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S. WARD

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

SECTION 1. In Colorado Revised Statutes, add part 1 of article 20 of title 6 as follows:

Colorado Secretary of State

6-20-100. 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 SERVICES IS NOT ALWAYS PRACTICAL WHEN 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.

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

**PART 1
HEALTHCARE BILLING TRANSPARENCY**

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

6-20-102. Definitions. AS USED IN THIS PART 1, UNLESS THE CONTEXT OTHERWISE REQUIRES:

- (1) "BOARD" MEANS THE STATE BOARD OF PHARMACY CREATED IN SECTION 12-42.5-103.
- (2) "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.
- (3) "CHARGEMASTER", ALSO REFERRED TO AS "CHARGE MASTER", "CHARGE DESCRIPTION MASTER", "CDM", OR OTHER SUCH SIMILAR NAME THAT HAS THE SAME MEANING AS MAY BE USED, 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.
- (4) "CMS" MEANS THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.

- (5) "COMMISSIONER" MEANS THE COMMISSIONER OF INSURANCE APPOINTED PURSUANT TO SECTION 10-1-104.
- (6) "EXECUTIVE DIRECTOR" MEANS THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT APPOINTED PURSUANT TO SECTION 25-1-105.
- (7) "FEE SCHEDULE", ALSO REFERRED TO AS "FEES", "PRICE LIST", "MASTER PRICE LIST", "LIST PRICES", OR OTHER SUCH SIMILAR NAME THAT HAS THE SAME MEANING, 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 GIVEN HEALTHCARE SERVICE BEFORE THE APPLICATION OF ANY DISCOUNTS, REBATES, NEGOTIATIONS, OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT AND REGARDLESS OF PAYER.
- (8) "HEALTH INSURANCE" OR "HEALTH INSURANCE PLAN" HAS THE SAME MEANING AS "HEALTH COVERAGE PLAN", AS DEFINED IN SECTION 10-16-102 (34).
- (9) "HEALTH INSURANCE CARRIER", "INSURANCE CARRIER", OR "CARRIER" HAS THE SAME MEANING AS "CARRIER", AS DEFINED IN SECTION 10-16-102 (8).
- (10) "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; OR
 - (e) A MEDICAL GROUP, INDEPENDENT PRACTICE ASSOCIATION, OR PROFESSIONAL CORPORATION PROVIDING HEALTHCARE SERVICES.
 - (f) TO THE EXTENT NOT COVERED BY SUBSECTIONS 10(a) THROUGH 10(e) OF THIS SECTION, FREE-STANDING EMERGENCY ROOMS AND URGENT CARE CENTERS AND THOSE PROVIDING HEALTHCARE SERVICES UNDER OTHER DESCRIPTIONS.

- (11) "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).
- (12) "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). THE TERM DOES NOT INCLUDE A HOSPITAL, AMBULATORY SURGICAL CENTER, OR OTHER PROVIDERS WHICH ADMINISTER PRESCRIPTION DRUGS AS PART OF A HEALTHCARE SERVICE AND FOR WHICH THE CHARGE FOR PRESCRIPTION DRUGS IS INCLUDED IN THEIR CHARGEMASTER OR FEE SCHEDULE.
- (13) "RETAIL DRUG PRICE" IS THE PRICE FOR PRESCRIPTION DRUGS THAT PHARMACIES CHARGE TO THE UNINSURED OR INSURED BEFORE THE APPLICATION OF ANY DISCOUNTS, REBATES, NEGOTIATIONS, OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT.
- (14) "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.

6-20-103. Transparency - healthcare prices - billing practices - providers required to publish - update - rules. (1) (a) EVERY HEALTHCARE PROVIDER MAINTAINING A PHYSICAL PRESENCE FOR THE PURPOSE OF RECEIVING OR TREATING PATIENTS SHALL PUBLISH ITS FEE SCHEDULE OR CHARGEMASTER FOR THE HEALTHCARE SERVICES IT PROVIDES IN A FORM AND MANNER SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE; AND

(b) IF A PROVIDER DOES NOT MAINTAIN ITS OWN PHYSICAL PRESENCE FOR THE PURPOSE OF RECEIVING OR TREATING PATIENTS, AND INSTEAD DELIVERS HEALTHCARE SERVICES AT A HEALTHCARE FACILITY DESCRIBED IN SECTION 6-20-102 (10)(a), (10)(b), OR (10)(c), THE PROVIDER SHALL PROVIDE HIS OR HER 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, ALONG WITH ITS PUBLISHED FEE SCHEDULE OR CHARGEMASTER, PROVIDE ANY OTHER INFORMATION REQUIRED BY THE EXECUTIVE DIRECTOR IN A FORM AND MANNER AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE.
- (3) (a) A HEALTHCARE PROVIDER IS NOT BE 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, AND AT A MINIMUM, THAT SHALL INCLUDE:

(I) THE SPECIFIC CMS 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 PROVIDER;

(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) 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.
- (5) IF, AT THE TIME A PATIENT RECEIVES A HEALTHCARE SERVICE FROM A HEALTHCARE PROVIDER, 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.

6-20-104. Billing practices - itemized bill required. 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.

6-20-105. Provider disclosures - participation in health plans. (1) 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).

