

Section by Section Summary of DOI Alignment Bill

Section 1. Amends §10-16-102. Definitions, pp.2-29.

- ▶ Eliminates obsolete definitions, e.g., "basic health benefit plan"; "business group of one"; "capped employees"; "late enrollee" (now addressed in new section 10-16-105.7 on enrollment periods, described below); "mandatory coverage provision"; "new business premium rate"; "qualifying event" (now addressed new section 10-16-105.7 on special enrollment periods, described below); "standard health benefit plan".
- ▶ Modifies definition of "case characteristics" that are used by carriers in determining premium rates to eliminate demographic characteristics no longer allowable under PPACA. (pp.7-8)
- ▶ Adds a definition of "catastrophic plan", which is a plan authorized by PPACA that does NOT include one of the "metal" levels of coverage and is available only to individuals under 30 years of age OR who meet eligibility requirements specified in PPACA.
- ▶ Modifies definition of "eligible employee" to specify that employees eligible for coverage under employer plans must be full-time employees in a bona fide employer-employee relationship with an employer, which relationship was not established for the purpose of obtaining small group health care coverage. The following are excluded from the definition of "eligible employee": temporary or substitute employees; sole proprietors; partners in a partnership (but a partner can participate in a small group plan established for employees of the partnership).
- ▶ Adds a definition of "essential health benefits" (EHBs) to mirror the definition in PPACA and lists the minimum services included in the definition. (p.12)
- ▶ Adds a definition of "essential health benefits package", which is the package required by PPACA and includes coverage for the essential health benefits; limits cost-sharing as required by PPACA; and provides the bronze, silver, gold, and platinum levels of coverage specified in PPACA. (pp.12-13)
- ▶ Adds a definition of "grandfathered health benefit plan", which is a plan provided to an individual or small employer on or before March 23, 2010, for

as long as the plan maintains that status; the term includes extension of a coverage under such plan to a dependent or a new employee. (p.14)

- ▶ Modifies the definition of "index rate" to specify the term means the premium rate established for a market segment based on the total combined claims costs for providing EHBs within the single risk pool of that market segment.
- ▶ Modifies the definition of "small employer" so that, as of January 1, 2016, in accordance with PPACA, "small employer" will apply to persons employing between 1 and 100 employees (current "small employer" definition applies to persons employing 50 or fewer employees); additionally, adds language from federal regulations pertaining to how number of employees are calculated to the definition. (pp. 25-27)
- ▶ Adds a definition of "student health insurance coverage", which term is used in connection with an exception to the "guaranteed issuance" of health benefit plans for carriers that only offer student health insurance coverage. (pp.27-28)

Section 2. Creates new §10-16-103.4. Essential health benefits, pp.29-31.

- ▶ Requires carriers offering individual and small group health benefit plans (HBPs), other than grandfathered HBPs, to ensure those plans include coverage for essential health benefits (EHBs).
- ▶ Requires carriers to offer at least one of the "metal" coverages: **Bronze** level, which is 60% of the full actuarial value of the benefits under the plan; **Silver** level, which is 70% of the full actuarial value of the benefits under the plan; **Gold** level, which is 80% of the full actuarial value of the benefits under the plan; or **Platinum** level, which is 90% of the full actuarial value of the benefits under the plan.
- ▶ Carriers offering a "catastrophic plan" (defined in Section 1) need not offer the metal coverage levels.
- ▶ Carriers offering an individual health benefit plan with a metal level of coverage must also offer that level of coverage in child-only plans.
- ▶ Carriers offering small group HBPs must comply with cost-sharing and annual deductible limitations specified in PPACA.
- ▶ Allows the commissioner to adopt rules to implement and administer the

section.

Section 3. Amends §10-16-104. Mandatory coverage provisions, pp.31-39.

