

**First Regular Session
Sixty-ninth General Assembly
STATE OF COLORADO**

REREVISED

*This Version Includes All Amendments
Adopted in the Second House*

LLS NO. 13-0666.01 Bart Miller x2173 Christy Chase x2008

HOUSE BILL 13-1266

HOUSE SPONSORSHIP

McCann and Gardner,

SENATE SPONSORSHIP

Aguilar,

House Committees

Health, Insurance & Environment

Senate Committees

Health & Human Services

A BILL FOR AN ACT

101 **CONCERNING THE ALIGNMENT OF STATE HEALTH INSURANCE LAWS**
102 **WITH THE REQUIREMENTS OF THE FEDERAL "PATIENT**
103 **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

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
*Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.*

SENATE
3rd Reading Unamended
April 30, 2013

SENATE
Amended 2nd Reading
April 29, 2013

HOUSE
3rd Reading Unamended
April 9, 2013

HOUSE
Amended 2nd Reading
April 8, 2013

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.

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

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

4 **10-16-102. Definitions.** As used in this article, unless the context
5 otherwise requires:

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

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

12 ~~(2.5)~~(3) "Affiliation period" means a period of time, not to exceed
13 two months, ~~three months for late enrollees~~, during which a health
14 maintenance organization does not collect ~~premium~~ PREMIUMS and
15 coverage issued ~~would~~ IS not ~~become~~ YET effective.

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

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

22 ~~(5)~~(4) "Basic health care services" means health care services that
23 an enrolled population of a health maintenance organization organized
24 pursuant to the provisions of part 4 of this article might reasonably
25 require in order to maintain good health, including, ~~as~~ AT a minimum,
26 emergency care, inpatient and outpatient hospital services, physician
27 services, outpatient medical services, and laboratory and X-ray services.

1 ~~(5.3)~~ (5) "Benefits ratio" means the ratio of the value of the actual
2 benefits, not including dividends, to the value of the actual premiums, not
3 reduced by dividends, over the entire period for which rates are computed
4 to provide coverage. "Benefits ratio" is also known as "targeted loss
5 ratio".

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

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

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

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

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

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

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

1 association for the purposes of this article.

2 (5.6) (7) "Bona fide volunteer":

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

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

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

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

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

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

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

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

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

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

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

1 ~~problems at the time the plan was issued, but who were issued basic or~~
2 ~~standard health benefit plan coverage as required under section 10-16-105~~
3 ~~(7.3)(c) regardless of the health status of the group. "Capped employees"~~
4 ~~only includes employees and dependents covered by a small employer~~
5 ~~group health benefit plan of a carrier at the time the carrier proposes to~~
6 ~~suspend its duty to issue basic or standard health benefit plan coverage as~~
7 ~~required under section 10-16-105 (7.3) (c).~~

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

14 (9) ~~(Deleted by amendment, L. 97, p. 630, § 3, effective May 1,~~
15 ~~1997.)~~

16 ~~(10)~~ (9) (a) "Case characteristics" means demographic
17 characteristics ~~of a small employer~~ that are considered by the carrier in
18 the determination of premium rates for ~~the~~ INDIVIDUALS AND small
19 ~~employer~~ EMPLOYERS.

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

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

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

1 ~~twenty-four years of age;~~
2 ~~(B) For adults and emancipated minors, age brackets in five-year~~
3 ~~intervals;~~
4 ~~(II) Geographic location of the policyholder; as determined by rule~~
5 ~~of the commissioner pursuant to section 10-16-104.9;~~
6 ~~(III) Family size; including the following size categories only:~~
7 AND
8 ~~(A) One adult;~~
9 ~~(B) One adult and any children;~~
10 ~~(C) Two adults; and~~
11 ~~(D) Two adults and any children;~~
12 ~~(IV) Smoking status and TOBACCO USE.~~
13 ~~(V) (Deleted by amendment, L. 2007, p. 1752, § 1, effective~~
14 ~~January 1, 2009.)~~
15 ~~(VI) Standard industrial classification.~~
16 ~~(VII) (Deleted by amendment, L. 2007, p. 1752, § 1, effective~~
17 ~~January 1, 2009.)~~
18 ~~(c) Effective September 1, 2003, "case characteristics" does not~~
19 ~~include duration of coverage or any other characteristic not specifically~~
20 ~~described in paragraph (b) of this subsection (10).~~
21 ~~(9) (10) "CATASTROPHIC PLAN" MEANS AN INDIVIDUAL HEALTH~~
22 ~~BENEFIT PLAN THAT DOES NOT PROVIDE A BRONZE, SILVER, GOLD, OR~~
23 ~~PLATINUM LEVEL OF COVERAGE, AS THOSE COVERAGE LEVELS ARE~~
24 ~~DESCRIBED IN SECTION 10-16-103.4, AND IS AVAILABLE ONLY TO~~
25 ~~INDIVIDUALS UNDER THIRTY YEARS OF AGE OR WHO MEET THE ELIGIBILITY~~
26 ~~REQUIREMENTS IN FEDERAL LAW FOR PARTICIPATION IN A CATASTROPHIC~~
27 ~~PLAN.~~

1 ~~(10.3)~~ (11) "Child-only plan" means a health benefit plan ~~that is~~
2 issued on or after April 29, 2011, ~~and~~ that provides coverage to an
3 individual under ~~nineteen~~ TWENTY-ONE years of age. A "child-only plan"
4 does not include coverage provided to a dependent under an individual or
5 group health benefit plan.

6 ~~(10.5)~~ (12) "Church plan" ~~shall have~~ HAS the same meaning as set
7 forth in 29 U.S.C. sec. 1002 (33) of the federal "Employee Retirement
8 Income Security Act of 1974".

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

11 ~~(12)~~ (13) "Commissioner" means the commissioner of insurance.

12 ~~(13)~~ (14) "Control" has the same meaning as set forth in section
13 10-3-801 (3).

14 ~~(13.5)~~ (15) "Covered person" means a person entitled to receive
15 benefits or services under a health coverage plan.

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

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

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

23 (c) An individual health benefit plan;

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

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

1 organization, a health plan offered under chapter 89 of title 5, United
2 States Code, a public health plan, or a health benefit plan under section
3 5 (e) of the federal "Peace Corps Act" 22 U.S.C. sec. 2504 (e).

4 ~~(14)~~ (17) "Dependent" means a spouse, A PARTNER IN A CIVIL
5 UNION, an unmarried child under nineteen years of age, an unmarried
6 child who is a full-time student under twenty-four years of age and who
7 is financially dependent upon the parent, and an unmarried child of any
8 age who is medically certified as disabled and dependent upon the parent.
9 "Dependent" ~~shall include~~ INCLUDES a designated beneficiary, as defined
10 in section 15-22-103 (1), C.R.S., if an employer elects to cover a
11 designated beneficiary as a dependent.

12 ~~(15)~~ (18) (a) "Eligible employee" means ~~an A FULL-TIME employee~~
13 ~~who has a regular work week of twenty-four or more hours and includes~~
14 ~~a sole proprietor and a partner of a partnership if the sole proprietor or~~
15 ~~partner is included as an employee under a health benefit plan of a small~~
16 ~~employer. but does not include an employee who works on a temporary~~
17 ~~or substitute basis~~ IN A BONA FIDE EMPLOYER-EMPLOYEE RELATIONSHIP
18 WITH AN EMPLOYER THAT HAS NOT BEEN ESTABLISHED FOR THE PURPOSE
19 OF OBTAINING A SMALL GROUP PLAN. THE TERM DOES NOT INCLUDE:

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

22 (II) AN INDIVIDUAL AND HIS OR HER SPOUSE OR PARTNER IN A
23 CIVIL UNION WITH RESPECT TO A TRADE OR BUSINESS, WHETHER
24 INCORPORATED OR UNINCORPORATED, THAT IS WHOLLY OWNED BY THE
25 INDIVIDUAL OR BY THE INDIVIDUAL AND HIS OR HER SPOUSE OR PARTNER
26 IN A CIVIL UNION; OR

27 (III) A PARTNER IN A PARTNERSHIP AND HIS OR HER SPOUSE OR

1 PARTNER IN A CIVIL UNION WITH RESPECT TO THE PARTNERSHIP; EXCEPT
2 THAT A PARTNER AND HIS OR HER SPOUSE OR PARTNER IN A CIVIL UNION
3 MAY PARTICIPATE IN A SMALL GROUP PLAN ESTABLISHED TO COVER ONE
4 OR MORE ELIGIBLE EMPLOYEES OF THE PARTNERSHIP WHO ARE NOT
5 PARTNERS IN THE PARTNERSHIP.

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

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

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

26 ~~(16)~~ (20) "Enrollee" means:

27 (a) An individual who is or has been enrolled in a health

1 maintenance organization; or

2 (b) An individual who is or has been enrolled in an individual or
3 group prepaid dental care plan as a principal subscriber ~~together with~~
4 ~~such~~ AND INCLUDES THE individual's dependents who are entitled to
5 PREPAID dental care services under the plan solely because of their status
6 as dependents of the principal subscriber.

7 ~~(17)~~ (21) "Enrollee coverage" means ~~any certificate or contract A~~
8 HEALTH COVERAGE PLAN issued pursuant to ~~section 10-16-507~~ THIS
9 ARTICLE to an enrollee setting out the ~~dental~~ coverage to which ~~such~~ THE
10 enrollee is entitled UNDER THE HEALTH COVERAGE PLAN.

11 (22) (a) "ESSENTIAL HEALTH BENEFITS" HAS THE SAME MEANING
12 AS SET FORTH IN SECTION 1302 (b) OF THE FEDERAL "PATIENT
13 PROTECTION AND AFFORDABLE CARE ACT OF 2010", AS AMENDED, PUB.L.
14 111-148;

15 (b) "ESSENTIAL HEALTH BENEFITS" INCLUDES:

16 (I) AMBULATORY PATIENT SERVICES;

17 (II) EMERGENCY SERVICES;

18 (III) HOSPITALIZATION;

19 (IV) LABORATORY SERVICES;

20 (V) MATERNITY AND NEWBORN CARE;

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

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

24 (VIII) PRESCRIPTION DRUGS;

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

27 (X) REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES.

1 (23) "ESSENTIAL HEALTH BENEFITS PACKAGE" MEANS THE
2 ESSENTIAL HEALTH BENEFITS PACKAGE REQUIRED UNDER SECTION 1302
3 (a) OF THE FEDERAL ACT AND INCLUDES COVERAGE THAT:

4 (a) PROVIDES FOR THE ESSENTIAL HEALTH BENEFITS;

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

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

11 ~~(18)~~ (24) "Established geographic service area" means the entire
12 state of Colorado or, for plans that do not cover the entire state, any
13 county within which the carrier is authorized to have arrangements
14 established with providers to provide services.

15 ~~(19)~~ (25) "Evidence of coverage" means any certificate,
16 agreement, or contract issued to an enrollee by a health maintenance
17 organization setting out the coverage to which the enrollee is or was
18 entitled.

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

21 ~~(20)~~ (27) "Executive director" means the executive director of the
22 department of public health and environment.

23 (28) "FEDERAL ACT" MEANS THE FEDERAL "PATIENT PROTECTION
24 AND AFFORDABLE CARE ACT", PUB.L. 111-148, AS AMENDED BY THE
25 FEDERAL "HEALTH CARE AND EDUCATION RECONCILIATION ACT OF
26 2010", PUB.L. 111-152, AND AS MAY BE FURTHER AMENDED, INCLUDING
27 ANY FEDERAL REGULATIONS ADOPTED UNDER THE FEDERAL ACT.

1 (29) "FEDERAL LAW" INCLUDES THE FEDERAL "PATIENT
2 PROTECTION AND AFFORDABLE CARE ACT OF 2010", PUB.L. 111-148, AS
3 AMENDED BY THE FEDERAL "HEALTH CARE AND EDUCATION
4 RECONCILIATION ACT OF 2010", PUB.L. 111-152, AND AS MAY BE
5 FURTHER AMENDED, ALSO REFERRED TO IN THIS ARTICLE AS THE "ACA";
6 THE FEDERAL "PUBLIC HEALTH SERVICE ACT", AS AMENDED, 42 U.S.C.
7 SEC. 201 ET SEQ., ALSO REFERRED TO IN THIS ARTICLE AS "PHSA"; THE
8 FEDERAL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
9 OF 1996", AS AMENDED, PUB.L. 104-191, ALSO REFERRED TO IN THIS
10 ARTICLE AS "HIPAA"; THE FEDERAL "EMPLOYEE RETIREMENT INCOME
11 SECURITY ACT OF 1974", AS AMENDED, 29 U.S.C. SEC. 1001 ET SEQ., ALSO
12 REFERRED TO IN THIS ARTICLE AS "ERISA"; AND ANY FEDERAL
13 REGULATION IMPLEMENTING THESE FEDERAL ACTS.

14 ~~(20.5)~~ (30) "Government plan" ~~shall have~~ HAS the same meaning
15 as set forth in 29 U.S.C. sec. 1002 (32) of the federal "Employee
16 Retirement Income Security Act of 1974", and as in any federal
17 governmental plan.

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

1 HEALTH BENEFIT PLANS ON AND AFTER THE EFFECTIVE DATE OF THIS
2 SUBSECTION (31).

3 ~~(21)~~ (32) (a) "Health benefit plan" means any hospital or medical
4 expense policy or certificate, hospital or medical service corporation
5 contract, or health maintenance organization subscriber contract or any
6 other similar health contract subject to the jurisdiction of the
7 commissioner available for use, offered, or sold in Colorado.

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

9 (I) Accident only;

10 (II) Credit;

11 (III) Dental;

12 (IV) Vision;

13 (V) Medicare supplement;

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

16 (VII) Disability income insurance;

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

19 (IX) Coverage for on-site medical clinics;

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

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

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

1 (c) Solely with respect to ~~the provisions of section 10-16-118, (H)~~
2 ~~(b) concerning creditable coverage for individual policies, the term~~
3 ~~"HEALTH BENEFIT PLAN" excludes individual short-term limited duration~~
4 ~~health insurance policies. issued after January 1, 1999. This means such~~
5 ~~policies do not have to recognize creditable coverage. For the purpose of~~
6 ~~this paragraph (b), "short-term limited duration health insurance policy"~~
7 ~~means a nonrenewable individual health benefit plan with a specified~~
8 ~~duration of not more than six months that meets the following~~
9 ~~requirements:~~

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

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

1 ~~policy will not be covered under this policy."~~

2 ~~(22)~~ (33) "Health care services" means any services included in
3 OR INCIDENTAL TO the furnishing ~~to any individual~~ of medical, mental,
4 dental, or optometric care; ~~or hospitalization; or nursing home care or~~
5 ~~incident to the furnishing of such care or hospitalization~~ TO AN
6 INDIVIDUAL, as well as the furnishing to any person of any ~~and all~~ other
7 services for the purpose of preventing, alleviating, curing, or healing
8 human physical or mental illness or injury. "Health care services"
9 includes the rendering of ~~such~~ THE services through the use of
10 telemedicine.

11 ~~(22.5)~~ (34) "Health coverage plan" means a policy, contract,
12 certificate, or agreement entered into, ~~by~~ offered, ~~to~~ or issued by a carrier
13 to provide, deliver, arrange for, pay for, or reimburse any of the costs of
14 health care services.

15 ~~(23)~~ (35) "Health maintenance organization" means any person
16 who:

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

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

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

26 ~~(24)~~ (36) "Health status" means the determination by a carrier of
27 the past, present, or expected risk of an individual or the employer due to

1 the health conditions of THE INDIVIDUAL OR the employees of the
2 employer.

3 ~~(24.5)~~ (37) "Health-status-related factor" means any of the
4 following factors:

- 5 (a) Health status;
- 6 (b) Medical condition, including both physical and mental
7 illnesses;
- 8 (c) Claims experience;
- 9 (d) Receipt of health care;
- 10 (e) Medical history;
- 11 (f) Genetic information;
- 12 (g) Evidence of insurability, including conditions arising out of
13 acts of domestic violence; and
- 14 (h) Disability.

15 ~~(24.7)~~ (38) "Hearing aid" means amplification technology that
16 optimizes audibility and listening skills in the environments commonly
17 experienced by the patient, including a wearable instrument or device
18 designed to aid or compensate for impaired human hearing. "Hearing aid"
19 ~~shall include~~ INCLUDES any parts or ear molds.

20 ~~(25)~~ (39) "Index rate" means ~~as to a rating period for small~~
21 ~~employers with similar case characteristics, the arithmetic average of the~~
22 ~~applicable base premium rate and the corresponding highest premium rate~~
23 THE PREMIUM RATE ESTABLISHED FOR A MARKET SEGMENT BASED ON THE
24 TOTAL COMBINED CLAIMS COSTS FOR PROVIDING ESSENTIAL HEALTH
25 BENEFITS WITHIN THE SINGLE RISK POOL OF THAT MARKET SEGMENT.

26 ~~(25.5)~~ (40) "Intermediary" means a person authorized by health
27 care providers to negotiate and execute provider contracts with carriers

1 on behalf of such providers.

2 ~~(26) "Late enrollee" means an eligible employee or dependent~~
3 ~~who requests enrollment in a group health benefit plan following the~~
4 ~~initial enrollment period for which such individual is entitled to enroll~~
5 ~~under the terms of the health benefit plan, if such initial enrollment period~~
6 ~~is a period of at least thirty days. An eligible employee or dependent shall~~
7 ~~not be considered a late enrollee if:~~

8 (a) ~~The individual:~~

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

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

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

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

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

26 or

27 (d) ~~(I) A person becomes a dependent of a covered person through~~

1 ~~marriage, birth, adoption, or placement for adoption and requests~~
2 ~~enrollment no later than thirty days after becoming such a dependent. In~~
3 ~~such case, coverage shall commence on the date the person becomes a~~
4 ~~dependent if a request for enrollment is received in a timely fashion~~
5 ~~before such date.~~

6 ~~(H) A person who becomes a dependent of a covered person~~
7 ~~through a designated beneficiary agreement pursuant to article 22 of title~~
8 ~~15, C.R.S., requests enrollment no later than thirty days after becoming~~
9 ~~such a dependent, and the employer of the covered person elects to cover~~
10 ~~designated beneficiaries as dependents. In such case, coverage shall~~
11 ~~commence on the date the person becomes a dependent if a request for~~
12 ~~enrollment is received in a timely fashion before said date.~~

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

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

24 ~~(g) The employee or dependent becomes eligible for premium~~
25 ~~assistance under the "Colorado Medical Assistance Act", articles 4 to 6~~
26 ~~of title 25.5, C.R.S., or the children's basic health plan established in~~
27 ~~article 8 of title 25.5, C.R.S., including under any waiver or~~

1 ~~demonstration project conducted under or in relation to such act or plan,~~
2 ~~and the employee or dependent requests coverage under the group health~~
3 ~~benefit plan within sixty days after the date the employee or dependent is~~
4 ~~determined to be eligible for such assistance.~~

5 (26.3) (41) "Licensed health care provider" shall have HAS the
6 same meaning as in section 10-4-601.

7 (26.4) (42) "Local government" means any city, county, city and
8 county, special district, or other political subdivision of this state.

9 (26.5) (43) "Managed care plan" means a policy, contract,
10 certificate, or agreement offered by a carrier to provide, deliver, arrange
11 for, pay for, or reimburse any of the costs of health care services through
12 the covered person's use of health care providers managed by, owned by,
13 under contract with, or employed by the carrier because the carrier either
14 requires the use of or creates incentives, including financial incentives,
15 for the covered person's use of those providers.

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

22 (27.3) (44) "Minor child" means any person under the age of
23 eighteen years OF AGE.

24 (27.5) (45) "Network" means a group of participating providers
25 providing services to a managed care plan. For the purposes of part 7 of
26 this article, any subdivision or subgrouping of a network is considered a
27 network if covered individuals are restricted to the subdivision or

1 subgrouping for covered benefits under the managed care plan.

2 ~~(28) "New business premium rate" means, as to a rating period,~~
3 ~~the lowest premium rate charged or offered or which could have been~~
4 ~~charged or offered by the small employer carrier to small employers with~~
5 ~~similar case characteristics for newly issued health benefit plans with the~~
6 ~~same or similar coverage.~~

7 ~~(28.5) (46) "Participating provider" means a provider that, under~~
8 ~~a contract with a carrier or with its contractor or subcontractor, has agreed~~
9 ~~to provide health care services to covered persons with an expectation of~~
10 ~~receiving payment, other than coinsurance, copayments, or deductibles,~~
11 ~~directly or indirectly from the carrier.~~

12 ~~(28.7) (47) "Patient with diabetes" means a person with elevated~~
13 ~~blood glucose levels who has been diagnosed as having diabetes by an~~
14 ~~appropriately licensed health care professional.~~

15 ~~(29) (48) "Person" means any individual, partnership, association,~~
16 ~~trust, or corporation and includes but is not limited to any hospital~~
17 ~~licensed or certified in this state, independent practice association of~~
18 ~~physicians, or professional service corporation for the practice of~~
19 ~~medicine.~~

20 ~~(29.5) (49) "Pharmacy benefit management firm" means any entity~~
21 ~~doing business in this state that contracts to administer or manage~~
22 ~~prescription drug benefits on behalf of any carrier that provides~~
23 ~~prescription drug benefits to residents of this state.~~

24 ~~(30) (50) "Policy of sickness and accident insurance" means any~~
25 ~~policy or contract of insurance against loss or expense resulting from the~~
26 ~~sickness of the insured, or from the bodily injury or death of the insured~~
27 ~~by accident, or both.~~

1 ~~(31)~~ (51) "Premium" means all moneys paid by a small employer
2 and eligible employees as a condition of receiving coverage from a
3 carrier, including any fees or other contributions associated with the
4 health benefit plan.

