CHAPTER 269

INSURANCE

HOUSE BILL 04-1177

BY REPRESENTATIVE(S) Spradley, Cloer, Butcher, Coleman, Crane, Fairbank, Frangas, Hoppe, Jahn, Madden, McFadyen, McGihon, Merrifield, Miller, Paccione, Rhodes, Rippy, Romanoff, Salazar, Schultheis, Spence, Stafford, Welker, Williams S., Young, Hall, Hefley, Mitchell, Ragsdale, Rose, Stengel, White, Wiens, and Williams T.;
also SENATOR(S) Hillman, Arnold, Chlouber, Johnson S., Kester, and Teck.

AN ACT

CONCERNING HEALTH INSURANCE, AND, IN CONNECTION THEREWITH, MAKING IT A DECEPTIVE TRADE PRACTICE UNDER THE CONSUMER PROTECTION ACT TO SELL HEALTH DISCOUNT SERVICES WITHOUT CERTAIN DISCLOSURES AND INCREASING INCENTIVES FOR INSURERS TO PROVIDE HEALTH BENEFIT COVERAGE TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

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

SECTION 1. 10-16-107, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-16-107. Rate regulation - approval of policy forms - benefit certificates - evidences of coverage - loss ratio guarantees - disclosures on treatment of intractable pain. (8) ON AND AFTER JANUARY 1, 2005, A CARRIER SHALL NOT REFUSE TO ISSUE OR RENEW A HEALTH BENEFIT PLAN TO AN INDIVIDUAL BASED SOLELY ON THE INDIVIDUAL'S PRIOR DONATION OF A KIDNEY.

SECTION 2. 10-16-902 (1) (b) (III), (3) (a), and (3) (c), Colorado Revised Statutes, are amended to read:

10-16-902. Authority to self-fund - pilot program - rules - fees - cash fund. (1) (b) The commissioner shall determine a description of the necessary contribution and reserve amounts for a MEWA authorized by this part 9. The commissioner shall promulgate rules to ensure the solvency and operation of all self-funded plans subject to this part 9. The commissioner may examine the self-funded plans pursuant to article 3 of this title. The commissioner may not issue a certificate of authority to a self-funded MEWA unless the arrangement establishes to the reasonable satisfaction of the commissioner that the following requirements have been met:

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

(III) The self-funded MEWA shall establish by the end of the first year of its operation and shall maintain at all times reserves equal to at least ~~thirty~~ TWENTY-FIVE percent of the annual expected claims liability of the MEWA. THE COMMISSIONER SHALL EVALUATE EACH SELF-FUNDED MEWA TO DETERMINE WHETHER THE SELF-FUNDED MEWA SHALL BE REQUIRED TO MAINTAIN EXCESS LOSS INSURANCE, AND, IF SO, THE COMMISSIONER MAY DETERMINE THE SPECIFIC AND AGGREGATE EXCESS LOSS INSURANCE AND THE SPECIFIC ATTACHMENT POINT FOR SUCH EXCESS LOSS INSURANCE TO ENSURE ACTUARIAL SOUNDNESS BASED ON THE RESERVES OF, AND THE NUMBER OF INDIVIDUALS ENROLLED IN, THE MEWA AND ANY OTHER MATTER DEEMED APPROPRIATE BY THE COMMISSIONER. IF A SELF-FUNDED MEWA MAINTAINS ADEQUATE EXCESS LOSS INSURANCE AS DETERMINED BY THE COMMISSIONER, THE COMMISSIONER MAY WAIVE A PORTION OF THE RESERVES REQUIRED TO BE MAINTAINED PURSUANT TO THIS SUBPARAGRAPH (III).

(3) (a) ~~Notwithstanding any provision of law to the contrary, any MEWA established pursuant to this part 9 shall be exempt from the small employer premium rating provisions in section 10-16-105 (8)~~ ANY MEWA MAY USE THE FOLLOWING FACTORS CONSISTENT WITH RATING PROVISIONS FOR THE SMALL EMPLOYER CARRIERS FOR THE ESTABLISHMENT OF RATES: AGE, FAMILY COMPOSITION, GEOGRAPHIC LOCATION, HEALTH STATUS, CLAIMS EXPERIENCE, AND STANDARD INDUSTRIAL CODE.

