DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

LIFE, ACCIDENT AND HEALTH, Series 4-2

3 CCR 702-4 Series 4-2

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

Regulation 4-2-1 REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

Section 1 Authority

This amended regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-1110, and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to reduce the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance. The scope of this regulation includes persons covered by an individual health care coverage plan offered by a health maintenance organization and individual accident and sickness insurance policies or plans, who are considering replacement of their coverage.

Section 3 Applicability

This regulation shall apply to individual accident and sickness insurance policies and all service or indemnity contracts offered by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10, except conversion to an individual or family policy from a group, blanket or group type policy, or any other insurance that is covered by a separate state statute.

Section 4 Definitions

A. "Accident and sickness insurance" means, for the purposes of this regulation, a policy, plan, contract, agreement, statement of coverage, rider or endorsement that provides accident or sickness benefits or medical, surgical or hospital benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts. For the purposes of this regulation, accident and sickness insurance includes health coverage plans.

B. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. "Direct response" means, for the purposes of this regulation, a solicitation through a sponsoring or endorsing entity or individually, solely through mail, telephone, the internet, or other mass communication media.

D. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

E. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.

Section 5 Rules

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has an accident and sickness insurance policy or health coverage plan in force, or whether an accident and sickness insurance policy or health coverage plan is intended to replace or be in addition to any other accident and sickness insurance policy or health coverage plan presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.

1. Statements

a. You normally do not require more than one of the same type of policy.

b. If you purchase this policy, you may want to evaluate your existing health insurance and decide if you need multiple coverages.

c. You may be eligible for benefits under Medicaid or Medicare and may not need another health insurance policy. If you are eligible for Medicare, you may want to purchase a Medicare supplement insurance policy.

d. If you are eligible for Medicare due to age or disability, counseling services are available in Colorado to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, Health First Colorado.

2. Questions

To the best of your knowledge:

a. Do you have another health insurance policy or contract in force?

(1) If so, with which company?

(2) If so, do you intend to replace your current health insurance policy or contract with this policy?

b. Do you have any other health insurance that provides benefits similar to this accident and sickness policy?

(1) If so, with which company?

(2) What kind of policy?

c. Are you covered for medical assistance through the state Medicaid program, Health First Colorado:

(1) As a Specified Low-Income Medicare Beneficiary (SLMB)?

(2) As a Qualified Medicare Beneficiary (QMB)?

(3) For other Medicaid medical benefits?

B. Producers must list all other accident and sickness insurance policies or contracts they have sold to the applicant.

1. List policies and/or contracts sold which are still in force; and

2. List policies and/or contracts sold in the past five (5) years which are no longer in force.

C. In the case of a direct response carrier, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the carrier, shall be returned to the applicant by the carrier upon delivery of the policy.

D. Delivery of Replacement Notice

1. Upon determining that a sale will involve replacement of an accident and sickness insurance policy or health coverage plan, a carrier, other than a direct response carrier, or its producer, shall furnish the applicant, prior to issuance or delivery of the accident and sickness insurance policy or health coverage plan, a notice regarding replacement of accident and sickness insurance. One (1) copy of such notice signed by the applicant and producer, except where the coverage is sold without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the carrier.

2. A direct response carrier shall deliver to the applicant, at the time of issuance of the policy, the appropriate notice, located in Appendix A or B of this regulation.

E. The notices required by subsection 5.D. must be provided in the format prescribed and adopted by the Commissioner of Insurance and are provided in Appendices A and B of this regulation.

F. Paragraph 1. of the notices provided in Appendices A and B, may be deleted by the carrier if the replacement does not involve the application of a new pre-existing condition limitation.

G. Failure to comply with the requirements of this section 5 constitutes an unfair method of competition and an unfair or deceptive act or practice in the business of insurance which is prohibited under § 10-3-1104, C.R.S.

Section 6 Additional Rules for the Replacement of Health Benefit Plans

A. Carriers are not required to provide the notice in Appendix B when an applicant is replacing his or her current individual health benefit plan with another individual health benefit plan during the annual open enrollment period or if the replacement is due to eligibility for a special enrollment due to one or more of the triggering events listed in Colorado Insurance Regulation 4-2-43.

B. Carriers are required to provide the notice in Appendix B when an applicant is replacing his or her current individual health benefit plan with an accident and sickness insurance policy or health coverage plan which does not meet the definition of a health benefit plan.

Section 7 Incorporation by Reference

Colorado Insurance Regulation 4-2-43, 3 CCR 702-4 published by the Colorado Division of Insurance shall mean Colorado Insurance Regulation 4-2-43, 3 CCR 702-4 as published on the effective date of this regulation and does not include later amendments to, or editions of, Colorado Insurance Regulation 4-2-43, 3 CCR 702-4. Colorado Insurance Regulation 4-2-43, 3 CCR 702-4 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Colorado Division of Insurance website at www.dora.colorado.gov/insurance. Certified copies of Colorado Insurance Regulation 4-2-43, 3 CCR 702-4 are available from the Division of Insurance for a fee.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

This regulation is effective April 1, 2018.

Section 11 History

Originally issued as Regulation 74-2, effective March 15, 1974.
Amended December 22, 1975, effective January 1, 1976.
Amended effective January 14, 1977.
Renumbered on June 1, 1992.
Repealed and Repromulgated in full, effective February 1, 2001.
Amended Regulation 4-2-1, effective May 1, 2010.
Amended Regulation effective November 1, 2013.
Amended Regulation effective April 1, 2018.

Appendix A

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF

ACCIDENT AND SICKNESS INSURANCE

[Carrier Name and Address]

According to [your application] [the information furnished by you], you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by [carrier name]. [Your new policy will provide [number of days of the free look period] days within which you may decide without cost whether you want to keep the policy.]

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision, you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY CARRIER OR PRODUCER:

I have reviewed your current health coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ Other. (Please specify.)

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in the denial or delay of a claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.

2. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or contract is guaranteed issued this paragraph need not appear.]

Do not cancel your current policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Producer or Other Representative) *

[Typed Name and Address of Carrier, Producer, or Other Representative]

[_____

(Carrier Acknowledgement of Receipt and Review) **

_____]

(Date)

_____

(Applicant's Signature)

_____

(Date)

* Signature not required for direct response sales.

** For use by direct response carriers.

Appendix B

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF A HEALTH BENEFIT PLAN

[Carrier Name and Address]

According to [your application] [the information furnished by you], you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by [carrier name]. [Your new policy will provide [number days of free look period] days within which you may decide without cost whether you want to keep the policy.]

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision, you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY CARRIER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage, which provides comprehensive medical coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ Other. (Please specify.)

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in the denial or delay of a claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy, which provides comprehensive coverage.

2. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or contract is guaranteed issued this paragraph need not appear.]

Do not cancel your current policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Producer or Other Representative) *

[Typed Name and Address of Carrier, Producer, or Other Representative]

[_____

(Carrier Acknowledgement of Receipt and Review) **

_____]

(Date)

_____

(Applicant's Signature)

_____

(Date)

* Signature not required for direct response sales.

** For use by direct response carriers.

Regulation 4-2-2 HOSPITAL INDEMNITY AND DISABILITY INCOME POLICIES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-16-109, C.R.S.

Section 2 Scope and Purpose

This regulation prohibits insurers from refusing to pay benefits under certain contracts because of hospitalization in government hospitals.

Section 3 Applicability

This regulation applies to all hospital indemnity and disability income policies, contracts, riders, endorsements, etc., which provide benefits because of hospitalization or disability originating out of hospitalization hereinafter referred to as hospital indemnity and disability income policies. It does not apply to hospital expense policies.

Section 4 Definitions

For the purposes of this regulation:

A. “Disability income policy” means, for the purposes of this regulation, a policy that provides periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury.

B. “Government hospital” means, for the purposes of this regulation, any hospital under governmental control whether federal, state, county or city. It includes Veterans Administration hospitals.

C. “Hospital indemnity policy” means, for the purposes of this regulation, a policy that provides a stated daily, weekly or monthly payment while the insured is hospitalized, regardless of expenses incurred and regardless of whether or not other insurance is in force. The insured can use the daily, weekly or monthly benefit as he or she chooses, for hospital or other expenses.

Section 5 Rules

All hospital indemnity and disability income policies delivered or issued for delivery in the State of Colorado which provide benefits predicated on hospitalization will not in any way deny such benefits on the basis that such hospitalization was in a government hospital.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspension or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall be effective December 1, 2013.

Section 9 History

Originally issued as Regulation 74-4, effective July 1, 1974.
Renumbered as Regulation 4-2-2, effective June 1, 1992.
Repealed and Repromulgated in full, effective January 1, 2001.
Amended Regulation 4-2-2, effective July 1, 2010.
Amended Regulation 4-2-2, effective December 1, 2013.

Regulation 4-2-3 ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109 and 10-3-1110, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish minimum criteria to assure proper and accurate description and to protect prospective purchasers with respect to the advertisement of accident and sickness insurance. This regulation assures the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as accident and sickness insurance by the establishment of standards of conduct in the advertising of accident and sickness insurance in a manner that prevents unfair, deceptive and misleading advertising and is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance producers and companies.

Section 3 Applicability

A. This regulation shall apply to any accident and sickness insurance “advertisement”, as that term is defined, intended for presentation, distribution or dissemination in Colorado when such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer or producer, as those terms are defined in the Colorado Revised Statutes and this regulation.

B. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All of the insurer's advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are advertised.

C. Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

Section 4 Definitions

A. "ACA" means, for the purposes of this regulation, the Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B. "Accident and sickness insurance policy" means, for the purposes of this regulation, a policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement that provides accident or sickness benefits or medical, surgical or hospital benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts.

1. An accident and sickness insurance policy does not include a Medicare supplement insurance policy or any other type of accident and sickness insurance with advertising guidelines covered by a separate statute and/or regulation.

2. The language "except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts" means it does not include disability, waiver of premium and double indemnity benefits included in life insurance, endowment or annuity contracts or contracts supplemental to the above contracts that contain only provisions that:

a. Provide additional benefits in case of death or dismemberment or loss of sight by accident; or

b. Operate to safeguard the contracts against lapse or to give a special surrender value, special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract.

C. "Advertisement" means, for the purposes of this regulation, printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, web sites and other Internet displays or communications, other forms of electronic communications, billboards and similar displays.

1. "Advertisement" also means:

a. Descriptive literature and sales aids of all kinds issued by an insurer or producer for presentation to members of the insurance-buying public, such as circulars, leaflets, booklets, depictions, illustrations, form letters and lead-generating devices of all kinds;

b. Prepared sales talks, presentations and material for use by producers whether prepared by the insurer or producer;

c Summary of Benefits and Coverage (SBC) forms; and

d. The Colorado Supplement to the Summary of Benefits and Coverage Form as found in Colorado Insurance Regulation 4-2-20.

2. The definition of "advertisement" includes advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.

3. The definition of "advertisement" extends to the use of all media for communications to the general public; to the use of all media for communications to specific members of the general public; and to the use of all media for communications by insurers or producers.

4. The definition of "advertisement" does not include:

   a. Material used solely for the training and education of an insurer's employees or producers;

   b. Material used in-house by insurers;

   c. Communications within an insurer's own organization not intended for dissemination to the public;

   d. Individual communications of a personal nature with current policyholders other than material urging the policyholders to increase or expand coverages;

   e. Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;

   f. Court-approved material ordered by a court to be disseminated to policyholders; or

   g. A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged, provided that the announcement clearly indicates that it is preliminary to the issuance of a booklet and that the announcement does not describe the specific benefits under the contract or program nor describe advantages as to the purchase of the contract or program. This does not prohibit a general endorsement of the program by the sponsor.

D. "Certificate" means, for the purposes of this regulation, a statement of the coverage and provisions of a group accident and sickness insurance policy, which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

E. "Exception" means, for the purposes of this regulation, any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

F. "Format" means, for the purposes of this regulation, the arrangement of the text and the captions.

G. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

H. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.

I. "Institutional advertisement" means, for the purposes of this regulation, an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of accident and sickness insurance, or the promotion of the insurer as a seller of accident and sickness insurance. Insurers are required to comply with section 15.A. of the regulation, clearly identifying the name of the insurer.

J. "Insurer" shall have the same meaning as "carrier" as found at § 10-16-102(8), C.R.S., and applies to any carrier subject to Title 10, Article 16, Parts 2, 3 or 4.

K. "Invitation to contract" means, for the purposes of this regulation, an advertisement that is neither an "invitation to inquire" nor an "institutional advertisement".

L. "Invitation to inquire" means, for the purposes of this regulation, an advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss for which benefits are payable, but may contain the dollar amount of benefits payable and the period of time during which benefits are payable.

1. An "invitation to inquire" shall not refer to cost.

2. An "invitation to inquire" shall contain a provision in the following or substantially similar form:

"This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance producer or the company [whichever is applicable]."

M. "Juxtaposition" means, for the purposes of this regulation, side-by-side or immediately above or below.

N. "Lead-generating device" means, for the purposes of this regulation, any communication directed to the public that, regardless of form, content or stated purpose is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of accident and sickness insurance.

O. "Limitation" means, for the purposes of this regulation, a provision that restricts coverage under the policy other than an exception or a reduction.

P. "Limited benefit health coverage" means, for the purposes of this regulation, any type of health coverage that is not provided by a health benefit plan, as found at § 10-16-102(32), C.R.S.

This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance.

Q. "Marketing" means, for the purposes of this regulation, any activity or effort directed toward the public which is intended to promote or sell products or services.

R. "Prominently" or "conspicuously" means, for the purposes of this regulation, that the information to be disclosed "prominently" or "conspicuously" shall be presented in a manner that is noticeably set apart from other information or images in the advertisement.

S. "Reduction" means, for the purposes of this regulation, a provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable had the reduction not been used.

T. "Short-term limited duration health insurance policy" shall have the same meaning as found at § 10-16-102(60), C.R.S.

U. "Summary of Benefits and Coverage" or "SBC" means, for the purposes of this regulation, the form required by 45 C.F.R. § 147.200(a).

Section 5 Method of Disclosure of Required Information

All information, exceptions, limitations, reductions and other restrictions required to be disclosed by this regulation shall be set out conspicuously and in close conjunction to the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading. This regulation permits, but is not limited to, the use of either of the following methods of disclosure:

A. Disclosure in the description of the related benefits or in a paragraph set out in close conjunction with the description of policy benefits; or

B. Disclosure not in conjunction with the provisions describing policy benefits but under appropriate captions of such prominence that the information shall not be minimized, rendered obscure or otherwise made to appear unimportant. The phrase “under appropriate captions” means that the title must be accurately descriptive of the captioned material. Appropriate captions include the following: “Exceptions”, “Exclusions”, “Conditions Not Covered”, and “Exceptions and Reductions”. The use of captions such as the following are prohibited because they do not provide adequate notice of the significance of the material: “Extent of Coverage”, “Only these Exclusions”, or “Minimum Limitations”.

Section 6 Format and Content of Advertisements

A. The format and content of an advertisement of an accident and sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive.