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

11 ~~(33)~~ (53) "Prepaid dental care plan organization" means any
12 person who undertakes to conduct one or more prepaid dental care plans
13 providing only dental care services.

14 ~~(34)~~ (54) "Prepaid dental care services" means services included
15 in the practice of dentistry, as defined in article 35 of title 12, C.R.S.,
16 THAT ARE PROVIDED TO ENROLLEES UNDER A PREPAID DENTAL CARE PLAN.

17 ~~(35)~~ (55) "Producer" means a person licensed by the division who
18 solicits, negotiates, effects, procures, delivers, renews, continues,
19 services, or binds health benefit plans and is licensed to conduct these
20 activities in Colorado.

21 ~~(36)~~ (56) "Provider" means any physician, dentist, optometrist,
22 anesthesiologist, hospital, X ray, laboratory and ambulance ~~services~~
23 SERVICE, or other person who is licensed or otherwise authorized in this
24 state to furnish health care services.

25 ~~(36.3)~~ "Qualifying event" includes ~~birth; adoption; marriage;~~
26 ~~dissolution of marriage; loss of employer-sponsored insurance; loss of~~
27 ~~eligibility under the "Colorado Medical Assistance Act", articles 4 5, and~~

1 ~~of title 25.5, C.R.S.; loss of eligibility under the children's basic health~~
2 ~~plan, article 8 of title 25.5, C.R.S.; entry of a valid court or administrative~~
3 ~~order mandating the A child be covered; or involuntary loss of other~~
4 ~~existing coverage for any reason other than fraud, misrepresentation, or~~
5 ~~failure to pay a premium.~~

6 ~~(36.5)~~ (57) "Rate increase" means an increase in the current rate.

7 ~~(37) (Deleted by amendment, L. 97, p. 630, § 3, effective May 1,~~
8 ~~1997.)~~

9 ~~(38)~~ (58) "Rating period" means the calendar period for which
10 premium rates established by a carrier are assumed to be in effect.

11 ~~(39)~~ (59) "Restricted network provision" means any provision of
12 an individual or group health benefit plan that conditions the payment of
13 benefits, in whole or in part, on the use of health care providers that have
14 entered into a contractual arrangement with the carrier to provide health
15 care services to covered individuals.

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

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

27 HAVE YOU OR ANY OTHER PERSON TO BE INSURED BEEN

1 COVERED UNDER TWO OR MORE NONRENEWABLE
2 SHORT-TERM POLICIES DURING THE PAST TWELVE MONTHS?
3 IF "YES", THEN THIS POLICY CANNOT BE ISSUED. YOU MUST
4 WAIT SIX MONTHS FROM THE DATE OF YOUR LAST SUCH
5 POLICY TO APPLY FOR A SHORT-TERM POLICY.

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

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

16 ~~(40)~~ (61) (a) (I) "Small employer" means any person, firm,
17 corporation, partnership, or association that:

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

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

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

1 (II) THIS PARAGRAPH (a) IS REPEALED, EFFECTIVE DECEMBER 31,
2 2015.

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

5 (I) IS ACTIVELY ENGAGED IN BUSINESS;

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

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

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

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

25 (e) [**Formerly 10-16-105 (12)**] In the case of an employer that
26 was not in existence throughout the preceding calendar quarter, the
27 determination of whether ~~such~~ THE employer is a small ~~or large~~ employer

1 ~~shall be~~ IS based on the average number of employees that THE EMPLOYER
2 is reasonably expected ~~such employer will~~ TO employ on business days
3 in the current calendar year.

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

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

8 (II) AN EMPLOYER AND ANY PREDECESSOR EMPLOYER.

9 ~~(41)~~ (62) "Small employer carrier" means a carrier that offers
10 health benefit plans covering eligible employees of one or more small
11 employers in this state.

12 ~~(42)~~ (63) "Small group sickness and accident insurance", "small
13 group plan", and "small group policy" mean that form of group sickness
14 and accident insurance issued by an entity subject to part 2 of this article,
15 that form of group service or indemnity type contract issued by an entity
16 organized pursuant to ~~the provisions of~~ part 3 of this article, or that form
17 of policy issued by an entity organized pursuant to ~~the provisions of~~ part
18 4 of this article ~~which~~ THAT provides coverage to small employers located
19 in Colorado. These terms include a bona fide association plan if such plan
20 provides coverage to one or more eligible employees of a small employer
21 in Colorado.

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

24 ~~(43.5)~~ (64) "Standing referral" means a referral by the covered
25 person's primary care provider to a specialist or specialized treatment
26 center participating in the carrier's network for ongoing treatment of a
27 covered person.

1 (65) "STUDENT HEALTH INSURANCE COVERAGE" MEANS A TYPE OF
2 INDIVIDUAL HEALTH INSURANCE COVERAGE THAT IS PROVIDED PURSUANT
3 TO A WRITTEN AGREEMENT BETWEEN AN INSTITUTION OF HIGHER
4 EDUCATION, AS DEFINED IN THE "HIGHER EDUCATION ACT OF 1965", AND
5 A HEALTH CARRIER AND PROVIDED TO STUDENTS ENROLLED IN THAT
6 INSTITUTION OF HIGHER EDUCATION AND THEIR DEPENDENTS, THAT:

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

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

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

15 ~~(43.7)~~ (66) "Targeted loss ratio" means the ratio of expected
16 policy benefits over the entire future period for which the proposed rates
17 are expected to provide coverage to the expected earned premium over
18 the same period. The anticipated loss ratio shall be calculated on an
19 incurred basis as the ratio of expected incurred losses to expected earned
20 premium.

21 ~~(44)~~ (67) "Uncovered expenditures" means the costs of those
22 health care services: ~~which~~

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

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

1 (68) [**Formerly 10-16-214 (2) (b)**] For purposes of this subsection
2 ~~(2)~~, "Valid multistate association" means an association ~~which~~ THAT has:
3 ~~(I)~~ (a) Been in active existence for at least five years;
4 ~~(II)~~ (b) Been organized and maintained in good faith for purposes
5 other than ~~that of obtaining~~ TO OBTAIN insurance;
6 ~~(III)~~ (c) A minimum of five hundred members;
7 ~~(IV)~~ (d) A constitution, charter, or bylaws ~~which~~ THAT provide
8 for regular meetings, at least annually, to further the purposes of the
9 members;
10 ~~(V)~~ (e) Collected dues or solicited contributions for members; and
11 ~~(VI)~~ (f) Provided the members with voting privileges and
12 representation on the governing board and committees.

13 ~~(45)~~ (69) "Waiting period" means, with respect to a group health
14 benefit plan and an individual that is a potential participant or beneficiary
15 in the plan, the period that must pass with respect to the individual, as
16 determined by the plan sponsor, before the individual is eligible to be
17 covered for benefits under the terms of the plan.

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

20 **10-16-103.4. Essential health benefits - requirements - rules.**

21 (1) CARRIERS OFFERING INDIVIDUAL OR SMALL GROUP HEALTH BENEFIT
22 PLANS IN THIS STATE SHALL ENSURE THAT THE COVERAGE INCLUDES THE
23 ESSENTIAL HEALTH BENEFITS PACKAGE. THIS SUBSECTION (1) DOES NOT
24 APPLY TO GRANDFATHERED HEALTH BENEFIT PLANS.

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

1 LEVELS OF COVERAGE:

2 (a) **Bronze level.** A HEALTH BENEFIT PLAN IN THE BRONZE LEVEL
3 PROVIDES A LEVEL OF COVERAGE DESIGNED TO PROVIDE BENEFITS
4 ACTUARIALLY EQUIVALENT TO SIXTY PERCENT OF THE FULL ACTUARIAL
5 VALUE OF THE BENEFITS PROVIDED UNDER THE PLAN.

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

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

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

18 (3) A CARRIER THAT OFFERS AN INDIVIDUAL HEALTH BENEFIT PLAN
19 THAT DOES NOT PROVIDE A BRONZE, SILVER, GOLD, OR PLATINUM LEVEL
20 OF COVERAGE, AS DESCRIBED IN SUBSECTION (2) OF THIS SECTION, MEETS
21 THE REQUIREMENTS OF THIS SECTION WITH RESPECT TO ANY POLICY YEAR
22 IF THE PLAN IS A CATASTROPHIC PLAN, AS DEFINED IN SECTION 10-16-102
23 (10).

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

1 (5) A CARRIER SUBJECT TO SUBSECTION (1) OF THIS SECTION SHALL
2 ENSURE THAT THE ANNUAL COST-SHARING AND ANNUAL DEDUCTIBLE
3 LIMITATIONS IMPOSED UNDER THE HEALTH BENEFIT PLAN IT OFFERS DO
4 NOT EXCEED THE LIMITATIONS UNDER FEDERAL LAW.

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

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

10 **SECTION 3.** In Colorado Revised Statutes, 10-16-104, **amend**
11 (1.3) (b) (II), (1.3) (b) (IV) introductory portion, (1.3) (d.5), (1.4) (a) (IV),
12 (1.4) (b), (5.5), (12) (a) introductory portion, (18) (a) (I) introductory
13 portion, (18) (a) (III), (18) (b) introductory portion, (18) (b) (III), (18) (b)
14 (VI), (18) (b) (VIII), (18) (b) (IX), and (21) (b); **repeal** (1.7) (c); and **add**
15 (18) (b) (X) as follows:

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

1 ~~general assembly to the annual appropriated rate to serve one child for~~
2 ~~one fiscal year in the state-funded early intervention program if that~~
3 ~~increase is more than the consumer price index increase~~ THE
4 COMMISSIONER SHALL SPECIFY, BY RULE, THE EXTENT OF THE COVERAGE
5 FOR EARLY INTERVENTION SERVICES REQUIRED BY THIS SUBSECTION (1.3),
6 WHICH, EXCEPT FOR GRANDFATHERED HEALTH BENEFIT PLANS, MUST
7 REQUIRE COVERAGE OF A NUMBER OF EARLY INTERVENTION SERVICES OR
8 VISITS THAT IS ACTUARIALLY EQUIVALENT TO THE DOLLAR LIMIT OF THE
9 BENEFIT AS IT EXISTED PRIOR TO THE EFFECTIVE DATE OF THIS
10 SUBPARAGRAPH (II), AS AMENDED.

11 (B) FOR GRANDFATHERED HEALTH BENEFIT PLANS, THE COVERAGE
12 REQUIRED BY THIS SUBSECTION (1.3) PER CALENDAR OR POLICY YEAR FOR
13 EARLY INTERVENTION SERVICES FOR EACH ELIGIBLE DEPENDENT CHILD
14 FROM BIRTH UP TO THE CHILD'S THIRD BIRTHDAY IS LIMITED TO SIX
15 THOUSAND THREE HUNDRED SIXTY-ONE DOLLARS, INCLUDING CASE
16 MANAGEMENT COSTS. EFFECTIVE JANUARY 1, 2014, AND EACH JANUARY
17 1 THEREAFTER, THE COMMISSIONER SHALL ANNUALLY ADJUST THE
18 DOLLAR LIMIT FOR EARLY INTERVENTION SERVICES COVERAGE BASED ON
19 THE CONSUMER PRICE INDEX FOR THE DENVER-BOULDER-GREELEY
20 METROPOLITAN STATISTICAL AREA FOR THE STATE FISCAL YEAR THAT
21 ENDS IN THE IMMEDIATELY PRECEDING CALENDAR YEAR, OR BY AN
22 ADDITIONAL AMOUNT EQUAL TO THE INCREASE BY THE GENERAL
23 ASSEMBLY IN THE ANNUAL APPROPRIATED RATE TO SERVE ONE CHILD FOR
24 ONE FISCAL YEAR IN THE STATE-FUNDED EARLY INTERVENTION PROGRAM
25 IF THAT INCREASE IS MORE THAN THE CONSUMER PRICE INDEX INCREASE.

26 (IV) ~~The~~ ANY limit on the amount of coverage for early
27 intervention services specified BY THE COMMISSIONER BY RULE PURSUANT

1 TO SUB-SUBPARAGRAPH (A) OF SUBPARAGRAPH (II) OF THIS PARAGRAPH
2 (b) OR, FOR GRANDFATHERED HEALTH BENEFIT PLANS, SPECIFIED IN
3 SUB-SUBPARAGRAPH (B) OF SUBPARAGRAPH (II) OF THIS PARAGRAPH (b) SHALL
4 NOT APPLY TO:

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

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

26 (1.4) **Autism spectrum disorders.** (a) As used in this subsection
27 (1.4), unless the context otherwise requires:

1 (IV) "Health benefit plan", ~~shall have the same meaning as~~
2 ~~provided in section 10-16-102 (21). In addition, the term "health benefit~~
3 ~~plan" as used in this subsection (1.4), excludes~~ DOES NOT INCLUDE:

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

7 (B) Individual GRANDFATHERED health benefit plans.

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

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

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

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

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

5 (1.7) **Therapies for congenital defects and birth abnormalities.**

6 (c) ~~The coverage described in this subsection (1.7) is subject to the~~
7 ~~provisions of section 10-16-118 (1) (b).~~

8 (5.5) **Biologically based mental illness and mental disorders -**

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

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

21 (III) Any preauthorization or utilization review mechanism used
22 in the determination to provide the coverage required by this paragraph
23 (a) ~~shall~~ MUST be the same as, or no more restrictive than, that used in the
24 determination to provide coverage for a physical illness. ~~except that a~~
25 ~~carrier that does not use utilization review mechanisms in determining~~
26 ~~whether to provide coverage for a physical illness may use utilization~~
27 ~~review mechanisms for determining whether to provide coverage for drug~~

1 ~~and alcohol disorders and eating disorders as part of the required~~
2 ~~coverage for mental disorders. The commissioner shall adopt such rules~~
3 ~~as are necessary to carry out the provisions of~~ IMPLEMENT AND
4 ADMINISTER this subsection (5.5). ~~In promulgating such rules, the~~
5 ~~commissioner shall recognize that the substance of the mechanisms for~~
6 ~~preauthorization or utilization review may differ between medical~~
7 ~~specialties, and that such mechanisms shall not be more restrictive with~~
8 ~~respect to a covered person or a mental health provider for a~~
9 ~~determination under this paragraph (a) than for any other physical illness.~~

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

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

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

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

27 (c) ~~The~~ A health care service plan issued by an entity subject to

1 ~~the provisions of~~ part 4 of this article may provide that the benefits
2 required ~~pursuant to~~ BY this subsection (5.5) ~~shall be~~ ARE covered
3 benefits only if the services are rendered by a provider who is designated
4 by and affiliated with the health maintenance organization.

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

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

25 (III) (A) EXCEPT AS PROVIDED IN SUB-SUBPARAGRAPH (B) OF THIS
26 SUBPARAGRAPH (III), coverage ~~shall~~ REQUIRED BY THIS SUBSECTION (18)
27 IS not ~~be~~ subject to policy deductibles, COPAYMENTS, or coinsurance.

1 Copayments may apply as required by the policy, contract, or other health
2 care coverage.

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

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

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

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

21 (C) Benefits for preventive mammography screenings ~~shall be~~
22 ARE determined on a calendar year or a contract year basis, which ~~shall~~
23 FACT MUST be specified in the policy or contract. The preventive and
24 diagnostic coverages provided pursuant to this subparagraph (III) ~~shall in~~
25 ~~no way~~ DO NOT diminish or limit diagnostic benefits otherwise allowable
26 under a policy ~~If a covered person who is eligible for a preventive~~
27 ~~mammography screening benefit pursuant to this subparagraph (III) has~~

1 ~~not utilized such benefit during a calendar year or a contract year, then the~~
2 ~~coverage shall apply to one diagnostic screening for that year OR~~
3 ~~CONTRACT. If THE COVERED PERSON RECEIVES more than one diagnostic~~
4 ~~screening is provided for the covered person in a given calendar year or~~
5 ~~contract year, the other diagnostic service benefit provisions in the policy~~
6 ~~or contract shall apply with respect to the additional screenings.~~

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

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

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

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

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

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

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

1 (5).

2 **SECTION 4.** In Colorado Revised Statutes, 10-16-104.3, **repeal**
3 (2); and **repeal and reenact, with amendments,** (1) as follows:

4 **10-16-104.3. Health coverage for persons under twenty-six**
5 **years of age - coverage for students who take medical leave of**
6 **absence.** (1) (a) A CARRIER THAT OFFERS A HEALTH BENEFIT PLAN IN THE
7 STATE AND THAT MAKES DEPENDENT COVERAGE FOR CHILDREN
8 AVAILABLE UNDER THE HEALTH BENEFIT PLAN SHALL MAKE THE
9 COVERAGE AVAILABLE FOR A CHILD WHO IS UNDER TWENTY-SIX YEARS OF
10 AGE. THE CARRIER SHALL NOT DENY OR RESTRICT COVERAGE FOR A CHILD
11 WHO IS UNDER TWENTY-SIX YEARS OF AGE BASED ON A FACTOR SUCH AS:

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

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

15 (III) MARITAL OR CIVIL UNION STATUS;

16 (IV) STUDENT STATUS;

17 (V) EMPLOYMENT STATUS; OR

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

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

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

27 (d) NOTHING IN THIS SUBSECTION (1) REQUIRES A CARRIER TO

1 MAKE COVERAGE AVAILABLE FOR THE CHILD OF A CHILD RECEIVING
2 DEPENDENT COVERAGE UNLESS THE GRANDPARENT BECOMES THE
3 PERMANENT LEGAL GUARDIAN OR ADOPTIVE PARENT OF THAT
4 GRANDCHILD.

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

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

11 **10-16-104.4. Child-only plans - legislative declaration - open**
12 **enrollment - reporting requirements.** (2) (b) During any period of open
13 enrollment, carriers shall offer child-only plan coverage to all applicants
14 under ~~nineteen~~ TWENTY-ONE years of age on a guaranteed-issue basis.

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

17 **10-16-105. Guaranteed issuance of health insurance coverage**
18 **- individual and small employer health benefit plans.**

19 (1) (a) (I) SUBJECT TO SUBSECTIONS (2) AND (4) TO (6) OF THIS SECTION,
20 EACH CARRIER THAT OFFERS AN INDIVIDUAL HEALTH BENEFIT PLAN IN THIS
21 STATE SHALL ISSUE ANY APPLICABLE HEALTH BENEFIT PLAN TO ANY
22 ELIGIBLE INDIVIDUAL WHO APPLIES FOR THE PLAN AND AGREES TO MAKE
23 THE REQUIRED PREMIUM PAYMENTS AND SATISFY THE OTHER REASONABLE
24 PROVISIONS OF THE HEALTH BENEFIT PLAN CONSISTENT WITH THIS
25 ARTICLE.

26 (II) DURING ANY PERIOD OF OPEN ENROLLMENT, A CARRIER SHALL
27 OFFER CHILD-ONLY PLAN COVERAGE TO ALL APPLICANTS UNDER

1 TWENTY-ONE YEARS OF AGE ON A GUARANTEED-ISSUANCE BASIS.

2 (b) (I) SUBJECT TO SUBSECTIONS (2) TO (6) OF THIS SECTION, EACH
3 CARRIER THAT OFFERS A SMALL EMPLOYER HEALTH BENEFIT PLAN IN THIS
4 STATE SHALL ISSUE ANY SMALL EMPLOYER HEALTH BENEFIT PLAN TO ANY
5 ELIGIBLE SMALL EMPLOYER THAT APPLIES FOR THE PLAN AND AGREES TO
6 MAKE THE REQUIRED PREMIUM PAYMENTS AND SATISFY THE OTHER
7 REASONABLE PROVISIONS OF THE HEALTH BENEFIT PLAN NOT
8 INCONSISTENT WITH THIS ARTICLE.

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

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

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

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

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

25 (b) SHALL ESTABLISH SPECIAL ENROLLMENT PERIODS FOR
26 TRIGGERING OR QUALIFYING EVENTS CONSISTENT WITH SECTION
27 10-16-105.7 AND IN ACCORDANCE WITH RULES ADOPTED BY THE

1 COMMISSIONER.

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

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

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

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

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

26 (e) SHALL NOT INCREASE ANY REQUIREMENT FOR MINIMUM
27 EMPLOYEE PARTICIPATION OR FOR MINIMUM EMPLOYER CONTRIBUTION

1 WITH RESPECT TO A SMALL EMPLOYER AT ANY TIME AFTER THE SMALL
2 EMPLOYER CARRIER ACCEPTS THE SMALL EMPLOYER FOR COVERAGE.

