First Regular Session
Sixty-ninth General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 13-0666.01 Bart Miller x2173 Christy Chase x2008 **HOUSE BILL 13-1266**

HOUSE SPONSORSHIP

McCann and Gardner,

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Aguilar,

House Committees
Health, Insurance & Environment

Senate Committees

A BILL FOR AN ACT

CONCERNING THE ALIGNMENT OF STATE HEALTH INSURANCE LAWS WITH THE REQUIREMENTS OF THE FEDERAL "PATIENT PROTECTION AND AFFORDABLE CARE ACT".

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://www.leg.state.co.us/billsummaries.)

The bill aligns the "Colorado Health Care Coverage Act" (Colorado law) with the federal "Patient Protection and Affordable Care Act of 2010" and the federal "Health Care and Education Reconciliation Act of 2010" (federal law) to give the insurance commissioner the

necessary authority to regulate health insurers with respect to new requirements of the federal law. The bill includes the following changes to Colorado law:

- Makes defined terms in Colorado law consistent with the requirements of federal law;
- Enacts the terms of Colorado's essential health benefits package;
- Conforms Colorado's current mandatory coverage provisions to the requirements of federal law;
- Requires all individual and small employer health insurance carriers selling health benefit plans in Colorado to issue and renew plans to all eligible individuals;
- Conforms Colorado law to federal law requirements for dependent health coverage for persons under 26 years of age;
- Prohibits discrimination against licensed or certified health care providers by health insurance carriers in the participation of health care providers in individual or group health benefit plans;
- Conforms Colorado law regulating health insurance rates and the filing of health insurance plans to the requirements of federal law;
- Aligns Colorado law with federal law for internal and external independent review of adverse determinations of health insurance carriers with respect to denial of benefits;
- Consistent with federal law, prohibits carriers offering individual or small employer health benefit plans from imposing any preexisting condition exclusion with respect to coverage;
- Makes wellness and prevention program requirements consistent with federal law;
- Conforms carrier network adequacy requirements to federal law; and
- Authorizes the insurance commissioner to adopt rules necessary to comply with requirements of federal law.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **amend with relocated provisions** 10-16-102 as follows:

10-16-102. Definitions. As used in this article, unless the context otherwise requires:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of part 10 of this article, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person that directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

~~(2.5)~~ (3) "Affiliation period" means a period of time, not to exceed two months, ~~three months for late enrollees,~~ during which a health maintenance organization does not collect ~~premium~~ PREMIUMS and coverage issued ~~would~~ IS not ~~become~~ YET effective.

~~(3) "Base premium rate" means, as to a rating period, the lowest premium rate charged or that could have been charged by the small employer carrier to small employers with similar case characteristics for health benefit plans subject to state insurance regulation.~~

~~(4) "Basic health benefit plan" means a health benefit plan developed pursuant to section 10-16-105 (7.2).~~

~~(5)~~ (4) "Basic health care services" means health care services that an enrolled population of a health maintenance organization organized pursuant to the provisions of part 4 of this article might reasonably require in order to maintain good health, including, ~~as~~ AT a minimum, emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services.

~~(5.3)~~ (5) "Benefits ratio" means the ratio of the value of the actual benefits, not including dividends, to the value of the actual premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. "Benefits ratio" is also known as "targeted loss ratio".

~~(5.5)~~ (6) "Bona fide association" means, with respect to health insurance coverage offered in Colorado, an association ~~which~~ THAT:

(a) Has been actively in existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association-sponsored insurance;

(c) Does not condition membership in the association on any health-status-related factor relating to an individual, including an employee of an employer or a dependent of an employee, and clearly so states in all membership and application materials;

(d) Makes health insurance coverage offered through the association available to all members regardless of any health-status-related factor relating to ~~such~~ THE members or individuals eligible for coverage through a member and clearly so states in all marketing and application materials;

(e) Does not make health insurance coverage offered through the association available other than in connection with a member of the association and clearly so states in all marketing and application materials; and

(f) Provides and annually updates information necessary for the commissioner to determine whether or not an association meets the definition of a bona fide association before qualifying as a bona fide

association for the purposes of this article.

~~(5.6)~~ (7) "Bona fide volunteer":

(a) Has the meaning set forth in section 31-30-1202, C.R.S.;

(b) Means any volunteer member of a not-for-profit nongovernmental entity that is organized to provide firefighting services, emergency medical services, or ambulance services; and

(c) Means any volunteer member of a rescue unit as defined in section 25-3.5-103, C.R.S.

~~(6) (a) "Business group of one" means, for purposes of qualification, an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works twenty-four hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application for coverage, has gross income as indicated on federal internal revenue service forms 1040, schedule C, F, or SE, or other forms recognized by the federal internal revenue service for income reporting purposes which generated gross income from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of the most recent consecutive three-year period. For the purposes of this subsection (6), "substantial part of such individual's income" means income derived from business activities of the business group of one that are sufficient to pay for annual health insurance premiums for the business group of one.~~

~~(b) "Business group of one" includes a full-time household employee who works twenty-four hours or more a week on a permanent basis as a household employee, if that employee has derived at least a~~

~~substantial part of such employee's earned income for one year out of the preceding three-year period from household employment, and if the employee's employer, on at least fifty percent of the days in a normal work week during the preceding calendar quarter, employed at least one household employee.~~

~~(c) For purposes of determining whether an applicant meets the requirements of the definition set forth in this subsection (6), a carrier may require an applicant to submit to the carrier any of the following forms of documentation that is applicable to the applicant's current business or employment:~~

~~(I) Employment-related tax and withholding information, including, but not limited to, a federal internal revenue service form 1099; and~~

~~(II) Relevant portions of federal and state tax returns or a certification by an attorney or certified public accountant that federal and state tax returns have been filed as a business.~~

~~(d) For purposes of determining whether an applicant meets the requirements of twenty-four hours or more per week on a permanent basis as set forth in this subsection (6), the commissioner shall promulgate a rule, within existing resources, to define what types of documentation may be requested by a carrier to substantiate this requirement.~~

~~(7) "Capped employees" means the number of employees and dependents with health problems at the time the plan of which such employees are a part was issued who are in small groups covered by the carrier where the small employer group would have failed the carrier's normal and actuarially-based small group underwriting criteria specifically because of the health status of those employees with health~~

~~problems at the time the plan was issued, but who were issued basic or standard health benefit plan coverage as required under section 10-16-105 (7.3) (c) regardless of the health status of the group. "Capped employees" only includes employees and dependents covered by a small employer group health benefit plan of a carrier at the time the carrier proposes to suspend its duty to issue basic or standard health benefit plan coverage as required under section 10-16-105 (7.3) (c).~~

(8) "Carrier" means any entity that provides health coverage in this state, including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to the insurance laws and ~~regulations~~ RULES of Colorado.

~~(9) (Deleted by amendment, L. 97, p. 630, § 3, effective May 1, 1997.)~~

~~(10)~~ (9) (a) "Case characteristics" means demographic characteristics ~~of a small employer~~ that are considered by the carrier in the determination of premium rates for ~~the~~ INDIVIDUALS AND small ~~employer~~ EMPLOYERS.

(b) "Case characteristics" are limited to the following demographic characteristics, AS FURTHER DEFINED AND DETERMINED BY THE COMMISSIONER BY RULE:

(I) The age of covered individuals; ~~according to the following brackets:~~

~~(A) For children who are dependents, a single bracket from newborn to nineteen years of age, unless the child is a full-time student covered as a dependent, in which case the bracket is newborn up to~~

~~twenty-four years of age;~~

~~(B) For adults and emancipated minors, age brackets in five-year intervals;~~

(II) Geographic location of the policyholder; ~~as determined by rule of the commissioner pursuant to section 10-16-104.9;~~

(III) Family size; ~~including the following size categories only:~~ AND

~~(A) One adult;~~

~~(B) One adult and any children;~~

~~(C) Two adults; and~~

~~(D) Two adults and any children;~~

(IV) ~~Smoking status and~~ TOBACCO USE.

~~(V) (Deleted by amendment, L. 2007, p. 1752, § 1, effective January 1, 2009.)~~

~~(VI) Standard industrial classification.~~

~~(VII) (Deleted by amendment, L. 2007, p. 1752, § 1, effective January 1, 2009.)~~

~~(c) Effective September 1, 2003, "case characteristics" does not include duration of coverage or any other characteristic not specifically described in paragraph (b) of this subsection (10).~~

~~(9)~~ (10) "CATASTROPHIC PLAN" MEANS AN INDIVIDUAL HEALTH BENEFIT PLAN THAT DOES NOT PROVIDE A BRONZE, SILVER, GOLD, OR PLATINUM LEVEL OF COVERAGE, AS THOSE COVERAGE LEVELS ARE DESCRIBED IN SECTION 10-16-103.4, AND IS AVAILABLE ONLY TO INDIVIDUALS UNDER THIRTY YEARS OF AGE OR WHO MEET THE ELIGIBILITY REQUIREMENTS IN FEDERAL LAW FOR PARTICIPATION IN A CATASTROPHIC PLAN.

~~(10.3)~~ (11) "Child-only plan" means a health benefit plan ~~that is~~ issued on or after April 29, 2011, ~~and~~ that provides coverage to an individual under ~~nineteen~~ TWENTY-ONE years of age. A "child-only plan" does not include coverage provided to a dependent under an individual or group health benefit plan.

~~(10.5)~~ (12) "Church plan" ~~shall have~~ HAS the same meaning as set forth in 29 U.S.C. sec. 1002 (33) of the federal "Employee Retirement Income Security Act of 1974".

~~(11) (Deleted by amendment, L. 2004, p. 980, § 3, effective August 4, 2004.)~~

~~(12)~~ (13) "Commissioner" means the commissioner of insurance.

~~(13)~~ (14) "Control" has the same meaning as set forth in section 10-3-801 (3).

~~(13.5)~~ (15) "Covered person" means a person entitled to receive benefits or services under a health coverage plan.

~~(13.7)~~ (16) "Creditable coverage" means benefits or coverage provided under:

(a) Medicare, ~~medicaid~~ THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5, C.R.S., or the children's basic health plan established pursuant to article 8 of title 25.5, C.R.S.;

(b) An employee welfare benefit plan or group health insurance or health benefit plan;

(c) An individual health benefit plan;

(d) A state health benefits risk pool; ~~(including but not limited to CoverColorado);~~ or

(e) Chapter 55 of title 10 of the United States Code, a medical care program of the federal Indian health service or of a tribal

organization, a health plan offered under chapter 89 of title 5, United States Code, a public health plan, or a health benefit plan under section 5 (e) of the federal "Peace Corps Act" 22 U.S.C. sec. 2504 (e).

~~(14)~~ (17) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent. "Dependent" ~~shall include~~ INCLUDES a designated beneficiary, as defined in section 15-22-103 (1), C.R.S., if an employer elects to cover a designated beneficiary as a dependent.

~~(15)~~ (18) (a) "Eligible employee" means ~~an~~ A FULL-TIME employee ~~who has a regular work week of twenty-four or more hours and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer. but does not include an employee who works on a temporary or substitute basis~~ IN A BONA FIDE EMPLOYER-EMPLOYEE RELATIONSHIP WITH AN EMPLOYER THAT HAS NOT BEEN ESTABLISHED FOR THE PURPOSE OF OBTAINING A SMALL GROUP PLAN. THE TERM DOES NOT INCLUDE:

(I) AN EMPLOYEE WHO WORKS ON A TEMPORARY OR SUBSTITUTE BASIS;

(II) AN INDIVIDUAL AND HIS OR HER SPOUSE WITH RESPECT TO A TRADE OR BUSINESS, WHETHER INCORPORATED OR UNINCORPORATED, THAT IS WHOLLY OWNED BY THE INDIVIDUAL OR BY THE INDIVIDUAL AND HIS OR HER SPOUSE; OR

(III) A PARTNER IN A PARTNERSHIP AND HIS OR HER SPOUSE WITH RESPECT TO THE PARTNERSHIP; EXCEPT THAT A PARTNER AND HIS OR HER

SPOUSE MAY PARTICIPATE IN A SMALL GROUP PLAN ESTABLISHED TO COVER ONE OR MORE ELIGIBLE EMPLOYEES OF THE PARTNERSHIP WHO ARE NOT PARTNERS IN THE PARTNERSHIP.

(b) Notwithstanding any provision of law to the contrary, an eligible employee of a small employer who could also be considered a dependent of the small employer ~~shall~~ MUST receive taxable income from ~~such~~ THE small employer in an amount equivalent to minimum wage for working ~~twenty-four hours per week~~ FULL-TIME on a permanent basis in order ~~for the employer group~~ to be considered ~~a business group of two or more~~ AN EMPLOYEE OF THE SMALL EMPLOYER.

(c) Nothing in this subsection ~~(15) is intended to limit~~ (18) LIMITS the employer's traditional ability to set valid and acceptable standards for employee eligibility based on the terms and conditions of employment, including a minimum weekly work requirement in excess of ~~twenty-four~~ THIRTY hours and eligibility based upon salaried versus hourly workers and management versus nonmanagement employees.

~~(15.5)~~ (19) "Emergency service provider" means a local government, or an authority formed by two or more local governments, that provides firefighting and fire prevention services, emergency medical services, ambulance services, or search and rescue services, or a not-for-profit nongovernmental entity organized for the purpose of providing any ~~such~~ OF THOSE services through the use of bona fide volunteers.

~~(16)~~ (20) "Enrollee" means:

(a) An individual who is or has been enrolled in a health maintenance organization; or

(b) An individual who is or has been enrolled in an individual or

group prepaid dental care plan as a principal subscriber ~~together with such~~ AND INCLUDES THE individual's dependents who are entitled to PREPAID dental care services under the plan solely because of their status as dependents of the principal subscriber.

~~(17)~~ (21) "Enrollee coverage" means ~~any certificate or contract~~ A HEALTH COVERAGE PLAN issued pursuant to ~~section 10-16-507~~ THIS ARTICLE to an enrollee setting out the ~~dental~~ coverage to which ~~such~~ THE enrollee is entitled UNDER THE HEALTH COVERAGE PLAN.

(22) (a) "ESSENTIAL HEALTH BENEFITS" HAS THE SAME MEANING AS SET FORTH IN SECTION 1302 (b) OF THE FEDERAL "PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010", AS AMENDED, PUB.L. 111-148;

(b) "ESSENTIAL HEALTH BENEFITS" INCLUDES:

(I) AMBULATORY PATIENT SERVICES;

(II) EMERGENCY SERVICES;

(III) HOSPITALIZATION;

(IV) LABORATORY SERVICES;

(V) MATERNITY AND NEWBORN CARE;

(VI) MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT;

(VII) PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE;

(VIII) PRESCRIPTION DRUGS;

(IX) PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT; AND

(X) REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES.

(23) "ESSENTIAL HEALTH BENEFITS PACKAGE" MEANS THE ESSENTIAL HEALTH BENEFITS PACKAGE REQUIRED UNDER SECTION 1302

(a) OF THE FEDERAL ACT AND INCLUDES COVERAGE THAT:

(a) PROVIDES FOR THE ESSENTIAL HEALTH BENEFITS;

(b) LIMITS COST-SHARING FOR THIS COVERAGE IN ACCORDANCE WITH SECTION 1302 (c) OF THE FEDERAL ACT; AND

(c) FOR INDIVIDUAL AND SMALL EMPLOYER HEALTH BENEFIT PLANS, PROVIDES BRONZE, SILVER, GOLD, OR PLATINUM LEVELS OF COVERAGE DESCRIBED IN SECTION 1302 (d) OF THE FEDERAL ACT, AS SPECIFIED IN SECTION 10-16-103.4.

~~(18)~~ (24) "Established geographic service area" means the entire state of Colorado or, for plans that do not cover the entire state, any county within which the carrier is authorized to have arrangements established with providers to provide services.

~~(19)~~ (25) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee by a health maintenance organization setting out the coverage to which the enrollee is or was entitled.

(26) "EXCHANGE" MEANS THE COLORADO HEALTH BENEFIT EXCHANGE CREATED IN ARTICLE 22 OF THIS TITLE.

~~(20)~~ (27) "Executive director" means the executive director of the department of public health and environment.

(28) "FEDERAL ACT" MEANS THE FEDERAL "PATIENT PROTECTION AND AFFORDABLE CARE ACT", PUB.L. 111-148, AS AMENDED BY THE FEDERAL "HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010", PUB.L. 111-152, AND AS MAY BE FURTHER AMENDED, INCLUDING ANY FEDERAL REGULATIONS ADOPTED UNDER THE FEDERAL ACT.

(29) "FEDERAL LAW" INCLUDES THE FEDERAL "PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010", PUB.L. 111-148, AS

AMENDED BY THE FEDERAL "HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010", PUB.L. 111-152, AND AS MAY BE FURTHER AMENDED, ALSO REFERRED TO IN THIS ARTICLE AS THE "ACA"; THE FEDERAL "PUBLIC HEALTH SERVICE ACT", AS AMENDED, 42 U.S.C. SEC. 201 ET SEQ., ALSO REFERRED TO IN THIS ARTICLE AS "PHSA"; THE FEDERAL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", AS AMENDED, PUB.L. 104-191, ALSO REFERRED TO IN THIS ARTICLE AS "HIPAA"; THE FEDERAL "EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974", AS AMENDED, 29 U.S.C. SEC. 1001 ET SEQ., ALSO REFERRED TO IN THIS ARTICLE AS "ERISA"; AND ANY FEDERAL REGULATION IMPLEMENTING THESE FEDERAL ACTS.

~~(20.5)~~ (30) "Government plan" ~~shall have~~ HAS the same meaning as set forth in 29 U.S.C. sec. 1002 (32) of the federal "Employee Retirement Income Security Act of 1974", and as in any federal governmental plan.

(31) "GRANDFATHERED HEALTH BENEFIT PLAN" MEANS A HEALTH BENEFIT PLAN PROVIDED TO AN INDIVIDUAL OR EMPLOYER BY A CARRIER ON OR BEFORE MARCH 23, 2010, FOR AS LONG AS IT MAINTAINS THAT STATUS IN ACCORDANCE WITH FEDERAL LAW AND INCLUDES ANY EXTENSION OF COVERAGE UNDER AN INDIVIDUAL OR EMPLOYER HEALTH BENEFIT PLAN THAT EXISTED ON OR BEFORE MARCH 23, 2010, TO A DEPENDENT OF AN INDIVIDUAL ENROLLED IN THE PLAN OR TO A NEW EMPLOYEE AND HIS OR HER DEPENDENTS WHO ENROLL IN THE EMPLOYER HEALTH BENEFIT PLAN. THIS ARTICLE, AS IT EXISTED PRIOR TO THE EFFECTIVE DATE OF THIS SUBSECTION (31), APPLIES TO GRANDFATHERED HEALTH BENEFIT PLANS ON AND AFTER THE EFFECTIVE DATE OF THIS SUBSECTION (31).

~~(21)~~ (32) (a) "Health benefit plan" means any hospital or medical expense policy or certificate, hospital or medical service corporation contract, or health maintenance organization subscriber contract or any other similar health contract subject to the jurisdiction of the commissioner available for use, offered, or sold in Colorado.

(b) "Health benefit plan" does not include:

(I) Accident only;

(II) Credit;

(III) Dental;

(IV) Vision;

(V) Medicare supplement;

(VI) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(VII) Disability income insurance;

(VIII) Liability insurance including general liability insurance and automobile liability insurance;

(IX) Coverage for on-site medical clinics;

(X) Coverage issued as a supplement to liability insurance, workers' compensation, or similar insurance; ~~or~~

(XI) Automobile medical payment insurance; ~~The term also excludes~~ OR

(XII) Specified disease, hospital confinement indemnity, or limited benefit health insurance if ~~such~~ THE types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(c) Solely with respect to ~~the provisions of~~ section 10-16-118, ~~(1) (b) concerning creditable coverage for individual policies, the term~~

"HEALTH BENEFIT PLAN" excludes individual short-term limited duration health insurance policies. ~~issued after January 1, 1999. This means such policies do not have to recognize creditable coverage. For the purpose of this paragraph (b), "short-term limited duration health insurance policy" means a nonrenewable individual health benefit plan with a specified duration of not more than six months that meets the following requirements:~~

~~(I) The short-term limited duration health insurance policy is issued only to individuals who have not had more than one such policy providing the same or similar nonrenewable coverage from any carrier within the past twelve months and so states in all marketing materials, application forms, and policy forms. An applicant shall be deemed to be eligible for coverage if a short-term carrier includes in its application form the following: "Have you or any other person to be insured been covered under two or more nonrenewable short-term policies during the past twelve months? If "yes", then this policy cannot be issued. You must wait six months from the date of your last such policy to apply for a short-term policy."~~

~~(II) The short-term limited duration health insurance policy contains the following disclosure in ten-point or larger bold-faced type in all marketing materials, application forms, and policy forms: "This policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health care professional, or taken prescription drugs within twelve months of the effective date of this policy will not be covered under this policy."~~

~~(22)~~ (33) "Health care services" means any services included in

OR INCIDENTAL TO the furnishing ~~to any individual~~ of medical, mental, dental, or optometric care; ~~or~~ hospitalization; or nursing home care ~~or incident to the furnishing of such care or hospitalization~~ TO AN INDIVIDUAL, as well as the furnishing to any person of any ~~and all~~ other services for the purpose of preventing, alleviating, curing, or healing human physical or mental illness or injury. "Health care services" includes the rendering of ~~such~~ THE services through the use of telemedicine.

~~(22.5)~~ (34) "Health coverage plan" means a policy, contract, certificate, or agreement entered into, ~~by~~ offered, ~~to~~ or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

~~(23)~~ (35) "Health maintenance organization" means any person who:

(a) Provides, either directly or through contractual or other arrangements with others, health care services to enrollees; and

(b) Provides, either directly or through contractual or other arrangements with other persons, health care services, including, ~~as~~ AT a minimum, ~~but not limited to,~~ emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services; and

(c) Is responsible for the availability, accessibility, and quality of the health care services provided or arranged.

~~(24)~~ (36) "Health status" means the determination by a carrier of the past, present, or expected risk of an individual or the employer due to the health conditions of THE INDIVIDUAL OR the employees of the employer.

~~(24.5)~~ (37) "Health-status-related factor" means any of the following factors:

(a) Health status;

(b) Medical condition, including both physical and mental illnesses;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(h) Disability.

~~(24.7)~~ (38) "Hearing aid" means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. "Hearing aid" ~~shall include~~ INCLUDES any parts or ear molds.

~~(25)~~ (39) "Index rate" means ~~as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate~~ THE PREMIUM RATE ESTABLISHED FOR A MARKET SEGMENT BASED ON THE TOTAL COMBINED CLAIMS COSTS FOR PROVIDING ESSENTIAL HEALTH BENEFITS WITHIN THE SINGLE RISK POOL OF THAT MARKET SEGMENT.

~~(25.5)~~ (40) "Intermediary" means a person authorized by health care providers to negotiate and execute provider contracts with carriers on behalf of such providers.

~~(26) "Late enrollee" means an eligible employee or dependent~~

~~who requests enrollment in a group health benefit plan following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:~~

~~(a) The individual:~~

~~(I) Was covered under other creditable coverage at the time of the initial enrollment period and, if required by the carrier or issuer, the employee stated at the time of initial enrollment that this was the reason for declining enrollment;~~

~~(II) Lost coverage under the other creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce, or employer contributions towards such coverage was terminated; and~~

~~(III) Requests enrollment within thirty days after termination of the other creditable coverage; or~~

~~(b) The individual is employed by an employer that offers multiple health benefit plans and elects a different plan during an open enrollment period; or~~

~~(c) A court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan and the request for enrollment is made within thirty days after issuance of such court order; or~~

~~(d) (I) A person becomes a dependent of a covered person through marriage, birth, adoption, or placement for adoption and requests enrollment no later than thirty days after becoming such a dependent. In~~

~~such case, coverage shall commence on the date the person becomes a dependent if a request for enrollment is received in a timely fashion before such date.~~

~~(II) A person who becomes a dependent of a covered person through a designated beneficiary agreement pursuant to article 22 of title 15, C.R.S., requests enrollment no later than thirty days after becoming such a dependent, and the employer of the covered person elects to cover designated beneficiaries as dependents. In such case, coverage shall commence on the date the person becomes a dependent if a request for enrollment is received in a timely fashion before said date.~~

~~(e) The parent or legal guardian of the dependent disenrolls the dependent from, or the dependent otherwise becomes ineligible for, the children's basic health plan, established pursuant to article 8 of title 25.5, C.R.S., and requests enrollment of the dependent no later than ninety days after the disenrollment.~~

~~(f) The employee or dependent is enrolled in the medical assistance program established under the "Colorado Medical Assistance Act", articles 4 to 6 of title 25.5, C.R.S., is terminated from the program as a result of loss of eligibility for the program, and requests coverage under the group health benefit plan within sixty days after the date of termination from the program.~~

~~(g) The employee or dependent becomes eligible for premium assistance under the "Colorado Medical Assistance Act", articles 4 to 6 of title 25.5, C.R.S., or the children's basic health plan established in article 8 of title 25.5, C.R.S., including under any waiver or demonstration project conducted under or in relation to such act or plan, and the employee or dependent requests coverage under the group health~~

~~benefit plan within sixty days after the date the employee or dependent is determined to be eligible for such assistance.~~

~~(26.3)~~ (41) "Licensed health care provider" ~~shall have~~ HAS the same meaning as in section 10-4-601.

~~(26.4)~~ (42) "Local government" means any city, county, city and county, special district, or other political subdivision of this state.

~~(26.5)~~ (43) "Managed care plan" means a policy, contract, certificate, or agreement offered by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services through the covered person's use of health care providers managed by, owned by, under contract with, or employed by the carrier because the carrier either requires the use of or creates incentives, including financial incentives, for the covered person's use of those providers.

~~(27) "Mandatory coverage provision" means any law requiring the coverage of a health care service or benefit. It does not include any law requiring the reimbursement, utilization, or consideration of a specific category of licensed health care practitioner if such reimbursement, utilization, or consideration does not exceed the amount authorized by an insurer in its policies and contracts pursuant to section 10-16-104 (7) (a).~~

~~(27.3)~~ (44) "Minor child" means any person under ~~the age of~~ eighteen years OF AGE.

~~(27.5)~~ (45) "Network" means a group of participating providers providing services to a managed care plan. For the purposes of part 7 of this article, any subdivision or subgrouping of a network is considered a network if covered individuals are restricted to the subdivision or subgrouping for covered benefits under the managed care plan.

~~(28) "New business premium rate" means, as to a rating period,~~

~~the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.~~

~~(28.5)~~ (46) "Participating provider" means a provider that, under a contract with a carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier.

~~(28.7)~~ (47) "Patient with diabetes" means a person with elevated blood glucose levels who has been diagnosed as having diabetes by an appropriately licensed health care professional.

~~(29)~~ (48) "Person" means any individual, partnership, association, trust, or corporation and includes ~~but is not limited to~~ any hospital licensed or certified in this state, independent practice association of physicians, or professional service corporation for the practice of medicine.

~~(29.5)~~ (49) "Pharmacy benefit management firm" means any entity doing business in this state that contracts to administer or manage prescription drug benefits on behalf of any carrier that provides prescription drug benefits to residents of this state.

~~(30)~~ (50) "Policy of sickness and accident insurance" means any policy or contract of insurance against loss or expense resulting from the sickness of the insured, ~~or from~~ the bodily injury or death of the insured by accident, or both.

~~(31)~~ (51) "Premium" means all moneys paid ~~by a small employer and eligible employees~~ as a condition of receiving coverage from a

carrier, including any fees or other contributions associated with the health benefit plan.

~~(32)~~ (52) "Prepaid dental care plan" means any contractual arrangement through an entity organized pursuant to ~~the provisions of~~ part 5 of this article to provide, either directly or through arrangements with others, dental care services to enrollees on a fixed prepayment basis or as a benefit of ~~such~~ THE enrollees' participation or membership in any other contract, agreement, or group.

~~(33)~~ (53) "Prepaid dental care plan organization" means any person who undertakes to conduct one or more prepaid dental care plans providing only dental care services.

~~(34)~~ (54) "Prepaid dental care services" means services included in the practice of dentistry, as defined in article 35 of title 12, C.R.S., THAT ARE PROVIDED TO ENROLLEES UNDER A PREPAID DENTAL CARE PLAN.

~~(35)~~ (55) "Producer" means a person licensed by the division who solicits, negotiates, effects, procures, delivers, renews, continues, services, or binds health benefit plans and is licensed to conduct these activities in Colorado.

~~(36)~~ (56) "Provider" means any physician, dentist, optometrist, anesthesiologist, hospital, X ray, laboratory and ambulance ~~services~~ SERVICE, or other person who is licensed or otherwise authorized in this state to furnish health care services.

~~(36.3) "Qualifying event" includes birth; adoption; marriage; dissolution of marriage; loss of employer-sponsored insurance; loss of eligibility under the "Colorado Medical Assistance Act", articles 4 5, and 6 of title 25.5, C.R.S.; loss of eligibility under the children's basic health plan, article 8 of title 25.5, C.R.S.; entry of a valid court or administrative~~

~~order mandating the A child be covered; or involuntary loss of other existing coverage for any reason other than fraud, misrepresentation, or failure to pay a premium.~~

~~(36.5)~~ (57) "Rate increase" means an increase in the current rate.

~~(37) (Deleted by amendment, L. 97, p. 630, § 3, effective May 1, 1997.)~~

~~(38)~~ (58) "Rating period" means the calendar period for which premium rates established by a carrier are assumed to be in effect.

~~(39)~~ (59) "Restricted network provision" means any provision of an individual or group health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

(60) "SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICY" OR "SHORT-TERM POLICY" MEANS A NONRENEWABLE INDIVIDUAL HEALTH BENEFIT PLAN WITH A SPECIFIED DURATION OF NOT MORE THAN SIX MONTHS THAT MEETS THE FOLLOWING REQUIREMENTS:

(a) THE POLICY IS ISSUED ONLY TO INDIVIDUALS WHO HAVE NOT HAD MORE THAN ONE SHORT-TERM POLICY PROVIDING THE SAME OR SIMILAR NONRENEWABLE COVERAGE FROM ANY CARRIER WITHIN THE PAST TWELVE MONTHS AND SO STATES IN ALL MARKETING MATERIALS, APPLICATION FORMS, AND POLICY FORMS. AN APPLICANT IS ELIGIBLE FOR COVERAGE IF A SHORT-TERM CARRIER INCLUDES IN ITS APPLICATION FORM THE FOLLOWING:

HAVE YOU OR ANY OTHER PERSON TO BE INSURED BEEN COVERED UNDER TWO OR MORE NONRENEWABLE SHORT-TERM POLICIES DURING THE PAST TWELVE MONTHS?

IF "YES", THEN THIS POLICY CANNOT BE ISSUED. YOU MUST WAIT SIX MONTHS FROM THE DATE OF YOUR LAST SUCH POLICY TO APPLY FOR A SHORT-TERM POLICY.

(b) THE POLICY CONTAINS THE FOLLOWING DISCLOSURE IN TEN-POINT OR LARGER, BOLD-FACED TYPE IN ALL MARKETING MATERIALS, APPLICATION FORMS, AND POLICY FORMS:

THIS POLICY DOES NOT PROVIDE PORTABILITY OF PRIOR COVERAGE. AS A RESULT, ANY INJURY, SICKNESS, OR PREGNANCY FOR WHICH YOU HAVE INCURRED CHARGES, RECEIVED MEDICAL TREATMENT, CONSULTED A HEALTH CARE PROFESSIONAL, OR TAKEN PRESCRIPTION DRUGS WITHIN TWELVE MONTHS BEFORE THE EFFECTIVE DATE OF THIS POLICY WILL NOT BE COVERED UNDER THIS POLICY.