B. Distinctly different advertisements are required for publication in different media, such as newspapers or magazines of general circulation as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this regulation.

C. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed.

D. Advertisements shall be truthful and not misleading in fact or implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

E. An insurer shall clearly identify its accident and sickness insurance policy as an insurance policy. A policy trade name shall be followed by the words “insurance policy” or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

F. An insurer, producer or other person shall not solicit a resident of this state for the purchase of accident and sickness insurance in connection with or as the result of the use of an advertisement by the person or any other persons, where the advertisement:

1. Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of the person or the true purpose of the advertisement; or

2. Otherwise violates the provisions of this regulation.

G. An insurer, producer or other person shall not solicit residents of this state for the purchase of accident and sickness insurance through the use of a true or fictitious name that is deceptive or misleading with regard to the status, character or proprietary or representative capacity of the person or the true purpose of the advertisement.

H. An insurer is prohibited from representing or naming any health coverage plan as a Bronze, Silver, Gold, or Platinum metal tier level of coverage unless that policy is a health benefit plan as specified in § 10-16-103.4, C.R.S. Use of these terms for a non-ACA compliant health coverage plan may be found to violate § 10-3-1104(1)(a)(V), C.R.S. This prohibition also applies to short-term limited duration health insurance policies.

I. An insurer is prohibited from advertising any health coverage plan which is not ACA-compliant as an alternative to, or a substitute for, a health benefit plan which meets federal and state requirements under the ACA.

Section 7 Advertisements of Benefits Payable, Losses Covered or Premiums Payable

A. Covered Benefits

1. The use of deceptive words, phrases or illustrations in advertisements of accident and sickness insurance is prohibited.

2. An advertisement that fails to state clearly the type of insurance coverage being offered is prohibited.

3. An advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of information or use of words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

4. An advertisement shall not contain or use words or phrases such as “all”, “full”, “complete”, “comprehensive”, “unlimited”, “up to”, “as high as”, “this policy will help fill some of the gaps that Medicare and your present insurance leave out”, “the policy will help to replace your income” (when used to express loss of time benefits), or similar words and phrases, in a manner that exaggerates a benefit beyond the terms of the policy.

5. An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the policyholder is prohibited unless, in making the reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility if an assignment of benefits is made by the policyholder. An advertisement of medical and surgical expense benefits shall comply with this regulation in regard to the disclosure of assignments of benefits to providers of services. Phrases such as “you collect”, “you get paid”, “pays you”, or other words or phrases of similar import may be used so long as the advertisement indicates that it is payable to the insured or someone designated by the insured.

6. An advertisement for basic hospital expense coverage, basic medical-surgical expense coverage, basic hospital/medical-surgical expense coverage, hospital confinement indemnity coverage, accident-only coverage, specified disease coverage, specified accident coverage, limited benefit health coverage or for coverage that covers only a certain type of loss is prohibited if:

   a. The advertisement refers to a total benefit maximum limit payable under the policy in any headline, lead-in or caption without, also in the same headline, a lead-in or caption specifying the applicable daily limits and other internal limits;

   b. The advertisement states a total benefit limit without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit; or

   c. The advertisement prominently displays a total benefit limit that would not, as a general rule, be payable under an average claim.

   Section 7.A.6. does not apply to individual health benefit plans or disability income insurance.

7. Advertisements that emphasize total amounts payable under hospital, medical or surgical accident and sickness insurance coverage or other benefits in a policy, such as benefits for private duty nursing, are prohibited unless the actual amounts payable per day for the indemnity or benefits are stated.

8. Advertisements that include examples of benefits payable under a policy shall not use examples in a way that implies that the maximum benefit payable under the policy will be paid, when less than maximum benefits are paid for an average claim.

9. When a range of benefit levels is set forth in an advertisement, it shall be clear that the insured will receive only the benefit level written or printed in the policy selected and issued. Language that implies that the insured may select the benefit level at the time of filing claims is prohibited.

10. Language in an advertisement that implies that the amount of benefits payable under a loss-of-time policy may be increased at the time of claim or disability according to the needs of the insured is prohibited.

11. Advertisements for policies with premiums that are modest because of their limited coverage or limited amount of benefits shall not describe premiums as “low”, “low cost”, “budget” or use qualifying words of similar import. The use of words such as “only” and “just” in conjunction with statements of premium amounts when used to imply a bargain are prohibited.

12. Advertisements that state or imply that premiums will not be changed in the future are prohibited unless the advertised policies expressly provide that the premiums will not be changed in the future.

13. An advertisement for a policy that does not require the premium to accompany the application shall not overemphasize that fact and shall clearly indicate under what circumstances coverage will become effective.

14. An advertisement that exaggerates the effects of statutorily-mandated benefits or required policy provisions or that implies that the provisions are unique to the advertised policy is prohibited.

15. An advertisement that implies that a common type of policy or a combination of common benefits is “new”, “unique”, “a bonus”, “a breakthrough”, or is otherwise unusual is prohibited. The addition of a novel method of premium payment to an otherwise common plan of insurance does not render it new or unique.

16. Language in an advertisement that states or implies that each member under a family contract is covered as to the maximum benefits advertised, where that is not the fact, is prohibited.

17. An advertisement that contains statements such as “anyone can apply”, or “anyone can join”, other than with respect to a guaranteed-issue policy for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is prohibited.

18. An advertisement that states or implies immediate coverage of a policy is prohibited unless administrative procedures exist so that the policy is issued within fifteen (15) business days after the insurer receives the completed application.

19. An advertisement that contains statements such as “here is all you do to apply”, or “simply” or “merely” to refer to the act of applying for a policy that is not a guaranteed-issue policy is prohibited unless it refers to the fact that the application is subject to acceptance or approval by the insurer.

20. An advertisement of accident and sickness insurance sold by direct response shall not state or imply that because no insurance producer will call and no commissions will be paid to producers that it is a low cost plan, or use other similar words or phrases because the cost of advertising and servicing the policies is a substantial cost in the marketing by direct response.

21. Applications, request forms for additional information and similar related materials are prohibited if they resemble paper currency, bonds, stock certificates, etc., or use any name, service mark, slogan, symbol or device in a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the U.S. Department of Health and Human Services.

22. An advertisement that implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical or surgical insurance coverage is prohibited.

23. An advertisement that uses words such as “extra”, “special” or “added” to describe a benefit in the policy is prohibited. No advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall use words or phrases such as “tax-free”, “extra cash”, “extra income”, “extra pay”, or substantially similar words or phrases because these words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

24. An advertisement of a hospital or other similar facility confinement benefit shall not advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless the statements of the monthly or weekly benefit amounts are in juxtaposition with equally prominent statements of the benefit payable on a daily basis. When the policy contains a limit on the number of days of coverage provided, the limit shall appear in the advertisement.

25. An advertisement of a policy covering only one disease or a list of specified diseases shall not imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

26. An advertisement that is an invitation to contract for a specified disease policy that provides lesser benefit amounts for a particular subtype of disease, shall clearly disclose the subtype and its benefits. This provision shall not apply to institutional advertisements.

27. An advertisement of a specified disease policy providing expense benefits shall not use the term “actual” when the policy only pays up to a limited amount for expenses. Instead, the term “charges” or substantially similar language should be used that does not create the misleading impression that there is full coverage for expenses.

28. An advertisement that describes any benefits that vary by age shall disclose that fact.

29. An advertisement that uses a phrase such as “no age limit”, if benefits or premiums vary by age or if age is an underwriting factor, shall disclose that fact.

30. A television, radio, internet, mail or newspaper advertisement or lead-generating device that is designed to produce leads either by use of a coupon, a request to write or e-mail or to call the insurer or a subsequent advertisement prior to contact shall include information disclosing that a producer may contact the applicant.

31. Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had his or her eligibility for the insurance individually determined in advance when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list.

32. An advertisement, including invitations to inquire or invitations to contract, shall not employ devices that are designed to create undue fear or anxiety in the minds of those to whom they are directed. Examples of prohibited devices are:

    a. The use of phrases such as “cancer kills somebody every two minutes” and “total number of accidents” without reference to the total population from which the statistics are drawn;

    b. The exaggeration of the importance of diseases rarely or seldom found in the class of persons to whom the policy is offered;

    c. The use of phrases such as “the finest kind of treatment”, implying that the treatment would be unavailable without insurance;

    d. The reproduction of newspaper articles, magazine articles, information from the Internet or other similar published material containing irrelevant facts and figures;

    e. The use of images that unduly emphasize automobile accidents, disabled persons or persons confined in beds who are in obvious distress, persons receiving hospital or medical bills or persons being evicted from their homes due to their medical bills;

f. The use of phrases such as “financial disaster”, “financial distress”, “financial shock”, or another phrase implying that financial ruin is likely without insurance is only permissible in an advertisement for major medical expense coverage, individual basic medical expense coverage or disability income coverage, and only if the phrase does not dominate the advertisement;

g. The use of phrases or devices that unduly excite fear of dependence upon relatives or charity; and

h. The use of phrases or devices that imply that long sicknesses or hospital stays are common among the elderly.

B. Exceptions, Reductions and Limitations

1. An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a “benefit builder” or stating “even preexisting conditions are covered after two years”. Words and phrases used in an advertisement to describe the policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered.

2. An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy.

3. When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement that is subject to the requirements of Section 7.B.2. shall prominently disclose the existence of such periods.

4. An advertisement shall not use the words “only”, “just”, “merely”, “minimum”, “necessary” or similar words or phrases to describe the applicability of any exceptions, reductions, limitations or exclusions such as: “This policy is subject to the following minimum exceptions and reductions.”

5. An advertisement that is an invitation to contract that fails to disclose the amount of any deductible or the percentage of any coinsurance factor is prohibited.

6. An advertisement for loss-of-time coverage that is an invitation to contract that sets forth a range of amounts of benefit levels is prohibited unless it also states that eligibility for the benefits is based upon condition of health, income or other economic conditions, or other underwriting standards of the insurer if that is the fact.

7. An advertisement that refers to “hospitalization for injury or sickness” omitting the word “covered” when the policy excludes certain sicknesses or injuries, or that refers to “whenever you are hospitalized”, “when you go to the hospital”, or “while you are confined in the hospital” omitting the phrase “for covered injury or sickness”, if the policy excludes certain injuries or sicknesses, is prohibited. Continued reference to “covered injury or sickness” is not necessary where this fact has been prominently disclosed in the advertisement and where the description of sicknesses or injuries not covered is prominently set forth.

8. An advertisement that fails to disclose that the definition of "hospital" does not include certain facilities that provide institutional care such as a nursing home, convalescent home or extended care facility, when the facilities are excluded under the definition of hospital in the policy, is prohibited.

9. The term "confining sickness" shall be explained in an advertisement containing the term. The explanation might be as follows: "Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors." Captions such as "Lifetime Sickness Benefits" or "Five-Year Sickness Benefits" are incomplete if the benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as "Lifetime House Confining Sickness Benefits" or "Five-Year House Confining Sickness Benefits" would be permissible.

10. An advertisement that fails to disclose any waiting or elimination periods for specific benefits is prohibited.

11. An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, or other policies providing benefits that are limited in nature, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "THIS IS A LIMITED POLICY", "THIS POLICY PROVIDES LIMITED BENEFITS", or "THIS IS A CANCER ONLY POLICY".

    Some advertisements disclose exceptions, reductions and limitations as required, but the advertisement is so lengthy as to obscure the disclosure. Where the length of an advertisement has this effect, special emphasis must be given by changing the format to show the restrictions in a manner that does not minimize, render obscure or otherwise make them appear unimportant.

C. Preexisting Conditions

1. An advertisement that is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered if the cause of the loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used.

    Negative features must be accurately set forth. Any limitation on benefits including preexisting conditions also must be restated under a caption concerning exclusions or limitations, notwithstanding that the preexisting condition exclusion has been disclosed elsewhere in the advertisement.

2. When an accident and sickness insurance policy does not cover losses resulting from preexisting conditions, an advertisement of the policy shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim under the policy. This regulation prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "guaranteed-issue". If an insurer requires a medical examination for a specified policy, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required.

3. When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement that reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, the application form shall contain a question or statement substantially as follows:

"Do you understand that this policy will not pay benefits during the first [insert number] [years, months] after the issue date for a disease or physical condition that you now have or have had in the past?

"YES"

Or substantially the following statement:

"I understand that the policy applied for will not pay benefits for any loss incurred during the first [insert number] [years, months] after the issue date on account of disease or physical condition that I now have or have had in the past."

Section 8 Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination

A. An advertisement that is an invitation to contract shall disclose the provisions relating to renewability, cancellability and termination, and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that shall not minimize or render obscure the qualifying conditions.

B. Advertisements of cancellable accident and sickness insurance policies shall state that the insurer may cancel or renew the contract using language substantially similar to the following: "This policy is renewable at the option of the company.", or "The company has the right to refuse renewal of this policy.", or "Renewable at the option of the insurer.", or "This policy can be cancelled by the company at any time."

C. Advertisements of insurance policies that are guaranteed renewable, cancellable or renewable at the option of the insurer shall disclose that the insurer has the right to increase premium rates if the policy so provides.

D. Qualifying conditions that constitute limitations on the permanent nature of the coverage shall be disclosed in advertisements of insurance policies that are guaranteed renewable, cancellable or renewable at the option of the insurer. Examples of qualifying conditions include, but are not limited to age limits; reservation of a right to increase premiums; and the establishment of aggregate limits.

1. Provisions for reduction of benefits at stated ages shall be set forth. For example, a policy may contain a provision that reduces benefits fifty percent (50%) after age sixty (60) although it is renewable to age sixty-five (65). Such a reduction shall be set forth. Also, a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time shall be set forth.

2. An advertisement for a policy that provides for step-rated premium rates based upon the policy year or the insured's attained age shall disclose the rate increases and the times or ages at which the premiums increase.

Section 9 Standards for Marketing

A. An insurer, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its producers will be fair and accurate;

2. Establish marketing procedures assuring excessive insurance is not sold or issued, except this requirement does not apply to group health benefit plans and disability income coverage; and

3. Establish auditable procedures for verifying compliance with Section 9.

B. The following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or tending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy, or to take out a policy of insurance with another insurer;

2. High Pressure Tactics. Employing a method of marketing that has the effect of inducing the purchase of insurance, or tends to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

3. Cold Lead Advertising. Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurer.

4. The marketing of any health coverage plan which is not ACA-compliant as an alternative to, or a substitute for, a health benefit plan which meets federal and state requirements under the ACA.

C. Summary of Benefits and Coverage (SBC)

1. The SBC form and the Colorado Supplement to the Summary of Benefits and Coverage form must be in compliance with the requirements of state and federal law, and Colorado Insurance Regulation 4-2-20.

2. The SBC must contain, in plain language, simple and consistent information about the benefits and coverage of the stated health benefit plan as specified in 45 C.F.R. § 147.200(a).

2. If upon review the Division finds that an SBC or the Colorado Supplement to the Summary of Benefits form is misleading, deceptive, or misrepresentative of the benefits in the stated health benefit plan, the submitting insurer may be found to have violated the marketing standards found at § 10-3-1104, C.R.S.

