Summary of Health Insurance Bills, 2010 Session (As of June 15, 2010)

Signed into Law

Bill Number:	**House Bill 10-1004**	Short Title:	**Standardized Health Insurance Information**
Sponsors:	*Rep. Massey* *Senator Foster*	Status:	Signed into Law

The act requires the Commissioner of Insurance to convene a group of stakeholders to develop standard formats for health insurance policies and explanation of benefit forms provided by health care carriers to consumers. The Insurance Commissioner is required to adopt rules after receiving input from the group of stakeholders. Insurance carriers must implement the standardized formats for health benefit policies issued after January 1, 2012.

Appropriations:

The bill does not require an appropriation. The Division of Insurance can accommodate rule changes and form changes within existing appropriations.

Bill Number:	**House Bill 10-1008**	Short Title:	**No Gender Rating for Individual Health Insurance**
Sponsors:	*Representatives Schafer and McCann* *Senators M. Carroll and Schwartz*	Status:	Signed into Law

The act prohibits health insurance carriers from using gender as a factor in determining the rate for an individual health insurance policy. Under the bill, a premium rate based on gender is considered unfairly discriminatory. The bill takes effect January 1, 2011.

Appropriations:

The bill does not require an appropriation. The Division of Insurance can accommodate rule changes and form changes within existing appropriations.

Bill Number:	**House Bill 10-1021**	Short Title:	**Required Coverage for Reproductive Services**
Sponsors:	*Representatives Frangas and McCann* *Senator Foster*	Status:	Signed into Law

The act requires individual health insurance policies to provide coverage for pregnancy and delivery and group and individual health insurance policies to provide coverage for contraception in the same manner as any other sickness, disease, or condition that is otherwise covered by that policy. Individual health insurance policies may exclude coverage for pregnancy and delivery on the grounds that pregnancy was a preexisting condition, however, the policy may not exclude coverage for subsequent pregnancies.

Appropriations:

The bill does not require an appropriation. The Division of Insurance is expected to field roughly 500 inquiries from policyholders during the first year of implementation. The fiscal note assumes that the division can respond to these inquiries with existing resources.

Signed into Law (Cont.)

Bill Number: **House Bill 10-1160**

Short Title: **Wellness Incentives Reward Outcomes**

Sponsors: *Representatives Rice and Stephens*
Senators Mitchell and Newell

Status: Signed into Law

Current law allows health insurance carriers offering individual health policies and small group plans to offer incentives or rewards to encourage persons covered under the plan to participate in a wellness and prevention program. The incentives or rewards cannot be tied to any particular outcome achieved by participation in the program. The act repeals the restriction on incentives based on outcomes and allows carriers to base the incentives or rewards on satisfaction of a standard related to a health risk factor if the incentive or reward is consistent with the nondiscrimination requirements of the federal Health Insurance Portability and Accountability Act (HIPAA). Health risk factors under HIPAA include health behaviors such as smoking, diet, alcohol consumption, exercise, and exposure to UV radiation.

The HIPAA requirements for wellness programs that base an incentive or reward on satisfying a standard related to a health risk factor are:

- the incentive or reward is reasonably related to the wellness and prevention program and does not exceed 20 percent of the cost of employee-only coverage;
- the wellness program is consistent with evidence-based research, has a reasonable likelihood of improving health, and is not overly burdensome;
- the wellness program must give individuals eligible to participate the opportunity to qualify for the incentive or reward upon enrollment and at least once per year thereafter;
- the program must be available to all similarly situated individuals and must allow a reasonable alternative standard; and
- the incentives or rewards are not based on an individual's health status.

The act requires health insurance carries to submit proposed incentives or rewards programs to an accredited nonprofit organization that certifies wellness and incentive programs. The nonprofit is required to determine if the proposed incentive plan meets statutory requirements.

Finally, the Commissioner of Insurance is required to collect information such as the types of incentive programs offered, the number of small groups participating, the nature of the incentive offered, and the dollar amount of the discount given. The commissioner is required to report the information to the House and Senate Health and Human Services committees on wellness and prevention programs being offered in Colorado by July 1, 2012.

