Second Regular Session
Seventy-first General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 18-0104.02 Christy Chase x2008 **HOUSE BILL 18-1358**

HOUSE SPONSORSHIP

Foote and Beckman,

SENATE SPONSORSHIP

Lundberg and Aguilar,

House Committees
Health, Insurance, & Environment

Senate Committees

A BILL FOR AN ACT

CONCERNING REQUIRED DISCLOSURES PERTAINING TO CHARGES FOR HEALTH CARE.

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 imposes requirements on health care facilities, health care providers, pharmacies, and health insurers, starting January 1, 2019, to disclose information about health care charges. Specifically, **section 2** of the bill enacts the "Comprehensive Health Care Billing Transparency Act" (act), which requires health care facilities, including hospitals, ambulatory surgical centers, community clinics, and physician practice

groups, to:

- Publish their fee schedules or other lists of charges the facilities bill for specific health care services before applying any discounts, rebates, or other charge adjustment mechanisms;
- Include in every bill sent to a patient an itemized detail of each health care service provided, the charge for the service, how any payment or adjustment by the patient's health insurer was applied to each line item in the bill, and, for hospitals, the amount of the healthcare affordability and sustainability fee the hospital is charged; and
- In situations where an individual provides health insurance information to the facility or a provider in a facility setting, disclose whether the facility or provider participates in the individual's health insurance plan; whether the services the facility or provider will render will be covered as an in-network or out-of-network benefit; and whether the individual will receive a service from an out-of-network provider at an in-network facility.

For an individual health care provider who provides health care services at a health care facility, has a separate fee schedule for the services the provider delivers in the facility setting, and whose fees for those services are not included in the facility's published fee schedule, the provider must provide a fee schedule to the facility for posting on the facility's website.

Section 2 also prohibits a facility or provider from billing a patient or third-party payer an amount in excess of the lower of any established self-pay rate or the lowest rate negotiated with or reimbursed by any third-party payer, including the federal centers for medicare and medicaid services in the United States department of health and human services, for the particular health care services rendered to the patient if the facility or provider has failed to publish or provide its fee schedule.

Additionally, section 2 requires a pharmacy to publish a list of its retail drug prices, which is a list of the charges the pharmacy charges to an insured or uninsured person for prescription drugs it administers or dispenses, before any rebates, discounts, or other price adjustment mechanisms are applied. **Section 4** specifies that failure to comply with the requirements to publish retail drug prices constitutes grounds for the state board of pharmacy to discipline a pharmacist.

Health insurers, facilities, and providers are prohibited from including any provision in a contract between the parties issued, amended, or renewed on or after January 1, 2019, that restricts the ability of a provider, facility, or health insurer to provide patients with the charge information required to be published. Section 2 also directs the state board of pharmacy to adopt rules necessary to implement the provisions

of the act that are applicable to pharmacies and the executive director of the department of public health and environment to adopt any other rules necessary to implement and administer the act.

Section 3 requires health insurers to publish information about contract terms, cost-sharing arrangements, and prescription drug prices. The commissioner of insurance is directed to adopt rules to implement and administer these requirements and is authorized to use enforcement powers under current law to enforce the requirements on health insurers.

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

SECTION 1. Legislative declaration. The general assembly finds and determines that it is important to bring price transparency to patient health care transactions, including health care facility and provider pricing, insurance carriers' negotiated pricing, and pharmaceutical pricing, in order to transform Colorado's health care system into a functional market-based system with fairer prices for health care services that are determined by the marketplace.

SECTION 2. In Colorado Revised Statutes, **repeal and reenact, with amendments,** part 1 of article 20 of title 6 as follows:

PART 1

HEALTH CARE BILLING TRANSPARENCY

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

6-20-102. 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

PURSUANT TO SECTION 12-42.5-103.

