CHAPTER 238

INSURANCE

HOUSE BILL 97-1122

BY REPRESENTATIVES Morrison, Tool, Gordon, Kaufman, Schwarz, Grossman, Lawrence, Leyba, Udall, and Veiga; also SENATORS Hopper and Weddig.

AN ACT

CONCERNING CONSUMER PROTECTION STANDARDS FOR THE OPERATION OF MANAGED CARE PLANS.

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

SECTION 1. 10-16-102, Colorado Revised Statutes, 1994 Repl. Vol., as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS to read:

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

(27.5) "NETWORK" MEANS A GROUP OF PARTICIPATING PROVIDERS PROVIDING SERVICES TO A MANAGED CARE PLAN. FOR THE PURPOSES OF PART 7 OF THIS ARTICLE, ANY SUBDIVISION OR SUBGROUPING OF A NETWORK IS CONSIDERED A NETWORK IF COVERED INDIVIDUALS ARE RESTRICTED TO THE SUBDIVISION OR SUBGROUPING FOR COVERED BENEFITS UNDER THE MANAGED CARE PLAN.

(28.5) "PARTICIPATING PROVIDER" MEANS A PROVIDER THAT, UNDER A CONTRACT WITH A CARRIER OR WITH ITS CONTRACTOR OR SUBCONTRACTOR, HAS AGREED TO PROVIDE HEALTH CARE SERVICES TO COVERED PERSONS WITH AN EXPECTATION OF RECEIVING PAYMENT, OTHER THAN COINSURANCE, COPAYMENTS, OR DEDUCTIBLES, DIRECTLY OR INDIRECTLY FROM THE CARRIER.

SECTION 2. Article 16 of title 10, Colorado Revised Statutes, 1994 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PART to read:

PART 7
CONSUMER PROTECTION STANDARDS ACT FOR THE OPERATION OF MANAGED CARE PLANS

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

10-16-701. Short title. THIS PART 7 SHALL BE KNOWN AND MAY BE CITED AS THE "CONSUMER PROTECTION STANDARDS ACT FOR THE OPERATION OF MANAGED CARE PLANS".

10-16-702. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT THE PURPOSES OF THIS PART 7 ARE:

(a) TO INCORPORATE CONSUMER PROTECTIONS IN THE CREATION AND MAINTENANCE OF PROVIDER NETWORKS BY CARRIERS;

(b) TO ESTABLISH STANDARDS TO ASSURE THE ADEQUACY, ACCESSIBILITY, AND QUALITY OF HEALTH CARE SERVICES OFFERED UNDER A MANAGED CARE PLAN; AND

(c) TO ESTABLISH REQUIREMENTS FOR WRITTEN AGREEMENTS BETWEEN CARRIERS OFFERING MANAGED CARE PLANS AND PARTICIPATING PROVIDERS REGARDING THE STANDARDS, TERMS, AND PROVISIONS UNDER WHICH THE PARTICIPATING PROVIDER WILL PROVIDE SERVICES TO COVERED PERSONS.

10-16-703. Applicability. THIS PART 7 APPLIES TO ALL MANAGED CARE PLANS, EXCEPT FOR WORKERS' COMPENSATION AND AUTOMOBILE INSURANCE CONTRACTS, THAT ARE ISSUED, RENEWED, EXTENDED, OR MODIFIED ON OR AFTER JANUARY 1, 1998.

10-16-704. Network adequacy. (1) A CARRIER PROVIDING A MANAGED CARE PLAN SHALL MAINTAIN A NETWORK THAT IS SUFFICIENT IN NUMBERS AND TYPES OF PROVIDERS TO ASSURE THAT ALL COVERED BENEFITS TO COVERED PERSONS WILL BE ACCESSIBLE WITHOUT UNREASONABLE DELAY. IN THE CASE OF EMERGENCY SERVICES, COVERED PERSONS SHALL HAVE ACCESS TO HEALTH CARE SERVICES TWENTY-FOUR HOURS PER DAY, SEVEN DAYS PER WEEK. SUFFICIENCY SHALL BE DETERMINED IN ACCORDANCE WITH THE REQUIREMENTS OF THIS SECTION AND MAY BE ESTABLISHED BY REFERENCE TO ANY REASONABLE CRITERIA USED BY THE CARRIER, INCLUDING BUT NOT LIMITED TO:

(a) PROVIDER-COVERED PERSON RATIOS BY SPECIALTY;

(b) PRIMARY CARE PROVIDER-COVERED PERSON RATIOS;

(c) GEOGRAPHIC ACCESSIBILITY;

(d) WAITING TIMES FOR APPOINTMENTS WITH PARTICIPATING PROVIDERS;

(e) HOURS OF OPERATION; AND

(f) THE VOLUME OF TECHNOLOGICAL AND SPECIALTY SERVICES AVAILABLE TO SERVE THE NEEDS OF COVERED PERSONS REQUIRING COVERED TECHNOLOGICALLY ADVANCED OR SPECIALTY CARE.

(2) IN ANY CASE WHERE THE CARRIER HAS NO PARTICIPATING PROVIDERS TO PROVIDE A COVERED BENEFIT, THE CARRIER SHALL ARRANGE FOR A REFERRAL TO A PROVIDER WITH THE NECESSARY EXPERTISE AND ENSURE THAT THE COVERED PERSON

OBTAINS THE COVERED BENEFIT AT NO GREATER COST TO THE COVERED PERSON THAN IF THE BENEFIT WERE OBTAINED FROM PARTICIPATING PROVIDERS.

(3) WHEN A COVERED PERSON RECEIVES SERVICES OR TREATMENT IN ACCORDANCE WITH PLAN PROVISIONS AT A NETWORK FACILITY, THE BENEFIT LEVEL FOR ALL COVERED SERVICES AND TREATMENT RECEIVED THROUGH THE FACILITY SHALL BE THE IN-NETWORK BENEFIT.

(4) WHEN A TREATMENT OR PROCEDURE HAS BEEN PREAUTHORIZED BY THE PLAN, BENEFITS CANNOT BE RETROSPECTIVELY DENIED EXCEPT FOR FRAUD AND ABUSE. IF A HEALTH CARRIER PROVIDES PREAUTHORIZATION FOR TREATMENT OR PROCEDURES THAT ARE NOT COVERED BENEFITS UNDER THE PLAN, THE CARRIER SHALL PROVIDE THE BENEFITS AS AUTHORIZED WITH NO PENALTY TO THE COVERED PERSON.

(5) A MANAGED CARE PLAN SHALL NOT DENY BENEFITS FOR EMERGENCY SERVICES PREVIOUSLY RENDERED, BASED UPON THE COVERED PERSON'S FAILURE TO PROVIDE SUBSEQUENT NOTIFICATION IN ACCORDANCE WITH PLAN PROVISIONS, WHERE THE COVERED PERSON'S MEDICAL CONDITION PREVENTED TIMELY NOTIFICATION.

(6) THE CARRIER SHALL ESTABLISH AND MAINTAIN ADEQUATE ARRANGEMENTS TO ENSURE REASONABLE PROXIMITY OF PARTICIPATING PROVIDERS TO COVERED PERSONS AND SHALL ONLY MARKET A NETWORK PLAN IN A GEOGRAPHIC AREA WHERE NETWORK PROVIDERS ARE ACCESSIBLE WITHOUT UNREASONABLE DELAY. IN DETERMINING WHETHER A HEALTH CARRIER HAS COMPLIED WITH THIS SUBSECTION (6), CONSIDERATION SHALL BE GIVEN TO THE RELATIVE AVAILABILITY OF HEALTH CARE PROVIDERS IN THE SERVICE AREA UNDER CONSIDERATION.

(7) A CARRIER SHALL MONITOR, ON AN ONGOING BASIS, THE CAPACITY AND LEGAL AUTHORITY OF THE PARTICIPATING PROVIDERS AND FACILITIES WITH WHICH IT CONTRACTS TO FURNISH ALL COVERED BENEFITS TO COVERED PERSONS.

