First Regular Session
Sixty-third General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 01-0528.01 Julie Hoerner **SENATE BILL** 01-030

SENATE SPONSORSHIP

Taylor

HOUSE SPONSORSHIP

(None)

Senate Committees
Business, Labor, and Finance

House Committees

A BILL FOR AN ACT

CONCERNING MEASURES TO INCREASE THE AVAILABILITY OF HEALTH INSURANCE, AND, IN CONNECTION THEREWITH, CHANGING NETWORK ADEQUACY REQUIREMENTS FOR PREFERRED PROVIDER ORGANIZATIONS IN ORDER TO INCREASE AVAILABILITY OF COVERAGE IN METROPOLITAN AND RURAL AREAS, RELAXING RESTRICTION ON DISCONTINUING PARTICULAR INSURANCE PRODUCTS TO THE SMALL GROUP MARKET, AND EXTENDING THE REQUIREMENT TO OFFER BASIC AND STANDARD PLANS TO THE SMALL GROUP MARKET.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently

adopted.)

Requires the health benefit plan advisory committee to submit recommendations for basic health benefit plans and standard health benefit plans to the commissioner of insurance within the department of regulatory agencies by July 1 of each year. Continues small group sickness and accident insurance, guaranteed issue, and mandated provisions for basic and standard health benefit plans. Repeals the requirement for legislative council staff to review the operations of small group accident and sickness insurance, guaranteed issue, and provisions for basic and standard plans.

Removes some network adequacy provisions for preferred provider options.

Changes the open enrollment period for business groups of one from 31 days to 60 days. Allows small group carriers to increase the premium rate for the business group of one for persons who are eligible for the Colorado uninsurable health insurance plan up to 150% of the average premium. Allows small group carriers to increase or decrease premiums for the business group of one for persons who do not meet the eligibility requirements for the Colorado uninsurable health insurance plan plus or minus 20%.

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

SECTION 1. 10-8-606 (3) (d) and (4), Colorado Revised Statutes, are amended to read:

10-8-606. Health benefit plan advisory committee. (3) (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~~ PLAN BY JULY 1 OF EACH YEAR. The commissioner shall have sixty days after any such submittal to review and approve any such recommendations.

(4) ~~This section is repealed, effective July 1, 2001.~~

SECTION 2. The introductory portion to 10-16-105 (7.3) (i), Colorado Revised Statutes, is amended, and the said 10-16-105 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. (7.3) (i) In lieu of accepting applications from and guarantee issuing the basic and standard plans to business groups of one year round, small employer carriers may limit their issuance of coverage as provided in this paragraph (i). A small employer carrier may establish open enrollment periods for guarantee issued basic or standard plan applications from business groups of one for a period of ~~thirty-one~~ SIXTY days following the birth date of the person qualifying as a business group of one. A small employer carrier may establish annual open enrollment periods for business groups of one for ~~thirty-one~~ SIXTY days following the birth date of the applicant and may limit issuance of a basic health benefit plan and a standard health benefit plan to such ~~thirty-one~~ SIXTY day period. Carrier marketing and sales materials for business groups of one shall clearly disclose the open enrollment period. If a person qualifying as a business group of one applies for coverage under a plan other than the basic or standard plan, and if the business group of one is denied coverage as provided by law, then the small employer carrier shall offer the business group of one a choice of coverage under the basic or standard plan during the applicant's appropriate open enrollment period. A small employer carrier shall accept applications from business groups of one for a basic or standard plan through the ~~thirty-first~~ SIXTIETH day after the birth date of the person qualifying as a business group of one. The date upon

receipt of the signed application and the applicant's birth date shall be used in determining whether the ~~thirty-one~~ SIXTY day open enrollment applies to a particular person qualifying as a business group of one. Eligible dependents of such person may also be covered at the same time as the applicant. Small employer carriers that use open enrollment periods shall also accept applications from business groups of one and issue a basic or standard plan as provided by law if such applications are submitted within ~~thirty-one~~ SIXTY days of any one of the following events:

(8.3) (a) FOR SMALL GROUP HEALTH BENEFIT PLANS ISSUED TO BUSINESS GROUPS OF ONE ON OR AFTER JANUARY 1, 2001, CARRIERS MAY ADJUST FOR HEALTH STATUS PLUS OR MINUS TWENTY PERCENT OF THE INDEX RATE AT ISSUE OR RENEWAL AFTER JANUARY 1, 2002.

