CHAPTER 311

INSURANCE

HOUSE BILL 94-1210

BY REPRESENTATIVES Coffman, Armstrong, Blue, Dyer, Friednash, Gordon, Greenwood, Hagedorn, Hernandez, June, Linkhart, Lyle, Pierson, Prinster, Snyder, Eisenach, Keller, Kerns, and Reeser;
also SENATORS Schroeder, Bird, Bishop, Blickensderfer, Cassidy, Gallagher, Hopper, Johnson, Mares, Norton, L. Powers, Ruddick, Tebedo, and Traylor.

AN ACT

CONCERNING MEASURES TO IMPROVE THE SYSTEM OF FINANCING HEALTH CARE COSTS USING ARRANGEMENTS WITH PRIVATE THIRD-PARTY PAYORS PURSUANT TO EXISTING MANDATORY COVERAGE PROVISIONS, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

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

SECTION 1. Part 6 of article 8 of title 10, Colorado Revised Statutes, 1987 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

10-8-601.5. Applicability and scope. (1) (a) EXCEPT AS PROVIDED IN PARAGRAPH (b) OF THIS SUBSECTION (1), THIS ARTICLE AND ARTICLE 16 OF THIS TITLE SHALL APPLY TO ANY HEALTH BENEFIT PLAN THAT PROVIDES COVERAGE TO THE EMPLOYEES OF AN 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; OR

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

(IV) THE PLAN IS MARKETED TO INDIVIDUAL EMPLOYEES THROUGH AN EMPLOYER OR AT A PLACE OF BUSINESS.

(b) THE PROVISIONS OF THIS ARTICLE AND ARTICLE 16 OF THIS TITLE 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).

(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 AND ARTICLE 16 OF THIS TITLE 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 ARTICLE 16 OF THIS TITLE MAY BE CONSIDERED TO BE A SEPARATE CARRIER FOR PURPOSES OF THIS SUBSECTION (2).

(c) UNLESS OTHERWISE AUTHORIZED BY THE COMMISSIONER, A SMALL EMPLOYER CARRIER SHALL NOT ENTER INTO ONE OR MORE CEDING ARRANGEMENTS WITH RESPECT TO HEALTH BENEFIT PLANS DELIVERED OR ISSUED FOR DELIVERY TO SMALL EMPLOYERS IN THIS STATE IF SUCH ARRANGEMENTS WOULD RESULT IN LESS THAN FIFTY PERCENT OF THE INSURANCE OBLIGATION OR RISK FOR SUCH HEALTH BENEFIT PLANS BEING RETAINED BY THE CEDING CARRIER. 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.

SECTION 2. 10-8-602 (1), (3), (6), and (11), Colorado Revised Statutes, 1987 Repl. Vol., as amended, are amended, and the said 10-8-602 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

10-8-602. Definitions. As used in this part 6, unless the context otherwise requires:

(1) ~~"Basic health benefit plan" means a lower cost health benefit plan developed pursuant to section 10-8-606.~~ "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 THIS PART 6 AND APPLICABLE PROVISIONS OF ARTICLE 16 OF THIS TITLE, 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.

(1.2) "AFFILIATE" OR "AFFILIATED" MEANS ANY ENTITY OR PERSON THAT DIRECTLY OR INDIRECTLY, THROUGH ONE OR MORE INTERMEDIARIES, CONTROLS OR IS

CONTROLLED BY, OR IS UNDER COMMON CONTROL WITH, A SPECIFIED ENTITY OR PERSON.

(1.3) "BASE PREMIUM RATE" MEANS, AS TO A RATING PERIOD, THE LOWEST PREMIUM RATE CHARGED OR THAT COULD HAVE BEEN CHARGED BY THE SMALL EMPLOYER CARRIER TO SMALL EMPLOYERS WITH SIMILAR CASE CHARACTERISTICS FOR HEALTH BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

(1.5) "BASIC HEALTH BENEFIT PLAN" MEANS A HEALTH BENEFIT PLAN DEVELOPED PURSUANT TO SECTION 10-16-105 (7.2).

(2.5) "BUSINESS GROUP OF ONE" MEANS, FOR PURPOSES OF INITIAL QUALIFICATION, AN INDIVIDUAL, A SOLE PROPRIETOR, OR A SINGLE FULL-TIME EMPLOYEE OF A SUBCHAPTER S CORPORATION, C CORPORATION, LIMITED LIABILITY COMPANY, OR PARTNERSHIP WHO HAS CARRIED ON SIGNIFICANT BUSINESS ACTIVITY FOR A PERIOD OF AT LEAST ONE YEAR PRIOR TO APPLICATION FOR COVERAGE, HAS TAXABLE INCOME AS INDICATED ON FEDERAL INTERNAL REVENUE SERVICE FORMS 1040, SCHEDULE C, F, OR SE, OR OTHER FORMS RECOGNIZED BY THE FEDERAL INTERNAL REVENUE SERVICE FOR INCOME REPORTING PURPOSES WHICH GENERATED TAXABLE INCOME IN ONE OF THE TWO PREVIOUS YEARS OR FROM WHICH THAT INDIVIDUAL, SOLE PROPRIETOR, OR SINGLE FULL-TIME EMPLOYEE HAS DERIVED AT LEAST A SUBSTANTIAL PART OF SUCH INDIVIDUAL'S INCOME FOR ONE YEAR OUT OF ANY CONSECUTIVE THREE-YEAR PERIOD. THIS DEFINITION SHALL BE MET BY AN INDIVIDUAL CERTIFYING IN AN AFFIDAVIT SIGNED UNDER OATH THAT SUCH INDIVIDUAL MEETS THE DEFINITION SET FORTH IN THIS SUBSECTION (2.5).

(3) "Carrier" means any entity that provides health ~~insurance~~ COVERAGE in this state, ~~For purposes of this part 6, "carrier" includes~~ INCLUDING a franchise insurance plan, A FRATERNAL BENEFIT SOCIETY, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to the insurance laws and regulations of Colorado.

(3.1) "CARRIER WAITING PERIOD" MEANS A PERIOD OF TIME NOT TO EXCEED SIXTY DAYS DURING WHICH NO PREMIUM SHALL BE COLLECTED AND COVERAGE ISSUED WOULD NOT BECOME EFFECTIVE.

(3.2) (a) "CASE CHARACTERISTICS" MEANS DEMOGRAPHIC CHARACTERISTICS OF A SMALL EMPLOYER THAT ARE CONSIDERED BY THE CARRIER IN THE DETERMINATION OF PREMIUM RATES FOR AN INDIVIDUAL OR SMALL EMPLOYER.

(b) EFFECTIVE JANUARY 1, 1995, "CASE CHARACTERISTICS" ARE LIMITED TO THE FOLLOWING DEMOGRAPHIC CHARACTERISTICS:

(I) THE AGE OF COVERED INDIVIDUALS ACCORDING TO THE FOLLOWING BRACKETS:

(A) FOR CHILDREN WHO ARE DEPENDENTS, A SINGLE BRACKET FROM NEWBORN TO NINETEEN YEARS OF AGE, UNLESS THE CHILD IS A FULL-TIME STUDENT COVERED AS A DEPENDENT, IN WHICH CASE THE BRACKET IS NEWBORN UP TO TWENTY-FOUR YEARS OF AGE;

(B) FOR ADULTS AND EMANCIPATED MINORS, AGE BRACKETS IN FIVE-YEAR INTERVALS;

(II) GEOGRAPHIC LOCATION OF THE POLICYHOLDER, INCLUDING THE FOLLOWING LOCATION CATEGORIES ONLY:

(A) COUNTIES IN COLORADO THAT ARE PART OF A PRIMARY METROPOLITAN STATISTICAL AREA OR A METROPOLITAN STATISTICAL AREA; EXCEPT THAT DIFFERENT PRIMARY METROPOLITAN STATISTICAL AREAS AND METROPOLITAN STATISTICAL AREAS MAY HAVE DIFFERENT RATES;

(B) COUNTIES IN COLORADO WITH A POPULATION OF TWENTY THOUSAND OR FEWER RESIDENTS; AND

(C) ALL OTHER COUNTIES IN COLORADO;

(III) FAMILY SIZE, INCLUDING THE FOLLOWING SIZE CATEGORIES ONLY:

(A) ONE ADULT;

(B) ONE ADULT AND ANY CHILDREN;

(C) TWO ADULTS; AND

(D) TWO ADULTS AND ANY CHILDREN.

(c) EFFECTIVE JANUARY 1, 1995, "CASE CHARACTERISTICS" DOES NOT INCLUDE CLAIM EXPERIENCE, HEALTH STATUS, AND DURATION OF COVERAGE, OR ANY OTHER CHARACTERISTIC NOT SPECIFICALLY DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (3.2).

(3.5) (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:

(I) THE USE OF MORE THAN ONE TYPE OF SYSTEM FOR THE MARKETING AND SALE OF HEALTH BENEFIT PLANS TO SMALL EMPLOYERS;

(II) THE ACQUISITION OF A CLASS OF BUSINESS FROM ANOTHER SMALL EMPLOYER CARRIER; OR

(III) THE PROVISION OF COVERAGE TO ONE OR MORE ASSOCIATION GROUPS THAT MEET THE REQUIREMENTS OF SECTION 10-16-214 (1).

(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.

(5.2) "CONTROL" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-3-801 (3).

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

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

(5.6) "ESTABLISHED GEOGRAPHIC SERVICE AREA" MEANS THE ENTIRE STATE OF COLORADO OR, FOR PLANS THAT DO NOT COVER THE ENTIRE STATE, ANY COUNTY WITHIN WHICH THE CARRIER IS AUTHORIZED TO HAVE ARRANGEMENTS ESTABLISHED WITH PROVIDERS TO PROVIDE SERVICES.

(6) (a) "Health benefit plan" means any hospital or medical EXPENSE policy or certificate, ~~or~~ HOSPITAL OR MEDICAL SERVICE CORPORATION CONTRACT, OR health maintenance organization subscriber contract AVAILABLE FOR USE, OFFERED, OR SOLD TO AN INDIVIDUAL OR TO A SMALL EMPLOYER.

(b) "Health benefit plan" does not include accident only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, ~~or~~ automobile medical payment insurance, SPECIFIED DISEASES, HOSPITAL CONFINEMENT INDEMNITY, OR LIMITED BENEFIT HEALTH INSURANCE IF:

(I) THE CARRIER FILES ON OR BEFORE MARCH 1 OF EACH YEAR A CERTIFICATION WITH THE COMMISSIONER THAT CONTAINS A STATEMENT BY AN OFFICER OF THE CARRIER CERTIFYING THAT POLICIES OR CERTIFICATES DESCRIBED IN THIS PARAGRAPH (b) ARE BEING OFFERED AND MARKETED AS SUPPLEMENTAL HEALTH INSURANCE AND NOT AS A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE OR MAJOR MEDICAL EXPENSE INSURANCE AND A SUMMARY DESCRIPTION OF EACH POLICY OR CERTIFICATE DESCRIBED IN THIS PARAGRAPH (b), INCLUDING THE AVERAGE ANNUAL PREMIUM RATES (OR RANGE OF PREMIUM RATES IN CASES WHERE PREMIUMS VARY BY AGE, GENDER, OR

OTHER FACTORS) CHARGED FOR SUCH POLICIES AND CERTIFICATES IN THIS STATE;

(II) IN THE CASE OF A POLICY OR CERTIFICATE THAT IS DESCRIBED IN THIS PARAGRAPH (b) AND THAT IS OFFERED FOR THE FIRST TIME IN THIS STATE ON OR AFTER JULY 1, 1994, THE CARRIER FILES WITH THE COMMISSIONER THE INFORMATION AND STATEMENT REQUIRED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (b) AT LEAST THIRTY DAYS PRIOR TO THE DATE SUCH A POLICY OR CERTIFICATE IS ISSUED OR DELIVERED IN THIS STATE.

