CHAPTER 154

INSURANCE

SENATE BILL 97-054

BY SENATORS Coffman, Johnson, Pascoe, and Schroeder;
also REPRESENTATIVES Leyba, Kreutz, Lawrence, Morrison, Nichol, and S. Williams.

AN ACT

CONCERNING MEASURES NECESSARY FOR COLORADO TO MAINTAIN REGULATORY AUTHORITY OVER CERTAIN ASPECTS OF HEALTH CARE COVERAGE UNDER THE FEDERAL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", AND, IN CONNECTION THEREWITH, MAKING COLORADO REQUIREMENTS RELATED TO THE RENEWABILITY OF HEALTH INSURANCE POLICIES, PREEXISTING CONDITION LIMITATIONS, AND GUARANTEED ISSUE OF COVERAGE CONSISTENT WITH FEDERAL LAW, REQUIRING THAT INDIVIDUAL PLANS ACCEPT ALL ELIGIBLE INDIVIDUALS APPLYING FOR COVERAGE, PROHIBITING PREMIUM RATE DISCRIMINATION BASED ON HEALTH STATUS, AND CLARIFYING THE COLORADO INCOME TAX EXCLUSION OF CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS AS A RESULT OF FEDERAL MEDICAL SAVINGS ACCOUNT PROVISIONS.

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

SECTION 1. Legislative declaration. (1) The general assembly hereby finds, determines, and declares that the intent of this legislation is solely to bring Colorado statutes into compliance with the provisions of the federal "Health Insurance Portability and Accountability Act of 1996", where Colorado laws do not already meet or exceed the minimum requirements of the federal act. This is being done in order to:

(a) Retain state jurisdiction over health insurance plans and avoid dual federal and state regulation;

(b) Reduce public confusion about the health insurance rights and responsibilities of carriers and residents by making Colorado law consistent with federal health insurance law wherever the federal "Health Insurance Portability and Accountability Act of 1996" preempts state law;

(c) Allow Coloradans covered by an insured health plan to continue to file all their

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

health insurance complaints with the Colorado division of insurance rather than having to file some of them with the federal government; and

(d) Ensure that where state law exceeds the minimum requirements of the federal "Health Insurance Portability and Accountability Act of 1996", consumers continue to be afforded the same higher level of protection they have had under Colorado law.

(2) (a) Nothing in Senate Bill 97-54 shall be construed to prevent or prohibit the chief executive officer of the state from giving the required notice to the secretary of the federal department of health and human services and activating the presumption under section 2744 of the federal "Health Insurance Portability and Accountability Act of 1996" that Colorado is implementing an acceptable alternative mechanism to the requirement of section 2741 of the federal act. No such notice or any other application for certification may take place without specific statutory authorization from the general assembly acting by bill.

(b) Nothing in Senate Bill 97-54 shall be construed to authorize implementation of the national association of insurance commissioners' model acts on either individual portability or individual availability.

SECTION 2. 10-8-602 (1), (1.2), (1.3), (3), (3.1), (3.2), (3.5), (5.4), (5.5), (5.6), (6), (6.3), (6.5), (6.7), (6.8), (7.5), (7.7), (8.5), (8.7), (9.5), (11), and (12), Colorado Revised Statutes, 1994 Repl. Vol., are amended to read:

10-8-602. Definitions. As used in this part 6, 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 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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (1).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (2).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (3).

(3) "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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (8).

(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~~ HAS THE SAME MEANING AS "AFFILIATION PERIOD" AS SET FORTH IN SECTION 10-16-102 (2.5).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (10).

(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:~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (11).

~~(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.~~

(5.4) "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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (14).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (15).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (18).

(6) (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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (21).

(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 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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (24).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (25).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (26).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (28).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (31).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (35).

(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~~ HAVE THE SAME MEANING AS "CREDITABLE COVERAGE" AS SET FORTH IN SECTION 10-16-102 (13.7).

(8.7) "Rating period" ~~means the policy period for which premium rates established by a carrier are assumed to be in effect~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (38).

(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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (39).

(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 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~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (40).

(12) "Small employer carrier" ~~means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state~~ HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (41).

SECTION 3. 10-16-102 (9), (21), (26), (37), and (43), Colorado Revised Statutes, 1994 Repl. Vol., are amended, and the said 10-16-102, as amended, 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:

(2.5) "AFFILIATION PERIOD" MEANS A PERIOD OF TIME NOT TO EXCEED TWO MONTHS (THREE MONTHS FOR LATE ENROLLEES) DURING WHICH A HEALTH MAINTENANCE ORGANIZATION DOES NOT COLLECT PREMIUM AND COVERAGE ISSUED WOULD NOT BECOME EFFECTIVE.

