Second Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 24-0643.01 Kristen Forrestal x4217 **SENATE BILL 24-080**

SENATE SPONSORSHIP

Fields and Jaquez Lewis,

HOUSE SPONSORSHIP

Young,

Senate Committees
Health & Human Services
Appropriations

House Committees

A BILL FOR AN ACT

CONCERNING HEALTH INSURANCE CARRIER PRICE TRANSPARENCY REQUIREMENTS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

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 requires health insurance carriers (carriers) to comply with federal price transparency laws and to make available an internet-based self-service tool that provides real-time responses to a covered person's questions concerning carrier prices that are based on cost-sharing information.

The bill also requires carriers to submit information required by federal pharmacy benefit and drug cost reporting laws to the commissioner of insurance. A carrier that violates the requirements of the bill engages in an unfair method of competition and an unfair or deceptive act or practice in the business of insurance.

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

SECTION 1. In Colorado Revised Statutes, **add** 10-16-167 and 10-16-168 as follows:

10-16-167. Carriers - health care - price transparency - violation - rules - legislative declaration - definitions. (1) (a) **Legislative declaration.** THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

(I) THE FEDERAL "PATIENT PROTECTION AND AFFORDABLE CARE ACT", PUB.L. 111-148, WAS ENACTED ON MARCH 23, 2010, AND THE FEDERAL "HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010", PUB.L. 111-152, WAS ENACTED ON MARCH 30, 2010, AND THESE ACTS ARE REFERRED TO COLLECTIVELY AS "PPACA";

(II) PPACA REORGANIZED, AMENDED, AND ADDED TO THE PROVISIONS OF PART A OF TITLE XXVII OF THE FEDERAL "PUBLIC HEALTH SERVICE ACT", PUB.L. 78-410, RELATING TO HEALTH COVERAGE REQUIREMENTS FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS IN THE GROUP AND INDIVIDUAL MARKETS;

(III) SECTION 2715A OF THE FEDERAL "PUBLIC HEALTH SERVICE ACT", PUB.L. 78-410, PROVIDES THAT GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS OFFERING GROUP OR INDIVIDUAL HEALTH INSURANCE COVERAGE MUST COMPLY WITH SECTION 1311 (e)(3) OF PPACA, WHICH ADDRESSES TRANSPARENCY IN HEALTH COVERAGE AND IMPOSES CERTAIN REPORTING AND DISCLOSURE REQUIREMENTS FOR HEALTH PLANS;

(IV) Effective January 11, 2021, the federal centers for medicare and medicaid services, or "CMS", published the final rule to implement PPACA, codified at 45 CFR 147.210 to 147.212;

(V) In its summary of the final rule, CMS states that requiring plans to disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates for prescription drugs "can help ensure the accurate and timely disclosure of information appropriate to support an efficient and competitive health care market"; and

(VI) As former United States President Donald Trump's "Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First" explains: "To make fully informed decisions about their healthcare, patients must know the price and quality of a good or service in advance." Additionally, the executive order then notes that "patients often lack both access to useful price and quality information and the incentives to find low-cost, high-quality care." The lack of this information is widely understood to be one of the root problems causing dysfunction within the United States' health-care system.

(b) Therefore, in order to protect Colorado health-care consumers, it is the intent of the general assembly to require carriers to provide consumer access to accurate and accessible health-care coverage price information.

(2) **Definitions.** As used in this section:

(a) "Carrier price transparency laws" means the

REQUIREMENTS CODIFIED IN 42 U.S.C. SEC. 18031 (e)(3), AS AMENDED, AND THE IMPLEMENTING RULES ADOPTED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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

(c) "ITEMS AND SERVICES" OR "ITEMS OR SERVICES" MEANS "ITEMS OR SERVICES" AS DEFINED IN 45 CFR 147.210 (a)(2)(xiii).

(d) "PHARMACY BENEFIT AND DRUG COST REPORTING LAWS" MEANS THE REQUIREMENTS CODIFIED IN 26 U.S.C. SEC. 9825, AS AMENDED.

(3) **Transparency - rules.** (a) BEGINNING JULY 1, 2024, A CARRIER SHALL COMPLY WITH CARRIER PRICE TRANSPARENCY LAWS, INCLUDING MAKING AVAILABLE AN INTERNET-BASED SELF-SERVICE TOOL THAT PROVIDES REAL-TIME RESPONSES TO EACH INDIVIDUAL ENROLLED IN A HEALTH BENEFIT PLAN WHO REQUESTS COST-SHARING INFORMATION.

(b) THE COMMISSIONER MAY ADOPT RULES TO IMPLEMENT THIS SUBSECTION (3) THAT ALIGN, TO THE EXTENT PRACTICABLE, WITH THE CARRIER PRICE TRANSPARENCY LAWS AND ANY SUBSEQUENT GUIDANCE FROM THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES.

