

[Colo. Rev. Stat. § 10-16-102.]

§ 10-16-102. Definitions: Colorado Health Care Coverage Act

- (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 part 10 of this article, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.
- (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.
- (3) "Affiliation period" means a period of time, not to exceed two months, during which a health maintenance organization does not collect premiums and coverage issued is not yet effective.
- (4) "Basic health care services" means health care services that an enrolled population of a health maintenance organization organized pursuant to the provisions of part 4 of this article might reasonably require in order to maintain good health, including, at a minimum, emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services.
- (5) "Benefits ratio" means the ratio of the value of the actual benefits, not including dividends, to the value of the actual premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. "Benefits ratio" is also known as "targeted loss ratio".
- (6) "Bona fide association" means, with respect to health insurance coverage offered in Colorado, an association that:
 - (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 the 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.
- (7) "Bona fide volunteer":

- (a) Has the meaning set forth in section 31-30-1202, C.R.S.;
- (b) Means any volunteer member of a not-for-profit nongovernmental entity that is organized to provide firefighting services, emergency medical services, or ambulance services; and
- (c) Means any volunteer member of a rescue unit as defined in section 25-3.5-103, C.R.S.
- (8) "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 rules of Colorado.
- (9) (a) "Case characteristics" means demographic characteristics that are considered by the carrier in the determination of premium rates for individuals and small employers.
- (b) "Case characteristics" are limited to the following demographic characteristics, as further defined and determined by the commissioner by rule:
 - (I) The age of covered individuals;
 - (II) Geographic location of the policyholder;
 - (III) Family size; and
 - (IV) Tobacco use.
- (10) "Catastrophic plan" means an individual health benefit plan that does not provide a bronze, silver, gold, or platinum level of coverage, as those coverage levels are described in section 10-16-103.4, and is available only to individuals under thirty years of age or who meet the eligibility requirements in federal law for participation in a catastrophic plan.
- (11) "Child-only plan" means a health benefit plan issued on or after April 29, 2011, that provides coverage to an individual under twenty-one years of age. A "child-only plan" does not include coverage provided to a dependent under an individual or group health benefit plan.
- (12) "Church plan" has the same meaning as set forth in 29 U.S.C. sec. 1002 (33) of the federal "Employee Retirement Income Security Act of 1974".
- (13) "Commissioner" means the commissioner of insurance.
- (14) "Control" has the same meaning as set forth in section 10-3-801 (3).
- (15) "Covered person" means a person entitled to receive benefits or services under a health coverage plan.
- (16) "Creditable coverage" means benefits or coverage provided under:
 - (a) Medicare, the "Colorado Medical Assistance Act", articles 4 to 6 of title 25.5, C.R.S., or the children's basic health plan established pursuant to article 8 of title 25.5, C.R.S.;
 - (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; 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).

(16.5) "Dementia diseases and related disabilities" is a condition where mental ability declines and is severe enough to interfere with an individual's ability to perform everyday tasks. Dementia diseases and related disabilities includes Alzheimer's disease, mixed dementia, Lewy body dementia, vascular dementia, frontotemporal dementia, and other types of dementia.

(17) "Dependent" means a spouse, a partner in a civil union, 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. "Dependent" includes a designated beneficiary, as defined in section 15-22-103 (1), C.R.S., if an employer elects to cover a designated beneficiary as a dependent.

(18) (a) "Eligible employee" means a full-time employee in a bona fide employer-employee relationship with an employer that has not been established for the purpose of obtaining a small group plan. The term does not include:

(I) An employee who works on a temporary or substitute basis;

(II) An individual and his or her spouse or partner in a civil union with respect to a trade or business, whether incorporated or unincorporated, that is wholly owned by the individual or by the individual and his or her spouse or partner in a civil union; or

(III) A partner in a partnership and his or her spouse or partner in a civil union with respect to the partnership; except that a partner and his or her spouse or partner in a civil union may participate in a small group plan established to cover one or more eligible employees of the partnership who are not partners in the partnership.

(b) Notwithstanding any provision of law to the contrary, an eligible employee of a small employer who could also be considered a dependent of the small employer must receive taxable income from the small employer in an amount equivalent to minimum wage for working full-time on a permanent basis in order to be considered an employee of the small employer.

