

**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. 24-0202.01 Christy Chase x2008

HOUSE BILL 24-1149

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A BILL FOR AN ACT

101 **CONCERNING MODIFICATIONS TO REQUIREMENTS FOR PRIOR**
102 **AUTHORIZATION OF BENEFITS UNDER HEALTH BENEFIT PLANS,**
103 **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>.)

With regard to prior authorization requirements imposed by carriers, private utilization review organizations (organizations), and pharmacy benefit managers (PBMs) for certain health-care services and prescription drug benefits covered under a health benefit plan, the bill requires carriers, organizations, and PBMs, as applicable, to adopt a

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing law.
Dashes through the words or numbers indicate deletions from existing law.

program, in consultation with participating providers, to eliminate or substantially modify prior authorization requirements in a manner that removes administrative burdens on qualified providers and their patients with regard to certain health-care services, prescription drugs, or related benefits based on specified criteria. Additionally, a carrier or organization is prohibited from denying a claim for a health-care procedure a provider provides, in addition or related to an approved surgical procedure, under specified circumstances or from denying an initially approved surgical procedure on the basis that the provider provided an additional or a related health-care procedure.

The bill extends the duration of an approved prior authorization for a health-care service or prescription drug benefit from 180 days to a calendar year.

Carriers are required to post, on their public-facing websites, specified information regarding:

- The number of prior authorization requests that are approved, denied, and appealed;
- The number of prior authorization exemptions or alternatives to prior authorization requirements provided pursuant to a program developed and offered by the carrier, an organization, or a PBM; and
- The prior authorization requirements as applied to prescription drug formularies for each health benefit plan the carrier or PBM offers.

The bill applies to conduct occurring on or after January 1, 2026.

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

2 **SECTION 1. Legislative declaration.** (1) The general assembly
3 finds and declares that:

4 (a) Timely access to necessary health care is of vital importance
5 to Coloradans;

6 (b) The provider-patient relationship is paramount and should not
7 be subject to intrusion by a third party;

8 (c) Coloradans and their health-care providers deserve easy access
9 to information regarding health insurance benefits so that, together, they
10 can determine the proper course of treatment;

11 (d) Utilization management processes, such as prior authorization,

1 delay care, which, according to thirty-four percent of physicians surveyed
2 nationally, leads to serious adverse events for their patients, including
3 hospitalization, permanent disability, or even death;

4 (e) These outcomes due to delays in timely accessing services and
5 prescriptions are known to disproportionately impact historically
6 marginalized populations, such as Black and Hispanic patients, furthering
7 health disparities in the state;

8 (f) Surveys have found that over sixty percent of physicians also
9 report that it is difficult to determine whether a prescription medication
10 or medical service requires prior authorization, adding burdensome
11 administrative steps for health-care providers and patients to understand
12 requirements for accessing necessary medical services or prescriptions;
13 and

14 (g) Health systems spend an average of twenty dollars, for a
15 primary care visit, to two hundred fifteen dollars, for an inpatient surgical
16 procedure, on administrative tasks to navigate insurer utilization
17 management processes like processing prior authorization requests.

18 (2) Therefore, it is the intent of the general assembly, by
19 establishing transparent prescription formularies and enabling access to
20 prior authorization requirements at the point of care delivery; requiring
21 posting of data on prior authorization practices; and requiring carriers,
22 private utilization review organizations, and pharmacy benefit managers
23 to adopt a program that streamlines the administrative process for
24 qualifying health-care providers who satisfy certain objective criteria
25 regarding quality and appropriateness of care and specialty area and
26 experience, to:

27 (a) Ensure Coloradans have equitable access to medically

1 necessary care;

2 (b) Reduce administrative burdens and costs borne by health-care
3 providers; and

4 (c) Reduce overall costs to the health-care system.

5 **SECTION 2.** In Colorado Revised Statutes, 10-16-112.5, **amend**
6 (2)(a), (2)(c), (3)(a)(I), (3)(c)(II), (4)(b), (5)(a), (6), and (7)(e); and **add**
7 (3)(c)(III), (3.5), and (4)(c) as follows:

8 **10-16-112.5. Prior authorization for health-care services -**
9 **disclosures and notice - determination deadlines - criteria - limits and**
10 **exceptions - definitions - rules - enforcement. (2) Disclosure of**
11 **requirements - notice of changes. (a) (I) A carrier shall ~~make~~ POST**
12 **current prior authorization requirements and restrictions, including**
13 **written, clinical criteria, ~~readily accessible~~ on the carrier's PUBLIC-FACING**
14 **website IN A READILY ACCESSIBLE, STANDARDIZED, SEARCHABLE FORMAT.**
15 **The prior authorization requirements must be described in detail and in**
16 **clear and easily understandable language.**

17 (II) If a carrier contracts with a private utilization review
18 organization to perform prior authorization for health-care services, the
19 organization shall provide its prior authorization requirements and
20 restrictions, as required by this subsection (2), to the carrier with ~~whom~~
21 ~~WHICH~~ the organization contracted, and that carrier shall post the
22 organization's prior authorization requirements and restrictions on its
23 PUBLIC-FACING website IN THE MANNER REQUIRED BY SUBSECTION
24 (2)(a)(I) OF THIS SECTION.

25 ~~(HH) When posting prior authorization requirements and~~
26 ~~restrictions pursuant to this subsection (2)(a) or subsection (2)(b) of this~~
27 ~~section, a carrier is neither required to post nor prohibited from posting~~

1 ~~the prior authorization requirements and restrictions on a public-facing~~
2 ~~portion of its website.~~

3 (c) (I) A carrier shall post, on a public-facing portion of its
4 website, data regarding approvals and denials of prior authorization
5 requests, including requests for drug benefits pursuant to section
6 10-16-124.5, in a readily accessible, STANDARDIZED, SEARCHABLE format
7 and that include the following: ~~categories, in the aggregate:~~