Section 10 Testimonials or Endorsements by Third Parties

A. Testimonials and/or endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained in it, and the advertisement, including the statement, is subject to all of the provisions of this regulation. When a testimonial or endorsement is used more than one (1) year after it was originally given, a confirmation must be obtained.

B. A person shall be deemed a “spokesperson” if the person making the testimonial or endorsement:

1. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise;

2. Has been formed by the insurer, is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer;

3. Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or

4. Is in any way directly or indirectly compensated for making a testimonial or endorsement.

C. Any person or agency acting as a spokesperson, as defined in Section 10.B., who performs any of the following acts in an advertisement shall be considered soliciting an insurance product, and such person or agency shall be a licensed insurance producer or agency pursuant to Colorado insurance law:

1. Individual who solicits, negotiates, effects, procures, delivers, renews, continues or binds; or

2. A corporation, partnership, association, or other legal entity transacting the business of insurance.

D. The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the fact shall be disclosed in the advertisement by language substantially such as follows: “Paid Endorsement”. The requirement of this disclosure may be fulfilled by use of the phrase “Paid Endorsement” or words of similar import in a type style and size at least equal to that used for the spokesperson’s name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure shall be accomplished in the introductory portion of the advertisement and shall be given prominence.

E. The disclosure requirements of this regulation shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually the scale for TV or radio performances.

F. An advertisement shall not state or imply that an insurer or an accident and sickness insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed.

G. When a testimonial refers to benefits received under an accident and sickness insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of four (4) years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible.

Section 11 Use of Statistics

A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to an insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the current and relevant facts. The advertisement shall not imply that the statistics are derived from the policy advertised unless that is the fact, and when applicable to other policies or plans, shall specifically so state.

1. An advertisement shall specifically identify the accident and sickness insurance policy to which statistics relate and where statistics are given that are applicable to a different policy, it shall be stated clearly that the data does not relate to the policy being advertised.

2. An advertisement using statistics that describe an insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, shall be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for accident and sickness insurance that refers to the amount of life insurance which the insurer has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.

B. An advertisement shall not represent or imply that claim settlements by the insurer are “liberal” or “generous”, or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in the advertisement.

Section 12 Identification of Plan or Number of Policies

A. An advertisement that uses the word “plan” without prominently identifying it as an accident and sickness insurance policy is prohibited.

B. When a choice of the amount of benefits is referred to, an advertisement that is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

C. When an advertisement that is an invitation to contract refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement shall disclose that the benefits are provided only though a combination of policies.

Section 13 Disparaging Comparisons and Statements

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

A. An advertisement shall not contain statements such as “no red tape” or “here is all you do to receive benefits”.

B. Advertisements that state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are prohibited unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages.

C. Advertisements that state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are prohibited.

Section 14 Jurisdictional Licensing and Status of Insurer

A. An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of the state or the federal government. Terms such as "official" or words of similar import, used to describe any policy or application form are prohibited because of the potential for deceiving or misleading the public.

C. An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. Approval of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition.

D. For purposes of Section 14 and the multistate plan provisions of the ACA, a contract between the Office of Personal Management and a multistate insurer does not constitute approval, endorsement or accreditation by the federal government.

Section 15 Identity of Insurer

A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

B. An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government.

C. Advertisements, envelopes or stationery that employ words, letters, initials, symbols or other devices that are similar to those used in governmental agencies or by other insurers are not permitted if they may lead the public to believe:

1. That the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers; or

2. That the advertiser is the same as is connected with or is endorsed by the governmental agencies or the other insurers.

D. An advertisement shall not use the name of a state or political subdivision of a state in a policy name or description.

E. An advertisement in the form of envelopes or stationery of any kind may not use any name, service mark, slogan, symbol or any device in a manner that implies that the insurer or the policy advertised, or that any producer who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.

F. An advertisement may not incorporate the word “Medicare” in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating it from Medicare. The advertisement, however, shall not use the phrase “[ ] Medicare Department of the [ ] Insurance Company”, or language of similar import.

G. An advertisement may not imply that the reader may lose a right or privilege or benefit under federal, state or local law if he or she fails to respond to the advertisement.

H. The use of letters, initials or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark.

I. The use of the name of an agency or “[ ] Underwriters” or “[ ] Plan” in type, size and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer is prohibited.

J. The use of an address so as to mislead or deceive as to true identity of the insurer, its location or licensing status is prohibited.

K. An insurer shall not use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

L. Advertisements used by producers of an insurer shall have prior written approval of the insurer before they may be used.

M. A producer who makes contact with a consumer, as a result of acquiring that consumer’s name from a lead-generating device, shall disclose that fact in the initial contact with the consumer. A producer or insurer may not use names produced from lead-generating devices that do not comply with the requirements of this regulation.

Section 16 Group or Quasi-Group Implications

A. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as members, enjoy special rates or underwriting privileges, unless that is the fact.

B. This regulation prohibits the solicitations of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

C. Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited.

D. An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage when that is not the fact.

E. Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact.

Section 17 Introductory, Initial or Special Offers

A. An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. An advertisement shall not contain phrases describing an enrollment period as "special", "limited", or similar words or phrases when the insurer uses the enrollment periods as the usual method of marketing accident and sickness insurance.

B. This regulation prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless that is the fact.

C. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

D. Special awards, such as a "safe drivers' award", shall not be used in connection with advertisements of accident and sickness insurance.

Section 18 Statements about an Insurer

An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations.

Section 19 Enforcement Procedures

Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in another state, with a notation attached to each advertisement that indicates the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to regular and periodical inspection by the Commissioner. All of these advertisements shall be maintained in a file for a period of either four (4) years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

Section 20 Severability

If any provisions of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 21 Incorporated Materials

45 C.F.R. § 147.200(a) shall mean 45 C.F.R. § 147.200(a) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 147.200(a). A copy of 45 C.F.R. § 147.200(a) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 45 C.F.R. § 147.200(a) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 22 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 23 Effective Date

This regulation is effective February 1, 2020.

Section 24 History

Originally issued as Regulation 75-2, effective December 22, 1975.
Renumbered as Regulation 4-2-3, effective June 1, 1992.
Amended regulation, effective July 1, 1993.
Repealed and Repromulgated in full, effective February 1, 2001.
Amended regulation, effective August 1, 2001.
Amended regulation, effective February 1, 2003.
Amended regulation, effective May 1, 2010.
Amended regulation, effective October 1, 2013.
Amended regulation, effective April 15, 2014.
Amended regulation, effective February 1, 2020.

Regulation 4-2-5 [Repealed eff. 05/01/2010]

Regulation 4-2-6 CONCERNING THE DEFINITION OF THE TERM "COMPLICATIONS OF PREGNANCY"

Section 1 Authority

This amended regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-1110 and 10-16-109 and, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to standardize the definition of the term "complications of pregnancy" as used in sickness and accident insurance policies covering residents of this state consistent with the commonly perceived connotation of this term by the general public.

Section 3 Applicability

This regulation shall apply to all companies and entities marketing or selling sickness and accident policies providing coverage for disability due to sickness issued by an entity subject to the provisions of Part 2 of Article 16 of Title 10, and to those companies and entities marketing or selling individual or group services or indemnity contracts subject to the provisions of Part 3 of Article 16 of Title 10.

Section 4 Definitions

For the purposes of this regulation "complications of pregnancy" shall mean:

A. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy;

B. Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Section 5 Rules

All companies marketing sickness and accident insurance policies, as defined in this regulation, delivered or issued for delivery in the State of Colorado shall use in each insurance policy or certificate of insurance a definition of the complications of pregnancy no more restrictive than that required by this regulation, and must be in compliance with the requirements found at § 10-16-104(2), C.R.S.

Section 6 Severability

If any provisions of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This amended regulation shall become effective February 1, 2016.

Section 9 History

Originally issued as Regulation 78-16, effective June 30, 1979.
Amended Regulation 78-16, effective October 1, 1983.
Renumbered as Regulation 4-2-6, effective June 1, 1992.
Amended effective November 1, 2000.
Regulation amended, effective March 2, 2010.
Regulation amended effective February 1, 2016.

Regulation 4-2-8 CONCERNING REQUIRED HEALTH INSURANCE BENEFITS FOR HOME HEALTH SERVICES AND HOSPICE CARE

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-16-104(8)(d), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which state clearly and completely the criteria for and extent of coverage for home health services and hospice care and to facilitate prompt and informed decisions regarding patient placement and discharge.

Section 3 Applicability

The requirements of this regulation shall apply to:

A. Insurers subject to the provisions of Part 2 of Article 16 of Title 10, C.R.S. and non-profit hospital, medical surgical, and health service corporations subject to the provisions of Part 3 of Article 16 of Title 10, C.R.S., which provide: hospital, surgical or major medical coverage on an expense incurred basis, except as noted in paragraph B below, issued on or after the effective date hereof and to all such policies renewed after said date, unless the insurer certifies in writing to the Commissioner of Insurance that it no longer issues the type of policy being renewed. “Renewed” or “renewal” means to continue coverage for an additional policy period upon expiration of the current policy period of a policy.

B. This regulation does not apply to the following:

1. Medicare supplement policies issued under § 10-18-101 et seq., C.R.S.;

2. Credit accident and health policies issued under § 10-10-101 et seq., C.R.S.;

3. This regulation does not apply to health benefit plans as defined at § 10-16-102(32), C.R.S.; and

4. Any insurance policy, contract, or certificate which provides coverage exclusively for:

a. Disability loss of income;

b. Dental services;

c. Optical services;

d. Hospital confinement indemnity;

e. Accident only; or

f. Prescription drug services.

Section 4 Definitions

A. "Benefit period" means, for purposes of this regulation, a hospice care service period of ninety (90) days, during which services are provided on a regular basis.

B. "Bereavement" means, for purposes of this regulation, that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered during the bereavement period.

C. "Core services" means, for purposes of this regulation, nursing services, pastoral services, trained volunteers, and psychosocial services routinely provided by hospice staff or volunteers.

D. "Evaluation" means, for purposes of this regulation, an objective, formal and regular assessment of the functioning of the organization and of the provision of hospice care.

E. "Home care services" means, for purposes of this regulation, hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

F. "Home health agency" means, for purposes of this regulation, an agency which has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act", as amended, for licensed or certified home health agencies and which is engaged in arranging and providing nursing services, home health aide services and other therapeutic and related services.

G. "Home health services" means, for purposes of this regulation, the following services provided by a certified home health agency under a plan of care to eligible persons in their place of residence:

1. Skilled nursing services;

2. Certified and licensed nurse aide services, as defined in § 12-38.1-102(3), C.R.S.;

3. Physical therapy, occupational therapy, or speech and language pathology services, as such therapy and services are defined in § 12-43.7-101, et seq, C.R.S.;

4. Social Work Practice services, as defined in § 12-43-403,C.R.S., by a licensed social worker. "Licensed Social Worker" shall have the same meaning as provided in § 12-43-201(5.5), C.R.S.; and

5. Medical supplies, equipment and appliances suitable for use in the home.

H. "Home health visit" means, for purposes of this regulation, each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services of up to four (4) hours by a home health aide shall be considered as one visit.

I. "Homemaker services" means, for purposes of this regulation, services provided to the patient, which include:

1. General household activities including the preparation of meals and routine household care; and

2. Teaching, demonstrating and providing patient/family with household management techniques that promote self-care, independent living and good nutrition.

J. "Hospice" means, for purposes of this regulation, a facility or service licensed by the Department of Public Health and Environment under a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychosocial, spiritual, and bereavement care for terminally ill individuals and their families to be available 24 hours, 7 days a week. Hospice services shall be provided in the home, a hospice facility, and/or other licensed health facility. Hospice services include but shall not necessarily be limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral counseling, trained volunteer, and social services.

K. "Hospice care" means, for purposes of this regulation, an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care is not limited to medical intervention, but addresses physical, psychosocial, and spiritual needs of the patient. Hospice care is planned, implemented and evaluated by an interdisciplinary team of professionals and volunteers.

L. Hospice levels of care:

1. "Routine home care" means, for purposes of this regulation, the level of care a patient/family receives according to the interdisciplinary team's plan of care each day the patient is at home and not receiving continuous home care.

2. "Continuous home care" means, for purposes of this regulation, the level of care received by the patient during a period of medical crisis to achieve palliation and management of acute medical symptoms. The preponderance of care must be nursing care (at least half) and care must be provided for a period of at least eight hours (need not be consecutive) in one calendar day. Home health aide and homemaker services, or both, may be provided to supplement nursing care.

3. "Inpatient hospice respite care" means, for purposes of this regulation, the level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. Inpatient respite care may be provided only on an intermittent, non-routine, short-term basis. It may be limited to periods of five days or less.

4. "General inpatient hospice care" means, for purposes of this regulation, the level of care the patient receives when short-term inpatient care for pain control or acute symptom management cannot be achieved in the home. This level of care must be provided in a licensed facility with the approval of the physician and the hospice.

M. "Hospice per diem rate" means, for purposes of this regulation, the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

N. "Inpatient hospice facility" means, for purposes of this regulation, a facility which shall directly provide inpatient services and may provide any or all of the continuum of hospice services as described in Section 4.E. These services are provided twenty-four (24) hours a day and, to the extent possible, in a homelike setting.

O. "Inpatient services" means, for purposes of this regulation, hospice services provided to patient/families who require twenty-four (24) hour nursing supervision in a licensed hospice facility or other licensed health facility. In the event that a hospice provides inpatient services in a licensed health facility other than a hospice, such hospice shall maintain administrative control of and responsibility for the provision of all hospice services.

P. "Interdisciplinary team" means, for purposes of this regulation, a group of qualified individuals, which shall include, but is not limited to, a physician, registered nurse, clergy/counselors, social workers, volunteer director, and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of hospice patient/families.

Q. "Palliative services" means, for purposes of this regulation, those services and/or interventions which are not curative but which produce the greatest degree of relief from pain and other symptoms of the terminal illness.

R. "Patient" means, for purposes of this regulation, an individual in the terminal stage of illness who has an anticipated life expectancy of six (6) months or less and who alone or in conjunction with a family member or members, has voluntarily agreed to admission and been accepted into a hospice.

S. "Patient/family" means, for purposes of this regulation, one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties.

T. "Personal care" means services provided to a patient in his or her home to meet the patient's physical requirements and/or to accommodate a patient's maintenance or supportive needs.

U. "Unrelated illness" means, for purposes of this regulation, a diagnosed condition, which is not a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness.

Section 5 Requirements for Home Health Services

A. General Policy Provisions Pertaining to Home Health Care.

1. The policy offering shall provide that home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization. Prior hospitalization shall not be required.

2. The policy offering shall require, as a condition of coverage that home health care services are to be rendered pursuant to a physician's written order, under a plan of care established by the physician in collaboration with a home health care provider.

3. The policy offering may use case management requirements including, but not limited to, authorization of benefits prior to the beginning of services and review of treatment at periodic intervals.

4. The policy may require that all home health services included in the plan of care be coordinated by the home health agency.

