

CHAPTER 274

INSURANCE

SENATE BILL 04-105

BY SENATOR(S) Kester;
also REPRESENTATIVE(S) Spence, Hefley, Rippy, and Williams T.

AN ACT

CONCERNING THE REGULATION OF HEALTH INSURANCE, AND, IN CONNECTION THEREWITH, ADOPTING CERTAIN MODIFICATIONS TO HEALTH INSURANCE LAWS RECOMMENDED BY THE 2001 SUNSET REPORT CONDUCTED BY THE DEPARTMENT OF REGULATORY AGENCIES.

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

SECTION 1. 6-18-302 (1) (b) (II), Colorado Revised Statutes, is amended to read:

6-18-302. Creation of provider networks - requirements. (1) (b) (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.~~

SECTION 2. 10-2-301 (1), Colorado Revised Statutes, is amended to read:

10-2-301. Continuing education requirement - advisory committee. (1) Producers not exempt from the requirements of this section shall satisfactorily complete up to twenty-four hours of instruction by attending such courses or programs of instruction as may be approved by the commissioner. AT LEAST THREE OF THE TWENTY-FOUR HOURS OF CONTINUING EDUCATION SHALL BE FOR COURSES IN ETHICS. The insurance commissioner may adopt rules ~~and regulations~~ concerning testing requirements as a part of the certified continuing education. ~~coursework.~~ The

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

required hours of instruction shall be completed within twenty-four months after the date the producer's license is required to be renewed, beginning with renewal dates on or after January 1, 1993. ~~but applying to all subsequent years.~~ A PRODUCER MAY ACCUMULATE NO MORE THAN TWELVE CARRY-OVER CREDIT HOURS DURING THE ONE HUNDRED TWENTY DAYS BEFORE THE LICENSING CONTINUATION DATE. SUCH CARRY-OVER CREDITS MAY BE APPLIED TO THE NEXT CONTINUING EDUCATION PERIOD. If a producer has more than one license to sell insurance in this state, the required hours of instruction shall be completed within twenty-four months after the date the first such license is required to be renewed. For good cause shown, the commissioner may grant an extension of time within which to comply with the requirements of this section, such extension not to exceed an additional one year. An instructor of an approved course of instruction shall qualify for the same number of hours of continuing education as a person attending and successfully completing the course or program, but no instructor shall receive credit more than once for a course or program given more than once during the twenty-four-month period described in this subsection (1).

SECTION 3. 10-16-102 (1), (11), and (40) (a), Colorado Revised Statutes, are amended to read:

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

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of ~~part 6 of article 8 of this title and~~ PART 10 OF this article, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(11) (a) ~~"Class of business" means all or a distinct grouping of small employers as shown on the records of a small employer carrier. A small employer carrier may establish no more than nine separate classes of business, and each class shall reflect substantial differences in expected claims experience or administrative costs related to the following:~~

~~(f) The use of more than one type of system for the marketing and sale of health benefit plans to small employers;~~

~~(H) The acquisition of a class of business from another small employer carrier;~~

~~(HH) The provision of coverage to one or more association groups that meet the requirements of section 10-16-214 (1); or~~

~~(IV) The offering of a high deductible plan pursuant to section 10-16-105 (7.3) (c)~~
~~(H):~~

~~(b) The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer health~~

~~insurance marketplace.~~

(40) (a) "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, EXCEPT AS PROVIDED IN SECTION 10-16-105 (12), employed no more than fifty eligible employees, the majority of whom were employed within this state and that was not formed primarily for the purpose of purchasing insurance. "Small employer" includes a business group of one. 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.

SECTION 4. 10-16-104 (5) (c), Colorado Revised Statutes, is amended to read:

10-16-104. Mandatory coverage provisions. (5) Mental illness. Every group policy or contract providing hospitalization or medical benefits by an entity subject to the provisions of part 2 or 3 of this article shall provide benefits for conditions arising from mental illness at least equal to the following:

(c) An entity subject to the provisions of part 2 or 3 of this article may establish a copayment OR COINSURANCE requirement for mental illness, which may or may not differ from the copayment OR COINSURANCE requirement established for any other condition or illness; except that copayment OR COINSURANCE requirements for mental illness shall not exceed a fifty percent copayment OR COINSURANCE requirement. Such entity may establish a deductible amount for mental illness, but such deductible amount shall not differ from the deductible amount for any other condition or illness. In addition, such entity may limit the aggregate benefits payable under paragraph (b) of this subsection (5) to an amount of not less than one thousand dollars in any one twelve-month benefit period OR NOT LESS THAN TWENTY VISITS PER YEAR.

SECTION 5. 10-16-105 (5) (a), (5) (c), (5) (f), (6.5), (6.6), (7), (7.3) (b) (I), (7.3) (b) (II), (7.3) (b) (III), (7.3) (c), (7.3) (g), (8) (a), (8) (b), (8) (c) (I), (8) (e), (8.1), (8.2), and (8.5) (c), Colorado Revised Statutes, are amended to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans. (5) Each small group sickness and accident insurer or other entity shall make reasonable disclosure in solicitation and sales materials provided to small employers the following information in a form and manner prescribed by the commissioner and upon request of any such small employer shall provide such information in detail:

(a) ~~The extent to which~~ HOW premium rates for a specific employer are established or adjusted due to the experience OR health status ~~or duration of coverage~~ of employees or dependents of the small employer;

(c) ~~A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans;~~

(f) HOW TO ACCESS the benefits and premiums available under all health benefit plans for which the employer is qualified; and

(6.5) Each small employer carrier shall file with the commissioner annually, on or before March 1, an actuarial certification certifying that the small employer carrier is in compliance with the provisions of subsections (8), ~~to (8.2)~~ (8.5), AND (13) TO (15) of this section and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(6.6) A small employer carrier shall make the information and documentation described in subsection (6) of this section available to the commissioner upon request. Except in cases of violations of ~~the provisions of part 6 of article 8 of this title or this article~~, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the division except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(7) An individual, corporation, association, partnership, or any other entity engaged in the health insurance business subject to ~~the provisions of~~ this section shall not request or require from a small group applying for coverage, or from an individual in a small group applying for coverage, medical information going back more than five years ~~from~~ BEFORE the date of application. Medical information ~~which~~ THAT is more than five years old on any of the enrollee members of a small group shall not be used by the insurer in underwriting or setting premiums for the group. Nothing in this subsection (7) shall preclude a small group health insurer subject to the provisions of part 2 of this article from asking about the current health status of any of the individuals in a group applying for coverage or from using such information on current health status to underwrite or set premiums for the group AS PROVIDED BY LAW.

~~(7.3) (b) (I) A small employer carrier shall not be required to approve an application from a business group of one for a basic health benefit plan or a standard health benefit plan if:~~

~~(A) The small employer self funds any part of its current health benefit plan; and~~

~~(B) Such small employer does not have in force an excess insurance policy covering incurred but unpaid future liability of the small employer under its current health benefit plan.~~

~~(II) Any insurer providing insurance coverage for excess losses of a health benefit plan provided by a small employer shall also offer to insure the incurred but unpaid future liability upon termination of the contract on the anniversary of the contract. Any insurer providing insurance coverage for excess losses of a health benefit plan provided by a small employer shall disclose to the small employer at the time of sale and subsequently at each contract renewal period that claims incurred but unpaid on the date the contract is terminated will not be covered unless the small employer purchases insurance to cover such incurred but unpaid future liability.~~

~~(III) For purposes of this paragraph (b), an insurance policy covering incurred but unpaid future liability of a small employer under its health benefit plan shall provide coverage for claims in excess of the individual stop loss attachment point that are~~

~~incurred prior to the last day of the contract period and not paid as of the last day of the contract period and shall extend such coverage for a minimum of ninety days immediately following the termination of such excess insurance policy.~~

(c) (I) ~~Effective January 1, 1995,~~ A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan, EXCEPT AS PROVIDED IN PARAGRAPH (i) OF THIS SUBSECTION (7.3), to any eligible small employer that applies for such health benefit plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan that are ~~not inconsistent~~ CONSISTENT with this article. ~~Effective July 1, 1997,~~ A small employer carrier shall also issue any of its other small employer plans to any small employer that applies for such a plan; except that this requirement shall not apply to a business group of one where the business group of one does not meet the carrier's normal and actuarially-based underwriting criteria. The requirements of this ~~subparagraph (I)~~ PARAGRAPH (c) shall not apply to a health benefit plan offered by a carrier if such plan is made available in the small group market only through one or more bona fide association plans. ~~and except as provided in paragraph (i) of this subsection (7.3).~~

(II) ~~In the case of a small employer carrier that establishes more than one class of business, as defined in sections 10-8-602 (3.5) and 10-16-102 (11), the small employer carrier shall offer to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan for each type of plan it offers in the general market, including traditional indemnity, preferred provider, and health maintenance organization in each class of business so established. In addition to basic and standard plans, a small employer carrier may offer a high deductible plan that may be a traditional indemnity plan, a preferred provider plan, a health maintenance organization plan, or a point of service plan in each class of business established. High deductible plans offered by a small employer carrier may be offered in conjunction with a medical savings account. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if:~~

~~(A) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;~~

~~(B) The criteria are not related to the health status or claim experience of the small employer;~~

~~(C) The criteria are applied consistently to all small employers applying for coverage in the class of business; and~~

~~(D) The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.~~

(III) ~~The provisions of subparagraph (II) of this paragraph (c) shall not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.~~

(IV) If a small employer carrier offers a health benefit plan with a deductible of at least one thousand five hundred dollars, the small employer carrier shall provide to each covered person a clear and understandable disclosure in the health benefit

plan contract or materials indicating:

(A) The amount of the deductible;

(B) The policies related to copayments, deductibles, and cost-sharing arrangements.