8 (A) ~~Provider specialty~~ THE TOTAL NUMBER OF PRIOR
9 AUTHORIZATION REQUESTS RECEIVED IN THE IMMEDIATELY PRECEDING
10 CALENDAR YEAR IN EACH OF THE FOLLOWING CATEGORIES OF SERVICES:
11 MEDICAL PROCEDURES; DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES;
12 PRESCRIPTION DRUGS; AND ALL OTHER CATEGORIES OF HEALTH-CARE
13 SERVICES OR DRUG BENEFITS FOR WHICH A PRIOR AUTHORIZATION
14 REQUEST WAS RECEIVED;

15 (B) ~~Medication or diagnostic test or procedure~~ THE TOTAL
16 NUMBER OF PRIOR AUTHORIZATION REQUESTS THAT WERE APPROVED IN
17 EACH OF THE CATEGORIES SPECIFIED IN SUBSECTION (2)(c)(I)(A) OF THIS
18 SECTION;

19 (B.5) THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS
20 FOR WHICH AN ADVERSE DETERMINATION WAS ISSUED AND THE SERVICE
21 WAS DENIED IN EACH OF THE CATEGORIES SPECIFIED IN SUBSECTION
22 (2)(c)(I)(A) OF THIS SECTION; ■

23 (C) THE reason for THE denial IN EACH OF THE CATEGORIES
24 SPECIFIED IN SUBSECTION (2)(c)(I)(A) OF THIS SECTION, WITH THE DENIAL
25 REASONS SORTED BY CATEGORIES DEFINED BY RULE; and

26 (D) ~~Denials specified under subsection (2)(c)(I)(C) of this section~~
27 ~~that are overturned on appeal~~ IN EACH OF THE CATEGORIES SPECIFIED IN

1 SUBSECTION (2)(c)(I)(A) OF THIS SECTION, THE TOTAL NUMBER OF
2 ADVERSE DETERMINATIONS THAT WERE APPEALED AND WHETHER THE
3 DETERMINATION WAS UPHELD OR REVERSED ON APPEAL.

4 (II) An organization OR PBM that provides prior authorization for
5 a carrier shall provide the data specified in subsection (2)(c)(I) of this
6 section to the carrier with ~~whom~~ WHICH the organization OR PBM
7 contracted, and the carrier shall post the organization's OR PBM's data on
8 its PUBLIC-FACING website IN THE MANNER REQUIRED BY SUBSECTION
9 (2)(c)(I) OF THIS SECTION.

10 (III) Carriers and organizations shall use the data specified in this
11 subsection (2)(c) to refine and improve their utilization management
12 programs. CARRIERS AND ORGANIZATIONS SHALL REVIEW THE LIST OF
13 MEDICAL PROCEDURES, DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES,
14 PRESCRIPTION DRUGS, AND OTHER HEALTH-CARE SERVICES FOR WHICH THE
15 CARRIER OR ORGANIZATION REQUIRES PRIOR AUTHORIZATION AT LEAST
16 ANNUALLY AND SHALL ELIMINATE THE PRIOR AUTHORIZATION
17 REQUIREMENTS FOR THOSE PROCEDURES, DIAGNOSTIC TESTS AND
18 DIAGNOSTIC IMAGES, PRESCRIPTION DRUGS, OR OTHER HEALTH-CARE
19 SERVICES FOR WHICH PRIOR AUTHORIZATION ■■■ NEITHER PROMOTES
20 HEALTH-CARE QUALITY OR EQUITY NOR SUBSTANTIALLY REDUCES
21 HEALTH-CARE SPENDING. ■■■ EACH CARRIER AND ORGANIZATION SHALL
22 ANNUALLY ATTEST TO THE COMMISSIONER THAT IT HAS COMPLETED THE
23 REVIEW REQUIRED BY THIS SUBSECTION (2)(c)(III) AND HAS ELIMINATED
24 PRIOR AUTHORIZATION REQUIREMENTS CONSISTENT WITH THE
25 REQUIREMENTS OF THIS SUBSECTION (2)(c)(III).

26 (IV) A CARRIER SHALL POST, ON A PUBLIC-FACING PORTION OF ITS
27 WEBSITE, IN A READILY ACCESSIBLE, STANDARDIZED, SEARCHABLE

1 FORMAT, DATA ON THE NUMBER OF EXEMPTIONS FROM PRIOR
2 AUTHORIZATION REQUIREMENTS OR ALTERNATIVES TO PRIOR
3 AUTHORIZATION REQUIREMENTS PROVIDED PURSUANT TO A PROGRAM
4 ADOPTED BY THE CARRIER, ORGANIZATION, OR PBM PURSUANT TO
5 SUBSECTION (4)(b)(II) OF THIS SECTION OR SECTION 10-16-124.5 (5.5), AS
6 APPLICABLE. THE CARRIER SHALL INCLUDE THE FOLLOWING DATA:

7 (A) THE NUMBER OF PROVIDERS OFFERED AN EXEMPTION OR
8 ALTERNATIVE PROGRAM, INCLUDING THEIR SPECIALTY AREAS;

9 (B) THE NUMBER AND CATEGORIZED TYPES OF EXEMPTIONS OR
10 ALTERNATIVE PROGRAMS OFFERED TO PROVIDERS; AND

11 (C) THE PRESCRIPTION DRUG, DIAGNOSTIC TEST, PROCEDURE, OR
12 OTHER HEALTH-CARE SERVICE FOR WHICH AN EXEMPTION OR
13 ALTERNATIVE PROGRAM WAS OFFERED.

14 (V) THE COMMISSIONER SHALL ADOPT RULES TO:

15 (A) IMPLEMENT SUBSECTIONS (2)(c)(I) AND (2)(c)(IV) OF THIS
16 SECTION TO ENSURE THAT THE DATA FIELDS REQUIRED TO BE POSTED
17 PURSUANT TO SUBSECTIONS (2)(c)(I) AND (2)(c)(IV) OF THIS SECTION ARE
18 PRESENTED CONSISTENTLY BY CARRIERS; AND

19 (B) DEFINE CATEGORIES OF PRIOR AUTHORIZATION REQUEST
20 DENIALS FOR PURPOSES OF SUBSECTION (2)(c)(I)(C) OF THIS SECTION.

