CHAPTER 312

CORPORATIONS AND ASSOCIATIONS

HOUSE BILL 94-1193

BY REPRESENTATIVES Foster, Jerke, Prinster, Sullivan, Coffman, Reeser, Kreutz, Adkins, Agler, Anderson, Berry, Dyer, George, Grampsas, Hagedorn, Martin, Salaz, Tucker, Acquafresca, Blue, Friednash, Greenwood, Lawrence, Linkhart, Lyle, Moellenberg, Morrison, Pierson, Snyder, Armstrong, Gordon, Kerns, and Nichol;
also SENATORS Traylor, Owens, Bird, Bishop, Blickensderfer, Cassidy, Feeley, Hopper, Mutzebaugh, Norton, L. Powers, R. Powers, Ruddick, Schroeder, Tebedo, and Wells.

AN ACT

CONCERNING HEALTH CARE COVERAGE PURCHASING ARRANGEMENTS, AND, IN CONNECTION THEREWITH, AUTHORIZING THE CREATION OF HEALTH CARE COVERAGE COOPERATIVES AND PROVIDER NETWORKS AND MAKING APPROPRIATIONS.

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

SECTION 1. Title 6, Colorado Revised Statutes, 1992 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 18
Health Care Coverage Cooperatives - Provider Networks

PART 1
GENERAL PROVISIONS

6-18-101. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS THAT:

(a) UNDER THE CURRENT HEALTH CARE SYSTEM IN THIS STATE, INDIVIDUALS RISK LOSING THEIR HEALTH CARE COVERAGE WHEN THEY MOVE, WHEN THEY LOSE OR CHANGE JOBS, WHEN THEY BECOME SERIOUSLY ILL, OR WHEN COVERAGE BECOMES UNAFFORDABLE;

(b) CONTINUED ESCALATION OF HEALTH CARE COSTS THREATENS THE CONTINUED ECONOMIC GROWTH OF THE STATE; AND

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(c) HEALTH CARE IS A CRITICAL PART OF THE ECONOMY OF THIS STATE AND CONSUMES A SIGNIFICANT PERCENTAGE OF PUBLIC AND PRIVATE SPENDING AND AFFECTS ALL INDUSTRIES AND INDIVIDUALS IN THIS STATE.

(2) THE GENERAL ASSEMBLY HEREBY DETERMINES THAT:

(a) COMPREHENSIVE HEALTH CARE BENEFITS THAT MEET THE FULL RANGE OF HEALTH NEEDS, INCLUDING PRIMARY, PREVENTIVE, AND SPECIALIZED CARE, SHOULD BE READILY AVAILABLE TO CITIZENS OF THIS STATE;

(b) THE CURRENT HIGH QUALITY OF HEALTH CARE IN THIS STATE SHOULD BE MAINTAINED;

(c) EMPLOYERS AND THEIR EMPLOYEES IN THIS STATE SHOULD BE AFFORDED A MEANINGFUL OPPORTUNITY TO CHOOSE FROM A RANGE OF HEALTH PLANS, HEALTH CARE PROVIDERS, AND TREATMENTS;

(d) COMPETITION IN THE HEALTH CARE INDUSTRY SHOULD ENSURE THAT HEALTH PLANS AND HEALTH CARE PROVIDERS ARE EFFICIENT AND CHARGE REASONABLE PRICES;

(e) ALL INDIVIDUALS SHOULD HAVE A RESPONSIBILITY TO PAY THEIR FAIR SHARE OF THE COSTS OF HEALTH CARE COVERAGE; AND

(f) COLORADO'S HEALTH CARE SYSTEM SHOULD BUILD ON THE STRENGTH OF THE EMPLOYMENT-BASED COVERAGE ARRANGEMENTS THAT NOW EXIST IN THIS STATE.

(3) THE GENERAL ASSEMBLY, THEREFORE, DECLARES THAT THE PURPOSES OF THIS ARTICLE ARE TO:

(a) PROMOTE CONTROL OF THE COST OF HEALTH CARE FOR EMPLOYERS, EMPLOYEES, AND OTHERS WHO PAY FOR HEALTH CARE COVERAGE BY POOLING PURCHASING POWER AMONG CONSUMERS AND ORGANIZING PROVIDERS SO THAT HEALTH CARE SERVICES ARE DELIVERED IN THE MOST EFFICIENT MANNER;

(b) ALLOW HEALTH CARE COOPERATIVES ESTABLISHED UNDER THIS ARTICLE FLEXIBILITY IN THE DETERMINATION OF PLANS AND COVERAGES THEY PROVIDE TO MEMBERS AND THE SELECTION OF HEALTH PROVIDER NETWORKS, PLANS, AND PROVIDERS WITH WHICH THEY CONTRACT FOR SERVICES;

(c) PROMOTE INDIVIDUAL CHOICE AMONG HEALTH PLANS AND HEALTH CARE PROVIDERS;

(d) ENSURE HIGH QUALITY HEALTH CARE; AND

(e) ENCOURAGE ALL INDIVIDUALS TO TAKE RESPONSIBILITY FOR THEIR HEALTH CARE COVERAGE BY BUILDING ON EXISTING EMPLOYMENT-BASED ARRANGEMENTS FOR HEALTH CARE BENEFITS.

6-18-102. Definitions. AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) (a) "BUSINESS GROUP OF ONE" MEANS, FOR PURPOSES OF INITIAL QUALIFICATION, AN INDIVIDUAL, A SOLE PROPRIETOR, OR A SINGLE FULL-TIME EMPLOYEE OF A SUBCHAPTER S CORPORATION, C CORPORATION, LIMITED LIABILITY COMPANY, OR PARTNERSHIP WHO HAS CARRIED ON SIGNIFICANT BUSINESS ACTIVITY FOR A PERIOD OF AT LEAST ONE YEAR PRIOR TO APPLICATION FOR COVERAGE, HAS TAXABLE INCOME AS INDICATED ON FEDERAL INTERNAL REVENUE SERVICE FORMS 1040, SCHEDULE C, F, OR SE, OR OTHER FORMS RECOGNIZED BY THE FEDERAL INTERNAL REVENUE SERVICE FOR INCOME REPORTING PURPOSES WHICH GENERATED TAXABLE INCOME IN ONE OF THE TWO PREVIOUS YEARS OR FROM WHICH THAT INDIVIDUAL, SOLE PROPRIETOR, OR SINGLE FULL-TIME EMPLOYEE HAS DERIVED AT LEAST A SUBSTANTIAL PART OF SUCH INDIVIDUAL'S INCOME FOR ONE YEAR OUT OF ANY CONSECUTIVE THREE-YEAR PERIOD. THIS DEFINITION SHALL BE MET BY AN INDIVIDUAL CERTIFYING IN AN AFFIDAVIT SIGNED UNDER OATH THAT SUCH INDIVIDUAL MEETS THE DEFINITION SET FORTH IN THIS SUBSECTION (1).

(b) THIS SUBSECTION (1) SHALL TAKE EFFECT JANUARY 1, 1996.

(2) "CARRIER" MEANS ANY ENTITY THAT PROVIDES HEALTH CARE COVERAGE IN THIS STATE. "CARRIER" INCLUDES A FRANCHISE INSURANCE PLAN, A HEALTH MAINTENANCE ORGANIZATION, A NONPROFIT HOSPITAL AND HEALTH SERVICE CORPORATION, A SICKNESS AND ACCIDENT INSURANCE COMPANY, AND ANY OTHER ENTITY PROVIDING A PLAN OF HEALTH INSURANCE OR HEALTH BENEFITS SUBJECT TO THE INSURANCE LAWS AND REGULATIONS OF COLORADO.

(3) "COMMISSIONER" MEANS THE COMMISSIONER OF INSURANCE.

(4) "COOPERATIVE" MEANS A HEALTH CARE COVERAGE COOPERATIVE CREATED PURSUANT TO PART 2 OF THIS ARTICLE AS AN ENTITY THAT PROVIDES MEMBER HEALTH COVERAGE AND HEALTH CARE PURCHASING SERVICES INCLUDING BUT NOT LIMITED TO DETAILED INFORMATION TO ITS MEMBERS ON COMPARATIVE PRICES, USAGE, OUTCOMES, QUALITY, AND MEMBER SATISFACTION WITH PROVIDER NETWORKS. "COOPERATIVE" DOES NOT INCLUDE A COOPERATIVE ASSOCIATION ORGANIZED WITHOUT CAPITAL STOCK IN ACCORDANCE WITH ARTICLE 55 OF TITLE 7, C.R.S., WHICH IS ESTABLISHED AS A NONPROFIT CORPORATION PURSUANT TO ARTICLES 20 TO 29 OF TITLE 7, C.R.S., AND WHICH HAD FILED ARTICLES OF INCORPORATION WITH THE SECRETARY OF STATE ON OR BEFORE MARCH 15, 1991.

(5) "DEPENDENT" MEANS A SPOUSE, AN UNMARRIED CHILD UNDER NINETEEN YEARS OF AGE, AN UNMARRIED CHILD WHO IS A FULL-TIME STUDENT UNDER TWENTY-FOUR YEARS OF AGE AND WHO IS FINANCIALLY DEPENDENT UPON THE PARENT, AND AN UNMARRIED CHILD OF ANY AGE WHO IS MEDICALLY CERTIFIED AS DISABLED AND DEPENDENT UPON THE PARENT.

(6) "ELIGIBLE EMPLOYEE" MEANS AN EMPLOYEE WHO HAS A REGULAR WORK WEEK OF TWENTY-FOUR OR MORE HOURS AND INCLUDES A SOLE PROPRIETOR, A PARTNER OF A PARTNERSHIP, AND AN INDEPENDENT CONTRACTOR, IF THE SOLE PROPRIETOR, PARTNER, OR INDEPENDENT CONTRACTOR IS INCLUDED AS AN EMPLOYEE UNDER A HEALTH BENEFIT PLAN OF A SMALL EMPLOYER, BUT DOES NOT INCLUDE AN EMPLOYEE

WHO WORKS ON A TEMPORARY OR SUBSTITUTE BASIS.

(7) "EXECUTIVE DIRECTOR" MEANS THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

(8) "HEALTH CARE COVERAGE PLAN" OR "PLAN" MEANS ANY HOSPITAL OR MEDICAL POLICY, CONTRACT, OR CERTIFICATE, HOSPITAL OR MEDICAL SERVICE PLAN CONTRACT, OR HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER CONTRACT, OR ANY OTHER PLAN OF HEALTH BENEFITS WHICH IS SUBJECT TO REGULATION BY THE DIVISION OF INSURANCE.