(c) Nothing in this subsection (18) limits the employer's traditional ability to set valid and acceptable standards for employee eligibility based on the terms and conditions of employment, including a minimum weekly work requirement in excess of thirty hours and eligibility based upon salaried versus hourly workers and management versus nonmanagement employees.

(19) "Emergency service provider" means a local government, or an authority formed by two or more local governments, that provides firefighting and fire prevention services, emergency medical services, ambulance services, or search and rescue services, or a not-for-profit nongovernmental entity organized for the purpose of providing any of those services through the use of bona fide volunteers.

(20) "Enrollee" means:

(a) An individual who is or has been enrolled in a health maintenance organization;

(b) An individual who is or has been enrolled in an individual or group prepaid dental care plan as a principal subscriber and includes the individual's dependents who are entitled to prepaid dental care services under the plan solely because of their status as dependents of the principal subscriber; or

(c) An individual who is or has been enrolled in a health coverage plan.

(21) "Enrollee coverage" means a health coverage plan issued pursuant to this article to an enrollee setting out the coverage to which the enrollee is entitled under the health coverage plan.

(22) (a) "Essential health benefits" has the same meaning as set forth in section 1302 (b) of the federal "Patient Protection and Affordable Care Act of 2010", as amended, Pub.L. 111-148;

(b) "Essential health benefits" includes:

(I) Ambulatory patient services;

(II) Emergency services;

(III) Hospitalization;

(IV) Laboratory services;

(V) Maternity and newborn care;

(VI) Behavioral, mental health, and substance use disorder services, including behavioral health treatment;

(VII) Pediatric services, including oral and vision care;

(VIII) Prescription drugs;

(IX) Preventive and wellness services and chronic disease management; and

(X) Rehabilitative and habilitative services and devices.

(23) "Essential health benefits package" means the essential health benefits package required under section 1302 (a) of the federal act and includes coverage that:

(a) Provides for the essential health benefits;

(b) Limits cost-sharing for this coverage in accordance with section 1302 (c) of the federal act; and

(c) For individual and small employer health benefit plans, provides bronze, silver, gold, or platinum levels of coverage described in section 1302 (d) of the federal act, as specified in section 10-16-103.4.

(24) "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.

(25) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee by a health maintenance organization setting out the coverage to which the enrollee is or was entitled.

(26) "Exchange" means the Colorado health benefit exchange created in article 22 of this title.

(27) "Executive director" means the executive director of the department of public health and environment.

(28) "Federal act" means the federal "Patient Protection and Affordable Care Act", Pub.L. 111-148, as amended by the federal "Health Care and Education Reconciliation Act of 2010", Pub.L. 111-152, and as may be further amended, including any federal regulations adopted under the federal act.

(29) "Federal law" includes the federal "Patient Protection and Affordable Care Act of 2010", Pub.L. 111-148, as amended by the federal "Health Care and Education Reconciliation Act of 2010", Pub.L. 111-152, and as may be further amended, also referred to in this article as the "ACA"; the federal "Public Health Service Act", as amended, 42 U.S.C. sec. 201 et seq., also referred to in this article as "PHSA"; the federal "Health Insurance Portability and Accountability Act of 1996", as amended, Pub.L. 104-191, also referred to in this article as "HIPAA"; the federal "Employee Retirement Income Security Act of 1974", as amended, 29 U.S.C. sec. 1001 et seq., also referred to in this article as "ERISA"; and any federal regulation implementing these federal acts.

(30) "Government plan" has the same meaning as set forth in 29 U.S.C. sec. 1002 (32) of the federal "Employee Retirement Income Security Act of 1974", and as in any federal governmental plan.

(31) "Grandfathered health benefit plan" means a health benefit plan provided to an individual or employer by a carrier on or before March 23, 2010, for as long as it maintains that status in accordance with federal law and includes any extension of coverage under an individual or employer health benefit plan that existed on or before March 23, 2010, to a dependent of an individual enrolled in the plan or to a new employee and his or her dependents who enroll in the employer health benefit plan. This article, as it existed prior to May 13, 2013, applies to grandfathered health benefit plans on and after May 13, 2013.

(32) (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 in Colorado.

