DATE FILED: March 28, 2018 5:59 PM

COLORADO SUPREME COURT Colorado State Judicial Building Two East 14th Avenue Denver, CO 80203	
Original Proceeding Pursuant to C.R.S. § 1-40-107(2) Appeal from the Colorado Ballot Title Setting Board In the Matter of the Title, Ballot Title, and Submission Clause for Proposed Initiative 2017-2018 #147	**▲ COURT USE ONLY ▲**
Petitioner: Deborah Farrell v. **Respondents:** David Silverstein and Andrew Graham and **Colorado Ballot Title Setting Board:** Suzanne Staiert, Julie Pelegrin, and Glenn Roper	Case No.:
Attorneys for Petitioner Deborah Farrell: Thomas M. Rogers III, #28809 Dietrich C. Hoefner, #46304 LEWIS ROCA ROTHGERBER CHRISTIE LLP 1200 Seventeenth Street, Suite 3000 Denver, CO 80202 Phone: 303.623.9000 Fax: 303.623.9222 Email: trogers@lrrc.com dhoefner@lrrc.com	

PETITION FOR REVIEW OF FINAL ACTION OF TITLE SETTING BOARD CONCERNING PROPOSED INITIATIVE 2017-2018 #147 ("TRANSPARENCY IN HEALTH INSURANCE CARRIER BILLING")

Petitioner Deborah Farrell, a registered elector of the State of Colorado, pursuant to C.R.S. § 1-40-107(2), respectfully petitions this Court to review the actions of the Ballot Title Setting Board with respect to the setting of the title and submission clause for Proposed Initiative 2017-2018 #147 ("Transparency in Health Care Insurance Carrier Billing"), and states:

STATEMENT OF THE CASE

I. Procedural History of Proposed Initiative #147

On February 8, 2018, Proponents David Silverstein and Andrew Graham filed Proposed Initiative 2017-2018 #147 (the "Initiative") with the Office of Legislative Council. The Initiative is one of a series of six similar healthcare initiatives for which Petitioner is seeking review of the Title Board's final action. In addition to the petition for review regarding Initiative #146, which is being filed concurrently with this Petition, the Title Board's final actions on Initiatives #119, #121, #122, and #123 are currently pending review by this Court. *See Matter of the Title, Ballot Title, and Submission Clause for Proposed Initiatives 2017-2018 #119, #121, #122, and #123*, Nos. 2018SA48, 2018SA49, 2018SA50, and 2018SA51.

Each of the six initiatives is related. Initiatives #119 and #147 would regulate health insurance carriers, Initiative #122 would regulate healthcare

providers, and Initiatives #121, #123, and #146 are omnibus measures that would each regulate health insurance carriers, pharmacies, and healthcare providers.[1]

The review and comment meeting for Initiative #147 was held under C.R.S. § 1-40-105(1) on February 22, 2018. Proponents submitted the original, amended, and final versions of the Initiative to the Secretary of State for title setting on February 23, 2018. On March 7, 2018, the Title Board set the Initiative's title. On March 14, 2018, Petitioner timely filed a Motion for Rehearing on the basis that the Title Board lacked jurisdiction to set title because the Initiative violates the single subject requirement of Colo. Const. art. V, §1(5.5) and C.R.S. § 1-40-106.5, and further that the title does not fairly express the true meaning and intent of the proposed measure.

The Title Board held a rehearing on March 21, 2018 and denied the Petitioner's motion.

II. Jurisdiction

Under C.R.S. § 1-40-107(2), Petitioner is entitled to Colorado Supreme Court review of the Title Board's actions in setting the Initiative's title. Petitioner filed a timely Motion for Rehearing, *see* C.R.S. § 1-40-107(1), and subsequently filed this Petition for Review within seven days from the date of the rehearing, *see*

[1] Initiative #146 is substantially similar to #123 and Initiative #147 is substantially similar to #119.

C.R.S. § 1-40-107(2). As required by C.R.S. § 1-40-107(2), attached to this Petition are certified copies of: (1) the Proponents' original, amended, and final drafts of the Initiative; (2) the title set by the Title Board on March 7, 2018; (3) the Motion for Rehearing filed by the Petitioner; and (4) the Title Board's rulings on the Motion for Rehearing as reflected by the title and submission clause set by the Board after rehearing on March 21, 2018. Petitioner respectfully submits that the Title Board erred in denying her motion for rehearing on the issues set forth below. For these reasons, this matter is properly before the Colorado Supreme Court.