(8) NO MANAGED CARE PLAN SHALL DENY OR RESTRICT IN-NETWORK COVERED BENEFITS TO A COVERED PERSON SOLELY BECAUSE THE COVERED PERSON OBTAINED TREATMENT OUTSIDE THE NETWORK. THIS PROTECTION SHALL BE DISCLOSED IN WRITING TO THE COVERED PERSON. NOTHING IN THIS SUBSECTION (8) SHALL BE CONSTRUED TO REQUIRE A MANAGED CARE PLAN TO PAY FOR ANY BENEFIT OBTAINED OUTSIDE THE PLAN'S NETWORK UNLESS THE CONTRACT OR CERTIFICATE PROVIDES FOR THAT OUT-OF-NETWORK BENEFIT.

(9) BEGINNING JANUARY 1, 1998, A CARRIER SHALL MAINTAIN AND MAKE AVAILABLE UPON REQUEST OF THE COMMISSIONER, THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, OR THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, IN A MANNER AND FORM THAT REFLECTS THE REQUIREMENTS SPECIFIED IN PARAGRAPHS (a) TO (k) OF THIS SUBSECTION (9), AN ACCESS PLAN FOR EACH MANAGED CARE NETWORK THAT THE CARRIER OFFERS IN THIS STATE. THE CARRIER SHALL MAKE THE ACCESS PLANS, ABSENT CONFIDENTIAL INFORMATION AS SPECIFIED IN SECTION 24-72-204 (3), C.R.S., AVAILABLE ON ITS BUSINESS PREMISES AND SHALL PROVIDE THEM TO ANY INTERESTED PARTY UPON REQUEST. IN ADDITION, ALL HEALTH BENEFIT PLANS AND MARKETING MATERIALS SHALL CLEARLY DISCLOSE THE EXISTENCE AND AVAILABILITY OF THE ACCESS PLAN. ALL RIGHTS AND RESPONSIBILITIES OF THE COVERED PERSON UNDER

THE HEALTH BENEFIT PLAN, HOWEVER, SHALL BE INCLUDED IN THE CONTRACT PROVISIONS, REGARDLESS OF WHETHER OR NOT SUCH PROVISIONS ARE ALSO SPECIFIED IN THE ACCESS PLAN. THE CARRIER SHALL PREPARE AN ACCESS PLAN PRIOR TO OFFERING A NEW MANAGED CARE NETWORK AND SHALL UPDATE AN EXISTING ACCESS PLAN WHENEVER THE CARRIER MAKES ANY MATERIAL CHANGE TO AN EXISTING MANAGED CARE NETWORK, BUT NOT LESS THAN ANNUALLY. THE ACCESS PLAN SHALL DESCRIBE OR CONTAIN AT LEAST THE FOLLOWING:

(a) THE CARRIER'S NETWORK, WHICH SHALL DEMONSTRATE THE FOLLOWING:

(I) AN ADEQUATE NUMBER OF ACCESSIBLE ACUTE CARE HOSPITAL SERVICES, WITHIN A REASONABLE DISTANCE OR TRAVEL TIME, OR BOTH;

(II) AN ADEQUATE NUMBER OF ACCESSIBLE PRIMARY CARE PROVIDERS, WITHIN A REASONABLE DISTANCE OR TRAVEL TIME, OR BOTH; AND

(III) AN ADEQUATE NUMBER OF ACCESSIBLE SPECIALISTS AND SUB-SPECIALISTS, WITHIN A REASONABLE DISTANCE OR TRAVEL TIME, OR BOTH;

(b) THE CARRIER'S PROCEDURES FOR MAKING REFERRALS WITHIN AND OUTSIDE ITS NETWORK THAT, AT A MINIMUM, MUST INCLUDE THE FOLLOWING:

(I) A COMPREHENSIVE LISTING, MADE AVAILABLE TO COVERED PERSONS AND PRIMARY CARE PROVIDERS, OF THE PLAN'S NETWORK PARTICIPATING PROVIDERS AND FACILITIES;

(II) A PROVISION THAT REFERRAL OPTIONS CANNOT BE RESTRICTED TO LESS THAN ALL PROVIDERS IN THE NETWORK THAT ARE QUALIFIED TO PROVIDE COVERED SPECIALTY SERVICES;

(III) TIMELY REFERRALS FOR ACCESS TO SPECIALTY CARE;

(IV) A PROCESS FOR EXPEDITING THE REFERRAL PROCESS WHEN INDICATED BY MEDICAL CONDITION;

(V) A PROVISION THAT REFERRALS APPROVED BY THE PLAN CANNOT BE RETROSPECTIVELY DENIED EXCEPT FOR FRAUD OR ABUSE.