(6.3) "HEALTH STATUS" MEANS THE DETERMINATION BY A CARRIER OF THE UNDERWRITING RISK OF AN INDIVIDUAL OR THE EMPLOYER DUE TO THE PAST,

PRESENT, OR EXPECTED HEALTH CONDITIONS OF THE EMPLOYEES AND DEPENDENTS OF THE EMPLOYER.

(6.5) "INDEX RATE" MEANS, AS TO A RATING PERIOD FOR SMALL EMPLOYERS WITH SIMILAR CASE CHARACTERISTICS, THE ARITHMETIC AVERAGE OF THE BASE PREMIUM RATE AND THE CORRESPONDING HIGHEST PREMIUM RATE.

(6.7) "LATE ENROLLEE" MEANS AN ELIGIBLE EMPLOYEE OR DEPENDENT WHO REQUESTS ENROLLMENT IN A HEALTH BENEFIT PLAN OF A SMALL EMPLOYER FOLLOWING THE INITIAL ENROLLMENT PERIOD FOR WHICH SUCH INDIVIDUAL IS ENTITLED TO ENROLL UNDER THE TERMS OF THE HEALTH BENEFIT PLAN, IF SUCH INITIAL ENROLLMENT PERIOD IS A PERIOD OF AT LEAST THIRTY DAYS. AN ELIGIBLE EMPLOYEE OR DEPENDENT SHALL NOT BE CONSIDERED A LATE ENROLLEE IF:

(a) THE INDIVIDUAL:

(I) WAS COVERED UNDER ANOTHER QUALIFYING PREVIOUS COVERAGE AT THE TIME OF THE INITIAL ENROLLMENT PERIOD;

(II) LOST COVERAGE UNDER THE OTHER QUALIFYING PREVIOUS COVERAGE AS A RESULT OF TERMINATION OF EMPLOYMENT OR ELIGIBILITY, THE INVOLUNTARY TERMINATION OF THE QUALIFYING PREVIOUS COVERAGE, DEATH OF A SPOUSE, OR DIVORCE; AND

(III) REQUESTS ENROLLMENT WITHIN THIRTY DAYS AFTER TERMINATION OF THE OTHER QUALIFYING PREVIOUS COVERAGE; OR

(b) THE INDIVIDUAL IS EMPLOYED BY AN EMPLOYER THAT OFFERS MULTIPLE HEALTH BENEFIT PLANS AND ELECTS A DIFFERENT PLAN DURING AN OPEN ENROLLMENT PERIOD; OR

(c) A COURT HAS ORDERED THAT COVERAGE BE PROVIDED FOR A DEPENDENT UNDER A COVERED EMPLOYEE'S HEALTH BENEFIT PLAN AND THE REQUEST FOR ENROLLMENT IS MADE WITHIN THIRTY DAYS AFTER ISSUANCE OF SUCH COURT ORDER.

(6.8) "NEW BUSINESS PREMIUM RATE" MEANS, AS TO A RATING PERIOD, THE LOWEST PREMIUM RATE CHARGED OR OFFERED OR WHICH COULD HAVE BEEN CHARGED OR OFFERED BY THE SMALL EMPLOYER CARRIER TO SMALL EMPLOYERS WITH SIMILAR CASE CHARACTERISTICS FOR NEWLY ISSUED HEALTH BENEFIT PLANS WITH THE SAME OR SIMILAR COVERAGE.

(7.5) "PREMIUM" MEANS ALL MONEYS PAID BY A SMALL EMPLOYER AND ELIGIBLE EMPLOYEES OR AN INDIVIDUAL AND ELIGIBLE DEPENDENTS AS A CONDITION OF RECEIVING COVERAGE FROM A CARRIER, INCLUDING ANY FEES OR OTHER CONTRIBUTIONS ASSOCIATED WITH THE HEALTH BENEFIT PLAN.

(7.7) "PRODUCER" MEANS A PERSON WHO SOLICITS, NEGOTIATES, EFFECTS, PROCURES, DELIVERS, RENEWS, CONTINUES, SERVICES, OR BINDS HEALTH BENEFIT PLANS AND IS LICENSED TO CONDUCT THESE ACTIVITIES IN COLORADO.

(8.5) "QUALIFYING PREVIOUS COVERAGE" AND "QUALIFYING EXISTING COVERAGE"

MEAN BENEFITS OR COVERAGE PROVIDED UNDER:

(a) MEDICARE OR MEDICAID;

(b) AN EMPLOYER-BASED OR GROUP HEALTH INSURANCE OR HEALTH BENEFIT PLAN THAT PROVIDES BENEFITS SIMILAR TO OR EXCEEDING BENEFITS PROVIDED UNDER THE BASIC OR STANDARD HEALTH BENEFIT PLAN; OR

(c) AN INDIVIDUAL HEALTH INSURANCE POLICY ISSUED UNDER THE PROVISIONS OF SECTIONS 10-16-201 TO 10-16-212, INCLUDING COVERAGE ISSUED BY A HEALTH MAINTENANCE ORGANIZATION OR PREPAID HOSPITAL OR MEDICAL CARE PLAN THAT PROVIDES BENEFITS SIMILAR TO OR EXCEEDING THE BENEFITS PROVIDED UNDER THE BASIC OR STANDARD HEALTH BENEFIT PLAN, IF SUCH POLICY HAS BEEN IN EFFECT FOR A PERIOD OF AT LEAST ONE YEAR; EXCEPT THAT SUCH INDIVIDUAL POLICY NEED NOT COVER MATERNITY OR MENTAL HEALTH CARE.

(8.7) "RATING PERIOD" MEANS THE POLICY PERIOD FOR WHICH PREMIUM RATES ESTABLISHED BY A CARRIER ARE ASSUMED TO BE IN EFFECT.

(9.5) "RESTRICTED NETWORK PROVISION" MEANS ANY PROVISION OF AN INDIVIDUAL OR GROUP HEALTH BENEFIT PLAN THAT CONDITIONS THE PAYMENT OF BENEFITS, IN WHOLE OR IN PART, ON THE USE OF HEALTH CARE PROVIDERS THAT HAVE ENTERED INTO A CONTRACTUAL ARRANGEMENT WITH THE CARRIER TO PROVIDE HEALTH CARE SERVICES TO COVERED INDIVIDUALS.

(11) "Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than ~~twenty-five~~ FIFTY eligible employees, the majority of whom were employed within this state AND THAT WAS NOT FORMED PRIMARILY FOR THE PURPOSE OF PURCHASING INSURANCE. ON AND AFTER JANUARY 1, 1996, "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 3. 10-8-603 (1) (a), Colorado Revised Statutes, 1987 Repl. Vol., as amended, is amended to read:

10-8-603. Notice of intent to operate as a risk assuming carrier or a reinsuring carrier. (1) (a) Each small employer carrier shall notify the commissioner by ~~February~~ AUGUST 1, 1994, whether such carrier intends to operate as a risk assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk assuming carrier shall make an application pursuant to section 10-8-604.

SECTION 4. 10-8-605 (3) (a), (5), (9), and (13), Colorado Revised Statutes, 1987 Repl. Vol., as amended, are amended to read:

10-8-605. Small employer health care coverage availability program - exemption from taxes. (3) (a) The program shall operate subject to the supervision and control of the board of directors of the Colorado small employer health

reinsurance program, which is hereby created. Subject to the provisions of paragraph (b) of this subsection (3), the board shall consist of ~~eight~~ NINE members appointed by the governor and confirmed by the senate, plus the commissioner who shall serve as an ex officio ~~voting~~ NONVOTING member of the board.

(5) Within one hundred eighty days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable, to assure the fair, reasonable, and equitable administration of the program. The commissioner shall, after notice and hearing pursuant to section 24-4-105, C.R.S., approve the plan of operation. The plan shall be suitable to assure the fair, reasonable, and equitable administration of the program, and provide for the sharing of program gains or losses on an equitable and proportionate basis pursuant to this section. ~~After such plan of operation has been approved pursuant to section 24-4-105, C.R.S., the board shall transmit such plan to the general assembly by December 1, 1993, for consideration in its deliberations a bill to implement a guaranteed access program based upon a recommendation for such program from the Colorado cost containment and guaranteed access commission created pursuant to section 24-40.5-103, C.R.S.~~ AFTER APPROVAL OF THE PLAN OF OPERATION AS PROVIDED IN THIS SUBSECTION (5), THE PROGRAM SHALL BE OPERATIONAL NO LATER THAN SEPTEMBER 30, 1994.

(9) (a) The board as part of the plan of operation shall establish and amend as necessary a methodology for determining premium rates to be charged by the program for reinsuring ~~small employers and individuals~~ CARRIERS pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in this state. ~~The methodology shall provide for the development of base reinsurance premium rates for coverages to be reinsured, which shall be multiplied by the factors set forth in paragraph (b) of this subsection (9) to determine the premium rates for the program.~~ The ~~base~~ reinsurance premium rates shall be established by the board, subject to the approval of the commissioner. ~~and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan adjusted to reflect retention levels required under this part 6.~~

(b) Premiums for the program shall be SET IN A FAIR AND EQUITABLE MANNER, DESIGNED TO SPREAD THE EXCESS COST OF HIGH RISK CASES AS BROADLY AS POSSIBLE.

~~(I) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established by the board.~~

~~(II) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established by the board.~~

(13) This section is repealed, effective ~~June 30, 1996~~ JULY 1, 2001.

SECTION 5. 10-8-606 (3) and (4), Colorado Revised Statutes, 1987 Repl. Vol., as amended, are amended to read:

10-8-606. Health benefit plan advisory committee. (3) (a) The committee shall recommend benefit levels, cost sharing factors, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan ~~which~~ THAT contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including mammography screening and any other restrictions imposed by federal law. The plans recommended by the committee may include cost containment features such as:

(I) Utilization review of health care services, including review of the medical necessity of hospital and physician services;

(II) Case management;

(III) Selective contracting with hospitals, physicians, and other health care providers;

(IV) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(V) Other managed care provisions.

(b) As part of the committee's report to the commissioner, the committee shall study and include in such report recommendations regarding the cost benefit of including and of excluding mental health benefits in the basic health benefit plan and the standard health benefit plan.

(c) The committee shall provide the Colorado cost containment and guaranteed access commission created pursuant to section 24-40.5-103, C.R.S., with a report concerning the recommendations of the committee for the creation of basic and standard health benefit plan packages best suited to small employers in Colorado. ~~for use in a guaranteed access program which shall be considered by the general assembly for purposes of implementation.~~ Such report shall be transmitted to the Colorado cost containment and guaranteed access commission by July 1, 1993.

(d) BY JULY 1, 1994, THE COMMITTEE SHALL SUBMIT THE HEALTH PLANS DESCRIBED IN THIS SUBSECTION (3) TO THE COMMISSIONER. THE COLORADO COST CONTAINMENT AND GUARANTEED ACCESS COMMISSION SHALL ALSO SUBMIT ITS COMMENTS ON THE PLANS TO THE COMMISSIONER. THE COMMISSIONER SHALL REVIEW AND APPROVE THE PLANS NO LATER THAN AUGUST 15, 1994. ANNUALLY, BEGINNING JULY 1, 1995, THE COMMITTEE SHALL, IF IT DEEMS NECESSARY, SUBMIT RECOMMENDATIONS TO THE COMMISSIONER FOR CHANGES IN THE PLANS. THE COMMISSIONER SHALL HAVE SIXTY DAYS AFTER ANY SUCH SUBMITTAL TO REVIEW AND APPROVE ANY SUCH RECOMMENDATIONS.