21 (3) **Nonurgent and urgent health-care services - timely**
22 **determination - notice of determination - deemed approved.**

23 (a) Except as provided in subsection (3)(b) of this section, a prior
24 authorization request is deemed granted if a carrier or organization fails
25 to:

26 (I) (A) Notify the provider and covered person, within five
27 business days after receipt of the request, that the request is approved,

1 denied, or incomplete and INDICATE: If DENIED, WHAT RELEVANT
2 ALTERNATIVE SERVICES OR TREATMENTS MAY BE A COVERED BENEFIT OR
3 ARE REQUIRED BEFORE APPROVAL OF THE DENIED SERVICE OR
4 TREATMENT; OR IF incomplete, indicate the specific additional
5 information, consistent with criteria posted pursuant to subsection (2)(a)
6 of this section, that is required to process the request; or

7 (B) Notify the provider and covered person, within five business
8 days after receiving the additional information required by the carrier or
9 organization pursuant to subsection (3)(a)(I)(A) of this section, that the
10 request is approved or denied AND, IF DENIED, INDICATE WHAT RELEVANT
11 ALTERNATIVE SERVICES OR TREATMENTS MAY BE A COVERED BENEFIT OR
12 ARE REQUIRED BEFORE APPROVAL OF THE DENIED SERVICE OR
13 TREATMENT; and

14 (c) (II) If the carrier or organization denies a prior authorization
15 request based on a ground specified in section 10-16-113 (3)(a), the
16 notification is subject to the requirements of section 10-16-113 (3)(a) and
17 commissioner rules adopted pursuant to that section and must:

18 (A) Include information concerning whether the carrier or
19 organization requires an alternative treatment, test, procedure, or
20 medication AND WHAT ALTERNATIVE SERVICES OR TREATMENTS WOULD
21 BE APPROVED AS A COVERED BENEFIT UNDER THE HEALTH BENEFIT PLAN;
22 OR

23 (B) IN THE CASE OF THE DENIAL OF A PRIOR AUTHORIZATION
24 REQUEST FOR A PRESCRIPTION DRUG, SPECIFY WHICH PRESCRIPTION DRUGS
25 AND DOSAGES IN THE SAME CLASS AS THE PRESCRIPTION DRUG FOR WHICH
26 THE PRIOR AUTHORIZATION REQUEST WAS DENIED ARE COVERED
27 PRESCRIPTION DRUGS UNDER THE HEALTH BENEFIT PLAN.

1 (III) A CARRIER'S, ORGANIZATION'S, OR PHARMACY BENEFIT
2 MANAGER'S COMPLIANCE WITH THIS SUBSECTION (3)(c)(II) DOES NOT
3 CONSTITUTE THE PRACTICE OF MEDICINE.

4 (3.5) (a) STARTING JANUARY 1, 2026, A CARRIER OR
5 ORGANIZATION SHALL HAVE, MAINTAIN, AND USE A PRIOR AUTHORIZATION
6 APPLICATION PROGRAMMING INTERFACE THAT AUTOMATES THE PRIOR
7 AUTHORIZATION PROCESS TO ENABLE A PROVIDER TO:

8 (I) DETERMINE WHETHER PRIOR AUTHORIZATION IS REQUIRED FOR
9 A HEALTH-CARE SERVICE;

10 (II) IDENTIFY PRIOR AUTHORIZATION INFORMATION AND
11 DOCUMENTATION REQUIREMENTS; AND

12 (III) FACILITATE THE EXCHANGE OF PRIOR AUTHORIZATION
13 REQUESTS AND DETERMINATIONS FROM THE PROVIDER'S ELECTRONIC
14 HEALTH RECORDS OR PRACTICE MANAGEMENT SYSTEMS THROUGH SECURE
15 ELECTRONIC TRANSMISSION.

16 (b) A CARRIER'S OR ORGANIZATION'S APPLICATION PROGRAMMING
17 INTERFACE MUST MEET THE MOST RECENT STANDARDS AND
18 IMPLEMENTATION SPECIFICATIONS ADOPTED BY THE SECRETARY OF THE
19 UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AS
20 SPECIFIED IN 45 CFR 170.215 (a).

21 (c) IF A PROVIDER SUBMITS A PRIOR AUTHORIZATION REQUEST
22 THROUGH THE CARRIER'S OR ORGANIZATION'S APPLICATION PROGRAMMING
23 INTERFACE, THE CARRIER OR ORGANIZATION SHALL ACCEPT AND RESPOND
24 TO THE REQUEST THROUGH THE INTERFACE.

25 (4) **Criteria, limits, and exceptions.** (b) (I) Carriers and
26 organizations shall consider limiting the use of prior authorization to
27 providers whose prescribing or ordering patterns differ significantly from

1 the patterns of their peers after adjusting for patient mix and other
2 relevant factors and present opportunities for improvement in adherence
3 to the carrier's or organization's prior authorization requirements.

4 (II) ~~(A)~~ NO LATER THAN JANUARY 1, 2026, a carrier or AN
5 organization ~~may offer providers with a history of adherence to the~~
6 ~~carrier's or organization's prior authorization requirements at least one~~
7 ~~alternative to prior authorization, including an exemption from prior~~
8 ~~authorization requirements for a provider that has at least an eighty~~
9 ~~percent approval rate of prior authorization requests over the immediately~~
10 ~~preceding twelve months.~~ SHALL ADOPT A PROGRAM, DEVELOPED IN
11 CONSULTATION WITH PROVIDERS PARTICIPATING WITH THE CARRIER, TO
12 ELIMINATE OR SUBSTANTIALLY MODIFY PRIOR AUTHORIZATION
13 REQUIREMENTS IN A MANNER THAT REMOVES THE ADMINISTRATIVE
14 BURDEN FOR QUALIFIED PROVIDERS, AS DEFINED UNDER THE PROGRAM,
15 AND THEIR PATIENTS FOR CERTAIN HEALTH-CARE SERVICES AND RELATED
16 BENEFITS BASED ON ANY OF THE FOLLOWING:

17 (A) THE PERFORMANCE OF PROVIDERS WITH RESPECT TO
18 ADHERENCE TO NATIONALLY RECOGNIZED, EVIDENCE-BASED MEDICAL
19 GUIDELINES, APPROPRIATENESS, EFFICIENCY, AND OTHER QUALITY
20 CRITERIA; AND

21 (B) PROVIDER SPECIALTY, EXPERIENCE, OR OTHER OBJECTIVE
22 FACTORS; EXCEPT THAT ELIGIBILITY FOR THE PROGRAM MUST NOT BE
23 LIMITED BY PROVIDER SPECIALTY.