(c) ~~The premium charged by the MEWA shall aggregate the health status of all individuals within the MEWA as a single large group and shall be the same for any employee or dependent of the employee~~ A SELF-FUNDED MEWA OR THE INSURANCE CARRIER FOR A FULLY INSURED MEWA MAY ADJUST PREMIUMS FOR AN INDIVIDUAL EMPLOYER WITHIN THE MEWA BASED ON THE HEALTH STATUS OR AGE OF THE EMPLOYER'S EMPLOYEES AND THEIR DEPENDENTS WITHIN THE MEWA. SUCH ADJUSTMENTS IN RATES SHALL BE MADE ON AND AFTER THE EFFECTIVE DATE OF THIS ACT FOR HEALTH STATUS, CLAIMS EXPERIENCE, AND STANDARD INDUSTRIAL CODE, BUT SHALL NOT BE CHARGED TO THE INDIVIDUALS UNDER THE PLAN AND SHALL NOT RESULT IN A RATE FOR THE MEWA THAT DEVIATES FROM THE AVERAGE RATE FOR MEMBERS OF THE MEWA BY MORE THAN THE AMOUNTS SET FORTH IN THE FOLLOWING SCHEDULE:

(I) ON AND AFTER THE EFFECTIVE DATE OF THIS ACT UNTIL SEPTEMBER 29, 2004, DECREASES MORE THAN FIFTEEN PERCENT FROM THE AVERAGE RATE FOR MEMBERS OF THE MEWA;

(II) ON AND AFTER SEPTEMBER 30, 2004, INCREASES MORE THAN TEN PERCENT FROM OR DECREASES MORE THAN TWENTY-FIVE PERCENT FROM THE AVERAGE RATE FOR MEMBERS OF THE MEWA.

SECTION 3. 10-4-902 (3), Colorado Revised Statutes, is amended to read:

10-4-902. Definitions. As used in this part 9, unless the context otherwise requires:

(3) "Licensed health care provider" means a person, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a hospital, health care facility, or dispensary or to practice and practicing

medicine, osteopathy, chiropractic, nursing, physical therapy, podiatry, dentistry, pharmacy, ACUPUNCTURE, or optometry in this state, or an officer, employee, or agent thereof working under the supervision of such person or institution in providing such health care services.

SECTION 4. Part 7 of article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-709. Evaluation - nonparticipating health care providers - legislative declaration - rules. (1) (a) THE GENERAL ASSEMBLY HEREBY FINDS AND DETERMINES THAT NOT ALL HEALTH CARE PROVIDERS CONTRACT WITH ALL HEALTH INSURERS AND THEREFORE NOT ALL ARE PARTICIPATING PROVIDERS. HEALTH CARE PROVIDERS WHO DO NOT CONTRACT WITH A CARRIER ARE CONSIDERED TO BE NONPARTICIPATING PROVIDERS AS TO THAT CARRIER. IN ADDITION, NOT ALL HEALTH CARE PROVIDERS ARE AWARE OF THE TERMS OF HEALTH INSURANCE COVERAGE FOR HEALTH CARE SERVICES PROVIDED TO A CONSUMER INSURED THROUGH INDIVIDUAL OR GROUP HEALTH CARE COVERAGE. THEREFORE, THE GENERAL ASSEMBLY DETERMINES THAT THERE IS A NEED TO INFORM INSURED CONSUMERS OF THE SCOPE OF HEALTH INSURANCE COVERAGE AVAILABLE TO THE CONSUMER FOR THE SERVICES OF NONPARTICIPATING PROVIDERS WHO RENDER SERVICES IN A PARTICIPATING FACILITY AND THE EXTENT OF AN INSURED CONSUMER'S RESPONSIBILITY WHEN SERVICES ARE RENDERED TO AN INSURED BY A NONPARTICIPATING PROVIDER.

(b) THE GENERAL ASSEMBLY HEREBY DECLARES THAT IT IS IN THE BEST INTEREST OF THE RESIDENTS OF THIS STATE TO PROVIDE ADMINISTRATIVE DIRECTION TO HEALTH INSURANCE CARRIERS, HEALTH CARE PROVIDERS, AND HEALTH FACILITIES TO PROVIDE TIMELY NOTICE TO A CONSUMER CONCERNING WHEN THE PERSON MAY OR MAY NOT INCUR ADDITIONAL CHARGES FOR COVERED HEALTH BENEFITS RECEIVED FROM HEALTH CARE PROVIDERS.