(g) The commissioner may, at any time after providing notice and an opportunity for a hearing to a small employer carrier, disapprove the continued use by the small employer carrier of the basic health benefit plan and the standard health benefit plan on the grounds that such plans do not meet the requirements of this article. ~~and part 6 of article 8 of this title.~~

(8) (a) ~~(f)~~ The premium rate charged during a rating period to small employers shall be based on a single, same index rate, applicable to all small employers, adjusted for case characteristics and coverage. ~~except that the index rate may be multiplied by a rate adjustment factor for each small employer group pursuant to subparagraphs (H) to (VH) of this paragraph (a) to calculate a different premium. The rate adjustment factor shall only be based on actual claims experience on the small employer carrier's plan, industry, and class of business; except that, for health benefit plans issued prior to July 1, 1994, the rate adjustment factor may also be based on duration of coverage since the original issue date and gender mix. Small employer carriers shall apply the rate adjustment factors uniformly with respect to all small employers.~~

~~(H) The rate adjustment factor for a particular small employer for a new rating period shall not be more than the previous rating period's rate adjustment factor plus ten percent annually, adjusted pro rata for rating periods of less than one year; except that in no case shall the rate adjustment factor be higher or lower than the boundaries defined in subparagraphs (H) to (VH) of this paragraph (a).~~

~~(HI) For health benefit plans newly issued on and after January 1, 1995, and before January 1, 1997, the rate adjustment factor shall be:~~

~~(A) No lower than 0.8; and~~

~~(B) No higher than 1.20.~~

~~(IV) For health benefit plans issued prior to January 1, 1995, the rate adjustment factor for a particular small employer for new rating periods beginning on and after January 1, 1995, and before January 1, 1996, shall not be more than the previous rating period's rate adjustment factor plus ten percent annually, adjusted pro rata for rating periods of less than one year.~~

~~(V) For health benefit plans issued prior to January 1, 1995, and renewed on and after January 1, 1996, and before January 1, 1997, the rate adjustment factor shall be:~~

~~(A) No lower than 0.8; and~~

~~(B) No higher than 1.20.~~

~~(VI) For health benefit plans newly issued and all health benefit plans renewed on and after January 1, 1997, the rate adjustment factor shall be:~~

~~(A) No lower than 0.90; and~~

~~(B) No higher than 1.10.~~

~~(VII) For health benefit plans newly issued and all health benefit plans renewed on and after January 1, 1998, no rate adjustment factor shall be used.~~

~~(VIII) (Deleted by amendment, L. 2003, p. 2691, § 1, effective January 1, 2004.)~~

~~(IX) For new rating periods beginning prior to January 1, 1997, for small employers continuously insured under the same health benefit plan since July 1, 1994, whose rates are below eighty percent of the index rate, a small employer carrier may increase premiums by an amount not to exceed the pro rata increase required to meet the requirements of subparagraph (V) of this paragraph (a).~~

~~(X) and (XI) (Deleted by amendment, L. 99, p. 147, § 2, effective March 25, 1999.)~~

~~(XII) All health coverage plans sponsored by or marketed through an employee leasing company shall be fully insured plans.~~

~~(b) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to section 10-8-605.~~

~~(c) (I) Small employer carriers shall apply rating factors, including case characteristics consistently with respect to all small employers. Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.~~

~~(e) The small employer carrier shall not use case characteristics, other than age, geographic area, and family composition, nor shall it use any other rating factors except as provided in subparagraph (f) of paragraph (a) of this subsection (8) and subsections (13) to (15) of this section.~~

~~(8.1) A small employer carrier shall not transfer an individual or a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.~~

~~(8.2) The commissioner may suspend for a specified period the application of paragraph (a) of subsection (8) of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would~~

~~enhance the efficiency and fairness of the marketplace for small employer health insurance.~~

(8.5) (c) The small employer carrier shall not use case characteristics other than age, geographic area, family composition, smoking status, health status, standard industrial classification, and claims experience, nor shall it use any other rating factors other than actual claims experience on that small employer carrier's health benefit plan, industry, ~~class of business~~, and plan design, without prior approval of the commissioner unless otherwise provided in this subsection (8.5).

SECTION 6. Part 1 of article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-105.2. Small employer health insurance availability program.

(1) (a) EXCEPT AS PROVIDED IN PARAGRAPHS (b), (c), AND (d) OF THIS SUBSECTION (1), THIS ARTICLE SHALL APPLY TO ANY HEALTH BENEFIT PLAN THAT PROVIDES COVERAGE TO THE EMPLOYEES OF A SMALL EMPLOYER IN THIS STATE IF ANY OF THE FOLLOWING CONDITIONS ARE MET:

(I) ANY PORTION OF THE PREMIUM OR BENEFIT IS PAID BY OR ON BEHALF OF A SMALL EMPLOYER;

(II) AN ELIGIBLE EMPLOYEE OR DEPENDENT IS REIMBURSED, WHETHER THROUGH WAGE ADJUSTMENTS OR OTHERWISE, BY OR ON BEHALF OF A SMALL EMPLOYER FOR ANY PORTION OF THE PREMIUM;

(III) THE HEALTH BENEFIT PLAN IS TREATED BY THE EMPLOYER OR ANY OF THE ELIGIBLE EMPLOYEES OR DEPENDENTS AS PART OF A PLAN OR PROGRAM FOR THE PURPOSES OF SECTION 106, 125, OR 162 OF THE FEDERAL "INTERNAL REVENUE CODE OF 1986", AS AMENDED, EXCEPT AS PROVIDED IN PARAGRAPH (d) OF THIS SUBSECTION (1); OR

(IV) THE PLAN IS MARKETED TO INDIVIDUAL EMPLOYEES THROUGH AN EMPLOYER OR AT A PLACE OF BUSINESS, EXCEPT AS OTHERWISE ALLOWED BY RULE. THE DIVISION OF INSURANCE SHALL PROMULGATE A RULE TO ALLOW, WITH THE PERMISSION OF OR AT THE REQUEST OF THE EMPLOYER:

(A) AGENTS TO MARKET HEALTH BENEFIT PLANS THROUGH AN EMPLOYER OR AT AN EMPLOYER'S PLACE OF BUSINESS TO SUCH EMPLOYER'S INELIGIBLE EMPLOYEES;

(B) SMALL EMPLOYER CARRIERS TO MARKET INDIVIDUAL HEALTH BENEFIT PLANS THROUGH AN EMPLOYER OR AT AN EMPLOYER'S PLACE OF BUSINESS TO SUCH EMPLOYER'S INELIGIBLE EMPLOYEES AND TO DEPENDENTS OF ELIGIBLE EMPLOYEES WHEN THE CARRIER HAS GROUP COVERAGE IN PLACE WITH THE EMPLOYER.

(b) THE PROVISIONS OF THIS ARTICLE SHALL NOT APPLY TO A MULTIPLE EMPLOYER HEALTH TRUST, AS SET FORTH IN SECTION 10-3-903.5 (7) (b) OR A MULTIPLE EMPLOYER WELFARE ARRANGEMENT, AS SET FORTH IN SECTION 10-3-903.5 (7) (c).

(c) (I) THE PROVISIONS OF THIS ARTICLE CONCERNING SMALL EMPLOYER CARRIERS AND SMALL GROUP PLANS SHALL NOT APPLY TO AN INDIVIDUAL HEALTH BENEFIT PLAN

NEWLY ISSUED TO A BUSINESS GROUP OF ONE THAT INCLUDES ONLY A SELF-EMPLOYED PERSON WHO HAS NO EMPLOYEES, OR A SOLE PROPRIETOR WHO IS NOT OFFERING OR SPONSORING HEALTH CARE COVERAGE TO HIS OR HER EMPLOYEES, TOGETHER WITH THE DEPENDENTS OF SUCH A SELF-EMPLOYED PERSON OR SOLE PROPRIETOR IF, PURSUANT TO RULES ADOPTED BY THE COMMISSIONER, ALL OF THE FOLLOWING CONDITIONS ARE MET:

(A) AS PART OF THE APPLICATION PROCESS, THE CARRIER DETERMINES WHETHER OR NOT THE APPLICANT IS A SELF-EMPLOYED PERSON WHO MEETS THE DEFINITION OF A BUSINESS GROUP OF ONE PURSUANT TO SECTION 10-8-602 (2.5).

(B) IF THE APPLICANT IS A BUSINESS GROUP OF ONE SELF-EMPLOYED PERSON, THE CARRIER ACCEPTS OR REJECTS SUCH PERSON AND, IF SUCH PERSON IS APPLYING FOR FAMILY COVERAGE, ACCEPTS OR REJECTS THE ENTIRE FAMILY UNLESS THE APPLICANT WAIVES COVERAGE FOR A FAMILY MEMBER WHO HAS OTHER COVERAGE IN EFFECT.