Appropriations:

The act does not require an appropriation. The Division of Insurance currently surveys insurance companies about wellness programs and can add data elements and make the information available to the public without increasing expenditures. If an insurance company denies an individual's request for an alternative standard or waiver of a standard, the individual can request an independent external review. This review is paid for by the insurance company, so no state funds are required.

Signed into Law (Cont.)

Bill Number:	**House Bill 10-1166**	Short Title:	**Plain Language in Insurance Policies**
Sponsors:	*Representative Kefalas* *Senator Newell*	Status:	Signed into Law

The act requires that insurance policies and plans issued or renewed on or after January 1, 2012, be written at or below a 10th-grade reading level. The act specifies that the text of policies longer than 3,000 words or 3 pages, must be in 10-point or larger type and must contain an index or table of contents. The act bill directs the Insurance Commissioner to promulgate rules regarding the electronic dissemination of policy forms or endorsements.

Appropriations:

The bill does not require an appropriation. The Division of Insurance can accommodate rule changes and form changes within existing appropriations.

Bill Number:	**House Bill 10-1202**	Short Title:	**Insurance Coverage Chemotherapy Treatment**
Sponsors:	*Representatives Primavera and McNulty* *Senator Tochtrop*	Status:	Signed into Law

Depending on the type of cancer and course of treatment, chemotherapy medications may be administered orally or injected. Intravenous or injected anticancer medications are often administered in a medical setting and generally covered under the major medical portion of a health plan. Some oral chemotherapy medications can be taken orally and self-administered. Oral medications are generally covered under the prescription drug benefit of a health plan and require higher out-of-pocket costs for the patient than intravenous or injected chemotherapy.

The act requires a health benefit plan that provides coverage for cancer chemotherapy treatment to cover orally administered anticancer medication at a cost not to exceed the coinsurance percentage or relative copayment amount as is applied to intravenously administered or injected anticancer medication. Under the act, oral medication is covered if it is approved by the federal Food and Drug Administration, determined to be medically necessary to kill or slow the growth of cancerous cells, and not prescribed primarily for the convenience of the patient or physician.

The act stipulates that a carrier cannot increase patient out-of-pocket costs for intravenously administered or injected chemotherapy. Carriers may specify which oral medications they cover and substitute an oral generic medication when available. The bill takes effect January 1, 2011.

Appropriations:

The act does not require an appropriation. In the short term, the bill will not affect state expenditures, but it may increase the premiums paid by state employees for health insurance. In the long term, the bill may also affect state expenditures, but only if employers other than the state increase the amount they contribute for employee health insurance coverage. Premiums may increase for health insurance for local government employees for policies that cover chemotherapy but have a disparity between co-payments or coinsurance for oral versus intravenous or injected chemotherapy. The size of the increase and who will bear the expense cannot be determined.

Signed into Law (Cont.)

Bill Number:	**House Bill 10-1228**	Short Title:	**Dependent Coverage State Health Benefits**
Sponsors:	*Representative Benefield* *Senator Hudak*	Status:	Signed into Law

The act requires the Director of Personnel in the Department of Personnel and Administration (DPA) to remove dependents of state employees from state group health benefit plans when they turn 25 years of age and become ineligible for coverage. Current practice requires the employee to remove the ineligible dependent and the employee's department to verify continuing dependent eligibility.

Appropriations:

For FY 2010-11, the Department of Personnel and Administration requires an appropriation of $4,400 from the Group Benefits Plan Reserve Fund. These expenses include $3,000 for one-time programming changes to the benefits system, and $1,400 in on-going transaction charges for verification.

Bill Number:	**House Bill 10-1242**	Short Title:	**Uniform Individual Health Insurance Application**
Sponsors:	*Representative Apuan* *Senate Tochtrop*	Status:	Signed into Law

The act requires the Commissioner of Insurance to implement an initial uniform application form for individual sickness and accident health benefit plans to be used on or after January 1, 2012. Upon receipt of an initial application form, an insurer can decide to issue coverage, request additional information, or deny coverage. If the insurer denies coverage based on the initial application form, the denial of coverage can be used for purposes of eligibility for coverage through CoverColorado.