24 (III) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (4)(b)(II)
25 OF THIS SECTION:

26 (A) MUST NOT REQUIRE QUALIFIED PROVIDERS TO REQUEST
27 PARTICIPATION IN THE PROGRAM; AND

1 (B) MAY INCLUDE LIMITING THE USE OF PRIOR AUTHORIZATION TO
2 PROVIDERS WHOSE PRESCRIBING OR ORDERING PATTERNS DIFFER
3 SIGNIFICANTLY FROM THE PATTERNS OF THEIR PEERS AFTER ADJUSTING
4 FOR PATIENT MIX AND OTHER RELEVANT FACTORS AND IN ORDER TO
5 PRESENT THOSE PROVIDERS WITH OPPORTUNITIES FOR IMPROVEMENT IN
6 ADHERENCE TO THE CARRIER'S OR ORGANIZATION'S PRIOR AUTHORIZATION
7 REQUIREMENTS.

8 (IV) At least annually, a carrier or AN organization shall:

9 (A) Reexamine a provider's prescribing or ordering patterns; ~~and~~

10 (B) Reevaluate the provider's status for exemption from ~~or other~~
11 ~~alternative to~~ prior authorization requirements OR FOR INCLUSION IN THE
12 PROGRAM DEVELOPED pursuant to ~~this~~ subsection (4)(b)(II) OF THIS
13 SECTION; AND

14 ~~(B) (C) The carrier or organization shall inform~~ NOTIFY the
15 provider of the provider's STATUS FOR exemption ~~status and provide~~
16 ~~information on the data considered as part of its reexamination of the~~
17 ~~provider's prescribing or ordering patterns for the twelve-month period of~~
18 ~~review~~ OR INCLUSION IN THE PROGRAM.

19 (V) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (4)(b)(II)
20 OF THIS SECTION MUST INCLUDE PROCEDURES FOR A PROVIDER TO
21 REQUEST:

22 (A) AN EXPEDITED, INFORMAL RESOLUTION OF A CARRIER'S OR AN
23 ORGANIZATION'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE
24 PROGRAM; AND

25 (B) IF THE MATTER IS NOT RESOLVED THROUGH INFORMAL
26 RESOLUTION, BINDING ARBITRATION AS SPECIFIED IN SUBSECTION
27 (4)(b)(VI) OF THIS SECTION.

1 (VI) IF A PROVIDER REQUESTS BINDING ARBITRATION PURSUANT
2 TO THE PROCEDURES A CARRIER OR AN ORGANIZATION DEVELOPS UNDER
3 SUBSECTION (4)(b)(V)(B) OF THIS SECTION, THE FOLLOWING PROVISIONS
4 GOVERN THE ARBITRATION PROCEDURE:

5 (A) THE PROVIDER AND CARRIER OR ORGANIZATION SHALL
6 JOINTLY SELECT AN ARBITRATOR FROM THE LIST OF ARBITRATORS
7 APPROVED PURSUANT TO SECTION 10-16-704 (15)(b). NEITHER THE
8 PROVIDER NOR THE CARRIER OR ORGANIZATION IS REQUIRED TO NOTIFY
9 THE DIVISION OF THE ARBITRATION OR OF THE SELECTED ARBITRATOR.

10 (B) THE SELECTED ARBITRATOR SHALL DETERMINE THE
11 PROVIDER'S ELIGIBILITY TO PARTICIPATE IN THE CARRIER'S OR
12 ORGANIZATION'S PROGRAM BASED ON THE PROGRAM CRITERIA DEVELOPED
13 PURSUANT TO SUBSECTION (4)(b)(II) OF THIS SECTION;

14 (C) WITHIN THIRTY DAYS AFTER THE DATE THE ARBITRATOR
15 ACCEPTS THE MATTER, THE PROVIDER AND THE CARRIER OR
16 ORGANIZATION SHALL SUBMIT TO THE ARBITRATOR WRITTEN MATERIALS
17 IN SUPPORT OF THEIR RESPECTIVE POSITIONS;

18 (D) THE ARBITRATOR MAY RENDER A DECISION BASED ON THE
19 WRITTEN MATERIALS SUBMITTED PURSUANT TO SUBSECTION (4)(b)(VI)(C)
20 OF THIS SECTION OR MAY SCHEDULE A HEARING, LASTING NOT LONGER
21 THAN ONE DAY, FOR THE PROVIDER AND CARRIER OR ORGANIZATION TO
22 PRESENT EVIDENCE;

23 (E) WITHIN THIRTY DAYS AFTER THE DATE THE ARBITRATOR
24 RECEIVES THE WRITTEN MATERIALS OR, IF A HEARING IS CONDUCTED, THE
25 DATE OF THE HEARING, THE ARBITRATOR SHALL ISSUE A WRITTEN
26 DECISION STATING WHETHER THE PROVIDER IS ELIGIBLE FOR THE
27 PROGRAM; AND

1 (F) IF THE ARBITRATOR OVERTURNS THE CARRIER'S OR
2 ORGANIZATION'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE
3 PROGRAM, THE CARRIER OR ORGANIZATION SHALL PAY THE ARBITRATOR'S
4 FEES AND COSTS, AND IF THE ARBITRATOR AFFIRMS THE CARRIER'S OR
5 ORGANIZATION'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE
6 PROGRAM, THE PROVIDER SHALL PAY THE ARBITRATOR'S FEES AND COSTS.

