITH THE COURT EVIDENCE THAT SATISFIES THE REQUIREMENTS OF

RULES 803(6) AND 902(11) OF THE COLORADO RULES OF EVIDENCE OR IS OTHERWISE AUTHORIZED BY LAW OR RULE THAT ESTABLISHES THE AMOUNT AND NATURE OF THE MEDICAL DEBT AND INCLUDES:

(I) THE ORIGINAL ACCOUNT NUMBER AT CHARGE-OFF;

(II) THE ORIGINAL CREDITOR AT CHARGE-OFF;

(III) THE AMOUNT DUE AT CHARGE-OFF OR, IF THE BALANCE HAS NOT BEEN CHARGED OFF, AN ITEMIZATION OF THE AMOUNT CLAIMED TO BE OWED, INCLUDING THE PRINCIPAL, INTEREST, FEES, AND OTHER CHARGES OR REDUCTIONS FROM PAYMENT MADE OR OTHER CREDITS;

(IV) AN ITEMIZATION OF POST CHARGE-OFF ADDITIONS, IF ANY;

(V) (A) THE DATE OF THE LAST PAYMENT, IF APPLICABLE; OR

(B) THE DATE OF THE LAST TRANSACTION; AND

(VI) THE DATE THE DEBT WAS INCURRED.

(b) AN AFFIDAVIT THAT DOES NOT INCLUDE THE EVIDENCE REQUIRED IN SUBSECTIONS (5) AND (6) OF THIS SECTION, DOES NOT SATISFY THE REQUIREMENTS OF SUBSECTION (5) AND (6) OF THIS SECTION.

SECTION 6. In Colorado Revised Statutes, 6-1-105, **add** (1)(uuu) and (vvv) as follows:

6-1-105. Unfair or deceptive trade practices. (1) A person engages in a deceptive trade practice when, in the course of the person's business, vocation, or occupation, the person:

(uuu) VIOLATES SECTION 12-30-112, SECTION 12-30-113.

(vvv) VIOLATES SECTION 25-49-106. <{***or do you want me to include with the other cites in (uuu)? Do they relate?***}>

SECTION 7. In Colorado Revised Statutes, **add** 25-49-106 as follows:

25-49-106. Required disclosure to self-pay recipients - estimate

of total cost of health-care services upon request. (1) (a) <{***This is just one attempt to do this. It may not include all of the language or concepts from the vehicle repair act. Feel free to change the language. Do we want to include a date after which an estimate may be requested within this section or use an effective date or applicability clause for this sectionof the bill?***}> UPON THE REQUEST OF A PERSON SEEKING A HEALTH-CARE SERVICE <{***Does the definition of "health-care service in this part 1 work for this section? "health-care provider", "health-care facility", and "recipient" used in this sectin are all defined terms. Please check the definitions. Also see note below re: using "health-care price" of the service?***}> WHO INTENDS TO SELF-PAY FOR THE SERVICE, PRIOR TO THE PROVISION OF THE HEALTH-CARE SERVICE, A HEALTH-CARE PROVIDER AND A HEALTH-CARE FACILITY SHALL PROVIDE A SELF-PAY ESTIMATE PURSUANT TO SUBSECTION (3) OF THIS SECTION OF THE TOTAL ESTIMATED COST TO THE RECIPIENT <{***or used the defined term "health-care price"? Does that term work?***}> OF THE ANTICIPATED HEALTH-CARE SERVICE.

(b) (I) EXCEPT AS PROVIDED IN SUBSECTION (1)(b)(II) OF THIS SECTION, THE FINAL COST OF THE HEALTH-CARE SERVICE FOR WHICH THE SELF-PAY ESTIMATE WAS MADE MUST BE WITHIN FIFTEEN PERCENT OF THE TOTAL ESTIMATED COST INDICATED IN THE SELF-PAY ESTIMATE.

(II) THE FINAL COST OF A HEALTH-CARE SERVICE MAY EXCEED FIFTEEN PERCENT OF THE SELF-PAY ESTIMATE IF A MEDICAL EMERGENCY OCCURS THAT IS ASSOCIATED WITH THE HEALTH-CARE SERVICE OR AN ADDITIONAL, UNFORSEEN, MEDICALLY NECESSARY HEALTH-CARE SERVICE IS REQUIRED DURING THE PROVISION OF THE HEALTH-CARE SERVICE. THE HEALTH-CARE PROVIDER OR HEALTH-CARE FACILITY SHALL MAKE ALL REASONABLE EFFORTS TO OBTAIN THE CONSENT OF THE RECIPIENT, OR, IF

THE RECIPIENT IS INCAPACITATED, THE RECIPIENT'S AUTHORIZED AGENT, PRIOR TO PROVIDING ANY EMERGENCY OR UNFORESEEN, MEDICALLY NECESSARY HEALTH-CARE SERVICE THAT WILL INCREASE BY MORE THAN FIFTEEN PERCENT THE TOTAL COST INDICATED IN THE SELF-PAY ESTIMATE. THE HEALTH

(2) THE RIGHT OF A PERSON TO REQUEST A SELF-PAY ESTIMATE PRIOR TO THE RECEIPT OF A HEALTH-CARE SERVICE MUST BE CLEARLY AND CONSPICUOUSLY STATED BY THE HEALTH-CARE PROVIDER AND AT THE HEALTH-CARE FACILITY IN A MANNER, LOCATION, AND AT A TIME REASONABLY CALCULATED TO INFORM THE PERSON OF THE RIGHT.

(3) THE SELF-PAY ESTIMATE:

(a) MUST BE IN WRITING; EXCEPT THAT, IF THE HEALTH-CARE PROVIDER OR HEALTH-CARE FACILITY IS UNABLE TO PROVIDE A WRITTEN SELF-PAY ESTIMATE, SPECIFIC INFORMATION RELATING TO THE SELF-PAY ESTIMATE MUST BE STATED IN A RECORDED TELEPHONE CALL, INCLUDING:

(I) THE DATE AND TIME OF THE TELEPHONE CALL;

(II) THE TELEPHONE NUMBER PROVIDED FOR THE SELF-PAY ESTIMATE;

(III) THE MANNER OF CONSENT FOR THE SELF-PAY ESTIMATE AMOUNT;

(IV) THE NAME OF THE INTENDED RECIPIENT OF THE HEALTH-CARE SERVICE;

(V) THE NAME OF THE HEALTH-CARE PROVIDER OR HEALTH-CARE FACILITY EMPLOYEE PROVIDING THE SELF-PAY ESTIMATE; AND

(VI) ANY OTHER INFORMATION MATERIAL TO THE DETERMINATION OF THE SELF-PAY ESTIMATE;

(b) MUST INCLUDE THE TOTAL COST OF THE HEALTH-CARE SERVICE,

INCLUDING AN ITEMIZATION OF ALL NECESSARY COMPONENTS OF THE SERVICE, WHICH MAY INCLUDE THE COST OF PERSONNEL, IMAGING, MEDICAL TOOLS OR DEVICES, AND MEDICINE; AND

(c) MUST BE EASY TO UNDERSTAND BY A PERSON WITHOUT KNOWLEDGE OF MEDICAL OR TECHNICAL JARGON AND WITH LIMITED PROFICIENCY IN MATH, SCIENCE, AND WRITTEN AND VERBAL COMMUNICATION SKILLS. <{***something like this?***}>

(4) A VIOLATION OF THIS SECTION IS A DECEPTIVE TRADE PRACTICE PURSUANT TO SECTION 6-1-105 (1)(vvv). <{***or combined in (uuu)?***}> <{***Anything else missing from this new section OR the bill?***}>

SECTION 8. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.