~~(40)~~ (61) (a) (I) "Small employer" means any person, firm, corporation, partnership, or association that:

(A) Is actively engaged in business; ~~that~~

(B) ~~On at least fifty percent of its working days during the preceding calendar quarter, except as provided in section 10-16-105 (12),~~ Employed ~~no~~ AN AVERAGE OF AT LEAST ONE BUT NOT more than fifty eligible employees ~~the majority of whom were employed within this state~~ ON BUSINESS DAYS DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR, EXCEPT AS PROVIDED IN PARAGRAPH (e) OF THIS SUBSECTION (61); and ~~that~~

(C) Was not formed primarily for the purpose of purchasing insurance. ~~"Small employer" includes a business group of one.~~

(II) THIS PARAGRAPH (a) IS REPEALED, EFFECTIVE DECEMBER 31, 2015.

(b) EFFECTIVE JANUARY 1, 2016, "SMALL EMPLOYER" MEANS ANY PERSON, FIRM, CORPORATION, PARTNERSHIP, OR ASSOCIATION THAT:

(I) IS ACTIVELY ENGAGED IN BUSINESS;

(II) EMPLOYED AN AVERAGE OF AT LEAST ONE BUT NOT MORE THAN ONE HUNDRED ELIGIBLE EMPLOYEES ON BUSINESS DAYS DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR, EXCEPT AS PROVIDED IN PARAGRAPH (e) OF THIS SUBSECTION (61); AND

(III) WAS NOT FORMED PRIMARILY FOR THE PURPOSE OF PURCHASING INSURANCE.

(c) ~~In~~ FOR PURPOSES OF determining WHETHER AN EMPLOYER IS A "SMALL EMPLOYER", the number of eligible employees ~~companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer~~ IS CALCULATED USING THE METHOD SET FORTH IN 26 U.S.C. SEC. 4980h (c) (2) (E).

~~(b)~~ (d) In order to be classified as a small employer with more than one employee when only one employee enrolls in the small employer's health benefit plan, the small employer shall submit to the small employer carrier the two most recent quarterly employment and tax statements substantiating that the employer had two or more eligible employees. Such small employer group shall also meet the participation requirements of the small employer carrier.

(e) **[Formerly 10-16-105 (12)]** In the case of an employer that was not in existence throughout the preceding calendar quarter, the determination of whether ~~such~~ THE employer is a small ~~or large~~ employer ~~shall be~~ IS based on the average number of employees that THE EMPLOYER is reasonably expected ~~such employer will~~ TO employ on business days

in the current calendar year.

(f) THE FOLLOWING EMPLOYERS ARE SINGLE EMPLOYERS FOR PURPOSES OF DETERMINING THE NUMBER OF EMPLOYEES:

(I) A PERSON OR ENTITY THAT IS A SINGLE EMPLOYER PURSUANT TO 26 U.S.C. SEC. 414 (b), (c), (m), OR (o); AND

(II) AN EMPLOYER AND ANY PREDECESSOR EMPLOYER.

~~(41)~~ (62) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

~~(42)~~ (63) "Small group sickness and accident insurance", "small group plan", and "small group policy" mean that form of group sickness and accident insurance issued by an entity subject to part 2 of this article, that form of group service or indemnity type contract issued by an entity organized pursuant to ~~the provisions of~~ part 3 of this article, or that form of policy issued by an entity organized pursuant to ~~the provisions of~~ part 4 of this article ~~which~~ THAT provides coverage to small employers located in Colorado. These terms include a bona fide association plan if such plan provides coverage to one or more eligible employees of a small employer in Colorado.

~~(43) "Standard health benefit plan" means a health benefit plan developed pursuant to section 10-16-105 (7.2).~~

~~(43.5)~~ (64) "Standing referral" means a referral by the covered person's primary care provider to a specialist or specialized treatment center participating in the carrier's network for ongoing treatment of a covered person.

(65) "STUDENT HEALTH INSURANCE COVERAGE" MEANS A TYPE OF INDIVIDUAL HEALTH INSURANCE COVERAGE THAT IS PROVIDED PURSUANT

TO A WRITTEN AGREEMENT BETWEEN AN INSTITUTION OF HIGHER EDUCATION, AS DEFINED IN THE "HIGHER EDUCATION ACT OF 1965", AND A HEALTH CARRIER AND PROVIDED TO STUDENTS ENROLLED IN THAT INSTITUTION OF HIGHER EDUCATION AND THEIR DEPENDENTS, THAT:

(a) DOES NOT MAKE HEALTH INSURANCE COVERAGE AVAILABLE OTHER THAN IN CONNECTION WITH ENROLLMENT AS A STUDENT, OR AS A DEPENDENT OF A STUDENT, IN THE INSTITUTION OF HIGHER EDUCATION;

(b) DOES NOT CONDITION ELIGIBILITY FOR HEALTH INSURANCE COVERAGE ON ANY HEALTH-STATUS-RELATED FACTOR RELATED TO A STUDENT, OR A DEPENDENT OF A STUDENT; AND

(c) MEETS ANY ADDITIONAL REQUIREMENT THAT MAY BE IMPOSED BY LAW.

~~(43.7)~~ (66) "Targeted loss ratio" means the ratio of expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage to the expected earned premium over the same period. The anticipated loss ratio shall be calculated on an incurred basis as the ratio of expected incurred losses to expected earned premium.

~~(44)~~ (67) "Uncovered expenditures" means the costs of those health care services: ~~which~~

(a) THAT are covered under the health maintenance organization's health care plans but ~~which~~ are not guaranteed, insured, or assumed by a person or organization other than the health maintenance organization; or

(b) For which a provider has not agreed to hold enrollees harmless if the provider is not paid by the health maintenance organization.

(68) **[Formerly 10-16-214 (2) (b)]** ~~For purposes of this subsection (2),~~ "Valid multistate association" means an association ~~which~~ THAT has:

~~(I)~~ (a) Been in active existence for at least five years;

~~(II)~~ (b) Been organized and maintained in good faith for purposes other than ~~that of obtaining~~ TO OBTAIN insurance;

~~(III)~~ (c) A minimum of five hundred members;

~~(IV)~~ (d) A constitution, charter, or bylaws ~~which~~ THAT provide for regular meetings, at least annually, to further the purposes of the members;

~~(V)~~ (e) Collected dues or solicited contributions for members; and

~~(VI)~~ (f) Provided the members with voting privileges and representation on the governing board and committees.

~~(45)~~ (69) "Waiting period" means, with respect to a group health benefit plan and an individual that is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual, as determined by the plan sponsor, before the individual is eligible to be covered for benefits under the terms of the plan.

SECTION 2. In Colorado Revised Statutes, **add** 10-16-103.4 as follows:

10-16-103.4. Essential health benefits - requirements - rules. (1) CARRIERS OFFERING INDIVIDUAL OR SMALL GROUP HEALTH BENEFIT PLANS IN THIS STATE SHALL ENSURE THAT THE COVERAGE INCLUDES THE ESSENTIAL HEALTH BENEFITS PACKAGE. THIS SUBSECTION (1) DOES NOT APPLY TO GRANDFATHERED HEALTH BENEFIT PLANS.

(2) EXCEPT AS PROVIDED IN SUBSECTION (3) OF THIS SECTION, CARRIERS SUBJECT TO SUBSECTION (1) OF THIS SECTION SHALL OFFER HEALTH BENEFIT PLANS THAT PROVIDE AT LEAST ONE OF THE FOLLOWING LEVELS OF COVERAGE:

(a) **Bronze level.** A HEALTH BENEFIT PLAN IN THE BRONZE LEVEL

PROVIDES A LEVEL OF COVERAGE DESIGNED TO PROVIDE BENEFITS ACTUARIALLY EQUIVALENT TO SIXTY PERCENT OF THE FULL ACTUARIAL VALUE OF THE BENEFITS PROVIDED UNDER THE PLAN.

(b) **Silver level.** A HEALTH BENEFIT PLAN IN THE SILVER LEVEL PROVIDES A LEVEL OF COVERAGE DESIGNED TO PROVIDE BENEFITS ACTUARIALLY EQUIVALENT TO SEVENTY PERCENT OF THE FULL ACTUARIAL VALUE OF THE BENEFITS PROVIDED UNDER THE PLAN.

(c) **Gold level.** A HEALTH BENEFIT PLAN IN THE GOLD LEVEL PROVIDES A LEVEL OF COVERAGE DESIGNED TO PROVIDE BENEFITS ACTUARIALLY EQUIVALENT TO EIGHTY PERCENT OF THE FULL ACTUARIAL VALUE OF THE BENEFITS PROVIDED UNDER THE PLAN.

(d) **Platinum level.** A HEALTH BENEFIT PLAN IN THE PLATINUM LEVEL PROVIDES A LEVEL OF COVERAGE DESIGNED TO PROVIDE BENEFITS ACTUARIALLY EQUIVALENT TO NINETY PERCENT OF THE FULL ACTUARIAL VALUE OF THE BENEFITS PROVIDED UNDER THE PLAN.

(3) A CARRIER THAT OFFERS AN INDIVIDUAL HEALTH BENEFIT PLAN THAT DOES NOT PROVIDE A BRONZE, SILVER, GOLD, OR PLATINUM LEVEL OF COVERAGE, AS DESCRIBED IN SUBSECTION (2) OF THIS SECTION, MEETS THE REQUIREMENTS OF THIS SECTION WITH RESPECT TO ANY POLICY YEAR IF THE PLAN IS A CATASTROPHIC PLAN, AS DEFINED IN SECTION 10-16-102 (10).

(4) IF A CARRIER SUBJECT TO SUBSECTION (1) OF THIS SECTION OFFERS AN INDIVIDUAL HEALTH BENEFIT PLAN IN ANY LEVEL OF COVERAGE SPECIFIED IN SUBSECTION (2) OF THIS SECTION, THE CARRIER SHALL ALSO OFFER COVERAGE IN THAT LEVEL AS CHILD-ONLY COVERAGE.

(5) A CARRIER SUBJECT TO SUBSECTION (1) OF THIS SECTION SHALL ENSURE THAT THE ANNUAL COST-SHARING AND ANNUAL DEDUCTIBLE

LIMITATIONS IMPOSED UNDER THE HEALTH BENEFIT PLAN IT OFFERS DO NOT EXCEED THE LIMITATIONS UNDER FEDERAL LAW.

(6) **Exclusion.** THIS SECTION DOES NOT APPLY TO STAND-ALONE DENTAL PLANS OFFERED SEPARATELY OR IN CONJUNCTION WITH A HEALTH BENEFIT PLAN.

(7) THE COMMISSIONER MAY ADOPT RULES AS NECESSARY FOR THE IMPLEMENTATION AND ADMINISTRATION OF THIS SECTION.

SECTION 3. In Colorado Revised Statutes, 10-16-104, **amend** (1.3) (b) (II), (1.3) (b) (IV) introductory portion, (1.3) (d.5), (1.4) (a) (IV), (1.4) (b), (5.5), (12) (a) introductory portion, (18) (a) (I) introductory portion, (18) (a) (III), (18) (b) introductory portion, (18) (b) (III), (18) (b) (VI), (18) (b) (VIII), (18) (b) (IX), and (21) (b); **repeal** (1.7) (c); and **add** (18) (b) (X) as follows:

10-16-104. Mandatory coverage provisions - definitions - rules. (1.3) **Early intervention services.** (b) (II) (A) The coverage required by this subsection (1.3) ~~shall~~ MUST be available annually to an eligible child from birth up to the child's third birthday ~~and shall be limited to five thousand seven hundred twenty-five dollars, including case management costs,~~ for early intervention services for each dependent child per calendar or policy year. ~~For policies or contracts issued or renewed on or after January 1, 2009, and on or after each January 1 thereafter, the limit shall be adjusted by the division based on the consumer price index for the Denver-Boulder-Greeley metropolitan statistical area for the state fiscal year that ends in the preceding calendar year, or by such additional amount to be equal to the increase by the general assembly to the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program if that~~

~~increase is more than the consumer price index increase~~ THE COMMISSIONER SHALL SPECIFY, BY RULE, THE EXTENT OF THE COVERAGE FOR EARLY INTERVENTION SERVICES REQUIRED BY THIS SUBSECTION (1.3), WHICH, EXCEPT FOR GRANDFATHERED HEALTH BENEFIT PLANS, MUST REQUIRE COVERAGE OF A NUMBER OF EARLY INTERVENTION SERVICES OR VISITS THAT IS ACTUARIALLY EQUIVALENT TO THE DOLLAR LIMIT OF THE BENEFIT AS IT EXISTED PRIOR TO THE EFFECTIVE DATE OF THIS SUBPARAGRAPH (II), AS AMENDED.

(B) FOR GRANDFATHERED HEALTH BENEFIT PLANS, THE COVERAGE REQUIRED BY THIS SUBSECTION (1.3) PER CALENDAR OR POLICY YEAR FOR EARLY INTERVENTION SERVICES FOR EACH ELIGIBLE DEPENDENT CHILD FROM BIRTH UP TO THE CHILD'S THIRD BIRTHDAY IS LIMITED TO SIX THOUSAND THREE HUNDRED SIXTY-ONE DOLLARS, INCLUDING CASE MANAGEMENT COSTS. EFFECTIVE JANUARY 1, 2014, AND EACH JANUARY 1 THEREAFTER, THE COMMISSIONER SHALL ANNUALLY ADJUST THE DOLLAR LIMIT FOR EARLY INTERVENTION SERVICES COVERAGE BASED ON THE CONSUMER PRICE INDEX FOR THE DENVER-BOULDER-GREELEY METROPOLITAN STATISTICAL AREA FOR THE STATE FISCAL YEAR THAT ENDS IN THE IMMEDIATELY PRECEDING CALENDAR YEAR, OR BY AN ADDITIONAL AMOUNT EQUAL TO THE INCREASE BY THE GENERAL ASSEMBLY IN THE ANNUAL APPROPRIATED RATE TO SERVE ONE CHILD FOR ONE FISCAL YEAR IN THE STATE-FUNDED EARLY INTERVENTION PROGRAM IF THAT INCREASE IS MORE THAN THE CONSUMER PRICE INDEX INCREASE.

(IV) ~~The~~ ANY limit on the amount of coverage for early intervention services specified BY THE COMMISSIONER BY RULE PURSUANT TO SUB-SUBPARAGRAPH (A) OF SUBPARAGRAPH (II) OF THIS PARAGRAPH (b) OR, FOR GRANDFATHERED HEALTH BENEFIT PLANS, SPECIFIED in

SUB-SUBPARAGRAPH (B) OF subparagraph (II) of this paragraph (b) shall not apply to:

(d.5) (I) UPON NOTICE FROM THE DEPARTMENT OF HUMAN SERVICES PURSUANT TO SECTION 27-10.5-709 (1), C.R.S., THAT A CHILD IS ELIGIBLE FOR EARLY INTERVENTION SERVICES, THE CARRIER SHALL SUBMIT payment of benefits for ~~an~~ THE eligible child ~~shall be made~~ in accordance with THIS SUBPARAGRAPH (I) AND section 27-10.5-709 (1), C.R.S. IF THE ELIGIBLE CHILD IS COVERED BY A GRANDFATHERED HEALTH BENEFIT PLAN, THE CARRIER SHALL SUBMIT PAYMENT IN THE AMOUNT SPECIFIED IN SUB-SUBPARAGRAPH (B) OF SUBPARAGRAPH (II) OF PARAGRAPH (b) OF THIS SUBSECTION (1.3), AS ADJUSTED ANNUALLY PURSUANT TO SAID SUB-SUBPARAGRAPH. IF THE ELIGIBLE CHILD IS COVERED BY ANY OTHER POLICY OR CONTRACT SUBJECT TO THIS SUBSECTION (1.3), THE CARRIER SHALL SUBMIT PAYMENT IN AN AMOUNT THAT EQUALS THE APPROXIMATE VALUE OF THE NUMBER OF EARLY INTERVENTION SERVICES OR VISITS SPECIFIED BY THE COMMISSIONER PURSUANT TO SUB-SUBPARAGRAPH (A) OF SUBPARAGRAPH (II) OF PARAGRAPH (b) OF THIS SUBSECTION (1.3).

(II) Qualified early intervention service providers that receive reimbursement in accordance with this paragraph (d.5) shall accept ~~such~~ THE reimbursement as payment in full for services provided under this subsection (1.3) and shall not seek additional reimbursement from either the covered person or the carrier.

(1.4) **Autism spectrum disorders.** (a) As used in this subsection (1.4), unless the context otherwise requires:

(IV) "Health benefit plan", ~~shall have the same meaning as provided in section 10-16-102 (21). In addition, the term "health benefit~~

~~plan" as used in this subsection (1.4), excludes~~ DOES NOT INCLUDE:

(A) Short-term limited duration health insurance policies; ~~as defined in section 10-16-102 (21) (b). "Health benefit plan", as used in this subsection (1.4), does not include~~ OR

(B) Individual GRANDFATHERED health benefit plans.

(b) (I) ~~On or after July 1, 2010,~~ All health benefit plans issued or renewed in this state ~~shall~~ MUST provide coverage for the assessment, diagnosis, and treatment of autism spectrum disorders for a child pursuant to this subsection (1.4) ~~For a child from birth through eight years of age up to, but not including, nine years of age, the annual maximum benefit for applied behavior analysis for autism spectrum disorders required by this subsection (1.4) shall be in an amount not to exceed thirty-four thousand dollars and for a child nine years of age or older and under nineteen years of age, the annual maximum benefit for applied behavior analysis for autism spectrum disorders required by this subsection (1.4) shall be in an amount not to exceed twelve thousand dollars~~ AS PRESCRIBED BY THE COMMISSIONER BY RULE. THE RULE MUST REQUIRE COVERAGE OF A NUMBER OF SERVICES OR VISITS THAT IS ACTUARIALLY EQUIVALENT TO THE DOLLAR LIMIT OF THE BENEFIT AS IT EXISTED PRIOR TO THE EFFECTIVE DATE OF THIS PARAGRAPH (b), AS AMENDED.

(II) Nothing in this subsection (1.4): ~~shall be construed to:~~

(A) ~~Require~~ REQUIRES or ~~permit~~ PERMITS a carrier to reduce benefits provided for autism spectrum disorders if a health benefit plan already provides coverage that exceeds the requirements of this subsection (1.4) AND RULES ADOPTED BY THE COMMISSIONER;

(B) ~~Prevent~~ PREVENTS a carrier from increasing benefits provided for autism spectrum disorders; or

(C) ~~Limit~~ LIMITS coverage for physical or mental health benefits covered under a health benefit plan.

(1.7) **Therapies for congenital defects and birth abnormalities.** (c) ~~The coverage described in this subsection (1.7) is subject to the provisions of section 10-16-118 (1) (b).~~

(5.5) **Biologically based mental illness and mental disorders - rules.** (a) (I) Every ~~group policy, plan certificate, and contract of a carrier~~ HEALTH BENEFIT PLAN subject to ~~the provisions of~~ part 2, 3, or 4 of this article, except those described in section ~~10-16-102 (21) (b)~~ 10-16-102 (32) (b), ~~shall~~ MUST provide coverage for the treatment of biologically based mental illness AND MENTAL DISORDERS that is no less extensive than the coverage provided for a physical illness.

(II) ~~Every group policy, plan certificate, and contract of a carrier subject to the provisions of part 2, 3, or 4 of this article, except a small group plan, as defined in section 10-16-102 (42), and a policy or plan as described in section 10-16-102 (21) (b), shall provide coverage for the treatment of mental disorders that is no less extensive than the coverage provided for a physical illness.~~

(III) Any preauthorization or utilization review mechanism used in the determination to provide the coverage required by this paragraph (a) ~~shall~~ MUST be the same as, or no more restrictive than, that used in the determination to provide coverage for a physical illness. ~~except that a carrier that does not use utilization review mechanisms in determining whether to provide coverage for a physical illness may use utilization review mechanisms for determining whether to provide coverage for drug and alcohol disorders and eating disorders as part of the required coverage for mental disorders.~~ The commissioner shall adopt ~~such~~ rules

as ~~are~~ necessary to ~~carry out the provisions of~~ IMPLEMENT AND ADMINISTER this subsection (5.5). ~~In promulgating such rules, the commissioner shall recognize that the substance of the mechanisms for preauthorization or utilization review may differ between medical specialties, and that such mechanisms shall not be more restrictive with respect to a covered person or a mental health provider for a determination under this paragraph (a) than for any other physical illness.~~

(IV) As used in this subsection (5.5):

(A) "Biologically based mental illness" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

(B) "Mental disorder" means posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, ANOREXIA NERVOSA, BULIMIA NERVOSA, and general anxiety disorder. ~~The term includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient, day treatment, and in-patient basis, exclusive of residential treatment.~~

(b) ~~Benefits provided under this subsection (5.5) through a small group plan are not required to be provided to the extent that such benefits duplicate benefits required to be provided under subsection (5) of this section~~ THE COMMISSIONER MAY ADOPT RULES AS NECESSARY TO ENSURE THAT THIS SUBSECTION (5.5) IS IMPLEMENTED AND ADMINISTERED IN COMPLIANCE WITH FEDERAL LAW.

(c) ~~The~~ A health care service plan issued by an entity subject to ~~the provisions of~~ part 4 of this article may provide that the benefits required ~~pursuant to~~ BY this subsection (5.5) ~~shall be~~ ARE covered

benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(12) **Hospitalization and general anesthesia for dental procedures for dependent children.** (a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to ~~the provisions of~~ part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to ~~the provisions of~~ part 3 or 4 of this article, except supplemental policies that cover a specific disease or other limited benefit, ~~shall~~ MUST provide coverages for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child, as dependent is defined in section 10-16-102 ~~(14)~~ (17), of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

(18) **Preventive health care services.** (a) (I) ~~Except as specified in subparagraph (II) of this paragraph (a),~~ The following policies and contracts that are delivered, issued, renewed, or reinstated on or after January 1, 2010, ~~shall~~ MUST provide coverage for the total cost of the preventive health care services specified in paragraph (b) of this subsection (18):

(III) (A) EXCEPT AS PROVIDED IN SUB-SUBPARAGRAPH (B) OF THIS SUBPARAGRAPH (III), coverage ~~shall~~ REQUIRED BY THIS SUBSECTION (18) IS not ~~be~~ subject to policy deductibles, COPAYMENTS, or coinsurance. ~~Copayments may apply as required by the policy, contract, or other health care coverage.~~

(B) FOR PURPOSES OF GRANDFATHERED HEALTH BENEFIT PLANS, COVERAGE REQUIRED BY THIS SUBSECTION (18) IS NOT SUBJECT TO POLICY DEDUCTIBLES OR COINSURANCE. COPAYMENTS MAY APPLY AS REQUIRED BY THE GRANDFATHERED HEALTH BENEFIT PLAN.

(b) The coverage required by this subsection (18) ~~shall~~ MUST include preventive health care services for the following, in accordance with the A or B recommendations of the task force for the particular preventive health care service:

(III) (A) ONE breast cancer screening with mammography PER YEAR, COVERING THE ACTUAL CHARGE FOR THE SCREENING WITH MAMMOGRAPHY.

(B) ~~Coverage for breast cancer screening with mammography shall be the lesser of one hundred dollars per mammography screening or the actual charge for such screening but in no case shall the covered person be required to pay more than the copayment required by the policy or contract for preventive health care services. The minimum benefit required under this subparagraph (III) shall be adjusted to reflect increases and decreases in the consumer price index.~~

(C) Benefits for preventive mammography screenings ~~shall be~~ ARE determined on a calendar year or a contract year basis, which ~~shall~~ FACT MUST be specified in the policy or contract. The preventive and diagnostic coverages provided pursuant to this subparagraph (III) ~~shall in no way~~ DO NOT diminish or limit diagnostic benefits otherwise allowable under a policy ~~If a covered person who is eligible for a preventive mammography screening benefit pursuant to this subparagraph (III) has not utilized such benefit during a calendar year or a contract year, then the coverage shall apply to one diagnostic screening for that year~~ OR

CONTRACT. If THE COVERED PERSON RECEIVES more than one ~~diagnostic~~ screening ~~is provided for the covered person~~ in a given calendar year or contract year, the other ~~diagnostic service~~ benefit provisions in the policy or contract ~~shall~~ apply with respect to the additional screenings.

(D) Notwithstanding the A or B recommendations of the task force, A POLICY OR CONTRACT SUBJECT TO THIS SUBSECTION (18) MUST COVER an annual breast cancer screening with mammography ~~shall be covered~~ for all individuals possessing at least one risk factor, including ~~but not limited to,~~ a family history of breast cancer, being forty years of age or older, or a genetic predisposition to breast cancer.

(VI) CHILD HEALTH SUPERVISION SERVICES AND childhood immunizations pursuant to the schedule established by the ACIP;

(VIII) Pneumococcal vaccinations pursuant to the schedule established by the ACIP; ~~and~~

(IX) Tobacco use screening of adults and tobacco cessation interventions by primary care providers; AND

(X) (A) ANY OTHER PREVENTIVE SERVICES INCLUDED IN THE A OR B RECOMMENDATION OF THE TASK FORCE OR REQUIRED BY FEDERAL LAW.

(B) THIS SUBPARAGRAPH (X) DOES NOT APPLY TO GRANDFATHERED HEALTH BENEFIT PLANS.

(21) **Oral anticancer medication.** (b) A carrier shall not achieve compliance with this subsection (21) by imposing an increase in patient out-of-pocket costs with respect to anticancer medications used to kill or slow the growth of cancerous cells covered under a policy beyond the modifications permitted pursuant to section ~~10-16-201.5 (8)~~ 10-16-105.1 (5).

SECTION 4. In Colorado Revised Statutes, 10-16-104.3, **repeal**

(2); and **repeal and reenact, with amendments,** (1) as follows:

10-16-104.3. Health coverage for persons under twenty-six years of age - coverage for students who take medical leave of absence. (1) (a) A CARRIER THAT OFFERS A HEALTH BENEFIT PLAN IN THE STATE AND THAT MAKES DEPENDENT COVERAGE FOR CHILDREN AVAILABLE UNDER THE HEALTH BENEFIT PLAN SHALL MAKE THE COVERAGE AVAILABLE FOR A CHILD WHO IS UNDER TWENTY-SIX YEARS OF AGE. THE CARRIER SHALL NOT DENY OR RESTRICT COVERAGE FOR A CHILD WHO IS UNDER TWENTY-SIX YEARS OF AGE BASED ON A FACTOR SUCH AS:

(I) RESIDENCY WITH THE POLICYHOLDER OR ANY OTHER PERSON;

(II) THE PRESENCE OR ABSENCE OF FINANCIAL DEPENDENCE ON THE POLICYHOLDER OR ANY OTHER PERSON;

(III) MARITAL STATUS;

(IV) STUDENT STATUS;

(V) EMPLOYMENT STATUS; OR

(VI) A COMBINATION OF ANY OF THE FACTORS LISTED IN PARAGRAPHS (a) TO (d) OF THIS SUBSECTION (1).

(b) A CARRIER SHALL NOT DENY OR RESTRICT DEPENDENT COVERAGE OF A CHILD BASED ON THE CHILD'S ELIGIBILITY FOR OTHER COVERAGE.

(c) EXCEPT AS OTHERWISE PROVIDED IN STATE LAW, A CARRIER OFFERING DEPENDENT COVERAGE OF CHILDREN IN A HEALTH BENEFIT PLAN SHALL NOT VARY THE TERMS OF COVERAGE IN THE POLICY OR CONTRACT BASED ON AGE, EXCEPT FOR PREMIUM RATES FOR CHILDREN WHO ARE TWENTY-ONE YEARS OF AGE OR OLDER.

(d) NOTHING IN THIS SUBSECTION (1) REQUIRES A CARRIER TO MAKE COVERAGE AVAILABLE FOR THE CHILD OF A CHILD RECEIVING

DEPENDENT COVERAGE UNLESS THE GRANDPARENT BECOMES THE LEGAL GUARDIAN OR ADOPTIVE PARENT OF THAT GRANDCHILD.

(2) ~~The additional premium, if applicable, for a rider or supplemental policy provision offered pursuant to subsection (1) of this section, shall be paid by the parent or the policyholder, at the discretion of the policyholder.~~

SECTION 5. In Colorado Revised Statutes, 10-16-104.4, **amend** (2) (b) as follows:

10-16-104.4. Child-only plans - legislative declaration - open enrollment - reporting requirements. (2) (b) During any period of open enrollment, carriers shall offer child-only plan coverage to all applicants under ~~nineteen~~ TWENTY-ONE years of age on a guaranteed-issue basis.

SECTION 6. In Colorado Revised Statutes, **repeal and reenact, with amendments,** 10-16-105 as follows:

10-16-105. Guaranteed issuance of health insurance coverage - individual and small employer health benefit plans. (1) (a) (I) SUBJECT TO SUBSECTIONS (2) AND (4) TO (6) OF THIS SECTION, EACH CARRIER THAT OFFERS AN INDIVIDUAL HEALTH BENEFIT PLAN IN THIS STATE SHALL ISSUE ANY APPLICABLE HEALTH BENEFIT PLAN TO ANY ELIGIBLE INDIVIDUAL WHO APPLIES FOR THE PLAN AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS AND SATISFY THE OTHER REASONABLE PROVISIONS OF THE HEALTH BENEFIT PLAN CONSISTENT WITH THIS ARTICLE.

(II) DURING ANY PERIOD OF OPEN ENROLLMENT, A CARRIER SHALL OFFER CHILD-ONLY PLAN COVERAGE TO ALL APPLICANTS UNDER TWENTY-ONE YEARS OF AGE ON A GUARANTEED-ISSUANCE BASIS.

(b) (I) SUBJECT TO SUBSECTIONS (2) TO (6) OF THIS SECTION, EACH

CARRIER THAT OFFERS A SMALL EMPLOYER HEALTH BENEFIT PLAN IN THIS STATE SHALL ISSUE ANY SMALL EMPLOYER HEALTH BENEFIT PLAN TO ANY ELIGIBLE SMALL EMPLOYER THAT APPLIES FOR THE PLAN AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS AND SATISFY THE OTHER REASONABLE PROVISIONS OF THE HEALTH BENEFIT PLAN NOT INCONSISTENT WITH THIS ARTICLE.

(II) A CARRIER OFFERING SMALL EMPLOYER HEALTH BENEFIT PLANS AS DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (b):

(A) SHALL OFFER COVERAGE TO ALL OF THE ELIGIBLE EMPLOYEES OF THE ELIGIBLE SMALL EMPLOYER AND THE EMPLOYEES' DEPENDENTS, IF THE SMALL EMPLOYER OFFERS DEPENDENT COVERAGE TO ITS EMPLOYEES, WHO APPLY FOR ENROLLMENT DURING THE PERIOD IN WHICH THE EMPLOYEE FIRST BECOMES ELIGIBLE TO ENROLL UNDER THE TERMS OF THE PLAN; AND

(B) SHALL NOT OFFER COVERAGE TO ONLY CERTAIN INDIVIDUALS OR DEPENDENTS IN THE SMALL GROUP OR TO ONLY PART OF THE SMALL GROUP.

