10-16-704. Network adequacy - rules - legislative declaration.

(1) A carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:

(a) Provider-covered person ratios by specialty, which may include the use of providers through telemedicine for services that may appropriately be provided through telemedicine;

(b) Primary care provider-covered person ratios;

(c) Geographic accessibility, which in some circumstances may require the crossing of county or state lines;

(d) Waiting times for appointments with participating providers;

(e) Hours of operation;

(f) The volume of technological and specialty services available to serve the needs of covered persons requiring covered technologically advanced or specialty care; and

(g) An adequate number of accessible acute care hospital services within a reasonable distance, travel time, or both.

(2) (a) In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

(b) (I) A carrier offering a managed care plan with out-of-network benefits, that is not a health maintenance organization or a health maintenance organization with a point of service plan, may require that a covered person travel a reasonable distance beyond the requirements of subsection (6) of this section for care within an adequate provider network in order to receive services from a participating provider. This paragraph (b) shall only apply if:

(A) The covered person resides outside of a metropolitan statistical area or primary metropolitan statistical area and the carrier has no participating providers to provide covered benefits in such geographic area; and

(B) The carrier demonstrates upon request by the commissioner, that the carrier has made unsuccessful good faith efforts to contract with local providers on reasonable terms.

(II) Subparagraph (I) of this paragraph (b) shall not apply to:

(A) Emergency services or primary care providers; and

(B) Cases in which the covered person is so severely ill or impaired that such person is unable to move from place to place without the aide of a mechanical device; has a physical or mental condition, verified by a physician licensed to practice medicine in this state or practicing medicine pursuant to section 12-36-106 (3) (i), C.R.S., that substantially limits the person's ability to move from place to place; or suffers from a physical hardship such that travel would threaten the safety or welfare of the covered person as verified by the covered

person's in-network treating physician. Decisions in which a carrier contests the covered person's ability to travel may be appealed pursuant to section 10-16-113 or 10-16-113.5.

(c) (I) In cases where, as a result of the provisions of subparagraph (I) of paragraph (b) of this subsection (2), a covered person is required to travel a reasonable distance beyond the requirements of subsection (6) of this section for an adequate network in order to receive services from a participating provider, and the covered person knowingly seeks services from a nonparticipating provider, the carrier shall be responsible to pay to the provider the lesser of:

(A) The nonparticipating provider's bill charges;

(B) A negotiated rate; or

(C) In the absence of a negotiated rate, the greater of the carrier's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area. Nothing in this paragraph (c) shall require either a carrier or a nonparticipating provider to attempt to negotiate a reimbursement rate.

(II) Upon request the carrier shall disclose to the covered person or the nonparticipating provider whether the amount reimbursed to the nonparticipating provider was the nonparticipating provider's billed charges, a negotiated rate, or the greater of the carrier's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area.

(III) A nonparticipating provider may balance bill the covered person in the event that the reimbursement rate described in subparagraph (I) of this paragraph (c) is not equal to the billed charges.

(IV) The commissioner shall promulgate rules defining the relevant geographic area for the purposes of sub-subparagraph (C) of subparagraph (I) of this paragraph (c). In the promulgation of such rules, the commissioner shall group together counties with similar demographic and economic characteristics. Such characteristics shall include, but not be limited to, average per capita income, the cost of housing, general cost of living, poverty and unemployment levels, or the primary economic base of the county.

(d) The carrier shall provide, in conspicuous, bold-faced type, an understandable disclosure in policy contract materials, certificates of coverage for a policyholder, and marketing materials about the following:

(I) Specific counties of the state where there are no participating providers;

(II) The circumstances under which the covered person may be balanced billed by nonparticipating providers; and

(III) The mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers for specific covered health care services.

(e) (I) A carrier shall make available upon request from the covered person or the nonparticipating provider, from whom the covered person is seeking treatment, the carrier's usual, customary, and reasonable rate for reimbursement for specific health care services.

(II) The commissioner may, upon receipt of one or more complaints from a covered person or a covered person's nonparticipating treating provider, review the carrier's usual, customary, and reasonable rate to determine if the rate is established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices.

(III) The carrier's methodology for determining usual, customary, and reasonable reimbursement rates shall be applied in a uniform manner statewide; except that geographic adjustments may be made apart from the standard methodology.

(f) For the purposes of this subsection (2):

(I) "Balance bill" means the amount that a nonparticipating provider may charge the covered person. Such amount charged equals the difference between the amount paid by the carrier and the amount of the nonparticipating provider's bill charge.

(II) "Negotiated rate" means the rate mutually agreed upon between the carrier and the provider in a specific instance.