(c) THE CARRIER'S PROCESS FOR MONITORING AND ASSURING ON AN ONGOING BASIS THE SUFFICIENCY OF THE NETWORK TO MEET THE HEALTH CARE NEEDS OF POPULATIONS THAT ENROLL IN MANAGED CARE PLANS;

(d) THE CARRIER'S QUALITY ASSURANCE STANDARDS, ADEQUATE TO IDENTIFY, EVALUATE, AND REMEDY PROBLEMS RELATING TO ACCESS, CONTINUITY, AND QUALITY OF CARE;

(e) THE CARRIER'S EFFORTS TO ADDRESS THE NEEDS OF COVERED PERSONS WITH LIMITED ENGLISH PROFICIENCY AND ILLITERACY, WITH DIVERSE CULTURAL AND ETHNIC BACKGROUNDS, AND WITH PHYSICAL AND MENTAL DISABILITIES;

(f) THE CARRIER'S METHODS FOR DETERMINING THE HEALTH CARE NEEDS OF COVERED PERSONS, TRACKING AND ASSESSING CLINICAL OUTCOMES FROM NETWORK SERVICES, AND EVALUATING CONSUMER SATISFACTION WITH SERVICES PROVIDED;

(g) THE CARRIER'S METHOD FOR INFORMING COVERED PERSONS OF THE PLAN'S SERVICES AND FEATURES, INCLUDING BUT NOT LIMITED TO THE FOLLOWING:

(I) THE PLAN'S GRIEVANCE PROCEDURES, WHICH SHALL BE IN CONFORMANCE WITH DIVISION RULES CONCERNING PROMPT INVESTIGATION OF HEALTH CLAIMS INVOLVING UTILIZATION REVIEW AND GRIEVANCE PROCEDURES;

(II) THE EXTENT TO WHICH SPECIALTY MEDICAL SERVICES, INCLUDING PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND REHABILITATION SERVICES ARE AVAILABLE;

(III) THE PLAN'S PROCESS FOR CHOOSING AND CHANGING NETWORK PROVIDERS; AND

(IV) THE PLAN'S PROCEDURES FOR PROVIDING AND APPROVING EMERGENCY AND MEDICAL CARE;

(h) THE CARRIER'S SYSTEM FOR ENSURING THE COORDINATION AND CONTINUITY OF CARE FOR COVERED PERSONS REFERRED TO SPECIALTY PROVIDERS;

(i) THE CARRIER'S PROCESS FOR ENABLING COVERED PERSONS TO CHANGE PRIMARY CARE PROFESSIONALS;

(j) THE CARRIER'S PROPOSED PLAN FOR PROVIDING CONTINUITY OF CARE IN THE EVENT OF CONTRACT TERMINATION BETWEEN THE CARRIER AND ANY OF ITS PARTICIPATING PROVIDERS OR IN THE EVENT OF THE CARRIER'S INSOLVENCY OR OTHER INABILITY TO CONTINUE OPERATIONS. THE DESCRIPTION SHALL EXPLAIN HOW COVERED PERSONS WILL BE NOTIFIED OF THE CONTRACT TERMINATION OR THE CARRIER'S INSOLVENCY OR OTHER CESSATION OF OPERATIONS AND TRANSFERRED TO OTHER PROVIDERS IN A TIMELY MANNER; AND

(k) ANY OTHER INFORMATION REQUIRED BY THE COMMISSIONER TO DETERMINE COMPLIANCE WITH THE PROVISIONS OF THIS PART 7.

10-16-705. Requirements for carriers and participating providers. (1) IN ADDITION TO ANY OTHER APPLICABLE REQUIREMENTS OF THIS PART 7, A CARRIER OFFERING A MANAGED CARE PLAN SHALL SATISFY ALL THE REQUIREMENTS OF THIS SECTION.

