Initiative 2017-2018 #147: Health Care Insurance Carrier Billing Transparency - Original Draft

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

SECTION 1. In Colorado Revised Statutes, **add** 10-16-147 as follows:

10-16-147. Carrier disclosures - carrier-provider contracts - rules - definitions. (1) A DECLARATION FROM THE PEOPLE OF COLORADO:

(a) 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.

(b) 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.

(2) 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.

(3) 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.

(4) 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 (4) MORE FREQUENTLY THAN ONCE A YEAR.

(5) 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) 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.

(7) 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.

(8) 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 HEALTHCARE SERVICES THAT A CARRIER WILL PAY OR REIMBURSE A HEALTHCARE PROVIDER FOR A SPECIFIC HEALTHCARE SERVICE.

(c) "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.

(d) "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.

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

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

(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 (8)(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" 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.

(k) "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.

(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" MEANS:

(I) 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;

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

(III) 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;

(IV) 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;

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

(VI) TO THE EXTENT NOT COVERED BY SUBSECTIONS (8)(n)(I) THROUGH (8)(n)(V) OF THIS SECTION, FREE-STANDING EMERGENCY ROOMS AND URGENT CARE CENTERS AND THOSE PROVIDING HEALTHCARE SERVICES UNDER OTHER DESCRIPTIONS.

(o) "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).

(p) "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). 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.

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

SECTION 2. Effective date. THIS ACT TAKES EFFECT JANUARY 1, 2019.

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