(4) This section is repealed, effective ~~June 30, 1996~~ JULY 1, 2001.

SECTION 6. 10-16-102 (1) and (16), Colorado Revised Statutes, 1987 Repl. Vol., as amended, are amended, and the said 10-16-102 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

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

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

(1.1) "AFFILIATE" OR "AFFILIATED" MEANS ANY ENTITY OR PERSON THAT DIRECTLY OR INDIRECTLY, THROUGH ONE OR MORE INTERMEDIARIES, CONTROLS OR IS CONTROLLED BY, OR IS UNDER COMMON CONTROL WITH, A SPECIFIED ENTITY OR PERSON.

(1.2) "BASE PREMIUM RATE" MEANS, AS TO A RATING PERIOD, THE LOWEST PREMIUM RATE CHARGED OR THAT COULD HAVE BEEN CHARGED BY THE SMALL EMPLOYER CARRIER TO SMALL EMPLOYERS WITH SIMILAR CASE CHARACTERISTICS FOR HEALTH BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

(1.3) "BASIC HEALTH BENEFIT PLAN" MEANS A HEALTH BENEFIT PLAN DEVELOPED PURSUANT TO SECTION 10-16-105 (7.2).

(1.4) "BASIC HEALTH CARE SERVICES" MEANS HEALTH CARE SERVICES THAT AN ENROLLED POPULATION OF A HEALTH MAINTENANCE ORGANIZATION ORGANIZED PURSUANT TO THE PROVISIONS OF PART 4 OF THIS ARTICLE MIGHT REASONABLY REQUIRE IN ORDER TO MAINTAIN GOOD HEALTH, INCLUDING AS A MINIMUM, EMERGENCY CARE, INPATIENT AND OUTPATIENT HOSPITAL SERVICES, PHYSICIAN SERVICES, OUTPATIENT MEDICAL SERVICES, AND LABORATORY AND X-RAY SERVICES.

(1.5) "BUSINESS GROUP OF ONE" MEANS, FOR PURPOSES OF INITIAL QUALIFICATION, AN INDIVIDUAL, A SOLE PROPRIETOR, OR A SINGLE FULL-TIME EMPLOYEE OF A SUBCHAPTER S CORPORATION, C CORPORATION, LIMITED LIABILITY COMPANY, OR PARTNERSHIP WHO HAS CARRIED ON SIGNIFICANT BUSINESS ACTIVITY FOR A PERIOD OF AT LEAST ONE YEAR PRIOR TO APPLICATION FOR COVERAGE, HAS TAXABLE INCOME AS INDICATED ON FEDERAL INTERNAL REVENUE SERVICE FORMS 1040, SCHEDULE C, F, OR SE, OR OTHER FORMS RECOGNIZED BY THE FEDERAL INTERNAL REVENUE SERVICE FOR INCOME REPORTING PURPOSES WHICH GENERATED TAXABLE INCOME IN ONE OF THE TWO PREVIOUS YEARS OR FROM WHICH THAT INDIVIDUAL, SOLE PROPRIETOR, OR SINGLE FULL-TIME EMPLOYEE HAS DERIVED AT LEAST A SUBSTANTIAL PART OF SUCH INDIVIDUAL'S INCOME FOR ONE YEAR OUT OF ANY CONSECUTIVE THREE-YEAR PERIOD. THIS DEFINITION SHALL BE MET BY AN INDIVIDUAL CERTIFYING IN AN INDIVIDUAL AFFIDAVIT SIGNED UNDER OATH THAT SUCH INDIVIDUAL MEETS THE DEFINITION SET FORTH IN THIS SUBSECTION (1.5).

(1.6) "CAPPED EMPLOYEES" MEANS THE NUMBER OF EMPLOYEES AND DEPENDENTS WITH HEALTH PROBLEMS AT THE TIME THE PLAN OF WHICH SUCH EMPLOYEES ARE A PART WAS ISSUED WHO ARE IN SMALL GROUPS COVERED BY THE CARRIER WHERE THE SMALL EMPLOYER GROUP WOULD HAVE FAILED THE CARRIER'S NORMAL AND ACTUARIALLY-BASED SMALL GROUP UNDERWRITING CRITERIA SPECIFICALLY BECAUSE OF THE HEALTH STATUS OF THOSE EMPLOYEES WITH HEALTH PROBLEMS AT THE TIME THE PLAN WAS ISSUED, BUT WHO WERE ISSUED BASIC OR STANDARD HEALTH BENEFIT PLAN COVERAGE AS REQUIRED UNDER SECTION 10-16-105 (7.3) (c) REGARDLESS OF THE HEALTH STATUS OF THE GROUP. "CAPPED EMPLOYEES" ONLY INCLUDES EMPLOYEES AND DEPENDENTS COVERED BY A SMALL EMPLOYER GROUP HEALTH BENEFIT PLAN OF A CARRIER AT THE TIME THE CARRIER PROPOSES UNDER SECTION 10-16-105 (7.3) (d.5) TO SUSPEND ITS DUTY TO ISSUE BASIC OR STANDARD HEALTH BENEFIT PLAN COVERAGE AS REQUIRED UNDER SECTION 10-16-105 (7.3) (c).

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

(1.75) "CARRIER WAITING PERIOD" MEANS A PERIOD OF TIME NOT TO EXCEED SIXTY DAYS DURING WHICH NO PREMIUM SHALL BE COLLECTED AND COVERAGE ISSUED WOULD NOT BECOME EFFECTIVE.

(1.8) (a) "CASE CHARACTERISTICS" MEANS DEMOGRAPHIC CHARACTERISTICS OF A SMALL EMPLOYER THAT ARE CONSIDERED BY THE CARRIER IN THE DETERMINATION OF PREMIUM RATES FOR THE SMALL EMPLOYER.

(b) EFFECTIVE JANUARY 1, 1995, "CASE CHARACTERISTICS" ARE LIMITED TO THE FOLLOWING DEMOGRAPHIC CHARACTERISTICS:

(I) THE AGE OF COVERED INDIVIDUALS ACCORDING TO THE FOLLOWING BRACKETS:

(A) FOR CHILDREN WHO ARE DEPENDENTS, A SINGLE BRACKET FROM NEWBORN TO NINETEEN YEARS OF AGE, UNLESS THE CHILD IS A FULL-TIME STUDENT COVERED AS A DEPENDENT, IN WHICH CASE THE BRACKET IS NEWBORN UP TO TWENTY-FOUR YEARS OF AGE;

(B) FOR ADULTS AND EMANCIPATED MINORS, AGE BRACKETS IN FIVE-YEAR INTERVALS;

(II) GEOGRAPHIC LOCATION OF THE POLICYHOLDER, INCLUDING THE FOLLOWING LOCATION CATEGORIES ONLY:

(A) COUNTIES IN COLORADO THAT ARE PART OF A PRIMARY METROPOLITAN STATISTICAL AREA OR A METROPOLITAN STATISTICAL AREA; EXCEPT THAT DIFFERENT PRIMARY METROPOLITAN STATISTICAL AREAS AND METROPOLITAN STATISTICAL AREAS MAY HAVE DIFFERENT RATES;

(B) COUNTIES IN COLORADO WITH A POPULATION OF TWENTY THOUSAND OR

FEWER RESIDENTS; AND

(C) ALL OTHER COUNTIES IN COLORADO;

(III) FAMILY SIZE, INCLUDING THE FOLLOWING SIZE CATEGORIES ONLY:

(A) ONE ADULT;

(B) ONE ADULT AND ANY CHILDREN;

(C) TWO ADULTS; AND

(D) TWO ADULTS AND ANY CHILDREN.

(c) EFFECTIVE JANUARY 1, 1995, "CASE CHARACTERISTICS" DOES NOT INCLUDE CLAIM EXPERIENCE, HEALTH STATUS, AND DURATION OF COVERAGE, OR ANY OTHER CHARACTERISTIC NOT SPECIFICALLY DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (1.8).

(1.9) (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:

(I) THE USE OF MORE THAN ONE TYPE OF SYSTEM FOR THE MARKETING AND SALE OF HEALTH BENEFIT PLANS TO SMALL EMPLOYERS;

(II) THE ACQUISITION OF A CLASS OF BUSINESS FROM ANOTHER SMALL EMPLOYER CARRIER; OR

(III) THE PROVISION OF COVERAGE TO ONE OR MORE ASSOCIATION GROUPS THAT MEET THE REQUIREMENTS OF SECTION 10-16-214 (1).

(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.

(2.3) "CONTROL" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-3-801 (3).

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

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

INCLUDE AN EMPLOYEE WHO WORKS ON A TEMPORARY OR SUBSTITUTE BASIS.

(4.5) "ESTABLISHED GEOGRAPHIC SERVICE AREA" MEANS THE ENTIRE STATE OF COLORADO OR, FOR PLANS THAT DO NOT COVER THE ENTIRE STATE, ANY COUNTY WITHIN WHICH THE CARRIER IS AUTHORIZED TO HAVE ARRANGEMENTS ESTABLISHED WITH PROVIDERS TO PROVIDE SERVICES.

(6.5) (a) "HEALTH BENEFIT PLAN" MEANS ANY HOSPITAL OR MEDICAL EXPENSE POLICY OR CERTIFICATE, HOSPITAL OR MEDICAL SERVICE CORPORATION CONTRACT, OR HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER CONTRACT AVAILABLE FOR USE, OFFERED, OR SOLD TO AN INDIVIDUAL OR TO A SMALL EMPLOYER.

(b) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE ACCIDENT ONLY, CREDIT, DENTAL, VISION, MEDICARE SUPPLEMENT, LONG-TERM CARE, OR DISABILITY INCOME INSURANCE, COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE, WORKERS' COMPENSATION OR SIMILAR INSURANCE, AUTOMOBILE MEDICAL PAYMENT INSURANCE, SPECIFIED DISEASE, HOSPITAL CONFINEMENT INDEMNITY, OR LIMITED BENEFIT HEALTH INSURANCE IF:

(I) THE CARRIER FILES ON OR BEFORE MARCH 1 OF EACH YEAR A CERTIFICATION WITH THE COMMISSIONER THAT CONTAINS A STATEMENT BY AN OFFICER OF THE CARRIER CERTIFYING THAT POLICIES OR CERTIFICATES DESCRIBED IN THIS PARAGRAPH (b) ARE BEING OFFERED AND MARKETED AS SUPPLEMENTAL HEALTH INSURANCE AND NOT AS A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE OR MAJOR MEDICAL EXPENSE INSURANCE AND A SUMMARY DESCRIPTION OF EACH POLICY OR CERTIFICATE DESCRIBED IN THIS PARAGRAPH (b), INCLUDING THE AVERAGE ANNUAL PREMIUM RATES (OR RANGE OF PREMIUM RATES IN CASES WHERE PREMIUMS VARY BY AGE, GENDER, OR OTHER FACTORS) CHARGED FOR SUCH POLICIES AND CERTIFICATES IN THIS STATE;

(II) IN THE CASE OF A POLICY OR CERTIFICATE THAT IS DESCRIBED IN THIS PARAGRAPH (b) AND THAT IS OFFERED FOR THE FIRST TIME IN THIS STATE ON OR AFTER JULY 1, 1994, THE CARRIER FILES WITH THE COMMISSIONER THE INFORMATION AND STATEMENT REQUIRED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (b) AT LEAST THIRTY DAYS PRIOR TO THE DATE SUCH A POLICY OR CERTIFICATE IS ISSUED OR DELIVERED IN THIS STATE.