(2) THE INSURANCE COMMISSIONER SHALL, IN COLLABORATION WITH THE DIVISION OF REGISTRATIONS WITHIN THE DEPARTMENT OF REGULATORY AGENCIES, THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, ANY OTHER STATE AGENCY, AND ANY INTERESTED PARTY, HOLD PUBLIC HEARINGS TO DETERMINE THE EXTENT AND SOURCE OF THE PROBLEM OF A CONSUMER BEING BILLED FOR AN AMOUNT NOT PAID BY HIS OR HER HEALTH INSURANCE AS A RESULT OF A NONPARTICIPATING PROVIDER DELIVERING HEALTH CARE SERVICES IN A PARTICIPATING FACILITY. THESE HEARINGS SHALL ALSO INCLUDE AN EVALUATION OF THE FOLLOWING:

(a) PAYMENTS TO NONPARTICIPATING PROVIDERS IN PARTICIPATING FACILITIES;

(b) METHODS TO IMPROVE DISCLOSURE TO CONSUMERS OF INDIVIDUAL AND GROUP HEALTH INSURANCE;

(c) WHEN A PERSON MAY BE RESPONSIBLE FOR AMOUNTS IN EXCESS OF THE PERSON'S COVERED BENEFITS FROM A NONPARTICIPATING PROVIDER;

(d) WHAT THE CARRIER'S RESPONSIBILITIES ARE FOR PAYMENT FOR HEALTH BENEFITS COVERED UNDER THE PERSON'S HEALTH BENEFIT PLAN; AND

(e) THE APPROPRIATE APPEALS PROCESS FOR INSURERS AND HEALTH CARE

PROVIDERS TO SETTLE DISPUTES.

(3) THE INSURANCE COMMISSIONER, THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, AND THE DIVISION OF REGISTRATIONS, INCLUDING, BUT NOT LIMITED TO, ANY TYPE 1 BOARD UNDER THE SUPERVISION OF THE DIVISION OF REGISTRATIONS, MAY PROMULGATE RULES IN ACCORDANCE WITH THE FINDINGS FROM THE EVALUATION CONDUCTED PURSUANT TO SUBSECTION (2) OF THIS SECTION.

(4) ON OR BEFORE FEBRUARY 1, 2005, THE INSURANCE COMMISSIONER SHALL REPORT THE FINDINGS OF THE EVALUATION PURSUANT TO SUBSECTION (2) OF THIS SECTION TO THE BUSINESS AFFAIRS AND LABOR COMMITTEES OF THE HOUSE OF REPRESENTATIVES AND THE SENATE. THE INSURANCE COMMISSIONER SHALL INCLUDE IN THE REPORT A DESCRIPTION OF THE RULES PROMULGATED PURSUANT TO SUBSECTION (3) OF THIS SECTION. IF A STATE AGENCY DID NOT PROMULGATE RULES PURSUANT TO SUBSECTION (3) OF THIS SECTION, THAT STATE AGENCY SHALL SUBMIT TO THE INSURANCE COMMISSIONER, FOR INCLUSION IN THE COMMISSIONER'S REPORT TO THE BUSINESS AFFAIRS AND LABOR COMMITTEES OF THE HOUSE OF REPRESENTATIVES AND SENATE, THE REASONS WHY RULES WERE NOT PROMULGATED PURSUANT TO SUBSECTION (3) OF THIS SECTION.

SECTION 5. 13-64-202 (3), Colorado Revised Statutes, is amended to read:

13-64-202. Definitions. As used in this part 2, unless the context otherwise requires:

(3) "Health care institution" means any licensed or certified hospital, health care facility, dispensary, ~~or~~ other institution for the treatment or care of the sick or injured, OR A LABORATORY CERTIFIED UNDER THE FEDERAL "CLINICAL LABORATORIES IMPROVEMENT ACT OF 1967", AS AMENDED, 42 U.S.C. SEC. 263a, TO PERFORM HIGH COMPLEXITY TESTING.

SECTION 6. 27-13-110, Colorado Revised Statutes, is amended to read:

27-13-110. Alternative uses for institute facilities - repeal. (1) The department of human services shall determine the existence of resources at Colorado mental health institute at Pueblo ~~which~~ THAT are in excess of the needs of the primary purpose of said institute and may make available to the regents of the university of Colorado, on mutually agreeable terms, a maximum of ten beds at said institute for the purpose of teaching students in the family practice medical training program conducted by and under the control of the regents. Such resources shall be a supplement to any existing health care resources and academic facilities in the region.