(2) A CARRIER OFFERING INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLANS:

(a) MAY RESTRICT ENROLLMENT IN AN INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLAN TO OPEN OR SPECIAL ENROLLMENT PERIODS; AND

(b) SHALL ESTABLISH SPECIAL ENROLLMENT PERIODS FOR TRIGGERING OR QUALIFYING EVENTS CONSISTENT WITH SECTION 10-16-105.7 AND IN ACCORDANCE WITH RULES ADOPTED BY THE COMMISSIONER.

(3) A CARRIER OFFERING SMALL EMPLOYER HEALTH BENEFIT

PLANS:

(a) SHALL NOT APPLY ANY WAITING PERIOD THAT EXCEEDS NINETY DAYS;

(b) SHALL APPLY ANY REQUIREMENTS IT USES TO DETERMINE WHETHER TO PROVIDE COVERAGE TO A SMALL EMPLOYER, INCLUDING REQUIREMENTS FOR MINIMUM PARTICIPATION OF ELIGIBLE EMPLOYEES AND MINIMUM EMPLOYER CONTRIBUTIONS, UNIFORMLY AMONG ALL SMALL EMPLOYERS WITH THE SAME NUMBER OF ELIGIBLE EMPLOYEES APPLYING FOR OR RECEIVING COVERAGE FROM THE SMALL EMPLOYER CARRIER;

(c) MAY VARY THE APPLICATION OF MINIMUM PARTICIPATION REQUIREMENTS AND MINIMUM EMPLOYER CONTRIBUTION REQUIREMENTS BASED ON THE SIZE OF THE SMALL EMPLOYER GROUP AND BY PRODUCT;

(d) IN APPLYING MINIMUM PARTICIPATION REQUIREMENTS WITH RESPECT TO A SMALL EMPLOYER, SHALL NOT CONSIDER EMPLOYEES OR DEPENDENTS WHO HAVE CREDITABLE GROUP COVERAGE OR INDIVIDUAL COVERAGE THAT HAS BEEN CONSISTENTLY MAINTAINED AND THAT WAS IN FORCE BEFORE THE INDIVIDUAL'S ELIGIBILITY FOR GROUP COVERAGE UNDER AN EXISTING GROUP PLAN WHEN DETERMINING WHETHER THE APPLICABLE PERCENTAGE OF PARTICIPATION IS MET. HOWEVER, A SMALL EMPLOYER CARRIER MAY CONSIDER EMPLOYEES OR DEPENDENTS OF THE SMALL EMPLOYER WHO HAVE COVERAGE UNDER ANOTHER HEALTH BENEFIT PLAN THAT IS SPONSORED BY THE SMALL EMPLOYER.

(e) SHALL NOT INCREASE ANY REQUIREMENT FOR MINIMUM EMPLOYEE PARTICIPATION OR FOR MINIMUM EMPLOYER CONTRIBUTION WITH RESPECT TO A SMALL EMPLOYER AT ANY TIME AFTER THE SMALL EMPLOYER CARRIER ACCEPTS THE SMALL EMPLOYER FOR COVERAGE.

(4) (a) SUBJECT TO PARAGRAPH (c) OF THIS SUBSECTION (4), WITH RESPECT TO COVERAGE OFFERED THROUGH A MANAGED CARE PLAN, A CARRIER IS NOT REQUIRED TO OFFER COVERAGE UNDER THAT PLAN OR ACCEPT APPLICATIONS FOR THAT PLAN PURSUANT TO SUBSECTION (1) OF THIS SECTION IN THE FOLLOWING SITUATIONS:

(I) IN AN AREA OUTSIDE OF THE CARRIER'S ESTABLISHED GEOGRAPHIC SERVICE AREA FOR THE MANAGED CARE PLAN;

(II) (A) UNDER AN INDIVIDUAL HEALTH BENEFIT PLAN, TO AN INDIVIDUAL WHEN THE INDIVIDUAL DOES NOT LIVE OR RESIDE WITHIN THE CARRIER'S ESTABLISHED GEOGRAPHIC SERVICE AREA FOR THE MANAGED CARE PLAN; OR

(B) UNDER A SMALL EMPLOYER HEALTH BENEFIT PLAN, TO AN EMPLOYEE WHEN THE EMPLOYEE DOES NOT LIVE, WORK, OR RESIDE WITHIN THE CARRIER'S ESTABLISHED GEOGRAPHIC SERVICE AREA FOR THE MANAGED CARE PLAN; OR

(III) WITHIN THE GEOGRAPHIC SERVICE AREA FOR THE MANAGED CARE PLAN WHERE THE CARRIER REASONABLY ANTICIPATES, AND DEMONSTRATES TO THE SATISFACTION OF THE COMMISSIONER, THAT IT WILL NOT HAVE THE CAPACITY WITHIN ITS ESTABLISHED GEOGRAPHIC SERVICE AREA TO DELIVER SERVICE ADEQUATELY TO ANY ADDITIONAL INDIVIDUALS AND THE MEMBERS OF THE SMALL EMPLOYER GROUPS BECAUSE OF ITS OBLIGATIONS TO EXISTING COVERED PERSONS.

(b) A CARRIER THAT CANNOT OFFER COVERAGE PURSUANT TO SUBPARAGRAPH (III) OF PARAGRAPH (a) OF THIS SUBSECTION (4) SHALL NOT OFFER COVERAGE IN THE INDIVIDUAL OR SMALL GROUP MARKET IN THE APPLICABLE GEOGRAPHIC SERVICE AREA TO NEW INDIVIDUALS OR SMALL EMPLOYER GROUPS UNTIL THE LATER OF:

(I) ONE HUNDRED EIGHTY DAYS FOLLOWING EACH REFUSAL; OR

(II) THE DATE ON WHICH THE CARRIER NOTIFIES THE COMMISSIONER THAT IT HAS REGAINED CAPACITY TO DELIVER SERVICES.

(c) A CARRIER SHALL APPLY THE REQUIREMENTS OF THIS SUBSECTION (4) UNIFORMLY TO ALL INDIVIDUALS AND SMALL EMPLOYERS IN THIS STATE CONSISTENT WITH APPLICABLE LAW AND WITHOUT REGARD TO THE CLAIMS EXPERIENCE OF OR ANY HEALTH-STATUS-RELATED FACTOR RELATING TO AN INDIVIDUAL AND HIS OR HER DEPENDENTS OR THE SMALL EMPLOYER AND ITS EMPLOYEES AND THEIR DEPENDENTS.

(5) (a) A CARRIER OFFERING INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLANS IS NOT REQUIRED TO PROVIDE COVERAGE IF:

(I) FOR ANY PERIOD OF TIME THE CARRIER DEMONSTRATES, AND THE COMMISSIONER DETERMINES, THAT THE CARRIER DOES NOT HAVE THE FINANCIAL RESERVES NECESSARY TO UNDERWRITE ADDITIONAL COVERAGE; AND

(II) THE CARRIER IS APPLYING THIS SUBSECTION (5) UNIFORMLY TO ALL INDIVIDUALS IN THE INDIVIDUAL MARKET AND TO ALL SMALL EMPLOYERS IN THE SMALL GROUP MARKET IN THIS STATE CONSISTENT WITH APPLICABLE STATE LAW AND WITHOUT REGARD TO THE CLAIMS EXPERIENCE OF OR ANY HEALTH-STATUS-RELATED FACTOR RELATING TO THE INDIVIDUAL AND HIS OR HER DEPENDENTS OR THE SMALL EMPLOYER AND ITS EMPLOYEES AND THEIR DEPENDENTS.

(b) A CARRIER THAT DENIES COVERAGE IN ACCORDANCE WITH PARAGRAPH (a) OF THIS SUBSECTION (5) SHALL NOT OFFER COVERAGE IN THE APPLICABLE INDIVIDUAL MARKET OR SMALL GROUP MARKET IN THIS STATE UNTIL THE LATER OF:

(I) ONE HUNDRED EIGHTY DAYS AFTER THE DATE THE COVERAGE

IS DENIED; OR

(II) THE DATE ON WHICH THE CARRIER DEMONSTRATES TO THE COMMISSIONER THAT IT HAS SUFFICIENT FINANCIAL RESERVES TO UNDERWRITE ADDITIONAL COVERAGE.

(6) THIS SECTION DOES NOT REQUIRE A CARRIER:

(a) OFFERING HEALTH BENEFIT PLANS ONLY IN CONNECTION WITH GROUP HEALTH PLANS TO OFFER COVERAGE IN THE INDIVIDUAL MARKET;

(b) OFFERING HEALTH BENEFIT PLANS ONLY IN CONNECTION WITH INDIVIDUAL HEALTH PLANS TO OFFER COVERAGE IN THE SMALL GROUP MARKET;

(c) OFFERING HEALTH BENEFITS PLANS ONLY THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS TO OFFER COVERAGE IN THE INDIVIDUAL MARKET. HOWEVER, IF THE CARRIER OFFERS BONA FIDE ASSOCIATION HEALTH BENEFIT PLAN COVERAGE IN THE INDIVIDUAL MARKET, THE HEALTH CARRIER SHALL OFFER THE COVERAGE TO ELIGIBLE INDIVIDUALS IN THE INDIVIDUAL MARKET AS REQUIRED UNDER PARAGRAPH (a) OF SUBSECTION (1) OF THIS SECTION; OR

(d) OFFERING ONLY STUDENT HEALTH INSURANCE COVERAGE TO OTHERWISE OFFER COVERAGE IN THE INDIVIDUAL MARKET, AS LONG AS THE CARRIER IS OFFERING STUDENT HEALTH INSURANCE COVERAGE CONSISTENT WITH THE PROVISIONS OF FEDERAL LAW.

(7) **[Formerly 10-16-104 (16)] Issuance of coverage to members of military.** (a) ALL SICKNESS AND ACCIDENT INSURANCE POLICIES AND ALL SERVICE OR INDEMNITY CONTRACTS ISSUED BY ANY ENTITY SUBJECT TO PART 3 OR 4 OF THIS ARTICLE SHALL NOT REFUSE TO PROVIDE COVERAGE TO AN INDIVIDUAL, REFUSE TO CONTINUE TO COVER AN INDIVIDUAL, OR LIMIT THE AMOUNT OR EXTENT OF COVERAGE

AVAILABLE TO AN INDIVIDUAL SOLELY BASED ON THAT INDIVIDUAL'S MEMBERSHIP IN THE UNIFORMED SERVICES OF THE UNITED STATES. NOTHING IN THIS SECTION PROHIBITS A CARRIER FROM EXCLUDING OR LIMITING COVERAGE FOR SOME OTHER FACTOR PERMITTED BY LAW.

(b) AS USED IN THIS SUBSECTION (7), UNLESS THE CONTEXT OTHERWISE REQUIRES:

(I) "MEMBERSHIP" MEANS ACTIVE DUTY, NATIONAL GUARD, OR RESERVE DUTY IN OR RETIREMENT FROM THE UNIFORMED SERVICES OF THE UNITED STATES.

(II) "UNIFORMED SERVICES OF THE UNITED STATES" MEANS THE UNITED STATES ARMY, UNITED STATES NAVY, UNITED STATES MARINE CORPS, UNITED STATES AIR FORCE, UNITED STATES COAST GUARD, NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION COMMISSIONED OFFICER CORPS, AND UNITED STATES PUBLIC HEALTH SERVICE COMMISSIONED CORPS.

(8) **Domestic partner coverage.** NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, A SMALL EMPLOYER CARRIER MAY OFFER, AND A SMALL EMPLOYER MAY ACCEPT OR REJECT, COVERAGE FOR EMPLOYEES' DOMESTIC PARTNERS AND THEIR DEPENDENTS OR FOR EMPLOYEES' DESIGNATED BENEFICIARIES AND THEIR DEPENDENTS.

SECTION 7. In Colorado Revised Statutes, **add** 10-16-105.1 as follows:

10-16-105.1. Guaranteed renewability - exceptions - individual and small employer health benefit plans - rules - repeal. (1) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (2) OF THIS SECTION, A CARRIER PROVIDING COVERAGE UNDER A HEALTH BENEFIT PLAN SHALL RENEW OR CONTINUE THE COVERAGE AT THE OPTION OF THE POLICYHOLDER.

(2) A CARRIER MAY REFUSE TO RENEW OR DISCONTINUE COVERAGE UNDER A HEALTH BENEFIT PLAN ONLY FOR THE FOLLOWING REASONS:

(a) NONPAYMENT OF THE REQUIRED PREMIUM OR FAILURE TO TIMELY PAY PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE HEALTH BENEFIT PLAN;

(b) THE POLICYHOLDER OR THE POLICYHOLDER'S REPRESENTATIVE HAS PERFORMED AN ACT OR PRACTICE THAT CONSTITUTES FRAUD OR HAS MADE AN INTENTIONAL MISREPRESENTATION OF A MATERIAL FACT UNDER THE TERMS OF COVERAGE;

(c) FOR SMALL GROUP HEALTH BENEFIT PLANS, THE POLICYHOLDER FAILS TO COMPLY WITH THE CARRIER'S MINIMUM PARTICIPATION OR EMPLOYER CONTRIBUTION REQUIREMENTS OR THE SMALL EMPLOYER IS NO LONGER ACTIVELY ENGAGED IN THE BUSINESS IN WHICH IT WAS ENGAGED ON THE EFFECTIVE DATE OF THE PLAN;

(d) IN THE CASE OF A CARRIER THAT OFFERS COVERAGE THROUGH A MANAGED CARE PLAN, THERE ARE NO LONGER ANY ENROLLED INDIVIDUALS OR EMPLOYEES LIVING, WORKING, OR RESIDING WITHIN THE CARRIER'S ESTABLISHED GEOGRAPHIC SERVICE AREA AND THE CARRIER WOULD DENY ENROLLMENT IN THE PLAN PURSUANT SECTION 10-16-105 (4) (a) (III);

(e) IN THE CASE OF AN INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLAN THAT IS MADE AVAILABLE ONLY THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS, THE MEMBERSHIP OF THE POLICYHOLDER OR SMALL EMPLOYER IN THE ASSOCIATION ON THE BASIS OF WHICH THE COVERAGE IS PROVIDED CEASES, BUT ONLY IF THE COVERAGE IS TERMINATED UNDER THIS PARAGRAPH (e) UNIFORMLY WITHOUT REGARD TO ANY HEALTH-STATUS-RELATED FACTOR RELATING TO ANY COVERED

PERSON;

(f) IN THE CASE OF INDIVIDUAL HEALTH BENEFIT PLANS THAT ARE MADE AVAILABLE AS STUDENT HEALTH INSURANCE COVERAGE, THE STUDENT POLICYHOLDER COVERED UNDER THE COVERAGE CEASES TO BE A STUDENT AT THE INSTITUTION OF HIGHER EDUCATION THROUGH WHICH THE STUDENT HEALTH INSURANCE COVERAGE IS OFFERED, AS LONG AS THE COVERAGE IS TERMINATED UNDER THIS PARAGRAPH (f) UNIFORMLY WITHOUT REGARD TO ANY HEALTH-STATUS-RELATED FACTOR RELATED TO ANY COVERED PERSON;

(g) THE CARRIER ELECTS TO DISCONTINUE OFFERING A PARTICULAR INDIVIDUAL OR SMALL GROUP HEALTH BENEFIT PLAN, BUT ONLY IF THE CARRIER:

(I) PROVIDES NOTICE OF THE DECISION NOT TO RENEW COVERAGE AT LEAST NINETY DAYS BEFORE THE NONRENEWAL OF THE HEALTH BENEFIT PLAN TO EACH POLICYHOLDER, INDIVIDUAL, CERTIFICATE HOLDER, PARTICIPANT, OR BENEFICIARY COVERED BY THE PLAN;

(II) OFFERS EACH POLICYHOLDER COVERED BY THE PLAN THE OPTION TO PURCHASE ANY OTHER HEALTH BENEFIT PLANS CURRENTLY BEING OFFERED BY THE CARRIER IN THIS STATE AND SPECIFIES THE SPECIAL ENROLLMENT PERIODS FOR THE PLANS PURSUANT TO SECTION 10-16-105.7;

(III) IN EXERCISING THE OPTION TO DISCONTINUE THAT PARTICULAR TYPE OF HEALTH BENEFIT PLAN, ACTS UNIFORMLY WITHOUT REGARD TO THE CLAIMS EXPERIENCE OF THE POLICYHOLDERS OR ANY HEALTH-STATUS-RELATED FACTOR RELATING TO ANY INDIVIDUAL, PARTICIPANT, OR BENEFICIARY COVERED BY THE PLAN OR NEW INDIVIDUALS, PARTICIPANTS, OR BENEFICIARIES WHO MAY BECOME

ELIGIBLE FOR COVERAGE;

(IV) PROVIDES NOTICE TO THE COMMISSIONER BEFORE PROVIDING THE NOTICE PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (g) AND CERTIFIES THE FOLLOWING TO THE COMMISSIONER:

(A) THE PREMIUMS FOR OTHER HEALTH BENEFIT PLANS THE CARRIER OFFERS PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH (g) ARE NOT EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY RELATIVE TO THE PLAN THAT THE CARRIER IS DISCONTINUING; AND

(B) THE BENEFIT LEVELS THE CARRIER OFFERS IN THE OTHER HEALTH BENEFIT PLANS COMPLY WITH THE REQUIREMENTS OF LAW APPLICABLE TO INDIVIDUAL AND SMALL EMPLOYER HEALTH BENEFIT PLANS; OR

(h) (I) THE CARRIER ELECTS TO DISCONTINUE OFFERING AND RENEWING ALL OF ITS INDIVIDUAL, SMALL GROUP, OR LARGE GROUP HEALTH BENEFIT PLANS DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE, BUT ONLY IF THE CARRIER:

(A) PROVIDES NOTICE OF THE DECISION TO DISCONTINUE COVERAGE, AT LEAST ONE HUNDRED EIGHTY DAYS BEFORE THE DISCONTINUANCE, TO ALL POLICYHOLDERS AND COVERED PERSONS; AND

(B) PROVIDES THE NOTICE TO THE COMMISSIONER AT LEAST THREE BUSINESS DAYS BEFORE THE DATE THE NOTICE IS SENT TO THE AFFECTED POLICYHOLDERS AND COVERED PERSONS PURSUANT TO SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (I).

(II) IN THE CASE OF A DISCONTINUANCE UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH (h), THE CARRIER SHALL:

(A) CONTINUE TO PROVIDE COVERAGE THROUGH THE FIRST RENEWAL PERIOD NOT TO EXCEED TWELVE MONTHS AFTER THE NOTICE

PROVIDED PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (h); AND

(B) NOT WRITE NEW HEALTH BENEFIT PLANS OF THE SAME TYPE AS THOSE THE CARRIER DISCONTINUED IN THIS STATE FOR FIVE YEARS AFTER THE DATE OF THE NOTICE TO THE COMMISSIONER PURSUANT TO SUB-SUBPARAGRAPH (B) OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (h).

(3) A CARRIER OFFERING INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLANS SHALL CLEARLY DISCLOSE IN ITS CONTRACTS AND MARKETING MATERIALS THE CONDITIONS OF RENEWABILITY, WHICH CONDITIONS MUST CONFORM WITH THE REQUIREMENTS OF THIS SECTION.

(4) A CARRIER OFFERING A LARGE GROUP HEALTH BENEFIT PLAN MAY MODIFY THE PLAN AT RENEWAL IF THE CARRIER MODIFIES THE PLAN UNIFORMLY FOR ALL LARGE GROUPS COVERED BY THE SAME PLAN.

(5) WITH RESPECT TO BENEFITS PROVIDED UNDER AN INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLAN, A CARRIER MAY MAKE REASONABLE MODIFICATIONS IF:

(a) THE MODIFICATION IS EFFECTIVE ONLY UPON RENEWAL OF THE PLAN;

(b) THE CARRIER MODIFIES THE BENEFITS UNIFORMLY FOR ALL INDIVIDUALS AND GROUPS COVERED BY THE PLAN;

(c) THE CARRIER PROVIDES THE PROPOSED MODIFICATION TO POLICYHOLDERS AND THE COMMISSIONER AT LEAST NINETY DAYS BEFORE THE EFFECTIVE DATE OF THE MODIFICATION; AND

(d) THE CARRIER PROVIDES EACH AFFECTED POLICYHOLDER THE OPPORTUNITY TO PURCHASE ANY OTHER HEALTH BENEFIT PLAN OFFERED BY THE CARRIER.

(6) (a) THE COMMISSIONER MAY PROMULGATE RULES AS NECESSARY TO IMPLEMENT AND ADMINISTER THIS SECTION.

(b) (I) THE COMMISSIONER MAY ADOPT RULES AS NECESSARY TO ADDRESS ISSUES RELATING TO THE RENEWABILITY OF HEALTH BENEFIT PLANS ISSUED PRIOR TO JANUARY 1, 2014, TO BUSINESS GROUPS OF ONE, AS THAT TERM WAS DEFINED IN SECTION 10-16-102 (6) PRIOR TO ITS REPEAL.

(II) THIS PARAGRAPH (b) IS REPEALED, EFFECTIVE JANUARY 1, 2015.

SECTION 8. In Colorado Revised Statutes, 10-16-105.2, **amend** (1) (a) introductory portion; and **repeal** (1) (c), (3), and (4) as follows:

10-16-105.2. Small employer health insurance availability program. (1) (a) Except as provided in paragraphs (b) ~~(c),~~ and (d) of this subsection (1), this article ~~shall apply~~ APPLIES to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(c) ~~(I) The provisions of this article concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met:~~

~~(A) As part of the application process, the carrier determines whether or not the applicant is a self-employed person who meets the definition of a business group of one pursuant to section 10-16-102 (6).~~

~~(B) If the applicant is a business group of one self-employed person, the carrier accepts or rejects such person and, if such person is~~

~~applying for family coverage, accepts or rejects the entire family unless the applicant waives coverage for a family member who has other coverage in effect.~~

~~(C) If the carrier rejects an application for a business group of one self-employed person and the carrier does business in both the individual and small group markets, the carrier shall notify the applicant of the availability of coverage through the small group market and of the availability of small group coverage through the carrier.~~

~~(D) As part of its application form, an individual carrier requires a business group of one self-employed person purchasing an individual health benefit plan pursuant to this subparagraph (I) to read and sign a disclosure form stating that, by purchasing an individual policy instead of a small group policy, such person gives up what would otherwise be his or her right to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three years after the date the individual health benefit plan is purchased, unless a small employer carrier voluntarily permits such person to purchase a business group of one policy within such three-year period. The disclosure form shall also briefly describe the factors used to set rates for the individual policy being purchased in comparison with the factors used to set rates for a business group of one small group policy. The individual carrier shall provide to the business group of one self-employed applicant a copy of the health benefit plan description form for the Colorado standard health benefit plan in addition to the description form for the individual plan being marketed. The disclosure form may be included within any other certification form that the carrier uses for the plan. The division of insurance shall make available a standard plan description~~

~~form to individual carriers upon request.~~

~~(II) Nothing in this paragraph (c) shall preclude a business group of one from applying for small group coverage.~~

~~(III) For the purposes of this paragraph (c), an individual health benefit policy shall not include one or more short-term limited duration health insurance policies issued within six months before the date of application for group coverage.~~

(3) ~~Pursuant to rules adopted by the commissioner, a small employer carrier may reject for coverage under a small group plan a business group of one self-employed person if, at the time of application for group coverage, the self-employed person has in place or, within the immediately preceding thirty days, has had in place an individual health benefit plan that meets the requirements of subparagraph (I) of paragraph (c) of subsection (1) of this section and has been in place for less than three years. An individual health benefit policy shall not include one or more short-term limited duration health insurance policies issued within six months before the date of application for group coverage.~~

(4) ~~Notwithstanding any provision of law to the contrary, a carrier may decline to renew or reenroll a business group of one that has been terminated by the carrier for nonpayment of premiums. The time period during which the carrier may so decline shall extend for up to six months after the date of termination or until the next open enrollment period, whichever is greater.~~

SECTION 9. In Colorado Revised Statutes, **add with amended and relocated provisions,** 10-16-105.6 as follows:

10-16-105.6. Rate usage. [Formerly 10-16-107 (6)] ~~(6) (a)~~ (1) A carrier offering ~~a~~ AN INDIVIDUAL OR group health benefit

plan ~~may~~ SHALL not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or, FOR GROUP PLANS, A contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health-status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

~~(b)~~ (2) The prohibition in ~~paragraph (a) of this subsection (6) shall not be construed to~~ SUBSECTION (1) OF THIS SECTION DOES NOT:

~~(I)~~ (a) Restrict the amount that A CARRIER MAY CHARGE an employer ~~may be charged~~ for coverage under a group health benefit plan; or

~~(II)~~ (b) Prevent a carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for:

~~(A)~~ (I) Adherence to programs of health promotion and disease prevention if otherwise allowed by state or federal law;

~~(B)~~ (II) Participation in a wellness and prevention program pursuant to section 10-16-136; or

~~(C)~~ (III) Satisfaction of a standard related to a health risk factor pursuant to a wellness and prevention program authorized in section 10-16-136.

(3) **[Formerly 10-16-105 (13) (a) (I)]** (a) On and after January 1, ~~2004~~ 2014, A CARRIER MAY IMPOSE ON a small employer ~~may be subject to~~ A premium ~~adjustments for health status~~ SURCHARGE OF up to thirty-five percent above the modified community rate for ~~a period no greater than~~ UP TO twelve months if the small employer has, at any time during the past twelve months, purchased health benefit coverage as a

small employer that is either self-funded or insured through a health benefit plan that is not a small group plan, except for health benefit plans sponsored by an employee leasing company, as defined in section 8-70-114 (2) (a) (V), C.R.S., pursuant to ~~sub-subparagraphs (D) to (F)~~ SUBPARAGRAPHS (II) TO (IV) of PARAGRAPH (b) OF this ~~subparagraph (I). The provisions of this subparagraph (I) shall~~ SUBSECTION (3).

(b) PARAGRAPH (a) OF THIS SUBSECTION (3) DOES not apply to:

~~(A)~~ (I) A small employer that has not previously sponsored a health benefit plan for its employees;

~~(B) A self-employed person who has not previously qualified as a business group of one;~~

~~(C) A small employer that meets the criteria of paragraph (b) of this subsection (13);~~

~~(D)~~ (II) A small employer that had previously participated in a health benefit plan through an employee leasing company, as defined in section 8-70-114 (2) (a) (V), C.R.S., if the small employer's coverage through the employee leasing company was subject to the small group laws;

~~(E)~~ (III) A small employer that had previously participated in a health benefit plan sponsored by an employee leasing company, as defined in section 8-70-114 (2) (a) (V), C.R.S., and ~~the small employer~~ THAT is no longer a party to an employee leasing company; OR

~~(F)~~ (IV) A small employer that is currently using the services of an employee leasing company, as defined in section 8-70-114 (2) (a) (V), C.R.S., that does not offer a health benefit plan as part of its employee leasing services or, because of an action by ~~an insurer~~ A CARRIER, has ceased offering a health benefit plan to employees assigned to client

locations pursuant to an employee leasing contract. ~~or~~

~~(G) A small employer that, due to a change in employment status within the state or a change in corporate structure motivated by a change in business purpose that is unrelated to health care, is no longer eligible to participate in a multiple employer welfare arrangement, and that, currently or immediately prior to seeking coverage in the small group market, participates or participated in a multiple employer welfare arrangement pursuant to part 9 of this article and that is fully insured by a licensed insurer as defined by section 10-16-901 (2).~~

(c) **[Formerly 10-16-105 (13) (a) (II)]** For ~~the~~ purposes of determining whether A CARRIER MAY IMPOSE A PREMIUM SURCHARGE PURSUANT TO THIS SUBSECTION (3) ON the small employer, ~~is eligible for the premium adjustment,~~ the carrier may require that the small employer submit ~~either of the following:~~

~~(A)~~ evidence of the SMALL EMPLOYER'S most recent health benefit coverage. ~~or~~

~~(B) In the circumstances in which the small employer does not currently sponsor a small group plan, a signed affidavit confirming that the small employer has never sponsored a group policy at any time during the past twelve months prior to applying for small group coverage, and acknowledging that failure to report such previous group coverage may result in the application of a premium adjustment for health status of up to thirty-five percent above the modified community rate for a small employer carrier.~~

(d) **[Formerly 10-16-105 (13) (d)]** A CARRIER SHALL USE the premium ~~adjustment for health status~~ SURCHARGE allowed pursuant to this subsection ~~(13) shall~~ (3) only ~~be used~~ for ~~the calculation of~~

CALCULATING premium amounts and shall not ~~be used by a small employer carrier~~ USE THE PREMIUM SURCHARGE as a basis ~~of acceptance or rejection of~~ FOR ACCEPTING OR REJECTING A SMALL EMPLOYER'S APPLICATION FOR health benefit coverage. ~~for a small employer.~~ The CARRIER SHALL NOT APPLY THE premium ~~adjustment for health status shall not apply~~ SURCHARGE to a group of more than fifty employees that subsequently becomes subject to small group coverage if ~~such~~ THE group has NOT had ~~no~~ A lapse of coverage greater than ninety days.

(4) **[Formerly 10-16-105 (14) (a)]** A SMALL EMPLOYER CARRIER MAY IMPOSE A PREMIUM SURCHARGE OF UP TO THIRTY-FIVE PERCENT ABOVE THE MODIFIED COMMUNITY RATE ON A small employer group whose small group insurance has been discontinued because of nonpayment of premiums or fraud. ~~may be subject to premium adjustments for health status of no more than thirty-five percent above the modified community rate for a~~ THE small employer carrier MAY IMPOSE THE PREMIUM SURCHARGE when the small business group reapplies for coverage in the small group market. A small employer carrier may require the increased premium to apply to the small business group for ~~a period no greater than~~ UP TO twelve months.

SECTION 10. In Colorado Revised Statutes, **add** 10-16-105.7 as follows:

10-16-105.7. Health benefit plan open enrollment periods - special enrollment periods - rules. (1) (a) A CARRIER OFFERING AN INDIVIDUAL HEALTH BENEFIT PLAN IN THIS STATE SHALL PERMIT AN INDIVIDUAL TO PURCHASE AN INDIVIDUAL HEALTH BENEFIT PLAN DURING THE INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS.

(b) THE INITIAL OPEN ENROLLMENT PERIOD BEGINS OCTOBER 1,

2013, AND EXTENDS THROUGH MARCH 31, 2014.

(c) FOR BENEFIT YEARS BEGINNING ON OR AFTER JANUARY 1, 2015, THE ANNUAL OPEN ENROLLMENT PERIOD BEGINS OCTOBER 15 AND EXTENDS THROUGH DECEMBER 7 OF THE PRECEDING CALENDAR YEAR.

(d) FOR PURPOSES OF THIS SUBSECTION (1), THE BENEFIT YEAR FOR HEALTH BENEFIT PLANS PURCHASED DURING THE INITIAL AND ANNUAL ENROLLMENT PERIODS IS A CALENDAR YEAR.

(e) THE COMMISSIONER SHALL ESTABLISH RULES IN ACCORDANCE WITH FEDERAL LAW FOR THE IMPLEMENTATION OF THIS SUBSECTION (1).

(2) (a) A CARRIER OFFERING A GROUP HEALTH BENEFIT PLAN IN THIS STATE SHALL PERMIT AN EMPLOYER TO PURCHASE A GROUP HEALTH BENEFIT PLAN AT ANY POINT DURING THE YEAR.