B. Benefits for Home Health Care Services.

1. Benefit levels for home health care services shall not be less than the deductible, coinsurance and stop loss provisions of the overall policy or certificate.

2. The policy or certificate may contain a limitation on the number of home health visits, but no policy offered may provide for fewer than sixty (60) home health visits in any calendar year.

3. The policy offered shall include benefits for the following services:

   a. Skilled nursing services provided by a Registered or Licensed Nurse;

   b. Certified nurse aide services;

   c. Physical therapy;

   d. Occupational therapy;

   e. Speech and language pathology;

   f. Respiratory and inhalation therapy;

   g. Nutrition counseling by a nutritionist or dietitian;

   h. Social work practice services;

   i. Medical supplies;

   j. Prosthesis and orthopedic appliances; and

   k. Rental or purchase of durable medical equipment.

4. The services identified in subsections B.3.i. through B.3.l. of this section may be included elsewhere in the policy, rather than specifically in the home health benefit provisions.

C. Limitations and Exclusions.

1. Benefits for home health services may be governed by policy or certificate limitations and exclusions, including but not limited to, exclusion for non-skilled personal care and conditions for surgery excluded in the policy or certificate.

2. The following items need not be considered as eligible expenses under home health care benefits:

   a. Services or supplies for personal comfort or convenience, including homemaker services;

   b. Services related to well-baby care; and

   c. Food services or meals other than dietary counseling excluding tube feedings.

Section 6 Requirements for Hospice Care

A. General Provisions Pertaining to Hospice Care.

1. The policy offering shall provide that hospice care services are to be covered when such services are provided under active management through a hospice which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished.

2. The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six (6) months or less, except that benefits may exceed six (6) months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.

3. The policy offering shall require a physician's certification of the patient's illness, including a prognosis for life expectancy and the appropriateness for hospice care. The insurer may also require a copy of the patient's plan of care and any changes made to the level of care or to the plan of care.

4. The policy offering may use case management requirements including, but not limited to, authorization of benefits prior to the beginning of services and review of care at periodic intervals.

5. The policy offering shall clearly indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

B. Benefits for Hospice Care Services.

1. Benefits for hospice care services shall be governed by the deductible, coinsurance and stop-loss provisions of the overall policy or certificate. The details of these provisions will be forwarded and updated to the provider upon authorization of benefits.

2. The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. Any policy offered shall provide a benefit of no less than $150 per day for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:

   a. Intermittent and twenty-four (24) hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;

   b. Intermittent and twenty-four (24) hour on-call social/counseling services: and;

   c. Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.

      The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety (90) days.

3. The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:

   a. Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than $1400.

b. Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in subsection 2 of this section). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

c. Medical supplies;

d. Drugs and biologicals;

e. Prosthesis and orthopedic appliances;

f. Oxygen and respiratory supplies;

g. Diagnostic testing;

h. Rental or purchase of durable equipment;

i. Transportation;

j. Physicians services;

k. Therapies including physical, occupational and speech; and

l. Nutritional counseling by a nutritionist or dietitian.

C. Limitations and Exclusions.

Benefits for hospice care services shall be governed by policy or certificate limitations and exclusions, to the extent that such policy or certificate is not in conflict with the statutory mandate that hospice care be offered with the minimum benefits required by this regulation. The insurer must notify the hospice in writing of any such limitation of benefits, and must do so within two business days of a request to determine if specific services are excluded or authorized under the coverage.

Section 7 Additional Requirements for Home Health Care Services and Hospice Care

A. The offer to a policyholder to purchase home health care and hospice care coverage must be in writing, either by means of a prominent statement or question on the application for the policy or on a separate form.

B. Nothing in this regulation shall prohibit the insurer from offering a higher level of benefits than required herein.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspension or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

The effective date of this regulation is January 1, 2014.

Section 11 History

Originally issued as Colorado Regulation 85-6, effective Oct 1, 1985.
Amended October 1, 1986.
Renumbered as Colorado Regulation 4-2-8, July 1, 1992.
Amended August 1, 1993.
Amended February 1, 1994.
Amended February 1, 2001.
Amended regulation, effective March 2, 2011.
Amended regulation, effective January 1, 2014.

Regulation 4-2-9 CONCERNING NON-DISCRIMINATORY TREATMENT OF ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) AND HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED ILLNESS BY LIFE AND HEALTH CARRIERS

Section 1 Authority

This amended regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-3-1104.5(3)(d)(II) and 10-3-1110, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish standards that will assure non-discriminatory treatment with respect to AIDS and HIV infection in underwriting practices, policy forms and benefit provisions utilized by entities subject to the provisions of this regulation. It also establishes what HIV/AIDS medical tests, permitted under § 10-3-1104.5, C.R.S., are considered medically reliable for underwriting decisions.

Section 3 Applicability

This regulation applies to all entities that provide life or a policy of sickness and accident insurance 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, a life or annuity company, and any other entity providing a life policy, annuity, or a policy of sickness and accident insurance subject to the insurance laws and regulations of Colorado.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

C. “Insurance coverage” shall mean life insurance policies, annuities, policies of sickness and accident insurance, and other coverage that is not a health benefit plan.

D. “Person” shall have the same meaning as found at § 10-3-1104.5(2)(f), C.R.S.

E. “Policy of sickness and accident insurance” shall have the same meaning as found at §10-16-102(50), C.R.S.

Section 5 Rules

A. No person, their agent or employee shall make any inquiry or investigation to determine an insurance applicant's sexual orientation.

B. Sexual orientation may not be used in the underwriting process or in the determination of insurability.

C. Insurance support organizations shall be directed by insurers and carriers to not investigate, directly or indirectly, the sexual orientation of an applicant or a beneficiary. All persons shall give written notice to their agents and employees who conduct investigations of applicants for insurance coverage, that they shall not investigate, either directly or indirectly, the sexual orientation of an applicant or beneficiary.

D. No question shall be used which is designed to establish the sexual orientation of the applicant.

E. Questions relating to the applicant having or having been diagnosed as having AIDS or HIV infection are permissible if they are designed solely to establish the existence of the condition. For example, straightforward questions on applications are acceptable, such as, “Have you had or been told by a member of the medical profession that you have AIDS or HIV infection?” or “Have you received treatment from a member of the medical profession for AIDS or HIV infection?” are acceptable.

F. Questions relating to medical and other factual matters intending to reveal the possible existence of a medical condition are permissible if they are not used as a proxy to establish the sexual orientation of the applicant, and the applicant has been given an opportunity to provide an explanation for any affirmative answers given in the application. For example: “Have you had chronic cough, significant weight loss, chronic fatigue, diarrhea, enlarged glands?” These types of questions should be related to a finite period of time preceding completion of the application and should be specific. Such questions should provide the applicant the opportunity to give a detailed explanation.

G. Persons may not use an applicant's marital status, living arrangements, occupation, gender, medical history, beneficiary designation, or zip code or other territorial classification to establish, or aid in establishing, the applicant's sexual orientation.

H. For the purpose of rating an applicant for health and life insurance, a person may impose territorial rates only if the rates are based on sound actuarial principles or are related to actual or reasonably anticipated experience.

I. No adverse underwriting decision shall be made because medical records or any investigation or report indicates that the applicant has demonstrated AIDS or HIV infection related concerns by seeking counseling from health care professionals. Neither shall an adverse underwriting decision be made on the basis of such AIDS or HIV infection related concerns unless a medical test which is a reliable predictor of infection, as defined in subsection J. of this section, has been administered. This subsection does not apply to an applicant seeking treatment and/or diagnosis.

J. Reliable predictors of infection are delineated in § 10-3-1104.5(3)(d)(I), C.R.S. Pursuant to § 10-3-1104.5(3)(d)(II), C.R.S., the Commissioner designates the following tests, approved by the Colorado Department of Public Health and Environment, as equally reliable predictors of AIDS or HIV infection:

1. A positive HIV-1 p24 antigen test, as defined by the U.S. Department of Public Health and Human Services, Center for Disease Control and Prevention (The Morbidity and Mortality Weekly Report, Volume 95, March 1, 1996).

2. A positive licensed polymerase chain reaction assay for HIV levels in the serum.

3. Two positive or repeatedly reactive commercially licensed serum, oral fluid or urine ELISA or EIA tests and either:

a. For serum or oral fluid specimens, a Western Blot test with bands present at any two of p24, gp41 or gp120/gp160;

b. for urine specimens, a Western Blot test with bands present at gp160, or

c. for serum specimens, a positive HIV 1/2 Multispot test.

K. To be used for issuing or underwriting a policy, a test described in subsection J. of this section must have been licensed by the U.S. Food and Drug Administration as of the effective date of this regulation. A list of such tests is attached as Appendix A.

L. If a specific test licensed by the U.S. Food and Drug Administration indicates the presence of the HIV infection or medical condition indicative of the HIV infection, the person shall, before relying on a single test result to deny or limit coverage or to rate the coverage, follow the U.S. Food and Drug Administration confirmation protocols licensed as of the effective date of this regulation and shall use any applicable confirmatory tests or series of tests licensed as of the effective date of this regulation by the U.S. Food and Drug Administration to confirm the indication. The confirmation protocols and applicable follow-up test regimens are attached as Appendix A.

M. If an applicant is required to take an AIDS or HIV infection test in connection with an application for life or health insurance, the use of such test must be revealed to the applicant and his or her written consent obtained. Test results shall be strictly confidential medical information. However, this regulation is not intended nor should it be interpreted as prohibiting reporting HIV infection to state and local departments of health as provided in § § 25-4-1402 and 25-4-1403, C.R.S.

N. Persons subject to this regulation may include questions on applications as to whether or not the applicant has tested positive on an AIDS or HIV infection test. However, in the event of an affirmative response, no adverse underwriting decisions shall be made on the basis of such response unless it can be determined that the test protocols in subsections J. and K. of this section above, have been followed.

O. Insurance coverage which excludes or limits coverages for expenses related to the treatment of AIDS and HIV related illness or complications of AIDS, e.g., opportunistic infection resulting from AIDS, shall not be issued for use in Colorado, except to the extent that such exclusions or limitations are consistent with the exclusions or limitations applicable to other covered illnesses or conditions covered by the policy or certificate.

Section 6 Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Incorporated Materials

The Morbidity and Mortality Weekly Report, Volume 95, March 1, 1996 published by U.S. Department of Public Health and Human Services, Center for Disease Control and Prevention shall mean Morbidity and Mortality Weekly Report, Volume 95, March 1, 1996 as published on the effective date of this regulation and does not include later amendments to or editions of Morbidity and Mortality Weekly Report, Volume 95, March 1, 1996. A copy of the Morbidity and Mortality Weekly Report, Volume 95, March 1, 1996 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of Morbidity and Mortality Weekly Report, Volume 95, March 1, 1996 may be requested from Centers for Disease Control and Prevention, 1600 Clifton Rd., Atlanta, GA 30333. A charge for certification or copies may apply.

A copy of the Morbidity and Mortality Weekly Report, Volume 95, March 1, 1996 may be examined at any state publications depository library.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation as amended is effective November 15, 2013.

Section 10 History

Originally issued as Regulation 87-2, effective January 1, 1988.
Renumbered as Regulation 4-2-9, effective June 1, 1992.
Amended Section IV(J), effective February 1, 1995.
Amended Regulation, effective March 2, 1999.
Amended Regulation, effective May 1, 2010.
Amended Regulation, effective July 1, 2012.
Amended Regulation effective November 15, 2013.

Appendix A

FDA Licensed/Approved HIV Tests for Colorado Regulation 4-2-9
Published as of 7/16/2013
Human Immunodeficiency Virus Type 1 (Anti-HIV-1 Assay)

Trade name(s) (Labeling may be out of date)	Infec-tious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
GS rLAV EIA	HIV-1	EIA	Serum / Plasma	Donor Screen (serum/plasma). Diagnostic (Dried blood spot).	Bio-Rad Laboratories Redmond, WA US License 1109	6/29/1998	BL102866/1031 , BL102866/1032
Fluorognost HIV-1 IFA	HIV-1	IFA	Serum / Plasma	Donor Supplemental. Donor Screen (Only in special cases).	Sanochemia Pharmazeutika AG Vienna, Austria US License 1631	2/5/1992	BL103288/0
Cambridge Biotech HIV-1 Western Blot Kit	HIV-1	WB	Serum / Plasma	Donor Supplemental. Diagnostic supplemental.	Maxim Biomedical, Inc. Rockville, MD US License 1741	2/25/1999	BL103843
GS HIV-1 Western Blot	HIV-1	WB	Serum / Plasma	Donor Supplemental	Bio-Rad Laboratories Redmond, WA US License 1109	11/13/1998	BL103655/0
Avioq HIV-1 Microelisa System	HIV-1	EIA	Serum, Plasma, Dried blood spot, Oral Fluid	Diagnostic: For the qualitative detection of antibodies to Human Immunodeficiency Virus Type 1 (HIV-1) in human specimens collected as serum, plasma, dried blood spots, or oral fluid specimens obtained with OraSure®.HIV-1 Oral Specimen Collection Device	Avioq Inc., Rockville, MD	9/21/2009	BP090022/0
HIVAB HIV-1 EIA	HIV-1	EIA	Dried Blood Spot	Diagnostic	Abbott Laboratories Abbott Park, IL US License 0043	4/22/1992	BL103404/0

Maxim Biotech HIV-1 Urine EIA	HIV-1	EIA	Urine	Diagnostic	Maxim Biomedical, Inc. Rockville, MD US License 1741	1/3/1991	BP000009
INSTI™ HIV-1 Antibody Test Kit	HIV-1	Rapid Immunoassay	Plasma / Whole Blood (venipuncture and finger stick)	Diagnostic: For the detection of antibodies to Human Immunodeficiency Virus Type 1 (HIV-1) in human venipuncture whole blood, finger stick blood, or plasma specimens.	bioLytical Laboratories Inc. British Columbia, Canada V6V 2X7	11/29/2010	BP090032/0
Reveal Rapid HIV-1 Antibody Test15	HIV-1	Rapid Immunoassay	Serum / Plasma	Diagnostic	MedMira Laboratories, Inc. Halifax, Nova Scotia Canada B3S 1B3	4/16/2003	BP000023/0
Uni-Gold Recombigen HIV	HIV-1	Rapid Immunoassay	Serum / Plasma / Whole Blood (venipuncture and finger stick)	Diagnostic	Trinity Biotech, plc Bray Co., Wicklow, Ireland	12/23/2003	BP030025/0
GS HIV-1 Western Blot	HIV-1	WB	Dried Blood Spot	Diagnostic Supplemental	Bio-Rad Laboratories Redmond, WA US License 1109	11/13/1998	BL103655/0
Fluorognost HIV-1 IFA	HIV-1	IFA	Dried Blood Spot	Diagnostic Supplemental	Sanochemia Pharmazeutika AG Vienna, Austria US License 1631	5/14/1996	BL103651/0
OraSure HIV-1 Western Blot Kit	HIV-1	WB	Oral Fluid	Diagnostic Supplemental	OraSure Technologies Bethlehem, PA	6/3/1996	BP950004/0
Cambridge Biotech HIV-1 Western Blot Kit	HIV-1	WB	Urine	Diagnostic Supplemental	Maxim Biomedical, Inc. Rockville, MD US License 1741	6/21/2001	BP010009/0