(b) FOR SMALL GROUP HEALTH BENEFIT PLANS ISSUED ON OR AFTER JANUARY 1, 2001, TO BUSINESS GROUPS OF ONE WHO, IF IN THE INDIVIDUAL MARKET, WOULD BE AUTOMATICALLY ELIGIBLE FOR HEALTH COVERAGE UNDER PART 5 OF ARTICLE 6 OF THIS TITLE BECAUSE OF A PARTICULAR CONDITION OR DISEASE, CARRIERS MAY ADJUST FOR HEALTH STATUS UP TO ONE HUNDRED FIFTY PERCENT OF THE INDEX RATE AT ISSUE OR RENEWAL ON OR AFTER JANUARY 1, 2002.

(c) (I) DURING THE REGULAR SESSION OF THE GENERAL ASSEMBLY IN THE YEAR 2006, THE LEGISLATIVE COUNCIL OF THE GENERAL ASSEMBLY SHALL CONDUCT A REVIEW OF THE OPERATION OF REQUIREMENTS CONTAINED IN THIS SUBSECTION (8.3) FOR PLANS ISSUED TO BUSINESS GROUPS OF ONE. 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. AS A RESULT OF THE REVIEW REQUIRED BY THIS SUBPARAGRAPH (I), THE

LEGISLATIVE COUNCIL MAY RECOMMEND TO THE GENERAL ASSEMBLY ANY LEGISLATION DETERMINED TO BE NECESSARY BASED ON SUCH REVIEW.

(II) THE REQUIREMENTS CONTAINED IN THIS SUBSECTION (8.3) FOR SMALL EMPLOYER PLANS ISSUED TO BUSINESS GROUPS OF ONE SHALL TERMINATE JULY 1, 2006, UNLESS THE GENERAL ASSEMBLY ACTS BY BILL TO EXTEND SAID REQUIREMENTS BEYOND JULY 1, 2006.

SECTION 3. Repeal. 10-16-105 (11), Colorado Revised Statutes, is repealed as follows:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans. (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 4. Repeal. 10-16-120, Colorado Revised Statutes, is repealed as follows:

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. 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.~~

~~(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 5. The introductory portion to 10-16-201.5 (6) and 10-16-201.5 (6) (a) and (6) (b), Colorado Revised Statutes, are amended, and the said 10-16-201.5 (6) is further amended BY THE ADDITION OF A NEW PARAGRAPH, to read:

10-16-201.5. Renewability of health benefit plans - modification of health benefit plans. (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~~

(d) WITH RESPECT TO THE DISCONTINUANCE OF A PARTICULAR SMALL GROUP PLAN, THE CARRIER SHALL NOTIFY THE COMMISSIONER PRIOR TO PROVIDING NOTIFICATION TO POLICYHOLDERS AND INSUREDS AS SPECIFIED IN PARAGRAPH (a) OF THIS SUBSECTION (6).

SECTION 6. 10-16-401 (4) (p), Colorado Revised Statutes, is

amended to read:

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

(p) ~~An access plan~~ A PROVIDER DIRECTORY for each separate network of the health maintenance organization as specified in section 10-16-704 (9). ~~To the extent that the information in the access plan contains the required information specified in paragraphs (e), (f), (k), (l), (m), and (n) of this subsection (4), the health maintenance organization shall be deemed to be in compliance with said paragraphs.~~

SECTION 7. 10-16-704, Colorado Revised Statutes, is amended to read:

10-16-704. Network adequacy. (1) A ~~carrier providing~~ HEALTH MAINTENANCE ORGANIZATION OFFERING a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:

(a) Provider-covered person ratios by specialty;

(b) Primary care provider-covered person ratios;

(c) Geographic accessibility, WHICH COULD IN SOME CIRCUMSTANCES, REQUIRE THE CROSSING OF COUNTY OR STATE LINES;

(d) Waiting times for appointments with participating providers;

(e) Hours of operation; and

(f) The volume of technological and specialty services available to serve the needs of covered persons requiring covered technologically advanced or specialty care.

