Be it enacted by the people of the state of Colorado:

SECTION 1. In Colorado Revised Statutes, **repeal and reenact, with amendments**, part 1 of article 20 of title 6 as follows:

PART 1
COMPREHENSIVE HEALTHCARE BILLING TRANSPARENCY

6-20-101. Short title. THE SHORT TITLE OF THIS PART 1 IS THE "COMPREHENSIVE HEALTHCARE BILLING TRANSPARENCY ACT".

6-20-102. Purpose. A DECLARATION FROM THE PEOPLE OF COLORADO.

(1) THE PEOPLE OF COLORADO ENACT THIS LAW REGARDING PRICE TRANSPARENCY IN HEALTHCARE BILLING TO ESTABLISH COMMON SENSE, ORDER, AND INTEGRITY IN COLORADO'S HEALTHCARE SYSTEM AND TO SET AN EXAMPLE FOR THE REST OF OUR NATION. THE PEOPLE BELIEVE TRANSPARENCY, IN ALL ASPECTS OF HEALTHCARE BILLING, IS OF PARAMOUNT IMPORTANCE AND THAT IT WILL NOT, IN ANY WAY, IMPEDE COMPETITION, BUT RATHER, WILL IMPROVE COMPETITION AND EMPOWER PATIENTS TO BECOME MORE ACTIVE PARTICIPANTS IN THEIR OWN CARE.

(2) THE PEOPLE UNDERSTAND THAT SOME IN THE HEALTHCARE INDUSTRY MAY FIND PROVISIONS OF THIS LAW ONEROUS. THE PEOPLE, HOWEVER, BELIEVE THAT THE LACK OF TRANSPARENCY THAT IS THE NORM AT THE TIME OF THIS LAW'S ENACTMENT IS FAR MORE ONEROUS AND DANGEROUS, AND THUS, FIND THIS LAW ABSOLUTELY NECESSARY IN ALL OF ITS DETAIL.

(3) THE PURPOSE OF TRANSPARENCY IN HEALTHCARE BILLING IS NOT MERELY TO PROVIDE PATIENTS WITH THE ABILITY TO SHOP FOR HEALTHCARE SERVICES ON THE BASIS OF PRICE. IN FACT, SHOPPING AROUND IS ONLY A SMALL ASPECT OF TRANSPARENCY IN HEALTHCARE BILLING, BECAUSE SHOPPING FOR A HEALTHCARE SERVICE IS NOT ALWAYS PRACTICAL WHEN A HEALTHCARE SERVICE IS NEEDED. THE PURPOSE OF TRANSPARENCY IN HEALTHCARE BILLING, AND OF THIS LAW, IS TO ENSURE THAT COLORADO'S HEALTHCARE SYSTEM BEGINS TO FUNCTION IN A MANNER WHERE PRICES ARE AVAILABLE TO ANYONE AND EVERYONE AT ALL TIMES. THE PEOPLE OF COLORADO BELIEVE THAT IF THERE IS TRANSPARENCY IN HEALTHCARE BILLING, PRICES WILL BE FAIR AND WILL BE DETERMINED BY THE MARKETPLACE, WHETHER OR NOT THEY PERSONALLY REVIEW ALL PRICES IN ADVANCE OF HEALTHCARE SERVICES.

6-20-103. Definitions. AS USED IN THIS PART 1, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "APC" MEANS THE AMBULATORY PAYMENT CLASSIFICATION SYSTEM DEVELOPED BY THE CMS AND USED TO GROUP SERVICES OF SIMILAR INTENSITY FOR THE PURPOSE OF REIMBURSEMENT ASSOCIATED WITH OUTPATIENT SERVICES.

(2) "BOARD" MEANS THE STATE BOARD OF PHARMACY CREATED IN SECTION 12-42.5-103.

(3) "CHARGE", WHETHER ON A CHARGEMASTER, FEE SCHEDULE, OR OTHER LIST OF FEES, IS THE MAXIMUM AMOUNT A PROVIDER BILLS FOR A SPECIFIC HEALTHCARE SERVICE BEFORE THE APPLICATION OF ANY DISCOUNTS, REBATES, NEGOTIATIONS, OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT AND REGARDLESS OF PAYER.

(4) "CHARGEMASTER", COMMONLY REFERRED TO AS "CHARGE MASTER", "CHARGE DESCRIPTION MASTER", OR "CDM", MEANS A UNIFORM SCHEDULE OF CHARGES REPRESENTED BY A HOSPITAL AS THE HOSPITAL'S GROSS BILLED CHARGE OR MAXIMUM CHARGE THAT ANY PATIENT WILL BE BILLED FOR A GIVEN HEALTHCARE SERVICE BEFORE THE APPLICATION OF ANY DISCOUNTS, REBATES, NEGOTIATIONS, OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT AND REGARDLESS OF PAYER.