GROUNDS FOR APPEAL

The following is an advisory list of the issues to be addressed in the Petitioner's brief:

(1) The Initiative violates the single subject requirement of article V, section 1(5.5) of the Colorado Constitution and C.R.S. § 1-40-106.5. While the Initiative purports to address "price transparency in healthcare billing," it also requires insurance carriers to make broad disclosures 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.

(2) The title violates C.R.S. § 1-40-106(3)(b) because it is misleading and does not reflect a central feature of the Initiative; specifically, the fact that although the Initiative purports to regulate "healthcare providers," the Initiative also regulates professionals such as social workers that are not commonly regarded to be healthcare providers.

PRAYER FOR RELIEF

Petitioner respectfully requests that the Court reverse the Title Board's denial of Petitioner's Motion for Rehearing and direct the Title Board to decline to set a title on the measure for failure to meet the single-subject requirement, or alternatively, to set a title that reflects the true intent and meaning of the Initiative.

Respectfully submitted this 28th day of March, 2018.

s/ Thomas M. Rogers III
Thomas M. Rogers III
Dietrich C. Hoefner
LEWIS ROCA ROTHGERBER CHRISTIE LLP

Attorneys for Petitioner Deborah Farrell

CERTIFICATE OF SERVICE

I hereby certify that on March 28, 2018, I electronically filed a true and correct copy of the foregoing PETITION FOR REVIEW OF FINAL ACTION OF TITLE SETTING BOARD CONCERNING PROPOSED INITIATIVE 2017-2018 #147 ("TRANSPARENCY IN HEALTH CARE INSURANCE CARRIER BILLING") with the clerk of Court via the Colorado Courts E-Filing system and served the same via email and via US Mail on the following:

Martha Tierney
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Attorney for Respondents David Silverstein and Andrew Graham

Matthew Grove, Assistant Attorney General
Office of the Colorado Attorney General
Ralph L. Carr Colorado Judicial Center
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Denver, CO 80203
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Attorney for the Title Board

s/ Tracy M. King
Of: Lewis Roca Rothgerber Christie LLP

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STATE OF COLORADO

DEPARTMENT OF STATE

CERTIFICATE

I, WAYNE W. WILLIAMS, Secretary of State of the State of Colorado, do hereby certify that:

the attached are true and exact copies of the filed text, initial fiscal impact statement, abstract, motion for rehearing, and the rulings thereon of the Title Board for Proposed Initiative "2017-2018 #147 'Transparency in Health Care Insurance Carrier Billing'".....

..... **IN TESTIMONY WHEREOF** I have unto set my hand .....
and affixed the Great Seal of the State of Colorado, at the
City of Denver this 26th day of March, 2018.

Wayne W. Williams

SECRETARY OF STATE

Initiative 2017-2018 #147: Health Care Insurance Carrier Billing Transparency - Final 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, PRESCRIPTION DRUGS, 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, PRESCRIPTION DRUG, MEDICAL DEVICE, OR MEDICATIONS TO DETERMINE THEIR FINANCIAL RESPONSIBILITY. IT IS RECOGNIZED THAT THE SERVICES TO BE RENDERED CANNOT ALWAYS BE ESTIMATED IN ADVANCE OF THE DELIVERY OF THE SERVICES. 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 LINE OF BUSINESS FOR EACH TYPE OF HEALTHCARE INSURANCE PLAN, 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 AND 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 THAT 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.

Submitted by:

David Silverstein, 555 17th Street (Suite 400), Denver, CO 80202
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Andrew Graham, 3464 S. Willow, Denver, CO 80231
andrewgraham@ahcc.com 303-755-2900 (tel) 805-690-8065 (fax)

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

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(3) FOR EACH PROVIDER, HEALTHCARE SERVICE, AND LINE OF BUSINESS FOR EACH 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:

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(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~~AND 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.

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(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.

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(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~~THAT RESULTS IN ANY DISCOUNT OR ADJUSTMENT TO THE TOTAL CHARGE FOR HEALTHCARE SERVICES. CONTRACT TERMS INCLUDE:

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(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;

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(A) ~~A~~A SPECIFIC LINE ITEM;

(B) ~~I~~INDIVIDUAL SERVICE, PROCEDURE, OR TREATMENT;

(C) ~~C~~CATEGORY OR GROUP OF SERVICES, PROCEDURES, OR TREATMENTS;

(D) ~~M~~MEDICAL DEVICE; OR

(E) ~~M~~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.