Appropriations:

The act does not require an appropriation. The commissioner will collect information from members of the insurance industry and promulgate rules to implement an initial uniform application form. This will require review of recommendations, drafting of a regulation, a public hearing on the proposed application form, and publication and distribution of the regulation. Because the bill requires only the development of an initial application form, the fiscal note assumes this can be addressed within existing appropriations.

Bill Number:	**House Bill 10-1252**	Short Title:	**Breast Cancer Screening with Mammography**
Sponsors:	*Representative Primavera* *Senator Boyd and Schwartz*	Status:	Signed into Law

The act requires that insurance companies cover annual breast cancer screening with mammography for all individuals possessing at least one risk factor, including, but not limited to, a family history of breast cancer, being forty years of age or older, or a genetic predisposition to breast cancer. Under current law, coverage is determined in accordance with the recommendations of the U.S. Preventative Services Task Force (USPSTF). The USPSTF recently recommended against routine breast cancer screening with mammography in women aged 40 to 49, and biennial breast cancer screening with mammography for women between the ages of 50 and 75. The bill is effective January 1, 2011, and applies to policies and contracts entered into or renewed on or after that date.

Appropriations:

The act does not require an appropriation. The Division of Insurance will revise its regulation concerning benefits required for health plans, but this activity can be addressed within existing resources.

Signed into Law (Cont.)

Bill Number: **House Bill 10-1330** Short Title: **All-payer Health Claims Database**

Sponsors: *Representatives Kefalas and Kagan*
Senator Morse

Status: Signed into Law

The act requires the Department of Health Care Policy and Financing (DHCPF) to create a 25-member advisory committee to make recommendations for creating a Colorado all-payer health claims database. The database is to be user-friendly, public, and meet certain criteria for transparency and data quality. The act details the membership of the committee, specifically requiring the participation of various stakeholders in the health care field.

The DHCPF is directed to appoint an administrator to guide the committee and seek funding from gifts, grants, and donations. If sufficient revenue is received by January 1, 2012, the database is required to be operational no later than January 1, 2013. The administrator is also charged with establishing agreements for voluntary reporting by claims payers that are not subject to mandatory reporting requirements, ensuring patient privacy, and producing reports.

Appropriations:

The act is assessed as having a conditional fiscal impact as state revenue and expenditures could increase with the receipt of gifts, grants, and donations, and if the new claims database is developed. The act's fiscal note assumes that the Center for Improving Value in Health Care (CIVHC) would be appointed by the DHCPF to be the administrator, and that CIVHC will perform all associated fundraising and program activities. The CIVHC was established by executive order in 2008 and receives administrative support, information, and data from the DHCPF. The CIVHC is permitted to cover its expenses by gifts, grants, and donations credited to the Governor's Office.

Bill Number: **House Bill 10-1332** Short Title: **Medical Clean Claims**

Sponsors: *Representative Miklosi*
Senate Romer

Status: Signed into Law

The act creates the Medical Clean Claims Transparency and Uniformity Act. If sufficient funding is received through gifts, grants and donations, the executive director of the Department of Health Care Policy and Financing is required to organize a task force of industry and government representatives to develop a standardized set of payment rules and claim edits to be used by payers and health care providers in Colorado.

Within two years after the task force is established, it is required to report a base set of standardized payment rules and claim edits to be used by payers and health care providers to the executive director of the department and to the General Assembly by November 30, 2012. As part of its recommendations, the task force is to address implementation, updating, and dissemination of the standardized set of payment rules and claim edits, including identifying who is responsible for establishing a central repository for the rules and edits.

The act encourages the task force to work in tandem with a national initiative by the American Society for Quality to create a level of understanding of the impact of coding edits on the industry. If the national initiative fails to reach consensus, the task force is encouraged to continue to develop rules and edits which may be recommended for implementation.