(b) IN THE CASE OF HEALTH BENEFIT PLANS OFFERED IN THE SMALL GROUP MARKET, A CARRIER MAY DECLINE TO OFFER COVERAGE TO A SMALL EMPLOYER THAT IS UNABLE TO COMPLY WITH A MATERIAL PLAN PROVISION RELATING TO EMPLOYER CONTRIBUTION OR GROUP PARTICIPATION RULES, AS REQUIRED BY SECTION 10-16-105 (3) (b), AND THAT CARRIER MAY LIMIT THE AVAILABILITY OF COVERAGE FOR A GROUP IT HAS DECLINED TO AN ENROLLMENT PERIOD THAT BEGINS NOVEMBER 15 AND ENDS DECEMBER 15 OF EACH YEAR OR BEGINS AND ENDS ON DATES SET BY THE COMMISSIONER BY RULE.

(c) THE COVERAGE IS EFFECTIVE CONSISTENT WITH THE DATES DETERMINED BY THE COMMISSIONER BY RULE.

(3) (a) (I) A CARRIER OFFERING AN INDIVIDUAL HEALTH BENEFIT PLAN IN THIS STATE SHALL ESTABLISH SPECIAL ENROLLMENT PERIODS DURING WHICH AN INDIVIDUAL FOR WHOM A TRIGGERING EVENT HAS OCCURRED MAY ENROLL IN AN INDIVIDUAL HEALTH BENEFIT PLAN

OFFERED BY THE CARRIER.

(II) A TRIGGERING EVENT OCCURS WHEN:

(A) AN INDIVIDUAL INVOLUNTARILY LOSES EXISTING CREDITABLE COVERAGE FOR ANY REASON OTHER THAN FRAUD, MISREPRESENTATION, OR FAILURE TO PAY A PREMIUM;

(B) AN INDIVIDUAL GAINS A DEPENDENT OR BECOMES A DEPENDENT THROUGH MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION OR BY ENTERING INTO A DESIGNATED BENEFICIARY AGREEMENT PURSUANT TO ARTICLE 22 OF TITLE 15, C.R.S.;

(C) AN INDIVIDUAL'S ENROLLMENT OR NONENROLLMENT IN A HEALTH BENEFIT PLAN IS UNINTENTIONAL, INADVERTENT, OR ERRONEOUS AND IS THE RESULT OF AN ERROR, MISREPRESENTATION, OR INACTION OF THE CARRIER, PRODUCER, OR EXCHANGE ESTABLISHED PURSUANT TO ARTICLE 22 OF THIS TITLE;

(D) AN INDIVIDUAL ADEQUATELY DEMONSTRATES TO THE COMMISSIONER THAT THE HEALTH BENEFIT PLAN IN WHICH THE INDIVIDUAL IS ENROLLED HAS SUBSTANTIALLY VIOLATED A MATERIAL PROVISION OF ITS CONTRACT IN RELATION TO THE INDIVIDUAL;

(E) THE EXCHANGE ESTABLISHED PURSUANT TO ARTICLE 22 OF THIS TITLE DETERMINES AN INDIVIDUAL TO BE NEWLY ELIGIBLE OR NEWLY INELIGIBLE FOR THE FEDERAL ADVANCE PAYMENT TAX CREDIT OR COST-SHARING REDUCTIONS AVAILABLE THROUGH THE EXCHANGE PURSUANT TO FEDERAL LAW;

(F) AN INDIVIDUAL GAINS ACCESS TO OTHER CREDITABLE COVERAGE AS A RESULT OF A PERMANENT CHANGE OF RESIDENCE; OR

(G) ANY OTHER EVENT OR CIRCUMSTANCE OCCURS AS SET FORTH IN RULES OF THE COMMISSIONER DEFINING TRIGGERING EVENTS.

(b) (I) A CARRIER OFFERING A GROUP HEALTH BENEFIT PLAN IN THIS STATE SHALL ESTABLISH SPECIAL ENROLLMENT PERIODS DURING WHICH AN INDIVIDUAL FOR WHOM A QUALIFYING EVENT HAS OCCURRED MAY ENROLL IN A GROUP HEALTH BENEFIT PLAN OFFERED BY THE CARRIER.

(II) A QUALIFYING EVENT OCCURS WHEN:

(A) AN INDIVIDUAL LOSES COVERAGE UNDER A HEALTH BENEFIT PLAN DUE TO THE DEATH OF A COVERED EMPLOYEE; THE TERMINATION OR REDUCTION IN NUMBER OF HOURS OF THE COVERED EMPLOYEE'S EMPLOYMENT; OR THE COVERED EMPLOYEE BECOMING ELIGIBLE FOR BENEFITS UNDER TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED;

(B) AN INDIVIDUAL LOSES COVERAGE UNDER A HEALTH BENEFIT PLAN DUE TO THE DIVORCE OR LEGAL SEPARATION OF THE COVERED EMPLOYEE FROM THE COVERED EMPLOYEE'S SPOUSE;

(C) AN INDIVIDUAL BECOMES A DEPENDENT OF A COVERED PERSON THROUGH MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION, BY ENTERING INTO A DESIGNATED BENEFICIARY AGREEMENT PURSUANT TO ARTICLE 22 OF TITLE 15, C.R.S., OR PURSUANT TO A COURT OR ADMINISTRATIVE ORDER MANDATING THAT THE INDIVIDUAL BE COVERED;

(D) AN INDIVIDUAL LOSES OTHER CREDITABLE COVERAGE DUE TO THE TERMINATION OF HIS OR HER EMPLOYMENT OR ELIGIBILITY FOR THE COVERAGE; REDUCTION IN NUMBER OF HOURS OF EMPLOYMENT; INVOLUNTARY TERMINATION OF COVERAGE; OR REDUCTION OR ELIMINATION OF HIS OR HER EMPLOYER'S CONTRIBUTIONS TOWARD THE COVERAGE;

(E) AN INDIVIDUAL LOSES ELIGIBILITY UNDER THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5, C.R.S., OR

THE CHILDREN'S BASIC HEALTH PLAN, ARTICLE 8 OF TITLE 25.5, C.R.S.; OR

(F) ANY OTHER EVENT OR CIRCUMSTANCE OCCURS AS SET FORTH IN RULES OF THE COMMISSIONER DEFINING QUALIFYING EVENTS.

(c) THE COMMISSIONER SHALL ADOPT RULES IN ACCORDANCE WITH FEDERAL LAW FOR THE IMPLEMENTATION OF THIS SECTION. THE COMMISSIONER MAY ADOPT RULES TO ALLOW INDIVIDUALS ENROLLED IN A HEALTH BENEFIT PLAN THROUGH AN EXCHANGE ESTABLISHED UNDER ARTICLE 22 OF THIS TITLE TO ENROLL IN OR CHANGE FROM ONE HEALTH BENEFIT PLAN TO ANOTHER UNDER CIRCUMSTANCES SPECIFIED IN THE RULES.

SECTION 11. In Colorado Revised Statutes, 10-16-106.5, **amend** (8) as follows:

10-16-106.5. Prompt payment of claims - legislative declaration - rules. (8) This section ~~shall~~ DOES not apply to ~~claims~~ A CLAIM filed:

(a) Pursuant to the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S.; OR

(b) FOR AN INDIVIDUAL ENTITLED TO A THREE-MONTH GRACE PERIOD AS DESCRIBED IN SECTION 10-16-140 (1), WHEN THE CLAIM IS FOR SERVICES RENDERED AFTER THE FIRST MONTH OF THE THREE-MONTH GRACE PERIOD. THE COMMISSIONER MAY ADOPT RULES AS NECESSARY TO IMPLEMENT AND ADMINISTER THIS PARAGRAPH (b).

SECTION 12. In Colorado Revised Statutes, **amend with relocated provisions** 10-16-107 as follows:

10-16-107. Rate filing regulation - rules - benefits ratio - rules. (1) (a) A CARRIER SUBJECT TO PART 2, 3, OR 4 OF THIS ARTICLE SHALL NOT ESTABLISH rates for any sickness, accident, or health insurance policy,

contract, certificate, or other evidence of coverage issued or delivered to any policyholder, enrollee, subscriber, or member in Colorado ~~by an insurer subject to the provisions of part 2 of this article or an entity subject to the provisions of part 3 or 4 of this article shall not be~~ THAT ARE excessive, inadequate, or unfairly discriminatory. To assure compliance with the requirements of this section that rates are not excessive in relation to benefits, the commissioner shall promulgate rules to require rate filings and, as part ~~thereof~~ OF THE RULES, may require the submission of adequate documentation and supporting information, including actuarial opinions or certifications and set expected benefits ratios. THE CARRIER SHALL SUBMIT expected rate increases ~~shall be submitted~~ to the commissioner at least sixty days prior to the proposed implementation of the rates. If the commissioner does not approve or disapprove the rate filings within a sixty-day period, the carrier may implement and reasonably rely upon the rates on the condition that the commissioner may require correction of any deficiencies in the rate filing upon later review if the rate THE CARRIER charged is excessive, inadequate, or unfairly discriminatory. A prospective rate adjustment ~~shall be~~ IS the sole remedy for rate deficiencies pursuant to this subsection (1). If the commissioner finds deficiencies in the rate filing after a sixty-day period, the commissioner shall provide notice to the carrier and the carrier shall correct the rate on a prospective basis.

(b) THE COMMISSIONER MAY REVIEW expected rate filing increases filed with the commissioner ~~on or after June 5, 2008, may be reviewed by the commissioner~~ and shall ~~be disapproved and resubmitted~~ DISAPPROVE THE RATE INCREASE AND REQUIRE THE CARRIER TO RESUBMIT for approval if any of the provisions of subsection ~~(1.6)~~ (3) of this section apply. Rate

filings that do not involve a requested rate increase, or THAT INVOLVE a requested rate increase of less than five percent for dental insurance, ~~shall~~ DO not require preapproval, and THE CARRIER may ~~be implemented~~ IMPLEMENT THE RATE upon filing with the commissioner.

(c) The filing requirements of this subsection (1) ~~shall~~ DO not apply to nondeveloped rates, including ~~but not limited to,~~ rates for medicaid, medicare, and the children's basic health plan, as defined by the commissioner.

(d) ~~Failure~~ IF THE CARRIER FAILS to supply the information required by this section, ~~will render~~ the filing IS incomplete. The commissioner shall make a determination of completeness no later than thirty days following submission of the filing for review. All filings not returned on or before the thirtieth day after receipt ~~will be~~ ARE considered complete.

(e) THE COMMISSIONER MAY REVIEW filings ~~may be reviewed~~ for substantive content, and if reviewed, ~~any deficiency~~ shall ~~be identified~~ IDENTIFY and ~~communicated~~ COMMUNICATE to the filing carrier, on or before the forty-fifth day after receipt, ANY DEFICIENCY IN THE FILING. THE CARRIER SHALL APPLY A correction of ~~any~~ A deficiency, including ~~deficiencies~~ A DEFICIENCY identified after the forty-fifth day, ~~shall be~~ on a prospective basis, and ~~no~~ THE COMMISSIONER SHALL NOT ASSESS A penalty ~~shall be applied for a~~ AGAINST THE CARRIER IF THE violation identified ~~that~~ was not willful.

(f) CARRIERS SHALL FILE rate filings for insurance regulated under parts 1 to 4 of this article ~~shall be filed~~ electronically in a format made available by the division, unless exempted by rule for an emergency situation as determined by the commissioner. THE DIVISION SHALL POST

ON ITS WEB SITE a rate filing summary for insurance regulated under parts 1 to 4 of this article ~~shall be posted on the division's internet site~~ in order to provide notice to the public.

(g) ~~Nothing in~~ This section ~~shall be construed to~~ DOES NOT:

(I) Limit the right of the public to inspect a rate filing and any supporting information pursuant to part 2 of article 72 of title 24, C.R.S.; ~~nor to~~ OR

(II) Impair the commissioner's ability to review rates and determine ~~that~~ WHETHER the rates are ~~not~~ excessive, inadequate, or unfairly discriminatory.

~~(1.5)~~ (2) (a) (I) Rates for an individual health coverage plan issued or delivered to any policyholder, enrollee, subscriber, or member in Colorado by an insurer subject to part 2 of this article or an entity subject to part 3 or 4 of this article shall not be excessive, inadequate, or unfairly discriminatory to assure compliance with the requirements of this section that rates are not excessive in relation to benefits. Rates are excessive if they are likely to produce a long run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered. In determining if rates are excessive, the commissioner may consider the expected filed rates in relation to the actual rates charged.

(II) ~~Concerning inadequacy,~~ Rates are not inadequate unless clearly insufficient to sustain projected losses and expenses, or the use of ~~such~~ THE rates, if continued, will tend to create a monopoly in the market.

(III) ~~Concerning unfair discrimination, unfair discrimination exists~~ RATES ARE UNFAIRLY DISCRIMINATORY if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in

expected losses and expenses.

(b) Notwithstanding any other provision of this article, ~~an insurer~~ A CARRIER subject to part 2, ~~of this article or an entity subject to part~~ 3, or 4 of this article shall not vary the premium rate for an individual health coverage plan due to the gender of the individual policyholder, enrollee, subscriber, or member. Any premium rate based on the gender of the individual policyholder, enrollee, subscriber, or member ~~shall be considered~~ IS unfairly discriminatory and ~~shall~~ IS not ~~be~~ allowed.

~~(1.6)~~ (3) (a) The commissioner shall disapprove the requested rate increase if any of the following apply:

(I) The benefits provided are not reasonable in relation to the premiums charged;

(II) The requested rate increase contains a provision or provisions that are excessive, inadequate, unfairly discriminatory, or otherwise do not comply with the provisions of this title;

(III) The requested rate increase is excessive or inadequate. In determining if the rate is excessive or inadequate, the commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve and reserve for losses, surpluses, executive salaries, expected benefits ratios, any factors in section 10-16-111, and any other appropriate actuarial factors as determined by current actuarial standards of practice.

(IV) The actuarial reasons and data based upon Colorado claims experience and data, when available, do not justify the necessity for the requested rate increase; or

(V) The rate filing is incomplete.

(b) In determining whether to approve or disapprove a rate filing, the commissioner may consider, ~~but shall not be limited to consideration of~~ WITHOUT LIMITATION, the expected benefits ratio for a health benefit plan or any other cost category determined appropriate by the commissioner. ~~The achievement of~~ IF THE CARRIER ACHIEVES a benefits ratio of eighty-five percent or higher for large group insurance, eighty percent for small group insurance, and ~~sixty-five~~ EIGHTY percent for individual insurance, ~~by a carrier~~ THE COMMISSIONER may expedite the review of the approval process for ~~a~~ THE carrier. ~~who meets the benefits ratio pursuant to this paragraph (b).~~

(c) THE COMMISSIONER SHALL ADOPT RULES THAT ESTABLISH THE BENEFITS RATIO FOR CARRIERS TO USE FOR RATE FILING PURPOSES FOR HEALTH BENEFIT PLANS, OTHER THAN GRANDFATHERED HEALTH BENEFIT PLANS, TO INCLUDE ACTIVITIES TO IMPROVE HEALTH CARE QUALITY AS SET FORTH UNDER THE AUTHORITY OF SECTION 2718 OF THE FEDERAL "PUBLIC HEALTH SERVICE ACT", AS AMENDED, AND IN 45 CFR 158.150 AND EXPENDITURES RELATED TO HEALTH INFORMATION TECHNOLOGY AND MEANINGFUL USE AS SET FORTH IN 45 CFR 158.151.

~~(1.7) (Deleted by amendment, L. 2008, p. 2251, § 6, effective July 1, 2008.)~~

~~(2) No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith~~

~~knowledge and belief, to Colorado law pursuant to section 10-16-107.2 and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.~~

~~(3) (a) (Deleted by amendment, L. 92, p. 1744, § 4, effective January 1, 1993.)~~

~~(b) An evidence of coverage shall contain:~~

~~(I) No provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in section 10-16-413 (1); and~~

~~(II) A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:~~

~~(A) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan, including the ability to obtain a second opinion for proposed treatment by the health care provider, if the health benefit plan provides such coverage;~~

~~(B) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;~~

~~(C) Where and in what manner information is available as to how services may be obtained;~~

~~(D) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;~~

~~(E) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.~~

~~(c) Any subsequent change may be evidenced in a separate document issued to the enrollee.~~

~~(d) A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, shall be subject to the filing and approval requirements of section 10-16-107.2 unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or nonprofit hospital, medical-surgical, and health service corporations in which event the filing and approval provisions of subsection (2) of this section shall apply. To the extent, however, that such provisions do not apply, the requirements in paragraph (b) of this subsection (3) shall be applicable.~~

~~(e) (Deleted by amendment, L. 2008, p. 2251, § 6, effective July 1, 2008.)~~

~~(f) (Deleted by amendment, L. 92, p. 1744, § 4, effective January 1, 1993.)~~

~~(g)~~ (4) The commissioner may require the submission of ~~whatever~~ ANY relevant information the commissioner deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

~~(4) (a) For prepaid dental care plans, no enrollee coverage or an amendment, advertising matter, or sales material shall be issued or delivered to any person in this state until a copy of the form of the enrollee coverage or amendment, advertising matter, or sales material has been filed with the commissioner.~~

~~(b) The enrollee coverage shall contain a clear and complete statement, of~~ IF a contract, or a reasonably complete summary, ~~if a certificate of contract, of:~~

~~(I) The prepaid dental care services to which the enrollee is entitled under the prepaid dental care plan;~~

~~(II) Any limitations of the services, kind of services, or benefits to be provided, including any deductible or copayment feature;~~

~~(III) Where and in what manner information is available as to how services may be obtained;~~

~~(IV) The enrollee's obligation respecting charges for the prepaid dental care plan.~~

~~(c) The enrollee coverage, advertising matter, and sales material shall contain no provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive, or which encourage misrepresentation, or which are untrue or misleading.~~

~~(d) The commissioner shall approve any form of enrollee coverage if the requirements of paragraphs (b) and (c) of this subsection (4) are met and the prepaid dental care plan is able, in the judgment of the commissioner, to meet its financial obligations under the enrollee coverage. It is unlawful to issue such form until approved. If the commissioner does not disapprove any such form within thirty days after the filing, it shall be deemed approved. If the commissioner disapproves a form of enrollee coverage, advertising matter, or sales material, the commissioner shall notify the prepaid dental care plan organization, specifying the reasons for disapproval. The commissioner shall grant a hearing on such disapproval within fifteen days after a request in writing is received from the prepaid dental care plan organization.~~

~~(5) Effective January 31, 1997, a managed care plan that provides coverage for reproductive health or gynecological care shall not be issued or renewed unless such plan either:~~

~~(a) Provides a woman covered by the plan direct access to an obstetrician, gynecologist, or an advanced practice nurse who is a certified nurse midwife pursuant to section 12-38-111.5, C.R.S., participating and available under the plan for her reproductive health care or gynecological care; or~~

~~(b) (I) Subject to rules promulgated by the commissioner, has procedures in place that ensure that, if a woman covered by the plan requests a timely referral to an obstetrician, gynecologist, or an advanced practice nurse who is a certified nurse midwife pursuant to section 12-38-111.5, C.R.S., participating and available under the plan for her reproductive health and gynecological care, the request for referral shall not be unreasonably withheld. Such rules shall include, but need not be limited to, the following issues:~~

~~(A) What constitutes a timely referral;~~

~~(B) Circumstances, practices, policies, contract provisions, or actions that constitute an undue or unreasonable interference with the ability of a woman to secure a referral or reauthorization for continuing care;~~

~~(C) The process for issuing a denial of a request, including the means by which a woman may obtain such a denial and the reasons therefor in writing;~~

~~(D) Actions that constitute improper penalties imposed upon primary providers as a result of referrals made pursuant to this subsection (5); and~~

~~(E) Such other issues the commissioner deems necessary.~~

~~(II) In developing rules pursuant to this subsection (5), the commissioner shall consult with providers, including, but not limited to,~~

~~family care physicians, representatives of health plans, and other appropriate persons and may conduct such surveys and analyses as may be necessary to develop the regulation.~~

~~(5.5) (a) No health coverage plan or managed care plan that provides coverage for eye care services shall be issued or renewed after January 1, 2001, by any entity subject to part 2, 3, or 4 of this article unless such health coverage plan or managed care plan:~~

~~(I) Provides a covered person direct access to any eye care provider participating and available under the plan or through its eye care services intermediary for eye care services;~~

~~(II) Ensures that all eye care providers on a health coverage plan or managed care plan are annually included on any publicly accessible list of participating providers for the health coverage plan or managed care plan; and~~

~~(III) Allows each eye care provider on a health coverage plan or managed care plan panel to furnish covered eye care services to covered persons without discrimination between classes of eye care providers and to provide such services as permitted by their license.~~

~~(b) A health coverage plan or managed care plan shall not:~~

~~(I) Impose a deductible or coinsurance for eye care services that is greater than the deductible or coinsurance imposed for other medical services under the health coverage plan or managed care plan;~~

~~(II) Require an eye care provider to hold hospital privileges as a condition of participation as a provider under the health coverage plan or managed care plan, unless an eye care provider is licensed pursuant to article 36 of title 12, C.R.S.; or~~

~~(III) Impose penalties upon primary care providers as a result of~~

~~the direct access provisions of this subsection (5.5).~~

~~(c) Nothing in this subsection (5.5) shall be construed as:~~

~~(I) Creating coverage for any health care service that is not otherwise covered under the terms of the health coverage plan or managed care plan;~~

~~(II) Requiring a health coverage plan or managed care plan to include as a participating provider every willing provider or health professional who meets the terms and conditions of the health coverage plan or managed care plan;~~

~~(III) Preventing a covered person from seeking eye care services from the covered person's primary care provider in accordance with the terms of the covered person's health coverage plan or managed care plan;~~

~~(IV) Increasing or decreasing the scope of the practice of optometry as defined in section 12-40-102, C.R.S.;~~

~~(V) Requiring eye care services to be provided in a hospital or similar medical facility; or~~

~~(VI) Prohibiting a health coverage plan or managed care plan from requiring a covered person to receive a referral or prior authorization from a primary care provider for any subsequent surgical procedures.~~

~~(d) As used in this subsection (5.5), unless the context otherwise requires:~~

~~(I) "Eye care provider" means a participating provider who is an optometrist licensed to practice optometry pursuant to article 40 of title 12, C.R.S., or an ophthalmologist licensed to practice medicine pursuant to article 36 of title 12, C.R.S.~~

~~(II) "Eye care services" means those health care services related~~

~~to the examination, diagnosis, treatment, and management of conditions and diseases of the eye and related structures that a managed care plan is obligated to pay, reimburse, arrange, or provide for covered persons or organizations as specified by a health coverage plan or managed care plan, excluding those health care services rendered in conjunction with a routine vision examination or the filling of prescriptions for corrective eyewear.~~

~~(6) (a) A carrier offering a group health benefit plan may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.~~

~~(b) The prohibition in paragraph (a) of this subsection (6) shall not be construed to:~~

~~(I) Restrict the amount that an employer may be charged for coverage under a group health benefit plan; or~~

~~(II) Prevent a carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for:~~

~~(A) Adherence to programs of health promotion and disease prevention if otherwise allowed by state or federal law;~~

~~(B) Participation in a wellness and prevention program pursuant to section 10-16-136; or~~

~~(C) Satisfaction of a standard related to a health risk factor pursuant to a wellness and prevention program authorized in section~~

~~10-16-136.~~

~~(7) (a) A service or indemnity contract issued or renewed on or after January 1, 1998, by any entity subject to part 2, 3, or 4 of this article shall disclose in the contract and in information on coverage presented to consumers whether the health coverage plan or managed care plan provides coverage for treatment of intractable pain. If the contract is silent on coverage of intractable pain, then the contract shall be presumed to offer coverage for the treatment of intractable pain. If the contract is silent or if the plan specifically includes coverage for the treatment of intractable pain, the plan shall provide access to such treatment for any individual covered by the plan either:~~

~~(I) By a primary care physician with demonstrated interest and documented experience in pain management whose practice includes up-to-date pain treatment;~~

~~(II) By providing direct access to a pain management specialist located within this state and participating in and available under the plan; or~~

~~(III) By having procedures in place that ensure that, if the individual requests a timely referral for intractable pain management to a pain management specialist participating in and available under the plan, the request for referral shall not be unreasonably denied by the plan. The commissioner shall promulgate rules pursuant to this subparagraph (III) that include, but need not be limited to, the following issues:~~

~~(A) What constitutes a timely referral;~~

~~(B) Circumstances, practices, policies, contract provisions, or actions that constitute an undue or unreasonable interference with the ability of an individual to secure a referral or reauthorization for~~

~~continuing care;~~

~~(C) The process for issuing a denial of a request, including the means by which an individual may receive notice of a denial and the reasons therefor in writing;~~

~~(D) Actions that constitute improper penalties imposed upon primary care physicians as a result of referrals made pursuant to this subsection (7); and~~

~~(E) Such other issues as the commissioner deems necessary.~~

~~(b) For purposes of this subsection (7), "intractable pain" means a pain state in which the cause of the pain cannot be removed and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.~~

~~(8) On and after January 1, 2005, a carrier shall not refuse to issue or renew a health benefit plan to an individual based solely on the individual's prior donation of a kidney.~~

(5) (a) (I) WITH RESPECT TO THE PREMIUM RATES CHARGED BY A CARRIER OFFERING AN INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLAN, THE CARRIER SHALL DEVELOP ITS PREMIUM RATES BASED ON, AND VARY THE PREMIUM RATES WITH RESPECT TO THE PARTICULAR PLAN OR COVERAGE ONLY BY THE FOLLOWING CASE CHARACTERISTICS:

(A) WHETHER THE PLAN OR COVERAGE COVERS AN INDIVIDUAL OR FAMILY;

(B) GEOGRAPHIC RATING AREA, ESTABLISHED IN ACCORDANCE WITH FEDERAL LAW;

(C) AGE, EXCEPT THAT THE RATE MUST NOT VARY BY MORE THAN THREE TO ONE FOR ADULTS; AND

(D) TOBACCO USE, EXCEPT THAT THE RATE MUST NOT VARY BY MORE THAN ONE AND ONE-FIFTEENTH TO ONE.

(II) THE CARRIER SHALL NOT VARY A PREMIUM RATE WITH RESPECT TO ANY PARTICULAR INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLAN BY ANY FACTOR OTHER THAN THE FACTORS DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (a).

(III) WITH RESPECT TO FAMILY COVERAGE UNDER AN INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLAN, THE CARRIER SHALL APPLY THE RATING VARIATIONS PERMITTED UNDER SUB-SUBPARAGRAPHS (C) AND (D) OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (a) BASED ON THE PORTION OF THE PREMIUM THAT IS ATTRIBUTABLE TO EACH FAMILY MEMBER COVERED UNDER THE PLAN IN ACCORDANCE WITH RULES OF THE COMMISSIONER.

(b) THE CARRIER SHALL NOT ADJUST THE PREMIUM CHARGED WITH RESPECT TO ANY PARTICULAR INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLAN MORE FREQUENTLY THAN ANNUALLY; EXCEPT THAT THE CARRIER MAY CHANGE THE PREMIUM RATES TO REFLECT:

(I) WITH RESPECT TO A SMALL EMPLOYER HEALTH BENEFIT PLAN, CHANGES TO THE ENROLLMENT OF THE SMALL EMPLOYER;

(II) CHANGES TO THE FAMILY COMPOSITION OF THE POLICYHOLDER OR EMPLOYEE;

(III) WITH RESPECT TO AN INDIVIDUAL HEALTH BENEFIT PLAN, CHANGES IN GEOGRAPHIC RATING AREA OF THE POLICYHOLDER, AS PROVIDED IN SUB-SUBPARAGRAPH (B) OF SUBPARAGRAPH (I) OF PARAGRAPH (a) OF THIS SUBSECTION (5);

(IV) CHANGES IN TOBACCO USE, AS PROVIDED IN SUB-SUBPARAGRAPH (D) OF SUBPARAGRAPH (I) OF PARAGRAPH (a) OF THIS SUBSECTION (5);

(V) CHANGES TO THE HEALTH BENEFIT PLAN REQUESTED BY THE POLICYHOLDER OR SMALL EMPLOYER; OR

(VI) OTHER CHANGES REQUIRED BY FEDERAL LAW OR REGULATIONS OR OTHERWISE EXPRESSLY PERMITTED BY STATE LAW OR COMMISSIONER RULE.

(c) (I) A CARRIER SHALL CONSIDER ALL INDIVIDUALS IN ALL INDIVIDUAL HEALTH BENEFIT PLANS, OTHER THAN GRANDFATHERED HEALTH BENEFIT PLANS, OFFERED BY THE CARRIER, INCLUDING THOSE INDIVIDUALS WHO DO NOT ENROLL IN THE PLANS THROUGH AN EXCHANGE ESTABLISHED UNDER ARTICLE 22 OF THIS TITLE, TO BE MEMBERS OF A SINGLE RISK POOL.

(II) A CARRIER SHALL CONSIDER ALL COVERED PERSONS IN ALL SMALL EMPLOYER HEALTH BENEFIT PLANS, OTHER THAN GRANDFATHERED HEALTH BENEFIT PLANS, OFFERED BY THE CARRIER, INCLUDING THOSE COVERED PERSONS WHO DO NOT ENROLL IN THE PLANS THROUGH AN EXCHANGE ESTABLISHED UNDER ARTICLE 22 OF THIS TITLE, TO BE MEMBERS OF A SINGLE RISK POOL.

(d) ANY INDIVIDUAL WHO DOES NOT QUALIFY FOR A LOWER RATE BASED ON TOBACCO USE MAY BE OFFERED THE OPTION OF PARTICIPATING IN A BONA FIDE WELLNESS PROGRAM, AS DEFINED UNDER THE FEDERAL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", AS AMENDED. A CARRIER MAY ALLOW ANY INDIVIDUAL WHO PARTICIPATES IN A BONA FIDE WELLNESS PROGRAM THE LOWER RATE. THE CARRIER SHALL DISCLOSE THE AVAILABILITY OF A TOBACCO RATING

ADJUSTMENT AND ANY BONA FIDE WELLNESS PROGRAM TO EACH POTENTIAL INSURED. THE PROVISIONS OF THIS PARAGRAPH (d) ARE APPLICABLE ONLY IF ALLOWED UNDER FEDERAL LAW.

(e) THE COMMISSIONER MAY ADOPT RULES TO IMPLEMENT AND ADMINISTER THIS SUBSECTION (5) AND TO ASSURE THAT RATING PRACTICES USED BY CARRIERS ARE CONSISTENT WITH THE PURPOSES OF THIS ARTICLE.

(f) A CARRIER SHALL MAKE A REASONABLE DISCLOSURE, AS PART OF ITS SOLICITATION AND SALES MATERIALS, OF ALL OF THE FOLLOWING:

(I) HOW PREMIUM RATES ARE ESTABLISHED;

(II) THE PROVISIONS OF THE COVERAGE CONCERNING THE CARRIER'S RIGHT TO CHANGE PREMIUM RATES, THE FACTORS THAT MAY AFFECT CHANGES IN PREMIUM RATES, AND THE FREQUENCY WITH WHICH THE CARRIER MAY CHANGE PREMIUM RATES; AND

(III) (A) WITH RESPECT TO INDIVIDUAL HEALTH BENEFIT PLANS, A LISTING OF AND DESCRIPTIVE INFORMATION ABOUT, INCLUDING BENEFITS AND PREMIUMS, ALL INDIVIDUAL HEALTH BENEFIT PLANS OFFERED BY THE CARRIER AND THE AVAILABILITY OF THE PLANS FOR WHICH THE INDIVIDUAL IS QUALIFIED; AND

(B) WITH RESPECT TO SMALL EMPLOYER HEALTH BENEFIT PLANS, A LISTING OF AND DESCRIPTIVE INFORMATION ABOUT, INCLUDING BENEFITS AND PREMIUMS, ALL SMALL EMPLOYER HEALTH BENEFIT PLANS FOR WHICH THE SMALL EMPLOYER IS QUALIFIED.