(III) "Usual, customary, and reasonable rate" means a rate established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices.

(g) A health maintenance organization offering health benefits in this state may:

(I) Offer health benefit coverage in accordance with paragraph (i) of this subsection (2) to a small employer that is not located, or whose employees do not work or reside, within the health maintenance organization's geographic service area;

(II) Offer health benefit coverage in accordance with paragraph (i) of this subsection (2) in a geographic area within the carrier's service area in which a health maintenance organization is unable to maintain an adequate network and is able to demonstrate to the commissioner upon request that the carrier has made unsuccessful good faith efforts to contract with local providers on reasonable terms; or

(III) A health maintenance organization that elects to offer coverage pursuant to this paragraph (g) shall offer such coverage within a geographic area consistent with the requirements of section 10-16-105 (7.3).

(h) The health maintenance organization shall provide a disclosure to a small employer and its employees who purchase health insurance coverage under the circumstance described in this paragraph (h). Such disclosure shall also be given in writing to all interested policyholders and certificate holders as part of the sales and marketing materials before the insurer or entity approves an application for insurance from an insured. The disclosure shall contain the following statement: "Interested policyholders, certificate holders, and enrollees are hereby given notice that this small group policy requires that an insured travel outside of the geographic area to receive covered health benefits." The carrier shall, in a conspicuous location on the policy contract materials, certificates of coverage for a policyholder, and marketing materials, provide the disclosure required by this paragraph (h) in bold-faced, twelve-point type and all capital letters.

(i) (I) A health maintenance organization that offers coverage pursuant to this section may require that a covered person travel a reasonable distance beyond the area specified under subsection (6) of this section in order to receive services from a participating provider. Except for emergency services and benefits available for out-of-network services, in such cases where the covered person is required to travel a reasonable distance to receive services from a participating provider and knowingly seeks services from a nonparticipating provider, the health maintenance organization shall be responsible to pay for the lesser of:

(A) The provider's billed charges;

(B) A negotiated rate; or

(C) In the absence of a negotiated rate, the greater of the health maintenance organization's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area.

(II) Upon request, the health maintenance organization shall disclose to the covered person or the nonparticipating provider whether the amount reimbursed to the nonparticipating provider was the nonparticipating provider's billed charges, a negotiated rate, or the greater of the carrier's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area.

(j) Nothing in paragraph (i) of this subsection (2) shall require either a carrier or a nonparticipating provider to attempt to negotiate a reimbursement rate.

(k) A nonparticipating provider may balance bill the covered person in the event that the reimbursement rate described in paragraph (i) of this subsection (2) is not equal to the provider's billed charges.

(l) The provisions of paragraph (i) of this subsection (2) shall not apply to cases in which the covered person is so severely ill or impaired that such person is unable to move from place to place without the aid of a mechanical device; has a physical or mental condition, verified by a physician licensed to practice medicine in this state or practicing medicine pursuant to section 12-36-106 (3) (i), C.R.S., that substantially limits the person's ability to move from place to place; or suffers from a physical hardship such that travel would threaten the safety or welfare of the covered person as verified by the covered person's in-network treating physician. Decisions in which a carrier contests the covered person's ability to travel may be appealed pursuant to section 10-16-113 or 10-16-113.5.

(m) Notwithstanding any other provision of law, on and after September 1, 2006, for the duration of the term of a policy in effect when the insured pays the amount charged for a covered health care service and seeks reimbursement from a carrier for such covered health care service, the insured shall be liable for no more than the in-network copayment, coinsurance, and deductible for such service if:

(I) The insured seeks reimbursement from the carrier within twelve months after the provision of the service;

(II) Preauthorization is not required for the particular type of service provided; and

(III) A contract between the provider and the carrier was in place when the service was provided.

(2.5) (a) In the event of a material change to the carrier's network that could result in the application of subparagraph (I) of paragraph (b) of subsection (2) of this section, the carrier shall provide at least forty-five days prior to the change, in conspicuous bold-faced type, an understandable disclosure to all affected covered persons about the following:

(I) Specific network changes in the geographic area;

(II) The circumstances under which the covered person may be balance billed by nonparticipating providers; and

(III) The mechanisms to obtain the carrier's reimbursement rates to a nonparticipating provider for specific covered health care services.

(b) In the event of a material change to the carrier's network that could result in the application of subparagraph (I) of paragraph (b) of subsection (2) of this section, the carrier shall provide notice of the change to the commissioner at least fifteen days prior to the change. Such notice may be provided by electronic means.