(2) A CARRIER SHALL MAINTAIN A MECHANISM BY WHICH PROVIDERS CAN ACCESS INFORMATION ON THE COVERED HEALTH SERVICES FOR WHICH THE PROVIDER IS RESPONSIBLE, INCLUDING ANY LIMITATIONS OR CONDITIONS ON SERVICES.

(3) EVERY CONTRACT BETWEEN A CARRIER AND A PARTICIPATING PROVIDER SHALL SET FORTH A HOLD HARMLESS PROVISION SPECIFYING THAT COVERED PERSONS SHALL, IN NO CIRCUMSTANCES, BE LIABLE FOR MONEY OWED TO PARTICIPATING PROVIDERS BY THE PLAN AND THAT IN NO EVENT SHALL A PARTICIPATING PROVIDER COLLECT OR ATTEMPT TO COLLECT FROM A COVERED PERSON ANY MONEY OWED TO THE PROVIDER

BY THE CARRIER. NOTHING IN THIS SECTION SHALL PROHIBIT A PARTICIPATING PROVIDER FROM COLLECTING COINSURANCE, DEDUCTIBLES, OR COPAYMENTS AS SPECIFICALLY PROVIDED IN THE COVERED PERSON'S CONTRACT WITH THE MANAGED CARE PLAN.

(4) (a) EVERY CONTRACT BETWEEN A CARRIER AND A PARTICIPATING PROVIDER SHALL INCLUDE PROVISIONS FOR CONTINUITY OF CARE AS SPECIFIED IN THIS SUBSECTION (4).

(b) EACH MANAGED CARE PLAN SHALL ALLOW COVERED PERSONS TO CONTINUE RECEIVING CARE FOR SIXTY DAYS FROM THE DATE A PARTICIPATING PROVIDER IS TERMINATED BY THE PLAN WITHOUT CAUSE WHEN PROPER NOTICE AS SPECIFIED IN SUBSECTION (7) OF THIS SECTION HAS NOT BEEN PROVIDED TO THE COVERED PERSON.

(c) IN THE CIRCUMSTANCE THAT COVERAGE IS TERMINATED FOR ANY REASON OTHER THAN NONPAYMENT OF THE PREMIUM, FRAUD, OR ABUSE, EVERY MANAGED CARE PLAN SHALL PROVIDE FOR CONTINUED CARE FOR COVERED PERSONS BEING TREATED AT AN IN-PATIENT FACILITY UNTIL THE PATIENT IS DISCHARGED.

(5) (a) EXCEPT AS PROVIDED FOR IN PARAGRAPH (b) OF THIS SUBSECTION (5), NOTWITHSTANDING ANY CONTRACTUAL PROVISION TO THE CONTRARY, A CARRIER THAT HAS ENTERED INTO CONTRACTS WITH ONE OR MORE CONTRACTORS OR SUBCONTRACTORS OR THEIR INTERMEDIARIES TO PROVIDE COVERED HEALTH CARE SERVICES TO COVERED PERSONS OF THE CARRIER UNDER ANY MANAGED CARE PLAN SHALL, IN THE EVENT OF NONPAYMENT BY, OR INSOLVENCY OF, SUCH CONTRACTORS OR SUBCONTRACTORS OR THEIR INTERMEDIARIES, REMAIN RESPONSIBLE FOR THE PAYMENT OF ALL PARTICIPATING PROVIDERS THAT HAVE PROVIDED COVERED HEALTH CARE SERVICES TO COVERED PERSONS OF THE CARRIER PURSUANT TO ONE OR MORE CONTRACTS WITH SUCH CONTRACTORS OR SUBCONTRACTORS OR THEIR INTERMEDIARIES. ANY CONTRACTING PROVIDER THAT PROVIDES COVERED HEALTH CARE SERVICES TO COVERED PERSONS OF THE CARRIER UNDER A MANAGED CARE CONTRACT SHALL, IN THE EVENT OF NONPAYMENT FOR SUCH SERVICES, HAVE LEGAL STANDING TO ENFORCE THE MANAGED CARE CONTRACT AGAINST THE CARRIER AND RECEIVE PAYMENT FOR SUCH SERVICES. IN THE EVENT OF THE INSOLVENCY OF A CARRIER, PARTICIPATING PROVIDER CLAIMS FOR UNPAID SERVICES SHALL BE A CLASS 6 CLAIM UNDER SECTION 10-3-541 (1) (f).