(9) "HEALTH INFORMATION" HAS THE SAME MEANING AS "MEDICAL INFORMATION", AS SET FORTH IN SECTION 18-4-412 (2) (b), C.R.S. "HEALTH INFORMATION" ALSO INCLUDES INFORMATION THAT RELATES TO THE PAST, PRESENT, OR FUTURE PHYSICAL OR MENTAL HEALTH OF THE MEMBER AND ITS ELIGIBLE EMPLOYEES AND TO PAYMENT FOR THE PROVISION OF HEALTH CARE TO THE MEMBER AND ITS ELIGIBLE EMPLOYEES.

(10) "HEALTH STATUS" MEANS AN ASSESSMENT OF AN INDIVIDUAL'S MENTAL AND PHYSICAL CONDITION.

(11) "LICENSED PROVIDER NETWORK" OR "LICENSED INDIVIDUAL PROVIDER" MEANS A PROVIDER NETWORK OR INDIVIDUAL PROVIDER THAT IS AUTHORIZED TO TRANSACT INSURANCE BUSINESS PURSUANT TO TITLE 10, C.R.S.

(12) "MANAGED CARE" MEANS SYSTEMS OR TECHNIQUES GENERALLY USED BY THIRD-PARTY PAYORS OR THEIR AGENTS TO AFFECT ACCESS TO AND CONTROL PAYMENT FOR HEALTH CARE SERVICES. MANAGED CARE TECHNIQUES MOST OFTEN INCLUDE ONE OR MORE OF THE FOLLOWING: PRIOR, CONCURRENT, AND RETROSPECTIVE REVIEW OF THE MEDICAL NECESSITY AND APPROPRIATENESS OF SERVICES OR SITE OF SERVICES; CONTRACTS WITH SELECTED HEALTH CARE PROVIDERS; FINANCIAL INCENTIVES OR DISINCENTIVES RELATED TO THE USE OF SPECIFIC PROVIDERS, SERVICES, OR SERVICE SITES; CONTROLLED ACCESS TO AND COORDINATION OF SERVICES BY A CASE MANAGER; AND PAYOR EFFORTS TO IDENTIFY TREATMENT ALTERNATIVES AND MODIFY BENEFIT RESTRICTIONS FOR HIGH-COST PATIENT CARE. "MANAGED CARE" ALSO INCLUDES BUT IS NOT LIMITED TO HEALTH MAINTENANCE ORGANIZATIONS, AS DEFINED IN SECTION 10-16-102 (8), C.R.S.

(13) (a) "MEMBER" MEANS ANY PUBLIC OR PRIVATE EMPLOYER THAT HAS EMPLOYEES COVERED FOR HEALTH BENEFITS THROUGH A COOPERATIVE.

(b) IF, PURSUANT TO SECTION 6-18-206 (2) (l), A COOPERATIVE PROVIDES COVERAGE TO INDIVIDUALS AND ALLOWS INDIVIDUALS TO JOIN THE COOPERATIVE, "MEMBER" MAY ALSO INCLUDE AN INDIVIDUAL AND ANY DEPENDENT WHO IS COVERED BY A PLAN PURCHASED THROUGH A COOPERATIVE AND WHO IS EIGHTEEN YEARS OF AGE OR OLDER AND WHO IS NOT:

(I) ELIGIBLE FOR OTHER COVERAGE WITH BENEFITS SUBSTANTIALLY SIMILAR TO THOSE INCLUDED IN THE BASIC AND STANDARD HEALTH BENEFIT PLANS; AND

(II) A DEPENDENT OF AN INDIVIDUAL WHO IS ELIGIBLE FOR OTHER COVERAGE WITH BENEFITS SUBSTANTIALLY SIMILAR TO THOSE INCLUDED IN THE BASIC AND STANDARD

HEALTH BENEFIT PLANS WHICH COVER SUCH INDIVIDUAL.

(14) "PERSON WITH FINANCIAL INTEREST IN THE COOPERATIVE'S BUSINESS" MEANS ONE OF THE FOLLOWING OR AN IMMEDIATE FAMILY MEMBER OF ONE OF THE FOLLOWING:

(a) A HEALTH CARE PROVIDER WHO IS CONTRACTING OR IS ATTEMPTING TO CONTRACT DIRECTLY OR INDIRECTLY WITH THE COOPERATIVE;

(b) AN INDIVIDUAL WHO IS AN EMPLOYEE OR MEMBER OF THE BOARD OF DIRECTORS OF, HAS A SUBSTANTIAL OWNERSHIP IN, OR DERIVES SUBSTANTIAL INCOME FROM AN ENTITY OR PERSON THAT IS CONTRACTING OR IS ATTEMPTING TO CONTRACT DIRECTLY OR INDIRECTLY WITH THE COOPERATIVE; OR

(c) AN EMPLOYEE OF AN ASSOCIATION, LAW FIRM, OR OTHER INSTITUTION OR ORGANIZATION THAT REPRESENTS THE INTERESTS OF ONE OR MORE ENTITIES OR PERSONS THAT ARE CONTRACTING OR ARE ATTEMPTING TO CONTRACT DIRECTLY OR INDIRECTLY WITH THE COOPERATIVE.

(15) "PROVIDER" MEANS A STATE-LICENSED, STATE-CERTIFIED, OR STATE-AUTHORIZED FACILITY OR A PRACTITIONER DELIVERING HEALTH CARE SERVICES TO INDIVIDUALS.

(16) "PROVIDER NETWORK" MEANS A GROUP OF HEALTH CARE PROVIDERS FORMED TO PROVIDE HEALTH CARE SERVICES TO INDIVIDUALS.

(17) "PURCHASER" MEANS AN INDIVIDUAL, AN ORGANIZATION, OR A GOVERNMENTAL ENTITY THAT MAKES HEALTH-BENEFIT PURCHASING DECISIONS ON BEHALF OF A GROUP OF INDIVIDUALS.

(18) "SMALL EMPLOYER" MEANS ANY PERSON, FIRM, CORPORATION, PARTNERSHIP, OR ASSOCIATION THAT IS ACTIVELY ENGAGED IN BUSINESS THAT, ON AT LEAST FIFTY PERCENT OF ITS WORKING DAYS DURING THE PRECEDING CALENDAR QUARTER, EMPLOYED NO MORE THAN FIFTY ELIGIBLE EMPLOYEES, THE MAJORITY OF WHOM WERE EMPLOYED WITHIN THIS STATE. IN DETERMINING THE NUMBER OF ELIGIBLE EMPLOYEES, COMPANIES THAT ARE AFFILIATED COMPANIES, OR THAT ARE ELIGIBLE TO FILE A COMBINED TAX RETURN FOR PURPOSES OF STATE TAXATION, SHALL BE CONSIDERED ONE EMPLOYER. ON AND AFTER JANUARY 1, 1996, "SMALL EMPLOYER" INCLUDES A BUSINESS GROUP OF ONE.

(19) "UTILIZATION MANAGEMENT" MEANS PROGRAMS DESIGNED TO ASSURE APPROPRIATE UTILIZATION OF HEALTH SERVICES RELATIVE TO ESTABLISHED STANDARDS OR NORMS.

6-18-103. Privacy of health information. (1) THE PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION COLLECTED FOR OR BY A COOPERATIVE SHALL BE PROTECTED. DISCLOSURE OF SUCH INFORMATION IS PROHIBITED EXCEPT:

(a) DISCLOSURES BY AN INDIVIDUAL IDENTIFIED IN THE INFORMATION OR WHOSE IDENTITY CAN BE ASSOCIATED WITH THE INFORMATION;

(b) DISCLOSURES EXPLICITLY AUTHORIZED THROUGH WRITTEN INFORMED CONSENT PROCEDURES BY AN INDIVIDUAL;

(c) DISCLOSURES TO FEDERAL, STATE, OR LOCAL LAW ENFORCEMENT AGENCIES FOR LAWFUL PURPOSES;

(d) SUBJECT TO RULES PROMULGATED BY THE EXECUTIVE DIRECTOR, DISCLOSURES FOR BONA FIDE RESEARCH PROJECTS.

(2) (a) ALL DISCLOSURES OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION SHALL BE RESTRICTED TO THE MINIMUM AMOUNT OF INFORMATION NECESSARY TO ACCOMPLISH THE PURPOSE FOR WHICH THE INFORMATION IS BEING DISCLOSED.

(b) ANY COOPERATIVE SHALL IMPLEMENT ADMINISTRATIVE, TECHNICAL, AND PHYSICAL SAFEGUARDS FOR THE SECURITY OF IDENTIFIABLE HEALTH INFORMATION.

(3) (a) SUBJECT TO APPROPRIATE PROCEDURES ESTABLISHED BY A COOPERATIVE, AN INDIVIDUAL HAS THE RIGHT TO KNOW WHETHER ANY INDIVIDUAL OR ENTITY USES OR MAINTAINS INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION CONCERNING THE INDIVIDUAL AND FOR WHAT PURPOSE THE INFORMATION MAY BE USED OR MAINTAINED.

(b) SUBJECT TO APPROPRIATE PROCEDURES ESTABLISHED BY A COOPERATIVE, AN INDIVIDUAL HAS THE RIGHT, WITH RESPECT TO IDENTIFIABLE HEALTH INFORMATION CONCERNING THE INDIVIDUAL THAT IS RECORDED IN ANY FORM OR MEDIUM, TO:

(I) SEE SUCH INFORMATION;

(II) COPY SUCH INFORMATION; AND

(III) HAVE A NOTATION MADE WITH OR IN SUCH INFORMATION INCLUDING SUGGESTIONS FOR AMENDMENTS OR CORRECTIONS TO SUCH INFORMATION REQUESTED BY THE INDIVIDUAL OR THE INDIVIDUAL'S REPRESENTATIVE.

(4) PROVIDER NETWORKS AND PROVIDERS IN A NETWORK SHALL MAINTAIN THE CONFIDENTIALITY OF MEDICAL RECORDS AS OTHERWISE REQUIRED BY LAW, INCLUDING SECTION 18-4-412, C.R.S.

PART 2
HEALTH CARE COVERAGE COOPERATIVES

6-18-201. Health care coverage cooperatives - establishment - fees. (1) (a) THERE IS HEREBY AUTHORIZED TO BE CREATED ENTITIES TO BE KNOWN AS HEALTH CARE COVERAGE COOPERATIVES. SUCH COOPERATIVES MAY BE CREATED AS ANY LAWFUL ENTITY UNDER ARTICLES 20 TO 29 OR ARTICLES 55 TO 57 OF TITLE 7, C.R.S., WHICH IS ENTITLED TO OPERATE NOT FOR PROFIT BUT FOR THE MUTUAL BENEFIT OF THE MEMBERS. ENTITIES CREATED PURSUANT TO THIS PART 2, IN ADDITION TO THE MATTERS OTHERWISE REQUIRED, SHALL BE SUBJECT TO THIS

ARTICLE.

