Initiative #85 - Disclosure of Health Care Charges

A Legislative Declaration from the People of Colorado.

THE PEOPLE OF COLORADO TAKE IT UPON THEMSELVES TO ENACT THIS LAW REGARDING PRICE TRANSPARENCY IN HEALTHCARE BILLING IN AN EFFORT TO RESTORE COMMON SENSE, ORDER, AND INTEGRITY TO 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 ANYWAY IMPEDE COMPETITION, BUT RATHER WILL IMPROVE COMPETITION AND EMPOWER PATIENTS TO BECOME MORE ACTIVE PARTICIPANTS IN THEIR OWN CARE.

THE PEOPLE OF COLORADO 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.

THE PURPOSE OF PRICE TRANSPARENCY IN HEALTHCARE IS NOT MERELY TO PROVIDE PATIENTS WITH THE ABILITY TO SHOP FOR HEALTHCARE SERVICES ON THE BASIS OF PRICE. IN FACT, SHOPPING AROUND IS ONLY A SMALL ASPECT OF HEALTHCARE PRICE TRANSPARENCY BECAUSE SHOPPING FOR SERVICES IS NOT ALWAYS PRACTICAL WHEN HEALTHCARE SERVICE IS NEEDED. THE PURPOSE OF HEALTHCARE PRICE TRANSPARENCY, AND OF THIS LAW, IS TO ENSURE THAT COLORADO'S HEALTHCARE SYSTEM BEGINS TO FUNCTION IN A NORMAL MANNER WHERE PRICE IS AVAILABLE TO ANYONE AND EVERYONE AT ALL TIMES. THE PEOPLE OF COLORADO BELIEVE THAT IF THERE IS PRICE TRANSPARENCY, PRICES WILL BE FAIR AND WILL BE DETERMINED BY THE MARKETPLACE, WHETHER THEY PERSONALLY REVIEW ALL PRICES IN ADVANCE OF SERVICES OR NOT.

SECTION 1. In Colorado Revised Statutes, repeal and reenact, with amendments, Part 1 of Article 20 of Title 6 as follows:

PART 1
HEALTHCARE CHARGES TRANSPARENCY

6-20-101. Short title. The short title of this Part 1 is the "HEALTHCARE CHARGES TRANSPARENCY ACT".

6-20-102. Definitions. As used in this Part 1, unless the context otherwise requires:

(1) "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 FROMS OF CHARGE REDUCTION OR ADJUSTMENT AND REGARDLESS OF WHO THE PAYER IS.

(2) "CHARGEMASTER", ALSO REFERRED TO AS "CHARGE MASTER", "CHARGE DESCRIPTION MASTER" OR "CDM", OR OTHER SUCH NAME AS MAY BE USED FROM TIME TO TIME, 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, REGARDLESS OF PAYER AND BEFORE ANY DISCOUNTS, REBATES, NEGOTIATIONS OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT ARE APPLIED.

(3) “FEE SCHEDULE,” ALSO REFERRED TO AS “FEES”, “PRICE LIST”, “MASTER PRICE LIST” “LIST PRICES” OR OTHER SUCH NAME AS MAY BE USED FROM TIME TO TIME, 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 GIVEN HEALTHCARE SERVICE REGARDLESS OF PAYER AND BEFORE ANY DISCOUNTS, REBATES, NEGOTIATIONS OR OTHER FORMS OF CHARGE REDUCTION OR ADJUSTMENT ARE APPLIED.

(4) "CPT CODE" MEANS THE CURRENT PROCEDURAL TERMINOLOGY CODE, OR ITS SUCCESSOR CODE, AS DEVELOPED AND COPYRIGHTED BY THE AMERICAN MEDICAL ASSOCIATION OR ITS SUCCESSOR ENTITY.