(8.3) "HEALTH STATUS" MEANS THE DETERMINATION BY A CARRIER OF THE PAST, PRESENT, OR EXPECTED RISK OF AN INDIVIDUAL OR THE EMPLOYER DUE TO THE HEALTH CONDITIONS OF THE EMPLOYEES OF THE EMPLOYER.

(8.5) "INDEX RATE" MEANS AS TO A RATING PERIOD FOR SMALL EMPLOYERS WITH SIMILAR CASE CHARACTERISTICS, THE ARITHMETIC AVERAGE OF THE APPLICABLE BASE PREMIUM RATE AND THE CORRESPONDING HIGHEST PREMIUM RATE.

(8.7) "LATE ENROLLEE" MEANS AN ELIGIBLE EMPLOYEE OR DEPENDENT WHO REQUESTS ENROLLMENT IN A HEALTH BENEFIT PLAN OF A SMALL EMPLOYER FOLLOWING THE INITIAL ENROLLMENT PERIOD FOR WHICH SUCH INDIVIDUAL IS ENTITLED TO ENROLL UNDER THE TERMS OF THE HEALTH BENEFIT PLAN, IF SUCH INITIAL ENROLLMENT PERIOD IS A PERIOD OF AT LEAST THIRTY DAYS. AN ELIGIBLE EMPLOYEE OR DEPENDENT SHALL NOT BE CONSIDERED A LATE ENROLLEE IF:

(a) THE INDIVIDUAL:

(I) WAS COVERED UNDER ANOTHER QUALIFYING PREVIOUS COVERAGE AT THE TIME OF THE INITIAL ENROLLMENT PERIOD;

(II) LOST COVERAGE UNDER THE OTHER QUALIFYING PREVIOUS COVERAGE AS A RESULT OF TERMINATION OF EMPLOYMENT OR ELIGIBILITY, THE INVOLUNTARY TERMINATION OF THE QUALIFYING PREVIOUS COVERAGE, DEATH OF A SPOUSE, OR DIVORCE; AND

(III) REQUESTS ENROLLMENT WITHIN THIRTY DAYS AFTER TERMINATION OF THE OTHER QUALIFYING PREVIOUS COVERAGE; OR

(b) THE INDIVIDUAL IS EMPLOYED BY AN EMPLOYER THAT OFFERS MULTIPLE HEALTH BENEFIT PLANS AND ELECTS A DIFFERENT PLAN DURING AN OPEN ENROLLMENT PERIOD; OR

(c) A COURT HAS ORDERED THAT COVERAGE BE PROVIDED FOR A DEPENDENT UNDER A COVERED EMPLOYEE'S HEALTH BENEFIT PLAN AND THE REQUEST FOR ENROLLMENT IS MADE WITHIN THIRTY DAYS AFTER ISSUANCE OF SUCH COURT ORDER.

(9.3) "NEW BUSINESS PREMIUM RATE" MEANS, AS TO A RATING PERIOD, THE LOWEST PREMIUM RATE CHARGED OR OFFERED OR WHICH COULD HAVE BEEN CHARGED OR OFFERED BY THE SMALL EMPLOYER CARRIER TO SMALL EMPLOYERS WITH SIMILAR CASE CHARACTERISTICS FOR NEWLY ISSUED HEALTH BENEFIT PLANS WITH THE SAME OR SIMILAR COVERAGE.

(11.5) "PREMIUM" MEANS ALL MONEYS PAID BY A SMALL EMPLOYER AND ELIGIBLE EMPLOYEES AS A CONDITION OF RECEIVING COVERAGE FROM A CARRIER, INCLUDING ANY FEES OR OTHER CONTRIBUTIONS ASSOCIATED WITH THE HEALTH BENEFIT PLAN.

(14.5) "PRODUCER" MEANS A PERSON LICENSED BY THE DIVISION WHO SOLICITS, NEGOTIATES, EFFECTS, PROCURES, DELIVERS, RENEWS, CONTINUES, SERVICES, OR BINDS HEALTH BENEFIT PLANS AND IS LICENSED TO CONDUCT THESE ACTIVITIES IN COLORADO.

(15.4) "QUALIFYING PREVIOUS COVERAGE" AND "QUALIFYING EXISTING COVERAGE" MEAN BENEFITS OR COVERAGE PROVIDED UNDER:

(a) MEDICARE OR MEDICAID;

(b) AN EMPLOYER-BASED OR GROUP HEALTH INSURANCE OR HEALTH BENEFIT PLAN THAT PROVIDES BENEFITS SIMILAR TO OR EXCEEDING BENEFITS PROVIDED UNDER THE BASIC OR STANDARD HEALTH BENEFIT PLAN; OR

(c) AN INDIVIDUAL HEALTH INSURANCE POLICY ISSUED UNDER THE PROVISIONS OF SECTIONS 10-16-201 TO 10-16-212, INCLUDING COVERAGE ISSUED BY A HEALTH MAINTENANCE ORGANIZATION OR PREPAID HOSPITAL OR MEDICAL CARE PLAN THAT PROVIDES BENEFITS SIMILAR TO OR EXCEEDING THE BENEFITS PROVIDED UNDER THE BASIC OR STANDARD HEALTH BENEFIT PLAN, IF SUCH POLICY HAS BEEN IN EFFECT FOR A PERIOD OF AT LEAST ONE YEAR; EXCEPT THAT SUCH INDIVIDUAL POLICY NEED NOT

COVER MATERNITY OR MENTAL HEALTH CARE.

(15.6) "RATING PERIOD" MEANS THE CALENDAR PERIOD FOR WHICH PREMIUM RATES ESTABLISHED BY A CARRIER ARE ASSUMED TO BE IN EFFECT.

(15.8) "RESTRICTED NETWORK PROVISION" MEANS ANY PROVISION OF AN INDIVIDUAL OR GROUP HEALTH BENEFIT PLAN THAT CONDITIONS THE PAYMENT OF BENEFITS, IN WHOLE OR IN PART, ON THE USE OF HEALTH CARE PROVIDERS THAT HAVE ENTERED INTO A CONTRACTUAL ARRANGEMENT WITH THE CARRIER TO PROVIDE HEALTH CARE SERVICES TO COVERED INDIVIDUALS.

(16) "Small employer" means any person, firm, corporation, partnership, or association THAT IS actively engaged in business ~~which has~~ THAT, on at least fifty percent of its working days during the preceding ~~year~~ CALENDAR QUARTER, employed no more than ~~twenty-five~~ FIFTY ELIGIBLE employees, ~~which~~ THE MAJORITY OF WHOM WERE EMPLOYED WITHIN THIS STATE AND THAT was not formed primarily for the purpose of purchasing insurance. ~~and in which a bona fide employer-employee relationship exists. For purposes of~~ ON AND AFTER JANUARY 1, 1996, "SMALL EMPLOYER" INCLUDES A BUSINESS GROUP OF ONE. IN determining the number of eligible employees, companies ~~which~~ THAT are affiliated companies, or ~~which~~ THAT are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

(16.2) "SMALL EMPLOYER CARRIER" MEANS A CARRIER THAT OFFERS HEALTH BENEFIT PLANS COVERING ELIGIBLE EMPLOYEES OF ONE OR MORE SMALL EMPLOYERS IN THIS STATE.

(16.4) "STANDARD HEALTH BENEFIT PLAN" MEANS A HEALTH BENEFIT PLAN DEVELOPED PURSUANT TO SECTION 10-16-105 (7.2).

SECTION 7. 10-16-105 (8), Colorado Revised Statutes, 1987 Repl. Vol., as amended, is amended, and the said 10-16-105 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans - annual report on implementation of guaranteed issue requirements. (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) 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.

(7.2) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT A BASIC HEALTH BENEFIT PLAN AND A STANDARD HEALTH BENEFIT PLAN TO BE OFFERED BY EACH SMALL EMPLOYER CARRIER AS A CONDITION OF TRANSACTING BUSINESS IN THIS STATE. SUCH RULES SHALL BE EFFECTIVE JANUARY 1, 1995, AND IN CONFORMITY WITH THE PROVISIONS OF ARTICLE 4 OF TITLE 24, C.R.S.

(7.3) (a) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION (7.3), EFFECTIVE JANUARY 1, 1995, EVERY SMALL EMPLOYER CARRIER SHALL, AS A CONDITION OF TRANSACTING BUSINESS IN THIS STATE WITH SMALL EMPLOYERS, ACTIVELY OFFER TO SUCH SMALL EMPLOYERS THE CHOICE OF A BASIC HEALTH BENEFIT PLAN OR A STANDARD HEALTH BENEFIT PLAN.

(b) (I) A SMALL EMPLOYER CARRIER SHALL NOT BE REQUIRED TO APPROVE AN APPLICATION 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.

(IV) A SMALL EMPLOYER CARRIER SHALL NOT BE REQUIRED TO OFFER TO A SMALL EMPLOYER A BASIC HEALTH BENEFIT PLAN OR A STANDARD HEALTH BENEFIT PLAN IF THE SMALL EMPLOYER HEALTH REINSURANCE PROGRAM IS NOT OPERATIONAL AS PROVIDED IN SECTION 10-8-605 (5).

(c) (I) EFFECTIVE JANUARY 1, 1995, A SMALL EMPLOYER CARRIER SHALL ISSUE A BASIC HEALTH BENEFIT PLAN OR A STANDARD HEALTH BENEFIT PLAN 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 WITH THIS ARTICLE.

(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 (1.9), 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. 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.

(d) NOTWITHSTANDING THE REQUIREMENTS OF PARAGRAPH (c) OF THIS SUBSECTION (7.3), NO SMALL EMPLOYER CARRIER IS REQUIRED TO OFFER COVERAGE OR ACCEPT APPLICATIONS PURSUANT TO THIS SECTION IF THE COMMISSIONER FINDS THAT ACCEPTANCE OF AN APPLICATION WOULD PLACE THE SMALL EMPLOYER CARRIER IN A FINANCIALLY IMPAIRED CONDITION. IN ADDITION, A SMALL EMPLOYER CARRIER THAT HAS NOT OFFERED COVERAGE OR ACCEPTED APPLICATIONS PURSUANT TO THIS PARAGRAPH (d) SHALL NOT OFFER COVERAGE OR ACCEPT APPLICATIONS UNTIL A DETERMINATION BY THE COMMISSIONER THAT THE SMALL EMPLOYER CARRIER IS NO LONGER FINANCIALLY IMPAIRED.