(C) IF THE CARRIER REJECTS AN APPLICATION FOR A BUSINESS GROUP OF ONE SELF-EMPLOYED PERSON AND THE CARRIER DOES BUSINESS IN BOTH THE INDIVIDUAL AND SMALL GROUP MARKETS, THE CARRIER SHALL NOTIFY THE APPLICANT OF THE AVAILABILITY OF COVERAGE THROUGH THE SMALL GROUP MARKET AND OF THE AVAILABILITY OF SMALL GROUP COVERAGE THROUGH THE CARRIER.

(D) AS PART OF ITS APPLICATION FORM, AN INDIVIDUAL CARRIER REQUIRES A BUSINESS GROUP OF ONE SELF-EMPLOYED PERSON PURCHASING AN INDIVIDUAL HEALTH BENEFIT PLAN PURSUANT TO THIS SUBPARAGRAPH (I) TO READ AND SIGN A DISCLOSURE FORM STATING THAT, BY PURCHASING AN INDIVIDUAL POLICY INSTEAD OF A SMALL GROUP POLICY, SUCH PERSON GIVES UP WHAT WOULD OTHERWISE BE HIS OR HER RIGHT TO PURCHASE A BUSINESS GROUP OF ONE STANDARD, BASIC, OR OTHER HEALTH BENEFIT PLAN FROM A SMALL EMPLOYER CARRIER FOR A PERIOD OF THREE YEARS AFTER THE DATE THE INDIVIDUAL HEALTH BENEFIT PLAN IS PURCHASED, UNLESS A SMALL EMPLOYER CARRIER VOLUNTARILY PERMITS SUCH PERSON TO PURCHASE A BUSINESS GROUP OF ONE POLICY WITHIN SUCH THREE-YEAR PERIOD. THE DISCLOSURE FORM SHALL ALSO BRIEFLY DESCRIBE THE FACTORS USED TO SET RATES FOR THE INDIVIDUAL POLICY BEING PURCHASED IN COMPARISON WITH THE FACTORS USED TO SET RATES FOR A BUSINESS GROUP OF ONE SMALL GROUP POLICY. THE INDIVIDUAL CARRIER SHALL PROVIDE TO THE BUSINESS GROUP OF ONE SELF-EMPLOYED APPLICANT A COPY OF THE HEALTH BENEFIT PLAN DESCRIPTION FORM FOR THE COLORADO STANDARD HEALTH BENEFIT PLAN IN ADDITION TO THE DESCRIPTION FORM FOR THE INDIVIDUAL PLAN BEING MARKETED. THE DISCLOSURE FORM MAY BE INCLUDED WITHIN ANY OTHER CERTIFICATION FORM THAT THE CARRIER USES FOR THE PLAN. THE DIVISION OF INSURANCE SHALL MAKE AVAILABLE A STANDARD PLAN DESCRIPTION FORM TO INDIVIDUAL CARRIERS UPON REQUEST.

(II) NOTHING IN THIS PARAGRAPH (c) SHALL PRECLUDE A BUSINESS GROUP OF ONE FROM APPLYING FOR SMALL GROUP COVERAGE.

(III) FOR THE PURPOSES OF THIS PARAGRAPH (c), AN INDIVIDUAL HEALTH BENEFIT POLICY SHALL NOT INCLUDE ONE OR MORE SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICIES ISSUED WITHIN SIX MONTHS BEFORE THE DATE OF APPLICATION FOR GROUP COVERAGE.

(d) A PLAN SHALL NOT BE SUBJECT TO THE SMALL GROUP PROVISIONS OF THIS ARTICLE IF THE PREMIUM FOR THE PLAN IS PAID FOR THROUGH A SECTION 125 PLAN OR PROGRAM OF THE FEDERAL "INTERNAL REVENUE CODE OF 1986", AS AMENDED, THE EMPLOYER MAKES NO CONTRIBUTION TO THE SECTION 125 PLAN OR PROGRAM, THE EMPLOYER DOES NOT HAVE IN PLACE AN EMPLOYER-SPONSORED HEALTH BENEFIT PLAN, AND THE EMPLOYER DOES NOT PAY FOR ANY PORTION OF THE PREMIUM OR BENEFIT PAID.

(2) (a) EXCEPT AS PROVIDED IN PARAGRAPH (b) OF THIS SUBSECTION (2), CARRIERS THAT ARE AFFILIATED COMPANIES OR THAT ARE ELIGIBLE TO FILE A CONSOLIDATED TAX RETURN SHALL BE TREATED AS ONE CARRIER AND ANY RESTRICTIONS OR LIMITATIONS IMPOSED BY THIS ARTICLE SHALL APPLY AS IF ALL HEALTH BENEFIT PLANS DELIVERED OR ISSUED FOR DELIVERY TO SMALL EMPLOYERS IN THIS STATE BY SUCH AFFILIATED CARRIERS WERE ISSUED BY ONE CARRIER.

(b) AN AFFILIATED CARRIER THAT IS A HEALTH MAINTENANCE ORGANIZATION HAVING A CERTIFICATE OF AUTHORITY UNDER THIS ARTICLE MAY BE CONSIDERED TO BE A SEPARATE CARRIER FOR PURPOSES OF THIS SUBSECTION (2).

(c) THE PROVISIONS OF SECTION 10-3-118 AND PART 7 OF ARTICLE 3 OF THIS TITLE SHALL APPLY IF A SMALL EMPLOYER CARRIER CEDES OR ASSUMES ALL OF THE INSURANCE OBLIGATION OR RISK WITH RESPECT TO ONE OR MORE HEALTH BENEFIT PLANS DELIVERED OR ISSUED FOR DELIVERY TO SMALL EMPLOYERS IN THIS STATE.

(3) PURSUANT TO RULES ADOPTED BY THE COMMISSIONER, A SMALL EMPLOYER CARRIER MAY REJECT FOR COVERAGE UNDER A SMALL GROUP PLAN A BUSINESS GROUP OF ONE SELF-EMPLOYED PERSON IF, AT THE TIME OF APPLICATION FOR GROUP COVERAGE, THE SELF-EMPLOYED PERSON HAS IN PLACE OR, WITHIN THE IMMEDIATELY PRECEDING THIRTY DAYS, HAS HAD IN PLACE AN INDIVIDUAL HEALTH BENEFIT PLAN THAT MEETS THE REQUIREMENTS OF SUBPARAGRAPH (I) OF PARAGRAPH (c) OF SUBSECTION (1) OF THIS SECTION AND HAS BEEN IN PLACE FOR LESS THAN THREE YEARS. AN INDIVIDUAL HEALTH BENEFIT POLICY SHALL NOT INCLUDE ONE OR MORE SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICIES ISSUED WITHIN SIX MONTHS BEFORE THE DATE OF APPLICATION FOR GROUP COVERAGE.

(4) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, A CARRIER MAY DECLINE TO RENEW OR REENROLL A BUSINESS GROUP OF ONE THAT HAS BEEN TERMINATED BY THE CARRIER FOR NONPAYMENT OF PREMIUMS. THE TIME PERIOD DURING WHICH THE CARRIER MAY SO DECLINE SHALL EXTEND FOR UP TO SIX MONTHS AFTER THE DATE OF TERMINATION OR UNTIL THE NEXT OPEN ENROLLMENT PERIOD, WHICHEVER IS GREATER.

SECTION 7. 10-16-113 (3) (b) (I), Colorado Revised Statutes, is amended to read:

10-16-113. Procedure for denial of benefits. (3) (b) (I) For the purposes of this paragraph (b), a "health coverage plan" does not include insurance arising out of the "Workers' Compensation Act of Colorado" or other similar law, automobile medical payment insurance, property and casualty insurance, or insurance under which benefits are payable with or without regard to fault and ~~which~~ THAT is required by law to be contained in any liability insurance policy or equivalent self-insurance. A

health coverage plan shall specify that an appeal from the denial of a request for covered benefits on the grounds that such benefits are not medically necessary, appropriate, effective, or efficient may include a two-level internal review of the decision followed by the right of the covered person to request an external review under section 10-16-113.5. The commissioner shall promulgate rules for such benefits denials that reflect the requirements in ~~29 CFR 2560.530-1 (a) to (j)~~ 29 CFR 2560.503-1 (a) TO (j). In addition, the commissioner shall promulgate rules specifying the elements of and timelines for external review appeals procedures, including but not limited to the review of appeals requiring expedited reviews and authorizations by the covered individual requesting an independent external review for access to medical records necessary for the conduct of the external review. The commissioner shall consult with and utilize public and private resources, including but not limited to health care providers, in the development of such rules.

SECTION 8. 10-16-116 (1), (2) (a), (2) (b), (2) (d), (2) (g), (2) (h) (II), and (3), Colorado Revised Statutes, are amended to read:

10-16-116. Catastrophic health insurance - coverage. (1) ~~On and after January 1, 1995, any AN employer who does not offer other health insurance~~ may offer catastrophic health insurance to its employees pursuant to sections 10-16-114 to 10-16-117. Employees who elect such coverage shall pay the cost of the insurance pursuant to section 10-16-117.