- ▶ General changes in this section are to align with PPACA's prohibition against the use of dollar limits in mandatory coverage provisions; any existing CO mandate that contains a dollar limit is amended in this section to exclude those dollar limits with regard to HBPs subject to PPACA (dollar limits are still permitted, in most instances, for grandfathered HBPs).
- ▶ Amends the early intervention services mandate to eliminate reference to an annual limit of \$5,725, adjusted annually based on the CPI (current level is \$6,361), and instead permits the commissioner to adopt rules establishing a number of early intervention services or visits that is actuarially equivalent to the dollar limit on services; the dollar limit remains applicable to grandfathered HBPs.
- ▶ Amends the autism spectrum disorders mandate to eliminate the \$34,000 annual maximum benefit for applied behavioral analysis for autism spectrum disorders for a child from birth to age 8 and the \$12,000 annual maximum benefit for a child between the ages of 9 and 18. The dollar amount is replaced with authority for the commissioner to establish, by rule, an actuarially equivalent number of services or visits that must be covered. Note that individual grandfathered HBPs are not subject to the autism spectrum disorders mandate.
- ▶ With regard to the mental illness coverage (in §10-16-104 (5)) and biologically based mental illness and mental disorders (in §10-16-104 (5.5)) mandates, repeals the mental illness mandate, which only applies to small group plans and provides coverage for specified numbers of days. The coverage for biologically based mental illness and mental disorders, which is currently only applicable to group plans, is amended to apply to all HBPs (i.e., individual AND group plans), and is required to be coverage comparable to that for a physical illness (i.e., parity).
- ▶ With regard to preventive health care services, to align with PPACA, prohibits the use of copayments for preventive health care services, BUT copayments are still permitted in grandfathered HBPs. Note that current law already prohibits deductibles and coinsurance for these services.

- ▶ Also under preventive services, amends the mammography mandate to eliminate reference to the dollar amount (\$100, as annually adjusted for inflation) and require coverage of the actual cost of one mammogram per year, regardless of whether it's preventive or diagnostic.
- ▶ Adds a catch-all under preventive services so that if additional preventive services are recommended by the U.S. preventive services task force or required by federal law, carriers would have to cover those services.

Section 4. Amends §10-16-104.3. Health coverage for persons under 26 years of age, pp.39-41.

- ▶ Requires carriers offering HBPs that include dependent coverage for children to make the coverage available to a child under age 26 and prohibits the carrier from denying or restricting the coverage based on factors like residency with or financial dependence on the policyholder, marital, student, or employment status, or any combination of those factors.
- ▶ Carriers cannot deny or restrict the dependent coverage based on the child's eligibility for other coverage and cannot vary the terms of the coverage based on age, except for premium rates for children 21 years of age or older.
- ▶ Coverage for grandchildren is not required under the grandparent becomes the legal guardian or adoptive parent of the grandchild.

Section 5. Amends §10-16-104.4. Child-only plans, p.41.

- ▶ Increases the age limit for applicants from under 19 to under 21 years of age.

Section 6. Repeals & reenacts, with amendments, §10-16-105. Guaranteed issuance of health coverage, pp.41-47.

- ▶ This section is repealed and reenacted, with amendments, to eliminate all reference to standard and basic health benefit plans and requirements particular to small group plans and how premium rates are set; rating provisions are all consolidated in and relocated to §10-16-107, governing rates.
- ▶ Requires carriers offering individual and small group HBPs to issue a plan

to any eligible individual who applies for the plan and agrees to make required premium payments.

- ▶ During any period of open enrollment, a carrier offering individual HBPs is required to offer child-only plan coverage to all applicants under twenty-one years of age on a guaranteed-issuance basis.
- ▶ Allows carriers to restrict enrollment in a plan to open or special enrollment periods and requires carriers to establish special enrollment periods consistent with new §10-16-105.7, described below.
- ▶ Carriers offering small group HBPs: cannot impose a waiting period that exceeds 90 days; must apply any requirements used to determine whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, uniformly among all small employers with the same number of eligible employees; may vary the application of minimum participation requirements and minimum employer contribution requirements based on the size of the small employer group and by product, but in applying minimum participation requirements, cannot consider employees or dependents who have creditable group coverage or individual coverage; and cannot increase any requirement for minimum employee participation or for minimum employer contribution with once the small employer carrier accepts the small employer for coverage.
- ▶ Sets forth several scenarios under which a carrier would NOT have to offer or issue coverage (e.g., for a managed care plan, carriers aren't required to offer coverage in an area outside of the carrier's established geographic service area for the plan; if the carrier demonstrates, and the commissioner determines, that the carrier does not have the financial reserves necessary to underwrite additional coverage; if the carrier only offers student health insurance coverage consistent with federal law).
- ▶ Moves the prohibition against denying or refusing to continue coverage to a person based on his or her membership in the uniformed services FROM the mandatory coverage section (10-16-104) TO this guaranteed issuance section as this seems to be a better location for the prohibition.
- ▶ The provision in current §10-16-105 (7.2)(c) specifying that carriers offering small group coverage may accept or reject coverage for domestic partners or for designated beneficiaries is retained in this section.

Section 7. New §10-16-105.1. Guaranteed renewability, pp.47-52.