(5.5) "BONA FIDE ASSOCIATION" MEANS, WITH RESPECT TO HEALTH INSURANCE COVERAGE OFFERED IN COLORADO, AN ASSOCIATION WHICH:

(a) HAS BEEN ACTIVELY IN EXISTENCE FOR AT LEAST FIVE YEARS;

(b) HAS BEEN FORMED AND MAINTAINED IN GOOD FAITH FOR PURPOSES OTHER THAN OBTAINING INSURANCE AND DOES NOT CONDITION MEMBERSHIP ON THE PURCHASE OF ASSOCIATION-SPONSORED INSURANCE;

(c) DOES NOT CONDITION MEMBERSHIP IN THE ASSOCIATION ON ANY HEALTH STATUS-RELATED FACTOR RELATING TO AN INDIVIDUAL (INCLUDING AN EMPLOYEE OF AN EMPLOYER OR A DEPENDENT OF AN EMPLOYEE) AND CLEARLY SO STATES IN ALL MEMBERSHIP AND APPLICATION MATERIALS;

(d) MAKES HEALTH INSURANCE COVERAGE OFFERED THROUGH THE ASSOCIATION AVAILABLE TO ALL MEMBERS REGARDLESS OF ANY HEALTH STATUS-RELATED FACTOR RELATING TO SUCH MEMBERS (OR INDIVIDUALS ELIGIBLE FOR COVERAGE THROUGH A MEMBER) AND CLEARLY SO STATES IN ALL MARKETING AND APPLICATION MATERIALS;

(e) DOES NOT MAKE HEALTH INSURANCE COVERAGE OFFERED THROUGH THE ASSOCIATION AVAILABLE OTHER THAN IN CONNECTION WITH A MEMBER OF THE ASSOCIATION AND CLEARLY SO STATES IN ALL MARKETING AND APPLICATION MATERIALS; AND

(f) PROVIDES AND ANNUALLY UPDATES INFORMATION NECESSARY FOR THE COMMISSIONER TO DETERMINE WHETHER OR NOT AN ASSOCIATION MEETS THE DEFINITION OF A BONA FIDE ASSOCIATION BEFORE QUALIFYING AS A BONA FIDE ASSOCIATION FOR THE PURPOSES OF THIS ARTICLE 16.

(9) ~~"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.~~

(13.7) "CREDITABLE COVERAGE" MEANS BENEFITS OR COVERAGE PROVIDED UNDER:

(a) MEDICARE OR MEDICAID;

(b) AN EMPLOYEE WELFARE BENEFIT PLAN OR GROUP HEALTH INSURANCE OR HEALTH BENEFIT PLAN;

(c) AN INDIVIDUAL HEALTH BENEFIT PLAN;

(d) A STATE HEALTH BENEFITS RISK POOL (INCLUDING BUT NOT LIMITED TO THE COLORADO UNINSURABLE HEALTH INSURANCE PLAN); OR

(e) CHAPTER 55 OF TITLE 10 OF THE UNITED STATES CODE, A MEDICAL CARE PROGRAM OF THE FEDERAL INDIAN HEALTH SERVICE OR OF A TRIBAL ORGANIZATION, A HEALTH PLAN OFFERED UNDER CHAPTER 89 OF TITLE 5, UNITED STATES CODE, A PUBLIC HEALTH PLAN, OR A HEALTH BENEFIT PLAN UNDER SECTION 5 (e) OF THE FEDERAL "PEACE CORPS ACT" (22 U.S.C. SEC. 2504 (e)).

(21) (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 OR ANY OTHER SIMILAR HEALTH CONTRACT SUBJECT TO THE JURISDICTION OF THE COMMISSIONER available for use, offered, or sold ~~to an individual or to a small employer~~ IN COLORADO.

(b) "Health benefit plan" does not include: Accident only; credit; dental; vision; medicare supplement; BENEFITS FOR long-term care, HOME HEALTH CARE, COMMUNITY-BASED CARE, OR ANY COMBINATION THEREOF; ~~or~~ disability income insurance; LIABILITY INSURANCE INCLUDING GENERAL LIABILITY INSURANCE AND AUTOMOBILE LIABILITY INSURANCE; COVERAGE FOR ON-SITE MEDICAL CLINICS; coverage issued as a supplement to liability insurance, workers' compensation or similar insurance; OR automobile medical payment insurance. THE TERM ALSO EXCLUDES specified disease, hospital confinement indemnity, or limited benefit health insurance if SUCH TYPES OF COVERAGE DO NOT PROVIDE COORDINATION OF BENEFITS AND ARE PROVIDED UNDER SEPARATE POLICES OR CERTIFICATES.

~~(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.~~

(24.5) "HEALTH STATUS-RELATED FACTOR" MEANS ANY OF THE FOLLOWING FACTORS: HEALTH STATUS; MEDICAL CONDITION, INCLUDING BOTH PHYSICAL AND MENTAL ILLNESSES; CLAIMS EXPERIENCE; RECEIPT OF HEALTH CARE; MEDICAL

HISTORY; GENETIC INFORMATION; EVIDENCE OF INSURABILITY INCLUDING CONDITIONS ARISING OUT OF ACTS OF DOMESTIC VIOLENCE; AND DISABILITY.