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

(a) Be issued to the employer unless issued as an individual plan pursuant to section ~~10-8-601.5 (1) (c.5)~~ 10-16-105.2 (1) (d);

(b) In order to be considered a qualified higher deductible plan for purposes of a medical savings account pursuant to section 39-22-504.7, C.R.S., OR OTHER PROVISIONS OF STATE LAW, MEET THE REQUIREMENTS FOR A QUALIFYING PLAN FOR A MEDICAL SAVINGS ACCOUNT UNDER FEDERAL LAW AND have a minimum deductible of at least one thousand five hundred dollars but no more than two thousand two hundred fifty dollars for individual coverage or at least three thousand dollars but no more than four thousand five hundred dollars for family coverage;

(d) Cover all employees who elect coverage and are not otherwise covered by medicare or another ~~employer's catastrophic~~ health insurance policy;

(g) Provide a clearly written contract of coverage including a list of procedures covered under the policy; ~~This list will be updated annually and sent to the insured.~~

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

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

(3) Insurers shall provide a written disclosure to a covered person that indicates the mandated benefits of section 10-16-104 (1), (1.7), (4), (5), (5.5), (8), (9), (10),

(11), (12), (13), and (14) are covered benefits of the high deductible health plan offered pursuant to section 10-16-105 (7.2) (b) (I) or (7.2) (b) (II); EXCEPT THAT THE MANDATED BENEFITS FOR MAMMOGRAPHY, PROSTATE SCREENINGS, AND CHILD HEALTH SUPERVISION SERVICES SHALL BE SUBJECT TO POLICY DEDUCTIBLES.

SECTION 9. 10-16-117, Colorado Revised Statutes, is amended to read:

10-16-117. Premium payments - pre-tax - election - reporting requirements.

(1) When ~~an employee has purchased~~ catastrophic health insurance IS PURCHASED pursuant to sections 10-16-114 to 10-16-117, ~~the employee is responsible for paying the entire cost of the insurance; however,~~ the employer, at its option, may pay all or a part of such cost.

(2) IF CLAIMING AN EXCLUSION OF PREMIUM PAYMENTS FOR STATE INCOME TAX PURPOSES PURSUANT TO SECTION 39-22-104.5, C.R.S., an employee shall elect to purchase catastrophic health insurance by signing a written election. Such election shall be in the form prescribed by the executive director of the department of revenue and shall be signed prior to the date the employer withholds the first contribution.

(3) An employer shall withhold the premium payments for catastrophic health insurance from the wages of an employee who has elected coverage PURSUANT TO SUBSECTION (2) OF THIS SECTION and shall remit the premiums to the insuring entity on the employee's behalf. All such premiums collected by an employer are withheld from the employee's wages on a pre-tax basis pursuant to section 39-22-104.5, C.R.S.

(4) An employer withholding premium payments from an employee's wages pursuant to SUBSECTION (3) OF this section shall report the amount withheld to the department of revenue, pursuant to rules promulgated by such department.

SECTION 10. 10-16-201 (3), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

10-16-201. Form and content of individual sickness and accident insurance policies. (3) (c) NOTHING IN THIS SUBSECTION (3) SHALL BE CONSTRUED TO NEGATE THE RENEWABILITY REQUIREMENTS FOR HEALTH BENEFIT PLANS SPECIFIED IN SECTION 10-16-201.5.

SECTION 11. 10-16-201.5 (1) (f), Colorado Revised Statutes, is amended to read:

10-16-201.5. Renewability of health benefit plans - modification of health benefit plans. (1) A carrier providing coverage under a health benefit plan shall not discontinue coverage or refuse to renew such plan except for the following reasons:

(f) With respect to individual health benefit plans, the commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders or certificate holders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations. Once the commissioner has made such a finding OR THE CARRIER PROVIDES THE INSURED THE OPTION TO PURCHASE ANY OTHER COMPARABLE HEALTH BENEFIT COVERAGE AS DETERMINED BY THE COMMISSIONER, the carrier shall provide notice to each covered individual provided coverage of this type of such

discontinuation at least ninety days prior to the date of discontinuation and shall provide each affected covered individual the opportunity to purchase any other individual health insurance coverage being offered by the carrier. In exercising this option, a carrier shall act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

SECTION 12. 10-16-214 (3) (a) (XI), (3) (a) (XIV), and (5), Colorado Revised Statutes, are amended to read:

10-16-214. Group sickness and accident insurance. (3) (a) Except as provided for in subsection (2) of this section, all policies of group sickness and accident insurance providing coverage to persons residing in the state shall contain in substance the following provisions or provisions which, in the opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

(XI) A provision that all benefits payable under the policy, other than benefits for loss of time, will be payable ~~not more than sixty days after receipt of proof~~ PURSUANT TO SECTION 10-16-106.5 AND that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of such proof;

(XIV) A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of ~~sixty days~~ THE TIME REQUIREMENTS FOR PAYMENT PURSUANT TO SECTION 10-16-106.5 AND after proof of loss has been filed in accordance with the requirements of the policy, and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy.

(5) A carrier writing health benefit coverage for an employee leasing company shall ensure that any health benefit plan marketed or sold to such company that covers employees in Colorado complies with all the provisions of Colorado law that apply to large employer health plans, including consumer and provider protections, mandated benefits, nondiscrimination and fair marketing rules, preexisting limitations, and other required health plan policy provisions. ALL HEALTH COVERAGE PLANS SPONSORED BY OR MARKETED THROUGH AN EMPLOYEE LEASING COMPANY SHALL BE FULLY INSURED PLANS.

SECTION 13. 10-16-421 (1), Colorado Revised Statutes, is amended to read:

10-16-421. Statutory construction and relationship to other laws. (1) Except for sections 10-1-102, 10-1-116, 10-1-117, 10-1-118, 10-3-109 (2), 10-3-118, 10-3-128, 10-3-208, and 10-8-530 (1.5), PART 2 OF ARTICLE 1 OF THIS TITLE, and parts 4 to 8 of article 3 of this title, and as otherwise provided in this article, the provisions of the insurance law and provisions of nonprofit hospital, medical-surgical, and health service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this part 4.

SECTION 14. Article 16 of title 10, Colorado Revised Statutes, is amended BY

THE ADDITION OF A NEW PART to read:

PART 10
HEALTH CARE COVERAGE COOPERATIVES
AND PROVIDER NETWORKS

10-16-1001. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY RECOGNIZES THAT, THROUGH THE SUNSET REVIEW FOR THE DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES IN OCTOBER, 2001, THE GENERAL ASSEMBLY ADOPTED A RECOMMENDATION TO CONSOLIDATE AND RELOCATE THE REGULATORY FUNCTIONS CONCERNING HEALTH CARE COOPERATIVES. THE PROVISIONS OF PARTS 1, 2, AND 4 OF ARTICLE 18 OF TITLE 6, C.R.S., WERE, THEREFORE, REPEALED AND RELOCATED TO THIS PART 10.

(2) 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 VITALITY OF THE STATE; AND

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

(3) 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.

(4) THE GENERAL ASSEMBLY, THEREFORE, DECLARES THAT THE PURPOSES OF THIS PART 10 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 PART 10 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.

(5) 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 10 IS ENACTED TO ENCOURAGE SUCH COLLABORATIVE ARRANGEMENTS AND TO PROMOTE MARKET-BASED COMPETITION AMONG HEALTH CARE PROVIDERS.

(6) 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.

(7) 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:

(a) EXISTING METHODS OF PROVIDING SERVICES, CONTRACTING, COLLABORATING, AND NETWORKING AMONG PROVIDERS; AND

(b) THE EXTENT AND TYPE OF REGULATORY OVERSIGHT OF LICENSED PROVIDER NETWORKS OR LICENSED INDIVIDUAL PROVIDERS THAT IS APPROPRIATE TO PROTECT THE PUBLIC.

10-16-1002. Definitions. AS USED IN THIS PART 10, UNLESS THE CONTEXT

OTHERWISE REQUIRES:

(1) "CLASS OF BUSINESS" MEANS ALL OR A DISTINCT GROUPING OF SMALL EMPLOYERS AS SHOWN ON THE RECORDS OF A SMALL CARRIER. EACH CLASS SHALL REFLECT SUBSTANTIAL DIFFERENCES IN ADMINISTRATIVE COSTS RELATED TO THE USE OF HEALTH CARE COOPERATIVES FOR THE MARKETING AND SALE OF HEALTH BENEFIT PLANS TO SMALL EMPLOYERS.

(2) "COOPERATIVE" OR "HEALTHCARE COVERAGE COOPERATIVE" MEANS A HEALTH CARE COVERAGE COOPERATIVE CREATED PURSUANT TO THIS PART 10 AS AN ENTITY THAT PROVIDES TO ITS MEMBERS HEALTH COVERAGE AND HEALTH CARE PURCHASING SERVICES, INCLUDING BUT NOT LIMITED TO DETAILED INFORMATION 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., THAT IS SUBJECT TO ARTICLES 121 TO 137 OF TITLE 7, C.R.S., AND THAT HAD FILED ARTICLES OF INCORPORATION WITH THE SECRETARY OF STATE ON OR BEFORE MARCH 15, 1991.

(3) "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.

(4) "LICENSED PROVIDER NETWORK" SHALL HAVE THE SAME MEANING AS IN SECTION 6-18-301.5 (1), C.R.S.