Submitted by:

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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.

Submitted by:

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Colorado Legislative Council Staff

Initiative #147

INITIAL FISCAL IMPACT STATEMENT

Date: March 5, 2018 **Fiscal Analyst:** Bill Zepernick (303-866-4777)

LCS TITLE: TRANSPARENCY IN HEALTH CARE INSURANCE CARRIER BILLING

Fiscal Impact Summary	FY 2018-19	FY 2019-20
State Revenue		**less than $20,000**
General Fund		less than $20,000
State Expenditures	**$16,056**	**$31,557**
Cash Funds	16,056	31,557

Note: This *initial* fiscal impact estimate has been prepared for the Title Board. If the initiative is placed on the ballot, Legislative Council Staff may revise this estimate for the Blue Book Voter Guide if new information becomes available.

Summary of Measure

Starting on June 1, 2019, Initiative #147 requires that health insurance carriers post specified information on their websites and make this information available in writing upon request. Specifically, health insurance carriers must disclose the following information for each provider, health care service, and type of health care plan as it pertains to each line of business it operates:

- the contract terms;
- the cost sharing arrangement; and
- prescription drug prices.

In addition, health insurance carriers must annually publish detailed information on all forms of remuneration derived from rebates and other forms of incentives received as a result of health care services or prescription drugs. The Commissioner of Insurance is required to promulgate rules concerning the measure's requirements on insurance carriers , and those rules must be in effect by April 1, 2019. If the Commissioner determines that a carrier is not in compliance with the measure, he or she may suspend or revoke the carrier's license, or impose a civil penalty up to $50,000, with an additional fine for each day of continued noncompliance. Fine revenue is deposited in the General Fund.

Lastly, the measure specifies that contracts between insurance carriers and health care providers and facilities cannot contain any provision that restricts the ability of the health insurance plan, third-party payer, or health care provider to furnish patients with any required information that must be published under the measure. Any such provision in a contract is void and unenforceable.

Initiative #147

State Revenue

Initiative #147 is expected to increase General Fund revenue by less than $20,000 per year beginning in FY 2019-20. This revenue is from civil fines levied against health insurance carriers. Because the Commissioner of Insurance has discretion in the amount of any fine imposed, the exact revenue impact cannot be estimated. Overall, a high level of compliance is assumed, so fine revenue is expected to be less than $20,000 per year. Based on the required disclosures starting on June 1, 2019, and allowing for a period of time for any complaints of non-compliance to be processed, it is assumed that fine revenue will not be received until FY 2019-20.

State Diversions

This measure, if enacted, will divert $16,056 from the General Fund in FY 2018-19 and $31,557 in FY 2019-20. This revenue diversion occurs because the measure increases costs in the Department of Regulatory Agencies, Division of Insurance, which is funded with premium tax revenue that would otherwise be credited to the General Fund.

State Expenditures

Initiative #147 increases expenditures by $16,056 and 0.1 FTE in FY 2018-19 and $31,557 and 0.3 FTE in FY 2019-20 in DORA. These costs are paid from the Division of Insurance Cash Fund. The measure will also potentially impact workload and costs in several other state agencies. Costs are summarized in Table 1 and discussed below.

Table 1. Expenditures Under Initiative #147

Cost Components	FY 2018-19	FY 2019-20
Personal Services	$9,100	$21,840
FTE	0.1 FTE	0.3 FTE
Legal Services	5,328	5,328
Employee Benefits and Insurance	1,628	4,389
TOTAL	**$16,056**	**$31,557**

Department of Regulatory Agencies. The Commissioner of Insurance is required to establish rules for disclosures by health insurance carriers. An additional 0.1 FTE is required to conduct rulemaking in the first year and an additional 0.3 FTE is required to respond to consumer inquiries and complaints on an ongoing basis. Staff costs are prorated in the first year to reflect a start date of February 1, 2019. The division will also have costs for legal services provided by the Department of Law for rulemaking and enforcement activity.

State employee health insurance. To the extent that this measure increases administrative costs for health insurance carriers, costs for state employee health insurance may increase. Because state employee health insurance contributions are based upon prevailing market rates, with costs shared between the employer and employee, this measure is not expected to affect the state's share of employee health insurance premiums until FY 2019-20. Because insurance rates are influenced by a number of variables, the exact effect of this measure cannot be determined. Any increase caused by the measure will be addressed through the total compensation analysis included in the annual budget process.