(26) "Late enrollee" means an eligible employee or dependent who requests enrollment in a GROUP 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~~ OTHER CREDITABLE coverage at the time of the initial enrollment period AND, IF REQUIRED BY THE CARRIER OR ISSUER, THE EMPLOYEE STATED AT THE TIME OF INITIAL ENROLLMENT THAT THIS WAS THE REASON FOR DECLINING ENROLLMENT;

(II) Lost coverage under the other ~~qualifying previous~~ CREDITABLE coverage as a result of termination of employment or eligibility, REDUCTION IN THE NUMBER OF HOURS OF EMPLOYMENT, the involuntary termination of the ~~qualifying previous~~ CREDITABLE coverage, death of a spouse, LEGAL SEPARATION or divorce, OR EMPLOYER CONTRIBUTIONS TOWARDS SUCH COVERAGE WAS TERMINATED; and

(III) Requests enrollment within thirty days after termination of the other ~~qualifying previous~~ CREDITABLE 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; OR

(d) A PERSON BECOMES A DEPENDENT OF A COVERED PERSON THROUGH MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION AND REQUESTS ENROLLMENT NO LATER THAN THIRTY DAYS AFTER BECOMING SUCH A DEPENDENT. IN SUCH CASE, COVERAGE SHALL COMMENCE ON THE DATE THE PERSON BECOMES A DEPENDENT IF A REQUEST FOR ENROLLMENT IS RECEIVED IN A TIMELY FASHION BEFORE SUCH DATE.

(37) ~~"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.~~

(43) "Small group sickness and accident insurance", "small group plan", and "small group policy" mean that form of group sickness and accident insurance issued by an entity subject to part 2 of this article, that form of group service or indemnity type contract issued by an entity organized pursuant to the provisions of part 3 of this article, or that form of policy issued by an entity organized pursuant to the provisions of part 4 of this article which provides coverage to small employers located in Colorado. THESE TERMS INCLUDE A BONA FIDE ASSOCIATION PLAN IF SUCH PLAN PROVIDES COVERAGE TO ONE OR MORE ELIGIBLE EMPLOYEES OF A SMALL EMPLOYER IN COLORADO.

(45) "WAITING PERIOD" MEANS, WITH RESPECT TO A GROUP HEALTH BENEFIT PLAN AND AN INDIVIDUAL THAT IS A POTENTIAL PARTICIPANT OR BENEFICIARY IN THE PLAN, THE PERIOD THAT MUST PASS WITH RESPECT TO THE INDIVIDUAL, AS DETERMINED BY THE PLAN SPONSOR, BEFORE THE INDIVIDUAL IS ELIGIBLE TO BE COVERED FOR BENEFITS UNDER THE TERMS OF THE PLAN.

SECTION 4. 10-16-105 (3), (4), (5), and (7.3) (a), the introductory portion to 10-16-105 (7.3) (b) (I), and 10-16-105 (7.3) (c) (I), (7.3) (d.5), (7.3) (e), (7.3) (h), and (7.4) (c), Colorado Revised Statutes, 1994 Repl. Vol., are amended, and the said 10-16-105, as amended, is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans. (3) A small group sickness and accident insurance plan, small group plan, or small group policy shall be renewable to all eligible employees and dependents at the option of the small employer, except ~~where there is~~ AS ALLOWED PURSUANT TO SECTION 10-16-201.5.

~~(a) Nonpayment of required premiums;~~

~~(b) Fraud or misrepresentation by the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or such individual's representative;~~

~~(c) Noncompliance with plan provisions;~~

~~(d) An insufficient number of individuals under the plan to meet the percentage requirements of the plan; or~~

~~(e) An employer which is no longer actively engaged in the business in which it was engaged on the effective date of the plan.~~

(4) ~~A small group sickness and accident insurer subject to the provisions of part 2 of this article or an entity subject to the provisions of part 3 or 4 of this article may cease to renew all plans under a class of business; however, the insurer or other entity shall provide notice to all affected health insurance plans and to the commissioner in each state in which an affected insured individual is known to reside at least ninety days prior to termination of coverage. An insurer or other entity which exercises its~~

~~right not to renew all plans in a class of business shall not:~~

~~(a) Establish a new class of business for a period of five years after the nonrenewal of the plans without prior approval of the commissioner; or~~

~~(b) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the insurer offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristic, claim experience, health status, or duration of coverage.~~

(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 premium rates for a specific employer are established or adjusted due to the experience, health status, or duration of coverage of employees or dependents of the small employer;

(b) The provisions concerning the insurer's or other entity's right to, and the frequency with which the insurer or other entity may, change premium rates and the factors, including case characteristics, which affect changes in premium rates;

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

(d) The provisions relating to renewability of coverage;

(e) THE PROVISIONS OF SUCH COVERAGE RELATING TO ANY PREEXISTING CONDITION EXCLUSION; AND

(f) THE BENEFITS AND PREMIUMS AVAILABLE UNDER ALL HEALTH BENEFIT PLANS FOR WHICH THE EMPLOYER IS QUALIFIED.