(5) "MANAGED CARE" MEANS SYSTEMS OR TECHNIQUES GENERALLY USED BY THIRD-PARTY PAYORS OR THEIR AGENTS TO AFFECT ACCESS TO, AND TO CONTROL, PAYMENT FOR HEALTH CARE SERVICES. FOR EXAMPLE, AND NOT FOR THE PURPOSE OF LIMITATION, MANAGED CARE TECHNIQUES MOST OFTEN INCLUDE ONE OR MORE OF THE FOLLOWING: PRIOR, CONCURRENT, AND RETROSPECTIVE REVIEW OF THE MEDICAL NECESSITY AND APPROPRIATENESS OF SERVICES OR OF THE SITE AT WHICH SERVICES ARE PROVIDED; CONTRACTS WITH SELECTED HEALTH CARE PROVIDERS; FINANCIAL INCENTIVES OR DISINCENTIVES RELATED TO THE USE OF SPECIFIC PROVIDERS, SERVICES, OR SERVICE SITES; CONTROLLED ACCESS TO AND COORDINATION OF SERVICES BY A CASE MANAGER; AND PAYOR EFFORTS TO IDENTIFY TREATMENT ALTERNATIVES AND MODIFY BENEFIT RESTRICTIONS FOR HIGH-COST PATIENT CARE. "MANAGED CARE" ALSO INCLUDES BUT IS NOT LIMITED TO HEALTH MAINTENANCE ORGANIZATIONS, AS DEFINED IN SECTION 10-16-102 (23).

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

(b) IF, PURSUANT TO SECTION 10-16-1009 (3) (1), A COOPERATIVE PROVIDES COVERAGE TO INDIVIDUALS AND ALLOWS INDIVIDUALS TO JOIN THE COOPERATIVE, "MEMBER" MAY ALSO INCLUDE AN INDIVIDUAL AND ANY DEPENDENT OF SUCH INDIVIDUAL WHO IS COVERED BY A PLAN PURCHASED THROUGH A COOPERATIVE, IS EIGHTEEN YEARS OF AGE OR OLDER, AND 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 THAT COVER THAT INDIVIDUAL.

(7) "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 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 INTEREST IN, OR DERIVES SUBSTANTIAL INCOME FROM AN ENTITY OR PERSON THAT IS CONTRACTING OR 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 ATTEMPTING TO CONTRACT, DIRECTLY OR INDIRECTLY, WITH THE COOPERATIVE.

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

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

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

(11) "WAIVERED HEALTH CARE COVERAGE COOPERATIVE" MEANS A COOPERATIVE THAT HAS BEEN APPROVED TO RECEIVE A WAIVER FROM THE COMMISSIONER PURSUANT TO SECTION 10-16-1011.

10-16-1003. 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 FOR:

(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 COMMISSIONER, 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 SECTION 18-4-412, C.R.S., OR OTHER APPLICABLE LAW.

10-16-1004. Health care coverage cooperatives - establishment - fees.

(1) (a) THERE IS HEREBY AUTHORIZED THE CREATION OF ENTITIES TO BE KNOWN AS HEALTH CARE COVERAGE COOPERATIVES. A HEALTH CARE COVERAGE COOPERATIVE MAY BE CREATED AS ANY LAWFUL ENTITY UNDER ARTICLES 55 AND 56, OR ARTICLES 101 TO 117, OR ARTICLES 121 TO 137 OF TITLE 7, C.R.S., SO LONG AS SUCH ENTITY OPERATES FOR THE MUTUAL BENEFIT OF ITS MEMBERS. ENTITIES CREATED PURSUANT TO THIS PART 10, IN ADDITION TO THE MATTERS OTHERWISE REQUIRED, SHALL BE SUBJECT TO THIS PART 10.

(b) EACH COOPERATIVE SHALL FOLLOW THE ORGANIZATIONAL REQUIREMENTS AND CORPORATE GOVERNANCE REQUIREMENTS OF ITS STATUTORY INCORPORATION AND, IN ADDITION, SHALL PROVIDE INTERNAL PROCEDURES THAT COMPLY WITH SECTION 10-16-1009.

(2) (a) (I) A COOPERATIVE ORGANIZED ON OR AFTER THE EFFECTIVE DATE OF THIS PART 10 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 COMMISSIONER IN SUCH FORM AS THE SECRETARY AND THE COMMISSIONER MAY

REQUIRE CONSISTENT WITH THIS PART 10 AND TITLE 7, C.R.S.

(II) FOR COOPERATIVES FORMED PRIOR TO THE EFFECTIVE DATE OF THIS PART 10, THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL PROVIDE THE COMMISSIONER WITH SUCH COOPERATIVES' ARTICLES OF ORGANIZATION.

(b) ANY PERSON OR ENTITY OPERATING OR HOLDING ITSELF OUT AS A COOPERATIVE SHALL APPLY FOR AND OBTAIN A CERTIFICATE OF AUTHORITY TO OPERATE AS A COOPERATIVE PURSUANT TO SECTIONS 10-16-1005 AND 10-16-1006.

(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 WITH 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 COMMISSIONER PURSUANT TO SECTION 10-16-1005 (1).

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

(4) EACH COOPERATIVE SHALL FILE A REPORT PURSUANT TO SECTION 7-136-107, C.R.S., AND PAY THE REQUIRED 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.

(5) EXCEPT AS ALLOWED BY SECTION 10-16-1014, THE DIVISION OF INSURANCE SHALL NOT PARTICIPATE IN THE FORMATION OR ADMINISTRATION OF A HEALTH CARE COVERAGE COOPERATIVE CREATED PURSUANT TO THIS PART 10.

10-16-1005. Issuance of certificate of authority by commissioner for cooperative to purchase health care coverage. (1) (a) (I) (A) ON AND AFTER THE EFFECTIVE DATE OF THIS PART 10, AN UNLICENSED COOPERATIVE CONDUCTING BUSINESS PURSUANT TO THIS PART 10 SHALL FILE AN APPLICATION WITH THE COMMISSIONER 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 10-16-1004 (2) (c) AND 10-16-1008 (3); AND THE NAMES OF MANAGING PERSONNEL

OF THE COOPERATIVE. THE COMMISSIONER SHALL GRANT A CERTIFICATE OF AUTHORITY TO AN APPLICANT UNDER THIS SECTION UNLESS THE APPLICATION FAILS TO COMPLY WITH THIS PART 10. THE COMMISSIONER SHALL ESTABLISH AN APPLICATION FILING FEE, NOT TO EXCEED ONE THOUSAND ONE HUNDRED DOLLARS, TO RECOVER THE DIRECT COSTS OF THE COMMISSIONER 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 COMMISSIONER MAY REASONABLY REQUIRE TO DETERMINE THAT A COOPERATIVE CONTINUES TO BE IN COMPLIANCE WITH THE PROVISIONS OF THIS PART 10. THE COMMISSIONER SHALL ESTABLISH A FEE, NOT TO EXCEED ONE THOUSAND ONE HUNDRED DOLLARS ANNUALLY, TO RECOVER THE DIRECT COSTS OF THE COMMISSIONER IN DETERMINING ANNUALLY THAT A COOPERATIVE IS IN COMPLIANCE WITH THE PROVISIONS OF THIS PART 10.

(B) EXCEPT AS PROVIDED IN SECTION 10-16-1004 (3) (b), NO COOPERATIVE SHALL TAKE ANY ACTION ENUMERATED IN SECTION 10-16-1009 UNLESS A CERTIFICATE OF AUTHORITY HAS BEEN ISSUED PURSUANT TO THIS SECTION BY THE COMMISSIONER. ANY PERSON OR ENTITY APPLYING TO OBTAIN A CERTIFICATE OF AUTHORITY AS REQUIRED BY SECTION 10-16-1004 (2) (b) THAT FAILS TO OBTAIN A CERTIFICATE OF AUTHORITY BY DECEMBER 1, 2004, SHALL CEASE TO ENGAGE IN ANY ACTIVITY FOR WHICH A CERTIFICATE OF AUTHORITY IS REQUIRED PURSUANT TO THIS PART 10 UNTIL A CERTIFICATE OF AUTHORITY IS ISSUED BY THE COMMISSIONER PURSUANT TO THIS SECTION AND SECTION 10-16-1006.

(C) COOPERATIVES THAT HAVE BEEN ISSUED A CERTIFICATE OF AUTHORITY BY THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING PRIOR TO THE EFFECTIVE DATE OF THIS PART 10 SHALL SUBMIT PROOF OF SUCH CERTIFICATE OF AUTHORITY TO THE COMMISSIONER PRIOR TO NOVEMBER 1, 2004. THE COMMISSIONER SHALL REISSUE A CERTIFICATE OF AUTHORITY TO THE COOPERATIVE ON OR BEFORE DECEMBER 1, 2004.

(II) A COOPERATIVE SHALL BE REQUIRED TO POST A FIDELITY OR EMPLOYEE DISHONESTY BOND OR DEPOSIT WITH THE COMMISSIONER A CERTIFICATE OF DEPOSIT OR SECURITIES IN A MINIMUM AMOUNT EQUAL TO AT LEAST TWO MONTHS' PREMIUMS HELD BY THE COOPERATIVE OR ITS ADMINISTRATOR AS OF ITS ANNUAL RENEWAL DATE IN ORDER TO BE GRANTED A CERTIFICATE OF AUTHORITY UNDER THIS SECTION. IF A COOPERATIVE CONTRACTS WITH AN OUTSIDE ADMINISTRATOR FOR ALL PREMIUM-HANDLING FUNCTIONS, THE COOPERATIVE ITSELF WILL NOT BE REQUIRED TO POST A BOND IN ORDER TO COMPLY WITH THE PROVISIONS OF THIS SUBPARAGRAPH (II) SO LONG AS THE COOPERATIVE SUBMITS TO THE COMMISSIONER EVIDENCE THAT SUCH ADMINISTRATOR HAS OBTAINED A BOND IN THE REQUIRED AMOUNT.

