A BILL FOR AN ACT

CONCERNING A REQUIREMENT THAT HEALTH CARE PROVIDERS DISCLOSE THE CHARGES THEY IMPOSE FOR COMMON HEALTH CARE SERVICES WHEN PAYMENT IS MADE DIRECTLY RATHER THAN BY A THIRD PARTY.

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 creates the "Transparency in Health Care Prices Act", which requires health care professionals and health care facilities to make available to the public the health care prices they assess directly for...
common health care services they provide. Health care professionals and facilities are not required to submit their health care prices to any government agency for review or approval. Additionally, the act prohibits health insurers, government agencies, or other persons or entities from penalizing a health care recipient, provider, facility, employer, or other person or entity who pays directly for health care services or otherwise exercises rights under or complies with the act. The bill takes effect January 1, 2018.

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

SECTION 1. In Colorado Revised Statutes, add article 49 to title 25 as follows:

ARTICLE 49

Transparency in Health Care Prices

25-49-101. Short title. The short title of this article 49 is the "TRANSPARENCY IN HEALTH CARE PRICES ACT".

25-49-102. Definitions. As used in this article 49, unless the context otherwise requires:

(1) "AGENCY" MEANS A GOVERNMENT DEPARTMENT OR AGENCY OR A GOVERNMENT-CREATED ENTITY.

(2) "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.

(3) "HEALTH CARE FACILITY" MEANS A FACILITY LICENSED OR CERTIFIED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT PURSUANT TO SECTION 25-1.5-103. THE TERM DOES NOT INCLUDE A NURSING CARE FACILITY OR ASSISTED LIVING RESIDENCE.

(4) (a) "HEALTH CARE PRICE" MEANS THE PRICE, BEFORE NEGOTIATING ANY DISCOUNTS, THAT A HEALTH CARE PROVIDER OR health care facility will charge a recipient for health care
SERVICES THAT WILL BE RENDERED. "HEALTH CARE PRICE" IS THE PRICE CHARGED FOR THE STANDARD SERVICE FOR THE PARTICULAR DIAGNOSIS AND DOES NOT INCLUDE ANY AMOUNT THAT MAY BE CHARGED FOR COMPLICATIONS OR EXCEPTIONAL TREATMENT.

(b) "HEALTH CARE PRICE" DOES NOT MEAN THE AMOUNT CHARGED IF A PUBLIC OR PRIVATE THIRD PARTY WILL BE PAYING OR REIMBURSING THE HEALTH CARE PROVIDER OR HEALTH CARE FACILITY FOR ANY PORTION OF THE COST OF SERVICES RENDERED.

(5) "HEALTH CARE PROVIDER" MEANS A PERSON WHO IS LICENSED, CERTIFIED, OR REGISTERED BY THIS STATE TO PROVIDE HEALTH CARE SERVICES.

(6) (a) "HEALTH CARE SERVICES" OR "SERVICES" MEANS SERVICES INCLUDED IN, OR INCIDENTAL TO, FURNISHING TO AN INDIVIDUAL:

(I) MEDICAL, MENTAL, DENTAL, OR OPTOMETRIC CARE OR HOSPITALIZATION; OR

(II) OTHER SERVICES FOR THE PURPOSE OF PREVENTING, ALLEVIATING, CURING, OR HEALING A PHYSICAL OR MENTAL ILLNESS OR INJURY.

(b) "HEALTH CARE SERVICES" INCLUDES SERVICES RENDERED THROUGH THE USE OF TELEMEDICINE.

(7) "HEALTH INSURER" MEANS A CARRIER, AS DEFINED IN SECTION 10-16-102 (8), DISABILITY INSURER, GROUP DISABILITY INSURER, OR BLANKET DISABILITY INSURER.

(8) (a) "PUBLIC OR PRIVATE THIRD PARTY" MEANS A HEALTH INSURER, SELF-INSURED EMPLOYER, OR OTHER THIRD PARTY, INCLUDING A THIRD-PARTY ADMINISTRATOR OR INTERMEDIARY, RESPONSIBLE FOR PAYING ALL OR A PORTION OF THE CHARGES FOR HEALTH CARE SERVICES.
(b) "PUBLIC OR PRIVATE THIRD PARTY" DOES NOT MEAN:

(I) AN EMPLOYER OF THE RECIPIENT OF THE HEALTH CARE SERVICES;

(II) A PERSON PAYING MONEY FROM A HEALTH SAVINGS ACCOUNT, FLEXIBLE SPENDING ACCOUNT, OR SIMILAR ACCOUNT; OR

(III) A FAMILY MEMBER, CHARITABLE ORGANIZATION, OR OTHER PERSON WHO IS NOT RESPONSIBLE FOR, BUT PAYS CHARGES FOR, HEALTH CARE SERVICES ON BEHALF OF THE RECIPIENT OF THE SERVICES.

(9) "PUNISH" MEANS TO IMPOSE A PENALTY, SURCHARGE, FEE, OR OTHER ADDITIONAL COST OR MEASURE THAT HAS THE SAME EFFECT AS A PENALTY OR THAT DISCOURAGES THE EXERCISE OF RIGHTS UNDER THIS ARTICLE 49.

(10) "RECIPIENT" MEANS AN INDIVIDUAL WHO RECEIVES HEALTH CARE SERVICES FROM A HEALTH CARE PROVIDER OR HEALTH CARE FACILITY.


