DEPARTMENT OF REGULATORY AGENCIES

State Board of Examiners of Nursing Home Administrators

NURSING HOME ADMINISTRATORS RULES AND REGULATIONS

3 CCR 717-1

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

…

1.16 Concerning Health Care Provider Disclosures to Consumers about the Potential Effects of Receiving Emergency or Nonemergency Services from an Out-of-Network Provider

This Rule is promulgated pursuant to sections 12-20-204, 12-30-112, and 12-265-107(1)(a), C.R.S., in consultation with the Commissioner of Insurance and the State Board of Health.

The purpose of this Rule is to establish requirements for health care providers to provide disclosures to consumers about the potential effects of receiving emergency or non-emergency services from an out-of-network provider.

This Rule applies to health care providers as defined in section 10-16-102(56), C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Publicly available" means, for the purposes of this regulation, searchable on the health care provider'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 health care provider'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.

B. Disclosure requirements.

1. An out of network provider may balance bill a covered person for post-stabilization services in accordance with section 10-16-704, C.R.S., and covered nonemergency services in an in-network facility that are not ancillary services if the provider meets the requirements set forth in section 12-30-112(3.5), C.R.S. If a consumer has incurred a claim for emergency or nonemergency health care services from an out-of-network provider, the health care provider shall provide the disclosures contained in Appendix A. The health care provider shall provide the disclosure contained in Appendix A in compliance with section 12-30-112(3.5), C.R.S.

C. Noncompliance with this Rule may result in the imposition of any of discipline made available by section 12-265-113(1)(d), C.R.S.

…

APPENDIX A

Your Rights and Protections Against Surprise Medical Bills

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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.

If you believe you've been wrongly billed by the provider, please contact the State Board of Examiners of Nursing Home Administrators at 303-894-2988 or Dora_nha@state.co.us.

Visit (www.cms.gov/nosurprises/consumers) for more information about your rights under federal law. For more information about your rights under state law, review section 12-30-112, C.R.S.

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 can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed by the provider, please contact the State Board of Examiners of Nursing Home Administrators at 303-894-2988 or Dora_nha@state.co.us. The federal phone number for information and complaints is: 1-800-985-3059.

Visit (www.cms.gov/nosurprises/consumers) for more information about your rights under federal law. Visit (https://dpo.colorado.gov/NursingHome) for more information about your rights under state law, pursuant to section 12-30-112, C.R.S.

1.

2.

Editor's Notes

History

Rules 1-6 eff. 07/30/2008.
Rules 1-7 eff. 10/30/2008.
Entire rule eff. 08/30/2009
Entire rule eff. 03/30/2010.
Entire rule eff. 07/15/2010.
Rule 2.B.1 eff. 07/01/2011.
Entire rule eff. 04/30/2012.
Entire rule eff. 09/01/2012.
Rule III.E.1.a eff. 10/30/2012.
Rules II.A.5.b-c, II.C.2.c.ii, II.C.3, II.E.1, III.C.1, III.D.3 eff. 12/30/2012.
Entire rule eff. 09/14/2013.

Rules 1.3.B.1.e, 1.3.D.1, 1.3.D.4.c eff. 05/15/2020.
Rules 1.1 Q, 1.2 B eff. 01/14/2021.
Entire rule eff. 07/15/2021.
Rule 1.4 2 eff. 11/14/2021.
Rules 1.4 B-C, 1.6, 1.8, 1.9 A.1, 1.9 C.3.b, 1.9 C.5, 1.11 eff. 12/30/2021.
Rules 1.17, 1.18 emer. rules eff. 09/14/2022.
Rules 1.8 B, 1.16, 1.17, 1.18, Appendix A eff. 10/30/2022.
Rule 1.15 A.1 eff. 12/30/2023. Rules 1.17, 1.18 repealed eff. 12/30/2023.
Rules 1.7 B-G, 1.8 B-D eff. 05/30/2025.