(3) "CHARGE", WHETHER ON A CHARGEMASTER, FEE SCHEDULE, OR OTHER LIST OF FEES, MEANS THE MAXIMUM AMOUNT A FACILITY OR PROVIDER BILLS FOR A SPECIFIC HEALTH CARE 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 HEALTH CARE 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 FEDERAL 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 FACILITY OR PROVIDER ON A FEE-FOR-SERVICE BASIS.

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

(8) "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.

(9) "DRG" MEANS THE DIAGNOSIS-RELATED GROUP DEVELOPED BY THE CMS TO GROUP SERVICES OF A 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.

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

(11) "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 FACILITY OR PROVIDER AS THE FACILITY'S OR PROVIDER'S GROSS BILLED CHARGE OR MAXIMUM CHARGE THAT ANY PATIENT WILL BE BILLED FOR A SPECIFIC HEALTH CARE SERVICE BEFORE THE APPLICATION OF ANY DISCOUNTS, REBATES, NEGOTIATIONS, OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT AND REGARDLESS OF PAYER.

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

(13) "HEALTH CARE FACILITY" OR "FACILITY" MEANS:

(a) A HEALTH CARE 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 PHYSICIAN PRACTICE, MEDICAL GROUP, INDEPENDENT PRACTICE ASSOCIATION, OR PROFESSIONAL CORPORATION PROVIDING HEALTH CARE SERVICES; OR

(e) TO THE EXTENT NOT COVERED BY SUBSECTIONS (13)(a) TO (13)(d) OF THIS SECTION, A FREESTANDING EMERGENCY DEPARTMENT, AN URGENT CARE CLINIC, A FEDERALLY QUALIFIED HEALTH CENTER AS DEFINED IN 42 U.S.C. SEC. 1395x (aa)(4), OR A RURAL HEALTH CLINIC AS DEFINED IN 42 U.S.C. SEC. 1395x (aa)(2).

(14) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A PERSON WHO:

(a) IS LICENSED, CERTIFIED, OR REGISTERED BY THE STATE TO PROVIDE HEALTH CARE SERVICES OR A MEDICAL GROUP, INDEPENDENT PRACTICE ASSOCIATION, OR PROFESSIONAL CORPORATION PROVIDING HEALTH CARE SERVICES;

(b) PROVIDES HEALTH CARE SERVICES TO PATIENTS IN A HEALTH CARE FACILITY; AND

(c) HAS A SEPARATE FEE SCHEDULE FOR THE SERVICES PROVIDED TO PATIENTS IN THE FACILITY.

(15) "HEALTH CARE SERVICE" OR "SERVICE" MEANS A SERVICE, PROCEDURE, TREATMENT, OR GROUP OF SERVICES, PROCEDURES, OR

TREATMENTS DELIVERED BY A HEALTH CARE FACILITY OR HEALTH CARE PROVIDER. "HEALTH CARE 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) "HEALTH INSURANCE" OR "HEALTH INSURANCE PLAN" HAS THE SAME MEANING AS "HEALTH COVERAGE PLAN", AS DEFINED IN SECTION 10-16-102 (34).

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

(18) "MEDICARE" MEANS FEDERAL INSURANCE OR ASSISTANCE AS PROVIDED BY TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED.

(19) (a) "PHARMACY" MEANS AN ENTITY REGISTERED 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 HEALTH CARE FACILITY THAT ADMINISTERS OR DISPENSES PRESCRIPTION DRUGS AS PART OF THE DELIVERY OF A HEALTH CARE SERVICE AND FOR WHICH THE CHARGE FOR PRESCRIPTION DRUGS IS INCLUDED IN ITS CHARGEMASTER OR FEE SCHEDULE.

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

(21) "THIRD-PARTY PAYER" 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 HEALTH CARE SERVICES DELIVERED TO A PATIENT.