(5) "CMS" MEANS THE UNITED STATES CENTERS FOR MEDICARE AND MEDICAID SERVICES IN THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(6) "CMS FEE SCHEDULE" MEANS THE COMPLETE LISTING OF FEES USED BY MEDICARE TO PAY OR REIMBURSE A PROVIDER ON A FEE-FOR-SERVICE BASIS.

(7) "CPT CODE" MEANS THE CURRENT PROCEDURAL TERMINOLOGY CODE, OR ITS SUCCESSOR CODE, AS DEVELOPED AND COPYRIGHTED BY THE AMERICAN MEDICAL ASSOCIATION OR ITS SUCCESSOR ENTITY.

(8) "DRG" MEANS THE DIAGNOSIS-RELATED GROUP DEVELOPED BY THE CMS TO GROUP SERVICES OF SIMILAR INTENSITY FOR THE PURPOSE OF REIMBURSING HOSPITALS FOR INPATIENT SERVICES BASED ON A FIXED FEE FOR EACH PATIENT CASE IN A GIVEN CATEGORY RATHER THAN BASED ON THE ACTUAL CHARGES.

(9) "EXECUTIVE DIRECTOR" MEANS THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT APPOINTED PURSUANT TO SECTION 25-1-105.

(10) "FEE SCHEDULE", COMMONLY REFERRED TO AS "FEES", "PRICE LIST", "MASTER PRICE LIST", "LIST PRICES", OR SIMILAR TERMINOLOGY, MEANS THE SCHEDULE OF CHARGES REPRESENTED BY A HEALTHCARE PROVIDER AS THE PROVIDER'S GROSS BILLED CHARGE OR MAXIMUM CHARGE THAT ANY PATIENT WILL BE BILLED FOR A SPECIFIC HEALTHCARE SERVICE BEFORE THE APPLICATION OF ANY DISCOUNTS, REBATES, NEGOTIATIONS, OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT AND REGARDLESS OF PAYER.

(11) "HCPCS" MEANS THE HEALTHCARE COMMON PROCEDURE CODING SYSTEM DEVELOPED BY THE CMS FOR IDENTIFYING HEALTHCARE SERVICES IN A CONSISTENT AND STANDARDIZED MANNER.

(12) "HEALTH INSURANCE" OR "HEALTH INSURANCE PLAN" HAS THE SAME MEANING AS "HEALTH COVERAGE PLAN", AS DEFINED IN SECTION 10-16-102 (34).

(13) "HEALTH INSURANCE CARRIER", "INSURANCE CARRIER", OR "CARRIER" HAS THE SAME MEANING AS "CARRIER", AS DEFINED IN SECTION 10-16-102 (8).

(14) "HEALTHCARE PROVIDER" OR "PROVIDER" MEANS:

(a) A HEALTHCARE FACILITY LICENSED OR CERTIFIED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT PURSUANT TO SECTION 25-1.5-103 (1)(a), WHICH INCLUDES A HOSPITAL, HOSPITAL UNIT AS DEFINED IN SECTION 25-3-101 (2), PSYCHIATRIC HOSPITAL, COMMUNITY CLINIC, REHABILITATION HOSPITAL, CONVALESCENT CENTER, COMMUNITY MENTAL HEALTH CENTER, ACUTE TREATMENT UNIT, FACILITY FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, NURSING CARE FACILITY, HOSPICE CARE, ASSISTED LIVING RESIDENCE, DIALYSIS TREATMENT CLINIC, AMBULATORY SURGICAL CENTER, BIRTHING CENTER, HOME CARE AGENCY, OR OTHER FACILITY OF A LIKE NATURE;

(b) A CLINICAL LABORATORY REGISTERED THROUGH THE CERTIFICATION PROGRAM ADMINISTERED BY THE CMS;

(c) A FACILITY THAT USES RADIATION MACHINES FOR MEDICAL PURPOSES AND THAT IS REGISTERED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT PURSUANT TO STATE BOARD OF HEALTH RULES ADOPTED IN ACCORDANCE WITH SECTION 25-11-104;

(d) A PERSON WHO IS LICENSED, CERTIFIED, OR REGISTERED BY THE STATE UNDER TITLE 12 OR ARTICLE 3.5 OF TITLE 25 TO PROVIDE HEALTHCARE SERVICES AND WHO DIRECTLY BILLS PATIENTS OR THIRD-PARTY PAYERS FOR THE SERVICES, INCLUDING AN ACUPUNCTURIST, ATHLETIC TRAINER, AUDIOLOGIST, PODIATRIST, CHIROPRACTOR, DENTIST, DENTAL HYGIENIST, MASSAGE THERAPIST, PHYSICIAN, PHYSICIAN ASSISTANT, ANESTHESIOLOGIST ASSISTANT, DIRECT-ENTRY MIDWIFE, NATUROPATHIC DOCTOR, NURSE, CERTIFIED NURSE AIDE, NURSING HOME ADMINISTRATOR, OPTOMETRIST,