(b) A CARRIER MAY APPLY TO THE COMMISSIONER FOR THE USE OF AN ALTERNATIVE MECHANISM TO ENSURE THAT ALL PARTICIPATING PROVIDERS THAT HAVE PROVIDED COVERED HEALTH CARE SERVICES TO COVERED PERSONS OF THE CARRIER PURSUANT TO ONE OR MORE CONTRACTS WITH SUCH CONTRACTORS OR SUBCONTRACTORS OR THEIR INTERMEDIARIES RECEIVE PAYMENT DUE. IF APPROVAL IS GRANTED, SAID CARRIER SHALL BE EXEMPT FROM THE REQUIREMENTS OF PARAGRAPH (a) OF THIS SUBSECTION (5).

(6) A CARRIER SHALL NOTIFY PARTICIPATING PROVIDERS OF THE PROVIDERS' RESPONSIBILITIES WITH RESPECT TO THE CARRIER'S APPLICABLE ADMINISTRATIVE POLICIES AND PROGRAMS, INCLUDING BUT NOT LIMITED TO, PAYMENT TERMS, UTILIZATION REVIEW, QUALITY ASSESSMENT AND IMPROVEMENT PROGRAMS, CREDENTIALING, GRIEVANCE PROCEDURES, DATA REPORTING REQUIREMENTS, CONFIDENTIALITY REQUIREMENTS, AND ANY APPLICABLE FEDERAL OR STATE

PROGRAMS.

(7) A CARRIER AND PARTICIPATING PROVIDER SHALL PROVIDE AT LEAST SIXTY DAYS WRITTEN NOTICE TO EACH OTHER BEFORE TERMINATING THE CONTRACT WITHOUT CAUSE. THE CARRIER SHALL MAKE A GOOD FAITH EFFORT TO PROVIDE WRITTEN NOTICE OF TERMINATION WITHIN FIFTEEN WORKING DAYS AFTER RECEIPT OF OR ISSUANCE OF A NOTICE OF TERMINATION TO ALL COVERED PERSONS THAT ARE PATIENTS SEEN ON A REGULAR BASIS BY THE PROVIDER WHOSE CONTRACT IS TERMINATING, REGARDLESS OF WHETHER THE TERMINATION WAS FOR CAUSE OR WITHOUT CAUSE. WHERE A CONTRACT TERMINATION INVOLVES A PRIMARY CARE PROVIDER, ALL COVERED PERSONS THAT ARE PATIENTS OF THAT PRIMARY CARE PROVIDER SHALL ALSO BE NOTIFIED. WITHIN FIVE WORKING DAYS AFTER THE DATE THAT THE PROVIDER EITHER GIVES OR RECEIVES NOTICE OF TERMINATION, THE PROVIDER SHALL SUPPLY THE CARRIER WITH A LIST OF THOSE PATIENTS OF THE PROVIDER THAT ARE COVERED BY A PLAN OF THE CARRIER.

(8) THE RIGHTS AND RESPONSIBILITIES UNDER A CONTRACT BETWEEN A CARRIER AND A PARTICIPATING PROVIDER SHALL NOT BE ASSIGNED OR DELEGATED BY THE PROVIDER WITHOUT THE PRIOR WRITTEN CONSENT OF THE CARRIER, AND ANY SUBCONTRACTS SHALL COMPLY WITH THE REQUIREMENTS OF THIS PART 7.

(9) A CARRIER'S CONTRACT WITH PARTICIPATING PROVIDERS SHALL INCLUDE A PROVISION THAT PARTICIPATING PROVIDERS DO NOT DISCRIMINATE, WITH RESPECT TO THE PROVISION OF MEDICALLY NECESSARY COVERED BENEFITS, AGAINST COVERED PERSONS THAT ARE PARTICIPANTS IN A PUBLICLY FINANCED PROGRAM.