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

6-20-103. Transparency - health care prices - billing practices - facilities required to publish - providers required to assist in publishing - update - rules. (1) (a) STARTING JANUARY 1, 2019, EVERY HEALTH CARE FACILITY 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 HEALTH CARE SERVICES IT PROVIDES. THE FACILITY 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 FACILITY'S PHYSICAL LOCATION; AND

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

(b) IF THE FACILITY DOES NOT HAVE A WEBSITE, THE FACILITY 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.

(c) A HEALTH CARE PROVIDER SHALL PROVIDE ITS FEE SCHEDULE, WHICH MUST INCLUDE THE INFORMATION SPECIFIED IN SUBSECTIONS (2) AND (4) OF THIS SECTION AND COMPLY WITH SUBSECTION (3) OF THIS SECTION, TO THE FACILITY IN WHICH THE PROVIDER DELIVERS HEALTH CARE SERVICES IF THE PROVIDER'S FEES FOR THE HEALTH CARE SERVICES IT PROVIDES AT THE FACILITY ARE NOT INCLUDED IN THE FACILITY'S FEE SCHEDULE OR CHARGEMASTER PUBLISHED PURSUANT TO SUBSECTION (1)(a) OF THIS SECTION. THE FACILITY SHALL POST THE PROVIDER'S FEE SCHEDULE ON THE FACILITY'S WEBSITE IN ACCORDANCE WITH SUBSECTION (1)(a)(II) OF THIS SECTION.

(2) EACH HEALTH CARE FACILITY AND HEALTH CARE PROVIDER SHALL INCLUDE THE INFORMATION AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE IN THE PUBLISHED OR PROVIDED FEE SCHEDULE OR CHARGEMASTER AND, AT A MINIMUM, SHALL INCLUDE THE FOLLOWING INFORMATION FOR EACH HEALTH CARE SERVICE THE FACILITY OR 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 OR USED 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) NEITHER A HEALTH CARE FACILITY NOR A HEALTH CARE PROVIDER IS REQUIRED TO PUBLISH OR PROVIDE ITS ENTIRE FEE SCHEDULE OR CHARGEMASTER IF THE FACILITY'S OR PROVIDER'S ENTIRE FEE SCHEDULE OR CHARGEMASTER IS BASED ON A PERCENTAGE OF A CMS FEE SCHEDULE FOR MEDICARE. IF A FACILITY OR PROVIDER BASES ALL OR A PORTION OF ITS FEE SCHEDULE OR CHARGEMASTER ON A PERCENTAGE OF A CMS FEE SCHEDULE, THE FACILITY OR PROVIDER SHALL PUBLISH OR PROVIDE INFORMATION AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE THAT, AT A MINIMUM, MUST INCLUDE:

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

(II) ANY OTHER INFORMATION NECESSARY TO ENABLE A PERSON TO DETERMINE CHARGES FOR A HEALTH CARE SERVICE.

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

(4) A HEALTH CARE FACILITY AND A HEALTH CARE PROVIDER SHALL INCLUDE WITH THE PUBLISHED OR PROVIDED FEE SCHEDULE OR CHARGEMASTER INFORMATION ABOUT THE FACILITY'S OR PROVIDER'S BILLING POLICIES AND PRACTICES, INCLUDING WHETHER THE FACILITY OR 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 HEALTH CARE FACILITY SHALL PUBLISH A LIST OF ALL HEALTH CARE PROVIDERS THAT PROVIDE HEALTH CARE SERVICES AT THE FACILITY. THE LIST MUST INCLUDE INFORMATION AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE AND, AT A MINIMUM, MUST SPECIFY FOR EACH PROVIDER THE NATURE OF THE RELATIONSHIP BETWEEN THE PROVIDER AND THE FACILITY, INCLUDING WHETHER THE PROVIDER IS EMPLOYED BY, CONTRACTED WITH, OR GRANTED PRIVILEGES BY THE FACILITY OR WHETHER THE FACILITY CONTRACTS WITH A THIRD PARTY TO SUPPLY PARTICULAR PROVIDERS TO DELIVER SERVICES AT THE FACILITY.