(g) (I) EACH CARRIER SHALL MAINTAIN AT ITS PRINCIPAL PLACE OF BUSINESS A COMPLETE AND DETAILED DESCRIPTION OF ITS RATING PRACTICES, INCLUDING INFORMATION AND DOCUMENTATION THAT DEMONSTRATE THAT ITS RATING METHODS AND PRACTICES ARE BASED

UPON COMMONLY ACCEPTED ACTUARIAL ASSUMPTIONS AND ARE IN ACCORDANCE WITH SOUND ACTUARIAL PRINCIPLES.

(II) EACH CARRIER SHALL ANNUALLY FILE WITH THE COMMISSIONER, ON OR BEFORE MARCH 15, AN ACTUARIAL CERTIFICATION CERTIFYING THAT THE CARRIER IS IN COMPLIANCE WITH THIS ARTICLE AND THAT THE RATING METHODS OF THE CARRIER ARE ACTUARIALLY SOUND. THE CERTIFICATION MUST BE IN A FORM AND MANNER AND MUST CONTAIN INFORMATION AS SPECIFIED BY THE COMMISSIONER. THE CARRIER SHALL RETAIN A COPY OF THE CERTIFICATION AT ITS PRINCIPAL PLACE OF BUSINESS.

(III) (A) A CARRIER SHALL MAKE THE INFORMATION AND DOCUMENTATION DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (g) AVAILABLE TO THE COMMISSIONER UPON REQUEST.

(B) EXCEPT IN CASES OF VIOLATIONS OF THIS SECTION, THE INFORMATION IS CONSIDERED PROPRIETARY AND TRADE SECRET INFORMATION AND IS NOT SUBJECT TO DISCLOSURE BY THE COMMISSIONER TO PERSONS OUTSIDE OF THE DIVISION EXCEPT AS AGREED TO BY THE CARRIER OR AS ORDERED BY A COURT OF COMPETENT JURISDICTION.

(6) (a) THE CARRIER SHALL USE THE APPLICABLE INDEX RATE FOR THE PREMIUM RATE FOR ALL OF THE CARRIER'S INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS AND SHALL ADJUST THE APPLICABLE INDEX RATE FOR TOTAL EXPECTED MARKET-WIDE PAYMENTS AND CHARGES UNDER THE RISK ADJUSTMENT AND REINSURANCE PROGRAMS IN THE STATE, SUBJECT ONLY TO THE ADJUSTMENTS PERMITTED IN FEDERAL AND STATE LAW. THE COMMISSIONER MAY ESTABLISH, BY RULE, THE COMPONENTS AND ADJUSTMENTS THAT CARRIERS ARE ABLE TO USE AND MAKE TO THE INDEX RATE.

(b) **[Formerly 10-16-105 (8) (c) (II)]** A ~~small employer~~ carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(c) **[Formerly 10-16-105 (8) (d)]** For the purposes of this subsection ~~(8)~~ (6), a health benefit plan that contains a restricted network provision ~~shall~~ IS not ~~be considered~~ similar coverage to a health benefit plan that does not contain ~~such~~ a RESTRICTED NETWORK provision if the restriction of benefits to network providers results in substantial differences in claim costs.

SECTION 13. In Colorado Revised Statutes, **amend** 10-16-107.2 as follows:

10-16-107.2. Filing of health policies - rules. (1) All ~~sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations~~ CARRIERS authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. ~~Such listing shall be submitted by January 15, 1993, and not later than~~ EACH CARRIER SHALL SUBMIT THE ANNUAL REPORT BY December 31 of each ~~subsequent~~ year and shall ~~contain~~ INCLUDE IN THE REPORT a certification by an officer of the ~~organization~~ CARRIER that, TO THE BEST OF THE CARRIER'S GOOD FAITH KNOWLEDGE AND BELIEF, each policy form, endorsement, or rider in use complies with Colorado law. The COMMISSIONER SHALL DETERMINE THE necessary elements of the

certification. ~~shall be determined by the commissioner.~~

(2) ~~(a)~~ All ~~sickness and accident insurers, health maintenance organizations, nonprofit hospital and health service corporations, and other entities providing health care coverage~~ CARRIERS authorized by the commissioner to conduct business in Colorado shall also submit to the commissioner a list of any new policy form, application, endorsement, or rider at least thirty-one days before using ~~such~~ THE policy form, application, endorsement, or rider for any health coverage. ~~Such~~ THE CARRIER SHALL INCLUDE IN THE listing ~~shall also contain~~ a certification by an officer of the ~~organization~~ CARRIER that each new policy form, application, endorsement, or rider proposed to be used complies, to the best of the ~~insurer's~~ CARRIER'S good faith knowledge and belief, with Colorado law. The COMMISSIONER SHALL DETERMINE THE necessary elements of the certification. ~~shall be determined by the commissioner.~~ A CARRIER SHALL NOT DELIVER OR ISSUE A NEW POLICY FORM, APPLICATION, ENDORSEMENT, OR RIDER UNTIL THE CARRIER FILES THE LISTING AND CERTIFICATION REQUIRED BY THIS SUBSECTION (2).

~~(b) (I) The commissioner shall develop a uniform employee application form for health benefit plans and shall require all small group sickness and accident insurers, health maintenance organizations, nonprofit hospital and health service corporations, and other entities providing small group health care coverage authorized by the commissioner to conduct business in Colorado to exclusively use such uniform employee application form for the conduct of business in this state. On and after January 1, 2007, all small group sickness and accident insurers, health maintenance organizations, nonprofit hospital and health service corporations, and other entities that provide small group health~~

~~care coverage shall use the uniform employee application form for small group sickness and accident health benefit plans.~~

~~(II) The division may permit carriers to use a modified electronic version of the uniform application form.~~

~~(c) (I) The commissioner shall implement an initial uniform application form for individual health benefit plans and, on and after January 1, 2012, shall require all individual sickness and accident insurers, health maintenance organizations, nonprofit hospital and service corporations, health insurance producers and producer organizations, and other entities providing individual health care coverage authorized by the commissioner to conduct business in this state to exclusively use the uniform application form for the conduct of business in this state. The initial uniform application form shall include the name of the applicant, contact information for the applicant, other demographic information approved by the commissioner, and questions concerning medical conditions for which the carrier may refuse to issue coverage.~~

~~(II) The commissioner shall consider recommendations regarding the initial uniform application form and content of the application that are submitted to the division by members of the insurance industry on or before January 1, 2011.~~

~~(III) The commissioner shall promulgate rules to implement the initial uniform application form on or before September 1, 2011.~~

~~(IV) On and after January 1, 2012, all individual sickness and accident insurers, health maintenance organizations, nonprofit hospital and service corporations, health insurance producers and producer organizations, and other entities that issue individual health benefit plans shall use the initial uniform application form for an individual's coverage.~~

~~(V) Upon receipt of an initial uniform application form from a consumer, the carrier shall review the application form and decide to issue coverage, to ask for additional unduplicated information, or to deny coverage.~~

~~(VI) If a carrier decides to deny coverage based upon information received in the initial uniform application form, the denial of coverage shall serve as~~ IS a denial for purposes of eligibility for coverage through ~~CoverColorado pursuant to part 5 of article 8 of this title.~~

(3) The commissioner shall promulgate rules, ~~and regulations by September 30, 1993, and periodically thereafter~~ as needed, setting forth the standards for policy forms, endorsements, and riders marketed in Colorado.

(4) The commissioner ~~shall have the power to~~ MAY examine and investigate ~~organizations~~ CARRIERS authorized to conduct business in Colorado to determine whether policy forms, endorsements, and riders comply with the certification of the ~~organization~~ CARRIER and statutory mandates.

SECTION 14. In Colorado Revised Statutes, **add with amended and relocated provisions** 10-16-107.5 as follows:

10-16-107.5. [Formerly 10-16-107.2 (2) (b)] Uniform application form - use by all carriers - rules. (1) The commissioner, BY RULE, shall develop a uniform ~~employee~~ application form for health benefit plans and shall require all ~~small group sickness and accident insurers, health maintenance organizations, nonprofit hospital and health service corporations, and other entities~~ CARRIERS providing ~~small group health care coverage~~ HEALTH BENEFIT PLANS THAT ARE authorized by the commissioner to conduct business in Colorado to exclusively use ~~such~~

THE uniform ~~employee~~ application form for the conduct of business in this state. ~~On and after January 1, 2007, all small group sickness and accident insurers, health maintenance organizations, nonprofit hospital and health service corporations, and other entities~~ BY A DATE SPECIFIED BY THE COMMISSIONER, ALL CARRIERS that provide ~~small group health care coverage~~ HEALTH BENEFIT PLANS shall use the uniform ~~employee~~ application form for ~~small group sickness and accident~~ THEIR health benefit plans.

(2) The ~~division~~ COMMISSIONER may permit carriers to use a modified electronic version of the uniform application form.

SECTION 15. In Colorado Revised Statutes, **add** 10-16-107.7 as follows:

10-16-107.7. Nondiscrimination against providers. (1) A CARRIER OFFERING AN INDIVIDUAL OR GROUP HEALTH BENEFIT PLAN IN THIS STATE SHALL NOT DISCRIMINATE WITH RESPECT TO PARTICIPATION UNDER THE PLAN OR COVERAGE AGAINST ANY PROVIDER WHO IS ACTING WITHIN THE SCOPE OF HIS OR HER LICENSE OR CERTIFICATION UNDER APPLICABLE STATE LAW.

(2) THIS SECTION DOES NOT:

(a) REQUIRE A CARRIER TO CONTRACT WITH ANY PROVIDER WILLING TO ABIDE BY THE TERMS AND CONDITIONS FOR PARTICIPATION ESTABLISHED BY THE PLAN OR CARRIER; OR

(b) PREVENT A CARRIER FROM ESTABLISHING VARYING REIMBURSEMENT RATES BASED ON QUALITY OR PERFORMANCE MEASURES.

SECTION 16. In Colorado Revised Statutes, **repeal and reenact, with amendments,** 10-16-108 as follows:

10-16-108. Continuation privileges. (1) **Group health benefit**

plans. (a) EVERY EMPLOYER GROUP HEALTH BENEFIT PLAN ISSUED BY A CARRIER MUST CONTAIN A PROVISION SPECIFYING THAT IF A COVERED EMPLOYEE'S EMPLOYMENT IS TERMINATED AND THE HEALTH BENEFIT PLAN REMAINS IN FORCE FOR ACTIVE EMPLOYEES OF THE EMPLOYER, THE COVERED EMPLOYEE WHOSE EMPLOYMENT IS TERMINATED MAY ELECT TO CONTINUE THE COVERAGE FOR HIMSELF OR HERSELF AND HIS OR HER DEPENDENTS. THE PROVISION MUST CONFORM TO THE REQUIREMENTS, WHERE APPLICABLE, OF PARAGRAPHS (b), (c), AND (e) OF THIS SUBSECTION (1).

(b) AN EMPLOYEE IS ELIGIBLE TO MAKE THE ELECTION DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (1) ON THE EMPLOYEE'S OWN BEHALF AND ON BEHALF OF ELIGIBLE, COVERED DEPENDENTS IF:

(I) THE EMPLOYEE'S ELIGIBILITY TO RECEIVE INSURANCE COVERAGE HAS ENDED FOR ANY REASON OTHER THAN DISCONTINUANCE OF THE GROUP POLICY IN ITS ENTIRETY OR WITH RESPECT TO AN INSURED CLASS;

(II) ANY PREMIUM OR CONTRIBUTION REQUIRED FROM OR ON BEHALF OF THE EMPLOYEE HAS BEEN PAID THROUGH THE EMPLOYMENT TERMINATION DATE; AND

(III) THE EMPLOYEE HAS BEEN CONTINUOUSLY COVERED UNDER THE GROUP HEALTH BENEFIT PLAN, OR UNDER ANY GROUP HEALTH BENEFIT PLAN PROVIDING SIMILAR BENEFITS THAT IT REPLACES, FOR AT LEAST SIX MONTHS IMMEDIATELY PRIOR TO TERMINATION.

(c) THE EMPLOYER IS NOT REQUIRED TO OFFER CONTINUATION OF COVERAGE TO ANY PERSON IF THE PERSON IS COVERED BY MEDICARE, TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", OR MEDICAID, TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT".

(d) ONCE PAYMENT OF DISABILITY BENEFITS HAS STARTED, A CARRIER SHALL NOT REDUCE BENEFITS DUE UNDER A POLICY OF INSURANCE INSURING AGAINST DISABILITY FROM SICKNESS OR ACCIDENT BASED ON AN INCREASE IN FEDERAL SOCIAL SECURITY BENEFITS.

(e) (I) UPON THE TERMINATION OF EMPLOYMENT OF AN ELIGIBLE EMPLOYEE, THE DEATH OF AN ELIGIBLE EMPLOYEE, OR THE CHANGE IN MARITAL STATUS OF AN ELIGIBLE EMPLOYEE, THE EMPLOYEE OR DEPENDENT HAS THE RIGHT TO CONTINUE THE COVERAGE FOR A PERIOD OF EIGHTEEN MONTHS AFTER LOSS OF COVERAGE OR UNTIL THE EMPLOYEE OR DEPENDENT BECOMES ELIGIBLE FOR OTHER GROUP COVERAGE, WHICHEVER OCCURS FIRST. HOWEVER, SHOULD THE NEW COVERAGE EXCLUDE A CONDITION COVERED UNDER THE CONTINUED PLAN, COVERAGE UNDER THE PRIOR EMPLOYER'S PLAN MAY BE CONTINUED FOR THE EXCLUDED CONDITION ONLY FOR EIGHTEEN MONTHS OR UNTIL THE NEW PLAN COVERS THE CONDITION, WHICHEVER OCCURS FIRST.

(II) THE EMPLOYER SHALL NOTIFY THE EMPLOYEE IN WRITING OF THE EMPLOYEE'S RIGHT TO CONTINUE HEALTH CARE COVERAGE UPON TERMINATION FROM EMPLOYMENT. A WRITTEN COMMUNICATION SIGNED BY THE EMPLOYEE OR A NOTICE POSTMARKED WITHIN TEN DAYS AFTER TERMINATION MAILED BY THE EMPLOYER TO THE LAST-KNOWN ADDRESS OF THE EMPLOYEE SATISFIES THE NOTICE REQUIREMENTS OF THIS SUBPARAGRAPH (II). THE NOTIFICATION MUST INFORM THE EMPLOYEE OF:

(A) THE EMPLOYEE'S RIGHT TO ELECT TO CONTINUE THE EXISTING COVERAGE AT THE APPLICABLE RATE;

(B) THE AMOUNT THE EMPLOYEE MUST PAY MONTHLY TO THE EMPLOYER TO RETAIN THE COVERAGE, WHICH PAYMENT INCLUDES THE EMPLOYER'S CONTRIBUTION FOR THE EMPLOYEE IN ADDITION TO THE

EMPLOYEE'S OWN CONTRIBUTION;

(C) THE MANNER IN WHICH, AND THE OFFICE OF THE EMPLOYER TO WHICH, THE EMPLOYEE MUST SUBMIT THE PAYMENT TO THE EMPLOYER;

(D) THE DATE AND TIME BY WHICH THE EMPLOYEE MUST SUBMIT THE PAYMENTS TO THE EMPLOYER TO RETAIN COVERAGE; AND

(E) THE FACT THAT THE EMPLOYEE WILL LOSE THE COVERAGE IF THE EMPLOYEE DOES NOT TIMELY SUBMIT THE PAYMENT TO THE EMPLOYER.

(III) THE EMPLOYEE SHALL NOTIFY THE EMPLOYER IN WRITING OF THE EMPLOYEE'S ELECTION TO CONTINUE COVERAGE AND SHALL MAKE PROPER PAYMENT TO THE EMPLOYER AS SOON AS POSSIBLE UPON NOTIFICATION BY THE EMPLOYER OF TERMINATION. IN NO CASE SHALL THE EMPLOYEE SUBMIT THE NOTIFICATION OF ELECTION OR THE PROPER PAYMENT MORE THAN THIRTY DAYS AFTER THE DATE OF TERMINATION OF EMPLOYMENT UNLESS THE EMPLOYER HAS FAILED TO GIVE TIMELY NOTICE IN ACCORDANCE WITH SUBPARAGRAPH (II) OF THIS PARAGRAPH (e). IF THE EMPLOYEE TIMELY SUBMITS THE REQUIRED PAYMENT AND NOTICE, THE EMPLOYEE'S HEALTH CARE COVERAGE IS CONTINUED AS IF THERE HAD BEEN NO INTERRUPTION OF COVERAGE. IF THE EMPLOYEE FAILS TO TIMELY SUBMIT PROPER PAYMENT AND NOTICE, THE EMPLOYER IS RELIEVED OF ANY RESPONSIBILITY TO THE EMPLOYEE FOR THE CONTINUATION OF HEALTH CARE COVERAGE.

(IV) IF THE EMPLOYER FAILS TO NOTIFY AN ELIGIBLE EMPLOYEE OF THE RIGHT TO ELECT TO CONTINUE THE COVERAGE, THE EMPLOYEE HAS THE OPTION TO RETAIN COVERAGE IF, WITHIN SIXTY DAYS AFTER THE DATE THE EMPLOYMENT IS TERMINATED, THE EMPLOYEE MAKES THE PROPER PAYMENT TO THE EMPLOYER TO PROVIDE CONTINUOUS COVERAGE.

(V) AFTER TIMELY RECEIPT OF THE MONTHLY PAYMENT FROM AN ELIGIBLE EMPLOYEE, IF THE EMPLOYER FAILS TO MAKE THE PAYMENT TO THE CARRIER, WITH THE RESULT THAT THE EMPLOYEE'S COVERAGE IS TERMINATED, THE EMPLOYER IS LIABLE FOR THE EMPLOYEE'S COVERAGE, BUT TO NO GREATER EXTENT THAN THE AMOUNT OF THE PREMIUM.

(2) **Group policies and group service contracts - reduction in hours of work.** EVERY GROUP POLICY OR GROUP SERVICE CONTRACT DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE BY AN INSURER SUBJECT TO PART 2 OF THIS ARTICLE OR BY AN ENTITY SUBJECT TO PART 3 OR 4 OF THIS ARTICLE THAT COVERS FULL-TIME EMPLOYEES WORKING FORTY OR MORE HOURS PER WEEK SHALL CONTAIN A PROVISION THAT THE POLICYHOLDER MAY ELECT TO CONTRACT WITH THE INSURER OR OTHER ENTITY TO CONTINUE THE POLICY OR CONTRACT UNDER THE SAME CONDITIONS AND FOR THE SAME PREMIUM FOR THE EMPLOYEES AND THEIR DEPENDENTS EVEN IF THE POLICYHOLDER OR EMPLOYER REDUCES THE WORKING HOURS OF THE EMPLOYEES TO LESS THAN THIRTY HOURS PER WEEK, IF THE FOLLOWING CONDITIONS ARE MET:

(a) THE COVERED EMPLOYEE IS EMPLOYED AS A FULL-TIME EMPLOYEE OF THE POLICYHOLDER OR EMPLOYER AND IS INSURED UNDER THE GROUP POLICY OR GROUP SERVICE CONTRACT, OR UNDER ANY GROUP POLICY OR GROUP SERVICE CONTRACT PROVIDING SIMILAR BENEFITS THAT THE GROUP POLICY OR GROUP SERVICE CONTRACT REPLACES, IMMEDIATELY PRIOR TO THE REDUCTION IN WORKING HOURS;

(b) THE POLICYHOLDER HAS IMPOSED THE REDUCTION IN WORKING HOURS DUE TO ECONOMIC CONDITIONS OR DUE TO THE EMPLOYEE'S INJURY, DISABILITY, OR CHRONIC HEALTH CONDITIONS; AND

(c) THE POLICYHOLDER INTENDS TO RESTORE THE EMPLOYEE TO

A FULL FORTY-HOUR WORK SCHEDULE AS SOON AS ECONOMIC CONDITIONS IMPROVE OR AS SOON AS THE EMPLOYEE IS ABLE TO RETURN TO FULL-TIME WORK.

SECTION 17. In Colorado Revised Statutes, 10-16-108.5, **amend** (1), (3) (a), (5), and (11); and **repeal** (4) as follows:

10-16-108.5. Fair marketing standards. (1) Each ~~small employer~~ carrier OFFERING INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLANS shall actively market health benefit plan coverage ~~including the basic health benefit plan and the standard health benefit plan,~~ to eligible INDIVIDUALS OR small employers in the state, AS APPLICABLE.

(3) (a) Except as provided in paragraph (b) of this subsection (3), ~~no small employer~~ A carrier shall NOT, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the INDIVIDUAL OR small employer.

(4) ~~A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the small employer health reinsurance program, to a producer, if any, for the sale of a basic or standard health benefit plan.~~

(5) ~~No small employer~~ A carrier shall NOT terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic area of the INDIVIDUALS OR small employers placed by the producer with the ~~small employer~~ carrier.

(11) (a) Effective January 1, ~~1998~~ 2014, all carriers offering or providing health benefit plan ~~coverage or medicare supplemental~~ coverage shall ~~make available a Colorado health benefit plan description form for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer~~ PROVIDE A SUMMARY OF BENEFITS AND COVERAGE FORM THAT COMPLIES WITH THE REQUIREMENTS OF FEDERAL LAW. THE COMMISSIONER SHALL ADOPT RULES SPECIFYING WHEN CARRIERS ARE REQUIRED TO PROVIDE THE FORM.

(b) (I) TO THE EXTENT CONSISTENT WITH THE SUMMARY OF BENEFITS AND COVERAGE FORM REQUIREMENTS IN FEDERAL LAW, AND IN ADDITION TO THE SUMMARY OF BENEFITS AND COVERAGE FORM REQUIRED BY PARAGRAPH (a) OF THIS SUBSECTION (11), THE COMMISSIONER MAY ADOPT AND REQUIRE CARRIERS TO PROVIDE ANY SUPPLEMENTAL HEALTH BENEFIT PLAN DESCRIPTION FORMS THE COMMISSIONER DEEMS APPROPRIATE. The COMMISSIONER, BY RULE, MAY DETERMINE THE format for and elements of the ~~Colorado~~ SUPPLEMENTAL health benefit plan description form. ~~shall be determined by rule of the commissioner after consultation with consumer, provider, and carrier representatives.~~

~~(c)~~ (II) ~~A Colorado~~ THE COMMISSIONER SHALL DESIGN THE SUPPLEMENTAL health benefit plan description form ~~shall include information of general interest to purchasers of health plans and persons insured under health plans. Such form shall be designed~~ to facilitate THE comparison of different health benefit plans. THE FORM MUST ALSO INCLUDE informational materials specifying the plan's cancer screening coverages and their respective parameters. ~~shall be included with the form.~~

~~(d)~~ (III) A carrier shall provide a completed ~~Colorado~~ SUPPLEMENTAL health benefit plan description form ~~for each of its health benefit plans:~~ WHEN THE CARRIER PROVIDES THE FORM DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (11).

~~(I) Upon request, to any person covered by such plan or such person's employer; and~~

~~(II) As part of its marketing materials, to any person or employer who may be interested in purchasing or obtaining coverage under such a plan. This requirement shall include the provision of the form by the carrier to every employee who has the option of selecting such a plan during an employer's open enrollment period.~~

SECTION 18. In Colorado Revised Statutes, **amend** 10-16-109 as follows:

10-16-109. Rules. Pursuant to ~~the provisions of~~ article 4 of title 24, C.R.S., the commissioner may promulgate ~~such~~ reasonable rules ~~and regulations not inconsistent~~ CONSISTENT with ~~the provisions of~~ this article ~~as~~ THAT are necessary or proper for ~~carrying out the provisions of~~ IMPLEMENTING AND ADMINISTERING this article, INCLUDING RULES NECESSARY TO ALIGN STATE LAW WITH THE REQUIREMENTS IMPOSED BY FEDERAL LAW REGARDING HEALTH CARE COVERAGE IN THIS STATE.

SECTION 19. In Colorado Revised Statutes, **amend** 10-16-113 as follows:

10-16-113. Procedure for denial of benefits - internal review - rules. (1) (a) A ~~health coverage plan~~ CARRIER shall not make ~~a~~ AN ADVERSE determination, in whole or in part, ~~that it will deny a request for benefits for a covered individual on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or~~

~~efficient~~ WITH RESPECT TO A HEALTH COVERAGE PLAN unless ~~such denial~~ THE DETERMINATION is made pursuant to this section.

(b) For the purposes of this section: ~~a denial of a preauthorization for a covered benefit shall be considered a denial of a request for benefits and shall be made pursuant to the provisions of this section.~~

(I) "ADVERSE DETERMINATION" MEANS:

(A) A DENIAL OF A PREAUTHORIZATION FOR A COVERED BENEFIT;

(B) A DENIAL OF A REQUEST FOR BENEFITS FOR AN INDIVIDUAL ON THE GROUND THAT THE TREATMENT OR COVERED BENEFIT IS NOT MEDICALLY NECESSARY, APPROPRIATE, EFFECTIVE, OR EFFICIENT OR IS NOT PROVIDED IN OR AT THE APPROPRIATE HEALTH CARE SETTING OR LEVEL OF CARE;

(C) A RESCISSION OR CANCELLATION OF COVERAGE UNDER A HEALTH COVERAGE PLAN THAT IS NOT ATTRIBUTABLE TO FAILURE TO PAY PREMIUMS AND THAT IS APPLIED RETROACTIVELY;

(D) A DENIAL OF A REQUEST FOR BENEFITS ON THE GROUND THAT THE TREATMENT OR SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL; OR

(E) A DENIAL OF COVERAGE TO AN INDIVIDUAL BASED ON AN INITIAL ELIGIBILITY DETERMINATION FOR ALL INDIVIDUAL SICKNESS AND ACCIDENT INSURANCE POLICIES ISSUED BY AN ENTITY SUBJECT TO PART 2 OF THIS ARTICLE, AND ALL INDIVIDUAL HEALTH CARE OR INDEMNITY CONTRACTS ISSUED BY AN ENTITY SUBJECT TO PART 3 OR 4 OF THIS ARTICLE, EXCEPT SUPPLEMENTAL POLICIES COVERING A SPECIFIED DISEASE OR OTHER LIMITED BENEFIT.

(II) "HEALTH COVERAGE PLAN" DOES NOT INCLUDE INSURANCE ARISING OUT OF THE "WORKERS' COMPENSATION ACT OF COLORADO", ARTICLES 40 TO 47 OF TITLE 8, C.R.S., OR OTHER SIMILAR LAW,

AUTOMOBILE MEDICAL PAYMENT INSURANCE, OR PROPERTY AND CASUALTY INSURANCE.

(III) "INDIVIDUAL" MEANS A PERSON AND INCLUDES THE DESIGNATED REPRESENTATIVE OF AN INDIVIDUAL.

(c) If a ~~health coverage plan~~ CARRIER denies a benefit because the treatment is an excluded benefit and the claimant presents evidence from a medical professional licensed pursuant to the "Colorado Medical Practice Act", article 36 of title 12, C.R.S., or, for dental plans only, a dentist licensed pursuant to the "Dental Practice Law of Colorado", article 35 of title 12, C.R.S., acting within his or her scope of practice, that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit, such evidence establishes that the benefit denial is subject to the appeals process ~~The denial of such benefit shall be subject to the appeals provisions of~~ PURSUANT TO this section and section 10-16-113.5.

(2) Following a denial of a request for benefits OR AN ADVERSE DETERMINATION by the ~~health coverage plan, such plan~~ CARRIER, THE CARRIER shall notify the ~~covered person~~ INDIVIDUAL in writing. The COMMISSIONER SHALL ADOPT RULES SPECIFYING THE content of ~~such~~ THE notification and the deadlines for making ~~such~~ THE notification, ~~shall be made pursuant to regulations promulgated by the commissioner~~ AND THE CARRIER SHALL NOTIFY THE INDIVIDUAL IN ACCORDANCE WITH THOSE RULES.

(3) (a) (I) All denials of requests for reimbursement for medical treatment, standing referrals, or ~~other benefits~~ ADVERSE DETERMINATIONS MADE on the ground that ~~such~~ A treatment or covered benefit is not medically necessary, appropriate, effective, or efficient, ~~shall~~ IS NOT

DELIVERED IN THE APPROPRIATE SETTING OR AT THE APPROPRIATE LEVEL OF CARE, OR IS EXPERIMENTAL OR INVESTIGATIONAL, MUST include:

(A) An explanation of the specific medical basis for the denial;

(B) The specific reasons for the DENIAL OR adverse determination;

(C) Reference to the specific health coverage plan provisions on which the determination is based;

(D) A description of the ~~health coverage plan's~~ CARRIER'S review procedures and the time limits applicable to such procedures and ~~shall advise the covered person and the covered person's designated representative of~~ A STATEMENT THAT THE INDIVIDUAL HAS the right to appeal ~~such~~ THE decision; and

(E) A description of any additional material or information necessary, if any, for the ~~covered person and the covered person's designated representative~~ INDIVIDUAL to perfect the request for benefits and an explanation of why ~~such~~ THE material or information is necessary.

(II) In the case of an adverse ~~benefit~~ determination by ~~health coverage plan~~ A CARRIER:

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the carrier shall furnish the ~~covered person and the covered person's representative~~ INDIVIDUAL with either the specific rule, guideline, protocol, or other similar criterion, or a statement that ~~such~~ THE rule, guideline, protocol, or other criterion was relied upon in making the adverse determination and that a copy of ~~such~~ THE rule, guideline, protocol, or other criterion will be provided free of charge to the ~~covered person and the covered person's designated representative~~ INDIVIDUAL upon request; or

(B) If the adverse ~~benefit~~ determination is based on a medical

necessity or experimental treatment or similar exclusion or limit, the carrier shall furnish the ~~covered person and the covered person's designated representative~~ INDIVIDUAL with either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the ~~covered person's~~ INDIVIDUAL'S medical circumstances, or a statement that ~~such~~ THE explanation will be provided free of charge upon request.

(III) In the event of an adverse ~~benefit~~ determination by a ~~health coverage plan~~ CARRIER concerning a request involving urgent care, a carrier:

(A) Shall provide TO THE INDIVIDUAL a description of the expedited review process applicable to ~~such requests to the covered person and the covered person's designated representative; and~~ THE REQUEST;

(B) May communicate the other information required pursuant to subparagraph (I) of this paragraph (a) to the ~~covered person~~ INDIVIDUAL orally within the time frame outlined in 29 CFR 2560.503-1 (f) (2) (i) so long as a written or electronic copy of ~~such~~ THE information is furnished to the ~~covered person~~ INDIVIDUAL no later than three days after the oral notification; AND

(C) MAY WAIVE THE DEADLINES SPECIFIED IN SUB-SUBPARAGRAPH (B) OF THIS SUBPARAGRAPH (III) AND IN SUBPARAGRAPH (IV) OF THIS PARAGRAPH (a) TO PERMIT THE INDIVIDUAL TO PURSUE AN EXPEDITED EXTERNAL REVIEW OF THE URGENT CARE CLAIM UNDER SECTION 10-16-113.5.

(IV) A CARRIER SHALL NOTIFY AN INDIVIDUAL OF A BENEFIT DETERMINATION, WHETHER ADVERSE OR NOT, WITH RESPECT TO A

REQUEST INVOLVING URGENT CARE AS SOON AS POSSIBLE, TAKING INTO ACCOUNT THE MEDICAL EXIGENCIES, BUT NOT LATER THAN SEVENTY-TWO HOURS AFTER THE RECEIPT OF THE REQUEST BY THE CARRIER, UNLESS THE INDIVIDUAL FAILS TO PROVIDE SUFFICIENT INFORMATION TO DETERMINE WHETHER, OR TO WHAT EXTENT, BENEFITS ARE COVERED OR PAYABLE UNDER THE COVERAGE.