(c) In the event that a network of a managed care plan with out-of-network benefits that is not a health maintenance organization or a health maintenance organization with a point of service plan changes, and notice to covered persons is provided pursuant to section 10-16-705 (7), such notice shall include an understandable disclosure of:

(I) The circumstances under which the covered person may be balance billed by nonparticipating providers; and

(II) The mechanisms to obtain the carrier's reimbursement rate to nonparticipating providers for specific covered health care services.

(d) In the event that a contract with a participating provider terminates or is terminated, notification to covered persons shall be provided pursuant to section 10-16-705 (7).

(2.7) (a) Nothing in subsection (2) or (2.5) of this section shall delay access to health care services.

(b) Nothing in subparagraph (I) of paragraph (b) of subsection (2) of this section shall exempt a carrier from having a participating provider for all covered benefits. In any case where the carrier has no participating providers to provide a covered benefit, the provisions of paragraph (a) of subsection (2) of this section shall apply.

(3) (a) (I) In 1997, the general assembly enacted this part 7 with the express intent to incorporate consumer protections into the creation and maintenance of provider networks and to establish standards to assure the adequacy, accessibility, and quality of health care services offered under a managed care plan.

(II) The general assembly hereby finds, determines, and declares that there are situations in which insured consumers receive health care services, including procedures approved by their insurance carrier, in a network facility, with a primary provider that is a network provider, but in which other health care professionals assisting with such procedures may not be in-network providers. In such situations, the consumer is not aware that the assisting providers are out-of-network providers. Further, the consumer may have little or no direct contact with the assisting health care professionals. The division of insurance has interpreted the network adequacy provisions in this section, along with the provisions related to relationships between an insurer and a health care provider in section 10-16-705, to hold the consumer harmless for additional charges from out-of-network providers for care rendered in a network facility. The division of insurance's interpretation of these statutes was challenged by an insurer and invalidated by a division of the Colorado court of appeals in *Pacific Life & Annuity Co. v. Colorado Div. of Ins.*, no. 04CA2169 (slip op.) (Feb. 23, 2006).

(III) The general assembly finds, determines, and declares that the division of insurance has correctly interpreted the provisions of this section to protect the insured from the additional expense charged by an assisting provider who is an out-of-network provider, and has properly required insurers to hold the consumer harmless. The division of insurance does not have regulatory authority over all health plans. Some consumers are enrolled in self-funded health insurance programs that are governed under the federal "Employee Retirement Income Security Act". Therefore, the general assembly encourages health care facilities, carriers, and providers to provide consumers disclosure about the potential impact of receiving services from an out-of-network provider.

(IV) The general assembly finds, determines, and declares that some consumers intentionally use out-of-network providers, which is the consumers' prerogative under certain health benefit plans. When consumers intentionally use an out-of-network provider, the consumer is only entitled to benefits at the out-of-network rate and may be subject to balance billing by the out-of-network provider.

(V) Therefore, the general assembly finds, determines, and declares that the purpose of Senate Bill 06-213 is to codify the interpretation of the division of insurance that holds consumers harmless for charges over and above the in-network rates for services rendered in a network facility.

(b) When a covered person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit. Covered services or treatment rendered at a network facility, including covered ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at a network facility, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider.

(c) Repealed.

(4) When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse. If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person.

(4.5) (a) All claims paid by a carrier shall be considered final unless adjustments are made pursuant to this subsection (4.5).

(b) Except as otherwise provided in this subsection (4.5), adjustments to claims by the provider or the carrier shall be made within the time period set out in a contract between the provider and the carrier. Such time period shall be the same for the provider and the carrier and shall not exceed twelve months after the date of the original explanation of benefits.

(c) Except as otherwise provided in this subsection (4.5), if there is no contract between a provider and a carrier, adjustments to claims paid to providers shall be made within twelve months after the date of the original explanation of benefits. The time period for adjustments shall be the same for the provider and the carrier.

(d) (I) Adjustments to claims paid under a risk assumption or risk sharing agreement shall be made within six months after the last date of service for a period for which a settlement is being reconciled. The period for which a settlement is reconciled shall not exceed twelve months.

(II) For purposes of this paragraph (d), "risk assumption" and "risk sharing" refer to a transaction whereby the chance of loss, including the expenses for the delivery of service, with respect to the health care of a person is transferred to or shared with another entity in return for full consideration. Such transactions include, but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnification agreements. Such transactions do not include fee-for-service arrangements, per diem payments, and diagnostic-related group payment agreements.

(e) Adjustments to claims related to coordination of benefits with federally funded health benefit plans, including medicare and medicaid, shall be made within thirty-six months after the date of service.

(f) A carrier shall not retroactively adjust a claim based on eligibility if the provider received verification of eligibility within two business days prior to the delivery of services.