(5) "HCPCS" MEANS THE HEALTHCARE COMMON PROCEDURE CODING SYSTEM DEVELOPED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (“CMS”) FOR IDENTIFYING HEALTHCARE SERVICES IN A CONSISTENT AND STANDARDIZED MANNER.

(6) “DRG” MEANS THE DIAGNOSIS RELATED GROUP WHICH IS THE SYSTEM DEVELOPED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (“CMS”) TO GROUP SERVICES OF SIMILAR INTENSITY FOR THE PURPOSE OF REIMBURSING HOSPITALS BASED ON A FIXED FEE FOR EACH PATIENT CASE IN A GIVEN CATEGORY, RATHER THAN BASED ON THE ACTUAL CHARGES

(7) "APC" MEANS THE AMBULATORY PAYMENT CLASSIFICATION SYSTEM WHICH IS THE SYSTEM DEVELOPED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (“CMS”) USED TO GROUP SERVICES OF SIMILAR INTENSITY FOR THE PURPOSE OF REIMBURSEMENT ASSOCIATED WITH OUTPATIENT SERVICES.

(8) "HEALTHCARE PROVIDER" OR "PROVIDER" MEANS:

(a) 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 FORPERSONS 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;

(b) A CLINICAL LABORATORY REGISTERED THROUGH THE CERTIFICATION PROGRAM ADMINISTERED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES;

(c) 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;

(d) 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 HERAPIST, PSYCHIATRIC TECHNICIAN, PHARMACIST, 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; OR

(e) A MEDICAL GROUP, INDEPENDENT PRACTICE ASSOCIATION, OR PROFESSIONAL CORPORATION PROVIDING HEALTHCARE SERVICES.

(9) (a) "HEALTHCARE SERVICE" OR "SERVICE" MEANS: A SERVICE, PROCEDURE OR TREATMENT OR GROUP OF SERVICES, PROCEDURES OR TREATMENTS DELIVERED BY A HEALHCARE PROVIDER.

(b) "HEALTHCARE SERVICE" INCLUDES SERVICES RENDERED THROUGH THE USE OF TELEMEDICINE.

(10) "HEALTH INSURANCE" OR "HEALTH INSURANCE PLAN" HAS THE SAME MEANING AS "HEALTH COVERAGE PLAN", AS DEFINED IN SECTION 10-16-102(34).

(11) "THIRD PARTY PAYER" MEANS A HEALTH INSURER, SELF-INSURED EMPLOYER, OR OTHER PUBLIC OR PRIVATE THIRD PARTY, INCLUDING A THIRD-PARTY ADMINISTRATOR OR INTERMEDIARY, THAT IS RESPONSIBLE FOR PAYING ALL OR A PORTION OF THE CHARGES FOR HEALTHCARE SERVICES DELIVERED TO A PATIENT.

(12) "UNIVERSAL BILLING CODE", ALSO REFERRED TO AS A “UPC” OR “UPC CODE” OR "REVENUE CODE", "DEPARTMENT CODE", OR "UB04 CODE", MEANS THE CODE USED BY A HEALTHCARE PROVIDER TO INDICATE WHERE A HEALTHCARE SERVICE WAS PERFORMED.

(13) “PRICE,” OR “ULTIMATE PRICE” MEANS THE CHARGE LESS ANY DISCOUNTS, REBATES, NEGOTIATIONS OR OTHER FROMS OF CHARGE REDUCTION OR ADJUSTMENT PROVIDED BY THE PROVIDER TO THE PATIENT, OR NEGOTIATED BY A THIRD PARTY PAYER. THE PRICE THEREFORE IS THE AMOUNT ULTIMATELY RECEIVED IN THE FORM OF PAYMENT OR REIMBURSEMENT BY THE PROVIDER WITHOUT REGARD TO THE PROPORTIONS OF SAID PAYMENT ALLOCATED TO PATIENT AND THIRD PARTY PAYER.

6-20-103. Transparency - healthcare prices - billing practices - providers required to publish - update.