Human Immunodeficiency Virus Type 1 (HIV-1 Nucleic Acid Assay) - see Multiplex Assays also, below

Trade name(s) (Labeling may be out of date)	Infec-tious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
Human Immunodeficiency Virus, Type 1 (HIV-1) Reverse Transcription (RT) Polymerase Chain Reaction (PCR) Assay	HIV-1	PCR	Plasma	Donor Screen: Qualitative detection of HIV-1 ribonucleic acid (RNA) in pools of human Source Plasma comprised of equal aliquots of not more than 512 individual plasma samples.	BioLife Plasma Services, L.P. Deerfield, IL US License 1640	1/31/2007	BL125100/0
UltraQual HIV-1 RT-PCR Assay	HIV-1	PCR	Plasma	Donor Screen: Qualitative detection of HIV-1 ribonucleic acid (RNA) in pools of human Source Plasma comprised of equal aliquots of not more than 512 individual plasma samples.	National Genetics Institute Los Angeles, CA US License 1582	9/18/2001	BL103902/0
COBAS Ampliscreen HIV-1 Test	HIV-1	PCR	Plasma/ Cadaveric serum or plasma	Donor Screen Expanded Indications For Use: Source Plasma donors, other living donors, and organ donors	Roche Molecular Systems, Inc. Pleasanton, CA US License 1636	12/20/2002	BL125059/0
APTIMA HIV-1 RNA Qualitative Assay	HIV-1	HIV-1 Nucleic Acid (TMA)	Plasma/ Serum	Diagnostic: For use as an aid in diagnosis of HIV-1 infection, including acute or primary infection.	Gen-Probe, Inc., San Diego, CA US License 1592	10/4/2006	BL103966/5040

Abbott RealTime HIV-1 Amplification Kit	HIV-1	PCR	Plasma	Patient Monitoring: Quantitation of Human Immunodeficiency Virus type 1 (HIV- 1) on the automated m2000 System. Not intended to be used as a donor screening test or as a diagnostic test to confirm the presence of HIV-1 infection.	ABBOTT Molecular, Inc., Des Plaines, IL	5/11/2007	BP060002/0
Roche Amplicor HIV-1 Monitor Test	HIV-1	PCR	Plasma	Patient Monitoring: Quantitation of Human Immunodeficiency Virus Type 1 (HIV-1) nucleic acid. Not intended as a donor screening test or as a diagnostic test to confirm the presence of HIV-1 infection.	Roche Molecular Systems, Inc. Pleasanton, CA US License 1636	3/2/1999	BP950005/004
COBAS AmpliPrep/COBAS TaqMan HIV-1 Test	HIV-1	PCR	Plasma	Patient Monitoring: Quantitation of Human Immunodeficiency Virus Type 1 (HIV-1) nucleic acid. Not intended to be used as a donor screening test or as a diagnostic test to confirm the presence of HIV-1 infection.	Roche Molecular Systems, Inc. Pleasanton, CA US License 1636	5/11/2007	BP050069/0

Versant HIV-1 RNA 3.0 (bDNA)	HIV-1	Signal amplification nucleic acid probe	Plasma	Patient Monitoring: Quantitation of Human Immunodeficiency Virus Type 1 (HIV-1) nucleic acid. Not intended to be used as a donor screening test or as a diagnostic test to confirm the presence of HIV-1 infection.	Siemens Healthcare Diagnostics, Inc.	9/11/2002	BP000028/0
ViroSeq HIV-1 Genotyping System with the 3700 Genetic Analyzer	HIV-1	HIV-1 Genotyping	Plasma	Patient Monitoring: For detecting HIV genomic mutations (in the protease and part of the reverse transcriptase regions of HIV) that confer resistance to specific types of antiretroviral drugs, as an aid in monitoring and treating HIV infection.	Celera Diagnostics Alameda, CA	6/11/2003	BK030033/0
Trugene HIV-1 Genotyping Kit and Open Gene DNA Sequencing System	HIV-1	HIV-1 Genotyping	Plasma	Patient Monitoring: For detecting HIV genomic mutations (in the protease and part of the reverse transcriptase regions of HIV) that confer resistance to specific types of antiretroviral drugs, as an aid in monitoring and treating HIV infection.	Siemens Healthcare Diagnostics, Inc.	4/24/2002	BK020005, BK090077, BK080073

Anti-HIV-1 Testing Service

Trade name(s) (Labeling may be out of date)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
Home Access HIV-1 Test System	HIV-1	Dried Blood Spot Collection Device	Dried Blood Spot	Diagnostic: Self-use by people who wish to obtain anonymous HIV testing	Home Access Health Corp., Hoffman Estates, IL	7/22/1996	BP950002/0

Anti-HIV-1 Oral Specimen Collection Device

Trade name(s) (Labeling may be out of date)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
OraSure HIV-1 Oral Specimen Collection Device	HIV-1	Oral Specimen Collection Device	Oral Fluid	For Use with HIV diagnostic assays that have been approved for use with this device.	OraSure Technologies Bethlehem, PA	12/23/1994	BP910001/0

Human Immunodeficiency Virus Type 2 (Anti-HIV-2 Assay)

Trade name(s) (Labeling may be out of date)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
GS HIV-2 EIA	HIV-2	EIA	Serum / Plasma	Donor Screen and diagnostic.	Bio-Rad Laboratories Redmond, WA US License 1109	4/25/1990	BL103227/0

Human Immunodeficiency Virus Types 1 & 2 (Anti-HIV-1/2 Assay)

Trade name(s) (Labeling may be out of date)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
Abbott HIVAB HIV-1/HIV-2 (rDNA) EIA	HIV-1, HIV-2	EIA	Serum / Plasma / Cadaveric Serum	Donor Screen and diagnostic	Abbott Laboratories Abbott Park, IL US License 0043	2/14/1992	BL103385/0

ABBOTT PRISM HIV O Plus assay	HIV-1, HIV-2	Chemi-luminescent Immunoassay (ChLIA)	Plasma / Serum/ Cadaveric Serum	Donor Screen: Qualitative detection of antibodies to HIV-1 (anti-HIV-1) groups M and O and/or antibodies to HIV-2 (anti-HIV-2) in human serum and plasma specimens. Organ donor screening when specimens are obtained while the donor's heart is still beating, in testing blood specimens to screen cadaveric (non-heart-beating) donors, and as an aid in the diagnosis of HIV- 1 /HIV-2 infection	Abbott Laboratories Abbott Park, IL US License 0043	9/18/2009	BL125318/0
GS HIV-1/HIV-2 Plus O EIA	HIV-1, HIV-2	EIA	Serum / Plasma / Cadaveric Serum	Use with the Ortho Summit™ System (OSS) in the screening of blood donors, also for diagnostics. Diagnostic detection of antibodies to HIV-1 (Groups M and O) and/or HIV-2 in human serum, plasma, and cadaveric serum specimens.	Bio-Rad Laboratories Redmond, WA US License 1109	8/5/2003	BL125030/0, BL125030/10, BL125030/24
ADVIA Centaur HIV 1/O/2 Enhanced ReadyPack Reagents	HIV-1, HIV-2	Microparticle Chemi-luminometric Immunoassay	Plasma/ Serum	Diagnostic: For qualitative determination of antibodies to the human immunodeficiency virus type 1, including Group O, and/or type 2 in serum or plasma	Siemens Healthcare Diagnostics, Inc.	5/18/2006	BP050030/0

Ortho VITROS HIV-1/HIV-2	HIV-1, HIV-2	EIA	Plasma/ Serum	Diagnostic: For use on the VITROS® 5600 Integrated and VITROS® 3600 Immunodiagnostic Systems	Ortho-Clinical Diagnostics, Inc Raritan, NJ US License 1236	3/27/2008	BP050051/0, BP050051/18
Multispot HIV-1/HIV-2 Rapid Test	HIV-1, HIV-2	Rapid Immunoassay	Plasma / Serum	Diagnostic	Bio-Rad Laboratories Redmond, WA US License 1109	11/12/2004	BP040046/0
SURE CHECK HIV 1/2 ASSAY	HIV-1, HIV-2	Rapid Immunoassay	Finger stick & venous whole blood, serum, plasma	Diagnostic	Chembio Diagnostic Systems, Inc. Medford, NY	5/25/2006	BP050009/0
HIV 1/2 STAT-PAK ASSAY	HIV-1, HIV-2	Rapid Immunoassay	Finger stick & venous whole blood, serum, plasma	Diagnostic	Chembio Diagnostic Systems, Inc. Medford, NY	5/25/2006	BP050010/0
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test	HIV-1, HIV-2	Rapid Immunoassay	Whole Blood, Plasma, Oral Fluid	Diagnostic	OraSure Technologies Bethlehem, PA	6/22/2004	BP010047/16
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test	HIV-1, HIV-2	Rapid Immunoassay	oral fluid, plasma, venous whole blood	Diagnostic	OraSure Technologies Bethlehem, PA	11/7/2002	BP010047/0

Human Immunodeficiency Virus Types 1 & 2 (Anti-HIV-1/2 Assay) and Anti-HIV-1 (HIV-1 Antigen Assay)

Trade name(s) (Labeling may be out of date)	Infec-tious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
ARCHITECT HIV Ag/Ab Combo	HIV-1, HIV-2	Chemi-luminescent Microparticle Immunoassay (CMIA)	Plasma / Serum	Diagnostic: For detection of antibodies to HIV-1 and HIV-2 and HIV-1 antigen	Abbott Laboratories Abbott Park, IL US License 0043	6/18/2010	BP090080
Bio-Rad GS HIV Ag/Ab Combo EIA	HIV-1, HIV-2	EIA	Plasma / Serum	Diagnostic: For detection of antibodies to HIV-1 and HIV-2 and HIV-1 antigen as an aid in the diagnosis of HIV infection, including in pediatric populations (children as young as two years old).	Bio-Rad Laboratories Redmond, WA US License 1109	7/22/2011	BP100064

Human T-Lymphotropic Virus Types I & II (Anti-HTLV-I/II Assay)

Trade name(s) (Labeling may be out of date)	Infec-tious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
Abbott HTLV-I/HTLV-II EIA	HTLV-1, HTLV-2	EIA	Serum / Plasma	Donor Screen	Abbott Laboratories Abbott Park, IL US License 0043	8/15/1997	BL103614/0
ABBOTT PRISM HTLV-I/HTLV-II	HTLV-1, HTLV-2	Chemi-luminescent Immunoassay (ChLIA)	Serum / Plasma	Donor Screen: Screening test for individual human donors, including volunteer donors of whole blood and blood components, and other living donors for the presence of anti-HTLV-I/HTLV-II. Also intended for use in testing blood and plasma to screen organ donors when specimens are obtained while the donor's heart is still beating.	Abbott Laboratories Abbott Park, IL US License 0043	1/16/2008	BL103761/0

Regulation 4-2-10 FILING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAS)

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, C.R.S., and 10-3-903.5(7)(d)(V)(A), C.R.S.

Section 2 Scope and Purpose

This regulation is intended to clarify the information to be filed under the provisions of § 10-3-903.5(7)(c), C.R.S., by Multiple Employer Welfare Arrangements (MEWAs) claiming exempt status from formal licensing requirements. Further, this regulation is intended to clarify the application requirements under the provisions of § 10-3-903.5(7)(d) by a MEWA seeking a waiver to operate in Colorado. This regulation also clarifies the responsibilities of licensed producers with respect to MEWAs.

Section 3 Applicability

This regulation applies to multiple employer welfare arrangements subject to § 10-3–903.5, C.R.S. For a MEWA seeking an exemption pursuant to § 10-3-903.5(7)(c), C.R.S, the MEWA must comply with the requirements of Section 5. MEWAs seeking a waiver pursuant to § 10-3-903.5(7)(d), C.R.S must comply with Section 6.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Covered lives” mean, for the purposes of this regulation, members, subscribers, and dependents.

C. “Fully insured” means, for the purposes of this regulation, an arrangement where a licensed entity is liable to pay all health care benefits, less any contractual deductibles, coinsurance or copayments to be made by the covered person. The liability of the licensed entity for payment of the covered services or benefits is directly to the individual employee, member or dependent(s) receiving the health care services or benefits. The contract issuance, claims payment, administration, and all other insurance related functions remain the ultimate responsibility of the licensed entity.

D. “Health plan” means, for the purposes of this regulation, an arrangement such as a fund, trust, plan, program or other funding mechanism that provides health care benefits.

E. "Licensed entity" means, for the purposes of this regulation, a licensed insurance company; health maintenance organization; or nonprofit hospital, medical-surgical, and health service corporation having a certificate of authority to transact business in this state.

F. "Producer" means, for the purposes of this regulation, a licensed person as defined by Article 2 of Title 10.

G. "SERFF" means, for the purposes of this regulation, System for Electronic Rates and Forms Filing.

H. "Substantial compliance" means, for the purposes of this regulation, that each benefit provided to an individual covered by a MEWA complies with the essential requirements of each mandated benefit.

Section 5 Filing Requirements of MEWAs Seeking Exemption Under § 10-3-903.5(7)(c), C.R.S.

A. A filing under this Section 5 is solely for the purpose of providing information required by the Commissioner to demonstrate a MEWA complies with the requirements of § 10-3-903.5(7)(c), C.R.S. Determination of compliance or noncompliance will be provided electronically via SERFF.

B. The following information must be filed electronically in SERFF in order to meet the filing requirements of § 10-3- 903.5(7)(c), C.R.S., and for the Commissioner to make a determination regarding the qualification of a MEWA seeking exemption from licensure requirements:

1. Evidence that the MEWA has existed continuously since January 1, 1983.

2. A copy of the sponsor association's organizational documents, membership criteria, ownership information and a summary of the activities and benefits, other than health plan coverage, provided to its membership.

3. A copy of the most recent financial report, which includes at a minimum, a balance sheet, income statement, cash flow report and a detailed listing of assets, as of the MEWA's most recent fiscal year end. The financial report must support the required unallocated reserve level of not less than five percent (5%) of the first two (2) million dollars for annual contributions made to each arrangement in the preceding fiscal year.

4. The method of marketing and enrolling eligible participants.

5. The actuarial information required by § 10-3-903.5(7)(c)(III), C.R.S., that must be prepared and signed by a qualified actuary. The actuarial information must include:

a. An opinion that:

(1) Is prepared in a format consistent with that required by the National Association of Insurance Commissioners for commercial health insurers; and

(2) Opines on the adequacy of the health plan reserves and liabilities reflected in the financial report.

b. A copy of the underlying actuarial report supporting such opinion, in accordance with the requirements of § 10-7-114, C.R.S., including all methods and assumptions employed. In addition, the report must evaluate the adequacy of the contribution and funding levels of the health plan for the current and immediately subsequent fiscal year.

6. A copy of the products offered along with a summary of benefits and a comparison of how each benefit is in substantial compliance with Colorado's mandated benefit provisions.

7. Such other relevant information as the Commissioner may request in order to evaluate the qualification status of the MEWA.