(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. EFFECTIVE JULY 1, 1997, EVERY SMALL EMPLOYER CARRIER SHALL ALSO OFFER TO SMALL EMPLOYERS A CHOICE OF ALL THE OTHER SMALL GROUP PLANS THE CARRIER MARKETS IN COLORADO; EXCEPT THAT THIS REQUIREMENT 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.

(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:

(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. 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) 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.

(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.~~

(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) (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~~ CREDITABLE 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.

(12) IN THE CASE OF AN EMPLOYER THAT WAS NOT IN EXISTENCE THROUGHOUT THE PRECEDING CALENDAR QUARTER, THE DETERMINATION OF WHETHER SUCH EMPLOYER IS A SMALL OR LARGE EMPLOYER SHALL BE BASED ON THE AVERAGE NUMBER OF EMPLOYEES THAT IS REASONABLY EXPECTED SUCH EMPLOYER WILL EMPLOY ON BUSINESS DAYS IN THE CURRENT CALENDAR YEAR.

SECTION 5. Part 1 of article 16 of title 10, Colorado Revised Statutes, 1994 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-105.5. Individual health benefit plans - limited guarantee issue. (1) EVERY CARRIER OFFERING INDIVIDUAL HEALTH BENEFIT PLANS IN COLORADO SHALL OFFER AND ACCEPT FOR ENROLLMENT PURSUANT TO SUBSECTION (2) OF THIS SECTION EVERY ELIGIBLE INDIVIDUAL WHO APPLIES FOR COVERAGE WITHIN SIXTY-TWO DAYS AFTER TERMINATION OF SUCH INDIVIDUAL'S PRIOR COVERAGE AND SHALL NOT IMPOSE ANY PREEXISTING CONDITION EXCLUSIONS OR LIMITATIONS ON THE NEW COVERAGE; EXCEPT THAT THIS REQUIREMENT SHALL NOT APPLY TO CARRIERS OFFERING COVERAGE ONLY THROUGH BONA FIDE ASSOCIATIONS OR TO CARRIERS OFFERING INDIVIDUAL COVERAGE ONLY THROUGH CONVERSION POLICIES. AS USED IN THIS SECTION, "ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL:

(a) FOR WHOM, AS OF THE DATE ON WHICH THE INDIVIDUAL SEEKS COVERAGE, THE AGGREGATE OF PERIODS OF CREDITABLE COVERAGE IS EIGHTEEN MONTHS OR MORE

AND WHOSE MOST RECENT PRIOR CREDITABLE COVERAGE WAS UNDER A GROUP PLAN. AS USED IN THIS SECTION, "GROUP PLAN" MEANS A SMALL OR LARGE GROUP HEALTH BENEFIT PLAN, AN EMPLOYER-SPONSORED PLAN, AN EMPLOYEE WELFARE BENEFIT PLAN, A GOVERNMENT PLAN, OR A CHURCH PLAN.

(b) WHO IS NOT ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFIT PLAN, MEDICARE, OR MEDICAID AND DOES NOT HAVE OTHER HEALTH BENEFIT PLAN COVERAGE;

(c) WHOSE MOST RECENT COVERAGE WAS NOT TERMINATED AS A RESULT OF NONPAYMENT OF PREMIUMS OR FRAUD; AND

(d) WHO DID NOT TURN DOWN AN OFFER OF CONTINUATION COVERAGE IF IT WAS OFFERED AND WHO SUBSEQUENTLY EXHAUSTED SUCH COVERAGE.

(2) A CARRIER SHALL MEET THE REQUIREMENTS OF SUBSECTION (1) OF THIS SECTION IF:

(a) THE CARRIER OFFERS AT LEAST TWO DIFFERENT HEALTH BENEFIT POLICY FORMS, BOTH OF WHICH ARE DESIGNED FOR, ARE MADE GENERALLY AVAILABLE AND ACTIVELY MARKETED TO, AND ENROLL BOTH ELIGIBLE AND OTHER INDIVIDUALS; AND

(b) THE OFFERING OF POLICY FORMS INCLUDES, AT A MINIMUM:

(I) THE POLICY FORMS FOR HEALTH BENEFIT PLAN COVERAGE WITH THE LARGEST AND NEXT TO LARGEST PREMIUMS VOLUME OF ALL SUCH POLICY FORMS OFFERED BY THE ISSUER IN COLORADO; OR