(2) (a) TO THE EXTENT THAT RESOURCES AT COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO ARE IN EXCESS OF THE NEEDS OF THE PRIMARY PURPOSE OF SAID INSTITUTE AND THE PURPOSES OF SUBSECTION (1) OF THIS SECTION, THE INSTITUTE IS AUTHORIZED TO ACCEPT AND TREAT UNINSURED INDIVIDUALS FOR MEDICAL CARE OR TREATMENT. AN UNINSURED PERSON SEEKING CARE OR TREATMENT FROM THE INSTITUTE SHALL PROVIDE SUFFICIENT EVIDENCE THAT HE OR SHE IS WITHOUT INSURANCE FROM HIS OR HER EMPLOYER AND NOT ENROLLED IN THE STATE'S MEDICAL ASSISTANCE PROGRAM PURSUANT TO ARTICLE 4 OF TITLE 26, C.R.S. THE DEPARTMENT OF HUMAN SERVICES MAY DETERMINE BY RULE WHAT EVIDENCE MAY

BE REQUESTED. THE UNINSURED PERSON SHALL BE RESPONSIBLE FOR PAYMENT OF CHARGES FOR CARE AND TREATMENT BY THE INSTITUTION. THE COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO SHALL CHARGE SUCH UNINSURED INDIVIDUALS A RATE THAT IS COMPARABLE TO THE RATE CHARGED FOR SERVICES RENDERED FOR ENROLLEES IN THE STATE'S MEDICAL ASSISTANCE PROGRAM PURSUANT TO ARTICLE 4 OF TITLE 26, C.R.S.

(b) THE OFFICE OF BEHAVIORAL HEALTH AND HOUSING WITHIN THE DEPARTMENT OF HUMAN SERVICES SHALL REPORT TO THE JOINT BUDGET COMMITTEE ON OR BEFORE JANUARY 15, 2009, THE FOLLOWING INFORMATION:

(I) THE NUMBER OF UNINSURED PATIENTS TREATED BY THE COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO PURSUANT TO THIS SUBSECTION (2);

(II) THE AMOUNT OF REVENUE GENERATED BY THE INSTITUTE BY TREATING THESE UNINSURED INDIVIDUALS; AND

(III) THE IMPACT, IF ANY, ON THE ABILITY OF THE INSTITUTE TO FULFILL ITS PRIMARY PURPOSES AS A RESULT OF TREATING UNINSURED INDIVIDUALS PURSUANT TO THIS SUBSECTION (2).

(c) THIS SUBSECTION (2) IS REPEALED, EFFECTIVE JULY 1, 2009.

SECTION 7. 6-1-102 (4.2) and (4.3), Colorado Revised Statutes, are amended, and the said 6-1-102 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

6-1-102. Definitions. As used in this article, unless the context otherwise requires:

(4.1) "DANCE STUDIO" MEANS ANY PERSON ENGAGED IN THE ADVERTISEMENT OR SALE OF DANCE STUDIO SERVICES.

(4.2) ~~"Dance studio" means any person engaged in the advertisement or sale of dance studio services.~~ "DANCE STUDIO SERVICES" MEANS INSTRUCTION, TRAINING, OR ASSISTANCE IN DANCING; THE USE OF DANCE STUDIO FACILITIES; MEMBERSHIP IN ANY GROUP, CLUB, OR ASSOCIATION FORMED BY A DANCE STUDIO; AND PARTICIPATION IN DANCE COMPETITIONS, DANCE SHOWCASES, TRIPS, TOURS, PARTIES, AND OTHER ORGANIZED EVENTS AND RELATED TRAVEL ARRANGEMENTS.

(4.3) ~~"Dance studio services" means instruction, training, or assistance in dancing; the use of dance studio facilities; membership in any group, club, or association formed by a dance studio; and participation in dance competitions, dance showcases, trips, tours, parties, and other organized events and related travel arrangements.~~ "DISCOUNT HEALTH PLAN" MEANS A PROGRAM EVIDENCED BY A MEMBERSHIP AGREEMENT, CONTRACT, CARD, CERTIFICATE, DEVICE, OR MECHANISM, WHICH OFFERS HEALTH CARE SERVICES, AS DEFINED IN SECTION 10-16-102 (22), C.R.S., OR RELATED PRODUCTS INCLUDING, BUT NOT LIMITED TO, PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT, AT PURPORTED DISCOUNTED RATES FROM HEALTH CARE PROVIDERS ADVERTISED AS PARTICIPATING IN THE PROGRAM. A "DISCOUNT HEALTH PLAN" DOES NOT INCLUDE A PROGRAM IN WHICH A PARTICIPATING PROVIDER HAS AGREED, AS A

CONDITION OF HIS OR HER PARTICIPATION IN THE PROGRAM, TO NEGOTIATE THE PRICES TO BE CHARGED FOR HIS OR HER SERVICES DIRECTLY WITH CONSUMERS IN THE PROGRAM AND THE PROVIDER IS NOT REQUIRED TO OFFER DISCOUNTED PRICES FOR HIS OR HER SERVICES AS PART OF THE PROGRAM.