(b) EACH COOPERATIVE SHALL FOLLOW THE ORGANIZATIONAL REQUIREMENTS AND CORPORATE GOVERNANCE REQUIREMENTS OF ITS STATUTORY INCORPORATION AND, IN ADDITION, SHALL PROVIDE INTERNAL PROCEDURES WHICH COMPLY WITH THE PROVISIONS OF SECTION 6-18-206.

(2) (a) A COOPERATIVE ORGANIZED UNDER THIS PART 2 FOR THE PURPOSES OF SECURING HEALTH CARE COVERAGE FOR ITS MEMBERS AND THEIR ELIGIBLE EMPLOYEES SHALL FILE ARTICLES OF ORGANIZATION WITH THE SECRETARY OF STATE AND SHALL PROVIDE A COPY OF SUCH ARTICLES TO THE EXECUTIVE DIRECTOR IN SUCH FORM AS THE SECRETARY AND THE EXECUTIVE DIRECTOR MAY REQUIRE CONSISTENT WITH THIS PART 2 AND TITLE 7, C.R.S.

(b) ANY PERSON OR ENTITY OPERATING OR HOLDING ITSELF OUT AS A COOPERATIVE CONDUCTING BUSINESS PURSUANT TO THIS PART 2 ON OR AFTER JANUARY 1, 1994, SHALL APPLY FOR AND OBTAIN A CERTIFICATE OF AUTHORITY TO OPERATE AS A COOPERATIVE PURSUANT TO SECTIONS 6-18-202 AND 6-18-203.

(c) NO INDIVIDUAL OR ENTITY THAT ORGANIZES A COOPERATIVE MAY BECOME OR ATTEMPT TO BECOME A PERSON WITH FINANCIAL INTEREST IN THE COOPERATIVE'S BUSINESS FOR A PERIOD OF THREE YEARS AFTER ORGANIZATION OF THE COOPERATIVE.

(3) (a) A COOPERATIVE IS ORGANIZED WHEN THE ARTICLES OF ORGANIZATION ARE FILED BY THE SECRETARY OF STATE OR, IF A DELAYED EFFECTIVE DATE IS SPECIFIED IN THE ARTICLES AS FILED WITH THE SECRETARY OF STATE AND A CERTIFICATE OF WITHDRAWAL IS NOT FILED, ON SUCH DELAYED EFFECTIVE DATE. THE EXISTENCE OF THE COOPERATIVE BEGINS UPON ORGANIZATION; EXCEPT THAT NO COOPERATIVE SHALL SECURE HEALTH CARE COVERAGE FOR ITS MEMBERS UNTIL A CERTIFICATE OF AUTHORITY HAS BEEN ISSUED BY THE EXECUTIVE DIRECTOR.

(b) EXCEPT IN A PROCEEDING BY THE STATE TO CANCEL OR REVOKE THE ORGANIZATION OR INVOLUNTARILY DISSOLVE THE COOPERATIVE, THE SECRETARY OF STATE'S FILING OF THE ARTICLES OF ORGANIZATION IS CONCLUSIVE AND IT SHALL BE INCONTESTABLE THAT ALL CONDITIONS PRECEDENT TO ORGANIZATION HAVE BEEN MET.

(4) EACH COOPERATIVE SHALL FILE A REPORT PURSUANT TO SECTIONS 7-28-101 AND 7-28-102, C.R.S., AND PAY A FEE WHICH SHALL BE DETERMINED AND COLLECTED PURSUANT TO SECTION 24-21-104 (3), C.R.S., IN LIEU OF ALL FRANCHISE OR CORPORATION LICENSE TAXES.

6-18-202. Issuance of certificate of authority by executive director for cooperative to purchase health care coverage. (1) (a) (I) (A) A COOPERATIVE CONDUCTING BUSINESS PURSUANT TO THIS PART 2 SHALL FILE AN APPLICATION WITH THE EXECUTIVE DIRECTOR FOR ISSUANCE OF A CERTIFICATE OF AUTHORITY TO PURCHASE HEALTH CARE COVERAGE FOR MEMBERS AND THEIR ELIGIBLE EMPLOYEES. AN APPLICATION SHALL INCLUDE THE FOLLOWING INFORMATION: THE NAME OF THE COOPERATIVE AND ANY AGENT FOR SERVICE OF PROCESS; DETAILS CONCERNING PROVISIONS TO GOVERN THE BUSINESS AND AFFAIRS OF THE COOPERATIVE, INCLUDING MANAGEMENT AND ORGANIZATIONAL STRUCTURE; AN AFFIDAVIT SIGNED UNDER OATH

BY AN OFFICER OF THE ORGANIZATION THAT THE COOPERATIVE IS IN COMPLIANCE WITH SECTIONS 6-18-201 (2) (c) AND 6-18-205 (3); AND THE NAMES OF MANAGING PERSONNEL OF THE COOPERATIVE. THE EXECUTIVE DIRECTOR SHALL GRANT A CERTIFICATE OF AUTHORITY TO AN APPLICANT UNDER THIS SECTION UNLESS THE APPLICATION FAILS TO COMPLY WITH THE PROVISIONS OF THIS ARTICLE. THE EXECUTIVE DIRECTOR SHALL ESTABLISH AN APPLICATION FILING FEE NOT IN EXCESS OF ONE THOUSAND ONE HUNDRED DOLLARS TO RECOVER THE DIRECT COSTS OF THE EXECUTIVE DIRECTOR IN CONDUCTING THE REVIEW REQUIRED BY THIS SECTION. EACH COOPERATIVE ISSUED A CERTIFICATE OF AUTHORITY PURSUANT TO THIS SECTION SHALL ANNUALLY SUBMIT SUCH INFORMATION AS THE EXECUTIVE DIRECTOR MAY REASONABLY REQUIRE TO DETERMINE THAT A COOPERATIVE CONTINUES TO BE IN COMPLIANCE WITH THE PROVISIONS OF THIS ARTICLE. THE EXECUTIVE DIRECTOR SHALL ESTABLISH A FEE NOT IN EXCESS OF ONE THOUSAND ONE HUNDRED DOLLARS ANNUALLY TO RECOVER THE DIRECT COSTS OF THE EXECUTIVE DIRECTOR IN DETERMINING ANNUALLY THAT A COOPERATIVE IS IN COMPLIANCE WITH THE PROVISIONS OF THIS ARTICLE.

(B) EXCEPT AS PROVIDED IN SECTION 6-18-201 (2) (b), NO COOPERATIVE SHALL TAKE ANY ACTION ENUMERATED IN SECTION 6-18-206 UNLESS A CERTIFICATE OF AUTHORITY HAS BEEN ISSUED PURSUANT TO THIS SECTION BY THE EXECUTIVE DIRECTOR. ANY PERSON OR ENTITY APPLYING TO OBTAIN A CERTIFICATE OF AUTHORITY AS REQUIRED BY SECTION 6-18-201 (2) (b) THAT FAILS TO OBTAIN A CERTIFICATE OF AUTHORITY BY JANUARY 1, 1996, SHALL CEASE TO ENGAGE IN ANY ACTIVITY FOR WHICH A CERTIFICATE OF AUTHORITY IS REQUIRED PURSUANT TO THIS ARTICLE UNTIL A CERTIFICATE OF AUTHORITY IS ISSUED BY THE EXECUTIVE DIRECTOR PURSUANT TO THIS SECTION AND SECTION 6-18-203.

(II) A COOPERATIVE SHALL BE REQUIRED TO POST A BOND RUNNING TO THE PEOPLE OF THE STATE OF COLORADO FOR THE BENEFIT OF MEMBERS OF THE COOPERATIVE AND THEIR ELIGIBLE EMPLOYEES OR DEPOSIT WITH THE EXECUTIVE DIRECTOR A CERTIFICATE OF DEPOSIT OR SECURITIES IN A MINIMUM AMOUNT EQUAL TO AT LEAST TWO MONTHS' PREMIUMS HELD BY THE COOPERATIVE AS OF ITS ANNUAL RENEWAL DATE IN ORDER TO BE GRANTED A CERTIFICATE OF AUTHORITY UNDER THIS SECTION.

(b) ANY COOPERATIVE OR ENTITY WHICH, PRIOR TO JANUARY 1, 1994, IS CONDUCTING ACTIVITIES SUBSTANTIALLY SIMILAR TO THOSE AUTHORIZED UNDER THIS PART 2 MAY CONTINUE TO ENGAGE IN SUCH ACTIVITIES IN ACCORDANCE WITH ANY LAWS OR REGULATIONS GOVERNING SUCH AN ENTITY'S ACTIVITIES, BUT SHALL NOT PERFORM ANY ACTIVITIES AUTHORIZED UNDER THIS PART 2 UNLESS IT HAS ORGANIZED TO BE SUCH A COOPERATIVE AS PROVIDED IN THIS PART 2. THE EXECUTIVE DIRECTOR MAY ESTABLISH PROCEDURES TO ALLOW SUCH ENTITIES AN EXPEDITED TRANSITION PERIOD FOR SECURING A CERTIFICATE OF AUTHORITY ISSUED PURSUANT TO THIS SECTION.

(c) THE EXECUTIVE DIRECTOR MAY GRANT A TEMPORARY CERTIFICATE OF AUTHORITY TO ANY COOPERATIVE. ANY SUCH TEMPORARY CERTIFICATE OF AUTHORITY SHALL BE VALID FOR A PERIOD OF ONE YEAR FROM THE DATE OF ISSUANCE.

(d) NOTWITHSTANDING THE PROVISIONS OF PART 2 OF ARTICLE 72 OF TITLE 24, C.R.S., ANY APPLICATION AND SUPPORTING MATERIAL AND RESPONSES FROM THE

EXECUTIVE DIRECTOR SHALL NOT BE CONSIDERED A PUBLIC RECORD UNTIL THE EXECUTIVE DIRECTOR APPROVES THE APPLICATION OR AN ORGANIZER REQUESTS A HEARING ON THE EXECUTIVE DIRECTOR'S ACTION TO DENY APPROVAL OF AN APPLICATION.

(2) THE EXECUTIVE DIRECTOR SHALL RESPOND IN WRITING TO EACH APPLICATION FOR A CERTIFICATE OF AUTHORITY WITHIN THIRTY DAYS AFTER RECEIPT BY THE EXECUTIVE DIRECTOR. THE EXECUTIVE DIRECTOR SHALL EITHER APPROVE ANY SUCH APPLICATION OR SHALL INFORM THE ORGANIZERS OF SPECIFIC CHANGES TO THE APPLICATION NECESSARY TO PERMIT APPROVAL BY VIRTUE OF COMPLIANCE WITH THIS PART 2. EACH APPLICANT MUST RESPOND TO THE EXECUTIVE DIRECTOR'S COMMENTS WITHIN THIRTY DAYS AFTER RECEIPT. THE EXECUTIVE DIRECTOR SHALL APPROVE THE APPLICATION WITHIN THIRTY DAYS AFTER RECEIPT OF SUCH CHANGES OR REQUEST ADDITIONAL CHANGES TO THE APPLICATION. THE TIME LIMITS CONTAINED IN THIS SUBSECTION (2) SHALL APPLY TO ALL PHASES OF THE APPLICATION PROCESS EXCEPT HEARINGS CONDUCTED PURSUANT TO ARTICLE 4 OF TITLE 24, C.R.S.