8. A copy of an audited annual financial report within 150 days of the MEWA's fiscal year end.

C. Subsections B.1. and B.2. are only required to be filed once, unless materially altered. B.3. through B.7. must be filed annually within sixty (60) days following the fiscal year end of the MEWA. Subsection B.8. must be filed annually.

Section 6 Filing Requirements of MEWAs Seeking A Waiver Under § 10-3-903.5(7)(d), C.R.S.

A. A MEWA seeking to submit a waiver application to operate in Colorado, as provided in § 10-3-903.5(7)(d), C.R.S., must comply with this Section 6.

B. Waiver application requirements.

1. A MEWA must submit a waiver application to the Division including all information and documentation outlined in § 10-3- 903.5(7)(d)(I), C.R.S., electronically via SERFF.

2. As part of the application materials, a MEWA seeking a waiver must demonstrate that it meets Colorado's minimum solvency requirements as outlined in Colorado Regulation 2-1-7.

C. Annual filing requirements. A MEWA that is granted a waiver under § 10-3-903.5(7)(d), C.R.S., must submit the following information to the Division on an annual basis electronically via SERFF:

1. Financial requirements.

a. Annual financial statements as outlined in Colorado Regulations 3-1-10 and 3-1-3.

b. Risk-based capital requirements as outlined in Colorado Regulations 2-1-7 and 3-1-12.

c. Annual audited financial report as outlined in Colorado Regulation 3-1-4.

2. Form filing requirements.

a. All policy forms associated with the benefits and coverages offered by the MEWA as outlined in Colorado Regulation 4-2-41.

b. All marketing materials associated with the benefits and coverages offered by the MEWA.

3. Rate filing requirements.

a. All rates associated with the benefits and coverages offered by the MEWA as outlined in Colorado Regulation 4-2-39.

b. For the purposes of rate review, the rates filed by a MEWA granted a waiver under § 10-3-903.5(7)(d), C.R.S. will be evaluated based on the number of covered lives with respect to the application of small group or large group rate filing requirements.

4. Network adequacy filing requirements.

a. Information demonstrating compliance with Colorado network adequacy standards as outlined in Colorado Regulations 4-2-53, 4-2-54, 4-2-55, and 4-2-56.

Section 7 Authorized Insurance Arrangements

Insurance arrangements that are not subject to licensure as an insurer under Colorado law are health plans that are:

A. Fully insured;

B. Established and maintained by a single employer;

C. Established and subject to a collectively bargained agreement pursuant to § 10-3-903.5(7)(b)(II), C.R.S.;

D. Established by a government entity, pursuant to § 10-3-903.5(7)(b)(I), C.R.S.; or

E. Determined to be in compliance with § 10-3-903.5(7)(c), C.R.S., and Section 5 of this regulation.

Insurance arrangements granted a waiver pursuant to § 10-3-903.5(7)(d), C.R.S, and this Section 6 remain subject to the Division's full enforcement authority under Title 10, and the Division may apply to the arrangement any requirements applicable to carriers as long as the arrangement is operating in Colorado.

Section 8 Producer Responsibilities

No producer may solicit, advertise, market, accept an application, or place coverage for a person who resides in this state with a MEWA unless the producer first verifies that the MEWA complies with the requirements of this regulation and the provisions of § 10-3-903.5(7), C.R.S. This is accomplished by the producer acquiring a copy of the Division's correspondence determining that the MEWA is in compliance with this regulation and the provisions of § 10-3-903.5(7)(c), C.R.S.

Lack of knowledge regarding the compliance of any organization or health plan is not a defense to a violation of this regulation. Any producer involved in the solicitation or sale of health plans through unauthorized insurers or MEWAs which are found not to be in compliance with the provisions of § 10-3-903.5(7), C.R.S. and this regulation are subject to discipline or action including fines, suspension or revocation of his or her license.

Section 9 Continuing Compliance

In the event that a MEWA ceases to qualify under Section 5 of this regulation, it will be transacting the business of insurance in the State of Colorado without a license and subject to the procedures of Parts 9 and 10 of Article 3 of Title 10, C.R.S., and the provisions of the State Administrative Procedure Act, Part 4 of Title 24, C.R.S., as applicable.

In the event a MEWA ceases to qualify for a waiver under Section 6, it will be transacting the business of insurance in Colorado unlawfully and subject to the procedures of Parts 9 and 10 of Article 3 of Title 10, C.R.S., and the provisions of the State Administrative Procedure Act, Part 4 of Title 24, C.R.S., as applicable.

Section 10 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 11 Enforcement

Noncompliance with this regulation may result in the imposition of any sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance or cease and desist orders, and/or suspensions or revocations of license, subject to the requirements of due process.

Section 12 Effective Date

This amended regulation shall be effective May 30, 2022.

Section 13 History

Regulation 4-2-10, effective July 1, 1994
Amended regulation effective October 2, 2006
Amended regulation effective August 1, 2012
Amended regulation effective September 1, 2017
Amended regulation effective May 30, 2022

Regulation 4-2-11 RATE FILING SUBMISSIONS FOR LIMITED BENEFIT HEALTH INSURANCE PLANS, EXCESS/STOP LOSS INSURANCE, LONG-TERM CARE INSURANCE, MEDICARE SUPPLEMENT INSURANCE, SICKNESS AND ACCIDENT INSURANCE, DISABILITY INCOME, DENTAL, OTHER THAN HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-1110, 10-16-107, 10-16-109, 10-18-105(2), and 10-19-113.7, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to ensure that health insurance rates on limited benefit plans, excess/stop loss Insurance, sickness and accident insurance, disability income, and other than health benefit plans, are not excessive, inadequate or unfairly discriminatory, by establishing the requirements for rate filings.

Section 3 Applicability

This regulation applies to all carriers offering certain types of limited benefit insurance, as found at § 10-16-102(32)(b), C.R.S., and including, but not limited to the following types of coverage: dental, including dental coverage plans (except for plans covering pediatric dental as an essential health benefit), long-term care, disability income insurance, paid family and medical leave insurance, , Medicare supplement, prepaid dental, supplemental health, travel accident/sickness, vision, and excess/stop loss carriers for employers with self-insured health plans, and any other type of insurance that does not meet the definition of a health benefit plan. This regulation does not apply to short-term limited duration health insurance policies.

Section 4 Definitions

A. “1990 Standardized Medicare supplement benefit plan” or “1990 plan” mean, for the purposes of this regulation, a group or individual policy of Medicare supplement insurance issued on or after May 1, 1992 and prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after April 30, 1992 which are not replaced by the issuer at the request of the insured.

B. "2010 Standardized Medicare supplement benefit plan," "2010 standardized benefit plan," or "2010 plan" mean, for the purposes of this regulation, a group or individual policy of Medicare supplement insurance issued with an effective date for coverage issued on or after June 1, 2010.

C. "Accident-only policy" means, for the purposes of this regulation, coverage for death, dismemberment, disability, and/or hospital and medical care caused by or necessitated as the result of an accident or specified kinds of accident.

D. "Accidental death and dismemberment coverage" means, for the purposes of this regulation, an insurance policy that pays "stated benefits" in the event of death or dismemberment caused by an accident. Medical care, disability income or other coverages, such as hospitalization, outpatient surgery, other injury benefits, or non-health coverages, shall be filed under the appropriate line of business for the product.

E. "Actuarial Memorandum" means, for the purposes of this regulation, the required 4-2-11 Rate Filing spreadsheet. The actuarial memorandum is the same as the Regulation 4-2-11 Excel Template spreadsheet available in SERFF.

F "Annual renewable term" means, for the purposes of this regulation, a policy that provides insurance coverage for one year and allows the insured to continue coverage under the policy without new evidence of insurability.

G. "Benefits ratio" shall have the same meaning as found at § 10-16-102(5), C.R.S.

H. "Blanket accident policy" means, for the purposes of this regulation, supplemental limited benefit expense policy providing supplemental medical benefits for accident-related medical losses. Benefits do not exceed a stated dollar amount per day, per month. Requirements are included in Section 6.C. of this regulation.

I. "Blanket accident and sickness policy" means, for the purposes of this regulation, supplemental health limited benefit expense policy providing medical benefits for sickness-related or accident-related medical losses. Benefits are not to exceed a stated dollar amount per day, per month. Requirements are included in Section 6.C. of this regulation.

J. "Blanket sickness policy" means, for the purposes of this regulation, a supplemental health limited benefit expense policy providing supplemental medical benefits for sickness related medical losses. Requirements are included in Section 6.C. of this regulation.

K. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S. and for the purposes of this regulation, shall also include issuers of Medicare supplement policies.

L. "Coordination of benefits" (COB) means, for the purposes of this regulation, a provision establishing an order in which policies pay the claims and permitting secondary policies to reduce the benefits so that the combined benefits of all plans do not exceed the total allowable expenses. Requirements are included in Section 6.C.

M. "Covered lives" means, for the purposes of this regulation, the number of members, subscribers and dependents.

N. "Credibility" means, for the purposes of this regulation, the degree of accuracy in predicting future events based on statistical reporting of past events. It is also a measure of the predictive value an actuary attaches to a particular set of data.

1. "Complement of credibility" means, for the purposes of this regulation, related experience to supplement data that is not fully credible. Complement of credibility is calculated as 1 – credibility.

2. "Fully credible experience" means, for the purposes of this regulation, at least 2000 life years and 2000 claims.

O. "Dental coverage plan" shall have the same meaning as found at § 10-16-165(1)(b), C.R.S.

P. "Disability income policy" means, for the purposes of this regulation, a policy that provides periodic payments to replace income lost when the insured is unable to work as a result of a sickness or injury.

Q. "Disabled Life Reserves" means, for the purposes of this regulation, the present value of all future expected payments for known and open claims that were incurred prior to the financial statement date (i.e., present value of amounts not yet due).

R. "Dividends" mean, for the purposes of this regulation, both policyholder and stockholder dividends.

S. "Effective date requested" means, for the purposes of this regulation, the specific date that the filed or approved rates can be charged to an individual or group.

T. "Excessive" means, for the purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided or if the rates include a provision for expenses that is unreasonably high in relation to the services rendered. In determining if the rate is excessive, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factor as determined by accepted actuarial standards of practice. The Commissioner may require the submission of additional relevant information deemed necessary in determining whether to reject, approve or disapprove a rate filing.

U. "File and Use" means, for the purposes of this regulation, a filing procedure that does not require approval by the Commissioner prior to distribution, release to producers, collection of premium, advertising, or any other use of the rate.

V. "Filing date" means, for the purposes of this regulation, the date the rate filing is received at the Division.

W. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

X. "Health care services" shall have the same meaning as found at § 10-16-102(33), C.R.S.

Y. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S. For purposes of this regulation, this definition shall not include health benefit plans.

Z. "Hospital indemnity coverage" means, for the purposes of this regulation, supplemental coverage that provides a stated daily, weekly or monthly payment while the insured is hospitalized, regardless of expenses incurred and regardless of whether or not other insurance is in force.

AA. "If-known" means, for the purposes of this regulation, the premium that would have been charged from the time of issue if the carrier could have predicted that the experience would develop as it has and the current assumptions were the original pricing assumptions discounted using maximum statutory valuation rates.

AB. "Inadequate" means, for the purposes of this regulation, rates that are insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace. In determining if the rate is inadequate, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

AC. "Inadequate rates" means, for the purposes of this regulation, rates that are clearly insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace. In determining if the rate is inadequate, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of whatever relevant information the Commissioner deems necessary in determining whether to approve or disapprove a rate filing.

AD. "Incurred But Not Reported liabilities" or "IBNR liabilities" means, for the purposes of this regulation, the present value of all future expected payments for unknown open claims that were incurred prior to the financial statement date, but not yet reported as of that date. Applies to both short and long term products.

AE. "Indemnity policy" means, for the purposes of this regulation, coverage that provides benefits based on an event incurred and pays a flat, fixed dollar amount rather than expenses incurred on a medical expense basis.

AF. "Insurance trend" means, for the purposes of this regulation, the combined effect of any other items impacting medical trend, including the impact on trend due to anticipated demographic changes. Insurance trend includes anti-selection resulting from rate increases and discontinuance of new sales.

AG. "Lifetime loss ratio" means, for the purposes of this regulation:

1. The sum of the accumulated value of policy benefits from the inception of the policy form(s) to the end of the experience period and the present value of expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage; divided by:

2. The sum of the accumulated value of earned premiums from the inception of the policy form(s) to the end of the experience period and the present value of expected earned premium over the entire future period for which the proposed rates are expected to provide coverage.

   Active life reserves do not represent claim payments, but provide for timing differences. Therefore, active life reserves shall not be included in this calculation. An appropriate interest rate should be used to calculate the accumulated values and the present values of incurred losses and earned premiums. If the statutory valuation rate is not used, the carrier should explain why using a different discount rate is more appropriate.

AH. "Lifetime loss ratio standard" means, for the purposes of this regulation, any policy form or forms for which the benefits ratio in any policy duration is expected to vary from the lifetime loss ratio.

AI. "Limited benefit health coverage" means, for the purposes of this regulation, any type of health coverage that is not provided by a health benefit plan, as found at § 10-16-102(32)(a), C.R.S.

AJ. "Medical trend" means, for the purposes of this regulation, the combined effect of medical provider price increases, utilization changes, medical cost shifting, new medical procedures and technology, and other insurance trend. Medical trend includes changes in unit costs of medical services or procedures, medical provider price changes, changes in utilization (other than due to advancing age), medical cost shifting, and new medical procedures and technology.

AK. "New policy form or product" means, for the purposes of this regulation, a policy form that has "substantially different new benefits" or unique characteristics associated with risk or cost that are different from existing policy forms offered by the company. For example, a guaranteed issue policy form is different from an underwritten policy form, a managed care policy form is different from a non-managed care policy form, and a direct written policy form is different from a policy sold using producers, etc.

AL. "Non-cancellable" means, for the purposes of this regulation, a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

AM. "On-rate level premium" means, for the purposes of this regulation, the premium that would have been generated if the present rates had been in effect during the entire period under consideration.

AN. "Paid family and medical leave insurance" means, for the purposes of this regulation, providing partial wage-replacement benefits to an eligible individual who takes leave from work to care for a new child or a family member with a serious health condition or who is unable to work due to the individual's own serious health condition or when the individual or the individual's family member is a victim of domestic violence, stalking, or sexual assault or circumstances related to a family member's active duty military service.

AO. "Plan" means, for the purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.

AP. "Premium" shall have the same meaning as found at § 10-16-102(51), C.R.S.

AQ. "Product(s)" means, for the purposes of this regulation, the services covered as a package under a policy form by a carrier, which may have several cost-sharing options and riders as options.

AR. "Qualified actuary" means, for the purposes of this regulation, a member of the American Academy of Actuaries or a person who has demonstrated to the satisfaction of the Commissioner that the person has sufficient educational background and who has no less than seven (7) years of recent actuarial experience relevant to the area of qualifications, as defined in Colorado Insurance Regulation 1-1-1.