OCCUPATIONAL THERAPIST, OCCUPATIONAL THERAPY ASSISTANT, PHYSICAL THERAPIST, PHYSICAL THERAPY ASSISTANT, RESPIRATORY THERAPIST, PSYCHIATRIC TECHNICIAN, PSYCHOLOGIST, SOCIAL WORKER, CLINICAL SOCIAL WORKER, MARRIAGE AND FAMILY THERAPIST, PROFESSIONAL COUNSELOR, PSYCHOTHERAPIST, ADDICTION COUNSELOR, SURGICAL ASSISTANT, SURGICAL TECHNOLOGIST, SPEECH-LANGUAGE PATHOLOGIST, OR EMERGENCY MEDICAL SERVICE PROVIDER;

(e) A MEDICAL GROUP, INDEPENDENT PRACTICE ASSOCIATION, OR PROFESSIONAL CORPORATION PROVIDING HEALTHCARE SERVICES; OR

(f) TO THE EXTENT NOT COVERED BY SUBSECTIONS (14)(a) THROUGH (14)(e) OF THIS SECTION, FREE-STANDING EMERGENCY ROOMS AND URGENT CARE CENTERS AND THOSE PROVIDING HEALTHCARE SERVICES UNDER OTHER DESCRIPTIONS.

(15) "HEALTHCARE SERVICE" OR "SERVICE" MEANS A SERVICE, PROCEDURE, TREATMENT, OR GROUP OF SERVICES, PROCEDURES, OR TREATMENTS DELIVERED BY A HEALTHCARE PROVIDER. HEALTHCARE SERVICE INCLUDES SERVICES RENDERED THROUGH TELEMEDICINE, AS DEFINED IN SECTION 12-36-102.5 (8), OR TELEHEALTH, AS DEFINED IN SECTION 10-16-123 (4)(e).

(16) (a) "PHARMACY" MEANS ANY ENTITY LICENSED BY THE BOARD PURSUANT TO ARTICLE 42.5 OF TITLE 12 TO ENGAGE IN THE PRACTICE OF PHARMACY, AS DEFINED IN SECTION 12-42.5-102 (31).

(b) PHARMACY DOES NOT INCLUDE A HOSPITAL, AMBULATORY SURGICAL CENTER, OR OTHER HEALTHCARE PROVIDER THAT ADMINISTERS OR DISPENSES PRESCRIPTION DRUGS AS PART OF A HEALTHCARE SERVICE AND FOR WHICH THE CHARGE FOR PRESCRIPTION DRUGS IS INCLUDED IN ITS CHARGEMASTER OR FEE SCHEDULE.

(17) "RETAIL DRUG PRICE" MEANS THE PRICE FOR A PRESCRIPTION DRUG THAT A PHARMACY CHARGES TO AN UNINSURED OR INSURED PERSON BEFORE THE APPLICATION OF ANY DISCOUNTS, REBATES, NEGOTIATIONS, OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT.

(18) "THIRD-PARTY PAYER", "THIRD-PARTY PAYOR", "PAYOR", OR "PAYER" MEANS A HEALTH INSURANCE CARRIER, SELF-INSURED EMPLOYER, OR OTHER PUBLIC OR PRIVATE THIRD-PARTY, INCLUDING A THIRD-PARTY ADMINISTRATOR OR INTERMEDIARY, THAT IS RESPONSIBLE FOR PAYING ALL, OR A PORTION OF, THE CHARGES FOR HEALTHCARE SERVICES DELIVERED TO A PATIENT.

(19) "UNIVERSAL BILLING CODE", COMMONLY REFERRED TO AS "UBC", "UBC CODE", "REVENUE CODE", "DEPARTMENT CODE", OR "UB04 CODE", MEANS THE CODE USED BY A HEALTHCARE PROVIDER TO INDICATE, FOR THE PURPOSES OF ACCOUNTING, WHERE WITHIN THE FACILITY OR PROVIDER'S SYSTEM A HEALTHCARE SERVICE WAS PERFORMED.

6-20-104. Transparency - healthcare prices - billing practices - providers required to publish - update - rules. (1) (a) STARTING JUNE 1, 2019, EVERY HEALTHCARE PROVIDER MAINTAINING A PHYSICAL PRESENCE IN THIS STATE TO RECEIVE OR TREAT PATIENTS SHALL PUBLISH, IN A PUBLIC, EASY-TO-FIND, AND EASY-TO-ACCESS LOCATION, ITS FEE SCHEDULE OR CHARGEMASTER FOR THE HEALTHCARE SERVICES IT PROVIDES. THE PROVIDER SHALL MAKE THE FEE SCHEDULE OR CHARGEMASTER AVAILABLE AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE, AND AT A MINIMUM, AS FOLLOWS:

(I) IN PRINTED FORM, UPON REQUEST, AT THE PROVIDER'S PHYSICAL LOCATION;

(II) IN NONPROPRIETARY, DOWNLOADABLE FORMATS ON THE PROVIDER'S WEBSITE USING COMMON STANDARDS THAT CAN BE READ AND IMPORTED INTO APPLICATIONS THAT ARE IN COMMON USE BY THE GENERAL PUBLIC; AND

(III) IF THE PROVIDER DOES NOT HAVE A WEBSITE, THE PROVIDER SHALL PROVIDE THE FEE SCHEDULE

OR CHARGEMASTER TO AN INDIVIDUAL IN A PRINTED, HARD-COPY FORM OR A NONPROPRIETARY ELECTRONIC FORMAT UPON REQUEST, WHICH ELECTRONIC FORMAT MAY INCLUDE A DISC, FLASH DRIVE, ELECTRONIC MAIL, OR OTHER COMMONLY USED FORMAT CURRENTLY AVAILABLE OR WHICH MAY BE AVAILABLE IN THE FUTURE;

(b) IF A PROVIDER DOES NOT MAINTAIN ITS OWN PHYSICAL PRESENCE FOR PURPOSES OF RECEIVING OR TREATING PATIENTS, AND INSTEAD DELIVERS HEALTHCARE SERVICES AT A HEALTHCARE FACILITY DESCRIBED IN SECTION 6-20-103 (14)(a), (14)(b), (14)(c), OR (14)(f), THE PROVIDER SHALL PROVIDE ITS FEE SCHEDULE TO THE FACILITY, AND THE FACILITY SHALL POST THE PROVIDER'S FEE SCHEDULE IN ACCORDANCE WITH SUBSECTION (1)(a) OF THIS SECTION.

(2) THE HEALTHCARE PROVIDER SHALL INCLUDE INFORMATION AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE IN THE PUBLISHED FEE SCHEDULE OR CHARGEMASTER AND, AT A MINIMUM, SHALL INCLUDE THE FOLLOWING INFORMATION FOR EACH HEALTHCARE SERVICE THAT THE HEALTHCARE PROVIDER PROVIDES:

(a) A UNIQUE IDENTIFIER ASSOCIATED WITH EACH LINE ITEM IN THE FEE SCHEDULE OR CHARGEMASTER;

(b) A WRITTEN DESCRIPTION OF THE SERVICE;

(c) THE CPT CODE, HCPCS CODE, DRG, APC, OR OTHER CODE AS MAY BE CREATED FOR THE SERVICE OR, IF APPLICABLE, AN INDICATION THAT NO SUCH CODE EXISTS FOR THE SERVICE;

(d) FOR A HOSPITAL, THE UNIVERSAL BILLING CODE; AND

(e) THE CHARGE FOR THE SERVICE.

(3) (a) A HEALTHCARE PROVIDER IS NOT REQUIRED TO PUBLISH ITS ENTIRE FEE SCHEDULE OR CHARGEMASTER IF THE HEALTHCARE PROVIDER'S ENTIRE FEE SCHEDULE OR CHARGEMASTER IS BASED ON A PERCENTAGE OF THE CMS FEE SCHEDULE. IF A HEALTHCARE PROVIDER BASES ALL OR A PORTION OF ITS FEE SCHEDULE OR CHARGEMASTER ON A PERCENTAGE OF THE CMS FEE SCHEDULE, THE HEALTHCARE PROVIDER SHALL PUBLISH INFORMATION AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE THAT, AT A MINIMUM, MUST INCLUDE:

(I) THE SPECIFIC CMS FEE SCHEDULE THAT THE HEALTHCARE PROVIDER USES, THE APPLICABLE DATE OF THE CMS FEE SCHEDULE ON WHICH THE HEALTHCARE PROVIDER'S FEE SCHEDULE OR CHARGEMASTER IS BASED AND THE PERCENTAGE OF THE CMS FEE SCHEDULE ON WHICH THE HEALTHCARE PROVIDER BASES ITS CHARGES; AND

(II) ANY OTHER INFORMATION NECESSARY TO ENABLE A PERSON TO DETERMINE THE CHARGES FOR A HEALTHCARE SERVICE;

(b) FOR ANY PORTION OF THE HEALTHCARE PROVIDER'S FEE SCHEDULE OR CHARGEMASTER THAT IS NOT BASED ON A PERCENTAGE OF A CMS FEE SCHEDULE, THE HEALTHCARE PROVIDER SHALL PUBLISH THAT PORTION OF ITS FEE SCHEDULE OR CHARGEMASTER IN ACCORDANCE WITH SUBSECTIONS (1) AND (2) OF THIS SECTION.