6-18-203. Authority to deny application for certificate of authority or to revoke or suspend certificate of authority. (1) THE EXECUTIVE DIRECTOR MAY DENY AN APPLICATION FOR A CERTIFICATE OF AUTHORITY PURSUANT TO SECTION 6-18-202 OR REVOKE OR SUSPEND A CERTIFICATE OF AUTHORITY OF ANY COOPERATIVE FOUND TO BE IN VIOLATION OF THIS ARTICLE.

(2) (a) ANY PARTY MAY REQUEST A HEARING PURSUANT TO ARTICLE 4 OF TITLE 24, C.R.S., ON ANY ACTION OF THE EXECUTIVE DIRECTOR DENYING AN APPLICATION FOR A CERTIFICATE OF AUTHORITY OR REVOKING OR SUSPENDING A CERTIFICATE OF AUTHORITY.

(b) ANY HEARING CONDUCTED UNDER THIS SECTION SHALL BE CONDUCTED PURSUANT TO ARTICLE 4 OF TITLE 24, C.R.S., AND THE EXECUTIVE DIRECTOR SHALL USE THE SERVICES OF AN ADMINISTRATIVE LAW JUDGE APPOINTED PURSUANT TO PART 10 OF ARTICLE 30 OF TITLE 24, C.R.S.

(c) ANY FINAL DECISION OF THE EXECUTIVE DIRECTOR UNDER THIS PART 2 SHALL BE SUBJECT TO JUDICIAL REVIEW BY THE COURT OF APPEALS PURSUANT TO SECTION 24-4-106 (11), C.R.S.

6-18-204. Prohibition on cooperatives transacting insurance business. A COOPERATIVE SHALL NOT PERFORM ANY ACTIVITY INCLUDED IN THE DEFINITION OF TRANSACTING INSURANCE BUSINESS IN THIS STATE, AS PROVIDED IN SECTION 10-3-903, C.R.S., EXCEPT AS OTHERWISE AUTHORIZED IN THE POWERS, DUTIES, AND RESPONSIBILITIES OF COOPERATIVES AS SET FORTH IN SECTION 6-18-206. A COOPERATIVE SHALL NOT ESTABLISH OR OTHERWISE ENGAGE IN THE ACTIVITIES OF A HEALTH MAINTENANCE ORGANIZATION, AS PROVIDED IN SECTION 10-16-102 (8), C.R.S.

6-18-205. Administrative structure of cooperatives - board of directors - officers - employees. (1) THE AFFAIRS OF THE COOPERATIVE SHALL BE MANAGED IN ACCORDANCE WITH THE LEGAL STRUCTURE REQUIRED OF THE ENTITY AND GOVERNED BY PERSONS ELECTED BY THE MEMBERS FROM THEIR OWN NUMBER. THE GOVERNING BODY OF THE COOPERATIVE SHALL ADOPT BYLAWS AND RULES FOR THE COOPERATIVE.

MEMBERS OF A COOPERATIVE SHALL BE ENTITLED TO EQUAL PARTICIPATION AND BENEFIT FROM THE COOPERATIVE; EXCEPT THAT A COOPERATIVE AT ITS OPTION MAY EXTEND VOTING RIGHTS TO ELIGIBLE EMPLOYEES. THE GOVERNING BODY OF THE COOPERATIVE SHALL MEET AT SUCH TIMES AND PLACES AS IT DETERMINES NECESSARY TO OPERATE THE COOPERATIVE IN ACCORDANCE WITH THIS PART 2.

(2) A COOPERATIVE MAY PROVIDE A FAIR REMUNERATION FOR THE TIME ACTUALLY SPENT BY ITS OFFICERS AND DIRECTORS IN ITS SERVICE AND FOR THE SERVICE OF THE MEMBERS OF ITS EXECUTIVE COMMITTEE.

(3) AN INDIVIDUAL WHO IS A MEMBER OF A GOVERNING BODY OF A COOPERATIVE MAY NOT BE A PERSON WITH FINANCIAL INTEREST IN THE COOPERATIVE'S BUSINESS DURING:

(a) THE TWELVE-MONTH PERIOD IMMEDIATELY PRIOR TO MEMBERSHIP ON THE GOVERNING BODY; OR

(b) THE INDIVIDUAL'S TERM ON THE GOVERNING BODY OR DURING THE TWELVE-MONTH PERIOD IMMEDIATELY AFTER SERVICE ON SUCH GOVERNING BODY.

(4) THE BYLAWS MAY PROVIDE THAT NO MEMBER OF THE GOVERNING BODY OF A COOPERATIVE SHALL OCCUPY ANY POSITION IN THE COOPERATIVE EXCEPT THE CHIEF EXECUTIVE OFFICER AND SECRETARY ON REGULAR SALARY OR SUBSTANTIALLY FULL-TIME PAY. THE BYLAWS MAY PROVIDE FOR AN EXECUTIVE COMMITTEE AND MAY ALLOT TO THE COMMITTEE ALL THE FUNCTIONS AND POWERS OF THE BOARD OF DIRECTORS, SUBJECT TO THE GENERAL DIRECTION AND CONTROL OF THE BOARD.

(5) WHEN A VACANCY OCCURS ON THE GOVERNING BODY OF A COOPERATIVE OTHER THAN BY EXPIRATION OF TERM, THE REMAINING MEMBERS OF THE GOVERNING BODY SHALL FILL THE VACANCY BY MAJORITY VOTE.

(6) THE GOVERNING BODY OF A COOPERATIVE MAY APPOINT A CHIEF EXECUTIVE OFFICER OF THE COOPERATIVE AND OTHER STAFF NECESSARY TO ADMINISTER THE COOPERATIVE. THE CHIEF EXECUTIVE OFFICER AND OTHER STAFF SERVE AT THE PLEASURE OF THE GOVERNING BODY.

(7) NO COOPERATIVE MAY ASSUME ANY LIABILITY FOR PAYMENT FOR HEALTH CARE SERVICES COVERED BY A PLAN PURCHASED THROUGH THE COOPERATIVE.

6-18-206. Powers, duties, and responsibilities of cooperatives. (1) EACH COOPERATIVE ORGANIZED PURSUANT TO THIS PART 2 SHALL:

(a) ESTABLISH THE CONDITIONS OF COOPERATIVE MEMBERSHIP;

(b) PROVIDE TO COOPERATIVE MEMBERS AND THEIR ELIGIBLE EMPLOYEES CLEAR, STANDARDIZED INFORMATION ABOUT EACH LICENSED PROVIDER NETWORK, PROVIDER NETWORK, CARRIER, OR OTHER PROVIDER CONTRACTED WITH BY THE COOPERATIVE INCLUDING BUT NOT LIMITED TO INFORMATION ON PRICE, BENEFITS, COSTS, QUALITY, PATIENT SATISFACTION, MEMBERSHIP, AND RESPONSIBILITIES AND OBLIGATIONS;

(c) ANNUALLY OFFER TO ALL COOPERATIVE MEMBERS ALL OF THE PLANS,

PROVIDER NETWORKS, PROVIDERS, AND HEALTH CARRIERS SELECTED BY THE COOPERATIVE; EXCEPT THAT MEMBERS THAT ARE NOT SELF-INSURED MAY ONLY BE OFFERED PLANS OR SERVICES OFFERED BY LICENSED PROVIDER NETWORKS, LICENSED INDIVIDUAL PROVIDERS, AND OTHER CARRIERS. FOR PURPOSES OF THIS PART 2, "SELF-INSURED" MEANS A MEMBER OF A COOPERATIVE THAT IS NOT INSURED UNDER A PLAN UNDERWRITTEN BY A CARRIER OR LICENSED PROVIDER NETWORK. A SELF-INSURED EMPLOYER OR INDIVIDUAL MAY JOIN A COOPERATIVE IN ORDER TO HAVE ACCESS TO THE DISCOUNTED PROVIDER RATES (EXCLUDING CAPITATED AGREEMENTS) WHICH THE COOPERATIVE MAY NEGOTIATE FOR ON BEHALF OF ITS SELF-INSURED MEMBERS.

(d) OFFER DEPENDENT COVERAGE;

(e) OFFER TO ALL MEMBERS AND THEIR ELIGIBLE EMPLOYEES THE STANDARD AND BASIC HEALTH BENEFIT PLANS PROMULGATED PURSUANT TO SECTION 10-8-606, C.R.S.;

(f) OBTAIN THE NECESSARY DATA AND INFORMATION TO PROVIDE TO MEMBERS AND THEIR ELIGIBLE EMPLOYEES THE INFORMATION DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (1);

(g) CONTRACT ONLY FOR INSURANCE FUNCTIONS LISTED IN SECTION 10-3-903, C.R.S., WITH ENTITIES AUTHORIZED TO DO BUSINESS IN THIS STATE BY THE DIVISION OF INSURANCE PURSUANT TO TITLE 10, C.R.S., WHICH HAVE:

(I) THE CAPACITY TO ADMINISTER THE HEALTH BENEFIT PLAN OR SERVICES TO BE OFFERED;

(II) THE ABILITY TO MONITOR AND EVALUATE THE QUALITY AND COST-EFFECTIVENESS OF CARE AND APPLICABLE PROCEDURES;

(III) THE ABILITY TO REPORT QUALITY AND OUTCOMES INFORMATION NECESSARY FOR THE COOPERATIVE TO REPORT QUALITY INFORMATION TO MEMBERS AND THEIR ELIGIBLE EMPLOYEES; AND

(IV) THE ABILITY TO ASSURE MEMBERS AND THEIR ELIGIBLE EMPLOYEES ADEQUATE ACCESS TO HEALTH CARE PROVIDERS, INCLUDING AN ADEQUATE NUMBER AND TYPE OF PROVIDERS FOR THE RISK POOL INVOLVED;

(h) DEVELOP AND IMPLEMENT A MARKETING PLAN THAT WILL WIDELY PUBLICIZE THE COOPERATIVE TO POTENTIAL MEMBERS AND THEIR ELIGIBLE EMPLOYEES AND DEVELOP AND IMPLEMENT METHODS FOR INFORMING THE PUBLIC ABOUT THE COOPERATIVE AND ITS SERVICES;