(g) (I) (A) In circumstances where a carrier determines that a premium has not been received during a grace period required by section 10-16-202 (4) for an individual policy, the carrier may report to the provider that eligibility is contingent on payment of the premium due and that eligibility cannot be confirmed for the period that the premium is outstanding. In such cases, a carrier shall comply with the requirements of section 10-16-705 (12) (b) and (12) (c).

(B) If a carrier fails to report to the provider that eligibility is contingent on payment of premium due pursuant to sub-subparagraph (A) of this subparagraph (I), the carrier shall comply with paragraph (f) of this section.

(II) In circumstances where the provider receives information from the carrier that coverage is contingent upon receipt of a premium, the requirements of section 10-16-705 (3) shall not apply and the provider may collect payment for services from the enrollee.

(III) If the provider has collected payment from the enrollee and subsequently receives payment from the carrier, the provider shall reimburse the enrollee less any applicable copayments, deductibles, or coinsurance amounts.

(h) In circumstances where a carrier determines that a premium has not been received during a grace period required by section 10-16-214 (3) for a group policy, the carrier may report to the provider that the carrier is not required to pay for health care services rendered to an enrollee during a time in which the carrier can demonstrate that the policyholder has secured coverage with another carrier.

(i) Nothing in this subsection (4.5) shall prohibit the carrier from requiring the enrollee to reimburse the carrier for claims paid by the carrier to the provider if:

(I) A change in eligibility status has occurred making the enrollee ineligible for coverage on the date services were provided; or

(II) An enrollee has committed fraud or material misrepresentation in applying for coverage or in receiving or filing for benefits.

(j) A carrier shall not retroactively adjust a claim based on eligibility if the provision of benefits is a required policy provision pursuant to section 10-16-202 (4) or section 10-16-214 (3).

(k) Nothing in this subsection (4.5) shall be construed to require a grace period for the payment of premiums to a health maintenance organization.

(l) (I) Any adjustment made by the carrier that recovers carrier overpayments to a provider shall include a written notice to the provider and shall contain a complete and specific explanation of such adjustments and information regarding the carrier's provider dispute resolution procedures pursuant to section 10-16-705 (13). Such notice shall be made to both the provider and the enrollee to the extent that the adjustment will result in enrollee liability. Notice to the enrollee required by this paragraph (l) shall include information regarding the carrier's enrollee appeals procedure rather than the carrier's provider dispute resolution procedures.

(II) (A) For claims adjusted by the carrier due to coordination of benefits, in addition to the requirements of this paragraph (l), upon request of the provider, the carrier shall provide all available information regarding the party responsible for payment of the claim to the provider.

(B) The carrier shall provide notice to the provider with the explanation of benefits regarding the availability of the information related to the party responsible for payment of the claim.

(m) Adjustments to claims made in cases where a carrier, pursuant to section 10-1-128 (5) (a) (IV), has reported fraud or abuse committed by the provider, shall not be subject to the requirements of this subsection (4.5).

(5) A managed care plan shall not deny benefits for emergency services previously rendered, based upon the covered person's failure to provide subsequent notification in accordance with plan provisions, where the covered person's medical condition prevented timely notification.

(6) The carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to covered persons and shall only market a network plan in a geographic area where network providers are accessible without unreasonable delay. In determining whether a health carrier has complied with this subsection (6), consideration shall be given to the relative availability of health care providers in the service area under consideration.

(7) A carrier shall monitor, on an ongoing basis, the capacity and legal authority of the participating providers and facilities with which it contracts to furnish all covered benefits to covered persons.

(8) No managed care plan shall deny or restrict in-network covered benefits to a covered person solely because the covered person obtained treatment outside the network. This protection shall be disclosed in writing to the covered person. Nothing in this subsection (8) shall be construed to require a managed care plan to pay for any benefit obtained outside the plan's network unless the contract or certificate provides for that out-of-network benefit.

(9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan. The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. The access plan of a carrier offering a

managed care plan shall demonstrate the following:

(a) An adequate number of accessible acute care hospital services, within a reasonable distance or travel time, or both;

(a.3) An adequate number of accessible primary care providers within a reasonable distance or travel time, or both;

(a.5) An adequate number of accessible specialists and sub-specialists within a reasonable distance or travel time, or both, or who may be available through the use of telemedicine;

(a.7) Geographic accessibility, which in some circumstances may require the crossing of county or state lines;

(a.9) If the covered person has a pharmacy benefit, an adequate number of pharmacy providers within a reasonable distance, travel time, delivery time, or all three. Nothing in this paragraph (a.9) shall preclude the use of a retail or mail-order pharmacy provider.