(4) A HEALTHCARE PROVIDER SHALL INCLUDE WITH THE PUBLISHED FEE SCHEDULE OR CHARGEMASTER INFORMATION ABOUT THE PROVIDER'S BILLING POLICIES AND PRACTICES, INCLUDING WHETHER THE PROVIDER AUTHORIZES DISCOUNTS, SUCH AS FOR ADVANCE PAYMENT, FOR TIMELY PAYMENT, OR TO PARTICULAR CLASSES OF PATIENTS, AND THE BASIS FOR DETERMINING WHETHER AN INDIVIDUAL QUALIFIES FOR OR HAS SATISFIED THE REQUIREMENTS FOR OBTAINING A DISCOUNT.

(5) A HEALTHCARE PROVIDER THAT IS A HEALTHCARE FACILITY DESCRIBED IN SECTION 6-20-103 (14)(a),

(14)(b), (14)(c), OR (14)(f) SHALL PUBLISH A LIST OF ALL PERSONS DESCRIBED IN SECTION 6-20-103 (14)(d) AND (14)(e) THAT PROVIDE HEALTHCARE SERVICES AT THE HEALTHCARE FACILITY. THE LIST MUST INCLUDE INFORMATION AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE AND, AT A MINIMUM, MUST SPECIFY FOR EACH PERSON THE NATURE OF THE RELATIONSHIP BETWEEN THE PERSON AND THE HEALTHCARE FACILITY, INCLUDING WHETHER THE PERSON IS EMPLOYED BY, CONTRACTED WITH, OR GRANTED PRIVILEGES BY THE HEALTHCARE FACILITY OR WHETHER THE HEALTHCARE FACILITY CONTRACTS WITH A THIRD-PARTY TO SUPPLY PARTICULAR PROVIDERS TO DELIVER SERVICES AT THE HEALTHCARE FACILITY.

(6) (a) A HEALTHCARE PROVIDER SHALL UPDATE THE INFORMATION IN ITS PUBLISHED FEE SCHEDULE OR CHARGEMASTER REQUIRED BY THIS SECTION PROMPTLY UPON ANY CHANGE IN THE INFORMATION, AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE; AND

(b) A HEALTHCARE PROVIDER SHALL MAINTAIN RECORDS OF ALL CHANGES TO THE CHARGES LISTED IN ITS PUBLISHED FEE SCHEDULE OR CHARGEMASTER, INCLUDING THE DATE OF THE CHANGE, AS SPECIFIED BY THE EXECUTOR DIRECTOR BY RULE.

(7) ON OR AFTER JUNE 1, 2019, IF, AT THE TIME A PATIENT RECEIVES A HEALTHCARE SERVICE FROM A HEALTHCARE PROVIDER, AND THE HEALTHCARE PROVIDER HAS FAILED TO PUBLISH ITS FEE SCHEDULE OR CHARGEMASTER IN ACCORDANCE WITH THIS SECTION, THE HEALTHCARE PROVIDER SHALL NOT BILL THE PATIENT OR THIRD-PARTY PAYER FOR THE HEALTHCARE SERVICES RENDERED TO THE PATIENT, AND THE PATIENT AND THIRD-PARTY PAYER SHALL NOT BE RESPONSIBLE FOR PAYING THE CHARGES FOR THE HEALTHCARE SERVICES.

6-20-105. Billing practices - itemized bill required. STARTING JUNE 1, 2019, A HEALTHCARE PROVIDER SHALL INCLUDE, IN EVERY BILL PRESENTED OR TRANSMITTED TO A PATIENT, AN ITEMIZED DETAIL OF EACH HEALTHCARE SERVICE PROVIDED, THE CHARGE FOR THE SERVICE, AND HOW THE PAYMENT OR ADJUSTMENT BY THE PATIENT'S CARRIER WAS APPLIED TO EACH LINE ITEM.

6-20-106. Provider disclosures - participation in health plans. (1) STARTING JUNE 1, 2019, IF AN INDIVIDUAL PROVIDES HEALTH INSURANCE INFORMATION TO A HEALTHCARE PROVIDER IN CONNECTION WITH THE DELIVERY OR PROPOSED DELIVERY OF HEALTHCARE SERVICES, THE PROVIDER SHALL DISCLOSE TO THE INDIVIDUAL WHETHER:

(a) THE PROVIDER PARTICIPATES IN THE INDIVIDUAL'S HEALTH INSURANCE PLAN;

(b) THE HEALTHCARE SERVICES RENDERED OR TO BE RENDERED BY THE PROVIDER WILL BE COVERED BY THE INDIVIDUAL'S HEALTH INSURANCE AS AN IN-NETWORK OR OUT-OF-NETWORK BENEFIT; AND

(c) THE INDIVIDUAL WILL RECEIVE A HEALTHCARE SERVICE FROM AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY, AND IF SO, WHETHER, UNDER SECTION 10-16-704, THE PROVIDER IS PERMITTED TO BALANCE BILL THE INDIVIDUAL PURSUANT TO SECTION 10-16-704 (2), OR WHETHER THE SERVICES ARE COVERED AS AN IN-NETWORK BENEFIT AT NO GREATER COST TO THE INDIVIDUAL PURSUANT TO SECTION 10-16-704 (3).