(2) In any case where ~~the carrier~~ A HEALTH MAINTENANCE ORGANIZATION OFFERING A MANAGED CARE PLAN has no participating providers to provide a covered benefit, the ~~carrier~~ MANAGED CARE PLAN shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

(3) When a covered person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit, INCLUDING:

(a) A CARRIER OFFERING A MANAGED CARE PLAN WITH NO OUT-OF-NETWORK BENEFIT LEVELS SHALL ENSURE THAT THE COVERED PERSON OBTAINS THE COVERED BENEFIT AT NO GREATER COST TO THE COVERED PERSON THAN IF THE BENEFIT WERE OBTAINED FROM PARTICIPATING PROVIDERS.

(b) A CARRIER OFFERING A MANAGED CARE PLAN WITH OUT-OF-NETWORK BENEFIT LEVELS SHALL APPLY THE IN-NETWORK BENEFIT LEVEL TO THE MEMBER AND MAY DETERMINE THE REIMBURSEMENT RATE TO THE PROVIDER BY APPLYING THE APPLICABLE IN-NETWORK BENEFIT LEVEL TO THE LESSER OF THE PROVIDER'S BILLED CHARGE, THE CARRIER'S USUAL AND CUSTOMARY REIMBURSEMENT FOR NON-PARTICIPATING

PROVIDERS, OR THE NEGOTIATED RATE. NOTHING IN THIS PARAGRAPH (b) SHALL PRECLUDE BALANCE BILLING BY A NON-CONTRACTED PROVIDER. THE CARRIER SHALL PROVIDE AN UNDERSTANDABLE DISCLOSURE TO INSUREDS IN ALL POLICY CONTRACT MATERIALS, CERTIFICATES OF COVERAGE, OR MARKETING MATERIALS ABOUT BALANCE BILLING BY NON-CONTRACTED PROVIDERS. FOR THE PURPOSES OF THIS PARAGRAPH (b) A PROVIDER SHALL NOT INCLUDE A HOSPITAL.

(4) When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse. If a ~~health~~ carrier OFFERING A MANAGED CARE PLAN provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person.

(5) A CARRIER OFFERING A managed care plan shall not deny benefits for emergency services previously rendered, based upon the covered person's failure to provide subsequent notification in accordance with plan provisions, where the covered person's medical condition prevented timely notification.

(6) ~~The carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to covered persons and shall only market a network plan in a geographic area where network providers are accessible without unreasonable delay. In determining whether a health carrier has complied with this subsection (6), consideration shall be given to the relative availability of health care providers in the service area under consideration.~~

(7) A ~~carrier~~ HEALTH MAINTENANCE ORGANIZATION OFFERING A MANAGED CARE PLAN shall monitor, on an ongoing basis, the capacity and

legal authority of the participating providers and facilities with which it contracts to furnish all covered benefits to covered persons.

(8) ~~No managed care plan~~ A HEALTH MAINTENANCE ORGANIZATION WITH NO OUT-OF-NETWORK BENEFIT LEVELS shall NOT deny or restrict in-network covered benefits to a covered person solely because the covered person obtained treatment outside the network. This protection shall be disclosed in writing to the covered person. ~~Nothing in this subsection (8) shall be construed to require a managed care plan to pay for any benefit obtained outside the plan's network unless the contract or certificate provides for that out-of-network benefit.~~

(9) (a) ~~Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan.~~ All rights and responsibilities of the covered person under the health benefit plan ~~however,~~ shall be included in the contract provisions. ~~regardless of whether or not such provisions are also specified in the access plan.~~ The carrier ~~shall prepare an access plan prior to offering a new managed care network and~~ OFFERING A MANAGED CARE PLAN shall update ~~an existing access plan~~ PROVIDER DIRECTORIES

whenever the carrier makes any material change to an existing managed care network, ~~but not less than~~ AT LEAST annually. ~~The access plan shall describe or contain at least the following:~~

~~(a)~~ (a.3) ~~The carrier's~~ A HEALTH MAINTENANCE ORGANIZATION OFFERING A MANAGED CARE PLAN SHALL MAINTAIN A network, ~~which~~ THAT shall demonstrate the following:

(I) An adequate number of accessible acute care hospital services, within a reasonable distance or travel time, or both;

(II) An adequate number of accessible primary care providers, within a reasonable distance or travel time, or both; and

(III) An adequate number of accessible specialists and sub-specialists, within a reasonable distance or travel time, or both.