(4) (a) EACH CARRIER SHALL MAKE PUBLICLY AVAILABLE, IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER, THREE PRICE-TRANSPARENCY FILES. THE FILES MUST INCLUDE INFORMATION REGARDING:

(I) BEGINNING JULY 1, 2025, AND EVERY SIX MONTHS THEREAFTER, NEGOTIATED RATES FOR ALL COVERED ITEMS AND SERVICES

BETWEEN THE HEALTH BENEFIT PLAN OR CARRIER AND IN-NETWORK PROVIDERS;

(II) BEGINNING JULY 1, 2025, AND EVERY SIX MONTHS THEREAFTER, UNIQUE OUT-OF-NETWORK ALLOWED AMOUNTS AND BILLED CHARGES FOR COVERED ITEMS AND SERVICES FURNISHED BY OUT-OF-NETWORK PROVIDERS; AND

(III) NO EARLIER THAN TWELVE MONTHS AFTER THE DATE OF THE FINALIZATION OF REQUIREMENTS AND TECHNICAL SPECIFICATIONS BY THE UNITED STATES SECRETARY OF LABOR, THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES, AND THE UNITED STATES SECRETARY OF THE TREASURY, IN-NETWORK NEGOTIATED RATES AND HISTORICAL NET PRICES FOR ALL PRESCRIPTION DRUGS COVERED BY THE HEALTH BENEFIT PLAN OR CARRIER.

(b) INFORMATION SUBMITTED BY HEALTH INSURERS AND PHARMACY BENEFIT MANAGERS TO THE DIVISION IN ACCORDANCE WITH SUBSECTION (4)(a) OF THIS SECTION IS SUBJECT TO PUBLIC INSPECTION UNDER THE "COLORADO OPEN RECORDS ACT", PART 2 OF ARTICLE 72 OF TITLE 24.

(c) ON OR BEFORE JANUARY 1, 2025, THE COMMISSIONER SHALL CONDUCT A STAKEHOLDER ENGAGEMENT PROCESS THAT INCLUDES REPRESENTATIVES FROM CARRIERS REGULATED IN THIS STATE THAT ARE REQUIRED TO PRODUCE THE PRICE-TRANSPARENCY FILES TO CREATE A STANDARDIZED TEMPLATE, INCLUDING THE FORMAT AND METHOD OF SUBMISSION, FOR THE PRICE-TRANSPARENCY FILES. THE STANDARDIZED TEMPLATE MUST NOT REQUIRE DATA THAT IS IN ADDITION TO WHAT IS REQUIRED BY THE UNITED STATES SECRETARY OF LABOR, THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES, AND THE UNITED

STATES SECRETARY OF THE TREASURY. THE DATA AND FORMAT OF THE SUBMISSION SHALL NOT BE MATERIALLY DIFFERENT FROM THE DATA THAT CARRIERS ARE REQUIRED TO SUBMIT UNDER THE FEDERAL CARRIER PRICE TRANSPARENCY LAWS. SUBMISSION OF COLORADO-SPECIFIC DATA SHALL NOT BE CONSIDERED A MATERIAL DIFFERENCE.

(d) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT THIS SUBSECTION (4).

(e) EACH CARRIER SHALL UPDATE THE PRICE-TRANSPARENCY FILES AND INFORMATION REQUIRED BY SUBSECTION (4)(a) OF THIS SECTION AT LEAST EVERY SIX MONTHS. EACH CARRIER SHALL CLEARLY INDICATE THE DATE THAT THE FILES WERE MOST RECENTLY UPDATED.

10-16-168. Carriers - prescription drug coverage - transparency - violation. BEGINNING JULY 1, 2025, AND ON OR BEFORE EACH JULY 1 THEREAFTER, EACH CARRIER SHALL SUBMIT TO THE COMMISSIONER, IN THE SAME FORM AND MANNER AS SUBMITTED TO THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES, INFORMATION REQUIRED BY FEDERAL PHARMACY BENEFIT AND DRUG COST REPORTING LAWS.

SECTION 2. Appropriation. (1) For the 2024-25 state fiscal year, $267,758 is appropriated to the department of regulatory agencies. This appropriation is from the division of insurance cash fund created in section 10-1-103 (3)(a)(I), C.R.S. To implement this act, the department may use this appropriation as follows:

(a) $94,808 for use by the division of insurance for personal services, which amount is based on an assumption that the division will

require an additional 1.0 FTE;

(b) $112,950 for use by the division of insurance for operating expenses; and

(c) $60,000 for the purchase of information technology services.

(2) For the 2024-25 state fiscal year, $60,000 is appropriated to the office of the governor for use by the office of information technology. This appropriation is from reappropriated funds received from the department of regulatory agencies under subsection (1)(c) of this section. To implement this act, the office may use this appropriation to provide information technology services for the department of regulatory agencies.

SECTION 3. Safety clause. The general assembly finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety or for appropriations for the support and maintenance of the departments of the state and state institutions.