DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

DRAFT Proposed New Regulation 4-2-101

CONCERNING PRIOR AUTHORIZATION REPORTING REQUIREMENTS AND ANNUAL ATTESTATION REQUIREMENTS

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, 10-16-112.5(6), and 10-16-124.5(3.5)(b), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements, processes, and forms to be utilized by carriers to ensure compliance with the required disclosure of prior authorization requests and exemptions pursuant to § 10-16-112.5 (2)(c)(I) and (2)(c)(IV), C.R.S. and prior authorization reporting applicable to the prescription drug formulary for each health benefit plan pursuant to § 10-16-124.5(3.5)(a), C.R.S. The regulation also requires carriers offering health benefit plans to attest to the Commissioner of Insurance compliance with these annual reporting requirements.

Section 3 Applicability

This regulation applies to all health benefit plans issued or renewed on or after January 1, 2026. If a carrier utilizes a pharmacy benefit management firm or an organization to conduct utilization reviews, the carrier is responsible for the reporting requirements of this Regulation.

Section 4 Definitions

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

B. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

C. “Market segment” means, for the purposes of this regulation, the individual, small group, large group or student health insurance coverage markets.

D. “Pharmacy benefit management firm,” “pharmacy benefit manager,” or “PBM” shall have the same meaning as found at § 10-16-102(49), C.R.S.

E. "Prescription drug" has the same meaning as found at § 12-280-103(42) C.R.S; except that the term includes only prescription drugs that are intended for human use.

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

G. SERFF means, for the purpose of this regulation, the NAIC System for Electronic Rates and Forms filings.

Section 5 Disclosure Reporting Requirements for Prior Authorization Requests

Pursuant to § 10-16-112.5(2)(c)(I), C.R.S., carriers shall post on the carrier’s public facing website, in a readily accessible, standardized, and searchable format, data regarding approvals and denials of prior authorization requests using the template in Appendix A.

On or after April 1, 2026, and no later than each April 1st thereafter, the posted data must contain the following information for the previous calendar year:

A. Categories of services requiring prior authorization which must include at least the following:

1. Medical or surgical procedure;

2. Mental health or behavioral health treatment;

3. Substance use disorder treatment;

4. Diagnostic tests and diagnostic images;

5. Prescription drugs;

6. Durable Medical Equipment (DME);

a. Pharmacy DME

b. Medical DME

7. All other health care services and drug benefits that require a prior authorization request.

B. For each of the categories specified in Section 5.A, carriers shall report:

1. Total number of prior authorization requests received;

2. Total number of prior authorization requests fully approved;

3. Total number of prior authorization requests partially approved;

4. Total number of prior authorization requests denied by the carrier based on the following categories:

    a. Incomplete information submitted by the provider to the carrier or the utilization review organization or PBM;

    b. Lack of medical necessity;

    c. Not a covered benefit;

    d. Patient did not meet prior authorization criteria;

    e. Other.

5. Total number of prior authorization requests appealed and upheld;

6. Total number of prior authorization requests appealed and reversed;

7. Total number of prior authorization requests currently in process.

C. Carriers shall not count a prior authorization request or denial more than once for purposes of this template. Carriers shall select one category per decision.

Section 6 Disclosure Reporting Requirements for Prior Authorization Exemptions

Pursuant to § 10-16-112.5(2)(c)(IV), C.R.S., carriers shall post on the carrier's public facing website, in a readily accessible, standardized, and searchable format, data on the number of exemptions from prior authorization requirements or alternatives to prior authorization requirements provided pursuant to a program adopted by the carrier pursuant to § 10-16-112.5(4)(b)(II) and 10-16-124.5(5.5), C.R.S., using the template in Appendix B.

On or after April 1, 2026, and no later than each April 1st thereafter, the posted data must contain the following information for the previous calendar year:

A. Total number of providers offered an exemption or alternative program across all provider types;

B. Total number of providers offered an exemption or alternative program based on the following specialty types:

1. Behavioral Health or Mental health;

2. Cardiology;

3. Dermatology;

4. Endocrinology;

5. Neurosurgery;

6. Obstetrics and gynecology;

7. Oncology;

8. Orthopedics;

9. Pathology;

10. Physical, Occupational, and Speech Therapy;

11. Psychiatry;

12. Rheumatology;

13. Other.

B. Total number of providers offered an exemption or alternative program across all provider types and total number of providers within each category in Section 6.B offered an exemption or alternative program based on the following:

1. Provider performance;

Based on the providers adherence to national recognized, evidence-based, medical guidelines, appropriateness, efficiency and other quality criteria determined by the carrier.

2. Provider specialty or experience.

C. Total number of providers denied an exemption or alternative program across all provider types and total number of providers within each category in Section 6.B denied an exemption or alternative program.