(1) (a) EVERY HEALTHCARE PROVIDER MAINTAINING A PHYSICAL PRESENCE FOR THE PURPOSE OF RECEIVING OR TREATING PATIENTS SHALL PUBLISH, IN A PUBLIC, EASY-TO-FIND, AND EASY-TO-ACCESS LOCATION, ITS FEE SCHEDULE OR CHARGEMASTER FOR THE HEALTHCARE SERVICES IT PROVIDES. THE PROVIDER SHALL MAKE THE FEE SCHEDULE OR CHARGEMASTER AVAILABLE AS FOLLOWS:

(I) <u>IN PRINTED FORM AT:</u>

(A) EACH POINT OF ADMISSION OR WAITING AREA, INCLUDING EMERGENCY ROOM ADMISSION AREAS;

(B) THE PROVIDER'S BILLING OFFICE; AND

(C) THE PROVIDER'S FINANCIAL SERVICES OR COUNSELING OFFICE, IF ANY; AND

(II) IN A NON-PROPRIETARY DOWNLOADABLE FORMAT ON THE PROVIDER'S WEBSITE. NON-PROPRIETARY MEANS FORMATTED USING COMMON STANDARDS THAT CAN BE READ AND IMPORTED INTO COMMONLY USED APPLICATIONS SUCH AS MICROSOFT EXCEL, GOOGLE SHEETS, COMMA DELIMITED FILES, OR OTHER SUCH FORMATS AS ARE IN COMMON USE BY THE PUBLIC.

(b) IF THE PROVIDER DOES NOT HAVE A WEBSITE, THE PROVIDER SHALL PROVIDE THE FEE SCHEDULE OR CHARGEMASTER TO AN INDIVIDUAL IN A NON-PROPRIETARY ELECTRONIC FORMAT UPON REQUEST. THIS MAY BE DONE IN ANY REASONABLE MANNER INCLUDING A DISC, FLASH DRIVE OR VIA EMAIL OR OTHER SUCH COMMONLY USED AND AVAIALBLE MEANS AS MAY CHANGE OVER TIME.

(c) IF A PROVIDER DELIVERS HEALTHCARE SERVICES AT A HEALTHCARE FACILITY DESCRIBED IN SECTION 6-20-102 (7)(a), (7)(b), OR (7)(c), THE PROVIDER SHALL PROVIDE HIS OR HER FEE SCHEDULE TO THE FACILITY, AND THE FACILITY SHALL POST THE PROVIDER'S FEE SCHEDULE ON THE FACILITY'S WEBSITE IN ACCORDANCE WITH SUBSECTION (1)(a)(I) AND (1)(A)(II) OF THIS SECTION.

(2) AT A MINIMUM, THE HEALTHCARE PROVIDER SHALL INCLUDE THE FOLLOWING IN THE PUBLISHED FEE SCHEDULE OR CHARGEMASTER FOR EACH HEALTHCARE SERVICE THE HEALTHCARE PROVIDER PROVIDES:

(a) A UNIQUE IDENTIFIER ASSOCIATED WITH EACH LINE ITEM IN THE FEE SCHEDULE OR CHARGEMASTER;

(b) A WRITTEN DESCRIPTION OF THE SERVICE AS IT APPEARS IN THE PROVIDER'S DATABASE OR ON ITS FEE SCHEDULE;

(c) THE CPT CODE, HCPCS CODE, DRG, APC, OR OTHER CODE AS MAY FROM TIME-TO-TIME BE CREATED FOR THE SERVICE OR, IF APPLICABLE, AN INDICATION THAT NO SUCH CODE EXISTS FOR THE SERVICE;

(d) FOR A HOSPITAL, THE UNIVERSAL BILLING CODE.

(e) THE CHARGE FOR THE SERVICE.