Office of Administrative Courts and trial courts. The measure may potentially increase workload for the Office of Administrative Courts in the Department of Personnel and Administration and the trial courts in the Judicial Department in several ways. First, health insurance carriers may challenge enforcement actions against them for noncompliance with the measure, which would likely first be heard by an administrative law judge, and potentially appealed to the trial courts. Assuming a high level of compliance, these impacts are likely minimal and can be accomplished within existing appropriations.

Local Government Impact

Similar to the state employee insurance impact discussed above, local governments offering health insurance coverage to their employees may experience an increase in costs. To the extent that the requirements of the measure lead to higher insurance premiums, local government costs for employee health insurance may increase. Health insurance premiums depend on a variety of factors and an exact estimate of the potential increase cannot be determined.

Economic Impact

By promoting greater transparency in billing by health insurance carriers, Initiative #147 may help consumers more effectively spend their health care dollars, which over the long term could lead to lower health care costs for Coloradans. However, these savings may be offset by higher premiums to the extent that the measure increases administrative costs for health insurance carriers.

Effective Date

The measure takes effect on January 1, 2019, if approved by voters at the 2018 general election.

State and Local Government Contacts

Corrections	Counties	Health Care Policy and Financing
Higher Education	Human Services	Information Technology
Judicial	Law	Municipalities
Personnel	Regulatory Agencies	Public Health and Environment

Initiative #147

Abstract of Initiative #147: TRANSPARENCY IN HEALTH CARE INSURANCE CARRIER BILLING

This initial fiscal estimate, prepared by the nonpartisan Director of Research of the Legislative Council as of March 5, 2018, identifies the following impacts:

The abstract includes estimates of the fiscal impact of the initiative. If this initiative is to be placed on the ballot, Legislative Council Staff will prepare new estimates as part of a fiscal impact statement, which includes an abstract of that information. All fiscal impact statements are available at www.ColoradoBlueBook.com and the abstract will be included in the ballot information booklet that is prepared for the initiative.

State expenditures. Initiative #147 requires health insurance carriers to disclose cost and billing information to consumers. The Department of Regulatory Agencies must establish rules and take action to implement the measure's requirements, which will increase state expenditures by $16,056 in FY 2018-19 and $31,557 in FY 2019-20. Additional costs may be incurred to the extent the measure leads to higher state employee insurance premiums or results in litigation in the courts.

State revenue. Initiative #147 allows fines to be levied on health insurance carriers that do not comply with the measure's disclosure requirements. This is expected to increase state revenue from fines by less than $20,000 per year beginning in FY 2019-20.

Local government. The measure potentially increases costs for local governments that pay for employee health insurance.

Economic impact. By promoting greater transparency in billing by health insurance carriers, Initiative #147 may help consumers more effectively spend their health care dollars, which over the long term could lead to lower health care costs for Coloradans. However, these savings may be offset by higher premiums to the extent that the measure increases administrative costs for health insurance carriers.

Ballot Title Setting Board

Proposed Initiative 2017-2018 #147[1]

The title as designated and fixed by the Board is as follows:

A change to the Colorado Revised Statutes concerning a requirement that health care insurers publish health insurance plan information, and, in connection therewith, requiring health insurers to publicly disclose: 1) the basis for determining payment or reimbursement amounts to a broad range of health care providers, 2) the items that appear as charges on an explanation of benefits that the insurer does not pay, 3) detailed coverage and negotiated payment information by plan type and provider, 4) prescription drug prices negotiated with providers, pharmacies, distributors, and manufacturers, and 5) all health care related rebates or other incentives received; authorizing penalties for violations; and prohibiting any contract between a health insurance plan and a health care provider from restricting the publication of the required health insurance plan information.

The ballot title and submission clause as designated and fixed by the Board is as follows:

Shall there be a change to the Colorado Revised Statutes concerning a requirement that health care insurers publish health insurance plan information, and, in connection therewith, requiring health insurers to publicly disclose: 1) the basis for determining payment or reimbursement amounts to a broad range of health care providers, 2) the items that appear as charges on an explanation of benefits that the insurer does not pay, 3) detailed coverage and negotiated payment information by plan type and provider, 4) prescription drug prices negotiated with providers, pharmacies, distributors, and manufacturers, and 5) all health care related rebates or other incentives received; authorizing penalties for violations; and prohibiting any contract between a health insurance plan and a health care provider from restricting the publication of the required health insurance plan information?

Hearing March 7, 2018:
Single subject approved; staff draft amended; titles set.
Hearing adjourned 11:59 p.m.