(d.5) (I) NOTWITHSTANDING THE REQUIREMENTS OF PARAGRAPH (c) OF THIS SUBSECTION (7.3), A SMALL EMPLOYER CARRIER MAY, IN ANY CALENDAR YEAR WITH THE APPROVAL OF THE COMMISSIONER, SUSPEND ITS DUTY TO ISSUE A BASIC HEALTH BENEFIT PLAN OR A STANDARD HEALTH BENEFIT PLAN FOR SUCH PERIOD AS APPROVED BY THE COMMISSIONER TO ANY ELIGIBLE EMPLOYER THAT APPLIES FOR SUCH HEALTH BENEFIT PLAN, IF THE EMPLOYER'S GROUP DOES NOT MEET THE SMALL EMPLOYER CARRIER'S NORMAL AND ACTUARIALLY-BASED UNDERWRITING CRITERIA AND IF THE SMALL EMPLOYER CARRIER MEETS ALL THE FOLLOWING CONDITIONS:

(A) THE NUMBER OF CAPPED EMPLOYEES COVERED BY THE SMALL EMPLOYER CARRIER WHEN DIVIDED BY THE TOTAL NUMBER OF EMPLOYEES AND DEPENDENTS COVERED BY CONTRACTS, POLICIES, AND PLANS OF THE SMALL EMPLOYER CARRIER IN FORCE WITH SMALL EMPLOYERS IN COLORADO IS EQUAL TO OR EXCEEDS FOUR PERCENT;

(B) THE SMALL EMPLOYER CARRIER APPLIES TO THE COMMISSIONER, IN A FORM AND MANNER DETERMINED BY THE COMMISSIONER, FOR AN IMMEDIATE SUSPENSION FOR A SPECIFIED TIME PERIOD OF THE REQUIREMENT IN PARAGRAPH (c) OF THIS SUBSECTION (7.3) TO ISSUE A BASIC HEALTH BENEFIT PLAN OR A STANDARD HEALTH BENEFIT PLAN TO SMALL EMPLOYERS THAT DO NOT MEET THE SMALL EMPLOYER CARRIER'S NORMAL AND ACTUARIALLY-BASED UNDERWRITING CRITERIA;

(C) THE SMALL EMPLOYER CARRIER PROVIDES THE COMMISSIONER WITH CERTIFIED COPIES OF THE INFORMATION DEEMED NECESSARY BY THE COMMISSIONER TO MAKE A DETERMINATION OF WHETHER OR NOT THE SMALL EMPLOYER CARRIER HAS OR IS ABOUT TO REACH THE FOUR PERCENT CAP DESCRIBED IN SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (I); AND

(D) THE COMMISSIONER APPROVES THE REQUEST FOR THE SUSPENSION DESCRIBED IN THIS PARAGRAPH (d.5).

(II) IF THE COMMISSIONER DETERMINES THAT THE LIMITATIONS ON THE REQUIREMENTS TO ISSUE BASIC AND STANDARD HEALTH BENEFIT PLANS UNDER PARAGRAPH (c) OF THIS SUBSECTION (7.3) UNREASONABLY RESTRICT THE ACCESS OF RESIDENTS OF COLORADO TO HEALTH INSURANCE COVERAGE, THE COMMISSIONER SHALL HAVE THE AUTHORITY TO INCREASE OR DECREASE, ACTING PURSUANT TO ARTICLE 4 OF TITLE 24, C.R.S., THE PERCENTAGE LIMITATION SPECIFIED IN SUB-SUBPARAGRAPH (A) OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (d.5).

(III) THE COMMISSIONER MAY PROMULGATE SUCH RULES AND REGULATIONS AS ARE NECESSARY TO CARRY OUT THE PURPOSES OF THIS PARAGRAPH (d.5).

(e) A SMALL EMPLOYER IS ELIGIBLE UNDER PARAGRAPH (a) AND SUBPARAGRAPH (I) OF PARAGRAPH (c) OF THIS SUBSECTION (7.3) IF IT EMPLOYED TWO OR MORE ELIGIBLE EMPLOYEES WITHIN THIS STATE ON AT LEAST FIFTY PERCENT OF ITS WORKING DAYS DURING THE PRECEDING CALENDAR QUARTER; EXCEPT THAT, ON AND AFTER JANUARY 1, 1996, THESE PROVISIONS SHALL ALSO APPLY TO A BUSINESS GROUP OF ONE.

(f) BASIC AND STANDARD HEALTH BENEFIT PLANS OFFERED BY A SMALL EMPLOYER CARRIER SHALL BE SUBJECT TO THE CERTIFICATION REQUIREMENTS OF SECTION 10-16-107.2.

(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.

(h) THE REQUIREMENT THAT A SMALL EMPLOYER CARRIER ACTIVELY OFFER SMALL EMPLOYERS THE CHOICE OF A BASIC OR A STANDARD HEALTH BENEFIT PLAN PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (7.3) SHALL NOT APPLY IF:

(I) THE SMALL EMPLOYER CARRIER CERTIFIES TO THE COMMISSIONER, IN A CERTIFICATION SIGNED BY AN OFFICER OF THE COMPANY THAT:

(A) THE CARRIER IS NEITHER MARKETING TO NOR ACCEPTING ANY NEW APPLICATIONS FOR COVERAGE FROM ANY SMALL EMPLOYERS IN COLORADO ON AND AFTER JULY 1, 1994; AND

(B) THE CARRIER WILL TERMINATE NO LATER THAN DECEMBER 31, 1995, ALL SMALL GROUP BUSINESS WRITTEN PRIOR TO JULY 1, 1994;

(II) THE SMALL EMPLOYER CARRIER REQUESTS AND THE COMMISSIONER APPROVES A REQUEST FROM THE CARRIER TO SUSPEND ITS DUTY TO GUARANTEE THE ISSUANCE OF A BASIC AND STANDARD HEALTH BENEFIT PLAN PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (7.3).

(7.4) (a) EXCEPT AS PROVIDED IN PARAGRAPH (d) OF THIS SUBSECTION (7.4), THE REQUIREMENTS USED BY A SMALL EMPLOYER CARRIER TO DETERMINE WHETHER TO PROVIDE COVERAGE TO A SMALL EMPLOYER, INCLUDING REQUIREMENTS FOR MINIMUM PARTICIPATION OF ELIGIBLE EMPLOYEES AND MINIMUM EMPLOYER CONTRIBUTIONS, SHALL BE APPLIED UNIFORMLY AMONG ALL SMALL EMPLOYERS WITH THE SAME NUMBER OF ELIGIBLE EMPLOYEES APPLYING FOR COVERAGE OR RECEIVING COVERAGE FROM THE SMALL EMPLOYER CARRIER.

(b) A SMALL EMPLOYER CARRIER MAY VARY THE APPLICATION OF MINIMUM PARTICIPATION REQUIREMENTS AND MINIMUM EMPLOYER CONTRIBUTION REQUIREMENTS ONLY BY THE SIZE OF THE SMALL EMPLOYER GROUP.

(c) IN APPLYING MINIMUM PARTICIPATION REQUIREMENTS WITH RESPECT TO AN EMPLOYER, A SMALL EMPLOYER CARRIER SHALL NOT CONSIDER EMPLOYEES OR DEPENDENTS WHO HAVE QUALIFYING EXISTING COVERAGE WHEN DETERMINING WHETHER THE APPLICABLE PERCENTAGE OF PARTICIPATION IS MET. HOWEVER, A SMALL EMPLOYER CARRIER MAY CONSIDER EMPLOYEES OR DEPENDENTS OF SUCH EMPLOYER WHO HAVE COVERAGE UNDER ANOTHER HEALTH BENEFIT PLAN THAT IS SPONSORED BY SUCH SMALL EMPLOYER.

(d) A SMALL EMPLOYER CARRIER SHALL NOT INCREASE ANY REQUIREMENT FOR MINIMUM EMPLOYEE PARTICIPATION OR FOR MINIMUM EMPLOYER CONTRIBUTION WITH RESPECT TO A SMALL EMPLOYER AT ANY TIME AFTER SUCH EMPLOYER HAS BEEN ACCEPTED FOR COVERAGE.

(7.5) (a) EFFECTIVE JANUARY 1, 1995, IF A SMALL EMPLOYER CARRIER OFFERS COVERAGE TO A SMALL EMPLOYER, SUCH SMALL EMPLOYER CARRIER SHALL OFFER THE SAME COVERAGE TO ALL OF THE ELIGIBLE EMPLOYEES OF THE SMALL EMPLOYER AND THEIR DEPENDENTS. A SMALL EMPLOYER CARRIER SHALL NOT OFFER COVERAGE TO ONLY CERTAIN ELIGIBLE INDIVIDUALS IN A SMALL EMPLOYER GROUP OR TO ONLY PART OF THE GROUP, EXCEPT IN THE CASE OF LATE ENROLLEES AS PROVIDED IN SECTION 10-16-118 (1) (c).

(b) A SMALL EMPLOYER CARRIER SHALL NOT MODIFY A BASIC HEALTH BENEFIT PLAN OR A STANDARD HEALTH BENEFIT PLAN WITH RESPECT TO A SMALL EMPLOYER OR ANY ELIGIBLE EMPLOYEE OR DEPENDENT THROUGH A RIDER, ENDORSEMENT, OR OTHERWISE, IF THE EFFECT OF SUCH MODIFICATION IS TO RESTRICT OR EXCLUDE COVERAGE FOR CERTAIN DISEASES OR MEDICAL CONDITIONS THAT ARE OTHERWISE COVERED BY SUCH PLAN.

(7.6) (a) NO SMALL EMPLOYER CARRIER IS REQUIRED TO ACCEPT APPLICATIONS FROM OR OFFER COVERAGE PURSUANT TO PARAGRAPH (a) OF SUBSECTION (7.3) OF THIS SECTION:

(I) TO A SMALL EMPLOYER, WHERE THE EMPLOYER IS NOT PHYSICALLY LOCATED IN THE SMALL EMPLOYER CARRIER'S ESTABLISHED GEOGRAPHIC SERVICE AREA;

(II) TO AN EMPLOYEE, WHEN THE EMPLOYEE DOES NOT WORK OR RESIDE WITHIN THE SMALL EMPLOYER CARRIER'S ESTABLISHED GEOGRAPHIC AREA; OR

(III) WITHIN AN AREA WHERE THE SMALL EMPLOYER CARRIER REASONABLY ANTICIPATES AND DEMONSTRATES TO THE SATISFACTION OF THE COMMISSIONER, THAT IT DOES NOT HAVE THE CAPACITY WITHIN ITS ESTABLISHED GEOGRAPHIC SERVICE AREA TO DELIVER SERVICE ADEQUATELY TO THE MEMBERS OF SUCH GROUPS BECAUSE OF ITS OBLIGATIONS TO EXISTING GROUP POLICYHOLDERS AND ENROLLEES.

(b) A SMALL EMPLOYER CARRIER THAT CANNOT OFFER COVERAGE PURSUANT TO SUBPARAGRAPH (III) OF PARAGRAPH (a) OF THIS SUBSECTION (7.6) MAY NOT OFFER COVERAGE IN THE APPLICABLE AREA TO ANY NEW EMPLOYER GROUP WITH MORE THAN FIFTY EMPLOYEES OR TO ANY SMALL EMPLOYER GROUP UNTIL THE LATER OF ONE HUNDRED EIGHTY DAYS AFTER EACH SUCH REFUSAL OR THE DATE ON WHICH THE SMALL EMPLOYER CARRIER NOTIFIES THE COMMISSIONER THAT IT HAS REGAINED CAPACITY TO OFFER HEALTH BENEFIT PLANS TO SMALL EMPLOYER GROUPS.

(8) (a) (I) ~~The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:~~

~~(a) The percentage change in the new business premium rate for the policy under which the small employer is covered measured from the first day of the prior rating period to the first day of the new rating period; in the case of a class of business for which the small employer insurer or other entity is not issuing new policies, the insurer or other entity shall use the percentage change in new business premium rate for the class of business which is most similar to the closed class of business and for which the insurer or other entity is issuing new policies; and~~

~~(b) An adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the insurer's rate manual for the class of business; and~~

~~(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the insurer's or other entity's rate manual for the class of business.~~ 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 (III) TO (VII) 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.