(3) A HEALTHCARE PROVIDER SHALL INCLUDE IN THE PUBLISHED FEE SCHEDULE OR CHARGEMASTER INFORMATION ABOUT THE PROVIDER'S BILLING POLICIES AND PRACTICES, INCLUDING WHETHER THE PROVIDER AUTHORIZES DISCOUNTS, SUCH AS FOR ADVANCE PAYMENT, FOR TIMELY PAYMENT, OR TO PARTICULAR CLASSES OF PATIENTS, AND THE BASIS FOR DETERMINING WHETHER AN INDIVIDUAL QUALIFIES FOR OR HAS SATISFIED THE REQUIREMENTS FOR OBTAINING A DISCOUNT SUCH THAT A PATIENT HAS SUFFICIENT INFORMATION TO INDEPENDENTLY DETERMINE THEIR PRICE.

(4) A PROVIDER THAT IS A HEALTHCARE FACILITY DESCRIBED IN SECTION 6-20-102(7)(A), (7)(B), (7)(C), OR (7)(D) SHALL PUBLISH A LIST OF ALL PHYSICIANS THAT PROVIDE HEALTHCARE SERVICES AT THE HEALTHCARE FACILITY. THE LIST MUST SPECIFY THE FOLLOWING FOR EACH PHYSICIAN:

(a) ANY SPECIALITIES THE PHYSICIAN HOLDS; AND

(b) THE NATURE OF THE RELATIONSHIP BETWEEN THE PHYSICIAN AND THE HEALTHCARE FACILITY, INCLUDING WHETHER THE PHYSICIAN IS EMPLOYED BY, CONTRACTED WITH, OR GRANTED PRIVILEGES BY THE HEALTHCARE FACILITY OR WHETHER THE HEALTHCARE FACILITY CONTRACTS WITH A CONTRACT MANAGEMENT COMPANY OR OTHER THIRD PARTY TO SUPPLY PARTICULAR PROVIDERS TO DELIVER SERVICES AT THE HEALTHCARE FACILITY.

(5)(a) A HEALTHCARE PROVIDER SHALL UPDATE THE INFORMATION IN ITS PUBLISHED FEE SCHEDULE OR CHARGEMASTER REQUIRED BY THIS SECTION PROMPTLY UPON ANY CHANGE IN THE INFORMATION.

(b) A HEALTHCARE PROVIDER SHALL MAINTAIN RECORDS OF ALL CHANGES IN THE CHARGES LISTED IN ITS PUBLISHED FEE SCHEDULE OR CHARGEMASTER, INCLUDING THE DATE OF THE CHANGE OF THE PARTICULAR CHARGE.

(6) IF, AT THE TIME A PATIENT RECEIVES A HEALTHCARE SERVICE FROM A HEALTHCARE PROVIDER, THE HEALTHCARE PROVIDER HAS FAILED TO PUBLISH ITS FEE SCHEDULE OR CHARGEMASTER IN ACCORDANCE WITH SUBSECTIONS (1) AND (2) OF THIS SECTION, THE HEALTHCARE PROVIDER SHALL NOT BILL THE PATIENT OR THIRD PARTY PAYER FOR THE HEALTHCARE SERVICES RENDERED TO THE PATIENT AND THE PATIENT SHALL NOT BE RESPONSIBLE FOR PAYING THE CHARGES.

6-20-105. Billing practices - itemized bill required – disclose whether provider negotiates charges.

(1) A HEALTHCARE PROVIDER SHALL INCLUDE, IN EVERY BILL PRESENTED OR TRANSMITTED TO A PATIENT FOR HEALTHCARE SERVICES RENDERED BY THE PROVIDER TO THE PATIENT, AN ITEMIZED DETAIL OF EACH HEALTHCARE SERVICE PROVIDED AND THE CHARGE FOR THE SERVICE.