(b) (I) ~~For the purposes of this paragraph (b), a "health coverage plan" does not include insurance arising out of the "Workers' Compensation Act of Colorado" or other similar law, automobile medical payment insurance, or property and casualty insurance.~~ A GROUP health coverage plan ~~shall~~ ISSUED BY A CARRIER SUBJECT TO PART 2, 3, OR 4 OF THIS ARTICLE MUST specify that an appeal ~~from the denial of a request for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient, shall include~~ OF ANY ADVERSE DETERMINATION INCLUDES a two-level internal review of the decision, followed by the right of the ~~covered person~~ INDIVIDUAL to request an external review IF ALLOWED under section 10-16-113.5. The ~~covered person shall have~~ INDIVIDUAL HAS the option of choosing whether to utilize the voluntary second-level internal appeal process. ~~The commissioner shall promulgate rules for such benefits denials that reflect the requirements in 29 CFR 2560.503-1 (a) to (j). In addition, the commissioner shall promulgate rules specifying the elements of and timelines for external review appeals procedures, including but not limited to the review of appeals requiring expedited reviews and authorizations by the covered individual requesting an independent external review for access to medical records necessary for the conduct of the external review. The commissioner shall consult with and utilize~~

~~public and private resources, including but not limited to health care providers, in the development of such rules.~~

~~(II) and (III) (Deleted by amendment, L. 2003, p. 1384, § 1, effective January 1, 2004.)~~

~~(IV)~~ (II) The carrier shall notify the ~~covered person~~ INDIVIDUAL of his or her right to appeal a denial of benefits through a two-level internal review process and that the second level of internal review may be utilized at the INDIVIDUAL'S option. ~~of the covered person.~~

~~(V)~~ (III) (A) A PHYSICIAN SHALL EVALUATE the first-level appeal ~~shall be evaluated by a physician who~~ AND shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer; except that, in the case of dental care, A DENTIST MAY EVALUATE the first-level appeal, ~~may be evaluated by a dentist, who~~ AND THE REVIEWING DENTIST shall consult with an appropriate clinical peer or peers, unless the reviewing dentist is a clinical peer. ~~The~~ A physician, ~~or~~ dentist, ~~and~~ OR clinical ~~peers shall not have been~~ PEER WHO WAS involved in the initial adverse determination SHALL NOT EVALUATE OR BE CONSULTED REGARDING THE FIRST-LEVEL APPEAL. A person who was previously involved with the denial may answer questions.

(B) THIS SUBPARAGRAPH (III) DOES NOT APPLY TO AN ADVERSE DETERMINATION DESCRIBED IN SUB-SUBPARAGRAPH (C) OR (E) OF SUBPARAGRAPH (I) OF PARAGRAPH (b) OF SUBSECTION (1) OF THIS SECTION.

~~(VI)~~ (IV) (A) The second-level internal review of an appeal from the denial of a request for covered benefits PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (b) shall be reviewed by a health care professional who has appropriate expertise, who was not previously involved in the

appeal, and who does not have a direct financial interest in the appeal or outcome of the review.

(B) The ~~health coverage plan~~ CARRIER shall allow the ~~covered person~~ INDIVIDUAL to be present for the second-level internal review, either in person or by telephone conference. The ~~covered person shall have the opportunity to~~ INDIVIDUAL MAY bring counsel, advocates, and health care professionals to the review, ~~to~~ prepare in advance for the review, and ~~to~~ present materials to the health care professional prior to the review and at the time of the review. UPON REQUEST, the ~~health coverage plan~~ CARRIER and the ~~covered person~~ INDIVIDUAL shall ~~upon request,~~ provide ~~a copy~~ COPIES of the materials ~~it presents~~ THEY INTEND TO PRESENT at the review to the other party at least five days prior to the review. If new information is developed after the five-day deadline, ~~such~~ THE material may be presented when practicable. The ~~health coverage plan~~ CARRIER shall notify the ~~covered person~~ INDIVIDUAL that the ~~plan shall~~ CARRIER WILL make an audio or video recording of the review unless neither the ~~covered person~~ INDIVIDUAL nor the ~~health coverage plan~~ CARRIER wants the recording made. IF A RECORDING IS MADE, the ~~health coverage plan~~ CARRIER shall make ~~such~~ THE recording available to the ~~covered person~~ INDIVIDUAL. If there is an external review, THE CARRIER SHALL INCLUDE the audio or video recording ~~shall, at the request of either party, be included~~ in the material provided by the carrier to the reviewing entity IF REQUESTED BY EITHER PARTY.

(4) (a) EACH CARRIER ISSUING INDIVIDUAL HEALTH COVERAGE PLANS SHALL NOTIFY THE INDIVIDUAL OF HIS OR HER RIGHT TO APPEAL AN ADVERSE DETERMINATION THROUGH A SINGLE LEVEL OF INTERNAL REVIEW.

(b) (I) A PHYSICIAN SHALL EVALUATE THE APPEAL AND CONSULT WITH AN APPROPRIATE CLINICAL PEER OR PEERS UNLESS THE REVIEWING PHYSICIAN IS A CLINICAL PEER; EXCEPT THAT, IN THE CASE OF DENTAL CARE, A DENTIST MAY EVALUATE THE APPEAL, AND THE REVIEWING DENTIST SHALL CONSULT WITH AN APPROPRIATE CLINICAL PEER OR PEERS. A PHYSICIAN, DENTIST, OR CLINICAL PEER WHO WAS INVOLVED IN THE INITIAL ADVERSE DETERMINATION SHALL NOT EVALUATE OR BE CONSULTED REGARDING THE APPEAL. A PERSON WHO WAS PREVIOUSLY INVOLVED WITH THE DENIAL MAY ANSWER QUESTIONS.

(II) THIS PARAGRAPH (b) DOES NOT APPLY TO AN ADVERSE DETERMINATION DESCRIBED IN SUB-SUBPARAGRAPH (C) OR (E) OF SUBPARAGRAPH (I) OF PARAGRAPH (b) OF SUBSECTION (1) OF THIS SECTION.

(c) THE CARRIER SHALL ALLOW THE INDIVIDUAL TO BE PRESENT FOR THE APPEAL. THE INDIVIDUAL MAY BRING COUNSEL, ADVOCATES, AND HEALTH CARE PROFESSIONALS TO THE REVIEW, PREPARE IN ADVANCE FOR THE REVIEW, AND PRESENT MATERIALS TO THE PHYSICIAN OR DENTIST PRIOR TO THE REVIEW AND AT THE TIME OF THE REVIEW. UPON REQUEST, THE CARRIER AND THE INDIVIDUAL SHALL PROVIDE COPIES OF THE MATERIALS THEY INTEND TO PRESENT AT THE REVIEW TO THE OTHER PARTY AT LEAST FIVE DAYS PRIOR TO THE REVIEW. IF NEW INFORMATION IS DEVELOPED AFTER THE FIVE-DAY DEADLINE, THE MATERIAL MAY BE PRESENTED WHEN PRACTICABLE. THE CARRIER SHALL NOTIFY THE INDIVIDUAL THAT THE CARRIER WILL MAKE AN AUDIO OR VIDEO RECORDING OF THE REVIEW UNLESS NEITHER THE INDIVIDUAL NOR THE CARRIER WANTS THE RECORDING MADE. IF A RECORDING IS MADE, THE CARRIER SHALL MAKE THE RECORDING AVAILABLE TO THE INDIVIDUAL. IF

THERE IS AN EXTERNAL REVIEW, THE CARRIER SHALL INCLUDE THE AUDIO OR VIDEO RECORDING IN THE MATERIAL PROVIDED BY THE CARRIER TO THE REVIEWING ENTITY IF REQUESTED BY EITHER PARTY.

~~(4)~~ (5) All written ~~denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient, shall~~ ADVERSE DETERMINATIONS, EXCEPT AN ADVERSE DETERMINATION DESCRIBED IN SUB-SUBPARAGRAPH (C) OR (E) OF SUBPARAGRAPH (I) OF PARAGRAPH (b) OF SUBSECTION (1) OF THIS SECTION, MUST be signed by a licensed physician familiar with standards of care in Colorado; EXCEPT THAT, in the case of written ~~denials of requests for covered benefits for~~ ADVERSE DETERMINATIONS RELATING TO dental care, a licensed dentist familiar with standards of care in Colorado may sign the written ~~denial~~ ADVERSE DETERMINATION.

~~(5)~~ (6) ~~A covered person's~~ AN INDIVIDUAL'S health care provider may communicate with the physician or dentist involved in the initial decision to ~~deny reimbursement for or coverage of medical treatment or other benefits~~ MAKE AN ADVERSE DETERMINATION.

~~(6) (Deleted by amendment, L. 2003, p. 1384, § 1, effective January 1, 2004.)~~

(7) Nothing in this section ~~shall preclude~~ PRECLUDES or ~~deny~~ DENIES the right of ~~the covered~~ AN individual to seek any other remedy or relief.

(8) IN THE CASE OF THE FAILURE OF A CARRIER TO STRICTLY ADHERE TO THE REQUIREMENTS OF THIS SECTION WITH RESPECT TO A COVERAGE REQUEST, THE INDIVIDUAL IS DEEMED TO HAVE EXHAUSTED THE INTERNAL CLAIMS AND APPEALS PROCESS OF THIS SECTION, REGARDLESS OF WHETHER THE CARRIER ASSERTS THAT IT SUBSTANTIALLY

COMPLIED WITH THE REQUIREMENTS OF THIS SECTION OR UNLESS ANY ERROR IT COMMITTED WAS DE MINIMIS, AS DEFINED BY THE COMMISSIONER BY RULE, AND AN INDIVIDUAL MAY INITIATE AN EXTERNAL REVIEW UNDER SECTION 10-16-113.5.

(9) CARRIERS SHALL MAINTAIN RECORDS OF ALL REQUESTS AND NOTICES ASSOCIATED WITH THE INTERNAL CLAIMS AND APPEALS PROCESS FOR SIX YEARS AND SHALL MAKE SUCH RECORDS AVAILABLE UPON REQUEST FOR EXAMINATION BY THE INDIVIDUAL, THE DIVISION OF INSURANCE, OR THE FEDERAL GOVERNMENT.

(10) THE COMMISSIONER MAY PROMULGATE RULES AS NECESSARY FOR THE IMPLEMENTATION AND ADMINISTRATION OF THIS SECTION.

SECTION 20. In Colorado Revised Statutes, **amend** 10-16-113.5 as follows:

10-16-113.5. Independent external review of adverse determinations - legislative declaration - definitions - rules. (1) The general assembly hereby finds, determines, and declares that, in the interest of improving accountability for health care coverage decisions, ~~covered~~ individuals should have the option of an independent external review by qualified experts when ~~they have been denied a request for coverage~~ THERE HAS BEEN AN ADVERSE DETERMINATION WITH RESPECT TO A HEALTH COVERAGE PLAN pursuant to ~~their health plan's~~ A CARRIER'S procedures ~~for denial of benefits~~ AS required by section 10-16-113.

(2) As used in this section, unless the context otherwise requires:

(a) ~~(I) "Covered individual requesting an independent external review" means a covered person who:~~

~~(A) Has gone through at least one of the internal appeals review levels offered by a health coverage plan and established pursuant to~~

~~section 10-16-113 (3) and who has requested an independent external review of a health coverage plan's decision to deny reimbursement for or coverage of medical treatment that is a covered benefit on the grounds that such treatment is not medically necessary, medically appropriate, medically effective, or medically efficient; or~~

~~(B) Has pursued an expedited review of a denial of a benefit pursuant to state regulation.~~

~~(II) The term "covered individual requesting an independent external review" shall also include the designated representative of a covered individual requesting an independent external review.~~ "ADVERSE DETERMINATION" MEANS A DENIAL OF:

(I) A PREAUTHORIZATION FOR A COVERED BENEFIT;

(II) A REQUEST FOR BENEFITS FOR AN INDIVIDUAL ON THE GROUNDS THAT THE TREATMENT OR COVERED BENEFIT IS NOT MEDICALLY NECESSARY, APPROPRIATE, EFFECTIVE, OR EFFICIENT OR IS NOT PROVIDED IN OR AT THE APPROPRIATE HEALTH CARE SETTING OR LEVEL OF CARE;

(III) A REQUEST FOR BENEFITS ON THE GROUNDS THAT THE TREATMENT OR SERVICES ARE EXPERIMENTAL OR INVESTIGATIONAL; OR

(IV) A BENEFIT AS DESCRIBED IN SECTION 10-16-113 (1) (c).

(b) "DIVISION" MEANS THE DIVISION OF INSURANCE IN THE DEPARTMENT OF REGULATORY AGENCIES, ESTABLISHED IN SECTION 10-1-103.

~~(b)~~ (c) "Expedited review" means a review following completion of procedures for expedited internal review of an adverse determination involving a situation where the time frame of the standard independent external review procedures would seriously jeopardize the life or health of the ~~covered person~~ INDIVIDUAL or would jeopardize the ~~covered~~

~~person's~~ INDIVIDUAL'S ability to regain maximum function. EXPEDITED REVIEW IS AVAILABLE IF THE ADVERSE DETERMINATION CONCERNS AN ADMISSION, AVAILABILITY OF CARE, CONTINUED STAY, OR HEALTH CARE SERVICES FOR WHICH THE INDIVIDUAL RECEIVED EMERGENCY SERVICES, AND THE INDIVIDUAL HAS NOT BEEN DISCHARGED FROM A FACILITY.

~~(c)~~ (d) (I) "Expert reviewer" means a physician or other appropriate health care provider assigned by an independent external review entity to conduct an independent external review. An expert reviewer shall not:

(A) Have been involved in the ~~covered~~ individual's care previously;

(B) Be a member of the board of directors of the ~~health coverage plan~~ CARRIER;

(C) Have been previously involved in the review process for the ~~covered~~ individual requesting an independent external review;

(D) Have a direct financial interest in the case or in the outcome of the review; or

(E) Be an employee of the ~~health coverage plan~~ CARRIER.

(II) Physicians or other appropriate health care providers who are expert reviewers ~~shall~~ MUST:

(A) Be experts in the treatment of the medical condition of the ~~covered~~ individual requesting an independent external review and knowledgeable about the recommended treatment or service that is the subject of the review through the expert's actual, current clinical experience;

(B) Hold a license issued by a state and, for physicians, a current certification by a recognized American medical specialty board in the area

appropriate to the subject of review; and

(C) Have no history of disciplinary action or sanction, including loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

~~(d)~~ (e) (I) EXCEPT AS SPECIFIED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH (e), "health coverage plan" has the same meaning as set forth in section ~~10-16-102 (22.5)~~ 10-16-102 (34).

(II) "Health coverage plan" does not include insurance arising out of the "Workers' Compensation Act of Colorado", ARTICLES 40 TO 47 OF TITLE 8, C.R.S., or other similar law, automobile medical payment insurance, property and casualty insurance, or insurance under which benefits are payable with or without regard to fault and ~~which~~ THAT is required by law to be contained in any liability insurance policy or equivalent self-insurance.

~~(e)~~ (f) "Independent external review entity" means an entity that meets the requirements of this section, IS ACCREDITED BY A NATIONALLY RECOGNIZED PRIVATE ACCREDITING ORGANIZATION, and is certified by the commissioner to conduct independent external reviews of:

(I) ADVERSE determinations by a ~~plan to deny a request for reimbursement for or coverage of medical treatment that is a covered benefit for a covered individual on the grounds that such treatment or covered benefit is not medically necessary, medically appropriate, medically effective, or medically efficient. The independent external review entity may not review health coverage plan decisions to deny a request for reimbursement for or coverage of a medical treatment that is not a covered benefit. The independent external review entity may review health care coverage plan decisions to deny a request for reimbursement~~

~~or coverage of a medical treatment on the grounds that it is an experimental or investigational procedure, but only if such procedure is not explicitly listed as an excluded benefit in the policy. Where a specific procedure is a listed excluded benefit, the plan shall deny coverage on the grounds that it is not a covered benefit and this shall not be reviewable by the independent external review entity~~ CARRIER; OR

(II) DENIALS UNDER SECTION 10-16-136 (3.5) (d) (III) BY A CARRIER.

(g) (I) "INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW" MEANS A COVERED PERSON WHO:

(A) HAS GONE THROUGH AT LEAST ONE OF THE INTERNAL APPEALS REVIEW LEVELS OFFERED BY A CARRIER AND ESTABLISHED PURSUANT TO SECTION 10-16-113 AND HAS REQUESTED AN INDEPENDENT EXTERNAL REVIEW OF A CARRIER'S DECISION TO UPHOLD AN ADVERSE DETERMINATION; OR

(B) HAS PURSUED AN EXPEDITED REVIEW OF AN ADVERSE DETERMINATION.

(II) "INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW" ALSO INCLUDES THE DESIGNATED REPRESENTATIVE OF AN INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW.

~~(f)~~ (h) "Medical and scientific evidence" includes ~~but is not limited to,~~ the following sources:

(I) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(II) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the national institute of health's national library of medicine for indexing in index medicus, excerpta medicus ("EMBASE"), medline, and MEDLARS ~~data base~~ DATABASE of health services technology assessment research ("HSTAR");

(III) Medical journals recognized by the United States secretary of health and human services, pursuant to section 1861 (t) (2) of the federal "Social Security Act", 42 U.S.C. 1395x;

(IV) The following standard reference compendia:

(A) The American hospital formulary service-drug information;

(B) The American medical association drug evaluation;

(C) The American dental association accepted dental therapeutics; and

(D) The United States pharmacopoeia - drug information.

(V) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the federal agency for health care policy and research, national institutes of health, the national cancer institute, the national academy of sciences, the health care financing administration, the congressional office of technology assessment, and the national board recognized by the national institutes of health for the purpose of evaluating the medical value of health services.

(3) ~~Health coverage plans~~ CARRIERS shall make available an independent external review process that meets the requirements of this section. The CARRIER SHALL PAY THE cost of an independent external review. ~~shall be paid by the health coverage plan.~~ THERE IS NO RESTRICTION ON THE MINIMUM DOLLAR AMOUNT OF A CLAIM FOR IT TO BE

ELIGIBLE FOR EXTERNAL REVIEW.

(4) (a) To qualify for certification by the commissioner as an independent external review entity, ~~such~~ THE entity ~~shall~~ MUST meet the following requirements:

(I) The independent external review entity shall ensure that cases are reviewed by expert reviewers knowledgeable about the recommended treatment or service through the expert reviewers' actual, current clinical experience and who have appropriate expertise in the same or similar specialties as would typically manage the case being reviewed.

(II) The independent external review entity shall ensure that the decision is based upon a case review that includes a review of the medical records of the ~~covered~~ individual requesting an independent external review and a review of relevant medical and scientific evidence.

(III) The independent external review entity shall have a quality assurance procedure that ensures the timeliness and quality of the reviews conducted pursuant to this section, the qualifications and independence of the expert reviewers, and the confidentiality of medical records and review materials.

(IV) The independent external review entity shall maintain patient confidentiality pursuant to Colorado and federal law.

(b) In addition to the requirements set forth in paragraph (a) of this subsection (4), the commissioner shall ~~only~~ certify ONLY an independent external review entity that:

(I) Is not a subsidiary of, or owned or controlled by, a carrier, A trade association of carriers, or a professional association of health care providers;

(II) Maintains documentation available for review by the division

~~of insurance~~ upon request that ~~shall include~~ INCLUDES the following:

(A) The names of all stockholders and owners of more than five percent of ~~such~~ stock or options;

(B) The names of all holders of bonds or notes in amounts in excess of one hundred thousand dollars;

(C) The names of all corporations and organizations that the independent external review entity controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's business activities;

(D) The names of all directors, officers, and executives of the independent external review entity and a statement regarding any relationship the directors, officers, or executives may have with any ~~health coverage plan or~~ carrier;

(III) Does not have any material professional, family, or financial conflict of interest with:

(A) The ~~health coverage plan~~ CARRIER or any officer, director, or executive of the ~~health coverage plan~~ CARRIER. This requirement ~~shall~~ DOES not prohibit a physician or qualified health care professional who contracts with the ~~health coverage plan~~ CARRIER as a participating provider from serving on a review panel of the independent external review entity if the physician or qualified health care professional meets the requirements of paragraph ~~(c)~~ (d) of subsection (2) of this section. If a participating provider serves on the panel reviewing the case of ~~a~~ ~~covered~~ AN individual requesting an independent external review, the ~~covered~~ REVIEW ENTITY SHALL NOTIFY THE individual requesting an independent external review ~~shall be notified~~ that a health care professional serving on the review panel has a contract as a participating

provider with the ~~health coverage plan~~ CARRIER.

(B) The physician or physician's medical group that treated the ~~covered~~ individual requesting an independent external review;

(C) The institution at which the treatment or service would be provided;

(D) The development or manufacture of the principal drug, device, procedure, treatment, or service proposed for the ~~covered~~ individual requesting an independent external review whose treatment is under review; or

(E) The ~~covered~~ individual requesting an independent external review.

(c) Nothing in subparagraph (III) of paragraph (b) of this subsection (4) ~~shall be construed to include~~ INCLUDES affiliations that are limited to staff privileges at a health care institution.

(d) The commissioner shall promulgate ~~such~~ rules as ~~are~~ necessary for the certification of independent external review entities under this section. The commissioner may deny, suspend, or revoke the certification of an independent external review entity that does not comply with the requirements of this section. The commissioner ~~shall have the authority to~~ MAY contract with any person or entity to develop the certification rules and for IMPLEMENTATION AND administration of the certification program. ~~The commissioner shall consult with and utilize public and private resources, including but not limited to health care providers, in the development of such rules.~~

(5) Upon receipt of a request from ~~a covered person~~ AN INDIVIDUAL requesting an independent external review of a denial, the ~~health care coverage plan~~ CARRIER shall contact the division. ~~of~~

~~insurance.~~ The division ~~of insurance~~ or its contractor shall inform the ~~health care coverage plan~~ CARRIER of the name of the ~~certified~~ independent external review entity to which the appeal should be sent.

(6) All health coverage plan materials dealing with the ~~plan's~~ CARRIER'S grievance procedures ~~shall~~ MUST advise ~~covered persons~~ INDIVIDUALS in writing of the availability of an independent external review process, the circumstances under which ~~a covered~~ AN individual requesting an independent external review may use the independent external review process, the procedures for requesting an independent external review, and the deadlines associated with an independent external review.

(7) ~~A covered~~ AN individual requesting an independent external review shall make ~~such~~ THE request within ~~sixty calendar days~~ FOUR MONTHS after receiving notification of ~~a second-level appeal~~ THE denial of ~~coverage for such treatment or service. Such~~ THE INDIVIDUAL'S INTERNAL APPEAL OF AN ADVERSE DETERMINATION. IN THE INTERNAL APPEAL DENIAL notification, ~~of the denial of coverage shall include a notification of~~ the ~~person's~~ CARRIER SHALL INFORM THE INDIVIDUAL OF HIS OR HER right to an independent external review. ~~A covered~~ AN individual requesting an independent external review shall notify the ~~plan~~ CARRIER if the ~~covered~~ individual ~~requesting an independent external review~~ requests an expedited review. AN INDIVIDUAL REQUESTING AN EXPEDITED INDEPENDENT EXTERNAL REVIEW MAY OBTAIN SUCH EXTERNAL REVIEW CONCURRENTLY WITH AN EXPEDITED INTERNAL APPEAL REQUEST UNDER SECTION 10-16-113.

(8) AN INDIVIDUAL MAY REQUEST AN INDEPENDENT EXTERNAL REVIEW OR AN EXPEDITED INDEPENDENT EXTERNAL REVIEW INVOLVING A

DENIAL OF COVERAGE OF A RECOMMENDED OR REQUESTED MEDICAL SERVICE THAT IS EXPERIMENTAL OR INVESTIGATIONAL IF THE INDIVIDUAL'S TREATING PHYSICIAN CERTIFIES IN WRITING THAT THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE OR TREATMENT THAT IS THE SUBJECT OF THE DENIAL WOULD BE SIGNIFICANTLY LESS EFFECTIVE IF NOT PROMPTLY INITIATED. THE INDIVIDUAL'S TREATING PHYSICIAN MUST CERTIFY IN WRITING THAT AT LEAST ONE OF THE FOLLOWING SITUATIONS APPLIES:

(a) STANDARD HEALTH CARE SERVICES OR TREATMENTS HAVE NOT BEEN EFFECTIVE IN IMPROVING THE CONDITION OF THE INDIVIDUAL OR ARE NOT MEDICALLY APPROPRIATE FOR THE INDIVIDUAL; OR

(b) THERE IS NO AVAILABLE STANDARD HEALTH CARE SERVICE OR TREATMENT COVERED BY THE CARRIER THAT IS MORE BENEFICIAL THAN THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE, AND THE PHYSICIAN IS A LICENSED, BOARD-CERTIFIED OR BOARD-ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE AREA OF MEDICINE APPROPRIATE TO TREAT THE INDIVIDUAL'S CONDITION. THE PHYSICIAN MUST CERTIFY THAT SCIENTIFICALLY VALID STUDIES USING ACCEPTED PROTOCOLS DEMONSTRATE THAT THE HEALTH CARE SERVICE OR TREATMENT REQUESTED BY THE INDIVIDUAL THAT IS THE SUBJECT OF THE DENIAL IS LIKELY TO BE MORE BENEFICIAL TO THE INDIVIDUAL THAN ANY AVAILABLE STANDARD HEALTH CARE SERVICES OR TREATMENTS.

~~(8)~~ (9) After receipt of a written request for an independent external review, ~~a health coverage plan~~ THE CARRIER shall notify the ~~covered~~ individual requesting an independent external review in writing. ~~Such~~ THE notification ~~shall~~ MUST include descriptive information on the ~~certified~~ independent external review entity that the division ~~of insurance~~

or its contractor has selected to conduct the independent external review.

~~(9)~~ (10) (a) The ~~health coverage plan~~ CARRIER shall provide to the ~~certified~~ independent external review entity a copy of the following documents after the division ~~of insurance~~ or its contractor has selected ~~a certified~~ AN independent external review entity for the case:

(I) Any information submitted to the ~~health coverage plan~~ CARRIER, UNDER THE CARRIER'S PROCEDURES, IN SUPPORT OF THE REQUEST FOR AN INDEPENDENT EXTERNAL REVIEW, by ~~a covered~~ AN individual requesting ~~an independent external~~ THE review or BY the physician or other health care professional of the ~~covered~~ individual seeking ~~an independent external~~ THE review. ~~in support of the request of the covered individual requesting an independent external review for coverage under the health coverage plan's procedures.~~ The ~~certified~~ independent external review entity shall maintain the confidentiality of any medical records submitted pursuant to this subsection ~~(9)~~ (10).

(II) A copy of any relevant documents used by the ~~plan to determine the medical necessity, medical appropriateness, medical effectiveness, or medical efficiency of~~ CARRIER IN MAKING ITS ADVERSE DETERMINATION ON the proposed service or treatment, and a copy of any denial letters issued by the ~~plan~~ CARRIER concerning the individual case under review. The ~~health coverage plan~~ CARRIER shall provide, upon request to the ~~covered~~ individual requesting an independent external review, all relevant information supplied to the independent external review entity that is not confidential or privileged under state or federal law concerning the individual case under review.

(III) THE INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW MAY SUBMIT ADDITIONAL INFORMATION DIRECTLY TO THE

INDEPENDENT EXTERNAL REVIEW ENTITY WITHIN FIVE BUSINESS DAYS AFTER THE NOTIFICATION UNDER SUBSECTION (9) OF THIS SECTION. THE INDEPENDENT EXTERNAL REVIEW ENTITY SHALL PROVIDE A COPY OF THE INFORMATION SUBMITTED BY THE INDIVIDUAL TO THE CARRIER WHOSE ADVERSE DETERMINATION IS BEING REVIEWED WITHIN ONE BUSINESS DAY AFTER RECEIPT OF THE INFORMATION.

(b) The ~~certified~~ independent external review entity shall notify the ~~covered~~ individual requesting an independent external review, the physician or other health care professional of the ~~covered~~ individual requesting an independent external review, and the ~~health coverage plan~~ CARRIER of any additional medical information required to conduct the review after receipt of the documentation required OR PROVIDED pursuant to this ~~section~~ SUBSECTION (10). The ~~covered~~ individual requesting AN independent external review or the physician or other health care professional of the ~~covered~~ individual requesting an independent external review shall submit the additional information, or an explanation of why the additional information is not being submitted, to the ~~certified~~ independent external review entity and the ~~health coverage plan~~ CARRIER after the receipt of such a request.

(c) The ~~health coverage plan~~ CARRIER may ~~at its discretion,~~ determine that additional information provided by the ~~covered~~ individual requesting independent external review or the physician or other health care professional of the ~~covered~~ individual requesting independent external review UNDER SUBPARAGRAPH (III) OF PARAGRAPH (a) AND PARAGRAPH (b) OF THIS SUBSECTION (10) justifies a reconsideration of its ~~denial of coverage~~ ADVERSE DETERMINATION, and a subsequent decision by the ~~health coverage plan~~ CARRIER to provide coverage ~~shall terminate~~

TERMINATES the independent external review upon notification in writing to the ~~certified~~ independent external review entity and the ~~covered~~ individual requesting an independent external review.

~~(10)~~ (11) (a) The ~~certified~~ independent external review entity shall submit the expert determination to the ~~health coverage plan~~ CARRIER, the ~~covered~~ individual requesting independent external review, and the physician or other health care professional of the ~~covered~~ individual requesting an independent external review within ~~thirty working~~ FORTY-FIVE CALENDAR days after the ~~health coverage plan~~ INDEPENDENT EXTERNAL REVIEW ENTITY has received a request for external review. ~~except that, at the request of the expert reviewer, such deadline shall be extended by up to ten working days for the consideration of additional information required pursuant to this section.~~ In the case of an expedited review, the INDEPENDENT EXTERNAL REVIEW ENTITY SHALL SUBMIT THE determinations ~~shall be submitted within seven working days~~ AS EXPEDITIOUSLY AS POSSIBLE AND NO MORE THAN SEVENTY-TWO HOURS after the ~~health coverage plan has~~ INDEPENDENT EXTERNAL REVIEW ENTITY received a request for AN EXPEDITED external review. ~~except that, at the request of the expert reviewer, the deadline shall be extended for five working days for the consideration of additional information required pursuant to this section.~~ IF THE NOTICE OF THE DETERMINATION IN AN EXPEDITED REVIEW IS NOT MADE IN WRITING, THE INDEPENDENT EXTERNAL REVIEW ENTITY SHALL PROVIDE WRITTEN CONFIRMATION OF THE DECISION WITHIN FORTY-EIGHT HOURS AFTER THE DATE THE NOTICE OF DECISION IS TRANSMITTED TO THE INDIVIDUAL, THE PHYSICIAN, OR OTHER HEALTH CARE PROFESSIONAL.

(b) The expert reviewer's determination ~~shall~~ MUST:

(I) Be in writing and state the reasons the requested treatment or service should or should not be covered; ~~The expert reviewer's determinations shall~~

(II) Specifically cite the relevant provisions in the health coverage plan documentation, the specific medical condition of the ~~covered~~ individual requesting an independent external review, and the relevant documents provided pursuant to this section to support the expert reviewer's determination; ~~The expert reviewer's determination shall~~ AND

(III) Be based on an objective review of relevant medical and scientific evidence.