Appropriations:

The act does not require an appropriation. The Executive Director of the Department of Health Care Policy and Financing is only required to appoint the task force and designate an organization to handle task force funding. The department is specifically exempted from providing administrative or research support to the task force, so no increase in expenditures is expected.

Summary of Health Insurance Bills, 2010 Session (As of June 15, 2010) (Cont.)

Signed into Law (Cont.)			
Bill Number:	**House Bill 10-1355**	Short Title:	**Off-label Use of Cancer Drugs**
Sponsors:	*Representative Gagliardi* *Senator* Kopp	Status:	Signed into Law
Under the act, a health benefit plan that provides prescription drug coverage is not permitted to exclude coverage for any cancer treatment drug on the basis that the drug has not been approved for the specific type of cancer being treated. If the drug is recognized for cancer treatment by the U.S. Department of Health and Human Services and the cancer treatment is covered under an individual's insurance plan, the health plan is prohibited from excluding the drug from coverage. The bill takes effect August 11, 2010.		*Appropriations:* The act does not require an appropriation. It makes state law consistent with federal policy concerning off-label drugs for cancer treatment.	
Bill Number:	**Senate Bill 10-076**	Short Title:	**Unreasonable Insurance Claims Practice**
Sponsors:	*Senator Carroll* *Representative Primavera*	Status:	Signed into Law
The act adds certain prohibitions to the unfair compensation practices concerning benefits claims. The act prohibits claims adjustors from receiving compensation or bonuses based on the number of policies cancelled, the number of times coverage is denied, the use of a quota limiting or restricting the number or volume of claims, and the use of an arbitrary quota or cap limiting or restricting the amount of claims payments without due consideration of the merits of the claim.		*Appropriations:* The act does not require an appropriation. It is not expected to generate many new cases and in instances where a new case is generated, it is anticipated that the need for court intervention will be minimal. As such, the impact to the Judicial Branch is seen as minimal and can be handled with existing resources.	
Awaiting Action by the Governor			
Bill Number:	**Senate Bill 10-183**	Short Title:	**Extend the Prohibition on Medical Balance Billing**
Sponsors:	*Senator Morse and Tochtrop* *Representative Gagliardi*	Status:	Sent to the Governor
Under current law, out-of-network health care providers are prohibited from "balance billing" patients for in-network services through July 1, 2010. Balance billing is the practice of a provider billing a patient for the difference between the out-of-network price and the amount reimbursed by the insurance company for in-network services. The act continues this prohibition indefinitely and removes obsolete language concerning reporting by the Division of Insurance within the Department of Regulatory Agencies.		*Appropriations:* The act does not require an appropriation as no work is created for a state or local government entity. This bill simply extends a current law which prohibits certain billing practices by health care providers.	

Summary of Health Insurance Bills, 2010 Session (As of June 15, 2010) (Cont.)

Postponed Indefinitely

Bill Number: **House Bill 10-1103**

Short Title: **Catastrophic Illness Fund For Children**

Sponsors: *Representative Todd*
Senator Steadman

Status: Postponed Indefinitely

The bill would have created the Relief Fund for Children with a Catastrophic Medical Condition. The purpose of the fund would have been to provide financial relief to a child who met the following conditions:

- had a chronic illness;
- had medical expenses for the illness that are not covered by insurance or a state or federal program;
- had expenses for the illness that exceed 10 percent of the family's gross annual income earning less than $100,000 or 15 percent of the family's gross annual income for families earning more than $100,000.

The bill would have allowed for financial assistance to an eligible child for medical treatment; hospital care; prescription drugs; nursing care; respite care, but not including emergency respite care; medically necessary supplies; formula; diapers; durable medical equipment; home modifications; and adaptions to transportation.

The bill would have established a commission in the Division of Insurance consisting of 11 members. The commission would have been responsible for administering the program, establishing procedures for applying to fund, and establishing procedures for reimbursement. The commission would have been responsible to screen each individual applying for the program for other sources of coverage and potential eligibility for government programs. The commission would have also been required to provide an annual report to the House and Senate Health and Human Services committees concerning the activities of the fund.