(2) IF, AFTER RENDERING HEALTHCARE SERVICES TO A PATIENT, A HEALTHCARE PROVIDER NEGOTIATES THE CHARGES OR OTHERWISE DEVIATES FROM THE CHARGES PUBLISHED IN ITS FEE SCHEDULE OR CHARGEMASTER PURSUANT TO SECTION 6-20-103, THE HEALTHCARE PROVIDER MUST DISCLOSE TO ALL PATIENTS THAT ITS PUBLISHED CHARGES ARE NEGOTIABLE. A HEALTHCARE PROVIDER IS NOT OBLIGATED TO NEGOTIATE ITS CHARGES WITH ANY PATIENT, BUT A HEALTHCARE PROVIDER THAT NEGOTIATES CHARGES WITH ANY PATIENT MUST INFORM ALL PATIENTS THAT THEY HAVE A RIGHT TO ATTEMPT TO NEGOTIATE THE PROVIDER'S CHARGES. A PROVIDER CANNOT AVOID THE REQUIREMENTS OF THIS SUBSECTION (2) BY TRANSFERRING COLLECTION OF A BILL TO AN INTERNAL COLLECTION OFFICE OR TO A COLLECTION AGENCY ACTING ON THE PROVIDER'S BEHALF.

6-20-106. Provider disclosures - participation in health plans.

(1) A PROVIDER SHALL NOT CLAIM OR REPRESENT TO ANY INDIVIDUAL THAT THE PROVIDER ACCEPTS ALL HEALTH INSURANCE MERELY BECAUSE THE PROVIDER WILL BILL ANY HEALTH INSURANCE CARRIER. THE PROVIDER MUST MAKE CLEAR WHETHER OR NOT IT PARTICIPATES IN THE INSURANCE CARRIER'S NETWORK. A PROVIDER IS RESPONSIBLE FOR KNOWING WHICH INSURANCE CARRIER NETWORKS IT PARTICIPATES IN.

(2) IF AN INDIVIDUAL PROVIDES HEALTH INSURANCE INFORMATION TO A HEALTHCARE PROVIDER IN CONNECTION WITH THE DELIVERY OR PROPOSED DELIVERY OF HEALTHCARE SERVICES THE PROVIDER SHALL DISCLOSE TO THE INDIVIDUAL WHETHER:

(a) THE PROVIDER PARTICIPATES IN THE INDIVIDUAL'S HEALTH INSURANCE PLAN;

(b) THE HEALTHCARE SERVICES RENDERED OR TO BE RENDERED BY THE PROVIDER WILL BE COVERED BY THE INDIVIDUAL'S HEALTH INSURANCE AS AN IN-NETWORK OR OUT-OF-NETWORK BENEFIT; AND

(c) THE INDIVIDUAL WILL RECEIVE A HEALTHCARE SERVICE FROM AN OUT-OF-NETWORK PROVIDER AT AN -IN-NETWORK FACILITY, AND IF SO, WHETHER, UNDER SECTION 10-16-704, THE PROVIDER IS PERMITTED TO BALANCE BILL THE INDIVIDUAL PURSUANT TO SECTION 10-16-704(2), OR WHETHER THE SERVICES ARE COVERED AS AN IN-NETWORK BENEFIT AT NOT GREATER COST TO THE INDIVIDUAL PURSUANT TO SECTION 10-16-704(3).

SECTION 2. In Colorado Revised Statutes, add 10-16-147 as follows:

10-16-147. Carrier disclosures - basis of payments to providers.

(1) THE PURPOSE OF THIS SECTION IS TO:

(a) PROVIDE TRANSPARENCY REGARDING HOW INSURANCE CARRIERS (AS DEFINED IN SECTION 10-16-102) CALCULATE PAYMENTS OR REIMBURSEMENTS TO PROVIDERS FOR HEALTHCARE SERVICES FURNISHED TO COVERED PERSONS; AND

(b) ENABLE A COVERED PERSON WHO HAS RECEIVED AND BEEN BILLED FOR A HEALTHCARE SERVICE TO CALCULATE THE AMOUNT THAT THE CARRIER WILL PAY OR REIMBURSE THE PROVIDER UNDER THE TERMS OF THE APPLICABLE HEALTH COVERAGE PLAN. 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 WHICH IS TO ENSURE THAT THE PRICE CAN BE ACCURATELY CALCULATED AFTER SERVICES ARE DELIVERED.