(b) THE COMMISSIONER 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 AFTER THE DATE OF ISSUANCE.

(c) NOTWITHSTANDING THE PROVISIONS OF PART 2 OF ARTICLE 72 OF TITLE 24, C.R.S., AN APPLICATION, TOGETHER WITH ANY SUPPORTING MATERIAL AND RESPONSES FROM THE COMMISSIONER, SHALL NOT BE CONSIDERED A PUBLIC RECORD UNTIL THE COMMISSIONER APPROVES THE APPLICATION OR UNTIL AN ORGANIZER REQUESTS A HEARING ON THE COMMISSIONER'S DENIAL OF THE APPLICATION.

(2) THE COMMISSIONER SHALL RESPOND IN WRITING TO EACH APPLICATION FOR A CERTIFICATE OF AUTHORITY WITHIN THIRTY DAYS AFTER RECEIPT BY THE COMMISSIONER. THE COMMISSIONER SHALL EITHER APPROVE THE APPLICATION OR SHALL INFORM THE ORGANIZERS OF SPECIFIC CHANGES TO THE APPLICATION THAT THE COMMISSIONER DEEMS NECESSARY FOR APPROVAL UNDER THIS PART 10. EACH APPLICANT SHALL RESPOND TO THE COMMISSIONER'S COMMENTS WITHIN THIRTY DAYS AFTER RECEIPT. THE COMMISSIONER SHALL EITHER 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.

10-16-1006. Authority to deny application for, revoke, or suspend certificate of authority. (1) ON AND AFTER THE EFFECTIVE DATE OF THIS PART 10, THE COMMISSIONER MAY DENY AN APPLICATION FOR A CERTIFICATE OF AUTHORITY PURSUANT TO SECTION 10-16-1005 OR REVOKE OR SUSPEND A CERTIFICATE OF AUTHORITY OF ANY COOPERATIVE FOUND TO BE IN VIOLATION OF THIS PART 10.

(2)(a) ANY PARTY MAY REQUEST A HEARING PURSUANT TO ARTICLE 4 OF TITLE 24, C.R.S., ON ANY ACTION OF THE COMMISSIONER 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 SECTION 10-1-127, AND THE COMMISSIONER MAY 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 COMMISSIONER UNDER THIS PART 10 SHALL BE SUBJECT TO JUDICIAL REVIEW BY THE COURT OF APPEALS PURSUANT TO SECTION 24-4-106 (11), C.R.S.

10-16-1007. Prohibition on cooperatives transacting insurance business. A COOPERATIVE SHALL NOT PERFORM ANY ACTIVITY INCLUDED IN THE DEFINITION OF TRANSACTING INSURANCE BUSINESS IN THIS STATE, AS PROVIDED IN SECTION 10-3-903, EXCEPT AS OTHERWISE AUTHORIZED IN THE POWERS, DUTIES, AND RESPONSIBILITIES OF COOPERATIVES AS SET FORTH IN SECTION 10-16-1009. A COOPERATIVE SHALL NOT ESTABLISH OR ENGAGE IN THE ACTIVITIES OF A HEALTH MAINTENANCE ORGANIZATION, AS DEFINED IN SECTION 10-16-102 (23).

10-16-1008. 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 10.

(2) A COOPERATIVE MAY PROVIDE 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 HIS OR HER TERM ON THE GOVERNING BODY OR DURING THE TWELVE-MONTH PERIOD IMMEDIATELY BEFORE OR 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 EXECUTIVE COMMITTEE ALL THE FUNCTIONS AND POWERS OF THE BOARD OF DIRECTORS, SUBJECT TO GENERAL DIRECTION AND CONTROL BY THE BOARD.

(5) WHEN A VACANCY OCCURS ON THE GOVERNING BODY OF A COOPERATIVE OTHER THAN BY EXPIRATION OF A MEMBER'S 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.

10-16-1009. Powers, duties, and responsibilities of cooperatives. (1) EACH COOPERATIVE ORGANIZED PURSUANT TO THIS PART 10 SHALL:

(a) ESTABLISH THE CONDITIONS OF COOPERATIVE MEMBERSHIP;

(b) PROVIDE TO COOPERATIVE MEMBERS AND THEIR ELIGIBLE EMPLOYEES CLEAR, STANDARDIZED INFORMATION ABOUT EACH PROVIDER NETWORK, LICENSED 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) OFFER DEPENDENT COVERAGE;

(d) EXCEPT FOR GROUPS OVER FIFTY, OFFER TO ALL MEMBERS AND THEIR ELIGIBLE EMPLOYEES THE STANDARD AND BASIC HEALTH BENEFIT PLANS;

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

(f) CONTRACT ONLY FOR INSURANCE FUNCTIONS LISTED IN SECTION 10-3-903, WITH ENTITIES AUTHORIZED TO DO BUSINESS IN THIS STATE BY THE COMMISSIONER PURSUANT TO THIS TITLE THAT 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;

(g) 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;

(h) 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 THAT MAY BE USED BY POTENTIAL MEMBERS IN DECIDING WHETHER TO JOIN THE COOPERATIVE;

(i) 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;

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

(k) MAINTAIN A TRUST ACCOUNT OR ACCOUNTS FOR THE DEPOSIT OF PREMIUM MONEYS COLLECTED PURSUANT TO PARAGRAPH (d) OF SUBSECTION (3) 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.

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

(m) DISCLOSE TO MEMBERS AND POTENTIAL MEMBERS WHETHER OR NOT THE COOPERATIVE HAS BEEN GRANTED A TEMPORARY CERTIFICATE OF AUTHORITY PURSUANT TO SECTION 10-16-1005 (1) (b);

(n) 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.

(2) 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 10, "SELF-INSURED" MEANS 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) THAT THE COOPERATIVE MAY NEGOTIATE ON BEHALF OF ITS SELF-INSURED MEMBERS.

(3) EACH COOPERATIVE ORGANIZED PURSUANT TO THIS PART 10 MAY:

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

(b) SET REASONABLE FEES FOR MEMBERSHIP IN THE COOPERATIVE THAT 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;

(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 ESTABLISH MINIMUM PERCENTAGES THAT DIFFER ACCORDING TO THE BENEFIT PLAN OR CARRIER OFFERED. THE COOPERATIVE MAY REQUIRE AN EMPLOYER MAKING MEMBERSHIP APPLICATION TO A COOPERATIVE THAT WOULD ENTAIL ENTERING FEWER THAN ONE HUNDRED PERCENT OF SUCH EMPLOYER'S ELIGIBLE EMPLOYEES OR DEPENDENTS TO DEMONSTRATE, UNDER STANDARDS CONSISTENT WITH PARAGRAPH (g) OF SUBSECTION (4) OF THIS SECTION, THAT SUCH MEMBERSHIP IS NOT LIKELY TO RESULT IN AN ADVERSE SELECTION GROUP BEING BROUGHT INTO THE COOPERATIVE AND WOULD NOT OTHERWISE ACT AS A FORM OF RISK SELECTION OR RISK AVOIDANCE.

(e) SUBJECT TO PARAGRAPH (1) 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 FAILS TO PAY PREMIUMS OR ENGAGES 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 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 PART 10;

(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. SUCH FEE SCHEDULE SHALL 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.

(m) ESTABLISH EMPLOYER CONTRIBUTION REQUIREMENTS. SUCH REQUIREMENTS MAY DIFFER BY BENEFIT PLAN, BENEFIT PACKAGE, OR CARRIER.

(4) NO COOPERATIVE ORGANIZED PURSUANT TO THIS PART 10 MAY:

(a) EXCLUDE FROM MEMBERSHIP IN THE COOPERATIVE ANY SMALL EMPLOYER OR ELIGIBLE EMPLOYEE OR DEPENDENT OF A SMALL EMPLOYER 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 AND SATISFIES THE REQUIREMENTS OF THE BENEFIT PLAN SELECTED;

(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 BY SECTION 10-3-1104 (1)(g). THE COMMISSIONER SHALL ENFORCE THIS PARAGRAPH (c) PURSUANT TO PART 11 OF ARTICLE 3 OF THIS TITLE.

(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 HEALTH CARE OR THE ADMINISTRATION OF HEALTH CARE PURCHASING FUNCTIONS;

(f) AS A CONDITION OF MEMBERSHIP, REQUIRE ANY MEMBER, ELIGIBLE EMPLOYEE, OR DEPENDENT TO SUBSCRIBE TO NON-HEALTH-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 THAT WOULD CAUSE THE COOPERATIVE TO SELECT A RISK POOL WITH ACTUARIALLY PROJECTED HEALTHCARE UTILIZATION OVER A TWO-YEAR PERIOD THAT 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, PROVIDER, LICENSED PROVIDER NETWORK, LICENSED INDIVIDUAL PROVIDER, OR INDIVIDUAL PROVIDER THAT DOES NOT COMPLY WITH OR CONFORM TO THE APPLICABLE REQUIREMENTS OR STANDARDS OF THIS TITLE.

10-16-1010. 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) 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. 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 BENEFIT PLANS AND THE TYPE OF MANAGED CARE SYSTEM UNDER WHICH BENEFITS WILL BE PROVIDED.