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

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

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

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

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

25 (b) A CARRIER THAT CANNOT OFFER COVERAGE PURSUANT TO
26 SUBPARAGRAPH (III) OF PARAGRAPH (a) OF THIS SUBSECTION (4) SHALL
27 NOT OFFER COVERAGE IN THE INDIVIDUAL OR SMALL GROUP MARKET IN

1 THE APPLICABLE GEOGRAPHIC SERVICE AREA TO NEW INDIVIDUALS OR
2 SMALL EMPLOYER GROUPS UNTIL THE LATER OF:

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

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

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

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

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

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

25 (b) A CARRIER THAT DENIES COVERAGE IN ACCORDANCE WITH
26 PARAGRAPH (a) OF THIS SUBSECTION (5) SHALL NOT OFFER COVERAGE IN
27 THE APPLICABLE INDIVIDUAL MARKET OR SMALL GROUP MARKET IN THIS

1 STATE UNTIL THE LATER OF:

2 (I) ONE HUNDRED EIGHTY DAYS AFTER THE DATE THE COVERAGE
3 IS DENIED; OR

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

7 (6) THIS SECTION DOES NOT REQUIRE A CARRIER:

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

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

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

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

24 (7) **[Formerly 10-16-104 (16)] Issuance of coverage to**
25 **members of military.** (a) ALL SICKNESS AND ACCIDENT INSURANCE
26 POLICIES AND ALL SERVICE OR INDEMNITY CONTRACTS ISSUED BY ANY
27 ENTITY SUBJECT TO PART 3 OR 4 OF THIS ARTICLE SHALL NOT REFUSE TO

1 PROVIDE COVERAGE TO AN INDIVIDUAL, REFUSE TO CONTINUE TO COVER
2 AN INDIVIDUAL, OR LIMIT THE AMOUNT OR EXTENT OF COVERAGE
3 AVAILABLE TO AN INDIVIDUAL SOLELY BASED ON THAT INDIVIDUAL'S
4 MEMBERSHIP IN THE UNIFORMED SERVICES OF THE UNITED STATES.
5 NOTHING IN THIS SECTION PROHIBITS A CARRIER FROM EXCLUDING OR
6 LIMITING COVERAGE FOR SOME OTHER FACTOR PERMITTED BY LAW.

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

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

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

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

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

25 **10-16-105.1. Guaranteed renewability - exceptions - individual**
26 **and small employer health benefit plans - rules - repeal.** (1) EXCEPT
27 AS OTHERWISE PROVIDED IN SUBSECTION (2) OF THIS SECTION, A CARRIER

1 PROVIDING COVERAGE UNDER A HEALTH BENEFIT PLAN SHALL RENEW OR
2 CONTINUE THE COVERAGE AT THE OPTION OF THE POLICYHOLDER.

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

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

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

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

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

23 (e) IN THE CASE OF AN INDIVIDUAL OR SMALL EMPLOYER HEALTH
24 BENEFIT PLAN THAT IS MADE AVAILABLE ONLY THROUGH ONE OR MORE
25 BONA FIDE ASSOCIATIONS, THE MEMBERSHIP OF THE POLICYHOLDER OR
26 SMALL EMPLOYER IN THE ASSOCIATION ON THE BASIS OF WHICH THE
27 COVERAGE IS PROVIDED CEASES, BUT ONLY IF THE COVERAGE IS

1 TERMINATED UNDER THIS PARAGRAPH (e) UNIFORMLY WITHOUT REGARD
2 TO ANY HEALTH-STATUS-RELATED FACTOR RELATING TO ANY COVERED
3 PERSON;

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

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

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

19 (II) OFFERS EACH POLICYHOLDER COVERED BY THE PLAN THE
20 OPTION TO PURCHASE ANY OTHER HEALTH BENEFIT PLANS CURRENTLY
21 BEING OFFERED BY THE CARRIER IN THIS STATE AND SPECIFIES THE SPECIAL
22 ENROLLMENT PERIODS FOR THE PLANS PURSUANT TO SECTION
23 10-16-105.7;

24 (III) IN EXERCISING THE OPTION TO DISCONTINUE THAT
25 PARTICULAR TYPE OF HEALTH BENEFIT PLAN, ACTS UNIFORMLY WITHOUT
26 REGARD TO THE CLAIMS EXPERIENCE OF THE POLICYHOLDERS OR ANY
27 HEALTH-STATUS-RELATED FACTOR RELATING TO ANY INDIVIDUAL,

1 PARTICIPANT, OR BENEFICIARY COVERED BY THE PLAN OR NEW
2 INDIVIDUALS, PARTICIPANTS, OR BENEFICIARIES WHO MAY BECOME
3 ELIGIBLE FOR COVERAGE;

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

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

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

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

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

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

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

1 (A) CONTINUE TO PROVIDE COVERAGE THROUGH THE FIRST
2 RENEWAL PERIOD NOT TO EXCEED TWELVE MONTHS AFTER THE NOTICE
3 PROVIDED PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (h); AND

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

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

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

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

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

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

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

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

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

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

8 (II) THIS PARAGRAPH (b) IS REPEALED, EFFECTIVE JANUARY 1,
9 2015.

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

12 **10-16-105.2. Small employer health insurance availability**
13 **program.** (1) (a) Except as provided in paragraphs (b) ~~(c)~~, and (d) of this
14 subsection (1), this article ~~shall apply~~ APPLIES to any health benefit plan
15 that provides coverage to the employees of a small employer in this state
16 if any of the following conditions are met:

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

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

1 ~~(B) If the applicant is a business group of one self-employed~~
2 ~~person, the carrier accepts or rejects such person and, if such person is~~
3 ~~applying for family coverage, accepts or rejects the entire family unless~~
4 ~~the applicant waives coverage for a family member who has other~~
5 ~~coverage in effect.~~

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

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

1 within any other certification form that the carrier uses for the plan. The
2 division of insurance shall make available a standard plan description
3 form to individual carriers upon request.

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

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

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

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

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

1 **10-16-105.6. Rate usage. [Formerly 10-16-107 (6)]**

2 ~~(6)(a)~~ (1) A carrier offering a AN INDIVIDUAL OR group health benefit
3 plan ~~may~~ SHALL not require any individual, as a condition of enrollment
4 or continued enrollment under the plan, to pay a premium or, FOR GROUP
5 PLANS, A contribution that is greater than the premium or contribution for
6 a similarly situated individual enrolled in the plan on the basis of any
7 health-status-related factor in relation to the individual or to an individual
8 enrolled under the plan as a dependent of the individual.

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

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

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

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

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

21 ~~(C)~~ (III) Satisfaction of a standard related to a health risk factor
22 pursuant to a wellness and prevention program authorized in section
23 10-16-136.

24 (3) **[Formerly 10-16-105 (13) (a) (I)]** (a) On and after January
25 1, ~~2004~~ 2014, A CARRIER MAY IMPOSE ON a small employer ~~may be~~
26 ~~subject to~~ A premium ~~adjustments for health status~~ SURCHARGE OF up to
27 thirty-five percent above the modified community rate for a ~~period no~~

1 ~~greater than~~ UP TO twelve months if the small employer has, at any time
2 during the past twelve months, purchased health benefit coverage as a
3 small employer that is either self-funded or insured through a health
4 benefit plan that is not a small group plan, except for health benefit plans
5 sponsored by an employee leasing company, as defined in section
6 8-70-114 (2) (a) (V), C.R.S., pursuant to ~~sub-subparagraphs (D) to (F)~~
7 ~~SUBPARAGRAPHS (II) TO (IV) OF PARAGRAPH (b) OF THIS SUBPARAGRAPH (F)~~.
8 ~~The provisions of this subparagraph (F) shall~~ SUBSECTION (3).

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

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

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

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

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

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

25 ~~(F) (IV)~~ A small employer that is currently using the services of
26 an employee leasing company, as defined in section 8-70-114 (2) (a) (V),
27 C.R.S., that does not offer a health benefit plan as part of its employee

1 leasing services or, because of an action by ~~an insurer~~ A CARRIER, has
2 ceased offering a health benefit plan to employees assigned to client
3 locations pursuant to an employee leasing contract. ~~or~~

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

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

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

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

27 (d) **[Formerly 10-16-105 (13) (d)]** A CARRIER SHALL USE the

1 premium ~~adjustment for health status~~ SURCHARGE allowed pursuant to
2 this subsection ~~(13) shall~~ (3) only ~~be used for the calculation of~~
3 CALCULATING premium amounts and shall not ~~be used by a small~~
4 ~~employer carrier~~ USE THE PREMIUM SURCHARGE as a basis of acceptance
5 ~~or rejection of~~ FOR ACCEPTING OR REJECTING A SMALL EMPLOYER'S
6 APPLICATION FOR health benefit coverage. ~~for a small employer.~~ The
7 CARRIER SHALL NOT APPLY THE premium ~~adjustment for health status~~
8 ~~shall not apply~~ SURCHARGE to a group of more than fifty employees that
9 subsequently becomes subject to small group coverage if ~~such~~ THE group
10 has NOT had ~~no~~ A lapse of coverage greater than ninety days.

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

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

24 **10-16-105.7. Health benefit plan open enrollment periods -**
25 **special enrollment periods - rules.** (1) (a) A CARRIER OFFERING AN
26 INDIVIDUAL HEALTH BENEFIT PLAN IN THIS STATE SHALL PERMIT AN
27 INDIVIDUAL TO PURCHASE AN INDIVIDUAL HEALTH BENEFIT PLAN DURING

1 THE INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS.

2 (b) THE INITIAL OPEN ENROLLMENT PERIOD BEGINS OCTOBER 1,
3 2013, AND EXTENDS THROUGH MARCH 31, 2014.

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

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

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

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

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

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

26 (3) (a) (I) A CARRIER OFFERING AN INDIVIDUAL HEALTH BENEFIT
27 PLAN IN THIS STATE SHALL ESTABLISH SPECIAL ENROLLMENT PERIODS

1 DURING WHICH AN INDIVIDUAL FOR WHOM A TRIGGERING EVENT HAS
2 OCCURRED MAY ENROLL IN AN INDIVIDUAL HEALTH BENEFIT PLAN
3 OFFERED BY THE CARRIER.

4 (II) A TRIGGERING EVENT OCCURS WHEN:

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

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

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

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

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

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

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

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

7 (II) A QUALIFYING EVENT OCCURS WHEN:

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

14 (B) AN INDIVIDUAL LOSES COVERAGE UNDER A HEALTH BENEFIT
15 PLAN DUE TO THE DIVORCE OR LEGAL SEPARATION OF THE COVERED
16 EMPLOYEE FROM THE COVERED EMPLOYEE'S SPOUSE OR PARTNER IN A
17 CIVIL UNION;

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

24 (D) AN INDIVIDUAL LOSES OTHER CREDITABLE COVERAGE DUE TO
25 THE TERMINATION OF HIS OR HER EMPLOYMENT OR ELIGIBILITY FOR THE
26 COVERAGE; REDUCTION IN NUMBER OF HOURS OF EMPLOYMENT;
27 INVOLUNTARY TERMINATION OF COVERAGE; OR REDUCTION OR

1 ELIMINATION OF HIS OR HER EMPLOYER'S CONTRIBUTIONS TOWARD THE
2 COVERAGE;

3 (E) AN INDIVIDUAL LOSES ELIGIBILITY UNDER THE "COLORADO
4 MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5, C.R.S., OR
5 THE CHILDREN'S BASIC HEALTH PLAN, ARTICLE 8 OF TITLE 25.5, C.R.S.; OR

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

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

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

17 **10-16-106.5. Prompt payment of claims - legislative**
18 **declaration - rules.** (8) This section ~~shall~~ DOES not apply to ~~claims~~ A
19 CLAIM filed:

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

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

27 **SECTION 12.** In Colorado Revised Statutes, **amend with**

1 **relocated provisions** 10-16-107 as follows:

2 **10-16-107. Rate filing regulation - rules - benefits ratio - rules.**

3 (1) (a) A CARRIER SUBJECT TO PART 2, 3, OR 4 OF THIS ARTICLE SHALL NOT
4 ESTABLISH rates for any sickness, accident, or health insurance policy,
5 contract, certificate, or other evidence of coverage issued or delivered to
6 any policyholder, enrollee, subscriber, or member in Colorado ~~by an~~
7 ~~insurer subject to the provisions of part 2 of this article or an entity~~
8 ~~subject to the provisions of part 3 or 4 of this article shall not be~~ THAT
9 ARE excessive, inadequate, or unfairly discriminatory. To assure
10 compliance with the requirements of this section that rates are not
11 excessive in relation to benefits, the commissioner shall promulgate rules
12 to require rate filings and, as part ~~thereof~~ OF THE RULES, may require the
13 submission of adequate documentation and supporting information,
14 including actuarial opinions or certifications and set expected benefits
15 ratios. THE CARRIER SHALL SUBMIT expected rate increases ~~shall be~~
16 ~~submitted~~ to the commissioner at least sixty days prior to the proposed
17 implementation of the rates. If the commissioner does not approve or
18 disapprove the rate filings within a sixty-day period, the carrier may
19 implement and reasonably rely upon the rates on the condition that the
20 commissioner may require correction of any deficiencies in the rate filing
21 upon later review if the rate THE CARRIER charged is excessive,
22 inadequate, or unfairly discriminatory. A prospective rate adjustment ~~shall~~
23 ~~be~~ IS the sole remedy for rate deficiencies pursuant to this subsection (1).
24 If the commissioner finds deficiencies in the rate filing after a sixty-day
25 period, the commissioner shall provide notice to the carrier and the carrier
26 shall correct the rate on a prospective basis.

27 (b) THE COMMISSIONER MAY REVIEW expected rate filing increases

1 filed with the commissioner on or after June 5, 2008, may be reviewed by
2 the commissioner and shall be disapproved and resubmitted DISAPPROVE
3 THE RATE INCREASE AND REQUIRE THE CARRIER TO RESUBMIT for approval
4 if any of the provisions of subsection ~~(1.6)~~ (3) of this section apply. Rate
5 filings that do not involve a requested rate increase, or THAT INVOLVE a
6 requested rate increase of less than five percent for dental insurance, shall
7 DO not require preapproval, and THE CARRIER may be implemented
8 IMPLEMENT THE RATE upon filing with the commissioner.

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

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

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

1 (f) CARRIERS SHALL FILE rate filings for insurance regulated under
2 parts 1 to 4 of this article ~~shall be filed~~ electronically in a format made
3 available by the division, unless exempted by rule for an emergency
4 situation as determined by the commissioner. THE DIVISION SHALL POST
5 ON ITS WEB SITE a rate filing summary for insurance regulated under parts
6 1 to 4 of this article ~~shall be posted on the division's internet site~~ in order
7 to provide notice to the public.

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

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

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

15 ~~(1.5)~~ (2) (a) (I) Rates for an individual health coverage plan issued
16 or delivered to any policyholder, enrollee, subscriber, or member in
17 Colorado by an insurer subject to part 2 of this article or an entity subject
18 to part 3 or 4 of this article shall not be excessive, inadequate, or unfairly
19 discriminatory to assure compliance with the requirements of this section
20 that rates are not excessive in relation to benefits. Rates are excessive if
21 they are likely to produce a long run profit that is unreasonably high for
22 the insurance provided or if expenses are unreasonably high in relation to
23 services rendered. In determining if rates are excessive, the commissioner
24 may consider the expected filed rates in relation to the actual rates
25 charged.

26 (II) ~~Concerning inadequacy,~~ Rates are not inadequate unless
27 clearly insufficient to sustain projected losses and expenses, or the use of

1 ~~such~~ THE rates, if continued, will tend to create a monopoly in the market.

2 (III) ~~Concerning unfair discrimination, unfair discrimination exists~~
3 RATES ARE UNFAIRLY DISCRIMINATORY if, after allowing for practical
4 limitations, price differentials fail to reflect equitably the differences in
5 expected losses and expenses.

6 (b) Notwithstanding any other provision of this article, ~~an insurer~~
7 A CARRIER subject to part 2, ~~of this article or an entity subject to part 3, or~~
8 4 of this article shall not vary the premium rate for an individual health
9 coverage plan due to the gender of the individual policyholder, enrollee,
10 subscriber, or member. Any premium rate based on the gender of the
11 individual policyholder, enrollee, subscriber, or member ~~shall be~~
12 ~~considered~~ IS unfairly discriminatory and ~~shall~~ IS not ~~be~~ allowed.

13 ~~(1.6)~~ (3) (a) The commissioner shall disapprove the requested rate
14 increase if any of the following apply:

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

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

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

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

4 (V) The rate filing is incomplete.

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

15 (c) THE COMMISSIONER SHALL ADOPT RULES THAT ESTABLISH THE
16 BENEFITS RATIO FOR CARRIERS TO USE FOR RATE FILING PURPOSES FOR
17 HEALTH BENEFIT PLANS, OTHER THAN GRANDFATHERED HEALTH BENEFIT
18 PLANS. THE RULES MUST INCLUDE, AS SUPPLEMENTAL CRITERIA THAT WILL
19 BE CONSIDERED DURING REVIEW, REQUIREMENTS FOR CARRIERS TO
20 PROVIDE INFORMATION ON ACTIVITIES TO IMPROVE HEALTH CARE QUALITY
21 AS SET FORTH UNDER THE AUTHORITY OF SECTION 2718 OF THE FEDERAL
22 "PUBLIC HEALTH SERVICE ACT", AS AMENDED, AND IN 45 CFR 158.150
23 AND EXPENDITURES RELATED TO HEALTH INFORMATION TECHNOLOGY AND
24 MEANINGFUL USE AS SET FORTH IN 45 CFR 158.151.

25 ~~(1.7) (Deleted by amendment, L. 2008, p. 2251, § 6, effective July~~
26 ~~1, 2008.)~~

27 ~~(2) No policy of sickness and accident insurance or subscription~~

1 ~~certificate or membership certificate or other evidence of health care~~
2 ~~coverage shall be delivered or issued for delivery in this state, nor shall~~
3 ~~any endorsement, rider, or application that becomes a part of any such~~
4 ~~policy, contract, or evidence of coverage be used, until the insurer has~~
5 ~~filed a certification with the commissioner that such policy, endorsement,~~
6 ~~rider, or application conforms, to the best of the insurer's good faith~~
7 ~~knowledge and belief, to Colorado law pursuant to section 10-16-107.2~~
8 ~~and copies of the rates and the classification of risks or subscribers~~
9 ~~pertaining thereto are filed with the commissioner.~~

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

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

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

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

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

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

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

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

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

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

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

18 ~~(e) (Deleted by amendment, L. 2008, p. 2251, § 6, effective July~~
19 ~~1, 2008.)~~

20 ~~(f) (Deleted by amendment, L. 92, p. 1744, § 4, effective January~~
21 ~~1, 1993.)~~

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

26 ~~(4) (a) For prepaid dental care plans, no enrollee coverage or an~~
27 ~~amendment, advertising matter, or sales material shall be issued or~~

1 delivered to any person in this state until a copy of the form of the
2 enrollee coverage or amendment, advertising matter, or sales material has
3 been filed with the commissioner.

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

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

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

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

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

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

19 (d) The commissioner shall approve any form of enrollee
20 coverage if the requirements of paragraphs (b) and (c) of this subsection
21 (4) are met and the prepaid dental care plan is able, in the judgment of the
22 commissioner, to meet its financial obligations under the enrollee
23 coverage. It is unlawful to issue such form until approved. If the
24 commissioner does not disapprove any such form within thirty days after
25 the filing, it shall be deemed approved. If the commissioner disapproves
26 a form of enrollee coverage, advertising matter, or sales material, the
27 commissioner shall notify the prepaid dental care plan organization,

1 specifying the reasons for disapproval. The commissioner shall grant a
2 hearing on such disapproval within fifteen days after a request in writing
3 is received from the prepaid dental care plan organization.

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

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

12 (b) (i) Subject to rules promulgated by the commissioner, has
13 procedures in place that ensure that, if a woman covered by the plan
14 requests a timely referral to an obstetrician, gynecologist, or an advanced
15 practice nurse who is a certified nurse midwife pursuant to section
16 12-38-111.5, C.R.S., participating and available under the plan for her
17 reproductive health and gynecological care, the request for referral shall
18 not be unreasonably withheld. Such rules shall include, but need not be
19 limited to, the following issues:

20 (A) What constitutes a timely referral;

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

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

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

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

5 ~~(H) In developing rules pursuant to this subsection (5), the~~
6 ~~commissioner shall consult with providers, including, but not limited to,~~
7 ~~family care physicians, representatives of health plans, and other~~
8 ~~appropriate persons and may conduct such surveys and analyses as may~~
9 ~~be necessary to develop the regulation.~~

10 ~~(5.5) (a) No health coverage plan or managed care plan that~~
11 ~~provides coverage for eye care services shall be issued or renewed after~~
12 ~~January 1, 2001, by any entity subject to part 2, 3, or 4 of this article~~
13 ~~unless such health coverage plan or managed care plan:~~

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

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

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

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

26 ~~(I) Impose a deductible or coinsurance for eye care services that~~
27 ~~is greater than the deductible or coinsurance imposed for other medical~~

1 services under the health coverage plan or managed care plan;

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

6 (HH) Impose penalties upon primary care providers as a result of
7 the direct access provisions of this subsection (5.5).