AS. "Rate" means, for purposes of this regulation, the amount of money a carrier charges as a condition of providing health care coverage. The rate charged normally reflects such factors as the carrier's expectation of the insured's future claim costs, the insured's share of the carrier's claim settlement, operational and administrative expenses, and the cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the contract.

AT. "Rate filing(s)" means, for the purposes of this regulation, a filing(s) that contains all of the items required in this regulation including the proposed base rates and all rating factors, the underlying rating assumptions, support for new product offerings and all changes in existing rates, factors and assumptions utilized, including the continued use of trend factors.

AU. "Rate increase" shall have the same meaning as found at § 10-16-102(57), C.R.S., and, for the purposes of this regulation, includes increases in any current rate or any factor, including trend factors, used to calculate premium rates for new or existing policyholders, members or certificate holders.

AV. "Rating period" shall have the same meaning as found at § 10-16-102(58), C.R.S.

AW. "Renewed" means, for the purposes of this regulation, a plan renewed upon the occurrence of the earliest of the annual anniversary date of issue; the date on which premium rates can be or are changed according to the terms of the plan; or the date on which benefits can be or are changed according to the terms of the plan. If the plan specifically allows for a change in premiums or benefits due to changes in state or federal requirements and a change in the health coverage plan premiums or benefits due solely to changes in state or federal requirements are not considered a renewal in the health care coverage contract, then such a change will not be considered a renewal for the purposes of this regulation.

AX. "Retention" means, for the purposes of this regulation, the sum of all non-claim expenses including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses as a percentage of total premium (or 100% minus the lifetime loss ratio for products priced on a lifetime loss ratio standard).

AY. "Review and Approval" means, for the purposes of this regulation, a filing procedure that requires a rate change to be affirmatively approved by the Commissioner prior to distribution, release to producers, collection of premium, advertising, or any other use of the rate.

AZ. "Sickness only policy" means, for the purposes of this regulation, limited benefit expense coverage that only covers illness and disease and does not cover any accidents.

BA. "Specified disease policy" means, for the purposes of this regulation, payment of benefits for the diagnosis and treatment of a specifically named disease or diseases. Medical conditions resulting from accidents are not diseases and shall not be included.

BB. "SERFF" means, for the purposes of this regulation, System for Electronic Rate and Form Filing.

BC. "Travel insurance" means, for the purposes of this regulation, limited benefit expense coverage providing medical benefits for losses incurred while traveling generally outside a 100-mile radius of the US borders but may extend to domestic as well as foreign travel. The policy may provide both sickness and injury benefits, and air transportation services for medically necessary emergencies.

BD. "Trend" means, for the purposes of this regulation, any procedure for projecting losses to the average date of loss, or of projecting premiums or exposures to the average date of writing. Trend used solely for restating historical experience from the experience period to the rating period, or which is used to project morbidity, is considered a rating assumption.

BE. "Trend factors" means, for purposes of this regulation, rates or rating factors that vary over time or due to the duration that the insured has been covered under the policy or certificate, and which reflect any of the components of medical or insurance trend assumptions used in pricing.

BF. "Unfairly discriminatory rates" means, for the purposes of this regulation, charging different rates for the same benefits provided to individuals or groups, with like expectations of loss; or if after allowing for practical limitations, differences in rates which fail to equitably reflect the differences in expected losses and expenses. A rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

BG. "Use of the rates" means, for the purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder including advertising, distributing rates or premiums to producers, and disclosing premium quotes. It does not include releasing information about the proposed rating change to other government entities or disclosing general information about the rate change to the public.

BH. "Valid group" means, for the purposes of this regulation, a group that meets the requirements as found in § 10-16-214(1), C.R.S.

BI. "Wellness benefits" means, for the purposes of this regulation, health benefits offered outside of the specifically defined line of coverage, such as annual preventive care and health screening, including laboratory services, x-ray services and similar services.

Section 5 General Rate and Dental Loss Ratio Filing Requirements

A. Rate Filings except for Medicare supplement and Dental

1. New Products

All New Product Filings are considered File & Use. Carriers must submit rate filings to the Division prior to usage.

2. Existing Products

a. Any existing product without any Colorado policyholder receiving a rate increase is considered File & Use.

b. If any Colorado policyholder is projected to receive an increase, the filing is considered Review & Approval.

B. Medicare supplement Rate Filings

1. All Medicare supplement filings are filed as Review & Approval.

2. Medicare supplement carriers shall not use the rates until the Division has closed the rate filing as approved.

C. Dental Product Rate and Dental Loss Ratio Filings

1. New Products

All New Product Filings are considered File & Use. Carriers must submit rate filings to the Division prior to usage.

2. Existing Products

a. Any existing products with all Colorado policyholders receiving a rate increase under five (5) percent are considered File & Use.

b. If any Colorado policyholder is projected to receive an increase of five (5) percent or more, the filing is considered Review & Approval.

c. All dental coverage plans must submit an annual dental loss ratio filing to comply with § 10-16-165, C.R.S. beginning in 2024 and due on July 31, with the first filing due July 31, 2024. This submission must include the Dental Loss Ratio form described in § 10-16-165, C.R.S. and prescribed by the Commissioner.

D. Timing and General Rate Filing Requirements

1. Carrier Requirements

a. Carriers shall submit rate filings for Review and Approval to the Commissioner at least sixty (60) days prior to the effective date requested.

b. Carriers shall submit File and Use rate filings at least one (1) day prior to the effective date requested.

c. Filings that are resubmissions of previously withdrawn, rejected or disapproved rate filings shall be considered new filings.

2. Rate Filing Deadlines

a. Rate Review Deadlines

(1) The filing shall be reviewed for completeness and if found incomplete, the Commissioner may reject or disapprove the filing within the first thirty (30) calendar days of the review period. If the Commissioner has not rejected or disapproved the filing on or before the thirtieth (30th) day, the filing shall be considered complete.

(2) For rates subject to File and Use: any deficiencies identified by the Commissioner past 30 days after filing shall be corrected on a prospective basis. Any rate deficiency identified, including but not limited to the requirements of § 10-16-107(3), C.R.S., may be subject to a penalty if the violation is determined to be willful. Violations may include, but are not limited to, rates found to be excessive, inadequate or unfairly discriminatory.

(3) For rates subject to Review and Approval:

i. If the Commissioner approves the rate filing within sixty (60) calendar days of the filing date, the carrier may utilize the rates for business effective on the effective date requested or later. Under no circumstances shall the carrier use the rates prior to the effective date requested specified in the rate filing.

ii. If the Commissioner does not approve or disapprove a rate filing within sixty (60) days of the filing date, the carrier may implement and reasonably rely on the rates. Any deficiencies identified by the Commissioner past 60 days after filing shall be corrected on a prospective basis.

(4) Medicare supplement carriers shall not use the proposed rates in their rate filing until the Division has closed the filing as approved. The SERFF Requested Filing Mode for Medicare supplement shall be “Review and Approval”.

(5) Withdrawn, Rejected or Disapproved Filings: Rates for withdrawn, rejected or disapproved filings shall not be used or distributed. Use of rates in rate filings that are withdrawn, rejected or disapproved shall constitute a violation of Colorado law.

(6) Rates Not on File

i. Rates not on file with the Division, including the continued use of trend factors beyond twelve (12) months, are deemed to be unfiled rates, which is a violation of Colorado law. Any rates or rating factors not on file with the Division shall not be used.

ii. Failure to file a compliant rate filing shall render the carrier as using unfiled rates and the Division may take appropriate action as allowed by Colorado law.

b. The Division will utilize the following, as provided in § 2-4-108, C.R.S.:

(1) To determine the start of the thirty (30) and sixty (60) calendar day period, the day after the filing date will be utilized. For example, if a filing is submitted in SERFF on June 1, the review period will begin on June 2, regardless of the day of the week.

(2) If the thirtieth (30th) or sixtieth (60th) calendar day falls on a Saturday, Sunday, or legal holiday, the review period will be extended to the next business day which is not a Saturday, Sunday, or legal holiday. For example, if the 60-day period expires on July 4, the review period will be extended to July 5, as long as July 5 falls on a business day.

3. Rate Filing Guidelines and Review Guidelines

a. General Rate Filing Requirements

(1) Rates on all health insurance policies, riders, contracts, endorsements, certificates, and other evidence of health care coverage, shall be filed with the Division prior to the marketing, issuance or deliverance of coverage.

(2) All carriers shall submit a compliant rate filing whenever the rates to be charged to new policyholders or certificate holders differ from the rates on file with the Division. Included in this requirement are the following:

i. Periodic experience submission;

ii. Change in rate calculation methodology or factor values;

iii. Continuing to use previously filed trend or proposing revised trend; and/or

iv. Other changes in rating assumptions.

(3) All carriers shall submit a compliant rate filing on at least an annual basis to support the continued use of trend factors that change on a predetermined basis. Trend factors that change on a predetermined basis can be continued for no more than a period of twelve (12) months. To continue the use of trend factors, a filing shall be submitted for that particular form with an effective date requested within one (1) year of the implementation of the most recent approved rate filing.

(4) All carriers shall submit a compliant rate filing when the rates are changed on an existing product even if the rate change pertains to new business only.

(5) All carriers shall submit a compliant rate filing within sixty (60) calendar days after Commissioner approval of the assumption, acquisition or merger of a block of business.

(6) Each line of business requires a separate rate filing. Rate filings shall not be combined with form filings.

(7) All carriers are expected to review their experience regularly, no less than annually, and file revisions, as appropriate and in a timely manner, to ensure that rates are not excessive, inadequate or unfairly discriminatory and to avoid filing large rate changes. All carriers shall submit complete rate filings for all products subject to this regulation at least every five (5) years, based on the filing date, to ensure that the rates are not excessive, inadequate or unfairly discriminatory. Required filing once every five (5) years is considered completed when rate filing is closed with a SERFF status of Approved, Approved by DOI, Disapproved, Disapproved by DOI or Filed. Please note: long-term care is excluded from this requirement. Also excluded are closed non-cancellable policy forms.

(8) Carriers shall not represent an existing product to be a new policy form or product unless it fits the definition set forth in Section 4.AK. of this regulation.

(9) A separate filing shall be submitted for each carrier. A single filing made for more than one carrier or a group of carriers is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/Indemnity/Point of Service plan.

(10) The Commissioner may, at any time, require a rate filing to be submitted for an in-force product. A carrier that has received this demand from the Commissioner must submit a rate filing in SERFF before the required due date specified, which shall not be less than 60 days from the date of the demand. Additionally, the Commissioner may, at any time, monitor the experience for an in-force product for potentially unsustainable loss ratios by requiring annual rate filings to be submitted for a period of up to five years. Required filing once every five (5) years is considered completed when rate filing is closed with a SERFF status of Approved, Approved by DOI, Disapproved, Disapproved by DOI or Filed. A carrier that has received a demand for annual rate filings from the Commissioner must submit a rate filing in SERFF before the required annual due date(s) specified in the demand.

b. General Elements of Rate Filings

(1) All rate filings shall be filed electronically in SERFF using a format made available by the Division, unless exempted by rule for an emergency situation as determined by the Commissioner.

(2) The rate filing shall demonstrate that the proposed rates are not excessive, inadequate, or unfairly discriminatory.

(3) The rate filing shall contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate.

(4) The rate filing shall contain Colorado experience.

(5) If Colorado experience is partially credible, similar coverage and/or nationwide experience shall also be submitted.

(6) Premium rounding and truncation rules shall be provided in the rate manual for all rate filings.

(7) Rating factors shall be calculated and displayed to four (4) decimal places.

(8) For an acquisition or merger, the acquiring or assuming carrier shall provide support for the rating factors, even if there is no change in the rating factors. The new filing shall demonstrate that the rating assumptions are still appropriate.

(9) The Form Schedule tab in SERFF shall be completed for all rate filings. This tab shall list all policies, riders, endorsements, or certificates affected by the rate filing. Actual forms shall not be attached to the rate filing.

(10) The ‘Effective Date Requested” field on the General Information tab shall be completed with a specific date. ‘On Approval” is not a valid response unless the rate filing is a long-term care rate filing.

(11) The Commissioner may require submission of any relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

c. Rate Filing Disapproval: The Commissioner shall disapprove the rate filing if any of the following apply:

(1) The benefits provided are not reasonable in relation to the premiums charged;

(2) The rate filing contains rates that are excessive, inadequate, or unfairly discriminatory;

(3) The data and/or actuarial support do not justify the requested rate change;

(4) The rate filing is incomplete;

(5) The data in the filing fails to support the proposed rates adequately; or

(6) The rate filing does not comply with the provisions of this regulation.

4. Confidentiality

a. All rate filings submitted shall be considered public and open to public inspection unless the information may be considered confidential pursuant to § 24-72-204, C.R.S.

b. The Division does not consider the following as confidential, including but not limited to:

(1) Rates;

(2) All rating factors applied to develop an individual's, a family's, a university's or an employer's rates.

(3) All required experience period data, including trend data.

(4) Support for general expenses for detailed expense categories as needed to verify expense loads.

(5) Required information in the actuarial memorandum.

c. The entire filing, including the actuarial memorandum, shall not be held as confidential.

d. There shall be a separate SERFF component for the confidential exhibits, which shall be indicated as such by the confidential icon in SERFF.

e. A "Confidentiality Index" shall be completed if the carrier requests confidential treatment of any information submitted. The Division will evaluate the reasonableness of any request for confidentiality and will notify the carrier if the request for confidentiality is rejected..

Section 6 Actuarial Memorandum

This section applies to all products except long-term care which is discussed in Section 7.

The rate filing shall contain a compliant actuarial memorandum completed and submitted in the Regulation 4-2-11 Excel Template spreadsheet available in SERFF. The actuarial memorandum shall contain complete support for any calculated item or provide adequate details. The actuarial memorandum and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. There should only be one (1) actuarial memorandum per rate filing. Only the rate manual shall be attached to the Rate/Rule Schedule tab in SERFF.

The memorandum shall contain the following sections in the following order.

A. Summary

The memorandum shall contain a summary that includes, but is not limited to, the following:

1. Block opened date: Enter the date the product was first offered.

2. Block closed date: Enter the date the product was closed (if applicable).

3. Effective Date Requested: Specify the date for which the rates will be effective.

4. Marketing Method(s): A brief description of the marketing method used for the filed form shall be listed.

5. Market Type(s)

   The carrier shall indicate the appropriate market. Also, the carrier shall identify if the product will be sold to associations, trusts, etc., and provide the name(s) of the associations or trusts, etc.

6. Premium Classification: This section shall state all attributes upon which the premium rates vary. Plans may vary premium rates utilizing the following factors when actuarially justified:

7. Age Basis: Choose the option which most closely matches how policyholders' ages are used in rating.

8. Renewability Provision: Indicate all renewability provisions for the forms as applicable.

9. Reason(s) for this Rate Filing: The carrier shall provide a statement as to whether this is a new product offering, a rate revision to an existing product, which includes rates applicable to new business only, or a new benefit being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated.

10. Requested Rate Action: The overall rate increase or decrease shall be listed. The listed rate change and the average change in each rate component shall be provided. The submission shall also list the twelve (12) month changes by component and the averages by component.