(i) STATE CLEARLY ALL ADMINISTRATIVE AND BROKER OR AGENT FEES ASSOCIATED WITH MEMBERSHIP IN ALL MATERIALS PUBLISHED FOR THE PURPOSE OF SOLICITING MEMBERS AND THEIR ELIGIBLE EMPLOYEES OR WHICH MAY BE USED BY POTENTIAL MEMBERS IN DECIDING WHETHER TO JOIN THE COOPERATIVE;

(j) ESTABLISH ADMINISTRATIVE AND ACCOUNTING PROCEDURES FOR THE OPERATION OF THE COOPERATIVE AND MEMBERS' SERVICES, PREPARE AN ANNUAL

COOPERATIVE BUDGET, AND PREPARE ANNUAL PROGRAM AND FISCAL REPORTS ON COOPERATIVE OPERATIONS;

(k) MAINTAIN ALL RECORDS, REPORTS, AND OTHER INFORMATION OF THE COOPERATIVE;

(l) MAINTAIN A TRUST ACCOUNT OR ACCOUNTS FOR THE DEPOSIT OF PREMIUM MONEYS COLLECTED PURSUANT TO PARAGRAPH (e) OF SUBSECTION (2) OF THIS SECTION, TO BE PAID TO CARRIERS OR LICENSED PROVIDER NETWORKS OR LICENSED INDIVIDUAL PROVIDERS FOR COVERAGE OFFERED THROUGH THE COOPERATIVE. A COOPERATIVE SHALL HAVE A FIDUCIARY DUTY WITH RESPECT TO PREMIUM MONEYS COLLECTED FOR CARRIERS AND LICENSED PROVIDER NETWORKS OFFERED THROUGH THE COOPERATIVE.

(m) ANNUALLY REPORT ON OPERATIONS OF THE COOPERATIVE, INCLUDING PROGRAM AND FINANCIAL OPERATIONS, AND PROVIDE FOR INTERNAL AND INDEPENDENT AUDITS;

(n) DISCLOSE TO MEMBERS AND POTENTIAL MEMBERS IF THE COOPERATIVE HAS BEEN GRANTED A TEMPORARY CERTIFICATE OF AUTHORITY PURSUANT TO SECTION 6-18-202 (1) (c);

(o) OFFER THE SAME PREMIUMS AND ANY NEGOTIATED HEALTH CARE PRICES TO ALL MEMBER CLASSES, IF ANY, EQUALLY; EXCEPT THAT A COOPERATIVE MAY OFFER DIFFERENT PREMIUMS OR NEGOTIATED HEALTH CARE PRICES TO MEMBERS WHO ARE NOT SMALL EMPLOYERS;

(p) TREAT ALL MEMBERS WITHIN A CLASS EQUALLY WITH REGARD TO MEMBERSHIP AND ADMINISTRATIVE FEES AND BENEFITS OF MEMBERSHIP.

(2) EACH COOPERATIVE ORGANIZED PURSUANT TO THIS PART 2 MAY:

(a) DETERMINE, FROM TIME TO TIME, THE NEED TO ESTABLISH CLASSES OF MEMBERSHIP;

(b) SET REASONABLE FEES FOR MEMBERSHIP IN THE COOPERATIVE WHICH WILL FINANCE ALL REASONABLE AND NECESSARY COSTS INCURRED IN ADMINISTERING THE COOPERATIVE;

(c) OFFER ANY AND ALL HEALTH BENEFIT PACKAGES PERMITTED UNDER LAW IN ADDITION TO THE STANDARD AND BASIC HEALTH BENEFIT PLANS PROMULGATED PURSUANT TO SECTION 10-8-606, C.R.S.;

(d) REQUIRE, AS A CONDITION OF MEMBERSHIP, THAT ALL EMPLOYERS INCLUDE ALL THEIR EMPLOYEES OR A MINIMUM PERCENTAGE OF EMPLOYEES IN COVERAGE PURCHASED THROUGH THE COOPERATIVE. THE COOPERATIVE MAY REQUIRE AN EMPLOYER MAKING MEMBERSHIP APPLICATION TO A COOPERATIVE WHICH WOULD ENTAIL ENTERING FEWER THAN ONE HUNDRED PERCENT OF SUCH EMPLOYER'S ELIGIBLE EMPLOYEES OR DEPENDENTS TO DEMONSTRATE, UNDER STANDARDS CONSISTENT WITH THE PROVISIONS OF PARAGRAPH (g) OF SUBSECTION (3) OF THIS SECTION, THAT THE RESULT OF SUCH MEMBERSHIP MAY NOT RESULT IN AN ADVERSE

SELECTION GROUP BEING BROUGHT INTO THE COOPERATIVE OR THAT THE ACTION WOULD OTHERWISE ACT AS A FORM OF RISK SELECTION OR RISK AVOIDANCE.

(e) SUBJECT TO PARAGRAPH (l) OF SUBSECTION (1) OF THIS SECTION, PROVIDE PREMIUM COLLECTION SERVICES FOR PLANS AND LICENSED PROVIDER NETWORKS OR LICENSED INDIVIDUAL PROVIDERS OFFERED THROUGH THE COOPERATIVE;

(f) REJECT OR ALLOW A CARRIER TO REJECT AN EMPLOYER FROM MEMBERSHIP OR DROP OR ALLOW A CARRIER TO DROP AN EMPLOYER FROM MEMBERSHIP IF THE EMPLOYER OR ANY OF ITS EMPLOYEE MEMBERS FAIL TO PAY PREMIUMS OR ENGAGE IN FRAUD OR MATERIAL MISREPRESENTATION IN CONNECTION WITH A PLAN PURCHASED THROUGH THE COOPERATIVE. IF AN EMPLOYER OR EMPLOYEE IS DROPPED FROM MEMBERSHIP, THE EMPLOYEE SHALL BE ENTITLED TO CONTINUATION AND CONVERSION COVERAGE AS PROVIDED FOR UNDER APPLICABLE STATE OR FEDERAL CONTINUATION LAWS AND THE STATE CONVERSION LAW.

(g) CONTRACT WITH QUALIFIED INDEPENDENT THIRD PARTIES FOR ANY SERVICE NECESSARY TO CARRY OUT THE POWERS AND DUTIES AUTHORIZED OR REQUIRED BY THIS ARTICLE;

(h) CONTRACT WITH LICENSED INSURANCE AGENTS OR BROKERS TO MARKET COVERAGE MADE AVAILABLE THROUGH THE COOPERATIVE TO ITS MEMBERS. A COOPERATIVE SHALL USE A UNIFORM FEE SCHEDULE FOR ALL AGENTS AND BROKERS WHICH MAY NOT VARY BASED ON THE ACTUAL OR EXPECTED HEALTH STATUS OR MEDICAL UTILIZATION OF THE GROUP TO WHICH COVERAGE IS SOLD.

(i) EXCLUDE ANY CARRIER, PROVIDER NETWORK, OR PROVIDER OR FREEZE ENROLLMENT IN ANY CARRIER, PROVIDER NETWORK, OR PROVIDER FOR FAILURE TO ACHIEVE ESTABLISHED QUALITY, ACCESS, OR INFORMATION REPORTING STANDARDS OF THE COOPERATIVE;

(j) PROHIBIT MEMBERS WHO DROP COVERAGE THROUGH THE COOPERATIVE FROM REENROLLING FOR UP TO TWELVE MONTHS IN COVERAGE PURCHASED THROUGH THE COOPERATIVE;

(k) REQUIRE THAT MEMBERS AND THEIR ELIGIBLE EMPLOYEES CONTINUE TO PAY ADMINISTRATIVE FEES THAT ARE PART OF THE CONTRACT WITH THE COOPERATIVE IF A MEMBER OR ELIGIBLE EMPLOYEE CANCELS PRIOR TO COMPLETION OF A CONTRACT PERIOD;

(l) OFFER COVERAGE FOR INDIVIDUALS WHO ARE MEMBERS. IF COVERAGE IS OFFERED TO INDIVIDUALS AS MEMBERS, THE COOPERATIVE MAY REQUIRE THAT INDIVIDUALS INCLUDE ALL DEPENDENTS UNDER SUCH COVERAGE.

(3) EACH COOPERATIVE ORGANIZED PURSUANT TO THIS PART 2 MAY NOT:

(a) EXCLUDE ANY SMALL EMPLOYER OR ELIGIBLE EMPLOYEE OR DEPENDENT OF A SMALL EMPLOYER FROM MEMBERSHIP IN THE COOPERATIVE WHO AGREES TO PAY FEES FOR MEMBERSHIP AND ANY PREMIUM FOR COVERAGE THROUGH THE COOPERATIVE AND WHO ABIDES BY THE BYLAWS AND RULES OF THE COOPERATIVE;

(b) DIFFERENTIATE CLASSES OF MEMBERSHIP ON THE BASIS OF INDUSTRY TYPE, RACE, RELIGION, GENDER, EDUCATION, HEALTH STATUS, OR INCOME;

(c) COMMIT ANY ACT CONSTITUTING A REBATE PROHIBITED PURSUANT TO SECTION 10-3-1104 (1) (g), C.R.S. THE EXECUTIVE DIRECTOR SHALL HAVE ALL OF THE POWERS OF THE INSURANCE COMMISSIONER CONTAINED IN PART 11 OF ARTICLE 3 OF TITLE 10, C.R.S., TO ENFORCE THE PROVISIONS OF THIS PARAGRAPH (c).

(d) PROHIBIT ANY HOSPITAL, HEALTH MAINTENANCE ORGANIZATION, OR OTHER PROVIDER, AS A CONDITION OF CONTRACTING TO PROVIDE SERVICES THROUGH THE COOPERATIVE, FROM PROVIDING SERVICES THROUGH A SUBCONTRACT OR SUBCONTRACTS WITH ANY OTHER HOSPITAL, HEALTH MAINTENANCE ORGANIZATION, OR OTHER PROVIDER MEETING THE COOPERATIVE'S QUALITY STANDARDS;

(e) CHARGE ANY FEE NOT DIRECTLY RELATED TO ADMINISTERING HEALTH CARE PURCHASING FUNCTIONS OR FOR NONHEALTH CARE RELATED ACTIVITIES;

(f) AS A CONDITION OF MEMBERSHIP, REQUIRE ANY MEMBER, ELIGIBLE EMPLOYEE, OR DEPENDENT TO SUBSCRIBE TO NONHEALTH CARE RELATED PRODUCTS OR SERVICES;

(g) KNOWINGLY OPERATE THE COOPERATIVE OR MARKET THE COOPERATIVE IN A COUNTY OR PRIMARY METROPOLITAN STATISTICAL AREA IN A WAY WHICH WOULD CAUSE THE COOPERATIVE TO SELECT A RISK POOL WITH ACTUARIALLY PROJECTED HEALTH CARE UTILIZATION OVER A TWO-YEAR PERIOD WHICH IS BELOW THE PROJECTED AVERAGE FOR ALL INDIVIDUALS RESIDING IN THAT COUNTY OR PRIMARY METROPOLITAN STATISTICAL AREA. SUCH MEASUREMENT AND COMPARISON OF PROJECTED UTILIZATION BY MEMBERS OF THE COOPERATIVE TO ALL INDIVIDUALS SHALL BE DONE ON A COUNTY OR PRIMARY METROPOLITAN STATISTICAL AREA BASIS AND NOT ACROSS ALL MEMBERS OF THE COOPERATIVE.