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

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

12 (H) Requiring a health coverage plan or managed care plan to
13 include as a participating provider every willing provider or health
14 professional who meets the terms and conditions of the health coverage
15 plan or managed care plan;

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

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

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

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

27 (d) As used in this subsection (5.5), unless the context otherwise

1 requires:

2 (I) ~~"Eye care provider" means a participating provider who is an~~
3 ~~optometrist licensed to practice optometry pursuant to article 40 of title~~
4 ~~12, C.R.S., or an ophthalmologist licensed to practice medicine pursuant~~
5 ~~to article 36 of title 12, C.R.S.~~

6 (H) ~~"Eye care services" means those health care services related~~
7 ~~to the examination, diagnosis, treatment, and management of conditions~~
8 ~~and diseases of the eye and related structures that a managed care plan is~~
9 ~~obligated to pay, reimburse, arrange, or provide for covered persons or~~
10 ~~organizations as specified by a health coverage plan or managed care~~
11 ~~plan, excluding those health care services rendered in conjunction with~~
12 ~~a routine vision examination or the filling of prescriptions for corrective~~
13 ~~eyewear.~~

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

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

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

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

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

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

5 ~~(C) Satisfaction of a standard related to a health risk factor~~
6 ~~pursuant to a wellness and prevention program authorized in section~~
7 ~~10-16-136.~~

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

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

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

24 ~~(HH) By having procedures in place that ensure that, if the~~
25 ~~individual requests a timely referral for intractable pain management to~~
26 ~~a pain management specialist participating in and available under the~~
27 ~~plan, the request for referral shall not be unreasonably denied by the plan.~~

1 The commissioner shall promulgate rules pursuant to this subparagraph
2 (HH) that include, but need not be limited to, the following issues:

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

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

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

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

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

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

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

25 (5) (a) (I) WITH RESPECT TO THE PREMIUM RATES CHARGED BY A
26 CARRIER OFFERING AN INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT
27 PLAN, THE CARRIER SHALL DEVELOP ITS PREMIUM RATES BASED ON, AND

1 VARY THE PREMIUM RATES WITH RESPECT TO THE PARTICULAR PLAN OR
2 COVERAGE ONLY BY THE FOLLOWING CASE CHARACTERISTICS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 (d) ANY INDIVIDUAL WHO DOES NOT QUALIFY FOR A LOWER RATE

1 BASED ON TOBACCO USE MAY BE OFFERED THE OPTION OF PARTICIPATING
2 IN A BONA FIDE WELLNESS PROGRAM, AS DEFINED UNDER THE FEDERAL
3 "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996",
4 AS AMENDED. A CARRIER MAY ALLOW ANY INDIVIDUAL WHO
5 PARTICIPATES IN A BONA FIDE WELLNESS PROGRAM THE LOWER RATE. THE
6 CARRIER SHALL DISCLOSE THE AVAILABILITY OF A TOBACCO RATING
7 ADJUSTMENT AND ANY BONA FIDE WELLNESS PROGRAM TO EACH
8 POTENTIAL INSURED. THE PROVISIONS OF THIS PARAGRAPH (d) ARE
9 APPLICABLE ONLY IF ALLOWED UNDER FEDERAL LAW.

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

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

16 (I) HOW PREMIUM RATES ARE ESTABLISHED;

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

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

26 (B) WITH RESPECT TO SMALL EMPLOYER HEALTH BENEFIT PLANS,
27 A LISTING OF AND DESCRIPTIVE INFORMATION ABOUT, INCLUDING

1 BENEFITS AND PREMIUMS, ALL SMALL EMPLOYER HEALTH BENEFIT PLANS
2 FOR WHICH THE SMALL EMPLOYER IS QUALIFIED.

3 (g) (I) EACH CARRIER SHALL MAINTAIN AT ITS PRINCIPAL PLACE OF
4 BUSINESS A COMPLETE AND DETAILED DESCRIPTION OF ITS RATING
5 PRACTICES, INCLUDING INFORMATION AND DOCUMENTATION THAT
6 DEMONSTRATE THAT ITS RATING METHODS AND PRACTICES ARE BASED
7 UPON COMMONLY ACCEPTED ACTUARIAL ASSUMPTIONS AND ARE IN
8 ACCORDANCE WITH SOUND ACTUARIAL PRINCIPLES.

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

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

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

25 (6) (a) THE CARRIER SHALL USE THE APPLICABLE INDEX RATE FOR
26 THE PREMIUM RATE FOR ALL OF THE CARRIER'S INDIVIDUAL AND SMALL
27 GROUP HEALTH BENEFIT PLANS AND SHALL ADJUST THE APPLICABLE INDEX

1 RATE FOR TOTAL EXPECTED MARKET-WIDE PAYMENTS AND CHARGES
2 UNDER THE RISK ADJUSTMENT AND REINSURANCE PROGRAMS IN THE
3 STATE, SUBJECT ONLY TO THE ADJUSTMENTS PERMITTED IN FEDERAL AND
4 STATE LAW. THE COMMISSIONER MAY ESTABLISH, BY RULE, THE
5 COMPONENTS AND ADJUSTMENTS THAT CARRIERS ARE ABLE TO USE AND
6 MAKE TO THE INDEX RATE.

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

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

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

18 **10-16-107.2. Filing of health policies - rules.** (1) All ~~sickness~~
19 ~~and accident insurers, health maintenance organizations, and nonprofit~~
20 ~~hospital and health service corporations~~ CARRIERS authorized by the
21 commissioner to conduct business in Colorado shall submit an annual
22 report to the commissioner listing any policy form, endorsement, or rider
23 for any sickness, accident, nonprofit hospital and health service
24 corporation, health maintenance organization, or other health insurance
25 policy, contract, certificate, or other evidence of coverage issued or
26 delivered to any policyholder, certificate holder, enrollee, subscriber, or
27 member in Colorado. ~~Such listing shall be submitted by January 15, 1993,~~

1 ~~and not later than~~ EACH CARRIER SHALL SUBMIT THE ANNUAL REPORT BY
2 December 31 of each ~~subsequent~~ year and shall ~~contain~~ INCLUDE IN THE
3 REPORT a certification by an officer of the ~~organization~~ CARRIER that, TO
4 THE BEST OF THE CARRIER'S GOOD FAITH KNOWLEDGE AND BELIEF, each
5 policy form, endorsement, or rider in use complies with Colorado law.
6 The COMMISSIONER SHALL DETERMINE THE necessary elements of the
7 certification. ~~shall be determined by the commissioner.~~

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

24 (b) (1) ~~The commissioner shall develop a uniform employee~~
25 ~~application form for health benefit plans and shall require all small group~~
26 ~~sickness and accident insurers, health maintenance organizations,~~
27 ~~nonprofit hospital and health service corporations, and other entities~~

1 ~~providing small group health care coverage authorized by the~~
2 ~~commissioner to conduct business in Colorado to exclusively use such~~
3 ~~uniform employee application form for the conduct of business in this~~
4 ~~state. On and after January 1, 2007, all small group sickness and accident~~
5 ~~insurers, health maintenance organizations, nonprofit hospital and health~~
6 ~~service corporations, and other entities that provide small group health~~
7 ~~care coverage shall use the uniform employee application form for small~~
8 ~~group sickness and accident health benefit plans.~~

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

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

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

27 ~~(HH) The commissioner shall promulgate rules to implement the~~

1 ~~initial uniform application form on or before September 1, 2011.~~

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

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

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

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

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

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

26 **10-16-107.5. [Formerly 10-16-107.2 (2) (b)] Uniform**
27 **application form - use by all carriers - rules.** (1) The commissioner, BY

1 RULE, shall develop a uniform ~~employee~~ application form for health
2 benefit plans and shall require all ~~small group sickness and accident~~
3 ~~insurers, health maintenance organizations, nonprofit hospital and health~~
4 ~~service corporations, and other entities~~ CARRIERS providing ~~small group~~
5 ~~health care coverage~~ HEALTH BENEFIT PLANS THAT ARE authorized by the
6 commissioner to conduct business in Colorado to exclusively use ~~such~~
7 THE uniform ~~employee~~ application form for the conduct of business in
8 this state. ~~On and after January 1, 2007, all small group sickness and~~
9 ~~accident insurers, health maintenance organizations, nonprofit hospital~~
10 ~~and health service corporations, and other entities~~ BY A DATE SPECIFIED
11 BY THE COMMISSIONER, ALL CARRIERS that provide ~~small group health~~
12 ~~care coverage~~ HEALTH BENEFIT PLANS shall use the uniform ~~employee~~
13 application form for ~~small group sickness and accident~~ THEIR health
14 benefit plans.

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

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

19 **10-16-107.7. Nondiscrimination against providers.** (1) A
20 CARRIER OFFERING AN INDIVIDUAL OR GROUP HEALTH BENEFIT PLAN IN
21 THIS STATE SHALL NOT DISCRIMINATE WITH RESPECT TO PARTICIPATION
22 UNDER THE PLAN OR COVERAGE AGAINST ANY PROVIDER WHO IS ACTING
23 WITHIN THE SCOPE OF HIS OR HER LICENSE OR CERTIFICATION UNDER
24 APPLICABLE STATE LAW.

25 (2) THIS SECTION DOES NOT:
26 (a) REQUIRE A CARRIER TO CONTRACT WITH ANY PROVIDER
27 WILLING TO ABIDE BY THE TERMS AND CONDITIONS FOR PARTICIPATION

1 ESTABLISHED BY THE PLAN OR CARRIER; OR

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

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

6 **10-16-108. Continuation privileges. (1) Group health benefit**
7 **plans.** (a) EVERY EMPLOYER GROUP HEALTH BENEFIT PLAN ISSUED BY A
8 CARRIER MUST CONTAIN A PROVISION SPECIFYING THAT IF A COVERED
9 EMPLOYEE'S EMPLOYMENT IS TERMINATED AND THE HEALTH BENEFIT PLAN
10 REMAINS IN FORCE FOR ACTIVE EMPLOYEES OF THE EMPLOYER, THE
11 COVERED EMPLOYEE WHOSE EMPLOYMENT IS TERMINATED MAY ELECT TO
12 CONTINUE THE COVERAGE FOR HIMSELF OR HERSELF AND HIS OR HER
13 DEPENDENTS. THE PROVISION MUST CONFORM TO THE REQUIREMENTS,
14 WHERE APPLICABLE, OF PARAGRAPHS (b), (c), AND (e) OF THIS SUBSECTION
15 (1).

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

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

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

26 (III) THE EMPLOYEE HAS BEEN CONTINUOUSLY COVERED UNDER
27 THE GROUP HEALTH BENEFIT PLAN, OR UNDER ANY GROUP HEALTH

1 BENEFIT PLAN PROVIDING SIMILAR BENEFITS THAT IT REPLACES, FOR AT
2 LEAST SIX MONTHS IMMEDIATELY PRIOR TO TERMINATION.

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

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

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

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

1 SUBPARAGRAPH (II). THE NOTIFICATION MUST INFORM THE EMPLOYEE OF:

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

4 (B) THE AMOUNT THE EMPLOYEE MUST PAY MONTHLY TO THE
5 EMPLOYER TO RETAIN THE COVERAGE, WHICH PAYMENT INCLUDES THE
6 EMPLOYER'S CONTRIBUTION FOR THE EMPLOYEE IN ADDITION TO THE
7 EMPLOYEE'S OWN CONTRIBUTION;

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

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

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

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

1 HEALTH CARE COVERAGE.

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

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

12 (2) **Group policies and group service contracts - reduction in**
13 **hours of work.** EVERY GROUP POLICY OR GROUP SERVICE CONTRACT
14 DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE BY AN INSURER
15 SUBJECT TO PART 2 OF THIS ARTICLE OR BY AN ENTITY SUBJECT TO PART
16 3 OR 4 OF THIS ARTICLE THAT COVERS FULL-TIME EMPLOYEES WORKING
17 FORTY OR MORE HOURS PER WEEK SHALL CONTAIN A PROVISION THAT THE
18 POLICYHOLDER MAY ELECT TO CONTRACT WITH THE INSURER OR OTHER
19 ENTITY TO CONTINUE THE POLICY OR CONTRACT UNDER THE SAME
20 CONDITIONS AND FOR THE SAME PREMIUM FOR THE EMPLOYEES AND THEIR
21 DEPENDENTS EVEN IF THE POLICYHOLDER OR EMPLOYER REDUCES THE
22 WORKING HOURS OF THE EMPLOYEES TO LESS THAN THIRTY HOURS PER
23 WEEK, IF THE FOLLOWING CONDITIONS ARE MET:

24 (a) THE COVERED EMPLOYEE IS EMPLOYED AS A FULL-TIME
25 EMPLOYEE OF THE POLICYHOLDER OR EMPLOYER AND IS INSURED UNDER
26 THE GROUP POLICY OR GROUP SERVICE CONTRACT, OR UNDER ANY GROUP
27 POLICY OR GROUP SERVICE CONTRACT PROVIDING SIMILAR BENEFITS THAT

1 THE GROUP POLICY OR GROUP SERVICE CONTRACT REPLACES,
2 IMMEDIATELY PRIOR TO THE REDUCTION IN WORKING HOURS;

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

6 (c) THE POLICYHOLDER INTENDS TO RESTORE THE EMPLOYEE TO
7 A FULL FORTY-HOUR WORK SCHEDULE AS SOON AS ECONOMIC CONDITIONS
8 IMPROVE OR AS SOON AS THE EMPLOYEE IS ABLE TO RETURN TO FULL-TIME
9 WORK.

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

12 **10-16-108.5. Fair marketing standards.** (1) Each ~~small~~
13 ~~employer~~ carrier OFFERING INDIVIDUAL OR SMALL EMPLOYER HEALTH
14 BENEFIT PLANS shall actively market health benefit plan coverage
15 ~~including the basic health benefit plan and the standard health benefit~~
16 ~~plan~~, to eligible INDIVIDUALS OR small employers in the state, AS
17 APPLICABLE.

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

25 (4) ~~A small employer carrier shall provide reasonable~~
26 ~~compensation, as provided under the plan of operation of the small~~
27 ~~employer health reinsurance program, to a producer, if any, for the sale~~

1 of a basic or standard health benefit plan.

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

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

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

26 (c) (II) ~~A Colorado~~ THE COMMISSIONER SHALL DESIGN THE
27 SUPPLEMENTAL health benefit plan description form ~~shall include~~

1 ~~information of general interest to purchasers of health plans and persons~~
2 ~~insured under health plans. Such form shall be designed to facilitate THE~~
3 ~~comparison of different health benefit plans. THE FORM MUST ALSO~~
4 ~~INCLUDE informational materials specifying the plan's cancer screening~~
5 ~~coverages and their respective parameters. shall be included with the~~
6 ~~form.~~

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

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

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

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

20 **10-16-109. Rules.** Pursuant to ~~the provisions~~ of article 4 of title
21 24, C.R.S., the commissioner may promulgate such reasonable rules and
22 ~~regulations not inconsistent~~ CONSISTENT with the provisions of this article
23 as THAT are necessary or proper for ~~carrying out the provisions of~~
24 IMPLEMENTING AND ADMINISTERING this article, INCLUDING RULES
25 NECESSARY TO ALIGN STATE LAW WITH THE REQUIREMENTS IMPOSED BY
26 FEDERAL LAW REGARDING HEALTH CARE COVERAGE IN THIS STATE.

27 **SECTION 19.** In Colorado Revised Statutes, **amend** 10-16-113

1 as follows:

2 **10-16-113. Procedure for denial of benefits - internal review**

3 **- rules.** (1) (a) A ~~health coverage plan~~ CARRIER shall not make a AN
4 ADVERSE determination, in whole or in part, ~~that it will deny a request for~~
5 ~~benefits for a covered individual on the ground that such treatment or~~
6 ~~covered benefit is not medically necessary, appropriate, effective, or~~
7 ~~efficient~~ WITH RESPECT TO A HEALTH COVERAGE PLAN unless ~~such denial~~
8 THE DETERMINATION is made pursuant to this section.

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

12 (I) "ADVERSE DETERMINATION" MEANS:

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

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

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

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

24 (E) A DENIAL OF COVERAGE TO AN INDIVIDUAL BASED ON AN
25 INITIAL ELIGIBILITY DETERMINATION FOR ALL INDIVIDUAL SICKNESS AND
26 ACCIDENT INSURANCE POLICIES ISSUED BY AN ENTITY SUBJECT TO PART 2
27 OF THIS ARTICLE, AND ALL INDIVIDUAL HEALTH CARE OR INDEMNITY

1 CONTRACTS ISSUED BY AN ENTITY SUBJECT TO PART 3 OR 4 OF THIS
2 ARTICLE, EXCEPT SUPPLEMENTAL POLICIES COVERING A SPECIFIED DISEASE
3 OR OTHER LIMITED BENEFIT.

4 (II) "HEALTH COVERAGE PLAN" DOES NOT INCLUDE INSURANCE
5 ARISING OUT OF THE "WORKERS' COMPENSATION ACT OF COLORADO",
6 ARTICLES 40 TO 47 OF TITLE 8, C.R.S., OR OTHER SIMILAR LAW,
7 AUTOMOBILE MEDICAL PAYMENT INSURANCE, OR PROPERTY AND
8 CASUALTY INSURANCE.

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

11 (c) If a ~~health coverage plan~~ CARRIER denies a benefit because the
12 treatment is an excluded benefit and the claimant presents evidence from
13 a medical professional licensed pursuant to the "Colorado Medical
14 Practice Act", article 36 of title 12, C.R.S., or, for dental plans only, a
15 dentist licensed pursuant to the "Dental Practice Law of Colorado", article
16 35 of title 12, C.R.S., acting within his or her scope of practice, that there
17 is a reasonable medical basis that the contractual exclusion does not apply
18 to the denied benefit, such evidence establishes that the benefit denial is
19 subject to the appeals process ~~The denial of such benefit shall be subject~~
20 ~~to the appeals provisions of~~ PURSUANT TO this section and section
21 10-16-113.5.

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

1 CARRIER SHALL NOTIFY THE INDIVIDUAL IN ACCORDANCE WITH THOSE
2 RULES.

3 (3) (a) (I) All denials of requests for reimbursement for medical
4 treatment, standing referrals, or ~~other benefits~~ ADVERSE DETERMINATIONS
5 MADE on the ground that ~~such~~ A treatment or covered benefit is not
6 medically necessary, appropriate, effective, or efficient, ~~shall~~ IS NOT
7 DELIVERED IN THE APPROPRIATE SETTING OR AT THE APPROPRIATE LEVEL
8 OF CARE, OR IS EXPERIMENTAL OR INVESTIGATIONAL, MUST include:

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

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

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

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

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

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

24 (A) If an internal rule, guideline, protocol, or other similar
25 criterion was relied upon in making the adverse determination, the carrier
26 shall furnish the ~~covered person and the covered person's representative~~
27 INDIVIDUAL with either the specific rule, guideline, protocol, or other

1 similar criterion, or a statement that ~~such~~ THE rule, guideline, protocol, or
2 other criterion was relied upon in making the adverse determination and
3 that a copy of ~~such~~ THE rule, guideline, protocol, or other criterion will be
4 provided free of charge to the ~~covered person and the covered person's~~
5 ~~designated representative~~ INDIVIDUAL upon request; or

6 (B) If the adverse ~~benefit~~ determination is based on a medical
7 necessity or experimental treatment or similar exclusion or limit, the
8 carrier shall furnish the ~~covered person and the covered person's~~
9 ~~designated representative~~ INDIVIDUAL with either an explanation of the
10 scientific or clinical judgment for the determination, applying the terms
11 of the plan to the ~~covered person's~~ INDIVIDUAL'S medical circumstances,
12 or a statement that ~~such~~ THE explanation will be provided free of charge
13 upon request.

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

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

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

27 (C) MAY WAIVE THE DEADLINES SPECIFIED IN SUB-SUBPARAGRAPH

1 (B) OF THIS SUBPARAGRAPH (III) AND IN SUBPARAGRAPH (IV) OF THIS
2 PARAGRAPH (a) TO PERMIT THE INDIVIDUAL TO PURSUE AN EXPEDITED
3 EXTERNAL REVIEW OF THE URGENT CARE CLAIM UNDER SECTION
4 10-16-113.5.

5 (IV) A CARRIER SHALL NOTIFY AN INDIVIDUAL OF A BENEFIT
6 DETERMINATION, WHETHER ADVERSE OR NOT, WITH RESPECT TO A
7 REQUEST INVOLVING URGENT CARE AS SOON AS POSSIBLE, TAKING INTO
8 ACCOUNT THE MEDICAL EXIGENCIES, BUT NOT LATER THAN SEVENTY-TWO
9 HOURS AFTER THE RECEIPT OF THE REQUEST BY THE CARRIER, UNLESS THE
10 INDIVIDUAL FAILS TO PROVIDE SUFFICIENT INFORMATION TO DETERMINE
11 WHETHER, OR TO WHAT EXTENT, BENEFITS ARE COVERED OR PAYABLE
12 UNDER THE COVERAGE.

13 (b) (I) ~~For the purposes of this paragraph (b), a "health coverage~~
14 ~~plan" does not include insurance arising out of the "Workers'~~
15 ~~Compensation Act of Colorado" or other similar law, automobile medical~~
16 ~~payment insurance, or property and casualty insurance. A GROUP health~~
17 ~~coverage plan shall~~ ISSUED BY A CARRIER SUBJECT TO PART 2, 3, OR 4 OF
18 THIS ARTICLE MUST specify that an appeal ~~from the denial of a request for~~
19 ~~covered benefits on the ground that such benefits are not medically~~
20 ~~necessary, appropriate, effective, or efficient, shall include~~ OF ANY
21 ADVERSE DETERMINATION INCLUDES a two-level internal review of the
22 decision, followed by the right of the ~~covered person~~ INDIVIDUAL to
23 request an external review IF ALLOWED under section 10-16-113.5. The
24 ~~covered person shall have~~ INDIVIDUAL HAS the option of choosing
25 whether to utilize the voluntary second-level internal appeal process. ~~The~~
26 ~~commissioner shall promulgate rules for such benefits denials that reflect~~
27 ~~the requirements in 29 CFR 2560.503-1 (a) to (j). In addition, the~~

1 commissioner shall promulgate rules specifying the elements of and
2 timelines for external review appeals procedures, including but not
3 limited to the review of appeals requiring expedited reviews and
4 authorizations by the covered individual requesting an independent
5 external review for access to medical records necessary for the conduct
6 of the external review. The commissioner shall consult with and utilize
7 public and private resources, including but not limited to health care
8 providers, in the development of such rules.

9 (H) and (III) (Deleted by amendment, L. 2003, p. 1384, § 1,
10 effective January 1, 2004.)