6-20-107. Transparency - prescription drug prices - pharmacies required to publish - update - rules. (1) STARTING JUNE 1, 2019, EVERY PHARMACY SHALL PUBLISH IN A PUBLIC, EASY-TO-FIND, AND EASY-TO-ACCESS LOCATION, ITS RETAIL DRUG PRICES IN A FORM AND MANNER DETERMINED BY THE BOARD BY RULE. THE PHARMACY SHALL MAKE ITS RETAIL DRUG PRICES AVAILABLE AS SPECIFIED BY THE BOARD BY RULE AND, AT A MINIMUM, AS FOLLOWS:

(a) IN PRINTED FORM, UPON REQUEST, AT THE PHARMACY;

(b) IN NONPROPRIETARY, DOWNLOADABLE FORMATS ON THE PHARMACY'S WEBSITE USING COMMON STANDARDS THAT CAN BE READ AND IMPORTED INTO APPLICATIONS THAT ARE IN COMMON USE BY THE GENERAL PUBLIC; AND

(c) IF THE PHARMACY DOES NOT HAVE A WEBSITE, THE PHARMACY SHALL PROVIDE ITS RETAIL DRUG PRICES TO AN INDIVIDUAL IN A NONPROPRIETARY ELECTRONIC FORMAT UPON REQUEST, WHICH ELECTRONIC FORMAT MAY INCLUDE A DISC, FLASH DRIVE, ELECTRONIC MAIL, OR OTHER COMMONLY USED FORMAT CURRENTLY AVAILABLE OR WHICH MAY BE AVAILABLE IN THE FUTURE.

(2) (a) A PHARMACY SHALL UPDATE ITS PUBLISHED RETAIL DRUG PRICES AND THE INFORMATION REQUIRED BY THIS SECTION PROMPTLY UPON ANY CHANGE IN THE INFORMATION, AS SPECIFIED BY THE BOARD BY RULE; AND

(b) A PHARMACY SHALL MAINTAIN RECORDS OF ALL CHANGES TO ITS PUBLISHED RETAIL DRUG PRICES AND THE INFORMATION REQUIRED BY THIS SECTION, INCLUDING THE DATE OF THE CHANGE, AS SPECIFIED BY THE BOARD BY RULE.

(3) THE BOARD SHALL PROMULGATE RULES AS ARE NECESSARY TO IMPLEMENT, ADMINISTER, AND ENFORCE THIS SECTION, WHICH RULES MUST TAKE EFFECT BY APRIL 1, 2019. THE BOARD SHALL AMEND THE RULES AS NECESSARY THEREAFTER.

(4) IF THE BOARD DETERMINES THAT A PHARMACY HAS VIOLATED THE REQUIREMENTS OF THIS SECTION, THE BOARD MAY SUSPEND OR REVOKE THE LICENSE OF THE PHARMACY OR IMPOSE A CIVIL FINE OF NOT MORE THAN FIFTY THOUSAND DOLLARS FOR EACH VIOLATION, AND IF THE PHARMACY CONTINUES TO VIOLATE THE REQUIREMENTS OF THIS SECTION, THE BOARD MAY IMPOSE A CIVIL FINE FOR EACH DAY OF VIOLATION. FINES IMPOSED AND PAID UNDER THIS SECTION SHALL BE DEPOSITED IN THE GENERAL FUND.

6-20-108. Provider-carrier contracts. A CONTRACT ISSUED, AMENDED, OR RENEWED ON OR AFTER JUNE 1, 2019, BY, BETWEEN, OR ON BEHALF OF A CARRIER AND A HEALTHCARE PROVIDER SHALL NOT CONTAIN ANY PROVISION THAT RESTRICTS THE ABILITY OF A HEALTHCARE PROVIDER OR CARRIER TO FURNISH PATIENTS ANY INFORMATION REQUIRED TO BE PUBLISHED UNDER THIS ACT. ANY CONTRACTUAL PROVISION INCONSISTENT WITH THIS SECTION SHALL BE VOID AND UNENFORCEABLE.

6-20-109. Rules. WITH THE EXCEPTION OF RULES TO BE ADOPTED BY THE BOARD PURSUANT TO SECTION 6-20-107 (3) TO IMPLEMENT, ADMINISTER, AND ENFORCE THAT SECTION, THE EXECUTIVE DIRECTOR SHALL PROMULGATE RULES AS ARE NECESSARY TO IMPLEMENT AND ADMINISTER THIS PART 1, WHICH RULES MUST TAKE EFFECT BY APRIL 1, 2019. THE EXECUTIVE DIRECTOR SHALL AMEND THE RULES AS NECESSARY THEREAFTER.

