Second Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 24-1028.02 Kristen Forrestal x4217

HOUSE BILL 24-1258

HOUSE SPONSORSHIP

Brown and Boesenecker,

SENATE SPONSORSHIP

(None),

House Committees
Health & Human Services
Appropriations

Senate Committees

A BILL FOR AN ACT

CONCERNING CREDIT FOR THE OUT-OF-POCKET EXPENSES PAID BY A COVERED PERSON WHEN A HEALTH INSURANCE CARRIER EXITS THE MARKET.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

For small group and individual health benefit plans, if an individual who is entitled to receive benefits or services under a health benefit plan has incurred any out-of-pocket expenses, including payments for a deductible or other coinsurance amount, under the health benefit plan during a plan year, and the individual's health insurance carrier exits

the health insurance market and can no longer provide coverage to the individual, the bill requires the individual's new health insurance carrier to credit all of the out-of-pocket expenses paid by the individual in accordance with the original health benefit plan in the given plan year to the new health benefit plan if the individual enrolls in the new health benefit plan in the established special enrollment period.

The bill grants rule-making authority to the commissioner of insurance.

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

SECTION 1. In Colorado Revised Statutes, **add** 10-16-105.9 as follows:

10-16-105.9. Health benefit plan - carrier insolvency - covered persons - deductible amounts - rules - definition. (1) AS USED IN THIS SECTION:

(a) "OUT-OF-POCKET EXPENSES" MEANS EXPENSES PAID TOWARD A HEALTH BENEFIT PLAN:

(I) DEDUCTIBLE FOR MEDICAL SERVICES AND PRESCRIPTION DRUGS THAT WERE CREDITED UNDER THE COVERED PERSON'S HEALTH BENEFIT PLAN; AND

(II) OUT-OF-POCKET MAXIMUM FOR MEDICAL SERVICES AND PRESCRIPTION DRUGS THAT WERE CREDITED UNDER THE PERSON'S HEALTH BENEFIT PLAN, INCLUDING ANY COINSURANCE AMOUNTS.

(b) "OUT-OF-POCKET EXPENSES" DOES NOT INCLUDE PREMIUM PAYMENTS MADE FOR A HEALTH BENEFIT PLAN.

(2) FOR INDIVIDUAL HEALTH BENEFIT PLANS, IF A COVERED PERSON HAS PAID ANY OUT-OF-POCKET EXPENSES FOR SERVICES COVERED BY A HEALTH BENEFIT PLAN IN A GIVEN PLAN YEAR, AND THE CARRIER THAT PROVIDES THE HEALTH BENEFIT PLAN TO THE COVERED PERSON EXITS THE HEALTH INSURANCE MARKET AND CAN NO LONGER PROVIDE HEALTH

INSURANCE BENEFITS TO THAT PERSON DURING THE SAME PLAN YEAR, A CARRIER OF A NEW HEALTH BENEFIT PLAN THAT COVERS THE PERSON DURING THE SAME PLAN YEAR SHALL CREDIT ALL OF THE OUT-OF-POCKET EXPENSES PAID BY THE COVERED PERSON TO THE NEW HEALTH BENEFIT PLAN.

(3) IF A COVERED PERSON'S OUT-OF-POCKET EXPENSES CREDITED TO THE NEW HEALTH BENEFIT PLAN IN ACCORDANCE WITH SUBSECTION (2) OF THIS SECTION FOR COVERAGE UNDER THE ORIGINAL HEALTH BENEFIT PLAN ARE GREATER THAN THE AMOUNT OF OUT-OF-POCKET EXPENSES REQUIRED BY THE NEW HEALTH BENEFIT PLAN, THE NEW CARRIER IS NOT REQUIRED TO APPLY THE AMOUNT IN EXCESS TO THE NEW HEALTH BENEFIT PLAN.