(10) A CARRIER SHALL NOTIFY THE PARTICIPATING PROVIDERS OF THEIR OBLIGATIONS, IF ANY, TO COLLECT APPLICABLE COINSURANCE, COPAYMENTS, OR DEDUCTIBLES FROM COVERED PERSONS PURSUANT TO THE EVIDENCE OF COVERAGE OR OF THE PROVIDERS' OBLIGATIONS, IF ANY, TO NOTIFY COVERED PERSONS OF THEIR PERSONAL FINANCIAL OBLIGATIONS FOR NONCOVERED SERVICES.

(11) A CARRIER SHALL NOT PENALIZE A PROVIDER BECAUSE THE PARTICIPATING PROVIDER, IN GOOD FAITH, REPORTS TO STATE OR FEDERAL AUTHORITIES ANY ACT OR PRACTICE BY THE CARRIER THAT JEOPARDIZES PATIENT HEALTH OR WELFARE, OR BECAUSE THE PARTICIPATING PROVIDER DISCUSSES THE FINANCIAL INCENTIVES OR FINANCIAL ARRANGEMENTS BETWEEN THE PROVIDER AND THE MANAGED CARE PLAN.

(12) A CARRIER SHALL ESTABLISH A MECHANISM BY WHICH THE PARTICIPATING PROVIDERS MAY DETERMINE, AT THE TIME SERVICES ARE PROVIDED, WHETHER OR NOT A PERSON IS COVERED BY THE CARRIER.

(13) A CARRIER SHALL ESTABLISH PROCEDURES FOR RESOLUTION OF ADMINISTRATIVE, PAYMENT, OR OTHER DISPUTES BETWEEN PROVIDERS AND THE CARRIER.

(14) EVERY CONTRACT BETWEEN A CARRIER AND A PARTICIPATING PROVIDER FOR A MANAGED CARE PLAN THAT REQUIRES PREAUTHORIZATION FOR PARTICULAR SERVICES, TREATMENTS, OR PROCEDURES SHALL INCLUDE A PROVISION THAT CLEARLY STATES THAT THE SOLE RESPONSIBILITY FOR OBTAINING ANY NECESSARY PREAUTHORIZATION RESTS WITH THE PARTICIPATING PROVIDER THAT RECOMMENDS

OR ORDERS SAID SERVICES, TREATMENTS, OR PROCEDURES, NOT WITH THE COVERED PERSON.

(15) A CONTRACT BETWEEN A CARRIER AND A PARTICIPATING PROVIDER SHALL NOT CONTAIN DEFINITIONS OR OTHER PROVISIONS THAT CONFLICT WITH THE DEFINITIONS OR PROVISIONS CONTAINED IN THE MANAGED CARE PLAN OR THIS PART 7.

10-16-706. Intermediaries. (1) IN ADDITION TO ANY OTHER APPLICABLE REQUIREMENTS OF THIS PART 7, A CONTRACT BETWEEN A CARRIER AND AN INTERMEDIARY SHALL SATISFY ALL THE REQUIREMENTS OF THIS SECTION.

(2) INTERMEDIARIES AND PARTICIPATING PROVIDERS WITH WHOM THEY CONTRACT SHALL COMPLY WITH ALL THE APPLICABLE REQUIREMENTS OF SECTION 10-16-705.

(3) THE RESPONSIBILITY TO ENSURE THAT PARTICIPATING PROVIDERS HAVE THE CAPACITY AND LEGAL AUTHORITY TO FURNISH COVERED BENEFITS SHALL BE RETAINED BY THE CARRIER.

(4) A CARRIER SHALL HAVE THE RIGHT TO APPROVE OR DISAPPROVE PARTICIPATION STATUS OF A SUBCONTRACTED PROVIDER IN ITS OWN OR A CONTRACTED NETWORK FOR THE PURPOSE OF DELIVERING COVERED BENEFITS TO THE CARRIER'S COVERED PERSONS.

(5) A CARRIER SHALL MAINTAIN COPIES OF ALL INTERMEDIARY HEALTH CARE SUBCONTRACTS.

(6) IF APPLICABLE, AN INTERMEDIARY SHALL TRANSMIT UTILIZATION DOCUMENTATION AND CLAIMS PAID DOCUMENTATION TO THE CARRIER. THE CARRIER SHALL MONITOR THE TIMELINESS AND APPROPRIATENESS OF PAYMENTS MADE TO PARTICIPATING PROVIDERS AND HEALTH CARE SERVICES RECEIVED BY COVERED PERSONS.