(6) (a) A HEALTH CARE FACILITY AND A HEALTH CARE PROVIDER THAT PROVIDES ITS FEE SCHEDULE TO A FACILITY PURSUANT TO SUBSECTION (1)(c) OF THIS SECTION SHALL UPDATE THE INFORMATION IN ITS PUBLISHED OR PROVIDED FEE SCHEDULE OR CHARGEMASTER REQUIRED BY THIS SECTION PROMPTLY UPON ANY CHANGE IN THE INFORMATION, AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE.

(b) EVERY HEALTH CARE FACILITY AND HEALTH CARE PROVIDER SHALL MAINTAIN RECORDS OF ALL CHANGES IN THE CHARGES LISTED IN ITS PUBLISHED OR PROVIDED FEE SCHEDULE OR CHARGEMASTER, INCLUDING THE DATE OF THE CHANGE IN THE PARTICULAR CHARGE, AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE.

(7) ON OR AFTER JANUARY 1, 2019, IF, AT THE TIME A PATIENT RECEIVES A HEALTH CARE SERVICE FROM A HEALTH CARE FACILITY OR HEALTH CARE PROVIDER, THE FACILITY OR PROVIDER HAS FAILED TO PUBLISH OR PROVIDE ITS FEE SCHEDULE OR CHARGEMASTER IN

ACCORDANCE WITH THIS SECTION, THE FACILITY OR PROVIDER, AS APPLICABLE, SHALL NOT BILL THE PATIENT OR THIRD-PARTY PAYER AN AMOUNT THAT EXCEEDS THE LOWER OF ANY ESTABLISHED RATE FOR PATIENTS WHO PAY DIRECTLY OR THE LOWEST RATE NEGOTIATED WITH OR REIMBURSED BY ANY THIRD-PARTY PAYER, INCLUDING CMS, AND THE PATIENT IS NOT RESPONSIBLE FOR PAYING ANY CHARGES FOR THE HEALTH CARE SERVICES THAT EXCEED THE LOWER OF ANY ESTABLISHED RATE FOR PATIENTS WHO PAY DIRECTLY OR THE LOWEST RATE NEGOTIATED WITH OR REIMBURSED BY ANY THIRD-PARTY PAYER, INCLUDING CMS, FOR THE SERVICES PROVIDED TO THE PATIENT.

6-20-104. Billing practices - itemized bill required. (1) STARTING JANUARY 1, 2019, EVERY HEALTH CARE FACILITY AND HEALTH CARE PROVIDER SHALL INCLUDE, IN EVERY BILL PRESENTED OR TRANSMITTED TO A PATIENT FOR HEALTH CARE SERVICES RENDERED BY THE FACILITY OR PROVIDER TO THE PATIENT, AN ITEMIZED DETAIL OF EACH HEALTH CARE SERVICE PROVIDED, THE CHARGE FOR THE SERVICE, AND HOW THE PAYMENT OR ADJUSTMENT BY THE PATIENT'S CARRIER WAS APPLIED TO EACH LINE ITEM.

(2) STARTING JANUARY 1, 2019, A HEALTH CARE FACILITY THAT IS A LICENSED OR CERTIFIED HOSPITAL AND THAT IS CHARGED A HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE PURSUANT TO SECTION 25.5-4-402.4 (4) SHALL INCLUDE THE AMOUNT OF THE FEE IN A SEPARATE LINE ITEM IN THE HOSPITAL'S BILLING STATEMENTS.

6-20-105. Facility and provider disclosures - participation in health plans. (1) STARTING JANUARY 1, 2019, IF AN INDIVIDUAL PROVIDES HEALTH INSURANCE INFORMATION TO A HEALTH CARE FACILITY OR HEALTH CARE PROVIDER IN CONNECTION WITH THE DELIVERY OR

PROPOSED DELIVERY OF HEALTH CARE SERVICES TO THE INDIVIDUAL BY THE FACILITY OR PROVIDER, THE FACILITY OR PROVIDER SHALL DISCLOSE TO THE INDIVIDUAL WHETHER:

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

(b) THE HEALTH CARE SERVICES RENDERED OR TO BE RENDERED BY THE FACILITY OR PROVIDER TO THE INDIVIDUAL 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 HEALTH CARE 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).