(b) "Health benefit plan" does not include:

(I) Accident only;

(II) Credit;

(III) Dental;

(IV) Vision;

(V) Medicare supplement;

(VI) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(VII) Disability income insurance;

(VIII) Liability insurance including general liability insurance and automobile liability insurance;

(IX) Coverage for on-site medical clinics;

(X) Coverage issued as a supplement to liability insurance, workers' compensation, or similar insurance;

(XI) Automobile medical payment insurance; or

(XII) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(c) Solely with respect to section 10-16-118, "health benefit plan" excludes individual short-term limited duration health insurance policies.

(33) "Health care services" means any services included in or incidental to the furnishing of medical, behavioral, mental health, or substance use disorder; dental, or optometric care; hospitalization; or nursing home care to an individual, as well as the furnishing to any person of any other services for the purpose of

preventing, alleviating, curing, or healing human physical illness or injury, or behavioral, mental health, or substance use disorder. "Health care services" includes the rendering of the services through the use of telehealth, as defined in section 10-16-123 (4)(e).

(34) "Health coverage plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(35) "Health maintenance organization" means any person who:

(a) Provides, either directly or through contractual or other arrangements with others, health care services to enrollees; and

(b) Provides, either directly or through contractual or other arrangements with other persons, health care services, including, at a minimum, emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services; and

(c) Is responsible for the availability, accessibility, and quality of the health care services provided or arranged.

(36) "Health status" means the determination by a carrier of the past, present, or expected risk of an individual or the employer due to the health conditions of the individual or the employees of the employer.

(37) "Health-status-related factor" means any of the following factors:

(a) Health status;

(b) Medical condition, including both physical illnesses and mental health disorders;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(h) Disability.

(38) "Hearing aid" means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. "Hearing aid" includes any parts or ear molds.

(39) "Index rate" means the premium rate established for a market segment based on the total combined claims costs for providing essential health benefits within the single risk pool of that market segment.

(40) "Intermediary" means a person authorized by health care providers to negotiate and execute provider contracts with carriers on behalf of such providers.

(41) "Licensed health care provider" has the same meaning as in section 10-4-601.

(42) "Local government" means any city, county, city and county, special district, or other political subdivision of this state.

(43) "Managed care plan" means a policy, contract, certificate, or agreement offered by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services through the covered person's use of health care providers managed by, owned by, under contract with, or employed by the carrier because the carrier either requires the use of or creates incentives, including financial incentives, for the covered person's use of those providers.

(44) "Minor child" means any person under eighteen years of age.

(45) "Network" means a group of participating providers providing services to a managed care plan. For the purposes of part 7 of this article, any subdivision or subgrouping of a network is considered a network if covered individuals are restricted to the subdivision or subgrouping for covered benefits under the managed care plan.

(46) "Participating provider" means a provider, either within or outside of Colorado, that, under a contract with a carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly, from the carrier.

(47) "Patient with diabetes" means a person with elevated blood glucose levels who has been diagnosed as having diabetes by an appropriately licensed health care professional.

(48) "Person" means any individual, partnership, association, trust, or corporation and includes any hospital licensed or certified in this state, independent practice association of physicians, or professional service corporation for the practice of medicine.

(49) "Pharmacy benefit management firm" means any entity doing business in this state that contracts to administer or manage prescription drug benefits on behalf of any carrier that provides prescription drug benefits to residents of this state.

(50) "Policy of sickness and accident insurance" means any policy or contract of insurance against loss or expense resulting from the sickness of the insured, the bodily injury or death of the insured by accident, or both.

(51) "Premium" means all moneys paid as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan.

(52) "Prepaid dental care plan" means any contractual arrangement through an entity organized pursuant to part 5 of this article to provide, either directly or through arrangements with others, dental care services to enrollees on a fixed prepayment basis or as a benefit of the enrollees' participation or membership in any other contract, agreement, or group.

(53) "Prepaid dental care plan organization" means any person who undertakes to conduct one or more prepaid dental care plans providing only dental care services.

(54) "Prepaid dental care services" means services included in the practice of dentistry, as defined in article 35 of title 12, C.R.S., that are provided to enrollees under a prepaid dental care plan.