(7) IF APPLICABLE, AN INTERMEDIARY SHALL MAINTAIN BOOKS, RECORDS, FINANCIAL INFORMATION, AND DOCUMENTATION OF SERVICES PROVIDED TO COVERED PERSONS AT THE INTERMEDIARY'S PLACE OF BUSINESS IN THIS STATE.

(8) AN INTERMEDIARY SHALL ALLOW THE COMMISSIONER ACCESS TO THE INTERMEDIARY'S BOOKS, RECORDS, FINANCIAL INFORMATION, AND ANY DOCUMENTATION OF SERVICES PROVIDED TO COVERED PERSONS AS NECESSARY TO DETERMINE COMPLIANCE WITH THIS PART 7.

(9) A CARRIER SHALL HAVE THE RIGHT, IN THE EVENT OF THE INTERMEDIARY'S INSOLVENCY, TO REQUIRE THE ASSIGNMENT TO THE CARRIER OF THE PROVISIONS OF A PARTICIPATING PROVIDER'S CONTRACT ADDRESSING THE PROVIDER'S OBLIGATION TO FURNISH COVERED SERVICES.

10-16-707. Enforcement. (1) IF IT IS DETERMINED THAT A CARRIER HAS NOT CONTRACTED WITH ENOUGH PARTICIPATING PROVIDERS TO ASSURE THAT COVERED PERSONS HAVE ACCESSIBLE HEALTH CARE SERVICES IN A GEOGRAPHIC AREA, THAT A CARRIER'S ACCESS PLAN DOES NOT ASSURE REASONABLE ACCESS TO COVERED

BENEFITS, THAT A CARRIER HAS ENTERED INTO A CONTRACT THAT DOES NOT COMPLY WITH THIS PART 7, OR THAT A CARRIER HAS NOT COMPLIED WITH A PROVISION OF THIS PART 7, THE COMMISSIONER MAY INSTITUTE A CORRECTIVE ACTION THAT SHALL BE FOLLOWED BY THE CARRIER OR MAY USE ANY OF THE COMMISSIONER'S OTHER ENFORCEMENT POWERS TO OBTAIN THE CARRIER'S COMPLIANCE WITH THIS PART 7.

(2) THE COMMISSIONER SHALL NOT ACT TO ARBITRATE, MEDIATE, OR SETTLE DISPUTES BETWEEN A MANAGED CARE PLAN AND A PROVIDER CONCERNING A PROVIDER'S INCLUSION OR TERMINATION FROM THE NETWORK.

10-16-708. Rule-making authority of commissioner. THE COMMISSIONER MAY PROMULGATE RULES AS NECESSARY FOR CARRYING OUT THE COMMISSIONER'S DUTIES UNDER THIS PART 7.

SECTION 3. 10-16-401 (4), Colorado Revised Statutes, 1994 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

10-16-401. Establishment of health maintenance organizations. (4) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(p) AN ACCESS PLAN FOR EACH SEPARATE NETWORK OF THE HEALTH MAINTENANCE ORGANIZATION AS SPECIFIED IN SECTION 10-16-704 (9). TO THE EXTENT THAT THE INFORMATION IN THE ACCESS PLAN CONTAINS THE REQUIRED INFORMATION SPECIFIED IN PARAGRAPHS (e), (f), (k), (l), (m), AND (n) OF THIS SUBSECTION (4), THE HEALTH MAINTENANCE ORGANIZATION SHALL BE DEEMED TO BE IN COMPLIANCE WITH SAID PARAGRAPHS.

SECTION 4. 10-3-1104 (1), Colorado Revised Statutes, 1994 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

10-3-1104. Unfair methods of competition and unfair or deceptive acts or practices. (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(y) VIOLATING ANY PROVISION OF THE "CONSUMER PROTECTION STANDARDS ACT FOR THE OPERATION OF MANAGED CARE PLANS", PART 7 OF ARTICLE 16 OF THIS TITLE BY THOSE SUBJECT TO SAID PART 7.

SECTION 5. Effective date. This act shall take effect July 1, 1997.

SECTION 6. 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 3, 1997