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

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

- (a) PROVIDE TRANSPARENCY REGARDING HOW INSURANCE CARRIERS CALCULATE PAYMENTS OR REIMBURSEMENTS TO PROVIDERS FOR HEALTHCARE SERVICES FURNISHED TO COVERED PERSONS; AND
- (b) ENABLE A COVERED PERSON WHO HAS RECEIVED AND BEEN BILLED FOR A HEALTHCARE SERVICE, MEDICAL DEVICE, OR PRESCRIPTION DRUG TO DETERMINE THE AMOUNT THAT THE CARRIER WILL PAY OR REIMBURSE THE PROVIDER UNDER THE TERMS OF THE APPLICABLE HEALTH COVERAGE PLAN. 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.
- (2) EACH CARRIER SHALL POST ON ITS WEBSITE AND PROVIDE, IN WRITING UPON REQUEST FROM A COVERED PERSON, THE FOLLOWING INFORMATION:

(a) THE SPECIFIC BASIS FOR DETERMINING THE PAYMENT OR REIMBURSEMENT TO A PROVIDER FOR A HEALTHCARE SERVICE RENDERED BY THE PROVIDER TO A COVERED PERSON UNDER THE HEALTH COVERAGE PLAN, INCLUDING:

(I) WHETHER THE PAYMENT IS BASED ON A PERCENTAGE OF THE PROVIDER'S CHARGES, A FLAT DAILY OR PER DIEM RATE, COPAYMENTS, DEDUCTIBLES, OR ANY OTHER FACTOR, VARIABLE, OR SYSTEM DEVISED AND NOT LISTED HERE THAT IS USED FOR DETERMINING THE PAYMENT OR REIMBURSEMENT AMOUNT; AND

(II) HOW THE PAYMENT OR REIMBURSEMENT IS CALCULATED FOR AN IN-NETWORK VERSUS OUT-OF-NETWORK PROVIDER;

(b) ITEMS THAT APPEAR AS CHARGES ON AN EXPLANATION OF BENEFITS OR PROVIDER BILLING STATEMENT BUT FOR WHICH THE CARRIER DOES NOT PAY;

(c) DETAILED INFORMATION REGARDING COVERAGE AND NEGOTIATED PAYMENT INFORMATION BY PLAN TYPE AND PARTICIPATING PROVIDER; AND

(d) PRESCRIPTION DRUG PRICES IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER BY RULE.

(3) EACH CARRIER SHALL PUBLISH ANNUALLY, UNLESS DIRECTED BY THE COMMISSIONER BY RULE TO PUBLISH MORE FREQUENTLY, DETAILED INFORMATION, IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER BY RULE, 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.

(4) ON OR BEFORE APRIL 30, 2019, THE COMMISSIONER SHALL PROMULGATE RULES AS ARE NECESSARY FOR THE IMPLEMENTATION, ADMINISTRATION, AND ENFORCEMENT OF THIS SECTION, AND SHALL, THEREAFTER, REVISE SUCH RULES AS ARE NECESSARY.

(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, "PRESCRIPTION DRUG PRICE" IS THE PRICE FOR PRESCRIPTION DRUGS THAT CARRIERS HAVE NEGOTIATED WITH PROVIDERS, PHARMACIES, DISTRIBUTORS, OR MANUFACTURERS.

SECTION 4. In Colorado Revised Statutes, add part 1 of article 20 of title 6 as follows:

6-20-106. Transparency - prescription drug prices - pharmacies required to publish - update - rules. (1) EVERY PHARMACY SHALL PUBLISH ITS RETAIL DRUG PRICES IN A FORM AND MANNER DETERMINED BY THE BOARD BY RULE.

(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) ON OR BEFORE APRIL 30, 2019, THE BOARD SHALL PROMULGATE RULES AS ARE NECESSARY FOR THE IMPLEMENTATION, ADMINISTRATION, AND ENFORCEMENT OF THIS SECTION, AND SHALL, THEREAFTER, REVISE SUCH RULES AS ARE NECESSARY.

(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.

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

SECTION 6. In Colorado Revised Statutes, **add** part 1 of article 20 of title 6 as follows:

6-20-107. Provider-carrier contracts. A CONTRACT ISSUED, AMENDED, OR RENEWED ON OR AFTER APRIL 30, 2019, BY, BETWEEN, OR ON BEHALF OF A HEALTH INSURANCE PLAN AND A HEALTHCARE PROVIDER SHALL NOT CONTAIN ANY PROVISION THAT RESTRICTS THE ABILITY OF THE HEALTH INSURANCE PLAN, THIRD-PARTY PAYER, OR HEALTHCARE PROVIDER TO FURNISH PATIENTS ANY INFORMATION REQUIRED TO BE PUBLISHED UNDER THIS ACT. ANY CONTRACTUAL PROVISION INCONSISTENT WITH THIS SECTION SHALL BE VOID AND UNENFORCEABLE.

SECTION 7. In Colorado Revised Statutes, **add** part 1 of article 20 of title 6 as follows:

6-20-108. Rules. ON OR BEFORE APRIL 30, 2019, THE EXECUTIVE DIRECTOR SHALL PROMULGATE RULES AS ARE NECESSARY FOR THE IMPLEMENTATION AND ADMINISTRATION OF PART 1 OF ARTICLE 20 OF TITLE 6, EXCEPT FOR SECTION 6-20-106 WHICH SHALL BE PROMULGATED BY THE BOARD, AND SHALL, THEREAFTER, REVISE SUCH RULES AS ARE NECESSARY.

SECTION 8. Effective date. THIS ACT TAKES EFFECT JANUARY 1, 2019.

Submitted by:

David Silverstein, 555 17th Street (Suite 400), Denver, CO 80202
davidsilverstein@brokenhealthcare.org 303-684-7391 (tel) 805-690-8065 (fax)

Andrew Graham, 3464 S. Willow, Denver, CO 80231
andrewsgraham@yahoo.com 303-755-2900 (tel) 805-690-8065 (fax)