(4) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT THIS SECTION THAT INCLUDE PROTOCOLS FOR EACH CARRIER TO FOLLOW WHEN CREDITING OUT-OF-POCKET EXPENSES PAID BY A COVERED PERSON TO A NEW HEALTH BENEFIT PLAN AND PROTOCOLS FOR THE DIVISION TO FOLLOW TO ENSURE THAT THE NECESSARY DATA TO DETERMINE THE AMOUNT OF THE OUT-OF-POCKET EXPENSES CREDIT FOR EACH NEW MEMBER IS DELIVERED TO EACH CARRIER IN A TIMELY AND ACCURATE MANNER BY THE COMMISSIONER. THE COMMISSIONER SHALL COLLECT THE NECESSARY DATA FROM THE CARRIERS FOR THE DIVISION'S DETERMINATION OF THE AMOUNT OF THE OUT-OF-POCKET EXPENSE CREDITS. THE PROTOCOLS MUST BE BASED ON THE OUT-OF-POCKET MAXIMUM AMOUNTS, AS DESCRIBED IN SECTION 10-16-161, FROM THE DIVISION. THE COMMISSIONER SHALL CONSULT WITH THE EXCHANGE TO DEVELOP THE PROTOCOLS.

(5) THE NEW HEALTH BENEFIT PLAN IS REQUIRED ONLY TO CREDIT

OUT-OF-POCKET EXPENSES TOWARD THE DEDUCTIBLE AND THE OUT-OF-POCKET MAXIMUM, WHICH ARE REPORTED BY THE PREVIOUS HEALTH BENEFIT PLAN, THE HEALTH BENEFIT PLAN'S CONSERVATORSHIP, OR THE DIVISION IN A TIME AND MANNER DETERMINED BY THE COMMISSIONER.

(6) (a) THE NEW CARRIER MAY FILE A CLAIM FOR THE AMOUNT OF THE INCREASE IN CLAIMS LIABILITY AS A RESULT OF THIS SECTION WITH THE ESTATE OF THE ORIGINAL HEALTH BENEFIT PLAN CARRIER.

(b) (I) A CARRIER MAY RECOUP, OVER A REASONABLE LENGTH OF TIME, A SUM EQUAL TO THE AMOUNT OF OUT-OF-POCKET EXPENSES CREDITED TO COVERED PERSONS, IN ACCORDANCE WITH THIS SECTION. THE AMOUNT MUST BE REASONABLY CALCULATED TO RECOUP THESE EXPENSES AND IS SUBJECT TO REVIEW BY THE COMMISSIONER. AN AMOUNT RECOUPED IS NOT CONSIDERED A PREMIUM FOR ANY OTHER PURPOSE, INCLUDING THE COMPUTATIONS OF GROSS PREMIUM TAX OR AN AGENT'S COMMISSION.

(II) A CARRIER THAT IMPOSES A SURCHARGE TO RECOUP THE AMOUNT OF OUT-OF-POCKET EXPENSES CREDITED PURSUANT TO THIS SECTION MUST INCLUDE THE AMOUNT OF THE SURCHARGE AS PART OF THE CARRIER'S RATE FILING PURSUANT TO SECTION 10-16-107 (1). THE CARRIER MUST SHOW THE SURCHARGE IN THE RATE FILING AS A SEPARATE COMPONENT OF THE RATE AND SHALL INCLUDE SUPPORTING DOCUMENTATION.

(7) A CARRIER SHALL NOT FILE A CLAIM FOR THE AMOUNT OF THE INCREASE IN CLAIMS LIABILITY DUE TO THIS SECTION WITH THE ESTATE OF THE ORIGINAL HEALTH BENEFIT PLAN IF THE CARRIER HAS RECOUPED COSTS FOR OUT-OF-POCKET EXPENSES CREDITED TO COVERED PERSONS IN

ACCORDANCE WITH SUBSECTION (6)(b) OF THIS SECTION.

(8) SUBJECT TO APPROVAL BY THE COMMISSIONER, A CARRIER IS NOT REQUIRED TO CREDIT ALL OF THE OUT-OF-POCKET EXPENSES PAID BY THE COVERED PERSON TO THE NEW HEALTH BENEFIT PLAN IN ACCORDANCE WITH SUBSECTION (2) OF THIS SECTION IF DOING SO WOULD CAUSE THE CARRIER TO BECOME INSOLVENT.

SECTION 2. Act subject to petition - effective date - applicability. (1) This act takes effect January 1, 2025; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within the ninety-day period after final adjournment of the general assembly, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2024 and, in such case, will take effect January 1, 2025, or on the date of the official declaration of the vote thereon by the governor, whichever is later.

(2) This act applies to health benefit plans issued or renewed on or after the applicable effective date of this act.