(II) A LOWER-LEVEL COVERAGE POLICY FORM AND A HIGHER-LEVEL COVERAGE POLICY FORM WHICH INCLUDE BENEFITS SUBSTANTIALLY SIMILAR TO OTHER INDIVIDUAL HEALTH INSURANCE COVERAGE OFFERED BY THE ISSUER IN COLORADO AND ARE COVERED UNDER A RISK ADJUSTMENT, RISK SPREADING, OR FINANCIAL SUBSIDIZATION METHOD CONSISTENT WITH FEDERAL REGULATIONS. AS USED IN THIS SUBPARAGRAPH (II):

(A) "HIGHER-LEVEL COVERAGE" MEANS A POLICY FORM FOR WHICH THE ACTUARIAL VALUE OF THE BENEFITS UNDER THE COVERAGE IS AT LEAST FIFTEEN PERCENT GREATER THAN THE ACTUARIAL VALUE OF LOWER-LEVEL COVERAGE OFFERED BY THE CARRIER IN COLORADO, AND THE ACTUARIAL VALUE OF THE BENEFITS UNDER THE COVERAGE IS AT LEAST ONE HUNDRED PERCENT BUT NOT GREATER THAN ONE HUNDRED TWENTY PERCENT OF THE POLICY FORM WEIGHTED AVERAGE.

(B) "LOWER-LEVEL COVERAGE" MEANS A POLICY FORM FOR WHICH THE ACTUARIAL VALUE OF THE BENEFITS UNDER THE COVERAGE IS AT LEAST EIGHTY-FIVE PERCENT BUT NOT GREATER THAN ONE HUNDRED PERCENT OF THE POLICY FORM WEIGHTED AVERAGE.

(C) "POLICY FORM WEIGHTED AVERAGE" MEANS THE AVERAGE ACTUARIAL VALUE OF THE BENEFITS PROVIDED BY ALL THE HEALTH INSURANCE COVERAGE ISSUED (AS ELECTED BY THE CARRIER) EITHER BY THAT CARRIER OR, IF SUCH DATA ARE

AVAILABLE, BY ALL CARRIERS IN COLORADO IN THE INDIVIDUAL HEALTH BENEFIT PLAN MARKET DURING THE PREVIOUS YEAR (NOT INCLUDING COVERAGE ISSUED UNDER THIS SECTION), WEIGHTED BY ENROLLMENT FOR THE DIFFERENT COVERAGE.

(3) WITH RESPECT TO THE PROVISIONS OF SUBSECTION (2) OF THIS SECTION, A CARRIER THAT OFFERS COVERAGE IN THE INDIVIDUAL MARKET THROUGH A MANAGED CARE PLAN MAY LIMIT THE INDIVIDUALS WHO MAY BE ENROLLED TO THOSE THAT LIVE, RESIDE, OR WORK WITHIN THE SERVICE AREA OF THE PLAN. SUCH A CARRIER MAY DENY COVERAGE TO ELIGIBLE INDIVIDUALS IF IT DEMONSTRATES TO THE COMMISSIONER THAT IT WILL NOT HAVE THE CAPACITY TO DELIVER SERVICES ADEQUATELY TO ADDITIONAL ENROLLEES AND IT IS APPLYING THIS SUBSECTION (3) UNIFORMLY TO INDIVIDUALS WITHOUT REGARD TO ANY HEALTH STATUS-RELATED FACTOR OF SUCH INDIVIDUALS AND WITHOUT REGARD TO WHETHER THE INDIVIDUALS ARE ELIGIBLE INDIVIDUALS.

(4) A CARRIER MAY APPLY TO THE COMMISSIONER TO SUSPEND FOR A PERIOD OF TIME ITS DUTY TO ISSUE COVERAGE PURSUANT TO SUBSECTION (2) OF THIS SECTION WHERE CONTINUED COMPLIANCE WOULD ADVERSELY AFFECT THE FINANCIAL CONDITION OF THE COMPANY. WHERE SUCH A SUSPENSION IS GRANTED, THE CARRIER MAY NOT OFFER COVERAGE IN THE INDIVIDUAL MARKET FOR A PERIOD OF AT LEAST ONE HUNDRED EIGHTY DAYS AFTER THE SUSPENSION IS GRANTED.

(5) FOR THE PURPOSES OF THIS SECTION, THE TERM "HEALTH BENEFIT PLAN", AS DEFINED IN SECTION 10-16-102 (21), DOES NOT INCLUDE NONRENEWABLE INDIVIDUAL HEALTH BENEFIT PLANS WITH A DURATION OF SIX MONTHS OR LESS.