- ▶ Requires a carrier providing coverage under a health benefit plan to renew or continue the coverage at the option of the policyholder.
- ▶ Excepts a carrier from this requirement for various reasons, including the policyholder's failure to make premium payments or to timely pay premiums; fraud or intentional misrepresentation of a material fact by the policyholder; or small employer failure to comply with minimum participation or employer contribution requirements.

Section 8. Amends §10-16-105.2. Small employer health insurance availability program, pp.52-54.

- ▶ Repeals language applicable only to business groups of one since that type of coverage is being eliminated

Section 9. New §10-16-105.6. Rate usage, pp.54-58.

- ▶ Contains provisions that are being relocated from current §§10-16-107 and 10-16-105 (and amended to align with PPACA); and
- ▶ Specifies restrictions and permitted practices relating to rate usage, e.g., prohibiting carriers from requiring different premium rates based on a health-status-related factor; allowing carriers to establish premium discounts or rebates for adherence to health promotion and disease prevention programs or wellness and prevention programs; allowing carriers to apply a surcharge on small employers who, in the previous 12 months, were covered under a self-funded plan or through a plan that was not a small group plan or whose coverage was discontinued for nonpayment of premiums or fraud.

Section 10. New §10-16-105.7. Open enrollment and special enrollment periods, pp.58-62.

- ▶ Establishes open enrollment periods for individual plans as follows: initial open enrollment period is October 1, 2013 through March 31, 2014; for plan years beginning on or after 1/1/15, enrollment periods are from October 15 through December 7 of the prior calendar year.
- ▶ Requires carriers offering group HBPs to allow small employers to purchase

a plan at any time during the year.

- ▶ Requires carriers offering individual HBPs to establish special enrollment periods for an individual for whom a "triggering event" has occurred, which includes involuntary loss of existing coverage; gaining or becoming a dependent through marriage, birth, or adoption; new determination of eligibility or ineligibility for a federal advance payment tax credit or cost sharing reductions available through the exchange.
- ▶ Requires carriers offering group HBPs to establish special enrollment periods for individuals for whom a "qualifying event" has occurred, which includes loss of coverage due to death of, termination of employment of, reduction in work hours of, or divorce or legal separation from a covered employee; the covered employee becoming eligible for Medicare; becoming eligible for the group HBP due to marriage, birth, or adoption; loss of eligibility for Medicaid of CHP+.
- ▶ Authorizes the commissioner to adopt rules to allow individuals enrolled in an exchange HBP to enroll in or change from one HBP to another HBP.

Section 11. Amends §10-16-106.5. Prompt payment of claims, p.62.

- ▶ Excludes from prompt payment of claims requirements a claim for an individual who is entitled to a 3-month grace period (i.e., a person enrolled in a HBP who is eligible for a subsidy), when the claim is for services rendered after the 1st month of the 3-month grace period.

Section 12. Amends §10-16-107. Rate filing regulation, pp.62-81.

- ▶ Maintains prohibition against carriers establishing rates that are excessive, inadequate, or unfairly discriminatory; authority for commissioner to adopt rules requiring carriers to submit adequate documentation and supporting information to justify rates; and commissioner prior approval of rate increases.
- ▶ Adjusts the "benefits ratio" (which is the Colorado terminology; PPACA uses "medical loss ratio" or "MLR") to comply with PPACA, i.e., for large group plans, carriers must achieve a benefits ratio of 85%; for small group plans, carriers must achieve an 80% benefits ratio; and for individual plans, increases the benefits ratio from 65% to 80%, as required by PPACA.
- ▶ Adds authority for the commissioner to adopt rules to establish the benefits

ratio for carriers to use for rate filings for non-grandfathered HBPs that include activities to improve health care quality and expenditures related to health information technology and meaningful use, pursuant to 45 CFR §§158.150 and 158.151, respectively.