(b) A carrier offering a managed care plan shall maintain procedures for making referrals within and outside its network that, at a minimum, must include the following:

(I) A comprehensive listing, made available to covered persons and primary care providers, of the plan's network participating providers and facilities;

(II) (A) A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a health maintenance organization may offer variable deductibles and copayments to encourage the selection of certain providers.

(B) A health maintenance organization that offers variable deductibles and copayments shall provide adequate and clear disclosure, as required by law, of variable deductibles and copayments to enrollees, and the amount of any deductible or copayment shall be reflected on the benefit card provided to the enrollees.

(III) Timely referrals for access to specialty care;

(IV) A process for expediting the referral process when indicated by medical condition; and

(V) (A) A provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse;

(B) A provision that referrals approved by the plan cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse.

(c) The carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans;

(d) The carrier's quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care;

(e) The carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(f) The carrier's methods for determining the health care needs of covered persons, tracking and assessing clinical outcomes from network services, and evaluating consumer satisfaction with services provided;

(g) The carrier's method for informing covered persons of the plan's services and features, including but not limited to the following:

(I) The plan's grievance procedures, which shall be in conformance with division rules concerning prompt investigation of health claims involving utilization review and grievance procedures;

(II) The extent to which specialty medical services, including physical therapy, occupational therapy, and rehabilitation services are available;

(III) The plan's process for choosing and changing network providers; and

(IV) The plan's procedures for providing and approving emergency and medical care;

(h) The carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers;

(i) The carrier's process for enabling covered persons to change primary care professionals;

(j) The carrier's proposed plan for providing continuity of care in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination or the carrier's insolvency or other cessation of operations and transferred to other providers in a timely manner.

(k) Any other information required by the commissioner to determine compliance with the provisions of this part 7.

(10) (a) In determining the reasonableness of travel time and distances for the purposes of this section, consideration shall be given to differences in travel times for rural areas as opposed to urban areas, the relative availability of health care providers, the location where the majority of people in the area access nonemergency services, and the managed care plan's good faith efforts to contract with local providers at reasonable rates.

(b) The commissioner, upon the commissioner's authority or upon review of one or more complaints, may require the carrier to demonstrate the adequacy of the network's plan as specified in subsection (9) of this section.

(c) The commissioner may utilize the remedies outlined in section 10-3-1108 for failing to provide proper disclosures to covered persons pursuant to subsection (2) or (2.5) of this section.

(11) The division of insurance, in cooperation with the chief medical officer for the state, shall evaluate a carrier's network adequacy plan concerning the use of telemedicine for providers who are specialists and sub-specialists for rural areas. Such review shall occur in a timely fashion so as not to delay access to health care services.

Source: L. 97: Entire part added, p. 1325, § 2, effective July 1. **L. 2001:** (1), (2), IP(9), (9)(a), IP(9)(b), and (9)(b)(V) amended and (2.5), (2.7), (9)(a.3), (9)(a.5), (9)(a.7), (9)(a.9), (10), and (11) added, pp. 1154, 1158, §§ 4, 5, effective January 1, 2002. **L. 2002:** (1)(c), (9)(a.7), and (9)(b)(II) amended and (2)(g) to (2)(l) added, pp. 1296, 1297, §§ 12, 13, effective January 1, 2003; (4.5) added, p. 884, § 1, effective January 1, 2003. **L. 2003:** (4.5)(m) amended, p. 618, § 20, effective July 1. **L. 2006:** (3) amended, p. 1566, § 1, effective June 2; (2)(m) added, p. 588, § 1, effective September 1. **L. 2010:** (3)(c) repealed, (SB 10-183), ch. 308, p. 1452, § 1, effective May 27.

Cross references: For the legislative declaration contained in the 2001 act amending subsections (1), (2), IP(9), (9)(a), IP(9)(b), and (9)(b)(V) and enacting subsections (2.5), (2.7), (9)(a.3), (9)(a.5), (9)(a.7), (9)(a.9), (10), and (11), see section 1 of chapter 300, Session Laws of Colorado 2001.

ANNOTATION

When an insured receives care or treatment from a nonparticipating provider at an in-network facility, there is no negotiated rate, and the nonparticipating provider is under no contractual obligation to charge a rate other than his or her normal rate, and the insurer is mandated to pay to an insured only in-network benefits. The insurer is not required to pay the nonparticipating provider's bill balance to shield the insured from making a payment above what it would make to a participating provider. Pac. Life & Annuity Co. v. Colo. Div. of Ins., 140 P.3d 181 (Colo. App. 2006).