10-16-1011. Requirements for waived health care coverage cooperatives. (1) THE COMMISSIONER SHALL PROMULGATE RULES SETTING FORTH THE APPLICATION PROCEDURE FOR COOPERATIVES SEEKING A WAIVER UNDER THIS SECTION THAT:

(a) ESTABLISH FAIR, EFFECTIVE, AND TIMELY PROCEDURES FOR ADDRESSING CONSUMER, CONTRACTOR, AND HEALTH PLAN GRIEVANCES. SUCH RULES SHALL INCLUDE, WITHOUT LIMITATION, A REQUIREMENT THAT HEALTH PLANS PROVIDE THE

COOPERATIVE WRITTEN NOTIFICATION OF ALL GRIEVANCES FILED WITH THE HEALTH PLANS AND AT LEAST A QUARTERLY SUMMARY OF SUCH GRIEVANCES. THIS PARAGRAPH (a) SHALL NOT BE CONSTRUED TO EXEMPT PARTICIPATING CARRIERS FROM ANY REQUIREMENTS OF THIS TITLE CONCERNING GRIEVANCE PROCEDURES.

(b) REQUIRE THE COOPERATIVE TO DEMONSTRATE THAT IT PROVIDES COVERAGE IN EVERY GEOGRAPHIC AREA IN WHICH ITS PARTICIPATING CARRIERS ARE AUTHORIZED TO DO BUSINESS BY THE DIVISION OF INSURANCE;

(c) ESTABLISH THAT SMALL EMPLOYERS THAT PURCHASE FULLY INSURED PRODUCTS THROUGH THE COOPERATIVE ARE NOT PERMITTED TO OFFER THEIR EMPLOYEES COMPARABLE FULLY INSURED OR SELF-INSURED PRODUCTS THROUGH ANY MEANS OTHER THAN THE COOPERATIVE;

(d) ENSURE THAT THE COOPERATIVE WILL AT ALL TIMES COMPLY WITH THE PROVISIONS OF SECTION 10-16-1009 (4) (g);

(e) REQUIRE THE COOPERATIVE TO OFFER, AT A MINIMUM, THE BASIC AND STANDARD BENEFIT PLANS FOR EMPLOYERS WITH FIFTY OR FEWER EMPLOYEES THAT ALL PARTICIPATING CARRIERS MUST OFFER. OTHER BENEFIT PLANS AND BENEFIT PACKAGES MAY BE ESTABLISHED AND OFFERED BY SOME OR ALL CARRIERS THAT CONTRACT WITH THE COOPERATIVE, AND SUCH PLANS OR PACKAGES MAY INCLUDE A RANGE OF COST-SHARING LEVELS. BENEFIT PACKAGES MAY ALSO INCLUDE SOME VARIATIONS FOR DIFFERENCES IN DELIVERY SYSTEMS, SUCH AS HEALTH MAINTENANCE ORGANIZATIONS, POINT-OF-SERVICE PLANS, PREFERRED PROVIDER PLANS, AND FEE-FOR-SERVICE PLANS.

(2) A WAIVER SHALL BE IN EFFECT FOR A PERIOD OF NOT LESS THAN TEN YEARS AFTER THE DATE OF ISSUE, UNLESS THE COMMISSIONER DETERMINES THAT THE WAIVERED COOPERATIVE IS IN VIOLATION OF SUBSECTION (1) OF THIS SECTION. IN SUCH A CASE, THE WAIVER MAY BE PHASED OUT OVER A PERIOD OF THREE YEARS BY THE COMMISSIONER IN A MANNER THAT IS CONSISTENT WITH THE MARKET VIABILITY OF THE COOPERATIVE.

(3) THE COMMISSIONER MAY GRANT A PERMANENT WAIVER EFFECTIVE UPON EXPIRATION OF A TEN-YEAR PERIOD. IF AT ANY TIME THE COMMISSIONER DETERMINES THAT A WAIVERED COOPERATIVE OPERATING UNDER A PERMANENT WAIVER IS IN VIOLATION OF SUBSECTION (1) OF THIS SECTION, THE PERMANENT WAIVER MAY BE PHASED OUT BY THE COMMISSIONER OVER A PERIOD OF THREE YEARS IN A MANNER THAT IS CONSISTENT WITH THE MARKET VIABILITY OF THE COOPERATIVE.

(4) THE COMMISSIONER SHALL PROMULGATE RULES FOR ANNUAL REPORTING REQUIREMENTS FOR WAIVERED COOPERATIVES. REPORTING REQUIREMENTS SHALL BE BASED ONLY ON THE REQUIREMENTS FOR OBTAINING A WAIVER AS OUTLINED UNDER SUBSECTION (1) OF THIS SECTION. SUCH REPORTING REQUIREMENTS SHALL BE INTEGRATED WITH OTHER REPORTING REQUIREMENTS FOR COOPERATIVES OPERATING UNDER THIS PART 10.

(5) (a) (I) ANY CARRIER DOING BUSINESS WITH A WAIVERED COOPERATIVE SHALL COMPLY WITH ALL RULES REGARDING UNDERWRITING, CLAIMS HANDLING, SALES, SOLICITATION, AND OTHER APPLICABLE REQUIREMENTS SPECIFIED PURSUANT TO THIS

TITLE.

(II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (a), IF A WAIVERED COOPERATIVE REQUIRES ITS PARTICIPATING SMALL EMPLOYER CARRIERS TO OFFER A STANDARDIZED HEALTH BENEFIT PLAN THAT SUCH CARRIERS DO NOT OFFER OUTSIDE OF THE WAIVERED COOPERATIVE, SUCH CARRIERS SHALL NOT BE REQUIRED TO MARKET THAT STANDARDIZED PLAN EITHER INSIDE OR OUTSIDE THE WAIVERED COOPERATIVE IN THOSE AREAS OF THE STATE THAT ARE NOT PART OF THE WAIVERED COOPERATIVE'S GEOGRAPHIC SERVICE AREA.

(b) (I) ANY CARRIER DOING BUSINESS WITH A WAIVERED COOPERATIVE SHALL COMPLY WITH ALL APPLICABLE RULES REGARDING RATING SPECIFIED PURSUANT TO THIS TITLE.

(II) (A) NOTWITHSTANDING SUBPARAGRAPH (I) OF THIS PARAGRAPH (b) AND SUBJECT TO THE PROVISIONS OF SUB-SUBPARAGRAPH (B) OF THIS SUBPARAGRAPH (II), A WAIVERED COOPERATIVE AND A PARTICIPATING CARRIER MAY NEGOTIATE A PERCENTAGE DISCOUNT OFF OF WHAT WOULD OTHERWISE BE ALLOWABLE RATES UNDER SECTIONS 10-16-105 (8) (a) AND 10-16-1012 FOR A PARTICULAR PLAN. THAT PERCENTAGE DISCOUNT SHALL BE APPLIED UNIFORMLY TO ALL SMALL EMPLOYER MEMBERS OF THE COOPERATIVE. PURSUANT TO SECTION 10-16-1012, A CARRIER MAY APPLY RATING FACTORS DIFFERENTLY FOR ITS BUSINESS WITH A WAIVERED COOPERATIVE THAN FOR THE CARRIER'S OTHER BUSINESS. PARTICIPATING CARRIERS SHALL NOTIFY THE DIVISION OF INSURANCE OF A NEGOTIATED COOPERATIVE DISCOUNT AT LEAST THIRTY DAYS PRIOR TO USE.

(B) A WAIVERED COOPERATIVE MAY NEGOTIATE THE NON-HEALTH-CARE EXPENSE COMPONENT OF THE PREMIUM RATES CHARGED WITH PARTICIPATING HEALTH CARE COVERAGE PLANS. AS USED IN THIS SUB-SUBPARAGRAPH (B), "NON-HEALTH-CARE EXPENSE" INCLUDES BUT IS NOT LIMITED TO MARKETING EXPENSES, ACQUISITION EXPENSES, COST OF PAYING CLAIMS, COMMISSIONS, MAINTENANCE EXPENSES, OTHER ADMINISTRATION COSTS, PROFITS, AND OTHER CONTINGENCY MARGINS. "NON-HEALTH-CARE EXPENSE" DOES NOT INCLUDE FEES PAID TO HEALTH CARE PROVIDERS FOR HEALTH CARE SERVICES REGARDLESS OF THE METHODOLOGY OF REIMBURSEMENT OR PAYMENT.

(C) PARTICIPATING HEALTH CARE COVERAGE PLANS, INCLUDING THOSE PLANS THAT ARE UNDER CONSIDERATION FOR PARTICIPATION, SHALL, UPON REQUEST, DISCLOSE TO WAIVERED COOPERATIVES A LIST AND DESCRIPTION OF ALL RELEVANT PUBLIC INFORMATION REGARDING ALL EXPENSES OF THE HEALTH PLANS, INCLUDING BUT NOT LIMITED TO: THE PLAN'S RECENT FILINGS AND PREVIOUSLY REQUIRED FILINGS WITH THE COLORADO DIVISION OF INSURANCE; FILINGS WITH THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC); HEALTH EMPLOYER DATA INFORMATION SET (HEDIS) REPORTS REGARDING PROVIDER COMPENSATION; AND FEDERAL HEALTH CARE FINANCING ADMINISTRATION AND FEDERAL OFFICE OF PERSONNEL MANAGEMENT FILINGS RELEVANT TO PROVIDER COMPENSATION. PUBLIC INFORMATION SHALL BE PROVIDED UPON REQUEST TO A COOPERATIVE WITHIN FIFTEEN DAYS AFTER SUCH REQUEST.