D. Total number of providers granted an exemption or alternative program across all providers and total number of providers granted an exemption or alternative program within each category in Section 6.B based on the following categories of type of service:

1. Prescription drug;

2. Diagnostic test;

3. Medical;

4. Durable medical equipment;

5. Mental health or behavioral health.

Section 7 Prior Authorization Requirements for Prescription Drug Formulary

Pursuant to § 10-16-124.5(3.5)(a), C.R.S., carriers shall post on the carrier's public facing website, in a readily accessible, standardized, and searchable format, prior authorization requirements applicable to the prescription drug formulary for each health benefit plan the carrier offers. The posting must contain the information specified in § 10-16-124.5(3.5)(a)(I) - (VIII), C.R.S., and be updated annually.

Section 8 Prior Authorization Annual Attestation Requirements

Pursuant to § 10-16-112.5(2)(c)(III), an annual attestation is required. The Prior Authorization Attestation Form will serve as the required documentation for prior authorization annual reporting.

A Timing

On or before May 31, 2026, and each year thereafter, a carrier that offers any health benefit plan shall submit a compliant annual prior authorization attestation to the Commissioner. In completing the Prior Authorization Attestation form, the carrier attests that the carrier has completed the review and has eliminated prior authorization requirements consistent with § 10-16-112.5(2)(c)(III), C.R.S. In addition, the carrier attests compliance with chronic health maintenance drugs provisions of § 10-16-124.5 (5)(b), C.R.S.

B. Filing Requirements

Carriers shall file the Prior Authorization Attestation Form electronically in SERFF as a form filing using the H21 TOI code and the "Annual Prior Authorization Attestation" SERFF Filing Type. The elements of Prior Authorization Attestation Form are as follows:

1. The name of the carrier;

2. A table identifying all market segments to which the attestation applies;

3. A statement attesting that the carrier has completed the requirements set forth in § 10-16-112.5 (2)(c)(III), C.R.S., and has eliminated prior authorization requirements consistent with the requirements of the statute;

4. A statement that the carrier complies with the provisions in § 10-16-124.5 (5)(b), C.R.S., for chronic health maintenance drugs;

5. The name and title of the officer signing the certification form and the date the certification form was signed. Signatures shall be dated within the sixty (60) days prior to the submission of the filing;

6. The original or valid electronic signature of the officer. Signature stamps, photocopies or a signature on behalf of the officer are not acceptable. Electronic signatures must be in compliance with § 24-71.3-101 et seq, C.R.S. and applicable regulations; and

7. If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel or an actuary that is also a corporate officer, documentation shall be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors.

Section 9 Severability

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

Section 10 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 11 Effective Date

This regulation shall be effective January 1, 2026.

Section 12 History

New regulation effective January 1, 2026.

APPENDIX A: Disclosure Reporting Template for Prior Authorization Requests

NAME OF CARRIER AND CONTACT INFORMATION:													
DATE LAST UPDATED:													
				Denials of Prior Authorization Requests						**Appeals of Prior Authorization Requests**			
Category of Service	Total PA requests received	Total PA requests fully approved	Total PA requests partially approved	Total PA requests denied	Total number of prior authorization requests denied for:					Total number of prior authorization requests::			
					Incomplete	Lack of medical necessity	Not a covered benefit	Not meet criteria	Other	Appealed and upheld	Appealed and reversed	In process	
Medical or Surgical Procedure													
Mental Health or Behavioral Health													
Substance Use Disorder Treatment													
Diagnostic tests and images													
Prescription drugs													
DME: Pharmacy													
DME: Medical													
Other													

APPENDIX B: Disclosure Reporting Template for Prior Authorization Exemptions

NAME OF CARRIER AND CONTACT INFORMATION:									
DATE LAST UPDATED:									
	Total number of providers offered an exemption or alternative program	Total number of providers offered an exemption or alternative program for prior authorization requests based on the following categories:		Total number of providers within each specialty type denied an exemption or alternative program for prior authorization requests:	Type of service for which an exemption or alternative program was granted:				
		Provider performance	Provider specialty or expertise		Prescription Drug	Diagnostic test	Medical	DME	Mental health or behavioral health
Total across all providers									
Behavioral or Mental Health									
Cardiology									
Dermatology									
Endocrinology									
Neurosurgery									
Obstetrics and gynecology									
Oncology									
Orthopedics									
Pathology									
Physical, Occupational and Speech Therapy									
Psychiatry									
Rheumatology									
All other									
Optional additional information on data clarifications									

*If an exemption is given at the practice level, the carrier should report the number of providers within the practice receiving the exemption. EX: Exemption is given to a practice with 6 providers, carriers should report the 6 providers.