6-20-106. Transparency - retail drug prices - pharmacies required to publish - update - rules. (1) (a) STARTING JANUARY 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:

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

(II) 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.

(b) 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 PROMPTLY UPON ANY CHANGE IN THE INFORMATION, AS SPECIFIED BY THE BOARD BY RULE.

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

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

6-20-107. Provider-carrier contracts - prohibited provision. A CONTRACT ISSUED, AMENDED, OR RENEWED ON OR AFTER JANUARY 1, 2019, BY, BETWEEN, OR ON BEHALF OF A CARRIER AND A HEALTH CARE FACILITY OR A HEALTH CARE PROVIDER MUST NOT CONTAIN ANY PROVISION THAT RESTRICTS THE ABILITY OF A FACILITY, PROVIDER, THIRD-PARTY PAYER, OR CARRIER TO FURNISH PATIENTS WITH ANY INFORMATION REQUIRED TO BE PUBLISHED OR PROVIDED UNDER THIS PART 1.

6-20-108. Rules. WITH THE EXCEPTION OF RULES TO BE ADOPTED BY THE BOARD PURSUANT TO SECTION 6-20-106 (3) TO IMPLEMENT AND ADMINISTER THAT SECTION, THE EXECUTIVE DIRECTOR SHALL ADOPT

RULES AS NECESSARY TO IMPLEMENT AND ADMINISTER THIS PART 1, WHICH RULES MUST TAKE EFFECT BY JANUARY 1, 2019. THE EXECUTIVE DIRECTOR SHALL AMEND THE RULES AS NECESSARY THEREAFTER.

SECTION 3. In Colorado Revised Statutes, **add** 10-16-147 as follows:

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

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

(b) ENABLE ALL PERSONS WHO WILL OR MAY RECEIVE, OR HAVE RECEIVED AND BEEN BILLED FOR, A HEALTH CARE SERVICE, MEDICAL DEVICE, MEDICATION, OR PRESCRIPTION DRUG TO DETERMINE THEIR FINANCIAL RESPONSIBILITY, RECOGNIZING THAT THE PAYMENT OR REIMBURSEMENT AMOUNT CANNOT ALWAYS BE ESTIMATED IN ADVANCE OF THE DELIVERY OF A HEALTH CARE SERVICE, MEDICAL DEVICE, MEDICATION, OR PRESCRIPTION DRUG;

(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 HEALTH CARE SERVICES DELIVERED TO AN INDIVIDUAL; AND

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

(2) FOR EACH PROVIDER, HEALTH CARE SERVICE, AND LINE OF BUSINESS FOR EACH TYPE OF HEALTH COVERAGE PLAN, STARTING

JANUARY 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 JANUARY 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 A RESULT OF HEALTH CARE 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) (a) THE COMMISSIONER SHALL ADOPT RULES AS NECESSARY TO IMPLEMENT, ADMINISTER, AND ENFORCE THIS SECTION, WHICH RULES MUST TAKE EFFECT BY JANUARY 1, 2019. THE COMMISSIONER SHALL AMEND THE RULES AS NECESSARY THEREAFTER.

(b) THE COMMISSIONER MAY USE ALL POWERS CONFERRED BY THE INSURANCE LAWS OF THIS STATE TO ENFORCE THIS SECTION.

(5) AS USED IN THIS SECTION:

(a) "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.

(b) "CARRIER FEE SCHEDULE" MEANS THE SCHEDULE OF A CARRIER

THAT REPRESENTS THE NEGOTIATED AMOUNTS FOR HEALTH CARE SERVICES THAT A CARRIER WILL PAY OR REIMBURSE A HEALTH CARE PROVIDER FOR PROVIDING A PARTICULAR SERVICE.