- ▶ Repeals and relocates provisions in current §10-16-107 that do not address or pertain to rates, e.g., current subsection (3) pertains to the evidence of coverage requirements, which applies only to HMO plans, so that provision is relocated to §10-16-406 (2) on page 135; subsection (4) applies only to prepaid dental plans, so that provision is relocated to §10-16-507 (3) on page 137; subsection (5) pertains to direct access to reproductive health or gynecological care providers and has been relocated to new section 10-16-139 (1) on page 125, and amended in accordance with PPACA to repeal the ability of carriers to require a covered person to obtain a referral to access this care; subsection (5.5) pertains to coverage for eye care services and has been relocated to a new section 10-16-139 (2), on pages 125-128; subsection (7) pertains to coverage for treatment of intractable pain and has been relocated to a new section 10-16-139 (3) on pages 128-129; and subsection (6), which prohibits a carrier from requiring an individual or employer group, as a condition of enrollment in a HBP, to pay a premium or contribution that is greater than the amount paid by similarly situated individuals on the basis of a health-status-related factor, has been relocated to new section 10-16-105.6 pertaining to rate usage, on pages 54-55.
- ▶ To align with PPACA, limits the ability of carriers to use specified case characteristics when developing premium rates, which case characteristics may only include: Whether the plan covers an individual or family; the geographic rating area; age, limited to a rate variation of not more than 3 to 1 for adults; and tobacco use, limited to a rate variation of not more than 1 1/15 to 1;
- ▶ Additionally, carriers may only adjust premiums annually, except to reflect changes: in enrollment of a small employer; in family composition; in the policyholder's geographic area; in tobacco use; in the HBP requested by the policyholder to small employer; or required by federal law, or as permitted by state law or commissioner rule;

- ▶ Authorizes the commissioner to adopt rules regarding premium rates and variations based on case characteristics;
- ▶ Requires a carrier to disclose, as part of its solicitation and sales materials, how it establishes and modifies premium rates, and benefits and premiums for all HBPs offered by the carrier for which a person qualifies.

Section 13. Amends §10-16-107.2. Filing of health policies, pp. 81-84.

- ▶ Continues the requirement that all carriers submit an annual report to the commissioner by December 31 listing any policy form, endorsement, or rider for policies it issued or delivered in the state and including a certification that, to the best of the carrier's good faith knowledge and belief, each policy form, endorsement, and rider complies with CO law.
- ▶ Continues the requirement that carriers submit to the commissioner a list of new policy forms, applications, endorsements, or riders at least 31 days before using the new document.
- ▶ Relocates the requirements in sec. 10-16-107.2 (2) (b) pertaining to a uniform application form for HBPs to a new section 10-16-107.5, described below.

Section 14. New §10-16-107.5. Uniform application form, pp.84-85.

- ▶ Contains a relocated provision from sec. 10-16-107.2 (2)(b), that requires the commissioner to develop, and carriers to use, a uniform application form for HBPs and authorizes the commissioner to allow carriers to use an electronic version of the uniform form.
- ▶ The current law only applies to small employer carriers; the relocated provision now applies to ALL carriers issuing HBPs

Section 15. New §10-16-107.7. Nondiscrimination against providers, p. 85.

- ▶ In accordance with PPACA, prohibits carriers from discriminating with respect to participation under a HBP the carrier offers against a provider acting within the scope of his or her license or certification under state law;
- ▶ Clarifies that carriers are not required to contract with any willing provider and may establish varying reimbursement rates based on quality or performance measures.

Section 16. Repeals & reenacts, with amendments, §10-16-108. Continuation privileges, pp. 85-90.

- ▶ Continues requirements under current law that permits employees whose employment is terminated to elect to continue coverage under the employer plan for the employee and dependents; and
- ▶ Repeals provisions pertaining to conversion of policies since no longer applicable under PPACA.

Section 17. Amends §10-16-108.5. Fair marketing standards, pp. 90-92.

- ▶ Eliminates requirement that carriers actively market standard and basic HBPs since those plans are repealed
- ▶ Applies marketing requirements currently applicable only to small employer carriers, to carriers offering individual HBPs
- ▶ Requires carriers to provide a summary of benefits and coverage form in compliance with federal law and when required pursuant to commissioner rules; the summary of benefits and coverage form replaces the current requirement for carriers to make available a Colorado health benefit plan description form, but the commissioner may adopt and require carriers to provide a "supplemental health benefit plan description form" if consistent with the forms required under federal law. The supplemental forms is to be designed to facilitate comparison of different HBPs

Section 18. Amends §10-16-109. Rules, p.92.

- ▶ Expands the commissioner's general rulemaking authority to allow the commissioner to adopt rules necessary to align state law with the requirements imposed by federal law regarding health care coverage in the state

Section 19. Amends §10-16-113. Procedures for denial of benefits - internal review, pp.92-102.