(c) Determinations ~~shall~~ MUST also include:

(I) The titles and qualifying credentials of the persons conducting the review;

(II) A statement of the understanding of the persons conducting the review of the nature of the grievance and all pertinent facts;

(III) The rationale for the decision;

(IV) Reference to medical and scientific evidence and documentation considered in making the determination; and

(V) In cases involving a determination adverse to the ~~covered~~ individual requesting an independent external review, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.

~~(11)~~ (12) The determinations of the expert reviewer ~~shall be~~ ARE binding on the ~~health coverage plan~~ CARRIER and on the ~~covered~~ individual requesting independent external review. A determination of the expert reviewer in favor of the ~~covered~~ individual requesting independent external review ~~shall create~~ CREATES a rebuttable presumption in any

subsequent action that the ~~health coverage plan's coverage~~ CARRIER'S ADVERSE determination was not appropriate. A determination of the expert reviewer in favor of the ~~health coverage plan shall create~~ CARRIER CREATES a rebuttable presumption in any subsequent action that the ~~health coverage plan's coverage~~ CARRIER'S ADVERSE determination was appropriate.

~~(12)~~ (13) Where an expert determination is made in favor of the ~~covered~~ individual requesting an independent external review, THE CARRIER SHALL PROVIDE coverage for the treatment and services required under this section ~~shall be provided~~ subject to the terms and conditions applicable to benefits under the health coverage plan.

~~(13)~~ (14) ~~A certified~~ AN independent external review entity and an expert reviewer assigned by ~~such~~ THE independent external review entity to conduct a review pursuant to this section ~~shall be~~ ARE immune from civil liability in any action brought by any person based upon the determinations made pursuant to this section. This subsection ~~(13) shall~~ (14) DOES not apply to an act or omission of the independent external review entity that is made in bad faith or involves gross negligence.

~~(14)~~ (15) ~~Nothing in this section shall make the health coverage plan~~ A CARRIER IS NOT liable for damages arising from any act or omission of the ~~certified~~ independent external review entity.

~~(15)~~ (16) A ~~health coverage plan~~ CARRIER may require a surety bond to indemnify the ~~health coverage plan~~ CARRIER for the ~~certified~~ independent external review entity's noncompliance with this section.

(17) AN INDEPENDENT EXTERNAL REVIEW ENTITY SHALL MAINTAIN WRITTEN RECORDS OF REVIEWS ON ALL REQUESTS FOR EXTERNAL REVIEW FOR WHICH IT WAS ASSIGNED TO CONDUCT AN EXTERNAL REVIEW FOR AT

LEAST THREE YEARS.

SECTION 21. In Colorado Revised Statutes, **amend with relocated provisions** 10-16-116 as follows:

10-16-116. Catastrophic health insurance - coverage - premium payments - reporting requirements - definitions - short title. (1) **[Formerly 10-16-114]** ~~Sections 10-16-114 to 10-16-117~~ THIS SECTION shall be known and may be cited as the "Colorado Catastrophic Health Insurance Coverage Act".

~~(1)~~ (2) An employer may offer catastrophic health insurance to its employees pursuant to ~~sections 10-16-114 to 10-16-117~~ THIS SECTION. Employees who elect ~~such~~ THE coverage shall pay the cost of the insurance pursuant to SUBSECTION (5) OF THIS section. ~~10-16-117.~~

~~(2)~~ (3) Each catastrophic health insurance policy issued pursuant to ~~subsection (1) of~~ this section ~~is required to~~ MUST:

(a) Be issued to the employer unless issued as an individual plan pursuant to section 10-16-105.2 (1) (d);

(b) In order to be considered a qualified higher deductible plan for purposes of a medical savings account pursuant to section 39-22-504.7, C.R.S., or other provisions of state law, meet the requirements for a qualifying plan for a ~~medical~~ HEALTH savings account under federal law and have a minimum deductible of at least one thousand five hundred dollars but no more than two thousand two hundred fifty dollars for individual coverage or at least three thousand dollars but no more than four thousand five hundred dollars for family coverage;

(c) Offer coverage for the spouse and dependent children of the insured employee;

(d) Cover all employees who elect coverage and are not otherwise

covered by medicare or another health insurance policy;

(e) For group coverage, cover an employee and eligible dependents regardless of health status; ~~except that a business group of one may be restricted to obtaining coverage during an open enrollment period as specified by section 10-16-105 (7.3) (i);~~

(f) Be priced according to appropriate rating requirements for health benefit plans as specified by law;

(g) Provide a clearly written contract of coverage, including a list of procedures covered under the policy;

~~(h) For group coverage, include a portability clause which provides that:~~

~~(I) When an employee leaves employment for any reason the employee, the employee's spouse, and the employee's dependent children may each elect to continue coverage or convert coverage to an individual policy pursuant to section 10-16-108; and~~

~~(II) Conversion benefits shall be the insured's choice of the same catastrophic coverage issued, without evidence of insurability, as an individual policy or the conversion coverage specified in section 10-16-108;~~

~~(i)~~ (h) Comply with requirements for health benefit plans specified in this article. ~~including those related to preexisting conditions in accordance with section 10-16-118.~~

~~(3) Insurers shall provide a written disclosure to a covered person that indicates the mandated benefits of section 10-16-104 (1), (1.7), (5), (5.5), (8), (9), (10), (11), (12), (13), (14), and (18) (b) (III) are covered benefits of the high deductible health plan; offered pursuant to section 10-16-105 (7.2) (b) (II); except that the mandated benefits for~~

~~mammography, prostate screenings, child health supervision services, and prosthetic devices shall be subject to policy deductibles.~~

(4) **[Formerly 10-16-117 (1)]** When catastrophic health insurance is purchased pursuant to ~~sections 10-16-114 to 10-16-117~~ THIS SECTION, the employer, at its option, may pay all or a part of ~~such~~ THE cost OF THE INSURANCE.

(5) (a) **[Formerly 10-16-117 (2)]** If claiming an exclusion of premium payments for state income tax purposes pursuant to section 39-22-104.5, C.R.S., an employee shall elect to purchase catastrophic health insurance by signing a written election, ~~Such election shall~~ WHICH MUST be in the form prescribed by the executive director of the department of revenue and ~~shall be~~ signed BY THE EMPLOYEE prior to the date the employer withholds the first contribution.

(b) **[Formerly 10-16-117 (3)]** An employer shall withhold the premium payments for catastrophic health insurance from the wages of an employee who has elected coverage pursuant to PARAGRAPH (a) OF THIS subsection ~~(2) of this section~~ (5) and shall remit the premiums to the insuring entity on the employee's behalf. All ~~such~~ premiums collected by an employer are withheld from the employee's wages on a pre-tax basis pursuant to section 39-22-104.5, C.R.S.

(c) **[Formerly 10-16-117 (4)]** An employer withholding premium payments from an employee's wages pursuant to PARAGRAPH (b) OF THIS subsection ~~(3) of this section~~ (5) shall report the amount withheld to the department of revenue, pursuant to rules promulgated by ~~such~~ THE EXECUTIVE DIRECTOR OF THE department.

(6) **[Formerly 10-16-115]** As used in ~~sections 10-16-114 to 10-16-117~~ THIS SECTION, unless the context otherwise requires:

(a) "Catastrophic health insurance" means insurance meeting the requirements set forth in SUBSECTION (3) OF THIS section. ~~10-16-116 (2).~~ THE TERM DOES NOT INCLUDE A CATASTROPHIC PLAN AS DEFINED IN SECTION 10-16-102 (10).

(b) "Dependent child" means an adopted or natural child of an employee who is:

(I) Under twenty-one years of age;

(II) Legally entitled to or the subject of a court order for the provision of proper or necessary subsistence, education, medical care, or any other care necessary for the individual's health, guidance, or well-being and who is not otherwise emancipated, self-supporting, married, or a member of the armed forces of the United States; or

(III) So mentally or physically incapacitated that the individual cannot provide for himself or herself.

(c) "Employee" means an individual who resides in this state and is employed by an employer.

(d) "Employer" means a person or entity employing one or more individuals in this state, excluding the federal government or businesses providing health insurance coverage through a self-insured plan ~~which~~ THAT has benefits equal to or greater than a catastrophic health insurance plan set forth in THIS section. ~~10-16-116.~~

SECTION 22. In Colorado Revised Statutes, **repeal and reenact, with amendments,** 10-16-118 as follows:

10-16-118. Prohibition against preexisting condition exclusions. A CARRIER OFFERING AN INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLAN IN THIS STATE SHALL NOT IMPOSE ANY PREEXISTING CONDITION EXCLUSION WITH RESPECT TO COVERAGE UNDER THE PLAN.

SECTION 23. In Colorado Revised Statutes, **amend** 10-16-129 as follows:

10-16-129. Health savings accounts. Any carrier authorized to conduct business in this state that offers coverage pursuant to part 2, 3, or 4 of this article may offer a high deductible health plan that would qualify for and may be offered in conjunction with a health savings account pursuant to 26 U.S.C. sec. 223, as amended. A carrier offering a high deductible health plan that may be offered in conjunction with a health savings account may apply the deductible to mandatory health benefits for ~~mammography,~~ prostate cancer screening ~~child health supervision services,~~ and prosthetic devices pursuant to section 10-16-104 (10) ~~(11),~~ AND (14) ~~and (18) (b) (III)~~ if ~~such~~ THOSE mandatory benefits are not considered by the federal department of treasury to be preventive or to have an acceptable deductible amount.

SECTION 24. In Colorado Revised Statutes, 10-16-136, **amend** (2) (a), (3.5) (a), and (5) (b); and **repeal** (5) (a) (III) (A) as follows:

10-16-136. Wellness and prevention programs - individual and small group health coverage plans - voluntary participation - incentives or rewards - definitions - legislative declaration - repeal. (2) (a) Consistent with section ~~10-16-107 (6)~~ 10-16-105.6 and subject to subsection (3) of this section, a carrier offering an individual health coverage plan or a small group plan in this state may offer incentives or rewards to encourage the individual or small group and other covered persons under the plan to participate in wellness and prevention programs. For purposes of small group plans, the incentives or rewards may be applied to the entire small group or to individuals in the small group based on their participation in wellness and prevention programs.

A carrier offering ~~such~~ incentives or rewards shall implement adequate measures to ensure that the privacy of individuals in the group is maintained and that individually identifiable health information is not shared or made available to an individual's employer or any other person not otherwise allowed access to the information under the federal "Health Insurance Portability and Accountability Act of 1996", as amended. A carrier shall not disclose to any third party, including a covered person's employer, and the covered person's employer shall not disclose, any information obtained from or about a covered person in connection with the covered person's participation in a wellness and prevention program that is reasonably attributable to the covered person, unless the covered person consents in writing to disclosure of ~~such~~ THE information.

(3.5) An incentive or reward based upon satisfaction of a standard related to a health risk factor may be offered or provided by a carrier only pursuant to a bona fide wellness and prevention program and if the following standards are met:

(a) (I) The incentive for the wellness and prevention program, together with the incentive for other wellness and prevention programs with respect to the INDIVIDUAL health coverage plan or small group plan that requires satisfaction of a standard related to a health risk factor:

(A) Is reasonably related to the program; and

(B) Does not exceed ~~twenty percent~~ A PERCENTAGE of the cost of employee-only coverage under the health coverage or small group plan, or, if an employee's dependents are allowed to participate in the program, does not exceed ~~twenty percent~~ A PERCENTAGE of the cost of the coverage in which an employee and dependents are enrolled. THE COMMISSIONER SHALL ADOPT A RULE, CONSISTENT WITH THE REQUIREMENTS OF FEDERAL

LAW, ESTABLISHING THE MAXIMUM AMOUNT OF THE INCENTIVE PERMITTED UNDER A WELLNESS AND PREVENTION PROGRAM FOR INDIVIDUAL HEALTH COVERAGE PLANS AND SMALL GROUP PLANS.

(I.5) An employer may also receive an incentive for participation of employees in a wellness and prevention program as long as the employees are allowed an incentive.

(II) For purposes of this paragraph (a), the cost of coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is, or the employee and any dependents are, receiving coverage.

(III) An incentive may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, including ~~but not limited to,~~ deductibles, copayments, or coinsurance, the absence of a surcharge, ~~or~~ the value of a benefit that would otherwise not be provided under the INDIVIDUAL health coverage or small group plan, OR OTHER FINANCIAL OR NONFINANCIAL INCENTIVES OR DISINCENTIVES.

(5) (a) The division of insurance shall determine which carriers are offering wellness and prevention programs in Colorado and collect the following information from those carriers:

(III) The total number of small groups in the small group market participating in programs offered by the carrier, specifying the number of each of the following small groups participating in such programs:

(A) ~~Business groups of one;~~

(b) The division shall determine the percentage of carriers issuing individual health coverage plans or small group plans in the state that offer wellness and prevention programs and shall provide that

information and the information collected pursuant to paragraph (a) of this subsection (5) to the health and human services ~~committees~~ COMMITTEE of the senate and THE HEALTH, INSURANCE, AND ENVIRONMENT COMMITTEE OF THE house of representatives, the business, labor, and technology committee of the senate, and the business, ~~affairs and~~ labor, AND ECONOMIC AND WORKFORCE DEVELOPMENT committee of the house of representatives, or their successor committees, ~~by January 1, 2012, and~~ by each January 1 ~~thereafter~~ until January 1, 2015. The division shall also make the information available to the public by that date.

SECTION 25. In Colorado Revised Statutes, **add with amended and relocated provisions** 10-16-139 as follows:

10-16-139. Access to care - rules. (1) **[Formerly 10-16-107 (5) (a)] Access to obstetricians and gynecologists.** ~~Effective January 1, 1997, a managed care plan~~ A HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED, RENEWED, OR REINSTATED IN THIS STATE ON OR AFTER JANUARY 1, 2014, that provides coverage for reproductive health or gynecological care shall not be DELIVERED, issued, ~~or~~ renewed, OR REINSTATED unless the plan ~~either:~~

~~(a)~~ provides a woman covered by the plan direct access to an obstetrician, gynecologist, or an advanced practice nurse who is a certified nurse midwife pursuant to section 12-38-111.5, C.R.S., participating and available under the plan for her reproductive health care or gynecological care.

(2) **[Formerly 10-16-107 (5.5)] Eye care services.** (a) ~~No~~ A health coverage plan or managed care plan that provides coverage for eye care services shall NOT be issued or renewed after January 1, 2001, by any entity subject to part 2, 3, or 4 of this article unless ~~such~~ THE health

coverage plan or managed care plan:

(I) Provides a covered person direct access to any eye care provider participating and available under the plan or through its eye care services intermediary for eye care services;

(II) Ensures that all eye care providers on a health coverage plan or managed care plan are annually included on any publicly accessible list of participating providers for the health coverage plan or managed care plan; and

(III) Allows each eye care provider on a health coverage plan or managed care plan panel to furnish covered eye care services to covered persons without discrimination between classes of eye care providers and to provide ~~such~~ THE services as permitted by their license.

(b) A CARRIER OFFERING A health coverage plan or managed care plan shall not:

(I) Impose a deductible or coinsurance for eye care services that is greater than the deductible or coinsurance imposed for other medical services under the health coverage plan or managed care plan;

(II) Require an eye care provider to hold hospital privileges as a condition of participation as a provider under the health coverage plan or managed care plan, unless an eye care provider is licensed pursuant to article 36 of title 12, C.R.S.; or

(III) Impose penalties upon primary care providers as a result of the direct access provisions of this ~~subsection (5.5)~~ SECTION.

(c) ~~Nothing in~~ This subsection ~~(5.5) shall be construed as~~ (2) DOES NOT:

(I) ~~Creating~~ CREATE coverage for any health care service that is not otherwise covered under the terms of the health coverage plan or

managed care plan;

(II) ~~Requiring~~ REQUIRE a health coverage plan or managed care plan to include as a participating provider every willing provider or health professional who meets the terms and conditions of the health coverage plan or managed care plan;

(III) ~~Preventing~~ PREVENT a covered person from seeking eye care services from the covered person's primary care provider in accordance with the terms of the covered person's health coverage plan or managed care plan;

(IV) ~~Increasing~~ INCREASE or ~~decreasing~~ DECREASE the scope of the practice of optometry as defined in section 12-40-102, C.R.S.;

(V) ~~Requiring~~ REQUIRE eye care services to be provided in a hospital or similar medical facility; or

(VI) ~~Prohibiting~~ PROHIBIT a health coverage plan or managed care plan from requiring a covered person to receive a referral or prior authorization from a primary care provider for any subsequent surgical procedures.

(d) As used in this subsection ~~(5.5)~~ (2), unless the context otherwise requires:

(I) "Eye care provider" means a participating provider who is an optometrist licensed to practice optometry pursuant to article 40 of title 12, C.R.S., or an ophthalmologist licensed to practice medicine pursuant to article 36 of title 12, C.R.S.

(II) "Eye care services" means those health care services related to the examination, diagnosis, treatment, and management of conditions and diseases of the eye and related structures that a HEALTH COVERAGE PLAN OR managed care plan is obligated to pay, reimburse, arrange, or

provide for covered persons or organizations as specified by a health coverage plan or managed care plan, excluding those health care services rendered in conjunction with a routine vision examination or the filling of prescriptions for corrective eyewear.

(3) **[Formerly 10-16-107 (7)] Treatment of intractable pain.** (a) A service or indemnity contract issued or renewed on or after January 1, 1998, by any entity subject to part 2, 3, or 4 of this article shall disclose in the contract and in information on coverage presented to consumers whether the health coverage plan or managed care plan provides coverage for treatment of intractable pain. If the contract is silent on coverage of intractable pain, ~~then~~ the contract ~~shall be~~ IS presumed to offer coverage for the treatment of intractable pain. If the contract is silent or if the plan specifically includes coverage for the treatment of intractable pain, the plan shall provide access to ~~such~~ THE treatment for any individual covered by the plan either:

(I) By a primary care physician with demonstrated interest and documented experience in pain management whose practice includes up-to-date pain treatment;

(II) By providing direct access to a pain management specialist located within this state and participating in and available under the plan; or

(III) By having procedures in place that ensure that, if the individual requests a timely referral for intractable pain management to a pain management specialist participating in and available under the plan, the CARRIER SHALL NOT UNREASONABLY DENY THE request for referral. ~~shall not be unreasonably denied by the plan.~~

(b) The commissioner ~~shall~~ MAY promulgate rules ~~pursuant to this~~

~~subparagraph (III)~~ TO IMPLEMENT AND ADMINISTER THIS SUBSECTION (3) that include ~~but need not be limited to,~~ the following issues:

~~(A)~~ (I) What constitutes a timely referral;

~~(B)~~ (II) Circumstances, practices, policies, contract provisions, or actions that constitute an undue or unreasonable interference with the ability of an individual to secure a referral or reauthorization for continuing care;

~~(C)~~ (III) The process for issuing a denial of a request, including the means by which an individual may receive notice of a denial and the reasons ~~therefor~~ FOR THE DENIAL in writing;

~~(D)~~ (IV) Actions that constitute improper penalties imposed upon primary care physicians as a result of referrals made pursuant to this ~~subsection (7)~~ SECTION; and

~~(E)~~ (V) Such other issues as the commissioner deems necessary.

~~(b)~~ (c) For purposes of this subsection ~~(7)~~ (3), "intractable pain" means a pain state in which the cause of the pain cannot be removed and FOR which, in the generally accepted course of medical practice, ~~no~~ relief or cure of the cause of the pain is ~~possible~~ IMPOSSIBLE or ~~none~~ has NOT been found after reasonable efforts, including ~~but not limited to,~~ evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.

(4) **Access to pediatric care.** (a) IF A CARRIER OFFERING AN INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLAN REQUIRES OR PROVIDES FOR THE DESIGNATION OF A PARTICIPATING PRIMARY HEALTH CARE PROFESSIONAL, THE CARRIER SHALL PERMIT THE PARENT OR LEGAL GUARDIAN OF EACH COVERED PERSON WHO IS A CHILD TO DESIGNATE ANY

PARTICIPATING PHYSICIAN WHO SPECIALIZES IN PEDIATRICS AS THE CHILD'S PRIMARY HEALTH CARE PROFESSIONAL IF THE PEDIATRICIAN IS AVAILABLE TO ACCEPT THE CHILD.

(b) THE PROVISIONS OF PARAGRAPH (a) OF THIS SUBSECTION (4) DO NOT WAIVE ANY EXCLUSIONS OF COVERAGE UNDER THE TERMS AND CONDITIONS OF THE HEALTH BENEFIT PLAN WITH RESPECT TO COVERAGE OF PEDIATRIC CARE.

SECTION 26. In Colorado Revised Statutes, **add** 10-16-140 as follows:

10-16-140. Grace periods - premium payments - rules. (1) FOR INDIVIDUAL AND SMALL EMPLOYER HEALTH BENEFIT PLANS ISSUED OR RENEWED FOR COVERAGE TO BEGIN ON OR AFTER JANUARY 1, 2014, FOR PERSONS RECEIVING A SUBSIDY UNDER THE FEDERAL ACT, THE COMMISSIONER SHALL ESTABLISH, BY RULE THAT COMPLIES WITH FEDERAL LAW, A REQUIREMENT THAT ALL INDIVIDUAL AND SMALL EMPLOYER HEALTH BENEFIT PLANS CONTAIN A PROVISION SPECIFYING THAT THE POLICYHOLDER IS ENTITLED TO A THREE-MONTH GRACE PERIOD FOR THE PAYMENT OF ANY PREMIUM DUE, OTHER THAN THE FIRST PREMIUM, DURING WHICH PERIOD THE PLAN CONTINUES IN FORCE UNLESS THE POLICYHOLDER SUBMITS WRITTEN NOTICE TO THE CARRIER, PRIOR TO DISCONTINUANCE OF THE PLAN IN ACCORDANCE WITH THE TERMS OF THE PLAN, THAT THE POLICYHOLDER IS DISCONTINUING THE COVERAGE. IN ACCORDANCE WITH FEDERAL LAW, THE COMMISSIONER'S RULE MAY PROVIDE THAT THE POLICYHOLDER IS LIABLE TO THE CARRIER FOR THE PAYMENT OF A PRO RATA PREMIUM FOR THE TIME THE COVERAGE WAS IN FORCE DURING THE GRACE PERIOD.

(2) FOR INDIVIDUAL AND SMALL EMPLOYER HEALTH BENEFIT

PLANS ISSUED OR RENEWED FOR COVERAGE TO BEGIN ON OR AFTER JANUARY 1, 2014, FOR PERSONS WHO ARE NOT RECEIVING A SUBSIDY UNDER THE FEDERAL ACT, THE COMMISSIONER SHALL ADOPT A RULE REQUIRING A THIRTY-ONE-DAY GRACE PERIOD.

(3) IF THE COVERED PERSON FAILS TO PAY ALL OR PART OF THE PREMIUM, THE CARRIER SHALL NOTIFY THE COVERED PERSON OF THE NONPAYMENT OF PREMIUM WITHIN THE GRACE PERIOD ESTABLISHED PURSUANT TO THIS SECTION AND IN ACCORDANCE WITH SECTION 10-16-222, 10-16-325, OR 10-16-429, AS APPLICABLE.

(4) THE COMMISSIONER MAY ADOPT RULES AS NECESSARY TO IMPLEMENT AND ADMINISTER THIS SECTION.

SECTION 27. Repeal of relocated provisions in this act. In Colorado Revised Statutes, **repeal** 10-16-104 (16), 10-16-114, 10-16-115, 10-16-117, and 10-16-214 (2) (b).

SECTION 28. In Colorado Revised Statutes, **repeal** 10-16-104 (5), (7), (9), (11), (15), and (18) (a) (II), 10-16-105.5, and 10-16-201.5.

SECTION 29. In Colorado Revised Statutes, 10-16-202, **amend** (3) and (4) (a) as follows:

10-16-202. Required provisions in individual sickness and accident policies. (3) Provisions as follows: "Time limit on certain defenses: (a) ~~After~~ Two years ~~from~~ AFTER the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period. THE POLICY CANNOT BE RETROACTIVELY TERMINATED EXCEPT FOR FRAUD OR INTENTIONAL MISREPRESENTATION. FOR ANY TERMINATION OTHER THAN

FOR FRAUD OR INTENTIONAL MISREPRESENTATION, THE CARRIER SHALL PROVIDE NOTICE THIRTY DAYS IN ADVANCE OF THE CANCELLATION OF THE POLICY."

"(The foregoing policy provision ~~shall~~ DOES not ~~be so construed as to~~ affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor ~~to~~ limit the application of section 10-16-203 in the event of misstatement with respect to age or occupation or other insurance.)"

(A policy ~~which~~ THAT the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age fifty, or in the case of a policy issued after age forty-four, for at least five years ~~from~~ AFTER its date of issue, may contain, in lieu of the foregoing, the following provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption "Incontestable":

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it ~~shall become~~ BECOMES incontestable as to the statements contained in the application.")

(b) Except for individual disability income insurance policies, no claim for loss incurred or disability, as defined in the policy, commencing ~~after~~ one year ~~from~~ AFTER the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

~~(An individual health benefit plan shall not define a preexisting condition more restrictively than an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted~~

~~a health care professional, or took prescription drugs within the twelve months immediately preceding the effective date of coverage.)~~

(c) If this is an individual disability income insurance policy then no claim for loss incurred or disability, as defined in this individual disability income insurance policy, commencing ~~after~~ two years ~~from~~ AFTER the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(4) (a) EXCEPT AS REQUIRED BY SECTION 10-16-140, IN A POLICY OTHER THAN A HEALTH BENEFIT PLAN, a provision as follows: "Grace period: A grace period of ..... (insert a number not less than '7' for weekly premium policies, '10' FOR monthly premium policies, and '31' for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

SECTION 30. In Colorado Revised Statutes, 10-16-214, **amend** (1) (c), (3) (a) introductory portion, and (3) (a) (I) as follows:

10-16-214. Group sickness and accident insurance. (1) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without their dependents, and issued upon the following bases:

(c) On and after July 1, 1994, under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class of individuals that could be insured under such group life insurance policy; except that, on and after July 1, 1994, ~~such~~ a GROUP SICKNESS AND ACCIDENT INSURANCE policy

~~shall~~ MUST cover at least two or more individuals at date of issue; ~~and on and after January 1, 1996, such a policy shall cover a business group of one at the date of issue;~~

(3) (a) Except as REQUIRED BY SECTION 10-16-140 OR AS provided for in subsection (2) of this section, all policies of group sickness and accident insurance providing coverage to persons residing in the state, ~~shall~~ MUST contain in substance the following provisions or provisions ~~which~~ THAT, in the opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

(I) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder has given the ~~insurer~~ CARRIER written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the policy. The policy may provide that the policyholder ~~shall be~~ IS liable to the ~~insurer~~ CARRIER for the payment of a pro rata premium for the time the coverage was in force during ~~such~~ THE grace period.

SECTION 31. In Colorado Revised Statutes, **add** 10-16-222 as follows:

10-16-222. Termination of policies. A CARRIER SHALL NOT RETROACTIVELY TERMINATE A POLICY ISSUED PURSUANT TO THIS PART 2 EXCEPT FOR FRAUD OR INTENTIONAL MISREPRESENTATION. FOR ANY TERMINATION OTHER THAN FOR FRAUD OR INTENTIONAL MISREPRESENTATION, THE CARRIER SHALL PROVIDE NOTICE THIRTY DAYS IN ADVANCE OF THE CANCELLATION OF THE POLICY.

SECTION 32. In Colorado Revised Statutes, **add** 10-16-325 as follows:

10-16-325. Termination of health policies. A CORPORATION SHALL NOT RETROACTIVELY TERMINATE A POLICY ISSUED PURSUANT TO THIS PART 3 EXCEPT FOR FRAUD OR INTENTIONAL MISREPRESENTATION. FOR ANY TERMINATION OTHER THAN FOR FRAUD OR INTENTIONAL MISREPRESENTATION, THE CORPORATION SHALL PROVIDE NOTICE THIRTY DAYS IN ADVANCE OF THE CANCELLATION OF THE POLICY.

SECTION 33. In Colorado Revised Statutes, **amend with relocated provisions** 10-16-406 as follows:

10-16-406. Evidence of coverage. (1) Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a nonprofit hospital, medical-surgical, and health service corporation, whether by option or otherwise, the insurer or the nonprofit hospital, medical-surgical, and health service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

(2) **[Formerly 10-16-107 (3) (b), (3) (c), and (3) (d)]** (a) THE COMMISSIONER MAY ESTABLISH, BY RULE, THE REQUIRED ELEMENTS OF an evidence of coverage, ~~shall contain~~ WHICH MUST:

(I) ~~No~~ NOT CONTAIN ANY provisions or statements ~~which~~ THAT are unjust, unfair, inequitable, misleading, or deceptive; ~~which~~ encourage misrepresentation; or ~~which~~ are untrue, misleading, or deceptive as defined in section 10-16-413 (1); and

(II) CONTAIN a clear and complete statement, if a contract, or a

reasonably complete summary, if a certificate, of:

(A) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan, including the ability to obtain a second opinion for proposed treatment by the health care provider, if the health benefit plan provides such coverage;

(B) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(C) Where and in what manner information is available as to how services may be obtained;

(D) The total amount of payment for health care services and the indemnity or service benefits, if any, ~~which~~ THAT the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;

(E) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

~~(c)~~ (b) ~~Any~~ THE CARRIER MAY EVIDENCE A subsequent change ~~may be evidenced~~ IN COVERAGE in a separate document issued to the enrollee.

~~(d)~~ (c) A copy of the form of the evidence of coverage to be used in this state, and any amendment ~~thereto, shall be~~ TO THE FORM, IS subject to the filing and approval requirements of section 10-16-107.2. ~~unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or nonprofit hospital, medical-surgical, and health service corporations, in which event the filing and approval provisions of subsection (2) of this section shall apply. To the extent, however, that such provisions do not apply, the requirements in paragraph~~

~~(b) of this subsection (3) shall be applicable.~~

SECTION 34. In Colorado Revised Statutes, **add** 10-16-429 as follows:

10-16-429. Termination of contract. A HEALTH MAINTENANCE ORGANIZATION SHALL NOT RETROACTIVELY TERMINATE A POLICY OR CONTRACT ISSUED PURSUANT TO THIS PART 4 EXCEPT FOR FRAUD OR INTENTIONAL MISREPRESENTATION. FOR ANY TERMINATION OTHER THAN FOR FRAUD OR INTENTIONAL MISREPRESENTATION, THE HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE NOTICE THIRTY DAYS IN ADVANCE OF THE CANCELLATION OF THE POLICY OR CONTRACT.

SECTION 35. In Colorado Revised Statutes, 10-16-507, **add with amended and relocated provisions** (3) as follows:

10-16-507. Enrollee coverage by prepaid dental care plan organizations - form filing requirements. (3) **[Formerly 10-16-107 (4)]** (a) For prepaid dental care plans, ~~no~~ THE PREPAID DENTAL CARE PLAN ORGANIZATION SHALL NOT ISSUE OR DELIVER enrollee coverage or AN amendment, advertising matter, or sales material ~~shall be issued or delivered~~ to any person in this state until THE CARRIER HAS FILED a copy of the form of the enrollee coverage or amendment, advertising matter, or sales material ~~has been filed~~ with the commissioner.