7

8 (c) (I) WHEN A CARRIER OR AN ORGANIZATION APPROVES A PRIOR
9 AUTHORIZATION REQUEST FOR A SURGICAL PROCEDURE FOR WHICH PRIOR
10 AUTHORIZATION IS REQUIRED, THE CARRIER OR ORGANIZATION SHALL NOT
11 DENY A CLAIM FOR AN ADDITIONAL OR A RELATED HEALTH-CARE
12 PROCEDURE IDENTIFIED DURING THE AUTHORIZED SURGICAL PROCEDURE
13 IF:

14 (A) THE PROVIDER, WHILE PROVIDING THE APPROVED SURGICAL
15 PROCEDURE TO TREAT THE COVERED PERSON, DETERMINES, IN
16 ACCORDANCE WITH GENERALLY ACCEPTED STANDARDS OF MEDICAL
17 PRACTICE, THAT PROVIDING A RELATED HEALTH-CARE PROCEDURE,
18 INSTEAD OF OR IN ADDITION TO THE APPROVED SURGICAL PROCEDURE, IS
19 MEDICALLY NECESSARY AS PART OF THE TREATMENT OF THE COVERED
20 PERSON AND THAT, IN THE PROVIDER'S CLINICAL JUDGMENT, TO INTERRUPT
21 OR DELAY THE PROVISION OF CARE TO THE COVERED PERSON IN ORDER TO
22 OBTAIN PRIOR AUTHORIZATION FOR THE ADDITIONAL OR RELATED
23 HEALTH-CARE PROCEDURE WOULD NOT BE MEDICALLY ADVISABLE;

24 (B) THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE IS A
25 COVERED BENEFIT UNDER THE COVERED PERSON'S HEALTH BENEFIT PLAN;

26 (C) THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE IS
27 NOT EXPERIMENTAL OR INVESTIGATIONAL;

1 (D) AFTER COMPLETING THE ADDITIONAL OR RELATED
2 HEALTH-CARE PROCEDURE AND BEFORE SUBMITTING A CLAIM FOR
3 PAYMENT, THE PROVIDER NOTIFIES THE CARRIER OR ORGANIZATION THAT
4 THE PROVIDER PERFORMED THE ADDITIONAL OR RELATED HEALTH-CARE
5 PROCEDURE AND INCLUDES IN THE NOTICE THE INFORMATION REQUIRED
6 UNDER THE CARRIER'S OR ORGANIZATION'S CURRENT PRIOR
7 AUTHORIZATION REQUIREMENTS POSTED IN ACCORDANCE WITH
8 SUBSECTION (2)(a)(I) OF THIS SECTION; AND

9 (E) THE PROVIDER IS COMPLIANT WITH THE CARRIER'S OR
10 ORGANIZATION'S POST-SERVICE CLAIMS PROCESS, INCLUDING SUBMISSION
11 OF THE CLAIM WITHIN THE CARRIER'S OR ORGANIZATION'S REQUIRED
12 TIMELINE FOR CLAIMS SUBMISSIONS.

13 (II) WHEN A PROVIDER PROVIDES AN ADDITIONAL OR A RELATED
14 HEALTH-CARE PROCEDURE AS DESCRIBED IN THIS SUBSECTION (4)(c), THE
15 CARRIER OR ORGANIZATION SHALL NOT DENY THE CLAIM FOR THE INITIAL
16 SURGICAL PROCEDURE FOR WHICH THE CARRIER OR ORGANIZATION
17 APPROVED A PRIOR AUTHORIZATION REQUEST ON THE BASIS THAT THE
18 PROVIDER PROVIDED THE ADDITIONAL OR RELATED HEALTH-CARE
19 PROCEDURE.

20 (5) **Duration of approval.** (a) Upon approval by the carrier or
21 organization, a prior authorization is valid for at least one ~~hundred eighty~~
22 ~~days~~ CALENDAR YEAR after the date of approval and continues for the
23 duration of the authorized course of treatment. Except as provided in
24 subsection (5)(b) of this section, once approved, a carrier or AN
25 organization shall not retroactively deny the prior authorization request
26 for a health-care service.



27 (6) **Rules - enforcement.** (a) The commissioner may adopt rules

1 as necessary to implement this section.

2 (b) THE COMMISSIONER MAY ENFORCE THE REQUIREMENTS OF THIS
3 SECTION AND IMPOSE A PENALTY OR OTHER REMEDY AGAINST A PERSON
4 THAT VIOLATES THIS SECTION.

5 (7) **Definitions.** As used in this section:

6 (e) "Private utilization review organization" or "organization" ~~has~~
7 ~~the same meaning as set forth~~ MEANS A PRIVATE UTILIZATION REVIEW
8 ORGANIZATION, AS DEFINED in section 10-16-112 (1)(a), THAT HAS A
9 CONTRACT WITH AND PERFORMS PRIOR AUTHORIZATION ON BEHALF OF A
10 CARRIER.

11  
12 **SECTION 3.** In Colorado Revised Statutes, 10-16-124.5, **amend**
13 (2)(a)(II)(A), (2)(c)(II)(A), (3)(a) introductory portion, (3)(a)(I),
14 (3)(a)(VI), (3)(b) introductory portion, (5), and (6); **repeal** (3)(a)(II) and
15 (4); and **add** (3.3), (3.5), (5.5), and (6.5) as follows:

16 **10-16-124.5. Prior authorization form - drug benefits - rules**
17 **of commissioner - definitions - repeal.** (2) (a) Except as provided in
18 subsection (2)(b) or (2)(c) of this section, a prior authorization request is
19 deemed granted if a carrier or pharmacy benefit management firm fails to:

20 (II) For prior authorization requests submitted electronically:

21 (A) Notify the prescribing provider, within two business days after
22 receipt of the request, that the request is approved, denied, or incomplete,
23 and if incomplete, indicate the specific additional information, consistent
24 with criteria posted pursuant to ~~subparagraph (H) of paragraph (a) of~~
25 ~~subsection (3)~~ SUBSECTION (3.5)(a) of this section, that is required to
26 process the request; or

27 (c) For nonurgent prior authorization requests related to a covered

1 person's HIV prescription drug coverage, the prior authorization request
2 is deemed granted if a carrier or pharmacy benefit management firm fails
3 to:

4 (II) For prior authorization requests submitted electronically:

5 (A) Notify the prescribing provider within one business day after
6 receipt of the request that the request is approved, denied, or incomplete,
7 and if incomplete, indicate the specific additional information, consistent
8 with criteria posted pursuant to ~~subsection (3)(a)(H)~~ SUBSECTION (3.5)(a)
9 of this section, that is required to process the request; or

10 (3) (a) ~~On or before July 31, 2014,~~ The commissioner shall
11 develop, by rule, a uniform prior authorization process that:

12 (I) Is made available electronically by the carrier or pharmacy
13 benefit management firm, ~~but that~~ does not require the prescribing
14 provider to submit a prior authorization request electronically, AND
15 SATISFIES THE REQUIREMENTS OF SUBSECTION (3.3) OF THIS SECTION;

16 (II) ~~Requires each carrier and pharmacy benefit management firm~~
17 ~~to make the following available and accessible in a centralized location~~
18 ~~on its website:~~

19 (A) ~~Its prior authorization requirements and restrictions, including~~
20 ~~a list of drugs that require prior authorization;~~

21 (B) ~~Written clinical criteria that are easily understandable to the~~
22 ~~prescribing provider and that include the clinical criteria for~~
23 ~~reauthorization of a previously approved drug after the prior authorization~~
24 ~~period has expired; and~~

25 (C) ~~The standard form for submitting requests;~~

26 (VI) Requires carriers and pharmacy benefit management firms,
27 when notifying a prescribing provider of its decision to deny a prior

1 authorization request, to include THE INFORMATION REQUIRED BY SECTION
2 10-16-112.5 (3)(c)(II) AND a notice that the covered person has a right to
3 appeal the adverse determination pursuant to sections 10-16-113 and
4 10-16-113.5.

5 (b) In developing the uniform prior authorization process, the
6 commissioner shall take into consideration ~~the recommendations, if any,~~
7 ~~of the work group established pursuant to subsection (4) of this section~~
8 ~~and~~ the following:

9 (3.3) STARTING JANUARY 1, 2026, IF A PROVIDER SUBMITS A PRIOR
10 AUTHORIZATION REQUEST TO A CARRIER OR PBM THROUGH A SECURE
11 ELECTRONIC TRANSMISSION SYSTEM THE CARRIER OR PBM USES THAT
12 COMPLIES WITH THE MOST RECENT VERSION OF THE NATIONAL COUNCIL
13 FOR PRESCRIPTION DRUG PROGRAMS SCRIPT STANDARD, OR ITS
14 SUCCESSOR STANDARD, AND 21 CFR 1311, THE CARRIER OR PBM SHALL
15 ACCEPT AND RESPOND TO THE REQUEST THROUGH THE SECURE ELECTRONIC
16 TRANSMISSION SYSTEM.

17 (3.5) (a) ON AND AFTER JANUARY 1, 2026, A CARRIER SHALL POST
18 ON THE CARRIER'S PUBLIC-FACING WEBSITE, IN A READILY ACCESSIBLE,
19 STANDARDIZED, SEARCHABLE FORMAT, PRIOR AUTHORIZATION
20 REQUIREMENTS AS APPLICABLE TO THE PRESCRIPTION DRUG FORMULARY
21 FOR EACH HEALTH BENEFIT PLAN THE CARRIER OFFERS, INCLUDING THE
22 FOLLOWING INFORMATION:

23 (I) THE CARRIER'S PRIOR AUTHORIZATION REQUIREMENTS AND
24 RESTRICTIONS, INCLUDING A LIST OF DRUGS THAT REQUIRE PRIOR
25 AUTHORIZATION;

26 (II) WRITTEN CLINICAL CRITERIA THAT ARE EASILY
27 UNDERSTANDABLE TO THE PRESCRIBING PROVIDER AND THAT INCLUDE THE

1 CLINICAL CRITERIA FOR REAUTHORIZATION OF A PREVIOUSLY APPROVED
2 DRUG AFTER THE PRIOR AUTHORIZATION PERIOD HAS EXPIRED;

3 (III) THE STANDARD FORM FOR SUBMITTING PRIOR AUTHORIZATION
4 REQUESTS;

5 (IV) THE HEALTH BENEFIT PLAN TO WHICH THE FORMULARY
6 APPLIES;

7 (V) EACH PRESCRIPTION DRUG THAT IS COVERED UNDER THE
8 HEALTH BENEFIT PLAN, INCLUDING BOTH GENERIC AND BRAND-NAME
9 VERSIONS OF A PRESCRIPTION DRUG;

10 (VI) ANY PRESCRIPTION DRUGS ON THE FORMULARY THAT ARE
11 PREFERRED OVER OTHER PRESCRIPTION DRUGS OR ANY ALTERNATIVE
12 PRESCRIPTION DRUGS THAT DO NOT REQUIRE PRIOR AUTHORIZATION;

13 (VII) ANY EXCLUSIONS FROM OR RESTRICTIONS ON COVERAGE,
14 INCLUDING:

15 (A) ANY TIERING STRUCTURE, INCLUDING COPAYMENT AND
16 COINSURANCE REQUIREMENTS;

17 (B) PRIOR AUTHORIZATION, STEP THERAPY, AND OTHER
18 UTILIZATION MANAGEMENT CONTROLS;

19 (C) QUANTITY LIMITS; AND

20 (D) WHETHER ACCESS IS DEPENDENT UPON THE LOCATION WHERE
21 A PRESCRIPTION DRUG IS OBTAINED OR ADMINISTERED; AND

22 (VIII) THE APPEAL PROCESS FOR A DENIAL OF COVERAGE OR
23 ADVERSE DETERMINATION FOR AN ITEM OR SERVICE FOR A PRESCRIPTION
24 DRUG.

25 (b) THE COMMISSIONER SHALL ADOPT RULES AS NECESSARY TO
26 IMPLEMENT THIS SUBSECTION (3.5).

27 (4) (a) ~~Within thirty days after May 15, 2013, the commissioner~~

1 shall establish a work group comprised of representatives of:
2 (I) The department of regulatory agencies;
3 (II) Local and national carriers;
4 (III) Captive and noncaptive pharmacy benefit management firms;
5 (IV) Providers, including hospitals, physicians, advanced practice
6 registered nurses with prescriptive authority, and pharmacists;
7 (V) Drug manufacturers;
8 (VI) Medical practice managers;
9 (VII) Consumers; and
10 (VIII) Other stakeholders deemed appropriate by the
11 commissioner.