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

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

26 (B) THIS SUBPARAGRAPH (III) DOES NOT APPLY TO AN ADVERSE
27 DETERMINATION DESCRIBED IN SUB-SUBPARAGRAPH (C) OR (E) OF

1 SUBPARAGRAPH (I) OF PARAGRAPH (b) OF SUBSECTION (1) OF THIS
2 SECTION.

3 ~~(VI)~~ (IV) (A) The second-level internal review of an appeal from
4 the denial of a request for covered benefits PURSUANT TO SUBPARAGRAPH
5 (I) OF THIS PARAGRAPH (b) shall be reviewed by a health care professional
6 who has appropriate expertise, who was not previously involved in the
7 appeal, and who does not have a direct financial interest in the appeal or
8 outcome of the review.

9 (B) The ~~health coverage plan~~ CARRIER shall allow the ~~covered~~
10 ~~person~~ INDIVIDUAL to be present for the second-level internal review,
11 either in person or by telephone conference. The ~~covered person shall~~
12 ~~have the opportunity to~~ INDIVIDUAL MAY bring counsel, advocates, and
13 health care professionals to the review, ~~to~~ prepare in advance for the
14 review, and ~~to~~ present materials to the health care professional prior to the
15 review and at the time of the review. UPON REQUEST, the ~~health coverage~~
16 ~~plan~~ CARRIER and the ~~covered person~~ INDIVIDUAL shall ~~upon request,~~
17 provide ~~a copy~~ COPIES of the materials ~~it presents~~ THEY INTEND TO
18 PRESENT at the review to the other party at least five days prior to the
19 review. If new information is developed after the five-day deadline, ~~such~~
20 THE material may be presented when practicable. The ~~health coverage~~
21 ~~plan~~ CARRIER shall notify the ~~covered person~~ INDIVIDUAL that the ~~plan~~
22 ~~shall~~ CARRIER WILL make an audio or video recording of the review unless
23 neither the ~~covered person~~ INDIVIDUAL nor the ~~health coverage plan~~
24 CARRIER wants the recording made. IF A RECORDING IS MADE, the ~~health~~
25 ~~coverage plan~~ CARRIER shall make ~~such~~ THE recording available to the
26 ~~covered person~~ INDIVIDUAL. If there is an external review, THE CARRIER
27 SHALL INCLUDE the audio or video recording ~~shall, at the request of either~~

1 ~~party, be included~~ in the material provided by the carrier to the reviewing
2 entity IF REQUESTED BY EITHER PARTY.

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

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

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

20 (c) THE CARRIER SHALL ALLOW THE INDIVIDUAL TO BE PRESENT
21 FOR THE APPEAL. THE INDIVIDUAL MAY BRING COUNSEL, ADVOCATES, AND
22 HEALTH CARE PROFESSIONALS TO THE REVIEW, PREPARE IN ADVANCE FOR
23 THE REVIEW, AND PRESENT MATERIALS TO THE PHYSICIAN OR DENTIST
24 PRIOR TO THE REVIEW AND AT THE TIME OF THE REVIEW. UPON REQUEST,
25 THE CARRIER AND THE INDIVIDUAL SHALL PROVIDE COPIES OF THE
26 MATERIALS THEY INTEND TO PRESENT AT THE REVIEW TO THE OTHER
27 PARTY AT LEAST FIVE DAYS PRIOR TO THE REVIEW. IF NEW INFORMATION

1 IS DEVELOPED AFTER THE FIVE-DAY DEADLINE, THE MATERIAL MAY BE
2 PRESENTED WHEN PRACTICABLE. THE CARRIER SHALL NOTIFY THE
3 INDIVIDUAL THAT THE CARRIER WILL MAKE AN AUDIO OR VIDEO
4 RECORDING OF THE REVIEW UNLESS NEITHER THE INDIVIDUAL NOR THE
5 CARRIER WANTS THE RECORDING MADE. IF A RECORDING IS MADE, THE
6 CARRIER SHALL MAKE THE RECORDING AVAILABLE TO THE INDIVIDUAL. IF
7 THERE IS AN EXTERNAL REVIEW, THE CARRIER SHALL INCLUDE THE AUDIO
8 OR VIDEO RECORDING IN THE MATERIAL PROVIDED BY THE CARRIER TO THE
9 REVIEWING ENTITY IF REQUESTED BY EITHER PARTY.

10 ~~(4) (5) All written denials of requests for covered benefits on the~~
11 ~~ground that such benefits are not medically necessary, appropriate,~~
12 ~~effective, or efficient, shall~~ ADVERSE DETERMINATIONS, EXCEPT AN
13 ADVERSE DETERMINATION DESCRIBED IN SUB-SUBPARAGRAPH (C) OR (E)
14 OF SUBPARAGRAPH (I) OF PARAGRAPH (b) OF SUBSECTION (1) OF THIS
15 SECTION, MUST be signed by a licensed physician familiar with standards
16 of care in Colorado; EXCEPT THAT, in the case of written ~~denials of~~
17 ~~requests for covered benefits for~~ ADVERSE DETERMINATIONS RELATING TO
18 dental care, a licensed dentist familiar with standards of care in Colorado
19 may sign the written ~~denial~~ ADVERSE DETERMINATION.

20 ~~(5) (6) A covered person's~~ AN INDIVIDUAL'S health care provider
21 may communicate with the physician or dentist involved in the initial
22 decision to ~~deny reimbursement for or coverage of medical treatment or~~
23 ~~other benefits~~ MAKE AN ADVERSE DETERMINATION.

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

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

1 or relief.

2 (8) IN THE CASE OF THE FAILURE OF A CARRIER TO ADHERE TO
3 THE REQUIREMENTS OF THIS SECTION WITH RESPECT TO A COVERAGE
4 REQUEST, THE INDIVIDUAL MAY BE DEEMED TO HAVE EXHAUSTED THE
5 INTERNAL CLAIMS AND APPEALS PROCESS OF THIS SECTION IF THE
6 COMMISSIONER DETERMINES THAT THE CARRIER DID NOT SUBSTANTIALLY
7 COMPLY WITH THE REQUIREMENTS OF THIS SECTION OR THAT ANY
8 ERROR THE CARRIER COMMITTED WAS NOT DE MINIMIS, AS DEFINED BY THE
9 COMMISSIONER BY RULE, IN WHICH CASE THE INDIVIDUAL MAY INITIATE
10 AN EXTERNAL REVIEW UNDER SECTION 10-16-113.5.

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

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

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

20 **10-16-113.5. Independent external review of adverse**
21 **determinations - legislative declaration - definitions - rules.** (1) The
22 general assembly hereby finds, determines, and declares that, in the
23 interest of improving accountability for health care coverage decisions,
24 ~~covered~~ individuals should have the option of an independent external
25 review by qualified experts when ~~they have been denied a request for~~
26 ~~coverage~~ THERE HAS BEEN AN ADVERSE DETERMINATION WITH RESPECT
27 TO A HEALTH COVERAGE PLAN pursuant to ~~their health plan's~~ A CARRIER'S

1 procedures for denial of benefits AS required by section 10-16-113.

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

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

5 ~~(A) Has gone through at least one of the internal appeals review~~
6 ~~levels offered by a health coverage plan and established pursuant to~~
7 ~~section 10-16-113 (3) and who has requested an independent external~~
8 ~~review of a health coverage plan's decision to deny reimbursement for or~~
9 ~~coverage of medical treatment that is a covered benefit on the grounds~~
10 ~~that such treatment is not medically necessary, medically appropriate,~~
11 ~~medically effective, or medically efficient; or~~

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

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

18 (I) A PREAUTHORIZATION FOR A COVERED BENEFIT;

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

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

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

26 (b) "DIVISION" MEANS THE DIVISION OF INSURANCE IN THE
27 DEPARTMENT OF REGULATORY AGENCIES, ESTABLISHED IN SECTION

1 10-1-103.

2 (b) (c) "Expedited review" means a review following completion
3 of procedures for expedited internal review of an adverse determination
4 involving a situation where the time frame of the standard independent
5 external review procedures would seriously jeopardize the life or health
6 of the ~~covered person~~ INDIVIDUAL or would jeopardize the ~~covered~~
7 ~~person's~~ INDIVIDUAL'S ability to regain maximum function. EXPEDITED
8 REVIEW IS AVAILABLE IF THE ADVERSE DETERMINATION CONCERNS AN
9 ADMISSION, AVAILABILITY OF CARE, CONTINUED STAY, OR HEALTH CARE
10 SERVICES FOR WHICH THE INDIVIDUAL RECEIVED EMERGENCY SERVICES,
11 AND THE INDIVIDUAL HAS NOT BEEN DISCHARGED FROM A FACILITY.

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

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

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

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

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

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

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

27 (A) Be experts in the treatment of the medical condition of the

1 covered individual requesting an independent external review and
2 knowledgeable about the recommended treatment or service that is the
3 subject of the review through the expert's actual, current clinical
4 experience;

5 (B) Hold a license issued by a state and, for physicians, a current
6 certification by a recognized American medical specialty board in the area
7 appropriate to the subject of review; and

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

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

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

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

25 (I) ADVERSE determinations by a ~~plan to deny a request for~~
26 ~~reimbursement for or coverage of medical treatment that is a covered~~
27 ~~benefit for a covered individual on the grounds that such treatment or~~

1 ~~covered benefit is not medically necessary, medically appropriate,~~
2 ~~medically effective, or medically efficient. The independent external~~
3 ~~review entity may not review health coverage plan decisions to deny a~~
4 ~~request for reimbursement for or coverage of a medical treatment that is~~
5 ~~not a covered benefit. The independent external review entity may review~~
6 ~~health care coverage plan decisions to deny a request for reimbursement~~
7 ~~or coverage of a medical treatment on the grounds that it is an~~
8 ~~experimental or investigational procedure, but only if such procedure is~~
9 ~~not explicitly listed as an excluded benefit in the policy. Where a specific~~
10 ~~procedure is a listed excluded benefit, the plan shall deny coverage on the~~
11 ~~grounds that it is not a covered benefit and this shall not be reviewable by~~
12 ~~the independent external review entity~~ CARRIER; OR

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

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

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

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

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

27 (f) (h) "Medical and scientific evidence" includes ~~but is not~~

1 ~~limited to~~, the following sources:

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

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

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

15 (IV) The following standard reference compendia:

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

17 (B) The American medical association drug evaluation;

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

19 and

20 (D) The United States pharmacopoeia - drug information.

21 (V) Findings, studies, or research conducted by or under the
22 auspices of federal government agencies and nationally recognized
23 federal research institutes, including the federal agency for health care
24 policy and research, national institutes of health, the national cancer
25 institute, the national academy of sciences, the health care financing
26 administration, the congressional office of technology assessment, and the
27 national board recognized by the national institutes of health for the

1 purpose of evaluating the medical value of health services.

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

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

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

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

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

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

27 (b) In addition to the requirements set forth in paragraph (a) of

1 this subsection (4), the commissioner shall ~~only~~ certify ONLY an
2 independent external review entity that:

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

6 (II) Maintains documentation available for review by the division
7 ~~of insurance~~ upon request that ~~shall include~~ INCLUDES the following:

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

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

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

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

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

22 (A) The ~~health coverage plan~~ CARRIER or any officer, director, or
23 executive of the ~~health coverage plan~~ CARRIER. This requirement ~~shall~~
24 DOES not prohibit a physician or qualified health care professional who
25 contracts with the ~~health coverage plan~~ CARRIER as a participating
26 provider from serving on a review panel of the independent external
27 review entity if the physician or qualified health care professional meets

1 the requirements of paragraph ~~(c)~~ (d) of subsection (2) of this section. If
2 a participating provider serves on the panel reviewing the case of a
3 ~~covered~~ AN individual requesting an independent external review, the
4 ~~covered~~ REVIEW ENTITY SHALL NOTIFY THE individual requesting an
5 independent external review ~~shall be notified~~ that a health care
6 professional serving on the review panel has a contract as a participating
7 provider with the ~~health coverage plan~~ CARRIER.

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

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

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

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

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

21 (d) The commissioner shall promulgate ~~such~~ rules as ~~are~~ necessary
22 for the certification of independent external review entities under this
23 section. The commissioner may deny, suspend, or revoke the certification
24 of an independent external review entity that does not comply with the
25 requirements of this section. The commissioner ~~shall have the authority~~
26 ~~to~~ MAY contract with any person or entity to develop the certification
27 rules and for IMPLEMENTATION AND administration of the certification

1 program. ~~The commissioner shall consult with and utilize public and~~
2 ~~private resources, including but not limited to health care providers, in the~~
3 ~~development of such rules.~~

4 (5) Upon receipt of a request from a ~~covered person~~ AN
5 INDIVIDUAL requesting an independent external review of a denial, the
6 ~~health care coverage plan~~ CARRIER shall contact the division. of
7 ~~insurance.~~ The division of insurance or its contractor shall inform the
8 ~~health care coverage plan~~ CARRIER of the name of the certified
9 independent external review entity to which the appeal should be sent.

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

18 (7) ~~A covered~~ AN individual requesting an independent external
19 review shall make ~~such~~ THE request within ~~sixty calendar days~~ FOUR
20 MONTHS after receiving notification of a ~~second-level appeal~~ THE denial
21 of ~~coverage for such treatment or service.~~ ~~Such~~ THE INDIVIDUAL'S
22 INTERNAL APPEAL OF AN ADVERSE DETERMINATION. IN THE INTERNAL
23 APPEAL DENIAL notification, ~~of the denial of coverage shall include a~~
24 ~~notification of the person's~~ CARRIER SHALL INFORM THE INDIVIDUAL OF HIS
25 OR HER right to an independent external review. ~~A covered~~ AN individual
26 requesting an independent external review shall notify the ~~plan~~ CARRIER
27 if the ~~covered~~ individual ~~requesting an independent external review~~

1 requests an expedited review. AN INDIVIDUAL REQUESTING AN EXPEDITED
2 INDEPENDENT EXTERNAL REVIEW MAY OBTAIN SUCH EXTERNAL REVIEW
3 CONCURRENTLY WITH AN EXPEDITED INTERNAL APPEAL REQUEST UNDER
4 SECTION 10-16-113.

5 (8) AN INDIVIDUAL MAY REQUEST AN INDEPENDENT EXTERNAL
6 REVIEW OR AN EXPEDITED INDEPENDENT EXTERNAL REVIEW INVOLVING A
7 DENIAL OF COVERAGE OF A RECOMMENDED OR REQUESTED MEDICAL
8 SERVICE THAT IS EXPERIMENTAL OR INVESTIGATIONAL IF THE INDIVIDUAL'S
9 TREATING PHYSICIAN CERTIFIES IN WRITING THAT THE RECOMMENDED OR
10 REQUESTED HEALTH CARE SERVICE OR TREATMENT THAT IS THE SUBJECT
11 OF THE DENIAL WOULD BE SIGNIFICANTLY LESS EFFECTIVE IF NOT
12 PROMPTLY INITIATED. THE INDIVIDUAL'S TREATING PHYSICIAN MUST
13 CERTIFY IN WRITING THAT AT LEAST ONE OF THE FOLLOWING SITUATIONS
14 APPLIES:

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

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

1 AVAILABLE STANDARD HEALTH CARE SERVICES OR TREATMENTS.

2 (8) (9) After receipt of a written request for an independent
3 external review, a ~~health coverage plan~~ THE CARRIER shall notify the
4 ~~covered~~ individual requesting an independent external review in writing.
5 ~~Such~~ THE notification shall MUST include descriptive information on the
6 ~~certified~~ independent external review entity that the division of insurance
7 or its contractor has selected to conduct the independent external review.

8 (9) (10) (a) The ~~health coverage plan~~ CARRIER shall provide to the
9 ~~certified~~ independent external review entity a copy of the following
10 documents after the division of insurance or its contractor has selected a
11 ~~certified~~ AN independent external review entity for the case:

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

22 (II) A copy of any relevant documents used by the ~~plan to~~
23 ~~determine the medical necessity, medical appropriateness, medical~~
24 ~~effectiveness, or medical efficiency~~ of CARRIER IN MAKING ITS ADVERSE
25 DETERMINATION ON the proposed service or treatment, and a copy of any
26 denial letters issued by the ~~plan~~ CARRIER concerning the individual case
27 under review. The ~~health coverage plan~~ CARRIER shall provide, upon

1 request to the ~~covered~~ individual requesting an independent external
2 review, all relevant information supplied to the independent external
3 review entity that is not confidential or privileged under state or federal
4 law concerning the individual case under review.

5 (III) THE INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL
6 REVIEW MAY SUBMIT ADDITIONAL INFORMATION DIRECTLY TO THE
7 INDEPENDENT EXTERNAL REVIEW ENTITY WITHIN FIVE BUSINESS DAYS
8 AFTER THE NOTIFICATION UNDER SUBSECTION (9) OF THIS SECTION. THE
9 INDEPENDENT EXTERNAL REVIEW ENTITY SHALL PROVIDE A COPY OF THE
10 INFORMATION SUBMITTED BY THE INDIVIDUAL TO THE CARRIER WHOSE
11 ADVERSE DETERMINATION IS BEING REVIEWED WITHIN ONE BUSINESS DAY
12 AFTER RECEIPT OF THE INFORMATION.

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

26 (c) The ~~health coverage plan~~ CARRIER may ~~at its discretion,~~
27 determine that additional information provided by the ~~covered~~ individual

1 requesting independent external review or the physician or other health
2 care professional of the ~~covered~~ individual requesting independent
3 external review UNDER SUBPARAGRAPH (III) OF PARAGRAPH (a) AND
4 PARAGRAPH (b) OF THIS SUBSECTION (10) justifies a reconsideration of its
5 ~~denial of coverage~~ ADVERSE DETERMINATION, and a subsequent decision
6 by the ~~health coverage plan~~ CARRIER to provide coverage shall terminate
7 TERMINATES the independent external review upon notification in writing
8 to the ~~certified~~ independent external review entity and the ~~covered~~
9 individual requesting an independent external review.

10 (10)(11) (a) The ~~certified~~ independent external review entity shall
11 submit the expert determination to the ~~health coverage plan~~ CARRIER, the
12 ~~covered~~ individual requesting independent external review, and the
13 physician or other health care professional of the ~~covered~~ individual
14 requesting an independent external review within ~~thirty working~~
15 FORTY-FIVE CALENDAR days after the ~~health coverage plan~~ INDEPENDENT
16 EXTERNAL REVIEW ENTITY has received a request for external review.
17 ~~except that, at the request of the expert reviewer, such deadline shall be~~
18 ~~extended by up to ten working days for the consideration of additional~~
19 ~~information required pursuant to this section.~~ In the case of an expedited
20 review, the INDEPENDENT EXTERNAL REVIEW ENTITY SHALL SUBMIT THE
21 determinations ~~shall be submitted within seven working days~~ AS
22 EXPEDITIOUSLY AS POSSIBLE AND NO MORE THAN SEVENTY-TWO HOURS
23 after the ~~health coverage plan~~ has INDEPENDENT EXTERNAL REVIEW
24 ENTITY received a request for AN EXPEDITED external review. ~~except that,~~
25 ~~at the request of the expert reviewer, the deadline shall be extended for~~
26 ~~five working days for the consideration of additional information required~~
27 ~~pursuant to this section.~~ IF THE NOTICE OF THE DETERMINATION IN AN

1 EXPEDITED REVIEW IS NOT MADE IN WRITING, THE INDEPENDENT
2 EXTERNAL REVIEW ENTITY SHALL PROVIDE WRITTEN CONFIRMATION OF
3 THE DECISION WITHIN FORTY-EIGHT HOURS AFTER THE DATE THE NOTICE
4 OF DECISION IS TRANSMITTED TO THE INDIVIDUAL, THE PHYSICIAN, OR
5 OTHER HEALTH CARE PROFESSIONAL.

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

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

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

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

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

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

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

22 (III) The rationale for the decision;

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

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

1 clinical review criteria used to make the determination.

2 ~~(11)~~ (12) The determinations of the expert reviewer ~~shall be~~ ARE
3 binding on the ~~health coverage plan~~ CARRIER and on the ~~covered~~
4 individual requesting independent external review. A determination of the
5 expert reviewer in favor of the ~~covered~~ individual requesting independent
6 external review ~~shall create~~ CREATES a rebuttable presumption in any
7 subsequent action that the ~~health coverage plan's coverage~~ CARRIER'S
8 ADVERSE determination was not appropriate. A determination of the
9 expert reviewer in favor of the ~~health coverage plan~~ ~~shall create~~ CARRIER
10 CREATES a rebuttable presumption in any subsequent action that the
11 ~~health coverage plan's coverage~~ CARRIER'S ADVERSE determination was
12 appropriate.

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

18 ~~(13)~~ (14) ~~A certified~~ AN independent external review entity and
19 an expert reviewer assigned by ~~such~~ THE independent external review
20 entity to conduct a review pursuant to this section ~~shall be~~ ARE immune
21 from civil liability in any action brought by any person based upon the
22 determinations made pursuant to this section. This subsection ~~(13)~~ ~~shall~~
23 (14) DOES not apply to an act or omission of the independent external
24 review entity that is made in bad faith or involves gross negligence.

25 ~~(14)~~ (15) ~~Nothing in this section shall make the health coverage~~
26 ~~plan~~ A CARRIER IS NOT liable for damages arising from any act or
27 omission of the ~~certified~~ independent external review entity.

1 ~~(15)~~ (16) A ~~health coverage plan~~ CARRIER may require a surety
2 bond to indemnify the ~~health coverage plan~~ CARRIER for the ~~certified~~
3 independent external review entity's noncompliance with this section.

4 (17) AN INDEPENDENT EXTERNAL REVIEW ENTITY SHALL MAINTAIN
5 WRITTEN RECORDS OF REVIEWS ON ALL REQUESTS FOR EXTERNAL REVIEW
6 FOR WHICH IT WAS ASSIGNED TO CONDUCT AN EXTERNAL REVIEW FOR AT
7 LEAST THREE YEARS.