(II) 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 (III) TO (VII) OF THIS PARAGRAPH (a).

(III) 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) (A) THE COMMISSIONER, IN CONSULTATION WITH THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, SHALL DEVELOP A METHOD FOR RISK ADJUSTMENT THAT WILL FAIRLY COMPENSATE SMALL EMPLOYER CARRIERS FOR THE RISKS ASSUMED WHEN ISSUING HEALTH INSURANCE TO SMALL EMPLOYERS AS REQUIRED IN SUBSECTION (7.3) OF THIS SECTION. IN DEVELOPING SUCH METHODOLOGY, THE EXECUTIVE DIRECTOR SHALL ACTIVELY SEEK INPUT FROM INSURANCE CARRIERS THAT WOULD BE AFFECTED BY SUCH A RISK ADJUSTMENT METHOD. BY JULY 1, 1995, THE COMMISSIONER SHALL PROMULGATE RULES FOR RISK ADJUSTMENT BASED ON THIS METHODOLOGY.

(B) THE REQUIREMENTS OF SUBPARAGRAPHS (VI) AND (VII) OF THIS PARAGRAPH (a) SHALL ONLY APPLY TO SMALL EMPLOYER CARRIERS WHEN THE REGULATIONS DEVELOPED PURSUANT TO THIS SUBPARAGRAPH (VIII) ARE PROMULGATED AS RULES. IF SUCH REGULATIONS ARE NOT PROMULGATED AS RULES, THE RESTRICTIONS CONTAINED IN SUBPARAGRAPHS (III) AND (V) OF THIS PARAGRAPH (a) SHALL CONTINUE TO APPLY NOTWITHSTANDING THE JANUARY 1, 1997, LIMITATION CONTAINED IN SUCH PROVISIONS.

(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).

(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.

(II) A SMALL EMPLOYER CARRIER SHALL TREAT ALL HEALTH BENEFIT PLANS ISSUED OR RENEWED IN THE SAME CALENDAR MONTH AS HAVING THE SAME RATING PERIOD.

(d) FOR THE PURPOSES OF THIS SUBSECTION (8), A HEALTH BENEFIT PLAN THAT CONTAINS A RESTRICTED NETWORK PROVISION SHALL NOT BE CONSIDERED SIMILAR COVERAGE TO A HEALTH BENEFIT PLAN THAT DOES NOT CONTAIN SUCH A PROVISION IF THE RESTRICTION OF BENEFITS TO NETWORK PROVIDERS RESULTS IN SUBSTANTIAL DIFFERENCES IN CLAIM COSTS.

(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 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, EXCEPT AS PROVIDED IN SUBPARAGRAPH (I) OF PARAGRAPH (a) OF THIS SUBSECTION (8).

(f) THE COMMISSIONER MAY ESTABLISH REGULATIONS TO IMPLEMENT THE PROVISIONS OF THIS SUBSECTION (8) AND TO ASSURE THAT RATING PRACTICES USED BY SMALL EMPLOYER CARRIERS ARE CONSISTENT WITH THE PURPOSES OF THIS SUBSECTION (8), INCLUDING REGULATIONS THAT:

(I) ASSURE THAT DIFFERENCES IN RATES CHARGED FOR HEALTH BENEFIT PLANS BY SMALL EMPLOYER CARRIERS ARE REASONABLE AND REFLECT OBJECTIVE DIFFERENCES IN PLAN DESIGN, NOT INCLUDING DIFFERENCES DUE TO THE NATURE OF THE GROUPS ASSUMED TO SELECT PARTICULAR HEALTH BENEFIT PLANS; AND

(II) PRESCRIBE THE MANNER IN WHICH CASE CHARACTERISTICS MAY BE USED BY SMALL EMPLOYER CARRIERS.

(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.

(10) THE COMMISSIONER OF INSURANCE IN COOPERATION WITH THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL ANNUALLY REPORT TO THE EXECUTIVE COMMITTEE OF THE LEGISLATIVE COUNCIL OF THE GENERAL ASSEMBLY ON THE IMPLEMENTATION OF THE GUARANTEED ISSUE PROVISIONS OF THIS SECTION ENACTED IN HB94-1210, ENACTED DURING THE SECOND REGULAR SESSION OF THE FIFTY-NINTH GENERAL ASSEMBLY. SUCH ANNUAL REPORT SHALL, AT A MINIMUM, INCLUDE INFORMATION ON THE NUMBER OF BASIC AND STANDARD PLANS THAT HAVE BEEN ISSUED BY SMALL EMPLOYER CARRIERS, THE NUMBER OF PEOPLE ON SUCH PLANS WHO WERE UNINSURED PRIOR TO ENROLLMENT, AND THE NUMBER OF GROUPS AND INDIVIDUALS ENROLLED IN THE REINSURANCE PLAN. THE REPORT SHALL ALSO INCLUDE AN ESTIMATE OF THE TOTAL NUMBER OF EMPLOYEES OF SMALL EMPLOYERS AND THEIR DEPENDENTS IN COLORADO WHO ARE INSURED AND WHO ARE UNINSURED FOR THE MOST RECENT YEAR FOR WHICH PUBLISHED DATA ARE AVAILABLE AND THE FIVE PREVIOUS YEARS. SMALL GROUP CARRIERS AND THE REINSURANCE BOARD SHALL PROVIDE THE DIVISION WITH ALL INFORMATION NECESSARY TO WRITE THIS REPORT.

(11) THE REQUIREMENTS CONTAINED IN THIS SECTION FOR SMALL EMPLOYER CARRIERS TO ISSUE BASIC AND STANDARD HEALTH BENEFIT PLANS SHALL TERMINATE JULY 1, 2001, UNLESS THE GENERAL ASSEMBLY ACTS BY BILL TO EXTEND SUCH REQUIREMENTS BEYOND SAID DATE AFTER CONDUCTING THE REVIEW REQUIRED IN

SECTION 10-16-120.

SECTION 8. 10-16-108 (1) (a), the introductory portion to 10-16-108 (1) (c) (I), 10-16-108 (1) (d) (I), (1) (e) (I), and (2) (c) (I), Colorado Revised Statutes, 1987 Repl. Vol., as amended, are amended, and the said 10-16-108 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

10-16-108. Conversion and continuation privileges. (1) **Group sickness and accident insurance - conversion privileges.** (a) If the group insurance policy provides hospital, surgical, or major medical insurance or any combination of these coverages on an expense-incurred basis, for other than specified diseases or accidental injuries only, ~~it~~ THE HEALTH BENEFIT PLAN shall also contain a conversion privilege conforming to the requirements of paragraph (c) of this subsection (1).

(c) (I) A group policy delivered or issued for delivery in this state which provides hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense-incurred basis, but not including a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee, DEPENDENT, or member whose insurance under the group policy has been terminated for any reason other than discontinuance of the group policy in its entirety or with respect to an insured class or failure of the employee or member to pay any required contribution and who has been continuously insured under the group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination is entitled to have issued ~~to him~~ by the insurer a policy of sickness and accident insurance, referred to in this paragraph (c) as the "converted policy", subject to the following conditions:

(d) (I) A converted policy issued upon the exercise of the conversion privilege of paragraph (c) of this subsection (1) shall ~~conform to the following:~~ OFFER A CHOICE OF A BASIC OR STANDARD HEALTH BENEFIT PLAN.

~~(I) If the group policy provided hospital, surgical, or hospital and surgical insurance, the converted policy shall provide benefits on an expense-incurred basis equal to the lesser of the hospital room and board, miscellaneous hospital and surgical benefits provided under the group policy, and the following corresponding benefits:~~

~~(A) Hospital room and board benefits in an amount per day equal to either sixty, seventy, or eighty percent, at the option of the insured, of the applicable amount determined by the commissioner, pursuant to the requirement set forth in this paragraph (d), as the average daily room and board charge of the hospitals in the state for other than private accommodations, such benefits to be payable for a maximum duration of seventy days for any period of hospital confinement as defined in the converted policy;~~

~~(B) Miscellaneous hospital benefits for any one period of hospital confinement in an amount up to twenty times the hospital room and board daily benefit provided under the converted policy;~~

~~(C) Surgical benefits according to a surgical schedule with a maximum amount equal to either sixty, seventy, or eighty percent, at the option of the insured, the choice to be consistent with the percentage chosen under sub-subparagraph (A) of~~

~~this subparagraph (I), of the applicable amount determined by the commissioner, pursuant to the requirement set forth in this paragraph (d), as a reasonable maximum surgical benefit based upon charges made by surgeons in this state. The maximum surgical benefit shall be applicable to all surgical operations of an individual resulting from or contributed to by the same and all related causes occurring in one period of disability. Two or more surgical procedures performed in the course of a single operation through the same incision or in the same natural body orifice may be treated as one surgical procedure with the payment determined by the scheduled benefit for the most expensive procedure performed. The surgical schedule shall be consistent with the schedule of operations customarily offered by the insurer under group or individual health insurance policies.~~

(e) (I) Upon the termination of employment of an eligible employee, THE DEATH OF ANY SUCH EMPLOYEE, OR THE CHANGE IN MARITAL STATUS OF ANY SUCH EMPLOYEE, the employee OR DEPENDENT has the right to continue the coverage for a period of ~~one hundred eighty days after termination of employment~~ EIGHTEEN MONTHS AFTER LOSS OF COVERAGE or until such employee OR DEPENDENT becomes eligible for other group coverage, whichever occurs first. However, should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the ~~one hundred eighty days~~ EIGHTEEN MONTHS or until the new plan covers the condition, whichever occurs first.

(2) **Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.** (c) (I) Upon the termination of employment of an eligible employee, THE DEATH OF ANY SUCH EMPLOYEE, OR THE CHANGE IN MARITAL STATUS OF ANY SUCH EMPLOYEE, the employee, OR DEPENDENT has the right to continue the coverage for a period of ~~one hundred eighty days after termination of employment~~ EIGHTEEN MONTHS AFTER LOSS OF COVERAGE or until the employee OR DEPENDENT becomes eligible for other group coverage, whichever occurs first. However, should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the ~~one hundred eighty days~~ EIGHTEEN MONTHS or until the new plan covers the condition, whichever occurs first.

(4) **Special provisions for small group health benefit plans.** (a) EFFECTIVE JANUARY 1, 1995, EACH SMALL EMPLOYER CARRIER SHALL, UPON TERMINATION OF A GROUP POLICY BY THE CARRIER OR EMPLOYER FOR REASONS OTHER THAN REPLACEMENT WITH ANOTHER GROUP POLICY OR FRAUD AND ABUSE IN PROCURING AND UTILIZING COVERAGE, OFFER TO ANY INDIVIDUAL THE CHOICE OF A BASIC OR STANDARD HEALTH BENEFIT PLAN, EXCEPT AS PROVIDED IN PARAGRAPH (b) OF THIS SUBSECTION (4). REASONS FOR TERMINATION INCLUDE, BUT ARE NOT LIMITED TO, THE GROUP NO LONGER MEETING PARTICIPATION REQUIREMENTS, CANCELLATION DUE TO NONPAYMENT OF PREMIUMS, OR THE POLICYHOLDER EXERCISING THE RIGHT TO CANCEL.