SECTION 2. In Colorado Revised Statutes, **add** 10-16-147 as follows:

10-16-147. Carrier disclosures - rules - definitions. (1) THE PURPOSE OF THIS SECTION IS TO:

(a) PROVIDE TRANSPARENCY REGARDING THE PAYMENTS OR REIMBURSEMENTS THAT CARRIERS MAKE TO PROVIDERS FOR HEALTHCARE SERVICES, MEDICAL DEVICES, AND MEDICATIONS THAT WILL OR MAY BE, OR HAVE BEEN PROVIDED TO ALL PERSONS;

(b) ENABLE ALL PERSONS WHO MAY RECEIVE, WILL RECEIVE, OR HAVE RECEIVED AND BEEN BILLED FOR A HEALTHCARE SERVICE, MEDICAL DEVICE, OR MEDICATIONS TO DETERMINE THEIR FINANCIAL RESPONSIBILITY. IT IS RECOGNIZED THAT THE SERVICES TO BE RENDERED ARE NOT ALWAYS ESTIMABLE PRIOR TO SERVICE DELIVERY. THAT SHOULD NOT BE CONFUSED WITH THE INTENT OF THIS SECTION;

(c) ENABLE ALL PERSONS TO KNOW THE TOTAL AMOUNT THAT A PROVIDER WILL BE PAID, THROUGH ANY COMBINATION OF PAYMENTS OR REIMBURSEMENTS BY THE PATIENT AND THE CARRIER, FOR

SERVICES DELIVERED TO AN INDIVIDUAL; AND

(d) ENABLE ALL PERSONS TO KNOW THE AMOUNT OR LIMIT A CARRIER WILL PAY TOWARD SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER.

(2) FOR EACH PROVIDER, HEALTHCARE SERVICE, AND TYPE OF HEALTHCARE INSURANCE PLAN, AS IT PERTAINS TO EACH LINE OF BUSINESS, STARTING JUNE 1, 2019, EVERY CARRIER SHALL POST ON ITS WEBSITE AND PROVIDE, IN WRITING UPON REQUEST FROM A PERSON, THE FOLLOWING INFORMATION, IN A FORM AND MANNER AS DETERMINED BY THE COMMISSIONER BY RULE:

(a) THE CONTRACT TERMS;

(b) THE COST SHARING ARRANGEMENT; AND

(c) PRESCRIPTION DRUG PRICES.

(3) STARTING JUNE 1, 2019, EACH CARRIER SHALL PUBLISH ANNUALLY, IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER BY RULE, DETAILED INFORMATION REGARDING ALL FORMS OF REMUNERATION DERIVED FROM REBATES OR OTHER FORMS OF INCENTIVE RECEIVED AS THE RESULT OF HEALTHCARE SERVICES OR PURCHASES OF PRESCRIPTION DRUGS OR MEDICAL DEVICES. THE COMMISSIONER BY RULE MAY REQUIRE CARRIERS TO PUBLISH THE INFORMATION REQUIRED BY THIS SUBSECTION (3) MORE FREQUENTLY THAN ONCE A YEAR.

(4) THE COMMISSIONER SHALL PROMULGATE RULES AS ARE NECESSARY TO IMPLEMENT, ADMINISTER, AND ENFORCE THIS SECTION, WHICH RULES MUST TAKE EFFECT BY APRIL 1, 2019. THE COMMISSIONER SHALL AMEND THE RULES AS NECESSARY THEREAFTER.

(5) IF THE COMMISSIONER DETERMINES THAT A CARRIER HAS VIOLATED THE REQUIREMENTS OF THIS SECTION, THE COMMISSIONER MAY SUSPEND OR REVOKE THE LICENSE OF THE CARRIER OR IMPOSE A CIVIL FINE OF NOT MORE THAN FIFTY THOUSAND DOLLARS FOR EACH VIOLATION, AND IF THE CARRIER CONTINUES TO VIOLATE THE REQUIREMENTS OF THIS SECTION, THE COMMISSIONER MAY IMPOSE A CIVIL FINE FOR EACH DAY OF VIOLATION. FINES IMPOSED AND PAID UNDER THIS SECTION SHALL BE DEPOSITED IN THE GENERAL FUND.

(6) AS USED IN THIS SECTION:

(a) "APC" HAS THE SAME MEANING AS "APC", AS DEFINED IN SECTION 6-20-103 (1).

(b) "CARRIER FEE SCHEDULE" MEANS THE SCHEDULE OF A CARRIER THAT REPRESENTS THE NEGOTIATED AMOUNTS FOR HEALTHCARE SERVICES THAT A CARRIER WILL PAY OR REIMBURSE A HEALTHCARE PROVIDER FOR A SPECIFIC HEALTHCARE SERVICE.