(h) KNOWINGLY AUTHORIZE OR SELECT ANY CARRIER, LICENSED PROVIDER NETWORK, LICENSED INDIVIDUAL PROVIDER, PROVIDER, OR INDIVIDUAL PROVIDER WHICH DOES NOT COMPLY WITH OR CONFORM TO THE APPLICABLE PROVISIONS OF TITLE 10, C.R.S.

6-18-207. Marketing requirements of cooperatives. (1) A COOPERATIVE SHALL USE APPROPRIATE, EFFICIENT, AND STANDARDIZED MEANS TO NOTIFY MEMBERS AND PROSPECTIVE MEMBERS AND THEIR ELIGIBLE EMPLOYEES OF THE AVAILABILITY OF SPONSORED HEALTH CARE COVERAGE FROM THE COOPERATIVE.

(2) A COOPERATIVE SHALL MAKE AVAILABLE TO MEMBERS AND PROSPECTIVE MEMBERS AND THEIR ELIGIBLE EMPLOYEES MARKETING MATERIALS THAT ACCURATELY SUMMARIZE THE HEALTH BENEFIT PLANS THAT ARE OFFERED BY ITS LICENSED PROVIDER NETWORKS, LICENSED INDIVIDUAL PROVIDERS, AND OTHER CARRIERS, AND RATES, COSTS, AND ACCREDITATION INFORMATION RELATING TO THOSE PLANS. A COOPERATIVE SHALL ALSO SUMMARIZE THE SERVICES OFFERED BY ALL OTHER PROVIDER NETWORKS AND INDIVIDUAL PROVIDERS THE COOPERATIVE OFFERS, THE RATES FOR THOSE SERVICES, AND ACCREDITATION INFORMATION RELATING TO THOSE PROVIDER NETWORKS.

(3) ANNUALLY, A COOPERATIVE SHALL OFFER EACH MEMBER ALL LICENSED

PROVIDER NETWORKS, LICENSED INDIVIDUAL PROVIDERS, AND CARRIERS AVAILABLE IN THE COOPERATIVE AND PROVIDE MEMBERS WITH THE APPROPRIATE MATERIALS RELATING TO THOSE PLANS. A COOPERATIVE MAY OFFER NONLICENSED PROVIDER NETWORKS OR INDIVIDUAL PROVIDERS ONLY TO SELF-INSURED MEMBERS OF THE COOPERATIVE. NONLICENSED PROVIDER NETWORKS OR INDIVIDUAL PROVIDERS MAY ALSO BE OFFERED TO MEMBERS NOT SELF-INSURED IF THE SERVICES OFFERED DO NOT INVOLVE TRANSACTING INSURANCE BUSINESS, AS DEFINED IN SECTION 10-3-903, C.R.S. THE MEMBERS MAY CHOOSE WHICH HEALTH BENEFIT PLANS SHALL BE OFFERED TO ELIGIBLE EMPLOYEES AND MAY CHANGE THE SELECTION EACH YEAR. THE EMPLOYEE MAY BE GIVEN OPTIONS WITH REGARD TO HEALTH BENEFITS PLANS AND THE TYPE OF MANAGED CARE SYSTEM UNDER WHICH BENEFITS WILL BE PROVIDED.

6-18-208. Violations of article by persons involved with operations of cooperatives - enforcement - penalties. (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES, "RESPONSIBLE PARTY" MEANS A MEMBER OF THE GOVERNING BODY OR AN EXECUTIVE OFFICER OF A COOPERATIVE.

(2) (a) AFTER PROVIDING A HEARING PURSUANT TO ARTICLE 4 OF TITLE 24, C.R.S., THE EXECUTIVE DIRECTOR MAY ENFORCE THE PROVISIONS OF THIS PART 2 BY ISSUING ORDERS DIRECTED TO ANY RESPONSIBLE PARTY, INCLUDING BUT NOT LIMITED TO CEASE AND DESIST ORDERS, AS ARE DEEMED NECESSARY IF THE EXECUTIVE DIRECTOR FINDS THAT:

(I) SUCH PERSON HAS VIOLATED THIS ARTICLE OR ANY LAWFUL REGULATION PROMULGATED THEREUNDER, ENGAGED IN ANY UNSAFE OR UNSOUND PRACTICE IN CONNECTION WITH A COOPERATIVE, ENGAGED IN AN ACT, OMISSION, OR PRACTICE WHICH CONSTITUTES A BREACH OF FIDUCIARY DUTY TO A COOPERATIVE, OR HAS BEEN FOUND LIABLE FOR OR GUILTY OF A CIVIL OR CRIMINAL OFFENSE AFFECTING SUCH PERSON'S QUALIFICATION TO SERVE IN SUCH CAPACITY; OR

(II) (A) THE COOPERATIVE HAS SUFFERED OR APPEARS LIKELY TO SUFFER SUBSTANTIAL FINANCIAL LOSS OR THAT THE INTERESTS OF ITS MEMBERS AND ELIGIBLE EMPLOYEES COULD BE SERIOUSLY PREJUDICED BY REASON OF SUCH VIOLATION, PRACTICE, BREACH OF FIDUCIARY DUTY, OR OFFENSE;

(B) SUCH PERSON HAS RECEIVED FINANCIAL GAIN FROM SUCH VIOLATION, PRACTICE, BREACH OF FIDUCIARY DUTY, OR OFFENSE; OR

(C) SUCH VIOLATION INVOLVES SERIOUS DISHONESTY OR DEMONSTRATES A WILLFUL OR CONTINUING DISREGARD FOR THE SAFETY OR SOUNDNESS OF THE COOPERATIVE.

(b) IN ADDITION, THE EXECUTIVE DIRECTOR MAY IMPOSE A CIVIL PENALTY IN AN AMOUNT UP TO TWENTY-FIVE THOUSAND DOLLARS FOR EACH VIOLATION.

(c) IN ADDITION TO THE PENALTY PROVIDED IN PARAGRAPH (b) OF THIS SUBSECTION (2), IF THE EXECUTIVE DIRECTOR DETERMINES THAT ANY PERSON IS IN VIOLATION OF THE PROVISIONS OF SECTION 6-18-201 (2) (c) OR 6-18-205 (3), THE EXECUTIVE DIRECTOR MAY ORDER THE RESPONSIBLE PARTY SUSPENDED OR REMOVED FROM OFFICE.

(d) IF THE EXECUTIVE DIRECTOR FINDS THAT EXTRAORDINARY CIRCUMSTANCES EXIST WHICH REQUIRE IMMEDIATE ACTION, SUCH ACTION MAY BE TAKEN IMMEDIATELY PURSUANT TO SECTION 24-4-105 (12), C.R.S., BUT A SUBSEQUENT HEARING SHALL PROMPTLY BE AFFORDED UPON APPLICATION TO RESCIND THE ACTION TAKEN.

(e) THE EXECUTIVE DIRECTOR MAY INITIATE INFORMAL ACTIONS TO ENFORCE THIS ARTICLE UNDER THE PROVISIONS OF THIS SECTION, SPECIFICALLY, WRITTEN AGREEMENTS WITH, INFORMAL COMMITMENT LETTERS FROM, OR THE FORWARDING OF A LETTER OF REPRIMAND TO A COOPERATIVE OR RESPONSIBLE PARTY.

(3) ANY PERSON ADVERSELY AFFECTED BY AN ORDER ISSUED PURSUANT TO THIS SECTION MAY, WITHIN TWENTY DAYS AFTER THE DATE OF THE ORDER, APPEAL SUCH ORDER UNDER SECTION 24-4-106 (11), C.R.S. ANY SUCH APPEAL SHALL NOT OPERATE TO STAY OR VACATE A DECISION OR ORDER UNLESS A COURT ISSUES SUCH AN ORDER. THE EXECUTIVE DIRECTOR MAY RECOVER REASONABLE ATTORNEY FEES INCURRED TO ENFORCE THE ORDER.

PART 3
PROVIDER NETWORKS

6-18-301. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT THE RAPIDLY CHANGING HEALTH CARE MARKET PROVIDES UNIQUE OPPORTUNITIES FOR HEALTH CARE PROVIDERS TO ORGANIZE THEMSELVES INTO NEW FORMS OF COLLABORATIVE SYSTEMS TO DELIVER HIGH QUALITY HEALTH CARE AT COMPETITIVE MARKET PRICES TO COOPERATIVES AND OTHER PURCHASERS. THIS PART 3 IS ENACTED TO ENCOURAGE SUCH COLLABORATIVE ARRANGEMENTS AND TO FURTHER MARKET-BASED COMPETITION AMONG HEALTH CARE PROVIDERS.

(2) THE GENERAL ASSEMBLY FURTHER RECOGNIZES THAT IN ORDER TO ACHIEVE THE MOST EFFECTIVE USE OF RESOURCES AND MEDICAL TECHNOLOGY TO RESPOND TO CHANGING MARKET CONDITIONS, PROVIDERS WHO WOULD OTHERWISE BE COMPETITORS WITH EACH OTHER WILL NEED TO HORIZONTALLY INTEGRATE IN ORDER TO DEVELOP COLLABORATIVE ARRANGEMENTS TO GUARANTEE AN ADEQUATE NUMBER OF PROVIDERS TO SERVICE THE MARKET AND TO VERTICALLY INTEGRATE IN ORDER TO GUARANTEE THAT THOSE WHO RECEIVE SERVICES WILL HAVE A CONTINUUM OF CARE AS APPROPRIATE TO THEIR CARE NEEDS.

(3) THE GENERAL ASSEMBLY ALSO RECOGNIZES THAT TO EFFECT SUCH NEW FORMS OF COLLABORATIVE SYSTEMS AND INTEGRATION OF PROVIDERS TO SERVICE THE MARKET WILL REQUIRE AN ANALYSIS OF EXISTING METHODS OF PROVIDING SERVICES, CONTRACTING, COLLABORATING, AND NETWORKING AMONG PROVIDERS AND THE EXTENT AND TYPE OF REGULATORY OVERSIGHT OF LICENSED PROVIDER NETWORKS OR LICENSED INDIVIDUAL PROVIDERS WHICH IS APPROPRIATE TO PROTECT THE PUBLIC.

