General Election Ballot Initiative 146: Transparency in Health Care Billing **(Action)**

Instructions: Read these items carefully to be fully prepared for the board discussion and a decision. Ballot Initiative 146, if enacted, would have a major impact on CMS members.

1. **Why the board is discussing Ballot Initiative 146**: While this ballot initiative is still in the signature-gathering phase, many anticipate that the measure will qualify and appear on the November general election ballot.

2. **Who is promoting Ballot Initiative 146 and their supporters:** Ballot Initiative 146 is being spearheaded by Broken Healthcare.

3. **Who opposes Ballot Initiative 146**: Colorado Hospital Association is currently recruiting a broad-based coalition to defeat the measure, similar to the coalition that defeated Broken Healthcare's transparency during the 2018 General Assembly.

4. **How Ballot Initiative 146 would apply to physicians**:

Summary of Initiative 146: All provisions would become effective (law) as of 6/1/2019.

6-20-104: All health care providers and facilities shall publish in a "public, easy-to-find, and easy-to-access" location a current and updated fee schedule or chargemaster of health care services, including:

(1) In printed form, upon request, at the provider's physical location;
(2) In downloadable formats on the provider's website;
(3) If the provider does not have a website, in a printed form or on a disc, flash drive, email or other common format.

The fee schedule or chargemaster must include:

(1) A unique identifier for each line item;
(2) A written description of the service;
(3) For hospitals, the universal billing code;
(4) The charge for the service;
(5) Information about billing policies and practices, including whether the provider authorizes discounts such as for advance or timely payment, or to particular classes of patients and the bases for determining qualifications.

If the provider's entire fee schedule or chargemaster is based on a percentage of the CMS fee schedule, the provider need not publish it. However, the provider must publish the specific fee schedule the provider uses including the date of the fee schedule and the percentage of the fee schedule on which the provider bases the charges; and "any other information necessary to enable a person to determine the charges for a healthcare service."

Healthcare facilities must publish a list of all providers who provide services at the facility, including the nature of the relationship between the provider and facility. Providers must maintain records of all changes to charges on the fee schedule or chargemaster.
If a provider or facility violates the requirements of the law, they cannot bill the patient or any third-party payor, and neither is responsible for paying the charges.
6-20-105: Every bill to a patient must include an itemized detail of each service provided, the charge for the service, and how any payment or adjustment by a carrier was applied to each line item.
6-20-106: If a patient provides health insurance information to a provider or facility, the provider or facility must disclose whether:

(1) The provider or facility participates in the patient's plan;
(2) The services rendered or to be rendered will be covered by the plan as an in-network or out-of-network benefit; and
(3) The patient will receive services from an out-of-network provider at an in-network facility and, if so, whether the provider may balance bill the patient.

6-20-107: Every pharmacy shall publish retail drug prices.
6-20-108: Any contract between a carrier and provider cannot restrict the ability to furnish required information.
6-20-109: The Executive Director shall publish rules consistent with the law.
10-16-147: Each carrier must post on its website and provide to covered persons upon request:

(1) The specific basis for determining the payment or reimbursement to providers including whether the payment is based on:
    (a) A percentage of billed charges;
    (b) A flat daily or per diem rate;
    (c) Copayments;
    (d) Deductibles; and/or
    (e) Any other method; and
    (f) How the payment is calculated for in-network and out-of-network providers.
(2) Items that appear on EOBs or provider billing statements that the carrier does not pay.
(3) "Detailed information regarding coverage and negotiated payment information by plan type and participating provider."
(4) Prescription drug prices in a form and manner to be determined by the insurance commissioner.

Each carrier must publish at least annually a list of all rebates or incentive payments received for healthcare services or purchases of prescription drugs or medical devices.
For violations, the insurance commissioner can revoke or suspend a carrier's license or impose a fine of up to $50K per day.
Repeals Article 49 in Title 25, the healthcare transparency laws enacted in 2017.