

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

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S. WARD
2:32 P.M.

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 PROVIDER BILLING TRANSPARENCY**

6-20-101. Short title. THE SHORT TITLE OF THIS PART 1 IS THE "HEALTHCARE PROVIDER 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, WHICH IS THE SYSTEM DEVELOPED BY THE CMS USED TO GROUP SERVICES OF SIMILAR INTENSITY FOR THE PURPOSE OF REIMBURSEMENT ASSOCIATED WITH OUTPATIENT SERVICES.
- (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) "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.
- (6) "DRG" MEANS THE DIAGNOSIS RELATED GROUP, WHICH IS THE SYSTEM DEVELOPED BY THE CMS TO GROUP SERVICES OF SIMILAR INTENSITY FOR THE PURPOSE OF REIMBURSING HOSPITALS BASED ON A FIXED FEE FOR EACH PATIENT CASE IN A GIVEN CATEGORY, RATHER THAN BASED ON THE ACTUAL CHARGES.
- (7) "EXECUTIVE DIRECTOR" MEANS THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT APPOINTED PURSUANT TO SECTION 25-1-105.
- (8) "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.
- (9) "HCPCS" MEANS THE HEALTHCARE COMMON PROCEDURE CODING SYSTEM DEVELOPED BY THE CMS FOR IDENTIFYING HEALTHCARE SERVICES IN A CONSISTENT AND STANDARDIZED MANNER.
- (10) "HEALTH INSURANCE" OR "HEALTH INSURANCE PLAN" HAS THE SAME MEANING AS "HEALTH COVERAGE PLAN", AS DEFINED IN SECTION 10-16-102 (34).
- (11) "HEALTH INSURANCE CARRIER", "INSURANCE CARRIER", OR "CARRIER" HAS THE SAME MEANING AS "CARRIER", AS DEFINED IN SECTION 10-16-102 (8).
- (12) "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 12(a) THROUGH 12(e) OF THIS SECTION, FREE-STANDING EMERGENCY ROOMS AND URGENT CARE CENTERS AND THOSE PROVIDING HEALTHCARE SERVICES UNDER OTHER DESCRIPTIONS.

(13) "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).

(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.

(15) "UNIVERSAL BILLING CODE", ALSO 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.

6-20-103. 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, 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, FOR USE WHILE AT THE PROVIDER;

(II) IN NONPROPRIETARY, DOWNLOADABLE FORMATS ON THE PROVIDER'S WEBSITE USING COMMON STANDARDS THAT CAN BE READ AND IMPORTED INTO APPLICATIONS AS 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. THIS MAY BE DONE IN ANY REASONABLE MANNER INCLUDING A DISC, FLASH DRIVE, E-MAIL, OR OTHER SUCH COMMONLY USED AND AVAILABLE MEANS AS MAY CHANGE OVER TIME;

(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 (12)(a), (12)(b), OR (12)(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 INCLUDE INFORMATION AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE, AND AT A MINIMUM, THE HEALTHCARE PROVIDER SHALL INCLUDE THE FOLLOWING

INFORMATION IN THE PUBLISHED FEE SCHEDULE OR CHARGEMASTER 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 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 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, WITH THE PUBLISHED FEE SCHEDULE OR CHARGEMASTER, INCLUDE 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 SHALL PUBLISH A LIST OF ALL PERSONS, AS DEFINED IN SECTION 6-20-102 (12)(d) AND (e), THAT PROVIDE HEALTHCARE SERVICES. THE LIST MUST INCLUDE INFORMATION AS SPECIFIED BY THE EXECUTIVE DIRECTOR BY RULE, AND AT A MINIMUM THE NATURE OF THE RELATIONSHIP BETWEEN THE PERSON AND THE HEALTHCARE PROVIDER, INCLUDING WHETHER THE PERSON IS EMPLOYED BY, CONTRACTED WITH, OR GRANTED PRIVILEGES BY THE HEALTHCARE PROVIDER OR WHETHER THE HEALTHCARE PROVIDER CONTRACTS WITH A THIRD PARTY TO SUPPLY PARTICULAR PROVIDERS TO DELIVER SERVICES.
- (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) 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, **repeal** article 49 of title 25.

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

6-20-106. 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 5. In Colorado Revised Statutes, **add** part 1 of article 20 of title 6 as follows:

6-20-107. 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 6. Effective date. THIS ACT TAKES EFFECT JANUARY 1, 2019.

Submitted by:

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