DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-2-67

CONCERNING CARRIER DISCLOSURES FOR EMERGENCY AND NON-EMERGENCY OUT-OF-NETWORK SERVICES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-704(12)(b) and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish requirements for carriers to provide disclosures concerning a covered person's financial responsibility for emergency and non-emergency services rendered by out-of-network providers.

Section 3 Applicability

This regulation applies to carriers offering individual, small group and large group health benefit plans whose members may receive services from out-of-network providers on or after January 1, 2022, which are subject to the requirements of §§ 10-16-704(3) and 10-16-704(5.5), C.R.S.

Section 4 Definitions

A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

C. "Emergency services" shall have the same meaning as found at § 10-16-704(19)(e)(I), C.R.S.

D. "Health care services" shall have the same meaning as found at § 10-16-102(33), C.R.S.

E. “Out-of-network provider” means, for the purposes of this regulation, a provider in this state that has not entered into a contract with a carrier or with its contractor or subcontractor to provide health care services to covered persons.

F. “Participating provider” shall have the same meaning as found at § 10-16-102(46), C.R.S.

G. “Preauthorization” means, for the purposes of this regulation, a pre-service or pre-treatment confirmation provided by a carrier, at the request of a covered person and/or his or her healthcare provider, indicating that the service(s) and/or treatment(s) being considered by the covered person will be covered by his or her health plan.

H. “Prior authorization” shall have the same meaning as found at § 10-16-112.5(7)(d), C.R.S.

I. “Provider” shall have the same meaning as found at § 10-16-102(56), C.R.S.

J. “Publicly available” means, for the purposes of this regulation, searchable on the carrier’s public website, displayed in a manner that is easily accessible, without barriers, and that ensures that the information is accessible to the general public, including that it is findable through public search engines. The carrier’s public website must be accessible free of charge, without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information.

Section 5 Disclosure Requirements

A. When a covered person has incurred a claim for emergency or non-emergency health care services from an out-of-network provider, and the claim is subject to the requirements of §§ 10-16- 704(3) or 10-16-704(5.5), C.R.S., the carrier shall provide the disclosure contained in Appendix A as a separate document with any explanation of benefits form (EOB) that is provided to the covered person related to the payment and/or denial of an incurred claim subject to this regulation.

B. The disclosure contained in Appendix A of this regulation shall be made publicly available on a carrier’s website in a clear and conspicuous manner.

C. Carriers shall make the disclosure contained in Appendix A available in Spanish and available in languages other than English upon request to the carrier.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective November 30, 2022.

Section 9 History

Emergency regulation effective December 20, 2019.
Regulation effective April 15, 2020.
Regulation effective November 30, 2022.

Appendix A: Emergency and Non-emergency Services Disclosure

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, please contact your insurance company at the number on your ID card, or the Division of Insurance at 303-894-7490, 1-800-930-3745, or DORA_Insurance@state.co.us.

Visit the CMS No Surprises Act website for more information about your rights under federal law.

Visit DOI Out-of-Network website for more information about your rights under Colorado state law.

Ambulance Information: Balance billing claims related to services provided by air ambulances are governed by federal law. Services provided by ground ambulances are regulated by Colorado state law and do not allow private companies to balance bill. However, you may be balance billed for emergency services you receive if the ambulance service provider is a publicly funded fire agency or if the ambulance services are for a non-emergency, such as ambulance transport between hospitals, that is not a post-stabilization service.