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

10 **10-16-116. Catastrophic health insurance - coverage -**
11 **premium payments - reporting requirements - definitions - short title.**

12 (1) **[Formerly 10-16-114]** ~~Sections 10-16-114 to 10-16-117~~ THIS
13 SECTION shall be known and may be cited as the "Colorado Catastrophic
14 Health Insurance Coverage Act".

15 ~~(1)~~ (2) An employer may offer catastrophic health insurance to its
16 employees pursuant to ~~sections 10-16-114 to 10-16-117~~ THIS SECTION.
17 Employees who elect ~~such~~ THE coverage shall pay the cost of the
18 insurance pursuant to SUBSECTION (5) OF THIS section. ~~10-16-117.~~

19 ~~(2)~~ (3) Each catastrophic health insurance policy issued pursuant
20 to ~~subsection (1) of~~ this section ~~is required to~~ MUST:

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

23 (b) In order to be considered a qualified higher deductible plan for
24 purposes of a medical savings account pursuant to section 39-22-504.7,
25 C.R.S., or other provisions of state law, meet the requirements for a
26 qualifying plan for a ~~medical~~ HEALTH savings account under federal law
27 and have a minimum deductible of at least one thousand five hundred

1 dollars but no more than two thousand two hundred fifty dollars for
2 individual coverage or at least three thousand dollars but no more than
3 four thousand five hundred dollars for family coverage;

4 (c) Offer coverage for the spouse OR PARTNER IN A CIVIL UNION
5 and dependent children of the insured employee;

6 (d) Cover all employees who elect coverage and are not otherwise
7 covered by medicare or another health insurance policy;

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

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

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

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

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

22 ~~(II) Conversion benefits shall be the insured's choice of the same
23 catastrophic coverage issued, without evidence of insurability, as an
24 individual policy or the conversion coverage specified in section
25 10-16-108;~~

26 ~~(i) (h) Comply with requirements for health benefit plans specified
27 in this article. including those related to preexisting conditions in~~

1 ~~accordance with section 10-16-118.~~

2 (3) ~~Insurers shall provide a written disclosure to a covered person~~
3 ~~that indicates the mandated benefits of section 10-16-104 (1), (1.7), (5),~~
4 ~~(5.5), (8), (9), (10), (11), (12), (13), (14), and (18) (b) (III) are covered~~
5 ~~benefits of the high deductible health plan; offered pursuant to section~~
6 ~~10-16-105 (7.2) (b) (II); except that the mandated benefits for~~
7 ~~mammography, prostate screenings, child health supervision services, and~~
8 ~~prosthetic devices shall be subject to policy deductibles.~~

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

13 (5) (a) **[Formerly 10-16-117 (2)]** If claiming an exclusion of
14 premium payments for state income tax purposes pursuant to section
15 39-22-104.5, C.R.S., an employee shall elect to purchase catastrophic
16 health insurance by signing a written election, ~~Such election shall~~ WHICH
17 MUST be in the form prescribed by the executive director of the
18 department of revenue and ~~shall be~~ signed BY THE EMPLOYEE prior to the
19 date the employer withholds the first contribution.

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

27 (c) **[Formerly 10-16-117 (4)]** An employer withholding premium

1 payments from an employee's wages pursuant to PARAGRAPH (b) OF THIS
2 subsection ~~(3) of this section~~ (5) shall report the amount withheld to the
3 department of revenue, pursuant to rules promulgated by ~~such~~ THE
4 EXECUTIVE DIRECTOR OF THE department.

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

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

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

- 13 (I) Under twenty-one years of age;
- 14 (II) Legally entitled to or the subject of a court order for the
15 provision of proper or necessary subsistence, education, medical care, or
16 any other care necessary for the individual's health, guidance, or
17 well-being and who is not otherwise emancipated, self-supporting,
18 married, or a member of the armed forces of the United States; or
- 19 (III) So mentally or physically incapacitated that the individual
20 cannot provide for himself or herself.

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

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

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

3 **10-16-118. Prohibition against preexisting condition**
4 **exclusions.** A CARRIER OFFERING AN INDIVIDUAL OR SMALL EMPLOYER
5 HEALTH BENEFIT PLAN IN THIS STATE SHALL NOT IMPOSE ANY PREEXISTING
6 CONDITION EXCLUSION WITH RESPECT TO COVERAGE UNDER THE PLAN.

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

9 **10-16-129. Health savings accounts.** Any carrier authorized to
10 conduct business in this state that offers coverage pursuant to part 2, 3, or
11 4 of this article may offer a high deductible health plan that would qualify
12 for and may be offered in conjunction with a health savings account
13 pursuant to 26 U.S.C. sec. 223, as amended. A carrier offering a high
14 deductible health plan that may be offered in conjunction with a health
15 savings account may apply the deductible to mandatory health benefits for
16 ~~mammography, prostate cancer screening child health supervision~~
17 ~~services, and prosthetic devices pursuant to section 10-16-104 (10) (H),~~
18 ~~AND (14) and (18) (b) (H)~~ if ~~such~~ THOSE mandatory benefits are not
19 considered by the federal department of treasury to be preventive or to
20 have an acceptable deductible amount.

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

23 **10-16-136. Wellness and prevention programs - individual and**
24 **small group health coverage plans - voluntary participation -**
25 **incentives or rewards - definitions - legislative declaration - repeal.**
26 (2) (a) Consistent with section ~~10-16-107 (6)~~ 10-16-105.6 and subject to
27 subsection (3) of this section, a carrier offering an individual health

1 coverage plan or a small group plan in this state may offer incentives or
2 rewards to encourage the individual or small group and other covered
3 persons under the plan to participate in wellness and prevention
4 programs. For purposes of small group plans, the incentives or rewards
5 may be applied to the entire small group or to individuals in the small
6 group based on their participation in wellness and prevention programs.
7 A carrier offering ~~such~~ incentives or rewards shall implement adequate
8 measures to ensure that the privacy of individuals in the group is
9 maintained and that individually identifiable health information is not
10 shared or made available to an individual's employer or any other person
11 not otherwise allowed access to the information under the federal "Health
12 Insurance Portability and Accountability Act of 1996", as amended. A
13 carrier shall not disclose to any third party, including a covered person's
14 employer, and the covered person's employer shall not disclose, any
15 information obtained from or about a covered person in connection with
16 the covered person's participation in a wellness and prevention program
17 that is reasonably attributable to the covered person, unless the covered
18 person consents in writing to disclosure of ~~such~~ THE information.

19 (3.5) An incentive or reward based upon satisfaction of a standard
20 related to a health risk factor may be offered or provided by a carrier only
21 pursuant to a bona fide wellness and prevention program and if the
22 following standards are met:

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

27 (A) Is reasonably related to the program; and

1 (B) Does not exceed ~~twenty percent~~ A PERCENTAGE of the cost of
2 employee-only coverage under the health coverage or small group plan,
3 or, if an employee's dependents are allowed to participate in the program,
4 does not exceed ~~twenty percent~~ A PERCENTAGE of the cost of the coverage
5 in which an employee and dependents are enrolled. THE COMMISSIONER
6 SHALL ADOPT A RULE, CONSISTENT WITH THE REQUIREMENTS OF FEDERAL
7 LAW, ESTABLISHING THE MAXIMUM AMOUNT OF THE INCENTIVE
8 PERMITTED UNDER A WELLNESS AND PREVENTION PROGRAM FOR
9 INDIVIDUAL HEALTH COVERAGE PLANS AND SMALL GROUP PLANS.

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

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

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

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

27 (III) The total number of small groups in the small group market

1 participating in programs offered by the carrier, specifying the number of
2 each of the following small groups participating in such programs:

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

4 (b) The division shall determine the percentage of carriers issuing
5 individual health coverage plans or small group plans in the state that
6 offer wellness and prevention programs and shall provide that
7 information and the information collected pursuant to paragraph (a) of
8 this subsection (5) to the health and human services ~~committees~~
9 COMMITTEE of the senate and THE HEALTH, INSURANCE, AND
10 ENVIRONMENT COMMITTEE OF THE house of representatives, the business,
11 labor, and technology committee of the senate, and the business, ~~affairs~~
12 ~~and~~ labor, AND ECONOMIC AND WORKFORCE DEVELOPMENT committee of
13 the house of representatives, or their successor committees, ~~by January 1,~~
14 ~~2012, and~~ by each January 1 thereafter until January 1, 2015. The division
15 shall also make the information available to the public by that date.

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

18 **10-16-139. Access to care - rules.** (1) **[Formerly 10-16-107 (5)**
19 **(a)] Access to obstetricians and gynecologists.** Effective ~~January 1,~~
20 ~~1997, a managed care plan~~ A HEALTH BENEFIT PLAN THAT IS DELIVERED,
21 ISSUED, RENEWED, OR REINSTATED IN THIS STATE ON OR AFTER JANUARY
22 1, 2014, that provides coverage for reproductive health or gynecological
23 care shall not be DELIVERED, issued, ~~or~~ renewed, OR REINSTATED unless
24 the plan either:

25 (a) provides a woman covered by the plan direct access to an
26 obstetrician, gynecologist, or an advanced practice nurse who is a
27 certified nurse midwife pursuant to section 12-38-111.5, C.R.S.,

1 participating and available under the plan for her reproductive health care
2 or gynecological care.

3 (2) [Formerly 10-16-107 (5.5)] Eye care services. (a) ~~No~~ A
4 health coverage plan or managed care plan that provides coverage for eye
5 care services shall NOT be issued or renewed after January 1, 2001, by any
6 entity subject to part 2, 3, or 4 of this article unless ~~such~~ THE health
7 coverage plan or managed care plan:

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

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

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

19 (b) A CARRIER OFFERING A health coverage plan or managed care
20 plan shall not:

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

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

1 (III) Impose penalties upon primary care providers as a result of
2 the direct access provisions of this ~~subsection (5.5)~~ SECTION.

3 (c) ~~Nothing in~~ This subsection ~~(5.5)~~ shall be construed as (2) DOES
4 NOT:

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

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

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

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

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

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

24 (d) As used in this subsection ~~(5.5)~~ (2), unless the context
25 otherwise requires:

26 (I) "Eye care provider" means a participating provider who is an
27 optometrist licensed to practice optometry pursuant to article 40 of title

1 12, C.R.S., or an ophthalmologist licensed to practice medicine pursuant
2 to article 36 of title 12, C.R.S.

3 (II) "Eye care services" means those health care services related
4 to the examination, diagnosis, treatment, and management of conditions
5 and diseases of the eye and related structures that a HEALTH COVERAGE
6 PLAN OR managed care plan is obligated to pay, reimburse, arrange, or
7 provide for covered persons or organizations as specified by a health
8 coverage plan or managed care plan, excluding those health care services
9 rendered in conjunction with a routine vision examination or the filling
10 of prescriptions for corrective eyewear.

11 (3) **[Formerly 10-16-107 (7)] Treatment of intractable pain.**

12 (a) A service or indemnity contract issued or renewed on or after January
13 1, 1998, by any entity subject to part 2, 3, or 4 of this article shall disclose
14 in the contract and in information on coverage presented to consumers
15 whether the health coverage plan or managed care plan provides coverage
16 for treatment of intractable pain. If the contract is silent on coverage of
17 intractable pain, ~~then~~ the contract shall be IS presumed to offer coverage
18 for the treatment of intractable pain. If the contract is silent or if the plan
19 specifically includes coverage for the treatment of intractable pain, the
20 plan shall provide access to ~~such~~ THE treatment for any individual covered
21 by the plan either:

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

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

1 (III) By having procedures in place that ensure that, if the
2 individual requests a timely referral for intractable pain management to
3 a pain management specialist participating in and available under the
4 plan, the CARRIER SHALL NOT UNREASONABLY DENY THE request for
5 referral. ~~shall not be unreasonably denied by the plan.~~

6 (b) The commissioner ~~shall~~ MAY promulgate rules ~~pursuant to this~~
7 ~~subparagraph (HH)~~ TO IMPLEMENT AND ADMINISTER THIS SUBSECTION (3)
8 that include ~~but need not be limited to~~, the following issues:

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

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

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

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

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

21 ~~(b)~~ (c) For purposes of this subsection ~~(7)~~ (3), "intractable pain"
22 means a pain state in which the cause of the pain cannot be removed and
23 FOR which, in the generally accepted course of medical practice, ~~no~~ relief
24 or cure of the cause of the pain is ~~possible~~ IMPOSSIBLE or ~~none~~ has NOT
25 been found after reasonable efforts, including ~~but not limited to~~,
26 evaluation by the attending physician and one or more physicians
27 specializing in the treatment of the area, system, or organ of the body

1 perceived as the source of the pain.

2 (4) **Access to pediatric care.** (a) IF A CARRIER OFFERING AN
3 INDIVIDUAL OR SMALL EMPLOYER HEALTH BENEFIT PLAN REQUIRES OR
4 PROVIDES FOR THE DESIGNATION OF A PARTICIPATING PRIMARY HEALTH
5 CARE PROFESSIONAL, THE CARRIER SHALL PERMIT THE PARENT OR LEGAL
6 GUARDIAN OF EACH COVERED PERSON WHO IS A CHILD TO DESIGNATE ANY
7 PARTICIPATING PHYSICIAN WHO SPECIALIZES IN PEDIATRICS AS THE CHILD'S
8 PRIMARY HEALTH CARE PROFESSIONAL IF THE PEDIATRICIAN IS AVAILABLE
9 TO ACCEPT THE CHILD.

10 (b) THE PROVISIONS OF PARAGRAPH (a) OF THIS SUBSECTION (4) DO
11 NOT WAIVE ANY EXCLUSIONS OF COVERAGE UNDER THE TERMS AND
12 CONDITIONS OF THE HEALTH BENEFIT PLAN WITH RESPECT TO COVERAGE
13 OF PEDIATRIC CARE.

14 **SECTION 26.** In Colorado Revised Statutes, **add** 10-16-140 as
15 follows:

16 **10-16-140. Grace periods - premium payments - rules.** (1) FOR
17 INDIVIDUAL AND SMALL EMPLOYER HEALTH BENEFIT PLANS ISSUED OR
18 RENEWED FOR COVERAGE TO BEGIN ON OR AFTER JANUARY 1, 2014, FOR
19 PERSONS RECEIVING A SUBSIDY UNDER THE FEDERAL ACT, THE
20 COMMISSIONER SHALL ESTABLISH, BY RULE THAT COMPLIES WITH FEDERAL
21 LAW, A REQUIREMENT THAT ALL INDIVIDUAL AND SMALL EMPLOYER
22 HEALTH BENEFIT PLANS CONTAIN A PROVISION SPECIFYING THAT THE
23 POLICYHOLDER IS ENTITLED TO A THREE-MONTH GRACE PERIOD FOR THE
24 PAYMENT OF ANY PREMIUM DUE, OTHER THAN THE FIRST PREMIUM,
25 DURING WHICH PERIOD THE PLAN CONTINUES IN FORCE UNLESS THE
26 POLICYHOLDER SUBMITS WRITTEN NOTICE TO THE CARRIER, PRIOR TO
27 DISCONTINUANCE OF THE PLAN IN ACCORDANCE WITH THE TERMS OF THE

1 PLAN, THAT THE POLICYHOLDER IS DISCONTINUING THE COVERAGE. IN
2 ACCORDANCE WITH FEDERAL LAW, THE COMMISSIONER'S RULE MAY
3 PROVIDE THAT THE POLICYHOLDER IS LIABLE TO THE CARRIER FOR THE
4 PAYMENT OF A PRO RATA PREMIUM FOR THE TIME THE COVERAGE WAS IN
5 FORCE DURING THE GRACE PERIOD.

6 (2) FOR INDIVIDUAL AND SMALL EMPLOYER HEALTH BENEFIT
7 PLANS ISSUED OR RENEWED FOR COVERAGE TO BEGIN ON OR AFTER
8 JANUARY 1, 2014, FOR PERSONS WHO ARE NOT RECEIVING A SUBSIDY
9 UNDER THE FEDERAL ACT, THE COMMISSIONER SHALL ADOPT A RULE
10 REQUIRING A THIRTY-ONE-DAY GRACE PERIOD FOR THE PAYMENT OF ANY
11 PREMIUM DUE OTHER THAN THE FIRST PREMIUM.

12 (3) IF THE COVERED PERSON FAILS TO PAY ALL OR PART OF THE
13 PREMIUM, THE CARRIER SHALL NOTIFY THE COVERED PERSON OF THE
14 NONPAYMENT OF PREMIUM WITHIN THE GRACE PERIOD ESTABLISHED
15 PURSUANT TO THIS SECTION AND IN ACCORDANCE WITH SECTION
16 10-16-222, 10-16-325, OR 10-16-429, AS APPLICABLE.

17 (4) THE COMMISSIONER MAY ADOPT RULES AS NECESSARY TO
18 IMPLEMENT AND ADMINISTER THIS SECTION.

19 **SECTION 27. Repeal of relocated provisions in this act.** In
20 Colorado Revised Statutes, **repeal** 10-16-104 (16), 10-16-114, 10-16-115,
21 10-16-117, and 10-16-214 (2) (b).

22 **SECTION 28.** In Colorado Revised Statutes, **repeal** 10-16-104
23 (5), (7), (9), (11), (15), and (18) (a) (II), 10-16-105.5, and 10-16-201.5.

24 **SECTION 29.** In Colorado Revised Statutes, 10-16-202, **amend**
25 (3) and (4) (a) as follows:

26 **10-16-202. Required provisions in individual sickness and**
27 **accident policies.** (3) Provisions as follows: "Time limit on certain

1 defenses: (a) ~~After~~ Two years ~~from~~ AFTER the date of issue of this policy
2 no misstatements, except fraudulent misstatements, made by the applicant
3 in the application for such policy shall be used to void the policy or to
4 deny a claim for loss incurred or disability (as defined in the policy)
5 commencing after the expiration of such two-year period. THE POLICY
6 CANNOT BE RETROACTIVELY TERMINATED EXCEPT FOR FRAUD OR
7 INTENTIONAL MISREPRESENTATION. FOR ANY TERMINATION OTHER THAN
8 FOR FRAUD OR INTENTIONAL MISREPRESENTATION, THE CARRIER SHALL
9 PROVIDE NOTICE THIRTY DAYS IN ADVANCE OF THE CANCELLATION OF THE
10 POLICY."

11 "(The foregoing policy provision ~~shall~~ DOES not ~~be so construed~~
12 ~~as to~~ affect any legal requirement for avoidance of a policy or denial of
13 a claim during such initial two-year period, nor ~~to~~ limit the application of
14 section 10-16-203 in the event of misstatement with respect to age or
15 occupation or other insurance.)"

16 (A policy ~~which~~ THAT the insured has the right to continue in force
17 subject to its terms by the timely payment of premium until at least age
18 fifty, or in the case of a policy issued after age forty-four, for at least five
19 years ~~from~~ AFTER its date of issue, may contain, in lieu of the foregoing,
20 the following provision, from which the clause in parentheses may be
21 omitted at the insurer's option, under the caption "Incontestable":

22 "After this policy has been in force for a period of two years
23 during the lifetime of the insured (excluding any period during which the
24 insured is disabled), it ~~shall become~~ BECOMES incontestable as to the
25 statements contained in the application.")

26 (b) Except for individual disability income insurance policies, no
27 claim for loss incurred or disability, as defined in the policy, commencing

1 after one year from AFTER the date of issue of this policy shall be reduced
2 or denied on the ground that a disease or physical condition not excluded
3 from coverage by name or a specific description effective on the date of
4 loss had existed prior to the effective date of coverage of this policy.

5 ~~(An individual health benefit plan shall not define a preexisting~~
6 ~~condition more restrictively than an injury, sickness, or pregnancy for~~
7 ~~which a person incurred charges, received medical treatment, consulted~~
8 ~~a health care professional, or took prescription drugs within the twelve~~
9 ~~months immediately preceding the effective date of coverage.)~~

10 (c) If this is an individual disability income insurance policy then
11 no claim for loss incurred or disability, as defined in this individual
12 disability income insurance policy, commencing after two years from
13 AFTER the date of issue of the policy shall be reduced or denied on the
14 ground that a disease or physical condition not excluded from coverage
15 by name or a specific description effective on the date of loss had existed
16 prior to the effective date of coverage of this policy.

17 (4) (a) EXCEPT AS REQUIRED BY SECTION 10-16-140, IN A POLICY
18 OTHER THAN A HEALTH BENEFIT PLAN, a provision as follows: "Grace
19 period: A grace period of (insert a number not less than '7' for
20 weekly premium policies, '10' FOR monthly premium policies, and '31' for
21 all other policies) days will be granted for the payment of each premium
22 falling due after the first premium, during which grace period the policy
23 shall continue in force."