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[1] Unofficially captioned **"Transparency in Health Care Insurance Carrier Billing"** by legislative staff for tracking purposes. This caption is not part of the titles set by the Board.

BEFORE COLORADO STATE TITLE SETTING BOARD

In re Ballot Title and Submission Clause for 2017-2018 Initiative #147 ("Transparency in Health Insurance Carrier Billing")

Deborah Farrell, Objector.

MOTION FOR REHEARING

Pursuant to C.R.S. § 1-40-107, Objector, Deborah Farrell, a registered elector of the State of Colorado, through her legal counsel, Lewis Roca Rothgerber Christie LLP, submits this Motion for Rehearing of the Title Board's March 7, 2018 decision to set the title of 2017-2018 Initiative #147 ("Initiative"), and states:

I. The Initiative impermissibly contains multiple separate and distinct subjects in violation of the constitutional single-subject requirement.

While the Initiative purports to address only the subject of transparency in health care insurance carrier billing, several other subjects are impermissibly woven into the Initiative, including:

- Requiring broad disclosure by insurance carriers of "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.*" (*Initiative* § 10-16-147(4) (*emphasis* added).) Because many payments made to insurance carriers are related in some way to healthcare services, prescription drugs, or medical devices, this catch-all provision requires insurance carriers to disclose a large percentage of all payments or other compensation they receive, regardless of whether or not those activities are reasonably related to billing transparency.

These additional subjects represent distinct and additional purposes of the Initiative, thus violating the single-subject requirement. *See* C.R.S. § 1-40-106.5.

II. The title set by the Title Board is unfair and does not fairly express the true meaning and intent of the proposed constitutional amendment.

The title set for the Initiative by the Title Board fails to fairly, clearly, and accurately convey the central features of the measure because it does not:

- Explain that the initiative affects a very broad range of providers, including many that may not commonly be considered to be "health care" providers by the public, such as athletic trainers, massage therapists, psychologists, social workers, and professional counselors. (Initiative § 10-16-147(8)(n).) Instead, the title refers only to "a broad range of health care providers."

WHEREFORE, Objector respectfully requests that the Title Board set Initiative 147 for rehearing pursuant to *C.R.S. § 1-40-107(1).*

DATED: March 14, 2018.

s/ Thomas M. Rogers III
Thomas M. Rogers III
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CERTIFICATE OF SERVICE

I hereby certify that on March 14, 2018, a true and correct copy of this **MOTION FOR REHEARING** was served on proponents via email as follows:

David Silverstein
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Proponents

s/ Robin A. Newcomer

Ballot Title Setting Board

Proposed Initiative 2017-2018 #147[1]

The title as designated and fixed by the Board is as follows:

A change to the Colorado Revised Statutes concerning a requirement that health care insurers publish health insurance plan information, and, in connection therewith, requiring health insurers to publicly disclose: 1) the basis for determining payment or reimbursement amounts to a broad range of health care providers, 2) the items that appear as charges on an explanation of benefits that the insurer does not pay, 3) detailed coverage and negotiated payment information by plan type and provider, 4) prescription drug prices negotiated with providers, pharmacies, distributors, and manufacturers, and 5) all health care related rebates or other incentives received; authorizing penalties for violations; and prohibiting any contract between a health insurance plan and a health care provider from restricting the publication of the required health insurance plan information.

The ballot title and submission clause as designated and fixed by the Board is as follows:

Shall there be a change to the Colorado Revised Statutes concerning a requirement that health care insurers publish health insurance plan information, and, in connection therewith, requiring health insurers to publicly disclose: 1) the basis for determining payment or reimbursement amounts to a broad range of health care providers, 2) the items that appear as charges on an explanation of benefits that the insurer does not pay, 3) detailed coverage and negotiated payment information by plan type and provider, 4) prescription drug prices negotiated with providers, pharmacies, distributors, and manufacturers, and 5) all health care related rebates or other incentives received; authorizing penalties for violations; and prohibiting any contract between a health insurance plan and a health care provider from restricting the publication of the required health insurance plan information?

Hearing March 7, 2018:
Single subject approved; staff draft amended; titles set.
Hearing adjourned 11:59 p.m.

Rehearing March 21, 2018:
Motion for Rehearing denied.
Hearing adjourned 9:20 a.m.

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[1] Unofficially captioned **"Transparency in Health Care Insurance Carrier Billing"** by legislative staff for tracking purposes. This caption is not part of the titles set by the Board.