The bill would have assessed a $1.00 fee on health and dental policies for each covered person under the state's regulatory authority.

Appropriations:

For FY 2010-11, the bill was estimated to require an appropriation to the Department of Health Care Policy and Financing (DHCPF) of:

- $2,366,667 and 1.5 FTE from the Relief Fund for Children with a Catastrophic Medical Condition to fund grants for families with catastrophic illness; and
- $17,306 from the General Fund to complete the day-to-day work of the commission.

Summary of Health Insurance Bills, 2010 Session (As of June 15, 2010) (Cont.)

Postponed Indefinitely (Cont.)

Bill Number: **House Bill 10-1154**

Short Title: **Mandates Analysis Legislative Council Moratorium**

Sponsors: *Representatives Curry and Roberts*
Senator Mitchell

Status: Postponed Indefinitely

The bill would have repealed the Commission on Mandated Health Insurance Benefits and transferred its functions to the Director of Research of the Legislative Council. When a legislative measure containing a mandated health insurance benefit was proposed, the director was required to analyze the social and financial impact of the proposed mandate and include this information with the fiscal note. The Commissioner of Insurance would have charged insurance carriers fees to cover the costs of the analysis. The director could accept and expend federal funds, gifts, grants and donations. The bill also included a one year moratorium on the enactment of any new mandated health insurance benefits.

Appropriations:

This bill would have required an appropriation of $82,000 and 1.0 FTE in FY 2010-11 from the Legislative Department Cash Fund.

Bill Number: **House Bill 10-1163**

Short Title: **Interstate Purchase of Health Insurance**

Sponsors: *Representative Acree*
Senator Scheffel

Status: Postponed Indefinitely

The bill would have authorized the Commissioner of Insurance to enter into multi-state agreements with other states so that health coverage issuers (issuers) doing business in other states could offer, sell, or issue individual health plans in Colorado that are regulated by other states. Prior to entering into a multi-state agreement, the commissioner was required to ensure that an issuer:

- was financially viable;
- was able to provide adequate and appropriate access to health care providers and services; and
- had an adequate complaint and appeals process for Colorado consumers.

The bill specified that a multi-state agreement must specify that the home state for the plan had sole jurisdiction and responsibility to enforce the home state's laws in both the primary state and Colorado.

Appropriations:

The Department of Regulatory Agencies, Division of Insurance, required an appropriation of $53,449 and 0.2 FTE for FY 2010-11 from the Division of Insurance Cash Fund; of this, the Department of Law required $31,660 in reappropriated funds and 0.2 FTE.

Summary of Health Insurance Bills, 2010 Session (As of June 15, 2010) (Cont.)

Postponed Indefinitely (Cont.)			
Bill Number:	**House Bill 10-1266**	Short Title:	**Health Insurance for Local Governments and Small Businesses**
Sponsors:	*Representative Frangas*	Status:	Postponed Indefinitely

The bill would have allowed certain local governments, small businesses, and nonprofit organizations to offer their employees participation in state medical and dental plans as of January 1, 2011. By electing to extend state group benefits to its employees, an employer could have agreed to exclusively offer state plans and participate in them for at least 3 years. The state personnel director would have been authorized to set minimum employer contributions towards its employees' premiums and charge an administrative fee to cover the state's costs. In the event that claims by employees of local governments, small businesses, or nonprofit organizations created a year-end deficit in group benefit plans, the state would have been authorized to collect an additional amount from employers proportional to their participation rate.

Appropriations:

The Department of Personnel and Administration required a General Fund appropriation of $1,093,581 and 0.9 FTE in FY 2010-11 for program costs. The cost increase was due to an increase personal services and operating costs, legal services, actuarial services, and benefit solver system replacement. The state uses the Benefits Solver System to administer and track participants enrolled in the state's group benefit plans. This system is not capable of meeting the administrative requirements of tracking participants from multiple employers. The fiscal note assumed that the state would have needed to move to a more robust system than what it would have otherwise chosen. Based on prior year's estimates, the incremental cost of this replacement could have been up to $777,500 per year.