(II) A HEALTH CARE PROVIDER WHO IS A MEMBER OF A
PROFESSIONAL CORPORATION THAT CONTRACTS WITH A SINGLE HEALTH MAINTENANCE ORGANIZATION, AS DEFINED IN SECTION 10-16-102 (35), COMPLIES WITH THIS SECTION IF THE PROFESSIONAL CORPORATION OR ITS CONTRACTING HEALTH MAINTENANCE ORGANIZATION POSTS, EITHER ELECTRONICALLY OR ON ITS WEBSITE, THE HEALTH CARE PRICES FOR AT LEAST THE FIFTEEN MOST COMMON HEALTH CARE SERVICES THAT THE HEALTH CARE PROVIDER OR HEALTH MAINTENANCE ORGANIZATION WOULD CHARGE INDIVIDUALS WHO ARE NOT MEMBERS OF THE HEALTH MAINTENANCE ORGANIZATION.

(b) The health care provider shall identify the services by:

(I) A COMMON PROCEDURAL TERMINOLOGY CODE OR OTHER CODING SYSTEM COMMONLY USED BY THE HEALTH CARE PROVIDER AND ACCEPTED AS A NATIONAL STANDARD FOR BILLING; AND

(II) A PLAIN ENGLISH DESCRIPTION.

(c) The health care provider shall update the document as frequently as the health care provider deems appropriate, but at least annually.

(2) The health care provider shall include a disclosure specifying that the health care price for any given health care service is an estimate and that the actual charges for the health care service are dependent on the circumstances at the time the service is rendered.


(1) (a) A HEALTH CARE FACILITY SHALL MAKE AVAILABLE TO THE PUBLIC, IN A SINGLE DOCUMENT, EITHER ELECTRONICALLY OR ON ITS WEBSITE IF ONE EXISTS, THE HEALTH CARE PRICES FOR AT LEAST:
(I) The fifty most used, diagnosis-related group codes or other codes for in-patient health care services used by the health care facility for billing or, if those codes are not used, the codes under another coding system for in-patient health care services commonly used by the facility and accepted as a national standard for billing; and

(II) the twenty-five most used out-patient CPT codes or health care services procedure codes used for billing or, if those codes are not used, the codes under another coding system for out-patient health care services commonly used by the facility and accepted as a national standard for billing.

(b) If a health care facility did not use fifty codes for in-patient health care services at least eleven times in the previous twelve months or did not use twenty-five codes for out-patient health care services at least eleven times in the previous twelve months, the health care facility shall make available the health care price for only those most common in-patient and out-patient health care services or procedure codes that the health care facility used at least eleven times in the previous twelve months.

(c) A health care facility shall include with the health care price provided pursuant to this subsection (1) a plain English description of the service for which the health care price is provided.

(d) The health care facility shall update the document as frequently as it deems appropriate, but at least annually.

(2) The health care facility shall include a disclosure
SPECIFYING THAT THE HEALTH CARE PRICE FOR ANY GIVEN HEALTH CARE
SERVICE IS AN ESTIMATE AND THAT THE ACTUAL CHARGES FOR THE
HEALTH CARE SERVICE ARE DEPENDENT ON THE CIRCUMSTANCES AT THE
TIME THE SERVICE IS RENDERED.

(3) A HEALTH CARE FACILITY MAY DISCLOSE THE BASIS FOR ITS
HEALTH CARE PRICES AND MAY TAKE INTO CONSIDERATION ALL PAYER
SOURCES WHEN DETERMINING A HEALTH CARE PRICE.

25-49-105. No review of health care prices - no punishment for
exercising rights - no impairment of contracts. (1) NOTHING IN THIS
ARTICLE 49 REQUIRES A HEALTH CARE FACILITY OR HEALTH CARE
PROVIDER TO REPORT ITS HEALTH CARE PRICES TO ANY AGENCY FOR
REVIEW, FILING, OR OTHER PURPOSES, EXCEPT AS REQUIRED BY SECTION
25-3-112. THIS ARTICLE 49 DOES NOT GRANT ANY AGENCY THE
AUTHORITY TO APPROVE, DISAPPROVE, OR LIMIT A HEALTH CARE
FACILITY'S OR HEALTH CARE PROVIDER'S HEALTH CARE PRICES OR
CHANGES TO ITS HEALTH CARE PRICES. THE DEPARTMENT OF PUBLIC
HEALTH AND ENVIRONMENT IS NOT AUTHORIZED TO TAKE ANY ACTION
REGARDING OR PURSUANT TO THIS ARTICLE 49.

(2) THIS ARTICLE 49 IS INTENDED TO MAKE HEALTH CARE PRICES
AND PAYMENTS, AND PARTICIPATION IN OR EXERCISING RIGHTS UNDER
THIS ARTICLE 49, FREE FROM PAPERWORK, PUNISHMENT, REPORTING, AND
REGULATION TO THE FULL EXTENT PERMISSIBLE UNDER THE STATE
CONSTITUTION AND STATE AND FEDERAL LAW. A PERSON, ENTITY,
AGENCY, OR HEALTH INSURER SHALL NOT PUNISH A RECIPIENT, HEALTH
CARE PROVIDER, HEALTH CARE FACILITY, PERSON, ENTITY, OR EMPLOYER
FOR PARTICIPATING DIRECTLY IN, EXERCISING RIGHTS UNDER, OR
COMPLYING WITH THIS ARTICLE 49.
(3) NOTHING IN THIS ARTICLE 49 IMPAIRS CONTRACTS BETWEEN PRIVATE PARTIES.

SECTION 2. Act subject to petition - effective date. This act takes effect January 1, 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 the ninety-day period after final adjournment of the general assembly, 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.