(b) IF THE GROUP'S ORIGINAL PLAN HAD BENEFITS WHICH WERE SIGNIFICANTLY LESS GENEROUS IN MOST RESPECTS THAN THE STANDARD PLAN AS DETERMINED BY THE COMMISSIONER, THE CARRIER IS ONLY REQUIRED TO OFFER THE BASIC HEALTH BENEFIT PLAN TO SUCH GROUP OR INDIVIDUAL. IF AN INDIVIDUAL IS ELIGIBLE FOR

CONTINUATION COVERAGE OR CONVERSION COVERAGE PURSUANT TO SECTION 10-16-108 OR IS ELIGIBLE FOR CONTINUATION COVERAGE UNDER FEDERAL LAW, THEN THE PROVISIONS OF PARAGRAPH (a) OF THIS SUBSECTION (4) AND THIS PARAGRAPH (b) SHALL NOT APPLY TO SUCH AN INDIVIDUAL.

(c) EACH SMALL EMPLOYER CARRIER SHALL OFFER THE CHOICE OF A BASIC OR STANDARD HEALTH BENEFIT PLAN TO ANY INDIVIDUAL WHO LOSES NEXUS TO EXISTING SMALL GROUP COVERAGE; EXCEPT THAT:

(I) IF AN INDIVIDUAL IS ELIGIBLE FOR CONTINUATION COVERAGE OR CONVERSION COVERAGE PURSUANT TO SECTION 10-16-108 OR IS ELIGIBLE FOR CONTINUATION COVERAGE UNDER FEDERAL LAW, THEN THE PROVISIONS OF THIS PARAGRAPH (c) SHALL NOT APPLY TO SUCH AN INDIVIDUAL; AND

(II) IF AN INDIVIDUAL LOST NEXUS TO GROUP COVERAGE FOR FRAUD OR ABUSE IN PROCURING OR UTILIZING COVERAGE, THEN THE PROVISIONS OF THIS PARAGRAPH (c) SHALL NOT APPLY TO SUCH AN INDIVIDUAL.

SECTION 9. Part 1 of article 16 of title 10, Colorado Revised Statutes, 1987 Repl. Vol., as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

10-16-108.5. Fair marketing standards. (1) EACH SMALL EMPLOYER CARRIER SHALL ACTIVELY MARKET HEALTH BENEFIT PLAN COVERAGE, INCLUDING THE BASIC HEALTH BENEFIT PLAN AND THE STANDARD HEALTH BENEFIT PLAN, TO ELIGIBLE SMALL EMPLOYERS IN THE STATE. IF A SMALL EMPLOYER CARRIER DENIES COVERAGE TO A SMALL EMPLOYER ON THE BASIS OF THE HEALTH STATUS OR CLAIMS EXPERIENCE OF THE SMALL EMPLOYER OR ITS EMPLOYEES OR DEPENDENTS, THE CARRIER SHALL OFFER THE SMALL EMPLOYER THE OPPORTUNITY TO PURCHASE A BASIC HEALTH BENEFIT PLAN OR A STANDARD HEALTH BENEFIT PLAN.

(2) (a) EXCEPT AS PROVIDED IN PARAGRAPH (b) OF THIS SUBSECTION (2), NO CARRIER OR PRODUCER SHALL, DIRECTLY OR INDIRECTLY, ENGAGE IN THE FOLLOWING ACTIVITIES:

(I) ENCOURAGING OR DIRECTING INDIVIDUALS OR SMALL EMPLOYERS TO REFRAIN FROM FILING AN APPLICATION FOR COVERAGE WITH THE INDIVIDUAL OR SMALL EMPLOYER CARRIER BECAUSE OF THE HEALTH STATUS, CLAIMS EXPERIENCE, INDUSTRY, OCCUPATION, OR GEOGRAPHIC LOCATION OF THE INDIVIDUAL OR SMALL EMPLOYER;

(II) ENCOURAGING OR DIRECTING INDIVIDUALS OR SMALL EMPLOYERS TO SEEK COVERAGE FROM ANOTHER CARRIER BECAUSE OF THE HEALTH STATUS, CLAIMS EXPERIENCE, INDUSTRY, OCCUPATION, OR GEOGRAPHIC LOCATION OF THE INDIVIDUAL OR SMALL EMPLOYER.

(b) THE PROVISIONS OF PARAGRAPH (a) OF THIS SUBSECTION (2) SHALL NOT APPLY WITH RESPECT TO INFORMATION PROVIDED BY A CARRIER OR PRODUCER TO AN INDIVIDUAL OR A SMALL EMPLOYER REGARDING THE ESTABLISHED GEOGRAPHIC SERVICE AREA OR A RESTRICTED NETWORK PROVISION OF A CARRIER.

(3) (a) EXCEPT AS PROVIDED IN PARAGRAPH (b) OF THIS SUBSECTION (3), NO SMALL EMPLOYER CARRIER SHALL, DIRECTLY OR INDIRECTLY, ENTER INTO ANY CONTRACT, AGREEMENT, OR ARRANGEMENT WITH A PRODUCER THAT PROVIDES FOR OR RESULTS IN THE COMPENSATION PAID TO A PRODUCER FOR THE SALE OF A HEALTH BENEFIT PLAN TO BE VARIED BECAUSE OF THE HEALTH STATUS, CLAIMS EXPERIENCE, INDUSTRY, OCCUPATION, OR GEOGRAPHIC LOCATION OF THE SMALL EMPLOYER.

(b) PARAGRAPH (a) OF THIS SUBSECTION (3) SHALL NOT APPLY TO A COMPENSATION ARRANGEMENT WITH A PRODUCER ON THE BASIS OF A PERCENTAGE OF PREMIUM IF SUCH PERCENTAGE DOES NOT VARY BECAUSE OF THE HEALTH STATUS, CLAIMS EXPERIENCE, INDUSTRY, OCCUPATION, OR GEOGRAPHIC AREA OF THE INDIVIDUAL OR SMALL EMPLOYER.

(4) A SMALL EMPLOYER CARRIER SHALL PROVIDE REASONABLE COMPENSATION, AS PROVIDED UNDER THE PLAN OF OPERATION OF THE SMALL EMPLOYER HEALTH REINSURANCE PROGRAM, TO A PRODUCER, IF ANY, FOR THE SALE OF A BASIC OR STANDARD HEALTH BENEFIT PLAN.

(5) NO SMALL EMPLOYER CARRIER SHALL TERMINATE, FAIL TO RENEW, OR LIMIT ITS CONTRACT OR AGREEMENT OF REPRESENTATION WITH A PRODUCER FOR ANY REASON RELATED TO THE HEALTH STATUS, CLAIMS EXPERIENCE, OCCUPATION, OR GEOGRAPHIC AREA OF THE SMALL EMPLOYERS PLACED BY THE PRODUCER WITH THE SMALL EMPLOYER CARRIER.

(6) NO CARRIER SHALL INDUCE OR OTHERWISE ENCOURAGE A SMALL EMPLOYER TO EXCLUDE AN EMPLOYEE FROM HEALTH COVERAGE OR BENEFITS PROVIDED IN CONNECTION WITH THE EMPLOYEE'S EMPLOYMENT.

(7) ANY DENIAL BY A CARRIER OF AN APPLICATION FOR COVERAGE FROM AN INDIVIDUAL OR A SMALL EMPLOYER SHALL BE IN WRITING AND SHALL STATE ANY REASON FOR THE DENIAL.

(8) THE COMMISSIONER MAY ESTABLISH REGULATIONS SETTING FORTH ADDITIONAL STANDARDS TO PROVIDE FOR THE FAIR MARKETING AND BROAD AVAILABILITY OF HEALTH BENEFIT PLANS TO INDIVIDUALS AND SMALL EMPLOYERS IN THIS STATE.

(9) A VIOLATION OF THIS SECTION BY A CARRIER OR A PRODUCER IS AN UNFAIR OR DECEPTIVE ACT OR PRACTICE PURSUANT TO THE PROVISIONS OF PART 11 OF ARTICLE 3 OF THIS TITLE.

(10) IF A SMALL EMPLOYER CARRIER ENTERS INTO A CONTRACT, AGREEMENT, OR OTHER ARRANGEMENT WITH A THIRD-PARTY ADMINISTRATOR TO PROVIDE ADMINISTRATIVE MARKETING OR OTHER SERVICE RELATED TO THE OFFERING OF HEALTH BENEFIT PLANS TO SMALL EMPLOYERS IN THIS STATE, THE THIRD-PARTY ADMINISTRATOR SHALL BE SUBJECT TO THIS SECTION AS IF IT WERE A SMALL EMPLOYER CARRIER.

10-16-118. Limitations on preexisting condition limitations. (1) A HEALTH BENEFIT PLAN THAT COVERS RESIDENTS OF THIS STATE SHALL:

(a) (I) NOT DENY, EXCLUDE, OR LIMIT BENEFITS FOR A COVERED INDIVIDUAL

BECAUSE OF A PREEXISTING CONDITION FOR LOSSES INCURRED MORE THAN SIX MONTHS FOLLOWING THE EFFECTIVE DATE OF SUCH INDIVIDUAL'S COVERAGE. A HEALTH BENEFIT PLAN SHALL NOT DEFINE A PREEXISTING CONDITION MORE RESTRICTIVELY THAN AN INJURY, SICKNESS, OR PREGNANCY FOR WHICH A PERSON INCURRED CHARGES, RECEIVED MEDICAL TREATMENT, CONSULTED A HEALTH CARE PROFESSIONAL, OR TOOK PRESCRIPTION DRUGS WITHIN SIX MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE; EXCEPT THAT AN INDIVIDUAL HEALTH BENEFIT PLAN MAY EXTEND THE EXCLUSION OF A PREEXISTING CONDITION FOR A PERIOD NOT TO EXCEED TWELVE MONTHS AND MAY NOT DEFINE THE PREEXISTING CONDITION MORE RESTRICTIVELY THAN AN INJURY, SICKNESS, OR PREGNANCY FOR WHICH A PERSON INCURRED CHARGES, RECEIVED MEDICAL TREATMENT, CONSULTED A HEALTH CARE PROFESSIONAL, OR TOOK PRESCRIPTION DRUGS WITHIN TWELVE MONTHS.

(II) A CARRIER THAT DOES NOT UTILIZE PREEXISTING CONDITION LIMITATIONS IN ANY HEALTH BENEFIT PLAN MAY IMPOSE A CARRIER WAITING PERIOD.

(b) WAIVE ANY CARRIER WAITING PERIOD OR TIME PERIOD APPLICABLE TO A PREEXISTING CONDITION EXCLUSION OR LIMITATION PERIOD WITH RESPECT TO PARTICULAR SERVICES FOR THE PERIOD OF TIME AN INDIVIDUAL WAS PREVIOUSLY COVERED BY QUALIFYING PREVIOUS COVERAGE THAT PROVIDED BENEFITS WITH RESPECT TO SUCH SERVICES, IF SUCH QUALIFYING PREVIOUS COVERAGE WAS CONTINUOUS TO A DATE NOT MORE THAN NINETY DAYS PRIOR TO THE EFFECTIVE DATE OF THE NEW COVERAGE. THE PERIOD OF CONTINUOUS COVERAGE SHALL NOT INCLUDE ANY WAITING PERIOD FOR THE EFFECTIVE DATE OF THE NEW COVERAGE APPLIED BY THE EMPLOYER OR THE CARRIER. THIS PARAGRAPH (b) SHALL NOT PRECLUDE APPLICATION OF ANY WAITING PERIOD APPLICABLE TO ALL NEW ENROLLEES UNDER THE PLAN.