- ▶ Adds a definition of "adverse determination", which includes: a denial of a preauthorization for a covered benefit; a denial of a request for benefits on the grounds that the treatment or covered benefit is not medically necessary,

appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; a rescission or cancellation of coverage, applied retroactively, where the action is not attributable to failure to pay premiums; a denial of a request for benefits for "experimental or investigational" treatment or services; a denial of coverage based on an initial eligibility determination for all individual HBPs

- ▶ With regard to the current 2-level internal review process, specifies that this process applies only to group HBPs
- ▶ For individual HBPs, carriers are to institute a single level of internal review, akin to the first level of review for group HBPs, which is to be evaluated by a physician who must consult with appropriate clinical peers. Carriers must allow the individual to be present for the appeal; to bring counsel, advocates, and health care professionals; & to present materials to the evaluating physician before and during the review. The carrier and individual are to share materials at least 5 days before the review. If the carrier makes a video or audio recording of the review, the carrier must make the recording available to the individual and, if requested, include it in any material provided to a reviewing entity in the event of an external review
- ▶ If a carrier fails to "strictly adhere" to requirements regarding a coverage request, the individual is deemed to have exhausted internal review and appeals and may initiate external review
- ▶ Requires carriers to maintain records of requests and notices associated with internal claims and appeals for 6 years and to make the records available, upon request, for review by the individual, the DOI, or the federal government
- ▶ Allows the commissioner to adopt necessary rules to implement and administer the section pertaining to internal review of denials

Section 20. Amends §10-16-113.5 Independent external review, pp.102-117.

- ▶ Defines "adverse determination", for purposes of the independent external review process, as a denial of: a preauthorization for a covered benefit, a request for benefits on the grounds that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; a denial of a

request for benefits for "experimental or investigational" treatment or services; or a benefit that is excluded but for which the claimant presented evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply.

- ▶ In addition to the current standard for employing an expedited review of an adverse determination, specifies that an expedited review is available if the adverse determination concerns an admission, availability of care, continued stay, or health care services for which the individual receive emergency services, and the individual has not been discharged from a facility
- ▶ Requires an independent external review entity to be accredited by a nationally recognized private accrediting organization
- ▶ Requires the individual seeking external review to submit its request to the carrier within 4 months, rather than 60 calendar days, after receipt of notice of a denial of an internal appeal
- ▶ Specifies that a claim need not meet a minimum dollar amount to be eligible for external review
- ▶ Allows an individual to request an independent external review or expedited external review of a claim involving denial of coverage of a recommended experimental or investigational medical service if the treating physician certifies that the treatment would be significantly less effective if not promptly initiated
- ▶ Permits the individual requesting the external review to submit additional information directly to the review entity within 5 business days after the carrier notifies the individual of the review entity that will conduct the external review, and the entity is to provide the additional information to the carrier within 1 business day after receipt
- ▶ The reviewing entity is to submit its determination within 45 calendar days, rather than 30 working days, after receipt of the external review request; in the case on an expedited review, the entity is to submit its determination as expeditiously as possible and no more than 72 hours after receipt of the request (current law required a determination within 7 working days); if the determination is not submitted in writing, the entity must provide written conformation of the determination within 48 hours
- ▶ Review entities are to maintain written records of reviews for at least 3 years

Section 21. Amends §10-16-116. Catastrophic health insurance/HSA plans, pp.118-121.

- ▶ Current law pertaining to catastrophic plans is contained in sections 16-16-114 through 10-16-116; this section consolidates the 3 sections into a single section, 10-16-116
- ▶ Repeals references to business groups of one, conversion coverage, preexisting condition exclusions, and other obsolete provisions
- ▶ Clarifies that this section does not apply to or include a catastrophic plan as defined in sec. 10-16-102 (10), which, as authorized by PPACA, does not provide the "metal" coverage levels

Section 22. Repeals and reenacts §10-16-118. Prohibition against preexisting conditions., p.121.

- ▶ Repeals and reenacts sec. 10-16-118 to eliminate all references to preexisting condition exclusions and instead, in alignment with PPACA, prohibit carriers from imposing any preexisting condition exclusions with respect to coverage under an individual or small employer HBP.

Section 23. Amends §10-16-129. Health savings accounts, pp.121-122.

- ▶ Repeals reference to the ability of HSA plans to apply deductible amounts to mandatory health benefits for mammography and child health supervision services since, under PPACA, carriers may not apply deductibles to preventive health services (mammography and child health supervision services are preventive services)

Section 24. Amends §10-16-136. Wellness and prevention programs, pp.122-125.

- ▶ Eliminates reference to a specific percentage amount as a cap on incentives available for satisfaction of a standard related to a health risk factor under a wellness and prevention program and instead requires the commissioner to adopt a rule, consistent with federal law, establishing the maximum amount of the incentive
- ▶ Eliminates references to business groups of one

Section 25. New §10-16-139. Access to care, pp. 125-130.