SECTION 6. 10-16-107, Colorado Revised Statutes, 1994 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-16-107. Rate regulation - approval of policy forms - benefit certificates - evidences of coverage - loss ratio guarantees. (6) A CARRIER OFFERING A GROUP HEALTH BENEFIT PLAN MAY NOT REQUIRE ANY INDIVIDUAL (AS A CONDITION OF ENROLLMENT OR CONTINUED ENROLLMENT UNDER THE PLAN) TO PAY A PREMIUM OR CONTRIBUTION THAT IS GREATER THAN SUCH PREMIUM OR CONTRIBUTION FOR A SIMILARLY SITUATED INDIVIDUAL ENROLLED IN THE PLAN ON THE BASIS OF ANY HEALTH STATUS-RELATED FACTOR IN RELATION TO THE INDIVIDUAL OR TO AN INDIVIDUAL ENROLLED UNDER THE PLAN AS A DEPENDENT OF THE INDIVIDUAL. THIS PROHIBITION SHALL NOT BE CONSTRUED TO RESTRICT THE AMOUNT THAT AN EMPLOYER MAY BE CHARGED FOR COVERAGE UNDER A GROUP HEALTH BENEFIT PLAN OR TO PREVENT A CARRIER FROM ESTABLISHING PREMIUM DISCOUNTS OR REBATES OR MODIFYING OTHERWISE APPLICABLE COPAYMENTS OR DEDUCTIBLES IN RETURN FOR ADHERENCE TO PROGRAMS OF HEALTH PROMOTION AND DISEASE PREVENTION, IF OTHERWISE ALLOWED BY LAW.

SECTION 7. 10-16-118, Colorado Revised Statutes, 1994 Repl. Vol., is amended to read:

10-16-118. Limitations on preexisting condition limitations. (1) A health ~~benefit~~ COVERAGE plan that covers residents of this state: ~~shall:~~

(a) (I) IF IT IS A GROUP HEALTH BENEFIT PLAN, SHALL 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~~ DATE OF ENROLLMENT OF THE INDIVIDUAL IN SUCH PLAN OR, IF EARLIER, THE FIRST DAY OF THE WAITING PERIOD FOR SUCH ENROLLMENT. ~~A health benefit plan shall not define a preexisting condition more restrictively than an injury, sickness, or pregnancy~~ A GROUP HEALTH BENEFIT PLAN MAY IMPOSE A PREEXISTING CONDITION EXCLUSION OR LIMITATION ONLY IF SUCH EXCLUSION RELATES TO A CONDITION (WHETHER PHYSICAL OR MENTAL), REGARDLESS OF THE CAUSE OF THE CONDITION, for which ~~a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs~~ MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED within six months immediately preceding the ~~effective date of coverage~~ DATE OF ENROLLMENT OF THE INDIVIDUAL IN SUCH PLAN OR, IF EARLIER, THE FIRST DAY OF THE WAITING PERIOD FOR SUCH ENROLLMENT; except that A GROUP HEALTH BENEFIT PLAN SHALL NOT IMPOSE ANY PREEXISTING CONDITION EXCLUSION IN THE CASE OF A CHILD THAT IS ADOPTED OR PLACED FOR ADOPTION BEFORE ATTAINING EIGHTEEN YEARS OF AGE, OR RELATING TO PREGNANCY.

(II) IF IT IS an individual health benefit plan, ~~may extend the exclusion of a preexisting condition for a period not to exceed~~ OR A GROUP HEALTH COVERAGE PLAN TO WHICH SUBPARAGRAPH (I) OF THIS PARAGRAPH (a) DOES NOT APPLY, SHALL NOT DENY, EXCLUDE, OR LIMIT BENEFITS FOR A COVERED INDIVIDUAL BECAUSE OF A PREEXISTING CONDITION FOR LOSSES INCURRED MORE THAN twelve months FOLLOWING THE EFFECTIVE DATE OF COVERAGE and may not define ~~the~~ 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 twelve months.

~~(II)~~ (III) ~~A carrier~~ IF IT IS A HEALTH MAINTENANCE ORGANIZATION that does not utilize preexisting condition limitations in any health benefit plan, may impose ~~a carrier waiting~~ AN AFFILIATION period. AN AFFILIATION PERIOD SHALL RUN CONCURRENTLY WITH ANY WAITING PERIOD. SUCH A HEALTH MAINTENANCE ORGANIZATION MAY, IN LIEU OF AN AFFILIATION PERIOD, USE AN ALTERNATIVE METHOD TO ADDRESS ADVERSE SELECTION WITH THE PRIOR APPROVAL OF THE COMMISSIONER.

(b) SHALL waive any ~~carrier waiting~~ AFFILIATION 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~~ CREDITABLE coverage ~~that provided benefits with respect to such services,~~ if such ~~qualifying previous~~ CREDITABLE 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. THE METHOD OF CREDITING AND CERTIFYING COVERAGE SHALL BE DETERMINED BY THE COMMISSIONER BY RULE.

(c) SHALL exclude coverage for late enrollees for the greater of twelve months or for NO MORE THAN 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. HEALTH MAINTENANCE ORGANIZATIONS THAT DO NOT USE PREEXISTING CONDITION EXCLUSION PERIODS IN ANY OF THEIR PLANS MAY IMPOSE UP TO A THREE-MONTH AFFILIATION PERIOD IN LIEU OF THE EIGHTEEN-MONTH PREEXISTING CONDITION PERIOD.