6-18-302. Creation of provider networks. (1) (a) PROVIDERS ARE HEREBY AUTHORIZED TO CONDUCT BUSINESS COLLABORATIVELY AS PROVIDER NETWORKS.

SUCH NETWORKS ARE ENTITIES EXISTING ON OR BEFORE JULY 1, 1994, THAT MEET THE DEFINITION OF A PROVIDER NETWORK OR MAY BE CREATED AS ANY LAWFUL ENTITY UNDER TITLE 7, C.R.S., OR AS OTHERWISE ALLOWED BY LAW. PROVIDER NETWORKS EXISTING ON OR BEFORE JULY 1, 1994, AND PROVIDER NETWORKS CREATED ON AND AFTER JULY 1, 1994, CONDUCTING BUSINESS PURSUANT TO THIS PART 3, IN ADDITION TO THE MATTERS OTHERWISE REQUIRED, SHALL BE SUBJECT TO THIS ARTICLE.

(b) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH (b), IF A PROVIDER NETWORK OR INDIVIDUAL PROVIDER ORGANIZED ON OR AFTER JULY 1, 1994, OR ORGANIZED PRIOR TO SAID DATE, PROPOSES OR IS ENGAGED IN THE TRANSACTION OF INSURANCE BUSINESS, AS DEFINED IN SECTION 10-3-903, C.R.S., OR THE ACTIVITIES OF A HEALTH MAINTENANCE ORGANIZATION AS DEFINED IN SECTION 10-16-102 (8), C.R.S., SUCH PROVIDER NETWORK OR INDIVIDUAL PROVIDER MUST HOLD A CERTIFICATE OF AUTHORITY FROM THE COMMISSIONER OF INSURANCE TO DO BUSINESS AS AN INSURANCE COMPANY UNDER TITLE 10, C.R.S., OR TO ESTABLISH A HEALTH MAINTENANCE ORGANIZATION UNDER SECTION 10-16-402, C.R.S.

(II) THE FACT THAT A PROVIDER NETWORK OR INDIVIDUAL PROVIDER HAS A CAPITATED CONTRACT OR OTHER AGREEMENT WITH A CARRIER, PURSUANT TO WHICH THE PROVIDER NETWORK OR INDIVIDUAL PROVIDER SHARES SOME OF THE RISK OF PROVIDING SERVICES TO GROUPS OR INDIVIDUALS COVERED UNDER A HEALTH CARE COVERAGE PLAN ISSUED BY A CARRIER, SHALL NOT, IN AND OF ITSELF, BE GROUNDS FOR A DETERMINATION BY THE COMMISSIONER OF INSURANCE THAT THE PROVIDER NETWORK OR INDIVIDUAL PROVIDER IS ENGAGED IN THE TRANSACTION OF INSURANCE BUSINESS, SO LONG AS AN OFFICER OF THE PROVIDER NETWORK OR INDIVIDUAL PROVIDER ANNUALLY FILES A STATEMENT CERTIFYING THAT THE NETWORK OR PROVIDER IS NOT ENGAGED IN THE TRANSACTION OF INSURANCE BUSINESS, AS DEFINED IN SECTION 10-3-903, C.R.S.

(III) THE COMMISSIONER OF INSURANCE IN CONSULTATION WITH PROVIDERS AND OTHER APPROPRIATE PERSONS SHALL EVALUATE THE NEED FOR SPECIFIC LEGISLATION OR REGULATIONS FOR THE LICENSURE OF PROVIDER NETWORKS AND INDIVIDUAL PROVIDERS AND, IF DETERMINED APPROPRIATE, SHALL MAKE RECOMMENDATIONS THEREON TO THE GENERAL ASSEMBLY AND GOVERNOR AND SHALL ADOPT SUCH REGULATIONS THAT ARE SPECIFIC TO LICENSED PROVIDER NETWORKS AND LICENSED INDIVIDUAL PROVIDERS AS PROVIDED IN SECTION 10-1-108 (16), C.R.S. A LICENSED PROVIDER NETWORK OR LICENSED INDIVIDUAL PROVIDER SHALL BE SUBJECT TO APPLICABLE PROVISIONS OF TITLE 10, C.R.S., EXCEPT AS OTHERWISE PROVIDED IN STATUTE OR REGULATION ADOPTED PURSUANT TO THE SAID SECTION 10-1-108 (16), C.R.S.

(2) IF APPLICABLE, A NETWORK ORGANIZED ON AND AFTER JULY 1, 1994, IS ORGANIZED WHEN THE ARTICLES OF ORGANIZATION ARE FILED BY THE SECRETARY OF STATE OR, IF A DELAYED EFFECTIVE DATE IS SPECIFIED IN THE ARTICLES AS FILED WITH THE SECRETARY OF STATE AND A CERTIFICATE OF WITHDRAWAL IS NOT FILED, ON SUCH DELAYED EFFECTIVE DATE. THE EXISTENCE OF THE NETWORK BEGINS UPON ORGANIZATION.

(3) IF APPLICABLE, EACH PROVIDER NETWORK SHALL FILE A REPORT PURSUANT TO SECTIONS 7-28-101 AND 7-28-102, C.R.S., AND PAY A FEE TO THE SECRETARY OF STATE WHICH SHALL BE DETERMINED AND COLLECTED PURSUANT TO SECTION

24-21-104 (3), C.R.S., IN LIEU OF ALL FRANCHISE OR CORPORATION LICENSE TAXES.

(4) A PROVIDER NETWORK OR INDIVIDUAL PROVIDER MAY REQUEST THAT SPECIFIED INFORMATION SUBMITTED TO THE DIVISION OF INSURANCE BE KEPT CONFIDENTIAL BECAUSE IT IS A TRADE SECRET AS DEFINED IN SECTION 7-74-102 (4). THE DIVISION SHALL HONOR SUCH REQUEST UNLESS THE COMMISSIONER DETERMINES THAT THE INFORMATION IS ALREADY PUBLIC KNOWLEDGE OR THAT ITS CONFIDENTIALITY WOULD BE CONTRARY TO THE PUBLIC INTEREST OR THE PROVIDER SUBSEQUENTLY AUTHORIZED THE COMMISSIONER TO RELEASE SUCH INFORMATION.

6-18-303. Effect on scope of practice - limited exception to prohibitions on corporate practice of licensed health care providers. (1) EXCEPT AS PROVIDED IN SUBSECTION (2) OF THIS SECTION, THE FACT THAT AN ENTITY OR PROVIDER IS A MEMBER OF A PROVIDER NETWORK SHALL NOT EXEMPT SUCH ENTITY OR PROVIDER FROM ANY LICENSURE OR REGULATORY STATUTE, NOR SHALL ANY SCOPE OF PRACTICE OF ANY PROVIDER BE EXPANDED, REDUCED, OR OTHERWISE MODIFIED BY VIRTUE OF MEMBERSHIP IN OR AFFILIATION WITH ANY PROVIDER NETWORK.

(2) ANY PROVISION OF ARTICLE 29.5, 32, OR 33 OF TITLE 12, C.R.S., OR ANY OF THE PROVISIONS OF ARTICLES 35, 36, AND 38 TO 43 OF TITLE 12, C.R.S., PROHIBITING THE PRACTICE OF ANY LICENSED OR CERTIFICATED HEALTH CARE PROFESSION AS THE PARTNER, AGENT, OR EMPLOYEE OF OR IN JOINT VENTURE WITH A PERSON WHO DOES NOT HOLD A LICENSE OR CERTIFICATE TO PRACTICE SUCH PROFESSION WITHIN THIS STATE SHALL NOT APPLY TO PROFESSIONAL PRACTICE IF A PROFESSIONAL IS PARTICIPATING IN A PROVIDER NETWORK ORGANIZED PURSUANT TO THIS PART 3 AND:

(a) THE PARTNERSHIP, AGENCY, EMPLOYMENT, OR JOINT VENTURE IS EVIDENCED BY A WRITTEN AGREEMENT CONTAINING LANGUAGE TO THE EFFECT THAT THE RELATIONSHIP CREATED BY THE AGREEMENT MAY NOT AFFECT THE EXERCISE OF THE LICENSED OR CERTIFIED PROFESSIONAL'S INDEPENDENT JUDGMENT IN THE PRACTICE OF THE PROFESSION;

(b) THE LICENSED OR CERTIFICATED PROFESSIONAL'S INDEPENDENT JUDGMENT IN THE PRACTICE OF SUCH PROFESSION IS IN FACT UNAFFECTED BY THE RELATIONSHIP; AND

(c) THE LICENSED PROFESSIONAL IS NOT REQUIRED TO EXCLUSIVELY REFER ANY PATIENT TO A PARTICULAR PROVIDER OR SUPPLIER OR TAKE ANY OTHER ACTION THE LICENSED PROFESSIONAL DETERMINES NOT TO BE IN THE PATIENT'S BEST INTEREST.

6-18-304. Competitive behavior - restraints of trade prohibited. ORGANIZATION OR OPERATION AS A PROVIDER NETWORK IS AUTHORIZED UNDER THIS ARTICLE FOR THE PURPOSE OF MORE COST-EFFECTIVE DELIVERY OF HEALTH CARE SERVICES, AND SHALL NOT BE CONSTRUED AS PERMITTING ANY SUCH COLLABORATIVE SYSTEM OR ANY MEMBER OF SUCH PROVIDER NETWORK TO ACT IN A CONCERTED WAY TO RESTRAIN TRADE OR OTHERWISE ENGAGE IN PRACTICES WHICH ARE OTHERWISE PROHIBITED BY FEDERAL OR STATE ANTITRUST LAW.

PART 4
TECHNICAL ASSISTANCE TO AUTHORIZED COOPERATIVES FROM DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

6-18-401. Technical assistance to authorized cooperatives from department of health care policy and financing. (1) ON AND AFTER JULY 1, 1994, AND UNTIL JULY 1, 1995, THE EXECUTIVE DIRECTOR MAY PROVIDE TECHNICAL ASSISTANCE, WITHIN AVAILABLE GRANTS AND DONATIONS, IN THE FORM OF IN-KIND SERVICES TO COOPERATIVES AUTHORIZED PURSUANT TO THIS ARTICLE. THE EXECUTIVE DIRECTOR SHALL DETERMINE A FORMULA FOR BILLING EACH COOPERATIVE GIVEN TECHNICAL ASSISTANCE PURSUANT TO THIS PART 4 FOR THE MONETARY VALUE OF SUCH SERVICE. A COOPERATIVE SHALL BE REQUIRED TO REPAY THE AMOUNT OF THE MONETARY VALUE OF SERVICE PROVIDED UNDER THIS PART 4 WITHIN THREE YEARS AFTER THE EFFECTIVE DATE OF THE FIRST HEALTH CARE COVERAGE PLAN EXECUTED BY THE COOPERATIVE.