- ▶ Subsection (1) contains former sec. 10-16-107 (5), pertaining to access to obstetricians and gynecologists, which requires plans that cover reproductive health or gynecological care to provide covered women direct access to a participating obstetrician, gynecologist, or certified midwife, and eliminates the ability of plans to require a referral for such care
- ▶ Subsection (2) contains former sec. 10-16-107 (5.5) pertaining to coverage for eye care services, without any substantive changes
- ▶ Subsection (3) contains former sec. 10-16-107 (7) pertaining to coverage for treatment of intractable pain, without any substantive changes
- ▶ Subsection (4) adds a new provision, required by PPACA, specifying that a carrier offering HBPs that requires or allows designation of a participating primary health care professional must allow the parent of a covered child to designate a participating pediatrician as the child's primary care provider

Section 26. New §10-16-140. Grace periods, pp. 130-131.

- ▶ Requires the commissioner to adopt a rule, applicable to HBPs issued to persons eligible for a subsidy under PPACA on or after January 1, 2014, requiring the plans to contain a 3-month grace period provision for the payment of any premium due, other than the first premium, and the plan continues in force during the grace period
- ▶ Requires the commissioner to adopt a rule applicable to all other HBPs issued on or after January 1, 2014, specifying a 31-day grace period

Sections 27 and 28, p.131, repeal provisions that are no longer necessary or are being relocated.

Section 29. Amends §10-16-202. Required provisions in individual plans, pp. 131-133.

- ▶ Prohibits the retroactive termination of an individual policy except in cases of fraud or intentional misrepresentation; requires the carrier to provide 30 days advance notice of cancellation of the policy
- ▶ Eliminates language referring to preexisting condition exclusions
- ▶ Allows a different grace period than that specified in sec. 10-16-140 for policies that are not subject to PPACA grace period requirements

Section 30. Amends §10-16-214. Group policy provisions, pp.133-134.

- ▶ Eliminates reference to business groups of one exclusions
- ▶ Allows a different grace period than that specified in sec. 10-16-140 for policies that are not subject to PPACA grace period requirements

Section 31. New §10-16-222. Termination of policies, p. 134.

- ▶ Prohibits the retroactive termination of a sickness and accident insurance policy except in cases of fraud or intentional misrepresentation; requires the carrier to provide 30 days advance notice of cancellation of the policy

Section 32. New §10-16-325. Termination of health policies, p. 135.

- ▶ Prohibits the retroactive termination of a hospital plan or contract except in cases of fraud or intentional misrepresentation; requires the corporation to provide 30 days advance notice of cancellation of the policy

Section 33. Amends §10-16-406. Evidence of coverage, p. 135.

- ▶ Sec. 10-16-107 (3)(b)-(3)(d), pertaining to an evidence of coverage required in HMO plans, is relocated to the HMO evidence of coverage statute and authorizes the commissioner to establish the required elements of the evidence of coverage by rule.

Section 34. New §10-16-429. Termination of contract, p. 137.

- ▶ Prohibits a HMO from retroactively terminating of a policy or contract except in cases of fraud or intentional misrepresentation; requires the HMO to provide 30 days advance notice of cancellation of the policy

Section 35. Amend §10-16-507. Enrollee coverage under prepaid dental plans, pp. 137-138.

- ▶ Contains relocated sec. 10-16-107 (4), pertaining to prepaid dental plans, with no substantive changes

Section 36. Amends §10-16-704. Network adequacy, pp.138-141.

- ▶ Requires the commissioner to adopt rules to require carriers providing

- managed care plans to include essential community providers in the network
- ▶ Specifies that "essential community providers" include providers that serve predominantly low-income, medically underserved individuals such as Medicaid providers
 - ▶ Permits the commissioner to adopt rules to require carriers to be accredited by an accrediting entity recognized by the U.S. Department of Health and Human Services
 - ▶ If a carrier provides benefits for services in an emergency department of a hospital, the carrier must cover emergency services: without the need for a prior authorization; regardless of whether the provider is a participating provider; for services provided out of network; without imposing any administrative requirement or limit on coverage that is more restrictive than services provided by an in-network provider; and with the same cost sharing requirements as would apply for in-network providers

Sections 37 through 69, pp.141-158 - Conforming amendments.

Section 70. Effective date and applicability clause, p.158-159.

Section 71. Safety clause, p.159.