(c) "CHARGE" HAS THE SAME MEANING AS "CHARGE", AS DEFINED IN SECTION 6-20-103 (3).

(d) "CHARGEMASTER" HAS THE SAME MEANING AS "CHARGEMASTER", AS DEFINED IN SECTION 6-20-103 (4).

(e) "CMS" HAS THE SAME MEANING AS "CMS", AS DEFINED IN SECTION 6-20-103 (5).

(f) "CMS FEE SCHEDULE" HAS THE SAME MEANING AS "CMS FEE SCHEDULE", AS DEFINED IN SECTION 6-20-103 (6).

(g) "COMMISSIONER" MEANS THE COMMISSIONER OF INSURANCE APPOINTED PURSUANT TO SECTION 10-1-104.

(h) "CONTRACT TERMS" MEANS THE NEGOTIATED PAYMENT OR REIMBURSEMENT AMOUNT ACCORDING

TO THE CONTRACT BETWEEN THE PROVIDER AND CARRIER WHICH RESULTS IN ANY DISCOUNT OR ADJUSTMENT TO THE TOTAL CHARGE FOR HEALTHCARE SERVICES. CONTRACT TERMS INCLUDE:

(I) PERCENTAGE OF THE PROVIDER'S FEE SCHEDULE OR CHARGEMASTER;

(II) PERCENTAGE OF THE APPLICABLE CMS FEE SCHEDULE;

(III) CARRIER FEE SCHEDULE;

(IV) NEGOTIATED RATES FOR SPECIFIC HEALTHCARE SERVICES, INCLUDING A FIXED DAILY OR PER DIEM RATE;

(V) CARVE-OUTS WHICH MAY INCLUDE NEGOTIATED PRICES FOR:

(A) A SPECIFIC LINE ITEM;

(B) INDIVIDUAL SERVICE, PROCEDURE, OR TREATMENT;

(C) CATEGORY OR GROUP OF SERVICES, PROCEDURES, OR TREATMENTS;

(D) MEDICAL DEVICE; OR

(E) MEDICATION FOR SERVICE, PROCEDURE, OR TREATMENT;

(VI) PRICES, INCLUDING THOSE DERIVED FROM BASE RATES OR MULTIPLIERS, FOR BUNDLED HEALTHCARE SERVICES GROUPED BY APC OR DRG OR ANY OTHER CLASSIFICATION SYSTEM USED TO GROUP SERVICES OF SIMILAR INTENSITY FOR THE PURPOSE OF REIMBURSEMENT; OR

(VII) ANY OTHER FORM OF NEGOTIATED PAYMENT OR REIMBURSEMENT AMOUNT NOT OTHERWISE SET FORTH IN THIS SUBSECTION (6)(h).

(i) "COST SHARING ARRANGEMENT" MEANS COSTS FOR HEALTHCARE SERVICES THAT ARE NOT REIMBURSED BY A CARRIER UNDER A HEALTH COVERAGE PLAN. COST SHARING ARRANGEMENT INCLUDES A DEDUCTIBLE, CO-PAYMENT, OR CO-INSURANCE AMOUNT.

(j) "DRG" HAS THE SAME MEANING AS "DRG", AS DEFINED IN SECTION 6-20-103 (8).

(k) "FEE SCHEDULE" HAS THE SAME MEANING AS "FEE SCHEDULE", AS DEFINED IN SECTION 6-20-103 (10).

(l) "HEALTH INSURANCE" OR "HEALTH INSURANCE PLAN" HAS THE SAME MEANING AS "HEALTH COVERAGE PLAN", AS DEFINED IN SECTION 10-16-102 (34).

(m) "HEALTH INSURANCE CARRIER", "INSURANCE CARRIER", OR "CARRIER" HAS THE SAME MEANING AS "CARRIER", AS DEFINED IN SECTION 10-16-102 (8).

(n) "HEALTHCARE PROVIDER" OR "PROVIDER" HAS THE SAME MEANING AS "HEALTHCARE PROVIDER" OR "PROVIDER", AS DEFINED IN SECTION 6-20-103 (14).

(o) "HEALTHCARE SERVICE" OR "SERVICE" HAS THE SAME MEANING AS "HEALTHCARE SERVICE" OR "SERVICE", AS DEFINED IN SECTION 6-20-103 (15).

(p) "PHARMACY" HAS THE SAME MEANING AS "PHARMACY", AS DEFINED IN SECTION 6-20-103 (16).

(q) "PRESCRIPTION DRUG PRICE" MEANS THE PRICE FOR PRESCRIPTION DRUGS THAT CARRIERS HAVE NEGOTIATED WITH PROVIDERS, PHARMACIES, OR DISTRIBUTORS.

SECTION 3. In Colorado Revised Statutes, **repeal** article 49 of title 25.

SECTION 4. Effective date. THIS ACT TAKES EFFECT JANUARY 1, 2019.

Submitted by:

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