(D) ALL HEALTH CARE PLANS PARTICIPATING IN A COOPERATIVE SHALL SIGN AN AFFIDAVIT DECLARING THAT ALL COINSURANCE PAID BY THE INSURED PARTICIPANTS

OF THE EMPLOYER MEMBERS OF A WAIVERED COOPERATIVE SHALL BE BASED ON THE HEALTH PLAN'S CONTRACTED RATE WITHIN THE HEALTH PLAN'S PROVIDER NETWORK.

(6) IF THE COMMISSIONER DOES NOT ACT ON AN APPLICATION FOR A WAIVER UNDER THIS SECTION WITHIN SIXTY DAYS AFTER SUBMISSION OF THE APPLICATION, THE COOPERATIVE MAY REQUEST A FORMAL HEARING WITH THE COMMISSIONER.

10-16-1012. Application of rating factors inside a waived cooperative.

WITH THE PRIOR APPROVAL OF THE COMMISSIONER, A WAIVERED COOPERATIVE MAY REQUIRE ALL PARTICIPATING CARRIERS TO APPLY ALLOWABLE RATE ADJUSTMENT FACTORS AND CASE CHARACTERISTIC FACTORS TO ALL OF THAT WAIVERED COOPERATIVE'S BUSINESS IN A CONSISTENT FASHION, AS DETERMINED BY THE COOPERATIVE. IF A WAIVERED COOPERATIVE HAS RECEIVED SUCH APPROVAL, A PARTICIPATING CARRIER WITHIN THAT COOPERATIVE SHALL NOT BE REQUIRED TO APPLY ALLOWABLE RATE ADJUSTMENT FACTORS AND CASE CHARACTERISTIC FACTORS IN THE SAME WAY FOR ITS WAIVERED COOPERATIVE BUSINESS AS FOR ITS OTHER BUSINESS.

10-16-1013. 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 NOTICE AND THE OPPORTUNITY FOR A HEARING PURSUANT TO ARTICLE 4 OF TITLE 24, C.R.S., THE COMMISSIONER MAY ENFORCE THE PROVISIONS OF THIS PART 10 BY ISSUING ORDERS DIRECTED TO ANY RESPONSIBLE PARTY, INCLUDING BUT NOT LIMITED TO CEASE-AND-DESIST ORDERS, AS ARE DEEMED NECESSARY IF THE COMMISSIONER FINDS THAT:

(I) SUCH PERSON HAS VIOLATED THIS PART 10 OR ANY LAWFUL RULE PROMULGATED PURSUANT TO THIS PART 10, ENGAGED IN ANY UNSAFE OR UNSOUND PRACTICE IN CONNECTION WITH A COOPERATIVE, ENGAGED IN AN ACT, OMISSION, OR PRACTICE THAT 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 TO THE ACTIONS AUTHORIZED IN PARAGRAPH (a) OF THIS SUBSECTION (2), THE COMMISSIONER MAY IMPOSE A CIVIL PENALTY OF 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 COMMISSIONER DETERMINES THAT ANY PERSON IS IN VIOLATION OF THE PROVISIONS OF SECTION 10-16-1004 (2) (c) OR 10-16-1008 (3), THE COMMISSIONER MAY ORDER THE RESPONSIBLE PARTY SUSPENDED OR REMOVED FROM OFFICE.

(d) IF THE COMMISSIONER FINDS THAT EXTRAORDINARY CIRCUMSTANCES EXIST THAT 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 COMMISSIONER MAY INITIATE INFORMAL ACTIONS TO ENFORCE THIS PART 10 UNDER THIS SECTION. SUCH INFORMAL ACTIONS MAY INCLUDE 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, REQUEST JUDICIAL REVIEW UNDER SECTION 24-4-106 (11), C.R.S. AN ACTION FOR JUDICIAL REVIEW SHALL NOT OPERATE TO STAY OR VACATE A DECISION OR ORDER EXCEPT THAT THE COURT MAY ISSUE A STAY PENDING REVIEW. THE COMMISSIONER MAY RECOVER REASONABLE ATTORNEY FEES INCURRED TO ENFORCE THE ORDER.

10-16-1014. Technical assistance to authorized cooperatives from the division of insurance. (1) SUBJECT TO AVAILABLE APPROPRIATIONS, THE COMMISSIONER 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 THAT SPECIFY THAT EMPLOYER MEMBERS SHALL TAKE NO ACTION TO LIMIT THEIR EMPLOYEES' CHOICE OF PLANS OFFERED THROUGH THE COOPERATIVE OR TO ENCOURAGE OR DISCOURAGE EMPLOYEES 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.

10-16-1015. Health care cooperatives - rule-making authority. THE COMMISSIONER MAY PROMULGATE RULES CONSISTENT WITH THIS PART 10 FOR PURPOSES OF CARRYING OUT THE COMMISSIONER'S DUTIES UNDER THIS PART 10. THE COMMISSIONER MAY PROMULGATE RULES TO CARRY OUT THE COMMISSIONER'S DUTIES UNDER SECTION 10-16-1005, SO LONG AS SUCH RULES IMPOSE NO ADDITIONAL REQUIREMENTS BEYOND THOSE SPECIFICALLY ENUMERATED IN SECTION 10-16-1005.

SECTION 15. 10-20-103 (8) (i), Colorado Revised Statutes, is amended, and the said 10-20-103 (8) is further amended BY THE ADDITION OF A NEW PARAGRAPH, to read:

10-20-103. Definitions. As used in this article, unless the context otherwise requires:

(8) "Member insurer" means any insurer licensed or who holds a certificate of authority in this state to write any kind of insurance for which coverage is provided pursuant to section 10-20-104 and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn; but "member insurer" does not include:

(i) An interinsurance exchange; ~~and~~

(i.5) A HEALTH CARE COVERAGE COOPERATIVE; AND

SECTION 16. 6-4-108 (6), Colorado Revised Statutes, is amended 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 PART 3 OF article 18 of this title OR PART 10 OF ARTICLE 16 OF TITLE 10, C.R.S.

SECTION 17. Part 3 of article 18 of title 6, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

6-18-301.5. Definitions. AS USED IN THIS PART 3, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "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.

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

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

SECTION 18. 7-56-207 (1) (a), Colorado Revised Statutes, as it will become effective July 1, 2004, is amended to read:

7-56-207. Use of the term "cooperative" - penalty for unlawful use. (1) No person shall use the word "cooperative" or an abbreviation or derivation of it as a part of its business or domestic entity name or as a trade name, trademark, service mark, brand, or designation except:

(a) An entity incorporated under or subject to this article, article 55 of this title, article 33.5 of title 38, C.R.S., ~~article 18 of title 6~~ PART 10 OF ARTICLE 16 OF TITLE 10, C.R.S., or a similar law of another jurisdiction;

SECTION 19. 7-90-102 (31.1), Colorado Revised Statutes, as it will become effective July 1, 2004, is amended to read:

7-90-102. Definitions. As used in this title, except as otherwise defined for the purpose of any section, part, or article of this title, or unless the context otherwise requires:

(31.1) "Health care coverage cooperative" ~~means an entity created pursuant to part 2 of article 18 of title 6~~ SHALL HAVE THE SAME MEANING AS SET FORTH IN SECTION 10-16-1002 (2), C.R.S., OR A SUCCESSOR STATUTE.

SECTION 20. 7-90-303 (1) (f), Colorado Revised Statutes, is amended to read:

7-90-303. Filing, service, and copying fees - subpoenas. (1) The secretary of state shall charge and collect fees and other charges, which shall be determined and collected pursuant to section 24-21-104 (3), C.R.S., for:

(f) Filing any document required or permitted to be filed under part 2 or 3 of article 18 of title 6 OR PART 10 OF ARTICLE 16 OF TITLE 10 or part 3 of article 33.3 of title 38, C.R.S., or this title.

SECTION 21. 25-1-1202 (1) (a), Colorado Revised Statutes, is amended to read:

25-1-1202. Index of statutory sections regarding medical record confidentiality and health information. (1) Statutory provisions concerning policies, procedures, and references to the release, sharing, and use of medical records and health information include the following:

(a) Section ~~6-18-103~~ 10-16-1003, C.R.S., concerning use of information by health care cooperatives;

SECTION 22. 25.5-1-512 (7), Colorado Revised Statutes, is amended to read:

25.5-1-512. Immunity - notice requirements. (7) Nothing in this part 5 shall be construed to exempt a licensed provider network, as defined in section ~~6-18-102~~ ~~(1)~~ 6-18-301.5 (1), 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 cooperative agreement in accordance with the provisions of this part 5.

SECTION 23. Repeal. Parts 1, 2, and 4 of article 18 of title 6, part 6 of article 8 of title 10, article 21 of title 10, and part 4 of article 1 of title 25.5, Colorado Revised Statutes, are repealed.

SECTION 24. Effective date. This act shall take effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution (August 4, 2004, if adjournment sine die is on May 5, 2004); except that, if a referendum petition is filed against this act or an item, section, or part of this act within such period, then the act, item, section, or part, if approved by the people, shall take effect on the date of the official declaration of the vote thereon by proclamation of the governor.

Approved: May 21, 2004