SECTION 8. Part 7 of article 1 of title 6, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

6-1-712. Discount health plan and cards. (1) A PERSON ENGAGES IN A DECEPTIVE TRADE PRACTICE WHEN, IN THE COURSE OF SUCH PERSON'S BUSINESS, VOCATION, OR OCCUPATION, SUCH PERSON:

(a) SOLICITS, MARKETS, ADVERTISES, PROMOTES, OR SELLS TO A CONSUMER RESIDING IN COLORADO A DISCOUNT HEALTH PLAN AND SUCH PLAN MATERIALS:

(I) FAIL TO PROVIDE TO THE CONSUMER A CLEAR AND CONSPICUOUS DISCLOSURE THAT THE DISCOUNT HEALTH PLAN IS NOT INSURANCE AND THAT THE PLAN ONLY PROVIDES FOR DISCOUNT HEALTH CARE SERVICES FROM PARTICIPATING PROVIDERS WITHIN THE PLAN.

(II) FAIL TO PROVIDE THE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE ADMINISTRATOR OF THE DISCOUNT HEALTH PLAN.

(III) FAIL TO MAKE AVAILABLE TO THE CONSUMER THROUGH A TOLL-FREE TELEPHONE NUMBER, UPON REQUEST OF THE CONSUMER, A COMPLETE AND ACCURATE LIST OF THE PARTICIPATING PROVIDERS WITHIN THE PLAN IN THE CONSUMER'S LOCAL AREA AND A LIST OF THE SERVICES FOR WHICH THE DISCOUNTS ARE APPLICABLE. SUCH LIST SHALL BE AVAILABLE TO THE CONSUMER UPON REQUEST COMMENCING WITH THE TIME OF PURCHASE AND SHALL BE UPDATED AT LEAST EVERY SIX MONTHS.

(IV) FAIL TO USE COMMON USAGE FOR WORDS AND PHRASES IN DESCRIBING THE DISCOUNTS OR ACCESS TO DISCOUNTS OFFERED, AND SUCH FAILURE RESULTS IN REPRESENTATIONS OF THE DISCOUNTS THAT ARE MISLEADING, DECEPTIVE, OR FRAUDULENT.

(V) FAIL TO PROVIDE TO THE CONSUMER NOTICE OF THE RIGHT TO CANCEL SUCH DISCOUNT HEALTH PLAN PURSUANT TO PARAGRAPH (c) OF THIS SUBSECTION (1).

(b) OFFERS DISCOUNTED HEALTH SERVICES OR PRODUCTS THAT ARE NOT AUTHORIZED BY A CONTRACT WITH EACH PROVIDER LISTED IN CONJUNCTION WITH THE DISCOUNT HEALTH PLAN.

(c) FAILS TO ALLOW A PURCHASER OF A DISCOUNT HEALTH PLAN TO CANCEL SUCH PLAN WITHIN THIRTY DAYS AFTER PURCHASE.

(d) FAILS TO REFUND ALL MEMBERSHIP FEES PAID TO THE DISCOUNT HEALTH PLAN BY THE CONSUMER WITHIN THIRTY DAYS AFTER TIMELY NOTIFICATION OF THE CANCELLATION OF THE PLAN TO THE DISCOUNT HEALTH PLAN ADMINISTRATOR PURSUANT TO PARAGRAPH (c) OF THIS SUBSECTION (1).

(2) THE PROVISIONS OF THIS SECTION SHALL NOT APPLY TO:

(a) A CARRIER AS DEFINED IN SECTION 10-16-102 (8), C.R.S., THAT OFFERS DISCOUNTS FOR SERVICES TO A COVERED PERSON, AS DEFINED IN SECTION 10-16-102 (13.5), C.R.S., AND SUCH SERVICES ARE SUPPLEMENTAL TO AND NOT PART OF THE HEALTH COVERAGE PLAN OF THE CARRIER;

(b) A MEDICARE ENDORSED DRUG CARD AS APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES PURSUANT TO THE "MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003", PUBLIC LAW 108-173.

(3) FOR THE PURPOSES OF THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "HEALTH CARE SERVICES" SHALL HAVE THE SAME MEANING AS IN SECTION 10-16-102 (22), C.R.S.

(b) "PROVIDER" SHALL HAVE THE SAME MEANING AS IN SECTION 10-16-102 (36), C.R.S.

SECTION 9. Effective date - applicability. This act shall take effect upon passage and shall apply to health benefit coverage issued to a multiple employer welfare arrangement and health discount services sold on or after the applicable effective date of this act.

SECTION 10. 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: May 21, 2004