(b) The enrollee coverage ~~shall~~ MUST contain a clear and complete statement, ~~of~~ IF a contract, or a reasonably complete summary, if a certificate of contract, of:

(I) The prepaid dental care services to which the enrollee is entitled under the prepaid dental care plan;

(II) Any limitations of the services, kind of services, or benefits to be provided, including any deductible or copayment feature;

(III) Where and in what manner information is available as to how services may be obtained;

(IV) The enrollee's obligation respecting charges for the prepaid dental care plan.

(c) The enrollee coverage, advertising matter, and sales material ~~shall~~ MUST NOT contain ~~no~~ ANY provisions or statements ~~which~~ THAT are unjust, unfair, inequitable, misleading, or deceptive; ~~or which~~ encourage misrepresentation; or ~~which~~ are untrue or misleading.

(d) The commissioner shall approve any form of enrollee coverage if the requirements of paragraphs (b) and (c) of this subsection ~~(4)~~ (3) are met and the prepaid dental care plan ORGANIZATION is able, in the judgment of the commissioner, to meet its financial obligations under the enrollee coverage. It is unlawful to issue ~~such~~ THE form until approved BY THE COMMISSIONER. If the commissioner ~~does not~~ FAILS TO disapprove ~~any such~~ A form OF ENROLLEE COVERAGE within thirty days after the filing, ~~it shall be~~ THE FORM IS deemed approved. If the commissioner disapproves a form of enrollee coverage, advertising matter, or sales material, the commissioner shall notify the prepaid dental care plan organization, specifying the reasons for disapproval. The commissioner shall grant a hearing on ~~such~~ A disapproval within fifteen days after THE COMMISSIONER RECEIVES a request in writing ~~is received~~ from the prepaid dental care plan organization.

SECTION 36. In Colorado Revised Statutes, 10-16-704, **amend** (2) (g) (III); and **add** (1.5) and (5.5) as follows:

10-16-704. Network adequacy - rules - legislative declaration. (1.5) (a) (I) THE COMMISSIONER SHALL PROMULGATE RULES, CONSISTENT WITH FEDERAL LAW, TO:

(A) REQUIRE A CARRIER PROVIDING MANAGED CARE PLANS TO INCLUDE ESSENTIAL COMMUNITY PROVIDERS IN THE CARRIER'S NETWORK; OR

(B) ALLOW A CARRIER PROVIDING MANAGED CARE PLANS THAT PROVIDES A MAJORITY OF COVERED PROFESSIONAL SERVICES THROUGH PHYSICIANS EMPLOYED BY THE CARRIER OR THROUGH A SINGLE CONTRACTED MEDICAL GROUP TO COMPLY WITH THE ALTERNATE STANDARD FOR ESSENTIAL COMMUNITY PROVIDERS PERMITTED UNDER FEDERAL LAW.

(II) FOR PURPOSES OF THE RULES, "ESSENTIAL COMMUNITY PROVIDERS" INCLUDES PROVIDERS THAT SERVE PREDOMINATELY LOW-INCOME, MEDICALLY UNDERSERVED INDIVIDUALS, SUCH AS HEALTH CARE PROVIDERS DEFINED IN THE FEDERAL LAW AND UNDER PART 4 OF ARTICLE 4 OF TITLE 25.5, C.R.S.; EXCEPT THAT NOTHING IN THIS SUBSECTION (1.5) REQUIRES ANY CARRIER TO PROVIDE COVERAGE FOR ANY SPECIFIC MEDICAL PROCEDURE.

(b) THE COMMISSIONER MAY PROMULGATE RULES TO REQUIRE CARRIERS TO BE ACCREDITED BY AN ACCREDITING ENTITY RECOGNIZED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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

(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)~~ (1) AND (4).

(5.5) (a) NOTWITHSTANDING ANY PROVISION OF LAW, A CARRIER THAT PROVIDES ANY BENEFITS WITH RESPECT TO SERVICES IN AN

EMERGENCY DEPARTMENT OF A HOSPITAL SHALL COVER EMERGENCY SERVICES:

(I) WITHOUT THE NEED FOR ANY PRIOR AUTHORIZATION DETERMINATION;

(II) REGARDLESS OF WHETHER THE HEALTH CARE PROVIDER FURNISHING EMERGENCY SERVICES IS A PARTICIPATING PROVIDER WITH RESPECT TO EMERGENCY SERVICES;

(III) FOR SERVICES PROVIDED OUT OF NETWORK;

(IV) WITHOUT IMPOSING ANY ADMINISTRATIVE REQUIREMENT OR LIMITATION ON COVERAGE THAT IS MORE RESTRICTIVE THAN THE REQUIREMENTS OR LIMITATIONS THAT APPLY TO EMERGENCY SERVICES RECEIVED FROM IN-NETWORK PROVIDERS; AND

(V) WITH THE SAME COST SHARING REQUIREMENTS AS WOULD APPLY IF EMERGENCY SERVICES WERE PROVIDED IN-NETWORK.

(b) FOR PURPOSES OF THIS SUBSECTION (5.5):

(I) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT A PRUDENT LAYPERSON WITH AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY EXPECT, IN THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION, TO RESULT IN:

(A) PLACING THE HEALTH OF THE INDIVIDUAL OR, WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR HER UNBORN CHILD, IN SERIOUS JEOPARDY;

(B) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

(C) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

(II) "EMERGENCY SERVICES", WITH RESPECT TO AN EMERGENCY

MEDICAL CONDITION, MEANS:

(A) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE THE EMERGENCY MEDICAL CONDITION; AND

(B) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, FURTHER MEDICAL EXAMINATION AND TREATMENT AS REQUIRED TO STABILIZE THE PATIENT TO ASSURE, WITHIN REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE TRANSFER OF THE INDIVIDUAL FROM A FACILITY, OR WITH RESPECT TO AN EMERGENCY MEDICAL CONDITION.

SECTION 37. In Colorado Revised Statutes, 6-1-102, **amend** (4.3) as follows:

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

(4.3) "Discount health plan" means a program evidenced by a membership agreement, contract, card, certificate, device, or mechanism, which offers health care services, as defined in section 10-16-102 ~~(22)~~ (33), C.R.S., or related products including, but not limited to, prescription drugs and medical equipment, at purported discounted rates from health care providers advertised as participating in the program. A "discount health plan" does not include a program in which a participating provider has agreed, as a condition of his or her participation in the program, to negotiate the prices to be charged for his or her services directly with consumers in the program and the provider is not required to offer discounted prices for his or her services as part of the program.

SECTION 38. In Colorado Revised Statutes, 6-1-712, **amend** (2) (a), (3) (a), and (3) (b) as follows:

6-1-712. Discount health plan and cards - deceptive trade practices. (2) The provisions of this section shall not apply to:

(a) A carrier as defined in section 10-16-102 (8), C.R.S., that offers discounts for services to a covered person, as defined in section 10-16-102 ~~(13.5)~~ (15), C.R.S., and such services are supplemental to and not part of the health coverage plan of the carrier;

(3) For the purposes of this section, unless the context otherwise requires:

(a) "Health care services" ~~shall have~~ HAS the same meaning as in section 10-16-102 ~~(22)~~ (33), C.R.S.

(b) "Provider" ~~shall have~~ HAS the same meaning as in section 10-16-102 ~~(36)~~ (56), C.R.S.

SECTION 39. In Colorado Revised Statutes, 6-18-302, **amend** (1) (b) (I) as follows:

6-18-302. Creation of provider networks - requirements. (1) (b) (I) Except as provided in subparagraph (II) of this paragraph (b), if a provider network or individual provider organized on or after July 1, 1994, or organized prior to said date, proposes or is engaged in the transaction of insurance business, as defined in section 10-3-903, C.R.S., or the activities of a health maintenance organization as defined in section 10-16-102 ~~(23)~~ (35), C.R.S., such provider network or individual provider must hold a certificate of authority from the commissioner of insurance to do business as an insurance company under title 10, C.R.S., or to establish a health maintenance organization under section 10-16-402, C.R.S.

SECTION 40. In Colorado Revised Statutes, 6-20-202, **amend** (1) (a) as follows:

6-20-202. Notice to patient of debt. (1) (a) When a person has health benefit coverage to provide payment for care or treatment rendered by a health care provider and the person has notified the health care provider of coverage within thirty days after the date the care or treatment was rendered, and if the health coverage plan, as defined in section 10-16-102 ~~(22.5)~~ (34), C.R.S., pays only a portion of the debt, prior to the assignment of the debt to a licensed collection agency, the health care provider shall mail written notice to the last-known address of the person responsible for payment of the debt at least thirty days before any collection activity on any amount due and owing the health care provider.

SECTION 41. In Colorado Revised Statutes, 8-70-114, **amend** (2) (b) (VIII) as follows:

8-70-114. Employing unit - definitions - rules - employee leasing company certification fund - repeal. (2) (b) Notwithstanding subsection (1) of this section, an employee leasing company shall be considered an employing unit or the coemployer of a work-site employer's employees if, pursuant to an employee leasing company contract with the work-site employer, it has the following rights and responsibilities:

(VIII) An employee leasing company, as the employing unit or coemployer, may aggregate all employees for the purpose of sponsoring and administering workers' compensation plans pursuant to article 44 of this title and fully insured health coverage plans, as defined in section 10-16-102 ~~(22.5)~~ (34), C.R.S., employee pension benefit plans, and provision of benefits pursuant to such plans. As employing units or coemployers, employee leasing companies shall be entitled to sponsor

fully insured employer plans and offer employee benefits to the full extent afforded employers by law. A health plan sponsored by an employee leasing company with an aggregate of more than fifty employees shall comply with all the provisions of Colorado law that apply to large employer health plans, including consumer and provider protections, mandated benefits, nondiscrimination and fair marketing rules, preexisting limitations, and other required health plan policy provisions, and the carrier underwriting the plan shall be responsible for assuring compliance with this requirement pursuant to section 10-16-214 (5), C.R.S. Notwithstanding any provision of this section to the contrary, any workers' compensation insurance carrier may issue an insurance policy that insures either the employee leasing company or the work-site employer as the employer pursuant to the "Workers' Compensation Act of Colorado", articles 40 to 47 of this title. Article 41 of this title shall apply to both the employee leasing company and the work-site employer, regardless of whether the policy is issued to the employee leasing company or the work-site employer. Notwithstanding any provision of this section to the contrary, any insurance carrier may issue an insurance policy that insures the employee leasing company as the employer pursuant to article 16 of title 10, C.R.S. An insurance carrier that issues an insurance policy to an employee leasing company shall be entitled to rely upon a copy of the certification filed by the employee leasing company with the department under paragraph (e) of this subsection (2), if such certification is currently valid, for the purpose of determining whether the leasing company is an "employer" under Colorado law.

SECTION 42. In Colorado Revised Statutes, 10-3-1104, **amend** (1) (v) an (1) (w) as follows:

10-3-1104. Unfair methods of competition - unfair or deceptive acts or practices. (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(v) Failure to comply with all provisions of section 10-16-108.5 concerning fair marketing of ~~basic and standard~~ health benefit plans, and section 10-16-105 concerning guaranteed ~~issue of basic and standard~~ ISSUANCE OF INDIVIDUAL AND SMALL EMPLOYER health benefit plans;

(w) Failure to comply with the provisions of section ~~10-16-201.5~~ 10-16-105.1 concerning the renewability of ~~individual~~ health benefit plans;

SECTION 43. In Colorado Revised Statutes, 10-4-636, **amend** (4) (c) as follows:

10-4-636. Disclosure requirements for automobile insurance products offered - rules. (4) The disclosure form required by subsection (1) of this section shall include a disclosure specifying that:

(c) Medical payments coverage applies to any coinsurance or deductible amount required to be paid by the person's health coverage plan, as defined in section 10-16-102 ~~(22.5)~~ (34); and

SECTION 44. In Colorado Revised Statutes, 10-4-641, **amend** (1) as follows:

10-4-641. Rules - medical payments coverage. (1) The commissioner shall promulgate any necessary rules for the administration of medical payments coverage and coordination of benefits and the implementation of section 10-4-636 (4) concerning disclosures required to be made regarding medical payments coverage and the definition of commercial automobile insurance policies for purposes of the exception

allowed in section 10-4-636 (8). Medical payments coverage shall be primary to any health insurance benefit of a person injured in a motor vehicle accident, and medical payments coverage shall apply to any coinsurance or deductible amount required by the injured person's health coverage plan, as defined in section 10-16-102 ~~(22.5)~~ (34).

SECTION 45. In Colorado Revised Statutes, 10-8-503, **amend** (6.8), (7.5), (8), (10.5), and (17.5) as follows:

10-8-503. Definitions. As used in this part 5, unless the context otherwise requires:

(6.8) "Group health plan" ~~shall have the same meaning as "group health plan" as set forth in section 10-16-105.5 (1) (a)~~ MEANS AN EMPLOYEE WELFARE BENEFIT PLAN, AS DEFINED IN 29 U.S.C. SEC. 1002 (1) OF THE FEDERAL "EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974", TO THE EXTENT THAT THE PLAN PROVIDES HEALTH CARE SERVICES, INCLUDING ITEMS AND SERVICES PAID FOR AS HEALTH CARE SERVICES, TO EMPLOYEES OR THEIR DEPENDENTS DIRECTLY OR THROUGH INSURANCE REIMBURSEMENT OR OTHERWISE. A "GROUP HEALTH PLAN" INCLUDES A GOVERNMENT OR CHURCH PLAN.

(7.5) "Health benefit plan" has the same meaning as set forth in section 10-16-102 ~~(21)~~ (32).

(8) "Health care services" has the same meaning as set forth in section 10-16-102 ~~(22)~~ (33).

(10.5) "Insurer" means any entity that provides group or individual health benefit plans ~~as defined in section 10-16-102 (21)~~ subject to state insurance regulation in this state, as well as any entity that directly or indirectly provides stop-loss or excess loss insurance to a self-insured group health plan including a property and casualty insurance company.

(17.5) "Qualifying previous coverage" has the same meaning as "creditable coverage" as set forth in section 10-16-102 ~~(13.7)~~ (16).

SECTION 46. In Colorado Revised Statutes, 10-8-513.5, **amend** (1) (a) (I) and (2) as follows:

10-8-513.5. Federally eligible individuals. (1) (a) For the purposes of this part 5, "federally eligible individual" means any one of the following, to the extent federally eligible individuals are designated by the governor:

(I) Any individual: ~~who meets the definition of "federally eligible individual" pursuant to section 10-16-105.5 (1);~~

(A) FOR WHOM, AS OF THE DATE ON WHICH THE INDIVIDUAL SEEKS COVERAGE, THE AGGREGATE OF PERIODS OF CREDITABLE COVERAGE IS EIGHTEEN MONTHS OR MORE AND WHOSE MOST RECENT PRIOR CREDITABLE COVERAGE WAS UNDER A GROUP HEALTH PLAN;

(B) WHO IS NOT ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFIT PLAN, MEDICARE, MEDICAID, OR THE CHILDREN'S BASIC HEALTH PLAN AND DOES NOT HAVE OTHER HEALTH BENEFIT PLAN COVERAGE;

(C) WHOSE MOST RECENT COVERAGE WAS NOT TERMINATED AS A RESULT OF NONPAYMENT OF PREMIUMS OR FRAUD; AND

(D) WHO DID NOT TURN DOWN AN OFFER OF CONTINUATION COVERAGE IF IT WAS OFFERED AND WHO SUBSEQUENTLY EXHAUSTED THAT COVERAGE.

(2) A dependent of a federally eligible individual may be covered under the program if the dependent satisfies the definition of "dependent" set forth in section 10-16-102 ~~(14)~~ (17); except that the program need not offer the same health benefit plan or the same premium to such dependent as is offered to eligible individuals.

SECTION 47. In Colorado Revised Statutes, 10-16-104.8, **amend** (3) as follows:

10-16-104.8. Mental health services coverage - court-ordered. (3) For purposes of this section, "mental health services" includes ~~treatment for mental illness as described in section 10-16-104 (5) and~~ treatment for biologically based mental illness AND MENTAL DISORDERS as described in section 10-16-104 (5.5).

SECTION 48. In Colorado Revised Statutes, 10-16-122, **amend** (1) as follows:

10-16-122. Access to prescription drugs. (1) Except as provided in section 25.5-5-404 (1) (u), C.R.S., any pharmacy benefit management firm or intermediary whose contract with a carrier ~~as defined in section 10-16-102 (8)~~ includes an open network shall allow participation by each pharmacy provider in the contract service area. If a pharmacy benefit management firm or intermediary offers an open network, the pharmacy benefit management firm or intermediary may offer such network on a regional or local basis.

SECTION 49. In Colorado Revised Statutes, 10-16-201 **amend** (3) (c) as follows:

10-16-201. Form and content of individual sickness and accident insurance policies. (3) (c) Nothing in this subsection (3) ~~shall be construed to negate~~ NEGATES the renewability requirements for health benefit plans specified in section ~~10-16-201.5~~ 10-16-105.1.

SECTION 50. In Colorado Revised Statutes, 10-16-324, **amend** (4) (e) (I) (F) as follows:

10-16-324. Conversion of corporation to a stock insurance company. (4) The plan shall set forth with specificity the terms and

conditions of the proposed conversion and shall do all of the following:

(e) (I) Specify a reasonable treatment for the benefit of the citizens of the state of Colorado of the value of the corporation on all of the following terms that must be approved by the commissioner:

(F) The charitable mission and grant-making functions of each qualifying entity must be dedicated to promoting or serving the health care needs of the citizens of Colorado; except that in no event shall any qualifying entity use the consideration, or any proceeds or gains thereon, transferred to it by the corporation to compete directly as a licensed carrier ~~as defined in section 10-16-102 (8)~~ with the corporation or any of its affiliates;

SECTION 51. In Colorado Revised Statutes, 10-16-705, **amend** (12) (a) and (14) (b) as follows:

10-16-705. Requirements for carriers and participating providers. (12) (a) A carrier shall establish one or more mechanisms by which the participating providers may determine, at the time services are provided, whether or not a person is covered by the carrier OR IS WITHIN THE GRACE PERIOD ESTABLISHED UNDER SECTION 10-16-104 (1), DURING WHICH PERIOD A CARRIER MAY HOLD A CLAIM FOR SERVICES PENDING RECEIPT OF FULL PREMIUM PAYMENT. If a carrier maintains only one mechanism, such mechanism shall not require electronic access.

(14) Every contract between a carrier or entity that contracts with a carrier and a participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include:

(b) A provision that allows a covered person to receive a standing referral ~~as defined in section 10-16-102 (43.5)~~ for medically necessary

treatment, to a specialist or specialized treatment center participating in the carrier's network or participating in a subdivision or subgrouping of the carrier's network if the subdivision or subgrouping demonstrates network adequacy pursuant to section 10-16-704. The primary care provider for the covered person, in consultation with the specialist and covered person, shall determine that the covered person needs ongoing care from the specialist in order to make the standing referral. A time period for the standing referral of up to one year, or a longer period of time if authorized by the carrier or any entity that contracts with the carrier, shall be determined by the primary care provider in consultation with the specialist or specialized treatment center. The specialist or specialized treatment center shall refer the covered person back to the primary care provider for primary care. To be reimbursed by the carrier or entity contracting with a carrier, treatment provided by the specialist shall be for a covered person and must comply with provisions contained in the covered person's certificate or policy. The primary care physician shall record the reason, diagnosis, or treatment plan necessitating the standing referral.

SECTION 52. In Colorado Revised Statutes, 10-16-1002, **amend** (5) as follows:

10-16-1002. Definitions. As used in this part 10, unless the context otherwise requires:

(5) "Managed care" means systems or techniques generally used by third-party payors or their agents to affect access to, and to control, payment for health care services. For example, and not for the purpose of limitation, managed care techniques most often include one or more of the following: Prior, concurrent, and retrospective review of the medical

necessity and appropriateness of services or of the site at which services are provided; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care. "Managed care" also includes but is not limited to health maintenance organizations. ~~as defined in section 10-16-102 (23).~~

SECTION 53. In Colorado Revised Statutes, **amend** 10-16-1007 as follows:

10-16-1007. Prohibition on cooperatives transacting insurance business. A cooperative shall not perform any activity included in the definition of transacting insurance business in this state, as provided in section 10-3-903, except as otherwise authorized in the powers, duties, and responsibilities of cooperatives as set forth in section 10-16-1009. A cooperative shall not establish or engage in the activities of a health maintenance organization. ~~as defined in section 10-16-102 (23).~~

SECTION 54. In Colorado Revised Statutes, 10-16-1011, **amend** (5) (b) (II) (A) as follows:

10-16-1011. Requirements for waivered health care coverage cooperatives - rules. (5) (b) (II) (A) Notwithstanding subparagraph (I) of this paragraph (b) and subject to the provisions of sub-subparagraph (B) of this subparagraph (II), a waivered cooperative and a participating carrier may negotiate a percentage discount off of what would otherwise be allowable rates under sections ~~10-16-105 (8) (a)~~ 10-16-107 (6) (a) and 10-16-1012 for a particular plan. That percentage discount shall be applied uniformly to all small employer members of the cooperative.

Pursuant to section 10-16-1012, a carrier may apply rating factors differently for its business with a waivered cooperative than for the carrier's other business. Participating carriers shall notify the division of insurance of a negotiated cooperative discount at least thirty days prior to use.

SECTION 55. In Colorado Revised Statutes, 10-18-105, **amend** (1) as follows:

10-18-105. Loss ratio standards and filing requirements. (1) Every insurer providing group or individual medicare supplement insurance benefits to a resident of this state pursuant to section 10-18-102 shall file a copy of the group master policy or individual policy and any certificate used in this state in accordance with the filing requirements and procedures of sections ~~10-16-107 (2) and (3)~~ 10-16-107.2 and 10-16-406; except that no insurer shall be required to make a filing earlier than thirty days after insurance was provided to a resident of this state under a group master policy issued for delivery outside this state.

SECTION 56. In Colorado Revised Statutes, 10-20-104, **amend** (2) (b) (X) as follows:

10-20-104. Coverage and limitations - coordination of benefits. (2) (b) This article shall not provide coverage for:

(X) SERVICES COVERED UNDER A POLICY OF sickness and accident insurance as defined in section 10-16-102 ~~(30)~~ (50) when written by a property and casualty insurer as part of an automobile insurance contract;

SECTION 57. In Colorado Revised Statutes, 12-32-109.5, **amend** (6) (d.5) as follows:

12-32-109.5. Professional service corporations, limited liability companies, and registered limited liability partnerships for the

practice of podiatry - definitions. (6) As used in this section, unless the context otherwise requires:

(d.5) "Health benefit plan" ~~shall have~~ HAS the same meaning as set forth in section 10-16-102 ~~(21)~~ (32), C.R.S.

SECTION 58. In Colorado Revised Statutes, 12-41-124, **amend** (6) (a.5) and (6) (d.3) as follows:

12-41-124. Professional service corporations, limited liability companies, and registered limited liability partnerships for the practice of physical therapy - definitions. (6) As used in this section, unless the context otherwise requires:

(a.5) "Carrier" ~~shall have~~ HAS the same meaning as set forth in section 10-16-102 (8), C.R.S.

(d.3) "Health benefit plan" ~~shall have~~ HAS the same meaning as set forth in section 10-16-102 ~~(21)~~ (32), C.R.S.

SECTION 59. In Colorado Revised Statutes, 24-51-1204, **amend** (1) (a) as follows:

24-51-1204. Health care program - eligibility. (1) The following persons are eligible to enroll in the health care program:

(a) All benefit recipients, including those from the Denver public schools division, and their dependents, including any dependent as defined in section 10-16-102 ~~(14)~~ (17), C.R.S.; any unmarried children who are not natural or adopted children of the benefit recipient but who reside full time with the benefit recipient, are dependents of the benefit recipient for federal income tax purposes, and meet the age requirements of section 10-16-102 ~~(14)~~ (17), C.R.S.; and any qualified children as defined in the rules adopted by the board;

SECTION 60. In Colorado Revised Statutes, 25-1-801, **amend**

(1) (a) and (1) (b) (I) as follows:

25-1-801. Patient records in custody of health care facility. (1) (a) Every patient record in the custody of a health facility licensed or certified pursuant to section 25-1.5-103 (1) or article 3 of this title, or both, or any entity regulated under title 10, C.R.S., providing health care services, as defined in section 10-16-102 ~~(22)~~ (33), C.R.S., directly or indirectly through a managed care plan, as defined in section 10-16-102 ~~(26.5)~~ (43), C.R.S., or otherwise shall be available for inspection to the patient or the patient's designated representative through the attending health care provider or such provider's designated representative at reasonable times and upon reasonable notice, except records pertaining to mental health problems or notes by a physician that, in the opinion of a licensed physician who practices psychiatry and is an independent third party, would have significant negative psychological impact upon the patient. Such independent third-party physician shall consult with the attending physician prior to making a determination with regard to the availability for inspection of any patient record and shall report in writing findings to the attending physician and to the custodian of said record. A summary of records pertaining to a patient's mental health problems may, upon written request and signed and dated authorization, be made available to the patient or the patient's designated representative following termination of the treatment program.

(b) (I) Following any treatment, procedure, or health care service rendered by a health facility licensed or certified pursuant to section 25-1.5-103 (1) or article 3 of this title, or both, or by an entity regulated under title 10, C.R.S., providing health care services, as defined in section 10-16-102 ~~(22)~~ (33), C.R.S., directly or indirectly through a managed care

plan, as defined in section 10-16-102 ~~(26.5)~~ (43), C.R.S., or otherwise, copies of said records, including X rays, shall be furnished to the patient upon submission of a written authorization-request for records, dated and signed by the patient, and upon the payment of the reasonable costs.

SECTION 61. In Colorado Revised Statutes, 25-1.5-107, **amend** (2) (a) introductory portion as follows:

25-1.5-107. Pandemic influenza - purchase of antiviral therapy - definitions. (2) As used in this section, unless the context otherwise requires:

(a) "Authorized purchaser" means an entity licensed by the department pursuant to section 25-1.5-103 (1) (a), a local public health agency, or a health maintenance organization, as defined in section 10-16-102 ~~(23)~~ (35), C.R.S., authorized to operate in this state pursuant to part 4 of article 16 of title 10, C.R.S., that:

SECTION 62. In Colorado Revised Statutes, 25-3-109, **amend** (5.5) (b) as follows:

25-3-109. Quality management functions - confidentiality and immunity. (5.5) (b) For purposes of this subsection (5.5), "health care facility" includes a ~~health~~ carrier as defined in section 10-16-102 (8), C.R.S., and a health care practitioner licensed or certified pursuant to title 12, C.R.S.

SECTION 63. In Colorado Revised Statutes, 25.5-5-501, **amend** (1) (a) as follows:

25.5-5-501. Providers - drug reimbursement. (1) (a) As to drugs for which payment is made, the state board's rules for the payment therefor shall include the requirement that the generic equivalent of a brand-name drug be prescribed if the generic equivalent is a therapeutic

equivalent to the brand-name drug, except when reimbursement to the state for a brand-name drug makes the brand-name drug less expensive than the cost of the generic equivalent. The state department shall grant an exception to this requirement if the patient has been stabilized on a medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand-name drug would be unacceptably disruptive. The requirements of this subsection (1) shall not apply to medications for the treatment of ~~biologically based~~ mental illness, ~~as defined in section 10-16-104 (5.5), C.R.S., the treatment of~~ cancer, ~~the treatment of~~ epilepsy, or ~~the treatment of~~ human immunodeficiency virus and acquired immune deficiency syndrome.

SECTION 64. In Colorado Revised Statutes, 25.5-8-107, **amend** (1) (a) (I) as follows:

25.5-8-107. Duties of the department - schedule of services - premiums - copayments - subsidies. (1) In addition to any other duties pursuant to this article, the department shall have the following duties:

(a) (I) To design, and from time to time revise, a schedule of health care services included in the plan and to propose said schedule to the medical services board for approval or modification. The schedule of health care services as proposed by the department and approved by the medical services board shall include, but shall not be limited to, preventive care, physician services, prenatal care and postpartum care, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be medically necessary for the health of enrollees; ~~The department shall design and revise this schedule of health care services included in the plan to be based upon the basic and~~

~~standard health benefit plans defined in section 10-16-102 (4) and (43), C.R.S.;~~ except that the department may modify the ~~basic and the standard health benefit plans~~ SCHEDULE OF HEALTH CARE SERVICES to meet specific federal requirements or to accommodate those changes necessary for a program designed specifically for children.

SECTION 65. In Colorado Revised Statutes, 25.5-8-110, **amend** (1) as follows:

25.5-8-110. Participation by managed care plans. (1) Managed care plans, as defined in section 10-16-102 ~~(26.5)~~ (43), C.R.S., that participate in the plan shall do so by contract with the department and shall provide the health care services covered by the plan to each enrollee.

SECTION 66. In Colorado Revised Statutes, 26-1-304, **amend** (2) as follows:

26-1-304. Services for persons with traumatic brain injuries - limitations - covered services. (2) To be eligible for assistance from the trust fund, an individual shall have exhausted all other health or rehabilitation benefit funding sources that cover the services provided by the trust fund. An individual shall not be required to exhaust all private funds in order to be eligible for the program. Individuals who have continuing health insurance benefits, including, but not limited to, medical assistance pursuant to articles 4, 5, and 6 of title 25.5, C.R.S., may access the trust fund for services that are necessary but that are not covered by a health benefit plan, as defined in section 10-16-102 ~~(21)~~ (32), C.R.S., or any other funding source.

SECTION 67. In Colorado Revised Statutes, 27-10.5-702, **amend** (2) and (15) as follows:

27-10.5-702. Definitions. As used in this part 7, unless the

context otherwise requires:

(2) "Carrier" ~~shall have~~ HAS the same meaning as set forth in section 10-16-102 (8), C.R.S.

(15) "Private health insurance" means a health coverage plan, as defined in section 10-16-102 ~~(22.5)~~ (34), C.R.S., that is purchased by individuals or groups to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, as defined in section 10-16-102 ~~(22)~~ (33), C.R.S., provided to a person entitled to receive benefits or services under the health coverage plan.

SECTION 68. In Colorado Revised Statutes, 27-10.5-708, **amend** (4) as follows:

27-10.5-708. Certified early intervention service brokers - duties - payment for early intervention services - fees. (4) Use of a certified early intervention broker is voluntary; except that private health insurance carriers that are included under section 10-16-104 (1.3), C.R.S., ~~shall be~~ ARE required to make payment in trust under section 27-10.5-709. Nothing in this part 7 ~~shall prohibit~~ PROHIBITS a qualified provider of early intervention services from directly billing the appropriate program of public medical assistance or a participating provider, as defined in section 10-16-102 ~~(28.5)~~ (46), C.R.S., or from directly billing a private health insurance carrier for services rendered under this part 7 for insurance plans that are not included under section 10-16-104 (1.3), C.R.S.

SECTION 69. In Colorado Revised Statutes, **amend** 39-22-104.5 as follows:

39-22-104.5. Pretax payments - catastrophic health insurance. For income tax years commencing on or after January 1, 1995, amounts

withheld from an individual's wages that are used to pay for catastrophic health insurance pursuant to and within the limitations prescribed by section ~~10-16-117~~ 10-16-116, C.R.S., are excluded from the individual's federal taxable income for purposes of the state income tax imposed by section 39-22-104.

SECTION 70. Effective date - applicability. (1) This act takes effect upon passage and applies to health coverage plans issued or renewed on or after January 1, 2014.

(2) Health coverage plans in effect on the effective date of this act are subject to article 16 of title 10, Colorado Revised Statutes, as the said article existed prior to the effective date of this act, until those health coverage plans are issued or renewed on or after January 1, 2014.

SECTION 71. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.