(2) EACH CARRIER SHALL POST ON ITS WEBSITE AND PROVIDE, IN WRITING UPON REQUEST FROM A COVERED PERSON, THE FOLLOWING INFORMATION:

(a) THE SPECIFIC BASIS FOR CALCULATING THE PAYMENT OR REIMBURSEMENT TO A PROVIDER FOR A HEALTHCARE SERVICE RENDERED BY THE PROVIDER TO A COVERED PERSON UNDER THE HEALTH COVERAGE PLAN, INCLUDING:

(I) WHETHER THE PAYMENT IS BASED ON A PERCENTAGE OF THE PROVIDER'S

CHARGES, A FLAT DAILY OR PER DIEM RATE, COPAYMENTS, OR DEDUCTIBLES, OR ANY OTHER FACTOR OR SYSTEM DEVISED AND NOT LISTED HERE THAT IS USED FOR CALCULATING THE PAYMENT OR REIMBURSEMENT AMOUNT;

(II) HOW THE PAYMENT OR REIMBURSEMENT IS CALCULATED FOR A PARTICIPATING PROVIDER VERSUS A NONPARTICIPATING PROVIDER;

(b) ITEMS THAT APPEAR AS CHARGES ON AN EXPLANATION OF BENEFITS OR PROVIDER BILLING STATEMENT BUT FOR WHICH THE CARRIER DOES NOT PAY; AND

(c) DETAILED INFORMATION REGARDING COVERAGE AND NEGOTIATED PAYMENT INFORMATION BY PLAN TYPE AND PARTICIPATING PROVIDER.

(3) THE COMMISSIONER SHALL ADOPT RULES AS NECESSARY TO IMPLEMENT THIS SECTION.

SECTION 3. Transparency – drug prices – pharmacies and carriers required to publish - update.

(1) ANY ENTITY WHICH ENGAGES IN THE "PRACTICE OF PHARMACY" AS DEFINED IN SECTION 12-42.5-102 SHALL PUBLISH ITS RETAIL AND/OR LIST PRICES, WHICH SHALL BE THE PRICE CHARGED TO THE UNINSURED OR, INSURED BEFORE THE APPLICATION OF ANY DISCOUNTS OR REBATES OR OTHER FORMS OF REMUNERATION MADE BY CARRIERS (AS DEFINED IN SECTION 10-16-102).

(2) CARRIERS SHALL PUBLISH THEIR RETAIL AND/OR PRICES NET OF ANY DISCOUNTS OR REBATES OR OTHER FORMS OF REMUNERATION.

SECTION 4. In Colorado Revised Statutes, repeal article 49 of title 25.

SECTION 5. Provider-Carrier Contracts.

(1) A CONTRACT ISSUED, AMENDED, RENEWED, OR DELIVERED ON OR AFTER MARCH 31ST, 2019, BY OR ON BEHALF OF A HEALTH INSURANCE PLAN AND A HEALTH CARE PROVIDER SHALL NOT CONTAIN ANY PROVISION THAT RESTRICTS THE ABILITY OF THE HEALTH INSURANCE PLAN, THIRD PARTY PAYER, OR HEALTH CARE PROVIDER TO FURNISH PATIENTS ANY INFORMATION REQUIRED TO BE PUBLISH UNDER THIS ACT.

(2) ANY CONTRACTUAL PROVISION INCONSISTENT WITH THIS SECTION SHALL BE VOID AND UNENFORCEABLE.

SECTION 6. This act takes effect March 31st, 2019.

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