(a.5) IN DETERMINING THE REASONABLENESS OF TRAVEL TIME AND DISTANCE, CONSIDERATION SHALL BE GIVEN TO THE RELATIVE AVAILABILITY OF HEALTH CARE PROVIDERS, THE LOCATIONS WHERE THE MAJORITY OF PEOPLE IN THE AREA ACCESS NONEMERGENCY SERVICES, AND THE MANAGED CARE PLAN'S EFFORTS TO CONTRACT WITH LOCAL PROVIDERS AT REASONABLE RATES. THE COMMISSIONER MAY DEEM A MANAGED CARE PLAN'S CURRENT ACCREDITATION WITH A NATIONALLY RECOGNIZED ACCREDITING ENTITY AS SUFFICIENT TO MEET NETWORK ADEQUACY REQUIREMENTS.

(b) ~~The carrier's~~ A CARRIER OFFERING A MANAGED CARE PLAN SHALL MAINTAIN procedures for making referrals within and outside its network that, at a minimum, must include the following:

(I) A comprehensive listing, made available to covered persons and primary care providers, of the plan's network participating providers and facilities;

(II) A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services;

(III) Timely referrals for access to specialty care;

(IV) A process for expediting the referral process when indicated by medical condition;

(V) A provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse.

(c) ~~The carrier's~~ A HEALTH MAINTENANCE ORGANIZATION OFFERING A MANAGED CARE PLAN SHALL MAINTAIN A process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans.

(d) ~~The carrier's~~ A HEALTH MAINTENANCE ORGANIZATION OFFERING A MANAGED CARE PLAN SHALL MAINTAIN quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care.

(e) ~~The carrier's efforts~~ A HEALTH MAINTENANCE ORGANIZATION OFFERING A MANAGED CARE PLAN SHALL MAINTAIN INTERNAL PROCEDURES to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

(f) ~~The carrier's methods~~ A HEALTH MAINTENANCE ORGANIZATION OFFERING A MANAGED CARE PLAN SHALL MAINTAIN INTERNAL PROCEDURES for determining the health care needs of covered persons, tracking and assessing clinical outcomes from network services, and evaluating consumer satisfaction with services provided.

(g) ~~The carrier's method for informing covered persons of the plan's services and features, including but not limited to the following:~~ A HEALTH MAINTENANCE ORGANIZATION OFFERING A MANAGED CARE PLAN SHALL MAINTAIN GRIEVANCE PROCEDURES, WHICH SHALL BE IN CONFORMANCE WITH DIVISION RULES CONCERNING PROMPT INVESTIGATION OF HEALTH CLAIMS INVOLVING UTILIZATION REVIEW AND GRIEVANCE PROCEDURES.

~~(I) The plan's grievance procedures, which shall be in conformance with division rules concerning prompt investigation of health claims involving utilization review and grievance procedures;~~

~~(II) The extent to which specialty medical services, including physical therapy, occupational therapy, and rehabilitation services are available;~~

~~(III) The plan's process for choosing and changing network providers; and~~

~~(IV) The plan's procedures for providing and approving emergency and medical care;~~

(h) ~~The carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers;~~ A CARRIER OFFERING A MANAGED CARE PLAN SHALL MAINTAIN A PROCESS FOR CREDENTIALING NETWORK PROVIDERS.

(i) ~~The carrier's~~ A CARRIER OFFERING A MANAGED CARE PLAN THAT REQUIRES A MEMBER TO SELECT A PRIMARY CARE PROFESSIONAL SHALL INCLUDE PROVISIONS SPECIFYING THE CARRIER'S process for enabling covered persons to change primary care professionals.

(j) ~~The carrier's proposed plan~~ A CARRIER OFFERING A MANAGED CARE PLAN SHALL INCLUDE A PROVISION for providing continuity of care

in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The ~~description~~ PROVISION shall ~~explain~~ SPECIFY how covered persons will be notified of the contract termination or the carrier's insolvency or other cessation of operations and transferred to other providers in a timely manner.

(k) ~~Any other information required by the commissioner to determine compliance with the provisions of this part 7.~~

SECTION 8. Effective date - applicability. This act shall take effect July 1, 2001, and shall apply to health benefit plans issued or renewed on or after said date.

SECTION 9. 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.