(2) SUBJECT TO AVAILABLE APPROPRIATIONS, THE EXECUTIVE DIRECTOR MAY PROVIDE TECHNICAL ASSISTANCE TO ANY COOPERATIVE THAT:

(a) MAKES COVERAGE AVAILABLE TO EMPLOYER MEMBERS AND COVERED INDIVIDUALS STATEWIDE TO THE EXTENT POSSIBLE;

(b) REQUIRES THAT EMPLOYER MEMBERS NOT SELF-INSURE FOR ANY BENEFITS INCLUDED IN THE COOPERATIVE'S BASIC OR STANDARD HEALTH BENEFIT PLANS;

(c) SETS MAXIMUM EMPLOYER MEMBER CONTRIBUTIONS TO ANY PLAN FOR A COVERED INDIVIDUAL AT AN AMOUNT NOT TO EXCEED ONE HUNDRED PERCENT OF THE COST OF THE LOWEST-PRICED COVERAGE FOR THAT EMPLOYEE'S FAMILY COMPOSITION FOR ANY PARTICULAR PLAN PACKAGE WITH EMPLOYEE MEMBERS PAYING THE DIFFERENCE BETWEEN THE PREMIUM OF THE SELECTED PLAN AND THE EMPLOYER CONTRIBUTION;

(d) ESTABLISHES RULES WHICH SPECIFY THAT EMPLOYER MEMBERS SHALL TAKE NO ACTION TO LIMIT EMPLOYEE MEMBER CHOICES OF PLANS OFFERED THROUGH THE COOPERATIVE OR TO ENCOURAGE OR DISCOURAGE EMPLOYEE MEMBERS FROM MAKING PARTICULAR CHOICES OF PLANS OFFERED THROUGH THE COOPERATIVE;

(e) CONTRACTS WITH AS MANY CARRIERS AS IS ALLOWED BY THE MARKET AND THE COOPERATIVE'S QUALITY, ACCESS, AND INFORMATION REPORTING REQUIREMENTS;

(f) DEVELOPS AND IMPLEMENTS A MARKETING PLAN TO PUBLICIZE THE COOPERATIVE TO POTENTIAL MEMBERS AND DEVELOPS AND IMPLEMENTS METHODS FOR INFORMING THE PUBLIC ABOUT THE COOPERATIVE AND ITS SERVICES;

(g) DEVELOPS SPECIFIC PLANS TO EXPAND HEALTH CARE COVERAGE AND TO EXPAND ACCESS TO HEALTH CARE IN THIS STATE; AND

(h) GIVES EACH COVERED INDIVIDUAL THE OPPORTUNITY TO CHOOSE AMONG CARRIERS THAT CONTRACT WITH THE COOPERATIVE.

SECTION 2. 24-32-2712, Colorado Revised Statutes, 1988 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

24-32-2712. Immunity - notice requirements. (7) NOTHING IN THIS ARTICLE SHALL BE CONSTRUED TO EXEMPT A LICENSED PROVIDER NETWORK, AS DEFINED IN

SECTION 6-18-102 (11), C.R.S., FROM REGULATION BY THE COMMISSIONER OF INSURANCE AS REQUIRED BY PART 3 OF ARTICLE 18 OF TITLE 6, C.R.S., NOTWITHSTANDING THE FACT THAT SUCH A PROVIDER NETWORK MAY OPERATE COMPLETELY OR ENTIRELY UNDER AN APPROVED COLLABORATIVE AGREEMENT IN ACCORDANCE WITH THE PROVISIONS OF THIS ARTICLE.

SECTION 3. Part 1 of article 1 of title 25.5, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-1-109. Department of health care policy and financing cash fund. ALL MONEYS COLLECTED BY THE STATE DEPARTMENT AS FEES OR OTHERWISE SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING CASH FUND, WHICH FUND IS HEREBY CREATED IN THE STATE TREASURY. MONEYS IN THE FUND SHALL BE SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE DIRECT AND INDIRECT COSTS OF THE STATE DEPARTMENT'S DUTIES AS PROVIDED BY LAW.

SECTION 4. Article 1 of title 25.5, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PART to read:

PART 4
HEALTH CARE COVERAGE COOPERATIVE RULE-MAKING AUTHORITY

25.5-1-401. Health care coverage cooperatives - rule-making authority. THE EXECUTIVE DIRECTOR MAY PROMULGATE RULES AND REGULATIONS CONSISTENT WITH THE PROVISIONS OF SECTIONS 6-18-204, 6-18-206, AND 6-18-207, C.R.S., FOR PURPOSES OF CARRYING OUT THE EXECUTIVE DIRECTOR'S DUTIES UNDER SAID SECTIONS. THE EXECUTIVE DIRECTOR MAY PROMULGATE RULES AND REGULATIONS TO CARRY OUT THE EXECUTIVE DIRECTOR'S DUTIES UNDER SECTION 6-18-202, C.R.S., SO LONG AS SUCH RULES AND REGULATIONS ADD NO ADDITIONAL REQUIREMENTS OTHER THAN THOSE SPECIFICALLY ENUMERATED IN SAID SECTION 6-18-202, C.R.S.

SECTION 5. 6-4-108, Colorado Revised Statutes, 1992 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

6-4-108. Exemptions. (6) NOTHING IN THIS ARTICLE SHALL PROHIBIT OR BE CONSTRUED TO PROHIBIT THE FORMATION AND OPERATION OF HEALTH CARE COVERAGE COOPERATIVES OR PROVIDER NETWORKS PURSUANT TO ARTICLE 18 OF THIS TITLE.

SECTION 6. 10-1-108, Colorado Revised Statutes, 1987 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-1-108. Duties of commissioner - reports - publications - disposition of funds. (16) (a) IF DETERMINED APPROPRIATE FOR PURPOSES OF LICENSURE OF PROVIDER NETWORKS AND INDIVIDUAL PROVIDERS AS PROVIDED IN SECTION 6-18-302 (1) (b), C.R.S., THE COMMISSIONER MAY ADOPT RULES AND REGULATIONS AFTER CONSULTATION WITH PROVIDERS AND OTHER APPROPRIATE PERSONS THAT SET FORTH STANDARDS OR REQUIREMENTS SPECIFIC TO LICENSED PROVIDER NETWORKS OR

LICENSED INDIVIDUAL PROVIDERS CONCERNING SOLVENCY AND OPERATIONAL CAPACITY OR THE PERFORMANCE OF SERVICES CONSISTENT WITH THE EXTENT OF RISK BEING ACCEPTED BY THE LICENSED PROVIDER NETWORK OR LICENSED INDIVIDUAL PROVIDER.

(b) IN DETERMINING THE NEED FOR AND THE CONTENT OF SUCH REGULATIONS, THE COMMISSIONER SHALL TAKE INTO CONSIDERATION:

(I) THE DIFFERENCES BETWEEN LICENSED PROVIDER NETWORKS OR LICENSED INDIVIDUAL PROVIDERS AND THE TYPE, AMOUNT, AND EXTENT OF RISK THEY ACCEPT AND SERVICES THEY PROVIDE AS COMPARED WITH THAT ACCEPTED BY TRADITIONAL SICKNESS AND ACCIDENT INSURERS, NONPROFIT HOSPITAL, MEDICAL-SURGICAL, AND HEALTH SERVICE CORPORATIONS, AND HEALTH MAINTENANCE ORGANIZATIONS;

(II) THE TYPES OF INFORMATION THE COMMISSIONER WOULD NEED TO ASSESS A PROVIDER NETWORK OR INDIVIDUAL PROVIDER'S ABILITY TO ACCEPT AND MANAGE RISK AND MONITOR MATERIAL CHANGES IN THE FINANCIAL SOLVENCY OR OPERATIONAL CAPABILITIES OF A PROVIDER NETWORK OR INDIVIDUAL PROVIDER;

(III) THE NEED TO PROTECT CONSUMERS, MONITOR THE FINANCIAL SOLVENCY OF LICENSED PROVIDER NETWORKS AND LICENSED INDIVIDUAL PROVIDERS, AND ASSURE THE PROVISION OF SERVICES TO CONSUMERS, INCLUDING REASONABLE ACCESS TO COVERAGE, ACCORDING TO CONTRACTUAL OBLIGATIONS; AND

(IV) WHETHER SUCH RULES WOULD GIVE A LICENSED PROVIDER NETWORK OR LICENSED INDIVIDUAL PROVIDER AN UNREASONABLE COMPETITIVE ADVANTAGE OR DISADVANTAGE AS COMPARED TO TRADITIONAL INSURERS, NONPROFIT HOSPITAL, MEDICAL-SURGICAL, AND HEALTH SERVICE CORPORATIONS, AND HEALTH MAINTENANCE ORGANIZATIONS OFFERING SIMILAR PRODUCTS UNDER SIMILAR CIRCUMSTANCES.

(c) THE COMMISSIONER MAY ALSO CONSIDER WHETHER RATES ARE EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY.

(d) THE COMMISSIONER SHALL MAKE A RECOMMENDATION TO THE GENERAL ASSEMBLY AND THE GOVERNOR ON OR BEFORE JULY 1, 1995, CONCERNING THE NEED, IF ANY, FOR CHANGES IN LEGISLATION CONCERNING THE REGULATION OF LICENSED PROVIDER NETWORKS OR LICENSED INDIVIDUAL PROVIDERS, INCLUDING LIMITED SERVICE PROVIDERS.

(e) THE COMMISSIONER MAY ESTABLISH A FEE TO COVER THE DIRECT AND INDIRECT COSTS OF THE REGULATION OF PROVIDER NETWORKS PURSUANT TO THE PROVISIONS OF THIS SUBSECTION (16) AND PART 3 OF ARTICLE 18 OF TITLE 6, C.R.S.

SECTION 7. Appropriations. (1) In addition to any other appropriation, there is hereby appropriated, out of any moneys in the department of health care policy and financing cash fund not otherwise appropriated, to the department of health care policy and financing, for the fiscal year beginning July 1, 1994, the sum of sixty-one thousand dollars ($61,000) and 0.2 FTE, or so much thereof as may be necessary, for the implementation of this act.

(2) In addition to any other appropriation, there is hereby appropriated, out of any

moneys in the division of insurance cash fund not otherwise appropriated, to the department of regulatory agencies, for allocation to the division of insurance, for the fiscal year beginning July 1, 1994, the sum of thirty-five thousand five hundred eleven dollars ($35,511) and 0.8 FTE, or so much thereof as may be necessary, for the implementation of this act.

SECTION 8. Effective date. This act shall take effect July 1, 1994.

SECTION 9. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: June 2, 1994