SECTION 8. 10-16-201.5, Colorado Revised Statutes, 1994 Repl. Vol., as amended, is amended to read:

10-16-201.5. Renewability of health benefit plans. (1) ~~An insurer subject to this part 2, a nonprofit subject to part 3 of this article, and a health maintenance organization subject to part 4 of this article~~ A CARRIER providing coverage under ~~an individual~~ A health benefit plan shall not refuse to renew such plan except for the following reasons:

(a) Nonpayment of the required premium;

(b) Fraud or INTENTIONAL misrepresentation OF MATERIAL FACT on the part of the ~~insured individual~~ PLAN SPONSOR WITH RESPECT TO GROUP HEALTH BENEFIT PLAN COVERAGE AND THE INDIVIDUAL WITH RESPECT TO INDIVIDUAL COVERAGE;

(c) ~~Noncompliance by the insured individual with plan provisions;~~

(d) The ~~individual~~ carrier elects to DISCONTINUE OFFERING AND nonrenew all of its individual, SMALL GROUP, OR LARGE GROUP health benefit plans delivered or issued for delivery ~~to individuals~~ in this state. In such case the carrier shall provide notice of the decision not to renew coverage to all ~~affected individuals~~ POLICYHOLDERS AND COVERED PERSONS and to the insurance commissioner in each state in which an affected individual is known to reside at least ~~ninety~~ ONE HUNDRED EIGHTY days prior to the nonrenewal of the health benefit plan by the carrier. THE CARRIER SHALL ALSO DISCONTINUE AND NONRENEW ALL OF ITS INDIVIDUAL OR SMALL OR LARGE GROUP HEALTH BENEFIT PLANS IN COLORADO. Notice to the insurance commissioner under this paragraph (d) shall be provided at least three working days prior to the notice to the affected individuals.

(e) ~~Attainment of eligibility for medicare due to the insured individual's reaching the age for medicare eligibility set by the federal government. In the case of eligibility for medicare prior to that age, an individual health care benefit plan shall be renewable; except that the plan may be modified so that benefits that would otherwise be payable may be reduced by an amount no more than that paid by medicare.~~

(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. ~~In such instance, the commissioner shall assist affected individuals in finding replacement coverage~~ ONCE THE COMMISSIONER HAS MADE SUCH A FINDING, 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.

(g) ~~The commissioner finds that the product form is obsolete and is being replaced with comparable coverage.~~ WITH RESPECT TO GROUP HEALTH BENEFIT PLANS, THE POLICYHOLDER FAILS TO COMPLY WITH PARTICIPATION OR CONTRIBUTION RULES;

(h) WITH RESPECT TO A CARRIER THAT OFFERS GROUP HEALTH BENEFIT PLANS IN THE MARKET THROUGH A MANAGED CARE PLAN, THERE IS NO LONGER ANY ENROLLEE IN CONNECTION WITH SUCH PLAN THAT LIVES, RESIDES, OR WORKS IN THE SERVICE AREA OF THE CARRIER;

(i) WITH RESPECT TO SMALL GROUP HEALTH BENEFIT PLANS, AN EMPLOYER IS NO LONGER ACTIVELY ENGAGED IN THE BUSINESS IN WHICH IT WAS ENGAGED ON THE EFFECTIVE DATE OF THE PLAN; OR

(j) WITH RESPECT TO COVERAGE OF AN EMPLOYER THAT IS MADE AVAILABLE ONLY THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS, THE MEMBERSHIP OF AN EMPLOYER CEASES.

(2) A carrier that elects ~~not~~ to ~~renew~~ NONRENEW AND TO DISCONTINUE OFFERING all of its individual, SMALL GROUP, OR LARGE GROUP health benefit plans in this state pursuant to paragraph (d) of subsection (1) of this section shall be prohibited from writing new ~~individual~~ health benefit plans OF THE SAME TYPE (INDIVIDUAL, SMALL GROUP, OR LARGE GROUP) AS WAS NONRENEWED in this state for a period of five years from the date of the notice to the insurance commissioner.

(3) For the purposes of this section, the term "health benefit plan" in section 10-16-102 (21) does not include nonrenewable INDIVIDUAL HEALTH BENEFIT plans with a duration of six months or less.

(4) An individual health benefit plan must clearly disclose in its contracts and marketing materials the conditions of renewability which conform with the requirements of this section.

(5) A LARGE GROUP HEALTH BENEFIT PLAN CARRIER MAY MODIFY A LARGE GROUP HEALTH BENEFIT PLAN AT RENEWAL PURSUANT TO SECTION 10-16-214 (3) (a) (IV) IF ALL THOSE LARGE GROUPS COVERED BY THE SAME PLAN ARE UNIFORMLY MODIFIED.