24 **SECTION 30.** In Colorado Revised Statutes, 10-16-214, **amend**
25 (1) (c), (3) (a) introductory portion, and (3) (a) (I) as follows:

26 **10-16-214. Group sickness and accident insurance.** (1) Group
27 sickness and accident insurance is declared to be that form of sickness

1 and accident insurance covering groups of persons, with or without their
2 dependents, and issued upon the following bases:

3 (c) On and after July 1, 1994, under a policy issued to any person
4 or organization to which a policy of group life insurance may be issued
5 or delivered in this state to insure any class of individuals that could be
6 insured under such group life insurance policy; except that, on and after
7 July 1, 1994, ~~such~~ a GROUP SICKNESS AND ACCIDENT INSURANCE policy
8 ~~shall~~ MUST cover at least two or more individuals at date of issue; ~~and on~~
9 ~~and after January 1, 1996, such a policy shall cover a business group of~~
10 ~~one at the date of issue;~~

11 (3) (a) Except as REQUIRED BY SECTION 10-16-140 OR AS provided
12 for in subsection (2) of this section, all policies of group sickness and
13 accident insurance providing coverage to persons residing in the state,
14 ~~shall~~ MUST contain in substance the following provisions or provisions
15 ~~which~~ THAT, in the opinion of the commissioner, are more favorable to
16 the persons insured or at least as favorable to the persons insured and
17 more favorable to the policyholder:

18 (I) A provision that the policyholder is entitled to a grace period
19 of thirty-one days for the payment of any premium due except the first,
20 during which grace period the policy shall continue in force, unless the
21 policyholder has given the ~~insurer~~ CARRIER written notice of
22 discontinuance of the coverage in advance of the date of discontinuance
23 in accordance with the terms of the policy. The policy may provide that
24 the policyholder ~~shall be~~ IS liable to the ~~insurer~~ CARRIER for the payment
25 of a pro rata premium for the time the coverage was in force during ~~such~~
26 THE grace period.

27 **SECTION 31.** In Colorado Revised Statutes, **add** 10-16-222 as

1 follows:

2 **10-16-222. Termination of policies.** A CARRIER SHALL NOT
3 RETROACTIVELY TERMINATE A POLICY ISSUED PURSUANT TO THIS PART 2
4 EXCEPT FOR FRAUD OR INTENTIONAL MISREPRESENTATION. FOR ANY
5 TERMINATION OTHER THAN FOR FRAUD OR INTENTIONAL
6 MISREPRESENTATION, THE CARRIER SHALL PROVIDE NOTICE THIRTY DAYS
7 IN ADVANCE OF THE CANCELLATION OF THE POLICY.

8 **SECTION 32.** In Colorado Revised Statutes, **add** 10-16-325 as
9 follows:

10 **10-16-325. Termination of health policies.** A CORPORATION
11 SHALL NOT RETROACTIVELY TERMINATE A POLICY ISSUED PURSUANT TO
12 THIS PART 3 EXCEPT FOR FRAUD OR INTENTIONAL MISREPRESENTATION.
13 FOR ANY TERMINATION OTHER THAN FOR FRAUD OR INTENTIONAL
14 MISREPRESENTATION, THE CORPORATION SHALL PROVIDE NOTICE THIRTY
15 DAYS IN ADVANCE OF THE CANCELLATION OF THE POLICY.

16 **SECTION 33.** In Colorado Revised Statutes, **amend with**
17 **relocated provisions** 10-16-406 as follows:

18 **10-16-406. Evidence of coverage.** (1) Every enrollee residing in
19 this state is entitled to evidence of coverage under a health care plan. If
20 the enrollee obtains coverage under a health care plan through an
21 insurance policy or a contract issued by a nonprofit hospital,
22 medical-surgical, and health service corporation, whether by option or
23 otherwise, the insurer or the nonprofit hospital, medical-surgical, and
24 health service corporation shall issue the evidence of coverage.
25 Otherwise, the health maintenance organization shall issue the evidence
26 of coverage.

27 (2) [**Formerly 10-16-107 (3) (b), (3) (c), and (3) (d)**] (a) THE

1 COMMISSIONER MAY ESTABLISH, BY RULE, THE REQUIRED ELEMENTS OF an
2 evidence of coverage, ~~shall contain~~ WHICH MUST:

3 (I) ~~No~~ NOT CONTAIN ANY provisions or statements ~~which~~ THAT
4 are unjust, unfair, inequitable, misleading, or deceptive; ~~which~~ encourage
5 misrepresentation; or ~~which~~ are untrue, misleading, or deceptive as
6 defined in section 10-16-413 (1); and

7 (II) CONTAIN a clear and complete statement, if a contract, or a
8 reasonably complete summary, if a certificate, of:

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

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

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

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

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

24 ~~(e)~~ (b) ~~Any~~ THE CARRIER MAY EVIDENCE A subsequent change
25 ~~may be evidenced~~ IN COVERAGE in a separate document issued to the
26 enrollee.

27 ~~(d)~~ (c) A copy of the form of the evidence of coverage to be used

1 in this state, and any amendment thereto, shall be TO THE FORM, IS subject
2 to the filing and approval requirements of section 10-16-107.2. ~~unless it~~
3 ~~is subject to the jurisdiction of the commissioner under the laws~~
4 ~~governing health insurance or nonprofit hospital, medical-surgical, and~~
5 ~~health service corporations, in which event the filing and approval~~
6 ~~provisions of subsection (2) of this section shall apply. To the extent,~~
7 ~~however, that such provisions do not apply, the requirements in paragraph~~
8 ~~(b) of this subsection (3) shall be applicable.~~

9 **SECTION 34.** In Colorado Revised Statutes, **add** 10-16-429 as
10 follows:

11 **10-16-429. Termination of contract.** A HEALTH MAINTENANCE
12 ORGANIZATION SHALL NOT RETROACTIVELY TERMINATE A POLICY OR
13 CONTRACT ISSUED PURSUANT TO THIS PART 4 EXCEPT FOR FRAUD OR
14 INTENTIONAL MISREPRESENTATION. FOR ANY TERMINATION OTHER THAN
15 FOR FRAUD OR INTENTIONAL MISREPRESENTATION, THE HEALTH
16 MAINTENANCE ORGANIZATION SHALL PROVIDE NOTICE THIRTY DAYS IN
17 ADVANCE OF THE CANCELLATION OF THE POLICY OR CONTRACT.

18 **SECTION 35.** In Colorado Revised Statutes, 10-16-507, **add**
19 **with amended and relocated provisions** (3) as follows:

20 **10-16-507. Enrollee coverage by prepaid dental care plan**
21 **organizations - form filing requirements.** (3) [Formerly 10-16-107
22 (4)] (a) For prepaid dental care plans, ~~no~~ THE PREPAID DENTAL CARE
23 PLAN ORGANIZATION SHALL NOT ISSUE OR DELIVER enrollee coverage or
24 AN amendment, advertising matter, or sales material ~~shall be issued or~~
25 ~~delivered~~ to any person in this state until THE CARRIER HAS FILED a copy
26 of the form of the enrollee coverage or amendment, advertising matter,
27 or sales material ~~has been filed~~ with the commissioner.

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

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

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

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

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

12 (c) The enrollee coverage, advertising matter, and sales material
13 ~~shall~~ MUST NOT contain ~~no~~ ANY provisions or statements ~~which~~ THAT are
14 unjust, unfair, inequitable, misleading, or deceptive; ~~or which~~ encourage
15 misrepresentation; or ~~which~~ are untrue or misleading.

16 (d) The commissioner shall approve any form of enrollee
17 coverage if the requirements of paragraphs (b) and (c) of this subsection
18 ~~(4)~~ (3) are met and the prepaid dental care plan ORGANIZATION is able, in
19 the judgment of the commissioner, to meet its financial obligations under
20 the enrollee coverage. It is unlawful to issue ~~such~~ THE form until
21 approved BY THE COMMISSIONER. If the commissioner ~~does not~~ FAILS TO
22 disapprove ~~any such~~ A form OF ENROLLEE COVERAGE within thirty days
23 after the filing, ~~it shall be~~ THE FORM IS deemed approved. If the
24 commissioner disapproves a form of enrollee coverage, advertising
25 matter, or sales material, the commissioner shall notify the prepaid dental
26 care plan organization, specifying the reasons for disapproval. The
27 commissioner shall grant a hearing on ~~such~~ A disapproval within fifteen

1 days after THE COMMISSIONER RECEIVES a request in writing ~~is received~~
2 from the prepaid dental care plan organization.

3 **SECTION 36.** In Colorado Revised Statutes, 10-16-704, **amend**
4 (2) (g) (III); and **add** (1.5) and (5.5) as follows:

5 **10-16-704. Network adequacy - rules - legislative declaration.**

6 (1.5) (a) (I) THE COMMISSIONER SHALL PROMULGATE RULES, CONSISTENT
7 WITH FEDERAL LAW, TO:

8 (A) REQUIRE A CARRIER PROVIDING MANAGED CARE PLANS TO
9 INCLUDE ESSENTIAL COMMUNITY PROVIDERS IN THE CARRIER'S NETWORK;
10 OR

11 (B) ALLOW A CARRIER PROVIDING MANAGED CARE PLANS THAT
12 PROVIDES A MAJORITY OF COVERED PROFESSIONAL SERVICES THROUGH
13 PHYSICIANS EMPLOYED BY THE CARRIER OR THROUGH A SINGLE
14 CONTRACTED MEDICAL GROUP TO COMPLY WITH THE ALTERNATE
15 STANDARD FOR ESSENTIAL COMMUNITY PROVIDERS PERMITTED UNDER
16 FEDERAL LAW.

17 (II) FOR PURPOSES OF THE RULES, "ESSENTIAL COMMUNITY
18 PROVIDERS" INCLUDES PROVIDERS THAT SERVE PREDOMINATELY
19 LOW-INCOME, MEDICALLY UNDERSERVED INDIVIDUALS, SUCH AS HEALTH
20 CARE PROVIDERS DEFINED IN THE FEDERAL LAW AND UNDER PART 4 OF
21 ARTICLE 4 OF TITLE 25.5, C.R.S.; EXCEPT THAT NOTHING IN THIS
22 SUBSECTION (1.5) REQUIRES ANY CARRIER TO PROVIDE COVERAGE FOR
23 ANY SPECIFIC MEDICAL PROCEDURE.

24 (b) THE COMMISSIONER MAY PROMULGATE RULES TO REQUIRE
25 CARRIERS TO BE ACCREDITED BY AN ACCREDITING ENTITY RECOGNIZED BY
26 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

27 (2) (g) A health maintenance organization offering health benefits

1 in this state may:

2 (III) ~~A health maintenance organization that elects to Offer~~
3 coverage pursuant to this paragraph (g) ~~shall offer such coverage~~ within
4 a geographic area consistent with the requirements of section 10-16-105
5 ~~(7.3)~~ (1) AND (4).

6 (5.5) (a) NOTWITHSTANDING ANY PROVISION OF LAW, A CARRIER
7 THAT PROVIDES ANY BENEFITS WITH RESPECT TO SERVICES IN AN
8 EMERGENCY DEPARTMENT OF A HOSPITAL SHALL COVER EMERGENCY
9 SERVICES:

10 (I) WITHOUT THE NEED FOR ANY PRIOR AUTHORIZATION
11 DETERMINATION;

12 (II) REGARDLESS OF WHETHER THE HEALTH CARE PROVIDER
13 FURNISHING EMERGENCY SERVICES IS A PARTICIPATING PROVIDER WITH
14 RESPECT TO EMERGENCY SERVICES;

15 (III) FOR SERVICES PROVIDED OUT OF NETWORK;

16 (IV) WITHOUT IMPOSING ANY ADMINISTRATIVE REQUIREMENT OR
17 LIMITATION ON COVERAGE THAT IS MORE RESTRICTIVE THAN THE
18 REQUIREMENTS OR LIMITATIONS THAT APPLY TO EMERGENCY SERVICES
19 RECEIVED FROM IN-NETWORK PROVIDERS; AND

20 (V) WITH THE SAME COST SHARING REQUIREMENTS AS WOULD
21 APPLY IF EMERGENCY SERVICES WERE PROVIDED IN-NETWORK.

22 (b) FOR PURPOSES OF THIS SUBSECTION (5.5):

23 (I) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL
24 CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT
25 SEVERITY, INCLUDING SEVERE PAIN, THAT A PRUDENT LAYPERSON WITH AN
26 AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY
27 EXPECT, IN THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION, TO RESULT

1 IN:

2 (A) PLACING THE HEALTH OF THE INDIVIDUAL OR, WITH RESPECT
3 TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR HER UNBORN
4 CHILD, IN SERIOUS JEOPARDY;

5 (B) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

6 (C) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

7 (II) "EMERGENCY SERVICES", WITH RESPECT TO AN EMERGENCY
8 MEDICAL CONDITION, MEANS:

9 (A) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE
10 CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING
11 ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY
12 DEPARTMENT TO EVALUATE THE EMERGENCY MEDICAL CONDITION; AND

13 (B) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES
14 AVAILABLE AT THE HOSPITAL, FURTHER MEDICAL EXAMINATION AND
15 TREATMENT AS REQUIRED TO STABILIZE THE PATIENT TO ASSURE, WITHIN
16 REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION
17 OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE
18 TRANSFER OF THE INDIVIDUAL FROM A FACILITY, OR WITH RESPECT TO AN
19 EMERGENCY MEDICAL CONDITION.

20 **SECTION 37.** In Colorado Revised Statutes, 6-1-102, **amend**
21 (4.3) as follows:

22 **6-1-102. Definitions.** As used in this article, unless the context
23 otherwise requires:

24 (4.3) "Discount health plan" means a program evidenced by a
25 membership agreement, contract, card, certificate, device, or mechanism,
26 which offers health care services, as defined in section 10-16-102 ~~(22)~~
27 (33), C.R.S., or related products including, but not limited to, prescription

1 drugs and medical equipment, at purported discounted rates from health
2 care providers advertised as participating in the program. A "discount
3 health plan" does not include a program in which a participating provider
4 has agreed, as a condition of his or her participation in the program, to
5 negotiate the prices to be charged for his or her services directly with
6 consumers in the program and the provider is not required to offer
7 discounted prices for his or her services as part of the program.

8 **SECTION 38.** In Colorado Revised Statutes, 6-1-712, **amend** (2)
9 (a), (3) (a), and (3) (b) as follows:

10 **6-1-712. Discount health plan and cards - deceptive trade**
11 **practices.** (2) The provisions of this section shall not apply to:

12 (a) A carrier as defined in section 10-16-102 (8), C.R.S., that
13 offers discounts for services to a covered person, as defined in section
14 10-16-102 (~~13.5~~) (15), C.R.S., and such services are supplemental to and
15 not part of the health coverage plan of the carrier;

16 (3) For the purposes of this section, unless the context otherwise
17 requires:

18 (a) "Health care services" ~~shall have~~ HAS the same meaning as in
19 section 10-16-102 (~~22~~) (33), C.R.S.

20 (b) "Provider" ~~shall have~~ HAS the same meaning as in section
21 10-16-102 (~~36~~) (56), C.R.S.

22 **SECTION 39.** In Colorado Revised Statutes, 6-18-302, **amend**
23 (1) (b) (I) as follows:

24 **6-18-302. Creation of provider networks - requirements.**

25 (1) (b) (I) Except as provided in subparagraph (II) of this paragraph (b),
26 if a provider network or individual provider organized on or after July 1,
27 1994, or organized prior to said date, proposes or is engaged in the

1 transaction of insurance business, as defined in section 10-3-903, C.R.S.,
2 or the activities of a health maintenance organization as defined in section
3 10-16-102 (~~23~~) (35), C.R.S., such provider network or individual provider
4 must hold a certificate of authority from the commissioner of insurance
5 to do business as an insurance company under title 10, C.R.S., or to
6 establish a health maintenance organization under section 10-16-402,
7 C.R.S.

8 **SECTION 40.** In Colorado Revised Statutes, 6-20-202, **amend**
9 (1) (a) as follows:

10 **6-20-202. Notice to patient of debt.** (1) (a) When a person has
11 health benefit coverage to provide payment for care or treatment rendered
12 by a health care provider and the person has notified the health care
13 provider of coverage within thirty days after the date the care or treatment
14 was rendered, and if the health coverage plan, as defined in section
15 10-16-102 (~~22.5~~) (34), C.R.S., pays only a portion of the debt, prior to the
16 assignment of the debt to a licensed collection agency, the health care
17 provider shall mail written notice to the last-known address of the person
18 responsible for payment of the debt at least thirty days before any
19 collection activity on any amount due and owing the health care provider.

20 **SECTION 41.** In Colorado Revised Statutes, 8-70-114, **amend**
21 (2) (b) (VIII) as follows:

22 **8-70-114. Employing unit - definitions - rules - employee**
23 **leasing company certification fund - repeal.** (2) (b) Notwithstanding
24 subsection (1) of this section, an employee leasing company shall be
25 considered an employing unit or the coemployer of a work-site employer's
26 employees if, pursuant to an employee leasing company contract with the
27 work-site employer, it has the following rights and responsibilities:

1 (VIII) An employee leasing company, as the employing unit or
2 coemployer, may aggregate all employees for the purpose of sponsoring
3 and administering workers' compensation plans pursuant to article 44 of
4 this title and fully insured health coverage plans, as defined in section
5 10-16-102 ~~(22.5)~~ (34), C.R.S., employee pension benefit plans, and
6 provision of benefits pursuant to such plans. As employing units or
7 coemployers, employee leasing companies shall be entitled to sponsor
8 fully insured employer plans and offer employee benefits to the full extent
9 afforded employers by law. A health plan sponsored by an employee
10 leasing company with an aggregate of more than fifty employees shall
11 comply with all the provisions of Colorado law that apply to large
12 employer health plans, including consumer and provider protections,
13 mandated benefits, nondiscrimination and fair marketing rules,
14 preexisting limitations, and other required health plan policy provisions,
15 and the carrier underwriting the plan shall be responsible for assuring
16 compliance with this requirement pursuant to section 10-16-214 (5),
17 C.R.S. Notwithstanding any provision of this section to the contrary, any
18 workers' compensation insurance carrier may issue an insurance policy
19 that insures either the employee leasing company or the work-site
20 employer as the employer pursuant to the "Workers' Compensation Act
21 of Colorado", articles 40 to 47 of this title. Article 41 of this title shall
22 apply to both the employee leasing company and the work-site employer,
23 regardless of whether the policy is issued to the employee leasing
24 company or the work-site employer. Notwithstanding any provision of
25 this section to the contrary, any insurance carrier may issue an insurance
26 policy that insures the employee leasing company as the employer
27 pursuant to article 16 of title 10, C.R.S. An insurance carrier that issues

1 an insurance policy to an employee leasing company shall be entitled to
2 rely upon a copy of the certification filed by the employee leasing
3 company with the department under paragraph (e) of this subsection (2),
4 if such certification is currently valid, for the purpose of determining
5 whether the leasing company is an "employer" under Colorado law.

6 **SECTION 42.** In Colorado Revised Statutes, 10-3-1104, **amend**
7 (1) (v) an (1) (w) as follows:

8 **10-3-1104. Unfair methods of competition - unfair or deceptive**
9 **acts or practices.** (1) The following are defined as unfair methods of
10 competition and unfair or deceptive acts or practices in the business of
11 insurance:

12 (v) Failure to comply with all provisions of section 10-16-108.5
13 concerning fair marketing of ~~basic and standard~~ health benefit plans, and
14 section 10-16-105 concerning ~~guaranteed issue of basic and standard~~
15 ISSUANCE OF INDIVIDUAL AND SMALL EMPLOYER health benefit plans;

16 (w) Failure to comply with the provisions of section ~~10-16-201.5~~
17 10-16-105.1 concerning the renewability of ~~individual~~ health benefit
18 plans;

19 **SECTION 43.** In Colorado Revised Statutes, 10-4-636, **amend**
20 (4) (c) as follows:

21 **10-4-636. Disclosure requirements for automobile insurance**
22 **products offered - rules.** (4) The disclosure form required by subsection
23 (1) of this section shall include a disclosure specifying that:

24 (c) Medical payments coverage applies to any coinsurance or
25 deductible amount required to be paid by the person's health coverage
26 plan, as defined in section 10-16-102 (~~22.5~~) (34); and

27 **SECTION 44.** In Colorado Revised Statutes, 10-4-641, **amend**

1 (1) as follows:

2 **10-4-641. Rules - medical payments coverage.** (1) The
3 commissioner shall promulgate any necessary rules for the administration
4 of medical payments coverage and coordination of benefits and the
5 implementation of section 10-4-636 (4) concerning disclosures required
6 to be made regarding medical payments coverage and the definition of
7 commercial automobile insurance policies for purposes of the exception
8 allowed in section 10-4-636 (8). Medical payments coverage shall be
9 primary to any health insurance benefit of a person injured in a motor
10 vehicle accident, and medical payments coverage shall apply to any
11 coinsurance or deductible amount required by the injured person's health
12 coverage plan, as defined in section 10-16-102 ~~(22.5)~~ (34).

13 **SECTION 45.** In Colorado Revised Statutes, 10-8-503, **amend**
14 (6.8), (7.5), (8), (10.5), and (17.5) as follows:

15 **10-8-503. Definitions.** As used in this part 5, unless the context
16 otherwise requires:

17 (6.8) "Group health plan" ~~shall have the same meaning as "group~~
18 ~~health plan" as set forth in section 10-16-105.5 (1) (a)~~ MEANS AN
19 EMPLOYEE WELFARE BENEFIT PLAN, AS DEFINED IN 29 U.S.C. SEC. 1002 (1)
20 OF THE FEDERAL "EMPLOYEE RETIREMENT INCOME SECURITY ACT OF
21 1974", TO THE EXTENT THAT THE PLAN PROVIDES HEALTH CARE SERVICES,
22 INCLUDING ITEMS AND SERVICES PAID FOR AS HEALTH CARE SERVICES, TO
23 EMPLOYEES OR THEIR DEPENDENTS DIRECTLY OR THROUGH INSURANCE
24 REIMBURSEMENT OR OTHERWISE. A "GROUP HEALTH PLAN" INCLUDES A
25 GOVERNMENT OR CHURCH PLAN.

26 (7.5) "Health benefit plan" has the same meaning as set forth in
27 section 10-16-102 ~~(21)~~ (32).