(c) EXCLUDE COVERAGE FOR LATE ENROLLEES FOR THE GREATER OF TWELVE MONTHS OR FOR AN EIGHTEEN-MONTH-PREEXISTING CONDITION EXCLUSION; EXCEPT THAT, IF BOTH A PERIOD OF EXCLUSION FROM COVERAGE AND A PREEXISTING CONDITION EXCLUSION ARE APPLICABLE TO A LATE ENROLLEE, THE COMBINED PERIOD SHALL NOT EXCEED EIGHTEEN MONTHS FROM THE DATE THE INDIVIDUAL ENROLLS FOR COVERAGE UNDER THE HEALTH BENEFIT PLAN.

10-16-119. Requirements for excess loss insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act". (1) ANY ENTITY ISSUING EXCESS LOSS INSURANCE SHALL FILE ALL POLICY FORMS WITH THE DIVISION AND CERTIFY COMPLIANCE WITH THE PROVISIONS OF THIS TITLE.

(2) ALL EXCESS LOSS INSURANCE SHALL BE ISSUED TO COVER THE EMPLOYER'S LIABILITY UNDER THE EMPLOYER'S SELF-INSURED OBLIGATION. EXCESS LOSS INSURANCE SHALL MEET THE FOLLOWING REQUIREMENTS:

(a) THE POLICY SHALL ONLY BE ISSUED TO INSURE AN EMPLOYER AND NOT THE EMPLOYER'S EMPLOYEES;

(b) PAYMENT BY THE ISSUER OF THE INSURANCE SHALL ONLY BE MADE TO THE EMPLOYER AND NOT THE EMPLOYEES OR PROVIDERS;

(c) (I) EFFECTIVE JANUARY 1, 1995, THE MINIMUM RETENTION TO THE EMPLOYER SHALL BE NO LESS THAN TEN THOUSAND DOLLARS PER PERSON PER PLAN YEAR WITH A MINIMUM ONE HUNDRED TWENTY PERCENT OF EXPECTED CLAIMS AGGREGATE, EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH (c).

(II) FOR EXCESS LOSS POLICIES ISSUED AND IN FORCE PRIOR TO JANUARY 1, 1995, THE MINIMUM RETENTION TO THE EMPLOYER SHALL BE NO LESS THAN FIVE THOUSAND DOLLARS PER PERSON PER PLAN YEAR THROUGH DECEMBER 31, 1995, WITH A MINIMUM ONE HUNDRED TWENTY PERCENT OF EXPECTED CLAIMS AGGREGATE. EFFECTIVE ON POLICY ANNIVERSARY DATES OCCURRING ON AND AFTER JANUARY 1, 1996, SUCH POLICIES SHALL COMPLY WITH THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (c).

10-16-120. Legislative review of requirements for guaranteed issue of basic and standard health benefit plans. (1) DURING THE REGULAR SESSION OF THE GENERAL ASSEMBLY IN THE YEAR 2001, THE LEGISLATIVE COUNCIL OF THE GENERAL ASSEMBLY SHALL CONDUCT A REVIEW OF THE OPERATION OF REQUIREMENTS CONTAINED IN SECTION 10-16-105 FOR SMALL EMPLOYER CARRIERS TO ISSUE BASIC AND STANDARD HEALTH BENEFIT PLANS. SUCH REVIEW SHALL CONSIDER, BUT NOT BE LIMITED TO, THE EFFECT OF SUCH REQUIREMENT ON THE AVAILABILITY AND AFFORDABILITY OF HEALTH CARE COVERAGE TO RESIDENTS OF COLORADO. SUCH REVIEW SHALL ALSO CONSIDER THE ANNUAL REPORTS FILED PURSUANT TO SECTION 10-16-105 (10). AS A RESULT OF THE REVIEW REQUIRED BY THIS SUBSECTION (1), THE LEGISLATIVE COUNCIL MAY RECOMMEND TO THE GENERAL ASSEMBLY ANY LEGISLATION DETERMINED TO BE NECESSARY BASED ON SUCH REVIEW. THE LEGISLATIVE COUNCIL SHALL REPORT THE RESULTS OF THE REVIEW CONDUCTED PURSUANT TO THIS SUBSECTION (1) TO THE SENATE AND HOUSE OF REPRESENTATIVES BY MARCH 15, 2001.

(2) THE REQUIREMENTS CONTAINED IN SECTION 10-16-105 FOR SMALL EMPLOYER CARRIERS TO ISSUE BASIC AND STANDARD HEALTH BENEFIT PLANS SHALL TERMINATE JULY 1, 2001, UNLESS THE GENERAL ASSEMBLY ACTS BY BILL TO EXTEND SAID REQUIREMENTS BEYOND JULY 1, 2001.

SECTION 10. 10-16-116 (2), Colorado Revised Statutes, 1987 Repl. Vol., as enacted by House Bill 94-1094, enacted at the Second Regular Session of the Fifty-ninth General Assembly, is amended to read:

10-16-116. Catastrophic health insurance - coverage. (2) Each catastrophic health insurance policy ISSUED PURSUANT TO SUBSECTION (1) OF THIS SECTION is required to:

(a) Be ~~in the name of the insured employee~~ ISSUED TO THE EMPLOYER;

(b) Have a minimum deductible of two thousand five hundred dollars;

(c) Offer coverage for the spouse and dependent children of the insured employee;

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

(e) Cover an employee ~~who would be eligible except for underwriting considerations that relate to health~~ AND ELIGIBLE DEPENDENTS REGARDLESS OF HEALTH STATUS, if the employee was continuously covered for one year or more WITH A GAP IN COVERAGE OF NO MORE THAN NINETY DAYS under another health insurance policy;

(f) (I) Be priced pursuant to a modified form of community rating, EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH (f). The information to be taken into account by the insurer during the underwriting process is limited to the applicant's age, sex, health status, and the geographical area in which the applicant lives.

(II) IF THE CATASTROPHIC HEALTH INSURANCE POLICY COVERS THE EMPLOYEES OF A SMALL EMPLOYER, THEN IT SHALL BE PRICED PURSUANT TO SECTION 10-16-105 (8).

(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) Include a portability clause which provides that:

(I) When an employee leaves employment for any reason the employee, the employee's spouse, and the employee's dependent children may each elect to CONTINUE COVERAGE OR convert coverage to an individual policy ~~if they request to do so within thirty-one days after the date coverage is lost~~ PURSUANT TO SECTION 10-16-108; AND

~~(II) An employee or the spouse or covered dependents of an employee who elect to convert coverage shall pay all premiums after the date of the conversion, which premiums may not exceed one hundred thirty-five percent of premium amounts that would have been charged with respect to such person had he or she been covered as an employee under the plan during the same period. If the plan under which such person was covered is cancelled or not renewed, the premium rates shall be based on the rate which would have been charged to such person had the plan continued in force as determined by the insurer in accordance with standard actuarial principles.~~

~~(III)~~ (II) Benefits may not be less than those provided under the policy prior to the date of conversion AND MUST COMPLY WITH SECTION 10-16-108.

~~(IV) The insurer may apply against the benefit limits of the conversion policy any benefits paid prior to the date of conversion, if the insurer credits the insured with any waiting period or deductible which was credited under the policy prior to the date of conversion; and~~

~~(V) Upon the death of the insured, one of the surviving dependents of the insured may convert the policy to an individual policy.~~

SECTION 11. 10-16-202 (3), Colorado Revised Statutes, 1987 Repl. Vol., as amended, is amended to read:

10-16-202. Required provisions in individual sickness and accident policies. (3) Provisions as follows: "Time limit on certain defenses: (a) After two years from

the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period."

"(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of section 10-16-203 in the event of misstatement with respect to age or occupation or other insurance.)"

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age fifty, or in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain, in lieu of the foregoing, the following provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption "Incontestable":

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.")

"(b) No claim for loss incurred or disability, as defined in the policy, commencing after ~~two years~~ ONE YEAR from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(AN INDIVIDUAL HEALTH BENEFIT PLAN SHALL NOT DEFINE A PREEXISTING CONDITION MORE RESTRICTIVELY THAN AN INJURY, SICKNESS, OR PREGNANCY FOR WHICH A PERSON INCURRED CHARGES, RECEIVED MEDICAL TREATMENT, CONSULTED A HEALTH CARE PROFESSIONAL, OR TOOK PRESCRIPTION DRUGS WITHIN THE TWELVE MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE.)

SECTION 12. 10-16-214 (1) (c) and (3) (a) (V), Colorado Revised Statutes, 1987 Repl. Vol., as amended, are amended to read:

10-16-214. Group sickness and accident insurance. (1) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without their dependents, and issued upon the following bases:

(c) ~~Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class of individuals that could be insured under such group life insurance policy.~~ ON AND AFTER JULY 1, 1994, UNDER A POLICY ISSUED TO ANY PERSON OR ORGANIZATION TO WHICH A POLICY OF GROUP LIFE INSURANCE MAY BE ISSUED OR DELIVERED IN THIS STATE TO INSURE ANY CLASS OF INDIVIDUALS THAT COULD BE INSURED UNDER SUCH GROUP LIFE INSURANCE POLICY; EXCEPT THAT, NOTWITHSTANDING THE PROVISIONS OF SECTION 10-7-201 (1) (b), ON AND AFTER JULY 1, 1994, SUCH A POLICY SHALL COVER AT LEAST TWO OR MORE INDIVIDUALS AT DATE OF ISSUE, AND ON AND AFTER JANUARY 1, 1996, SUCH A POLICY SHALL COVER A BUSINESS GROUP OF ONE AT THE DATE OF ISSUE.

(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:

(V) (A) A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. ~~Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of coverage.~~ A HEALTH BENEFIT PLAN SHALL NOT DEFINE A PREEXISTING CONDITION MORE RESTRICTIVELY THAN AN INJURY, SICKNESS, OR PREGNANCY FOR WHICH A PERSON INCURRED CHARGES, RECEIVED MEDICAL TREATMENT, CONSULTED A HEALTH PROFESSIONAL, OR TOOK PRESCRIPTION DRUGS WITHIN SIX MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE.

(B) In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of the end of a continuous period of ~~twelve~~ SIX months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition and the end of the ~~one-year~~ SIX-MONTH period commencing on the effective date of the person's coverage, EXCEPT AS PROVIDED IN SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (V).

SECTION 13. 10-3-1104 (1), Colorado Revised Statutes, 1987 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

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

(v) FAILURE TO COMPLY WITH ALL PROVISIONS OF SECTION 10-16-108.5 CONCERNING FAIR MARKETING OF BASIC AND STANDARD HEALTH BENEFIT PLANS, AND SECTION 10-16-105 CONCERNING GUARANTEED ISSUE OF BASIC AND STANDARD HEALTH BENEFIT PLANS.

SECTION 14. Repeal. 10-16-108 (1) (d) (II), (1) (d) (III), (1) (d) (IV), (1) (d) (V), (1) (d) (VI), (1) (d) (VII), (1) (d) (XI), and (1) (d) (XII), Colorado Revised Statutes, 1987 Repl. Vol., as amended, are repealed.

SECTION 15. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the division of insurance cash fund not otherwise appropriated, to the department of regulatory agencies, for allocation to the division of insurance, for the fiscal year beginning July 1, 1994, the sum of forty thousand seven hundred ninety-five dollars ($40,795) and 0.8 FTE, or so much thereof as may be necessary, for the implementation of this act.

SECTION 16. Effective date - applicability. This act shall take effect July 1,

1994, and shall apply to health benefit plans issued or renewed on or after said date.

SECTION 17. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: June 2, 1994