12 (b) The work group shall assist the commissioner in developing
13 the prior authorization process and shall make recommendations to the
14 commissioner on the items set forth in paragraph (b) of subsection (3) of
15 this section. The work group shall report its recommendations to the
16 commissioner no later than six months after the commissioner appoints
17 the work group members. Regardless of whether the work group submits
18 recommendations to the commissioner, the commissioner shall not delay
19 or extend the deadline for the adoption of rules creating the prior
20 authorization process as specified in paragraph (a) of subsection (3) of
21 this section.

22 (5) (a) Notwithstanding any other provision of law, ~~on and after~~
23 ~~January 1, 2015~~ AND EXCEPT AS PROVIDED IN SUBSECTIONS (5)(b) AND
24 (5.5) OF THIS SECTION, every prescribing provider shall use the prior
25 authorization process developed pursuant to subsection (3) of this section
26 to request prior authorization for coverage of drug benefits, and every
27 carrier and pharmacy benefit management firm shall use that process for

1 prior authorization for drug benefits.

2 (b) (I) A CARRIER OR PBM THAT PROVIDES DRUG BENEFITS UNDER
3 A HEALTH BENEFIT PLAN SHALL NOT IMPOSE PRIOR AUTHORIZATION
4 REQUIREMENTS UNDER THE HEALTH BENEFIT PLAN MORE THAN ONCE
5 EVERY THREE YEARS FOR A DRUG THAT IS APPROVED BY THE FDA AND
6 THAT IS A CHRONIC MAINTENANCE DRUG IF THE CARRIER OR PBM HAS
7 PREVIOUSLY APPROVED A PRIOR AUTHORIZATION FOR THE COVERED
8 PERSON FOR USE OF THE CHRONIC MAINTENANCE DRUG.

9 (II) THIS SUBSECTION (5)(b) DOES NOT APPLY IF:

10 (A) THERE IS EVIDENCE THAT THE AUTHORIZATION WAS OBTAINED
11 FROM THE CARRIER OR PBM BASED ON FRAUD OR MISREPRESENTATION;

12 (B) FINAL ACTION BY THE FDA OR OTHER REGULATORY AGENCIES,
13 OR THE MANUFACTURER, REMOVES THE CHRONIC MAINTENANCE DRUG
14 FROM THE MARKET, LIMITS ITS USE IN A MANNER THAT AFFECTS THE
15 AUTHORIZATION, OR COMMUNICATES A PATIENT SAFETY ISSUE THAT
16 WOULD AFFECT THE AUTHORIZATION ALONE OR IN COMBINATION WITH
17 OTHER AUTHORIZATIONS; OR

18 (C) A GENERIC EQUIVALENT OR DRUG THAT IS BIOSIMILAR, AS
19 DEFINED IN 42 U.S.C. SEC. 262 (i)(2), TO THE PRESCRIBED CHRONIC
20 MAINTENANCE DRUG IS ADDED TO THE CARRIER'S OR PBM'S DRUG
21 FORMULARY.

22 (III) NOTHING IN THIS SUBSECTION (5)(b) REQUIRES A CARRIER OR
23 PBM TO PAY FOR A BENEFIT:

24 (A) THAT IS NOT A COVERED BENEFIT UNDER THE HEALTH BENEFIT
25 PLAN; OR

26 (B) IF THE PATIENT IS NO LONGER A COVERED PERSON UNDER THE
27 HEALTH BENEFIT PLAN ON THE DATE THE CHRONIC MAINTENANCE DRUG

1 WAS PRESCRIBED, DISPENSED, ADMINISTERED, OR DELIVERED.

2 (IV) AS USED IN THIS SUBSECTION (5)(b), "CHRONIC MAINTENANCE
3 DRUG" HAS THE MEANING SET FORTH IN SECTION 12-280-103 (9.5).

4

5 (5.5) (a) NO LATER THAN JANUARY 1, 2026, A CARRIER OR PBM
6 SHALL ADOPT A PROGRAM, DEVELOPED IN CONSULTATION WITH PROVIDERS
7 PARTICIPATING WITH THE CARRIER, TO ELIMINATE OR SUBSTANTIALLY
8 MODIFY PRIOR AUTHORIZATION REQUIREMENTS IN A MANNER THAT
9 REMOVES THE ADMINISTRATIVE BURDEN FOR QUALIFIED PROVIDERS, AS
10 DEFINED UNDER THE PROGRAM, AND THEIR PATIENTS FOR CERTAIN
11 PRESCRIPTION DRUGS AND RELATED DRUG BENEFITS BASED ON ANY OF THE
12 FOLLOWING:

13 (I) THE PERFORMANCE OF PROVIDERS WITH RESPECT TO
14 ADHERENCE TO NATIONALLY RECOGNIZED, EVIDENCE-BASED MEDICAL
15 GUIDELINES, APPROPRIATENESS, EFFICIENCY, AND OTHER QUALITY
16 CRITERIA; AND

17 (II) PROVIDER SPECIALTY, EXPERIENCE, OR OTHER OBJECTIVE
18 FACTORS; EXCEPT THAT ELIGIBILITY FOR THE PROGRAM MUST NOT BE
19 LIMITED BY PROVIDER SPECIALTY.

20 (b) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (5.5)(a) OF
21 THIS SECTION:

22 (I) MUST NOT REQUIRE QUALIFIED PROVIDERS TO REQUEST
23 PARTICIPATION IN THE PROGRAM; AND

24 (II) MAY INCLUDE LIMITING THE USE OF PRIOR AUTHORIZATION TO
25 PROVIDERS WHOSE PRESCRIBING OR ORDERING PATTERNS DIFFER
26 SIGNIFICANTLY FROM THE PATTERNS OF THEIR PEERS AFTER ADJUSTING
27 FOR PATIENT MIX AND OTHER RELEVANT FACTORS AND IN ORDER TO

1 PRESENT THOSE PROVIDERS WITH OPPORTUNITIES FOR IMPROVEMENT IN
2 ADHERENCE TO THE CARRIER'S OR ORGANIZATION'S PRIOR AUTHORIZATION
3 REQUIREMENTS.