1 (8) "Health care services" has the same meaning as set forth in
2 section 10-16-102 ~~(22)~~ (33).

3 (10.5) "Insurer" means any entity that provides group or individual
4 health benefit plans ~~as defined in section 10-16-102 (21)~~ subject to state
5 insurance regulation in this state, as well as any entity that directly or
6 indirectly provides stop-loss or excess loss insurance to a self-insured
7 group health plan including a property and casualty insurance company.

8 (17.5) "Qualifying previous coverage" has the same meaning as
9 "creditable coverage" as set forth in section 10-16-102 ~~(13.7)~~ (16).

10 **SECTION 46.** In Colorado Revised Statutes, 10-8-513.5, **amend**
11 (1) (a) (I) and (2) as follows:

12 **10-8-513.5. Federally eligible individuals.** (1) (a) For the
13 purposes of this part 5, "federally eligible individual" means any one of
14 the following, to the extent federally eligible individuals are designated
15 by the governor:

16 (I) Any individual: ~~who meets the definition of "federally eligible~~
17 ~~individual" pursuant to section 10-16-105.5 (1);~~

18 (A) FOR WHOM, AS OF THE DATE ON WHICH THE INDIVIDUAL SEEKS
19 COVERAGE, THE AGGREGATE OF PERIODS OF CREDITABLE COVERAGE IS
20 EIGHTEEN MONTHS OR MORE AND WHOSE MOST RECENT PRIOR CREDITABLE
21 COVERAGE WAS UNDER A GROUP HEALTH PLAN;

22 (B) WHO IS NOT ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH
23 BENEFIT PLAN, MEDICARE, MEDICAID, OR THE CHILDREN'S BASIC HEALTH
24 PLAN AND DOES NOT HAVE OTHER HEALTH BENEFIT PLAN COVERAGE;

25 (C) WHOSE MOST RECENT COVERAGE WAS NOT TERMINATED AS A
26 RESULT OF NONPAYMENT OF PREMIUMS OR FRAUD; AND

27 (D) WHO DID NOT TURN DOWN AN OFFER OF CONTINUATION

1 COVERAGE IF IT WAS OFFERED AND WHO SUBSEQUENTLY EXHAUSTED THAT
2 COVERAGE.

3 (2) A dependent of a federally eligible individual may be covered
4 under the program if the dependent satisfies the definition of "dependent"
5 set forth in section 10-16-102 ~~(14)~~ (17); except that the program need not
6 offer the same health benefit plan or the same premium to such dependent
7 as is offered to eligible individuals.

8 **SECTION 47.** In Colorado Revised Statutes, 10-16-104.8,
9 **amend** (3) as follows:

10 **10-16-104.8. Mental health services coverage - court-ordered.**

11 (3) For purposes of this section, "mental health services" includes
12 ~~treatment for mental illness as described in section 10-16-104 (5) and~~
13 treatment for biologically based mental illness AND MENTAL DISORDERS
14 as described in section 10-16-104 (5.5).

15 **SECTION 48.** In Colorado Revised Statutes, 10-16-122, **amend**
16 (1) as follows:

17 **10-16-122. Access to prescription drugs.** (1) Except as provided
18 in section 25.5-5-404 (1) (u), C.R.S., any pharmacy benefit management
19 firm or intermediary whose contract with a carrier ~~as defined in section~~
20 ~~10-16-102 (8)~~ includes an open network shall allow participation by each
21 pharmacy provider in the contract service area. If a pharmacy benefit
22 management firm or intermediary offers an open network, the pharmacy
23 benefit management firm or intermediary may offer such network on a
24 regional or local basis.

25 **SECTION 49.** In Colorado Revised Statutes, 10-16-201 **amend**
26 (3) (c) as follows:

27 **10-16-201. Form and content of individual sickness and**

1 **accident insurance policies.** (3) (c) Nothing in this subsection (3) shall
2 ~~be construed to negate~~ NEGATES the renewability requirements for health
3 benefit plans specified in section ~~10-16-201.5~~ 10-16-105.1.

4 **SECTION 50.** In Colorado Revised Statutes, 10-16-324, **amend**
5 (4) (e) (I) (F) as follows:

6 **10-16-324. Conversion of corporation to a stock insurance**
7 **company.** (4) The plan shall set forth with specificity the terms and
8 conditions of the proposed conversion and shall do all of the following:

9 (e) (I) Specify a reasonable treatment for the benefit of the citizens
10 of the state of Colorado of the value of the corporation on all of the
11 following terms that must be approved by the commissioner:

12 (F) The charitable mission and grant-making functions of each
13 qualifying entity must be dedicated to promoting or serving the health
14 care needs of the citizens of Colorado; except that in no event shall any
15 qualifying entity use the consideration, or any proceeds or gains thereon,
16 transferred to it by the corporation to compete directly as a licensed
17 carrier ~~as defined in section 10-16-102 (8)~~ with the corporation or any of
18 its affiliates;

19 **SECTION 51.** In Colorado Revised Statutes, 10-16-705, **amend**
20 (12) (a) and (14) (b) as follows:

21 **10-16-705. Requirements for carriers and participating**
22 **providers.** (12) (a) A carrier shall establish one or more mechanisms by
23 which the participating providers may determine, at the time services are
24 provided, whether or not a person is covered by the carrier OR IS WITHIN
25 THE GRACE PERIOD ESTABLISHED UNDER SECTION 10-16-140(1), DURING
26 WHICH PERIOD A CARRIER MAY HOLD A CLAIM FOR SERVICES PENDING
27 RECEIPT OF FULL PREMIUM PAYMENT. If a carrier maintains only one

1 mechanism, such mechanism shall not require electronic access.

2 (14) Every contract between a carrier or entity that contracts with
3 a carrier and a participating provider for a managed care plan that requires
4 preauthorization for particular services, treatments, or procedures shall
5 include:

6 (b) A provision that allows a covered person to receive a standing
7 referral ~~as defined in section 10-16-102 (43.5)~~ for medically necessary
8 treatment, to a specialist or specialized treatment center participating in
9 the carrier's network or participating in a subdivision or subgrouping of
10 the carrier's network if the subdivision or subgrouping demonstrates
11 network adequacy pursuant to section 10-16-704. The primary care
12 provider for the covered person, in consultation with the specialist and
13 covered person, shall determine that the covered person needs ongoing
14 care from the specialist in order to make the standing referral. A time
15 period for the standing referral of up to one year, or a longer period of
16 time if authorized by the carrier or any entity that contracts with the
17 carrier, shall be determined by the primary care provider in consultation
18 with the specialist or specialized treatment center. The specialist or
19 specialized treatment center shall refer the covered person back to the
20 primary care provider for primary care. To be reimbursed by the carrier
21 or entity contracting with a carrier, treatment provided by the specialist
22 shall be for a covered person and must comply with provisions contained
23 in the covered person's certificate or policy. The primary care physician
24 shall record the reason, diagnosis, or treatment plan necessitating the
25 standing referral.

26 **SECTION 52.** In Colorado Revised Statutes, 10-16-1002, **amend**
27 (5) as follows:

1 **10-16-1002. Definitions.** As used in this part 10, unless the
2 context otherwise requires:

3 (5) "Managed care" means systems or techniques generally used
4 by third-party payors or their agents to affect access to, and to control,
5 payment for health care services. For example, and not for the purpose of
6 limitation, managed care techniques most often include one or more of
7 the following: Prior, concurrent, and retrospective review of the medical
8 necessity and appropriateness of services or of the site at which services
9 are provided; contracts with selected health care providers; financial
10 incentives or disincentives related to the use of specific providers,
11 services, or service sites; controlled access to and coordination of services
12 by a case manager; and payor efforts to identify treatment alternatives and
13 modify benefit restrictions for high-cost patient care. "Managed care" also
14 includes but is not limited to health maintenance organizations. ~~as defined~~
15 ~~in section 10-16-102 (23).~~

16 **SECTION 53.** In Colorado Revised Statutes, **amend** 10-16-1007
17 as follows:

18 **10-16-1007. Prohibition on cooperatives transacting insurance**
19 **business.** A cooperative shall not perform any activity included in the
20 definition of transacting insurance business in this state, as provided in
21 section 10-3-903, except as otherwise authorized in the powers, duties,
22 and responsibilities of cooperatives as set forth in section 10-16-1009. A
23 cooperative shall not establish or engage in the activities of a health
24 maintenance organization. ~~as defined in section 10-16-102 (23).~~

25 **SECTION 54.** In Colorado Revised Statutes, 10-16-1011, **amend**
26 (5) (b) (II) (A) as follows:

27 **10-16-1011. Requirements for waived health care coverage**

1 **cooperatives - rules.** (5) (b) (II) (A) Notwithstanding subparagraph (I)
2 of this paragraph (b) and subject to the provisions of sub-subparagraph
3 (B) of this subparagraph (II), a waived cooperative and a participating
4 carrier may negotiate a percentage discount off of what would otherwise
5 be allowable rates under sections ~~10-16-105 (8) (a)~~ 10-16-107 (6) (a) and
6 10-16-1012 for a particular plan. That percentage discount shall be
7 applied uniformly to all small employer members of the cooperative.
8 Pursuant to section 10-16-1012, a carrier may apply rating factors
9 differently for its business with a waived cooperative than for the
10 carrier's other business. Participating carriers shall notify the division of
11 insurance of a negotiated cooperative discount at least thirty days prior to
12 use.

13 **SECTION 55.** In Colorado Revised Statutes, 10-18-105, **amend**
14 (1) as follows:

15 **10-18-105. Loss ratio standards and filing requirements.**

16 (1) Every insurer providing group or individual medicare supplement
17 insurance benefits to a resident of this state pursuant to section 10-18-102
18 shall file a copy of the group master policy or individual policy and any
19 certificate used in this state in accordance with the filing requirements
20 and procedures of sections ~~10-16-107 (2) and (3)~~ 10-16-107.2 and
21 10-16-406; except that no insurer shall be required to make a filing earlier
22 than thirty days after insurance was provided to a resident of this state
23 under a group master policy issued for delivery outside this state.

24 **SECTION 56.** In Colorado Revised Statutes, 10-20-104, **amend**
25 (2) (b) (X) as follows:

26 **10-20-104. Coverage and limitations - coordination of benefits.**

27 (2) (b) This article shall not provide coverage for:

1 (X) SERVICES COVERED UNDER A POLICY OF sickness and accident
2 insurance as defined in section 10-16-102 ~~(30)~~ (50) when written by a
3 property and casualty insurer as part of an automobile insurance contract;

4 **SECTION 57.** In Colorado Revised Statutes, 12-32-109.5,
5 **amend** (6) (d.5) as follows:

6 **12-32-109.5. Professional service corporations, limited liability**
7 **companies, and registered limited liability partnerships for the**
8 **practice of podiatry - definitions.** (6) As used in this section, unless the
9 context otherwise requires:

10 (d.5) "Health benefit plan" ~~shall have~~ HAS the same meaning as set
11 forth in section 10-16-102 ~~(21)~~ (32), C.R.S.

12 **SECTION 58.** In Colorado Revised Statutes, 12-41-124, **amend**
13 (6) (a.5) and (6) (d.3) as follows:

14 **12-41-124. Professional service corporations, limited liability**
15 **companies, and registered limited liability partnerships for the**
16 **practice of physical therapy - definitions.** (6) As used in this section,
17 unless the context otherwise requires:

18 (a.5) "Carrier" ~~shall have~~ HAS the same meaning as set forth in
19 section 10-16-102 (8), C.R.S.

20 (d.3) "Health benefit plan" ~~shall have~~ HAS the same meaning as set
21 forth in section 10-16-102 ~~(21)~~ (32), C.R.S.

22 **SECTION 59.** In Colorado Revised Statutes, 24-51-1204, **amend**
23 (1) (a) as follows:

24 **24-51-1204. Health care program - eligibility.** (1) The following
25 persons are eligible to enroll in the health care program:

26 (a) All benefit recipients, including those from the Denver public
27 schools division, and their dependents, including any dependent as

1 defined in section 10-16-102 ~~(14)~~ (17), C.R.S.; any unmarried children
2 who are not natural or adopted children of the benefit recipient but who
3 reside full time with the benefit recipient, are dependents of the benefit
4 recipient for federal income tax purposes, and meet the age requirements
5 of section 10-16-102 ~~(14)~~ (17), C.R.S.; and any qualified children as
6 defined in the rules adopted by the board;

7 **SECTION 60.** In Colorado Revised Statutes, 25-1-801, **amend**
8 (1) (a) and (1) (b) (I) as follows:

9 **25-1-801. Patient records in custody of health care facility.**

10 (1) (a) Every patient record in the custody of a health facility licensed or
11 certified pursuant to section 25-1.5-103 (1) or article 3 of this title, or
12 both, or any entity regulated under title 10, C.R.S., providing health care
13 services, as defined in section 10-16-102 ~~(22)~~ (33), C.R.S., directly or
14 indirectly through a managed care plan, as defined in section 10-16-102
15 ~~(26.5)~~ (43), C.R.S., or otherwise shall be available for inspection to the
16 patient or the patient's designated representative through the attending
17 health care provider or such provider's designated representative at
18 reasonable times and upon reasonable notice, except records pertaining
19 to mental health problems or notes by a physician that, in the opinion of
20 a licensed physician who practices psychiatry and is an independent third
21 party, would have significant negative psychological impact upon the
22 patient. Such independent third-party physician shall consult with the
23 attending physician prior to making a determination with regard to the
24 availability for inspection of any patient record and shall report in writing
25 findings to the attending physician and to the custodian of said record. A
26 summary of records pertaining to a patient's mental health problems may,
27 upon written request and signed and dated authorization, be made

1 available to the patient or the patient's designated representative following
2 termination of the treatment program.

3 (b) (I) Following any treatment, procedure, or health care service
4 rendered by a health facility licensed or certified pursuant to section
5 25-1.5-103 (1) or article 3 of this title, or both, or by an entity regulated
6 under title 10, C.R.S., providing health care services, as defined in section
7 10-16-102 (~~22~~) (33), C.R.S., directly or indirectly through a managed care
8 plan, as defined in section 10-16-102 (~~26.5~~) (43), C.R.S., or otherwise,
9 copies of said records, including X rays, shall be furnished to the patient
10 upon submission of a written authorization-request for records, dated and
11 signed by the patient, and upon the payment of the reasonable costs.

12 **SECTION 61.** In Colorado Revised Statutes, 25-1.5-107, **amend**
13 (2) (a) introductory portion as follows:

14 **25-1.5-107. Pandemic influenza - purchase of antiviral therapy**
15 **- definitions.** (2) As used in this section, unless the context otherwise
16 requires:

17 (a) "Authorized purchaser" means an entity licensed by the
18 department pursuant to section 25-1.5-103 (1) (a), a local public health
19 agency, or a health maintenance organization, as defined in section
20 10-16-102 (~~23~~) (35), C.R.S., authorized to operate in this state pursuant
21 to part 4 of article 16 of title 10, C.R.S., that:

22 **SECTION 62.** In Colorado Revised Statutes, 25-3-109, **amend**
23 (5.5) (b) as follows:

24 **25-3-109. Quality management functions - confidentiality and**
25 **immunity.** (5.5) (b) For purposes of this subsection (5.5), "health care
26 facility" includes a ~~health~~ carrier as defined in section 10-16-102 (8),
27 C.R.S., and a health care practitioner licensed or certified pursuant to title

1 12, C.R.S.

2 **SECTION 63.** In Colorado Revised Statutes, 25.5-5-501, **amend**
3 (1) (a) as follows:

4 **25.5-5-501. Providers - drug reimbursement.** (1) (a) As to
5 drugs for which payment is made, the state board's rules for the payment
6 therefor shall include the requirement that the generic equivalent of a
7 brand-name drug be prescribed if the generic equivalent is a therapeutic
8 equivalent to the brand-name drug, except when reimbursement to the
9 state for a brand-name drug makes the brand-name drug less expensive
10 than the cost of the generic equivalent. The state department shall grant
11 an exception to this requirement if the patient has been stabilized on a
12 medication and the treating physician, or a pharmacist with the
13 concurrence of the treating physician, is of the opinion that a transition to
14 the generic equivalent of the brand-name drug would be unacceptably
15 disruptive. The requirements of this subsection (1) shall not apply to
16 medications for the treatment of ~~biologically based~~ mental illness, ~~as~~
17 ~~defined in section 10-16-104 (5.5), C.R.S., the treatment of cancer, the~~
18 ~~treatment of epilepsy, or the treatment of human immunodeficiency virus~~
19 and acquired immune deficiency syndrome.

20 **SECTION 64.** In Colorado Revised Statutes, 25.5-8-107, **amend**
21 (1) (a) (I) as follows:

22 **25.5-8-107. Duties of the department - schedule of services -**
23 **premiums - copayments - subsidies.** (1) In addition to any other duties
24 pursuant to this article, the department shall have the following duties:

25 (a) (I) To design, and from time to time revise, a schedule of
26 health care services included in the plan and to propose said schedule to
27 the medical services board for approval or modification. The schedule of

1 health care services as proposed by the department and approved by the
2 medical services board shall include, but shall not be limited to,
3 preventive care, physician services, prenatal care and postpartum care,
4 inpatient and outpatient hospital services, prescription drugs and
5 medications, and other services that may be medically necessary for the
6 health of enrollees; ~~The department shall design and revise this schedule~~
7 ~~of health care services included in the plan to be based upon the basic and~~
8 ~~standard health benefit plans defined in section 10-16-102 (4) and (43),~~
9 ~~C.R.S.;~~ except that the department may modify the ~~basic and the standard~~
10 ~~health benefit plans~~ SCHEDULE OF HEALTH CARE SERVICES to meet specific
11 federal requirements or to accommodate those changes necessary for a
12 program designed specifically for children.

13 **SECTION 65.** In Colorado Revised Statutes, 25.5-8-110, **amend**
14 (1) as follows:

15 **25.5-8-110. Participation by managed care plans.** (1) Managed
16 care plans, as defined in section 10-16-102 ~~(26.5)~~ (43), C.R.S., that
17 participate in the plan shall do so by contract with the department and
18 shall provide the health care services covered by the plan to each enrollee.

19 **SECTION 66.** In Colorado Revised Statutes, 26-1-304, **amend**
20 (2) as follows:

21 **26-1-304. Services for persons with traumatic brain injuries**
22 **- limitations - covered services.** (2) To be eligible for assistance from
23 the trust fund, an individual shall have exhausted all other health or
24 rehabilitation benefit funding sources that cover the services provided by
25 the trust fund. An individual shall not be required to exhaust all private
26 funds in order to be eligible for the program. Individuals who have
27 continuing health insurance benefits, including, but not limited to,

1 medical assistance pursuant to articles 4, 5, and 6 of title 25.5, C.R.S.,
2 may access the trust fund for services that are necessary but that are not
3 covered by a health benefit plan, as defined in section 10-16-102 ~~(21)~~
4 (32), C.R.S., or any other funding source.

5 **SECTION 67.** In Colorado Revised Statutes, 27-10.5-702,
6 **amend** (2) and (15) as follows:

7 **27-10.5-702. Definitions.** As used in this part 7, unless the
8 context otherwise requires:

9 (2) "Carrier" ~~shall have~~ HAS the same meaning as set forth in
10 section 10-16-102 (8), C.R.S.

11 (15) "Private health insurance" means a health coverage plan, as
12 defined in section 10-16-102 ~~(22.5)~~ (34), C.R.S., that is purchased by
13 individuals or groups to provide, deliver, arrange for, pay for, or
14 reimburse any of the costs of health care services, as defined in section
15 10-16-102 ~~(22)~~ (33), C.R.S., provided to a person entitled to receive
16 benefits or services under the health coverage plan.

17 **SECTION 68.** In Colorado Revised Statutes, 27-10.5-708,
18 **amend** (4) as follows:

19 **27-10.5-708. Certified early intervention service brokers -**
20 **duties - payment for early intervention services - fees.** (4) Use of a
21 certified early intervention broker is voluntary; except that private health
22 insurance carriers that are included under section 10-16-104 (1.3), C.R.S.,
23 ~~shall be~~ ARE required to make payment in trust under section 27-10.5-709.
24 Nothing in this part 7 ~~shall prohibit~~ PROHIBITS a qualified provider of
25 early intervention services from directly billing the appropriate program
26 of public medical assistance or a participating provider, as defined in
27 section 10-16-102 ~~(28.5)~~ (46), C.R.S., or from directly billing a private

1 health insurance carrier for services rendered under this part 7 for
2 insurance plans that are not included under section 10-16-104 (1.3),
3 C.R.S.

4 **SECTION 69.** In Colorado Revised Statutes, **amend** 39-22-104.5
5 as follows:

6 **39-22-104.5. Pretax payments - catastrophic health insurance.**

7 For income tax years commencing on or after January 1, 1995, amounts
8 withheld from an individual's wages that are used to pay for catastrophic
9 health insurance pursuant to and within the limitations prescribed by
10 section ~~10-16-117~~ 10-16-116, C.R.S., are excluded from the individual's
11 federal taxable income for purposes of the state income tax imposed by
12 section 39-22-104.

13 **SECTION 70. Effective date - applicability.** (1) This act takes
14 effect upon passage and applies to health coverage plans issued or
15 renewed on or after January 1, 2014.

16 (2) Health coverage plans in effect on the effective date of this act
17 are subject to article 16 of title 10, Colorado Revised Statutes, as the said
18 article existed prior to the effective date of this act, until those health
19 coverage plans are issued or renewed on or after January 1, 2014.

20 **SECTION 71. Safety clause.** The general assembly hereby finds,
21 determines, and declares that this act is necessary for the immediate
22 preservation of the public peace, health, and safety.