(55) "Producer" means a person licensed by the division who solicits, negotiates, effects, procures, delivers, renews, continues, services, or binds health benefit plans and is licensed to conduct these activities in Colorado.

(56) "Provider" means any physician, dentist, optometrist, anesthesiologist, hospital, X ray, laboratory and ambulance service, or other person who is licensed or otherwise authorized in this state to furnish health care services.

(57) "Rate increase" means an increase in the current rate.

(58) "Rating period" means the calendar period for which premium rates established by a carrier are assumed to be in effect.

(59) "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.

(60) "Short-term limited duration health insurance policy" or "short-term policy" means a nonrenewable individual health benefit plan with a specified duration of not more than six months that meets the following requirements:

(a) The policy is issued only to individuals who have not had more than one short-term policy providing the same or similar nonrenewable coverage from any carrier within the past twelve months and so states in all marketing materials, application forms, and policy forms. An applicant is eligible for coverage if a short-term carrier includes in its application form the following:

Have you or any other person to be insured been covered under two or more nonrenewable short-term policies during the past twelve months? If "yes", then this policy cannot be issued. You must wait six months from the date of your last such policy to apply for a short-term policy.

(b) The policy contains the following disclosure in ten-point or larger, bold-faced type in all marketing materials, application forms, and policy forms:

This policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health care professional, or taken prescription drugs within twelve months before the effective date of this policy will not be covered under this policy.

(61) (a) Repealed.

(b) Effective January 1, 2016, "small employer" means any person, firm, corporation, partnership, or association that:

(I) Is actively engaged in business;

(II) Employed an average of at least one but not more than one hundred eligible employees on business days during the immediately preceding calendar year, except as provided in paragraph (e) of this subsection (61); and

(III) Was not formed primarily for the purpose of purchasing insurance.

(c) For purposes of determining whether an employer is a "small employer", the number of eligible employees is calculated using the method set forth in 26 U.S.C. sec. 4980h (c)(2)(E).

(d) In order to be classified as a small employer with more than one employee when only one employee enrolls in the small employer's health benefit plan, the small employer shall submit to the small employer carrier the two most recent quarterly employment and tax statements substantiating that the employer had

two or more eligible employees. Such small employer group shall also meet the participation requirements of the small employer carrier.

(e) In the case of an employer that was not in existence throughout the preceding calendar quarter, the determination of whether the employer is a small employer is based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(f) The following employers are single employers for purposes of determining the number of employees:

- (I) A person or entity that is a single employer pursuant to 26 U.S.C. sec. 414 (b), (c), (m), or (o); and
- (II) An employer and any predecessor employer.

(62) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

(63) "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 part 3 of this article, or that form of policy issued by an entity organized pursuant to part 4 of this article that 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.

(64) "Standing referral" means a referral by the covered person's primary care provider to a specialist or specialized treatment center participating in the carrier's network for ongoing treatment of a covered person.

(65) "Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education, as defined in the "Higher Education Act of 1965", and a health carrier and provided to students enrolled in that institution of higher education and their dependents, that:

- (a) Does not make health insurance coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education;
- (b) Does not condition eligibility for health insurance coverage on any health-status-related factor related to a student or a dependent of a student; and
- (c) Meets any additional requirement that may be imposed by law.

(66) "Targeted loss ratio" means the ratio of expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage to the expected earned premium over the same period. The anticipated loss ratio shall be calculated on an incurred basis as the ratio of expected incurred losses to expected earned premium.

(67) "Uncovered expenditures" means the costs of those health care services:

- (a) That are covered under the health maintenance organization's health care plans but are not guaranteed, insured, or assumed by a person or organization other than the health maintenance organization; or
- (b) For which a provider has not agreed to hold enrollees harmless if the provider is not paid by the health maintenance organization.

(68) "Valid multistate association" means an association that has:

- (a) Been in active existence for at least five years;
 - (b) Been organized and maintained in good faith for purposes other than to obtain insurance;
 - (c) A minimum of five hundred members;
 - (d) A constitution, charter, or bylaws that provide for regular meetings, at least annually, to further the purposes of the members;
 - (e) Collected dues or solicited contributions for members; and
 - (f) Provided the members with voting privileges and representation on the governing board and committees.
- (69) "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.