(c) "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 HEALTH CARE SERVICE BEFORE THE APPLICATION OF ANY DISCOUNTS, REBATES, NEGOTIATIONS, OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT AND REGARDLESS OF PAYER.

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

(e) "CONTRACT TERMS" MEANS THE NEGOTIATED PAYMENT OR REIMBURSEMENT AMOUNT ACCORDING TO THE CONTRACT BETWEEN THE PROVIDER AND CARRIER THAT RESULTS IN ANY DISCOUNT OR ADJUSTMENT TO THE TOTAL CHARGE FOR A HEALTH CARE SERVICE. THE TERM INCLUDES:

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

(II) THE PERCENTAGE OF THE APPLICABLE CMS FEE SCHEDULE;

(III) A CARRIER FEE SCHEDULE;

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

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

(A) A SPECIFIC LINE ITEM;

(B) AN INDIVIDUAL SERVICE, PROCEDURE, OR TREATMENT;

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

(D) A MEDICAL DEVICE; OR

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

(VI) PRICES, INCLUDING THOSE DERIVED FROM BASE RATES OR MULTIPLIERS, FOR BUNDLED HEALTH CARE SERVICES GROUPED BY APC, 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 (5)(e).

(f) "COST-SHARING ARRANGEMENT" MEANS THE COSTS FOR HEALTH CARE SERVICES THAT ARE NOT REIMBURSED BY A CARRIER UNDER A HEALTH COVERAGE PLAN AND INCLUDES A DEDUCTIBLE, COPAYMENT, OR COINSURANCE AMOUNT.

(g) "DRG" MEANS THE DIAGNOSIS-RELATED GROUP DEVELOPED BY THE CMS TO GROUP SERVICES OF A 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.

(h) "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 HEALTH CARE PROVIDER AS THE PROVIDER'S GROSS BILLED CHARGE OR MAXIMUM CHARGE THAT ANY PATIENT WILL BE BILLED FOR A SPECIFIC HEALTH CARE SERVICE BEFORE THE APPLICATION OF ANY DISCOUNTS, REBATES, NEGOTIATIONS, OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT

AND REGARDLESS OF PAYER.

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

(j) "PRESCRIPTION DRUG PRICE" MEANS THE PRICE FOR A PRESCRIPTION DRUG THAT A CARRIER HAS NEGOTIATED WITH HEALTH CARE PROVIDERS, PHARMACIES, DISTRIBUTORS, OR MANUFACTURERS.

SECTION 4. In Colorado Revised Statutes, 12-42.5-123, **add** (1)(t) as follows:

12-42.5-123. Unprofessional conduct - grounds for discipline. (1) The board may suspend, revoke, refuse to renew, or otherwise discipline any license or registration issued by it, after a hearing held in accordance with the provisions of this section, upon proof that the licensee or registrant:

(t) HAS FAILED TO COMPLY WITH THE REQUIREMENTS OF SECTION 6-20-106.

SECTION 5. In Colorado Revised Statutes, **repeal** article 49 of title 25.

SECTION 6. In Colorado Revised Statutes, 25.5-4-402.4, **repeal** (4)(f) as follows:

25.5-4-402.4. Hospitals - healthcare affordability and sustainability fee - legislative declaration - Colorado healthcare affordability and sustainability enterprise - federal waiver - fund

created - rules. (4) **Healthcare affordability and sustainability fee.** (f) ~~A hospital shall not include any amount of the healthcare affordability and sustainability fee as a separate line item in its billing statements.~~

SECTION 7. Act subject to petition - effective date. Sections 4 and 5 of this act take effect January 1, 2019, and the remainder of 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 (August 8, 2018, if adjournment sine die is on May 9, 2018); 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 2018 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor; except that sections 4 and 5 of this act take effect January 1, 2019.