4 (c) AT LEAST ANNUALLY, A CARRIER OR PBM SHALL:

5 (I) REEXAMINE A PROVIDER'S PRESCRIBING OR ORDERING
6 PATTERNS;

7 (II) REEVALUATE THE PROVIDER'S STATUS FOR EXEMPTION FROM
8 PRIOR AUTHORIZATION REQUIREMENTS OR FOR INCLUSION IN THE
9 PROGRAM DEVELOPED PURSUANT TO SUBSECTION (5.5)(a) OF THIS
10 SECTION; AND

11 (III) NOTIFY THE PROVIDER OF THE PROVIDER'S STATUS FOR
12 EXEMPTION OR INCLUSION IN THE PROGRAM.

13 (d) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (5.5)(a) OF
14 THIS SECTION MUST INCLUDE PROCEDURES FOR A PROVIDER TO REQUEST:

15 (I) AN EXPEDITED, INFORMAL RESOLUTION OF A CARRIER'S OR
16 PBM'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM;
17 AND

18 (II) IF THE MATTER IS NOT RESOLVED THROUGH INFORMAL
19 RESOLUTION, BINDING ARBITRATION AS SPECIFIED IN SUBSECTION (5.5)(e)
20 OF THIS SECTION.

21 (e) IF A PROVIDER REQUESTS BINDING ARBITRATION PURSUANT TO
22 THE PROCEDURES A CARRIER OR A PBM DEVELOPS UNDER SUBSECTION
23 (5.5)(d)(II) OF THIS SECTION, THE FOLLOWING PROVISIONS GOVERN THE
24 ARBITRATION PROCEDURE:

25 (I) THE PROVIDER AND CARRIER OR PBM SHALL JOINTLY SELECT
26 AN ARBITRATOR FROM THE LIST OF ARBITRATORS APPROVED PURSUANT TO
27 SECTION 10-16-704 (15)(b). NEITHER THE PROVIDER NOR THE CARRIER OR

1 PBM IS REQUIRED TO NOTIFY THE DIVISION OF THE ARBITRATION OR OF
2 THE SELECTED ARBITRATOR.

3 (II) THE SELECTED ARBITRATOR SHALL DETERMINE THE
4 PROVIDER'S ELIGIBILITY TO PARTICIPATE IN THE CARRIER'S OR PBM'S
5 PROGRAM BASED ON THE PROGRAM CRITERIA DEVELOPED PURSUANT TO
6 SUBSECTION (5.5)(a) OF THIS SECTION;

7 (III) WITHIN THIRTY DAYS AFTER THE DATE THE ARBITRATOR
8 ACCEPTS THE MATTER, THE PROVIDER AND THE CARRIER OR PBM SHALL
9 SUBMIT TO THE ARBITRATOR WRITTEN MATERIALS IN SUPPORT OF THEIR
10 RESPECTIVE POSITIONS;

11 (IV) THE ARBITRATOR MAY RENDER A DECISION BASED ON THE
12 WRITTEN MATERIALS SUBMITTED PURSUANT TO SUBSECTION (5.5)(e)(III)
13 OF THIS SECTION OR MAY SCHEDULE A HEARING, LASTING NOT LONGER
14 THAN ONE DAY, FOR THE PROVIDER AND CARRIER OR PBM TO PRESENT
15 EVIDENCE;


16 (V) WITHIN THIRTY DAYS AFTER THE DATE THE ARBITRATOR
17 RECEIVES THE WRITTEN MATERIALS OR, IF A HEARING IS CONDUCTED, THE
18 DATE OF THE HEARING, THE ARBITRATOR SHALL ISSUE A WRITTEN
19 DECISION STATING WHETHER THE PROVIDER IS ELIGIBLE FOR THE
20 PROGRAM; AND

21 (VI) IF THE ARBITRATOR OVERTURNS THE CARRIER'S OR PBM'S
22 FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM, THE
23 CARRIER OR PBM SHALL PAY THE ARBITRATOR'S FEES AND COSTS, AND IF
24 THE ARBITRATOR AFFIRMS THE CARRIER'S OR PBM'S FAILURE OR REFUSAL
25 TO INCLUDE THE PROVIDER IN THE PROGRAM, THE PROVIDER SHALL PAY
26 THE ARBITRATOR'S FEES AND COSTS.

27 (6) Upon approval by the carrier or pharmacy benefit management

1 firm, a prior authorization is valid for at least one ~~hundred eighty days~~
2 CALENDAR YEAR after the date of approval. If, as a result of a change to
3 the carrier's formulary, the drug for which the carrier or pharmacy benefit
4 management firm has provided prior authorization is removed from the
5 formulary or moved to a less preferred tier status, the change in the status
6 of the previously approved drug does not affect a covered person who
7 received prior authorization before the effective date of the change for the
8 remainder of the covered person's plan year. Nothing in this subsection
9 (6) limits the ability of a carrier or pharmacy benefit management firm,
10 in accordance with the terms of the health benefit plan, to substitute a
11 generic drug, with the prescribing provider's approval and patient's
12 consent, for a previously approved brand-name drug.

13 (6.5) THE COMMISSIONER MAY ENFORCE THE REQUIREMENTS OF
14 THIS SECTION AND IMPOSE A PENALTY OR OTHER REMEDY AGAINST A
15 PERSON THAT VIOLATES THIS SECTION.

16 
17 **SECTION 4. Appropriation.** (1) For the 2024-25 state fiscal
18 year, \$36,514 is appropriated to the department of regulatory agencies for
19 use by the division of insurance. This appropriation is from the division
20 of insurance cash fund created in section 10-1-103 (3)(a)(I), C.R.S. To
21 implement this act, the division may use this appropriation as follows:

22 (a) \$29,332 for personal services, which amount is based on an
23 assumption that the division will require an additional 0.4 FTE; and

24 (b) \$7,182 for operating expenses.

25 **SECTION 5. Act subject to petition - effective date -**
26 **applicability.** (1) This act takes effect at 12:01 a.m. on the day following
27 the expiration of the ninety-day period after final adjournment of the

1 general assembly; except that, if a referendum petition is filed pursuant
2 to section 1 (3) of article V of the state constitution against this act or an
3 item, section, or part of this act within such period, then the act, item,
4 section, or part will not take effect unless approved by the people at the
5 general election to be held in November 2024 and, in such case, will take
6 effect on the date of the official declaration of the vote thereon by the
7 governor.

8 (2) This act applies to conduct occurring on or after January 1,
9 2026.