(6) A LARGE GROUP HEALTH BENEFIT PLAN CARRIER MAY DISCONTINUE OFFERING A PARTICULAR TYPE OF LARGE GROUP HEALTH COVERAGE ONLY IF:

(a) THE LARGE GROUP HEALTH CARRIER PROVIDES NOTICE OF SUCH DISCONTINUATION AT LEAST NINETY DAYS PRIOR TO THE DATE OF THE DISCONTINUATION OF SUCH COVERAGE TO EACH POLICYHOLDER PROVIDED THIS TYPE OF COVERAGE AND EACH CERTIFICATE HOLDER, PARTICIPANT, AND BENEFICIARY COVERED BY SUCH A POLICY;

(b) THE LARGE GROUP HEALTH CARRIER OFFERS TO EACH POLICYHOLDER PROVIDED COVERAGE OF THIS TYPE THE OPTION TO PURCHASE ANY OTHER HEALTH INSURANCE COVERAGE CURRENTLY BEING OFFERED BY THE CARRIER TO A GROUP IN SUCH MARKET; AND

(c) IN EXERCISING THE OPTION TO DISCONTINUE COVERAGE OF THIS TYPE AND IN OFFERING THE OPTION OF COVERAGE UNDER PARAGRAPH (b) OF THIS SUBSECTION (6), THE CARRIER ACTS UNIFORMLY WITHOUT REGARD TO THE CLAIMS EXPERIENCE OF THOSE POLICYHOLDERS OR ANY HEALTH STATUS-RELATED FACTOR RELATING TO ANY CERTIFICATE HOLDERS, PARTICIPANTS, OR BENEFICIARIES COVERED OR NEW PARTICIPANTS OR BENEFICIARIES THAT MAY BECOME ELIGIBLE FOR SUCH COVERAGE.

(7) (a) THE PROVISIONS OF THIS SECTION THAT APPLY TO GROUP HEALTH BENEFIT PLANS SHALL APPLY TO GROUP HEALTH BENEFIT PLANS SOLD, ISSUED, RENEWED, OR EXTENDED ON OR AFTER JULY 1, 1997.

(b) THE PROVISIONS OF THIS SECTION THAT APPLY TO INDIVIDUAL HEALTH BENEFIT PLANS SHALL APPLY TO INDIVIDUAL HEALTH BENEFIT PLANS SOLD, ISSUED, RENEWED, IN EFFECT, OR OPERATED ON OR AFTER JULY 1, 1997.

SECTION 9. 10-16-214 (2) (a) and (3) (a) (V) (A), Colorado Revised Statutes, 1994 Repl. Vol., are amended, and the said 10-16-214, as amended, is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

10-16-214. Group sickness and accident insurance. (2) (a) The provisions of this section shall not apply to transactions in this state involving group sickness and accident insurance policies for policies which were lawfully issued and delivered in another jurisdiction in which the company was authorized to do insurance business and any such policy was issued to a valid multistate association located in the state of issue, if the policy is not designed, administered, or marketed as a plan for employers to provide coverage to one or more employees AND IS NOT A BONA FIDE ASSOCIATION PLAN.

(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. ~~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.~~ WITH RESPECT TO A GROUP HEALTH COVERAGE PLAN, SUCH PROVISION SHALL COMPLY WITH THE PROVISIONS OF SECTION 10-16-118; EXCEPT THAT, WITH RESPECT TO A GROUP DISABILITY INCOME INSURANCE POLICY, SUCH PROVISION SHALL COMPLY WITH THE PROVISIONS OF SUB-SUBPARAGRAPH (C)

OF THIS SUBPARAGRAPH (V).

(4) A CARRIER OFFERING A GROUP HEALTH BENEFIT PLAN SHALL NOT ESTABLISH RULES FOR ELIGIBILITY FOR ANY INDIVIDUAL TO ENROLL UNDER THE PLAN BASED ON ANY HEALTH STATUS-RELATED FACTORS IN RELATION TO THE INDIVIDUAL OR A DEPENDENT OF THE INDIVIDUAL.

SECTION 10. 39-22-104.6, Colorado Revised Statutes, 1994 Repl. Vol., is amended to read:

39-22-104.6. Pretax payments - medical savings accounts. TO THE EXTENT A TAXPAYER IS NOT OTHERWISE CLAIMING DEDUCTIONS ON FEDERAL INCOME TAX RETURNS FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS, amounts withheld from an individual's wages which are contributed to such individual's medical savings account, pursuant to section 39-22-504.7, are excluded from an individual's federal taxable income for purposes of the state income tax imposed by section 39-22-104.

SECTION 11. Effective date - applicability. This act shall take effect upon passage. Sections 1 through 7, and 9 of this act shall apply to health benefit plans issued, renewed, extended, or modified on or after July 1, 1997.

SECTION 12. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: May 1, 1997