11. Overall Rate Action: Identify the overall, minimum, and maximum rate percentage changes.

12. Rate Change Distribution: The carrier shall include a distribution of rate change for current Colorado policyholders.

13. For all products, the proposed base rates, all rating factors and the underlying rating assumptions shall be submitted. Support for all changes in existing rates, factors and assumptions shall be provided, including the continued use of trend factors. Support for new product offerings shall be provided.

14. For all group products, all groups shall meet the qualifications of “valid groups”. All non-employer groups, including, but not limited to, associations, trusts, unions, and organizations eligible for group life insurance, shall be submitted to the Division for approval prior to issuance of coverage. Policies issued to employers covering employees in a valid employer/employee relationship do not require Division approval. Groups formed for the purpose of insurance are prohibited under Colorado law. Multi-state associations shall also meet the requirements found in § 10-16-214(1), C.R.S. Bona fide associations shall meet the requirements found in § 10-16-102(6), C.R.S. Trusts shall meet the requirements found at § 10-7-201, C.R.S., and shall be formed by one or more employers or by one or more labor unions.

Blanket groups shall meet the requirements as a valid group under § 10-16-215, C.R.S. Each group shall cover a minimum of ten (10) persons and the policy shall be issued directly in the name of the entity. Each insured shall be a group member participating in a "series of activities or events" or for a "season" as related to the group.

B. Product Description: Describe the benefits provided by the policy, rider or contract.

C. Coordination of Benefits

The memorandum shall reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

Note: Limited benefit policies, hospital indemnity policies, fixed indemnity policies, specified disease policies, accidental death and dismemberment policies, accident only policies, sickness only policies, blanket accident policies, blanket sickness policies, blanket accident and sickness policies, and riders are prohibited from including a coordination of benefits provision unless permitted in § 10-16-203 (4), (5) or (6), C.R.S., that allows the policy to reduce its benefits with respect to any other coverage the covered insured may have.

D. Assumption, Acquisition or Merger

Identify whether or not the products included in the rate filing are part of an assumption, acquisition or merger of policies from/with another carrier. If so, the memorandum shall include the full name of the carrier(s) from which the policies were assumed, acquired or merged, the effective date requested of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.D.3.a(5) for merger, acquisition or assumption rate filing requirements.

E. Effect of Law Changes

Identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable mandates shall be listed, including those with no rating impact. This quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

F. Rate History

The memorandum shall include a chart showing, at minimum, all rate changes implemented in the three (3) rate filings immediately prior to the filing date, including the effective date of each rate change. Rate changes shall include the impact of trend factors.

1. This chart shall contain the following information: the filing number (State or SERFF tracking number), the effective date of each rate change, the average increase or decrease in rate, the minimum and maximum increase and cumulative rate change for the past twelve (12) months.

2. This chart shall contain the cumulative effect of all renewal rates on all rate filings, submitted in the prior year.

3. The rate history shall be provided on a Colorado basis.

G. Retention

The memorandum shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period. Carriers shall include all retention percentages from expenses, fees, and profits that will be loaded into rates. Rate filings shall be submitted when the actual loss ratio falls above or below the expected loss ratio as filed with the Division. The carrier shall comply with the following adjusted minimum benefits ratio guidelines:

1. For long-term care policies, see Section 7 and for Medicare supplement policies, see Section 8.

2. Retention Percentage: The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Note: Active life reserves do not represent claim payments but provide for timing differences. Benefits ratio calculations shall be displayed without the inclusion of active life reserves.

   a. The retention percentage on annual renewable term products (ART) is equal to the sum of all non-claim components of the rate including investment income.

   b. If the product was initially priced using a lifetime loss ratio standard, the retention percentage is equal to 1 minus the lifetime loss ratio.

      Each of these specific components shall be expressed as a percentage of the earned premium and should sum to the total carrier retention percentage. Each component shall reflect the average assumption used in pricing. Ranges for each assumption and flat dollar amounts are not permitted. The component for profit/contingencies shall reflect the target load for profit and contingencies and not the expected results or operating margin. Carriers shall provide the commission percentage by policy duration. The commission retention percentage for lifetime loss ratio standard products shall be the weighted average across all years of the product.

      The Commissioner will evaluate each component for reasonableness and consistency with other similar rate filings. Any change in these components from the previous rate filing shall be adequately supported.

      Annual renewable term products shall be priced to meet the same expected loss ratio per year.

      Annual renewable term products and products that use a lifetime loss ratio shall have a minimum benefits ratio not below the benefits ratio guidelines identified in Section 6.G.3.b of this regulation unless otherwise allowed by this regulation.

3. Benefits Ratio Guidelines

   The following are the Commissioner’s expectations pertaining to the acceptability of the carrier’s targeted benefits ratio or lifetime loss ratio.

   a. All rate filings justifying the relationship of benefits to premium using one of these guidelines shall list the components of the retention percentage, as defined in Section 6.G.2. Policy forms priced at, or above, these benefits ratios may be unacceptable if one or more of the retention components is not supported.

b. The Division's expectations regarding the benefits ratios are as listed below. Targeted benefits ratios below the following expectations shall submit substantial support or may be subject to disapproval.

Benefits Ratio Guidelines:

GROUP POLICIES:

Accident-only	60%
Dental	60%
Disability Income	60%
Excess Loss	60%
Medicare Supplement	75%
Hospital Indemnity	60%
Limited Benefit Plans	60%
Paid Family and Medical Leave	60%
Sickness-only	60%
Specified or Dread Disease	60%
Travel Accident/Sickness	60%
Vision	60%

INDIVIDUAL POLICIES:

Accident-only	55%
Dental	60%
Disability Income	55%
Hospital Indemnity	55%
Limited Benefit Plans	55%
Medicare Supplement	65%
Sickness-only	55%
Specified or Dread Disease	55%
Travel Accident/Sickness	55%
Vision	60%

Long-term care minimum loss ratio information is in Colorado Insurance Regulation 4-4-1.

c. Provision for Profit and Contingencies

Carriers shall indicate pre-tax and post-tax levels and how investment income has been accounted for in the setting of profit margins. Material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

H. Lifetime Loss Ratio Standard

The memorandum shall state whether or not the product was priced initially using a lifetime loss ratio standard. If the product was priced using a lifetime loss ratio standard, any subsequent rate change request shall be based on the same standard unless there has been a material change in assumptions used to price the product including changes in regulations covering the product. Changes to the lifetime loss ratio shall be identified and clearly supported. The lifetime loss ratio standard shall consider the effects of investment income.

For purposes of this regulation, the sum of the accumulated value of policy benefits from the inception of the policy form(s) to the end of the experience period and the present value of expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage; divided by and the sum of the accumulated value of earned premiums from the inception of the policy form(s) to the end of the experience period and the present value of expected earned premium over the entire future period for which the proposed rates are expected to provide coverage.

Any subsequent rate change request shall consider the variance in the expected benefits ratios over the duration of the policy. The rate filing shall include the average policy duration in years as of the endpoint of the experience period and the expected benefits ratio, as originally priced, for each year of the experience period.

Rate filings for Lifetime loss ratio standard products shall include:

1, An exhibit that details the lifetime projection of the product, showing that the product achieves the lifetime loss ratio using a reasonable discount rate (valuation rate recommended). This should include the projected loss ratio in each policy year accounting for expected in force by year.

2. If the product is new, an exhibit that details how the expected lapse rates were calculated.

I. Trend

The actuarial memorandum shall describe the trend assumptions used in pricing. These trend factor assumptions shall be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported. Trend factors do not renew automatically, therefore continued use of trend factors will still require the carrier to file a rate filing on an annual basis. Continued use of trend without an annual filing will be deemed as using unfiled rates.

1. The four (4) most recent years of experience data used to evaluate historical trends shall be provided, if available. This experience may include data from the plan being rated or data from other Colorado or national business for similar lines of insurance, product designs, or benefit configurations.

2. Provided loss data shall be on an incurred basis, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g. claim reserves and incurred but not reported (IBNR) reserves) as of the valuation date. The carrier shall indicate the number of months of run out used beyond the end of the incurred claims period.

3. The provided claims experience shall include the following separate data elements for each month: actual paid on incurred claims; total incurred claims (including estimated IBNR claims); and average covered lives.

4. Data elements shall be aggregated into 12-month annual periods, with yearly "per member, per month" (PMPM) data, and year-over-year PMPM. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified. The trend assumptions shall be quantified into two (2) categories:

   a. Medical trend

   b. Insurance trend. The components of the medical trend shall be determined or assumed before determining the impacts of the other insurance trend items, which shall be fully justified in the rate filing.

5. Trend factors that directly affect the rates (i.e. rating factors that are applied throughout the rating period) shall be included when calculating the requested rate change. Trend factors of this type shall be reflected anywhere a requested change is reported (all SERFF Rate/Rule Schedule tab items, rating factors included in the rate pages, Side-by-Side Comparison).

J. Credibility

1. Credibility Weighting Assigned to Experience Periods

   a. Colorado Experience Fully Credible.

      Carriers shall assign 100% credibility to Colorado experience for rate development if Colorado experience comprises more than 2000 claims and 2000 life years in the carrier's most recent three (3) years. Use the minimum number of most recent years needed to reach full credibility.

   b. Colorado Experience Partially Credible and Nationwide Experience Fully Credible

      If Colorado experience comprises less than 2000 claims or 2000 life years in the carriers' most recent three (3) years and nationwide experience comprises more than 2000 claims and 2000 life years in the carriers' most recent three (3) years:

      Credibility in this case is calculated by dividing the minimum of Colorado claims or Colorado life years over the most recent three (3) years by 2000, then calculating the square root of that value. Shown as an Excel formula:

Credibility=SQRT(Min(Colorado claims over most recent 3 years, Colorado life years over most recent 3 years)/2000)

The most recent three (3) years of nationwide experience shall be used as the complement of credibility.

c. Colorado Experience Partially Credible and Nationwide Experience Fully Credible when considering 3+ Years of Experience

If nationwide experience comprises less than 2000 claims and 2000 life years in the most recent three (3) years, then add historical years until nationwide experience achieves full credibility. Use this number of years of experience to achieve full credibility nationwide as the basis for rating based on the following mix of Colorado and nationwide experience:

Credibility in this case is calculated by dividing the minimum of Colorado claims or Colorado life years over the most recent years to achieve fully credible nationwide experience by 2000, then calculating the square root of that value. Shown as an Excel formula:

Credibility=SQRT(Min(Colorado claims over the most recent years to achieve fully credible nationwide experience, Colorado life years over the most recent years to achieve fully credible nationwide experience)/2000).

Nationwide experience over the most recent years needed to achieve full credibility is used as the complement of credibility.

An example of determining credibility for this case of nationwide experience not reaching full credibility in the most recent three (3) years is shown in Appendix A.

d. Nationwide Experience Partially Credible in Full Historic Period

If nationwide experience comprises less than 2000 claims and 2000 life years since inception:

Credibility in this case is calculated by dividing the minimum of nationwide claims or nationwide life years since inception by 2000, then calculating the square root of that value. Shown as an Excel formula:

Credibility=SQRT(Min(nationwide claims since inception, nationwide life years since inception)/2000).

The complement of credibility shall be a reliable secondary source such as original or updated pricing assumptions or industry study. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

2. The use of an alternative source complementing experience shall be justified in the filing. Any data used to support re-rating data shall be provided.

K. Experience

The memorandum shall include earned premium, loss experience, average covered lives and number of claims submitted on a Colorado-only basis for at least three (3) years.

Note: Additional experience requirements for long-term care policies are found in Section 7 and in Colorado Insurance Regulation 4-4-1.

Note: Additional experience requirements for Medicare supplement rate filings are found in Section 8 and in Colorado Insurance Regulation 4-3-1.

1. Existing Products

   a. If Colorado experience is less than fully credible, national or other relevant data new product shall be provided to support the rates.

   b. The experience period shall include consecutive data no older than six (6) months prior to the filing date for all products except long-term care. For long-term care policies, see Section 7.

   c. The loss experience shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Premiums and/or exposure data shall be stated on both an actual and on-rate-level basis. Capitation payments shall be considered as claim or loss payments.

   d. Additional general requirements for experience: If the policy contains a combination of expense benefits and fixed dollar amount benefits, these benefits shall be presented separately in the actuarial memorandum. For example, the experience and rate development for the fixed dollar amount benefits shall be shown separately from the experience and rate development for the benefits which are offered on an expense basis.

2. New Products

   a. If the purpose of the filing is to introduce a new product to Colorado, nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

   b. Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a “new product,” as defined in this regulation.

      Explain how the new product substantially differs from existing products offered by the company.

L. Complete Explanation as to How the Proposed Rates were Determined

The actuarial memorandum shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may reject or disapprove a rate filing if support for any rating assumption is found to be inadequate.

If this is a filing for an existing product:

1. If no rate changes are proposed, this section must describe why the current rates are appropriate based on the experience on the block and any changes since policy inception. Discussion must include indicated rate change calculation based on experience on the block.

2. If rate changes are proposed, this section must describe why the proposed rates are appropriate based on the experience on the block and any changes since policy inception.

   These changes may include past rate changes, law changes or any other changes.

   This explanation may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis, but it shall completely explain how the proposed rates were determined. The memorandum shall adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

   Other Factors. The memorandum shall clearly display or clearly reference all other rating factors and definitions used, including geographic factors, benefit factors, age factors, gender factors, morbidity factors, etc., and provide support for the use of each of these factors in the new rate filing. The same level of support for changes to any of these factors shall be included in all renewal rate filings. In addition, the Commissioner expects each carrier to review each of these rating factors every five (5) years, at a minimum, and provide detailed support for the continued use of each of these factors in a rate filing. Effective January 1, 2011, gender factors shall not vary for individual health care coverage but can vary for group health coverage plans. Individual plans shall meet the requirements of § 10-16-107 (2)(b), C.R.S. Note: This requirement does not apply to Medicare supplement or long-term care coverage.

M. Side-by-Side Comparison

Each actuarial memorandum shall include a “side-by-side comparison” identifying any proposed rate change(s). This comparison shall include four (4) columns: the first containing the category, the second containing the current rate, rating factor, or rating variable; the third containing the proposed rate, rating factor, or rating variable; and the fourth containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum shall specifically state this and provide detailed support for each rating factor.

N. Benefits Ratio Projections

The memorandum shall contain a section projecting the benefits ratio over the rating period, both with and without the requested rate change(s). The comparison shall be shown in chart form, listing projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations shall be included.

For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long-term disability, the projections shall include a timeframe as to when the lifetime loss ratio will be achieved.

If the filing is for a new product, the expected projected premiums and projected incurred claims shall be provided.

O. Rating Manual and Underwriting

1. All product lines are required to submit a complete rating manual in each filing. A complete rating manual and the underwriting guidelines that affect the calculation of the rates shall be submitted to the Division for each new product.

2. All changes to the rating manual and/or underwriting guidelines shall be filed with the Division in an appropriate rate filing. Underwriting guidelines based on an accept/reject basis are not required to be filed.

3. Rate pages and rating manuals shall be attached to the Rate/Rule Schedule tab in SERFF.

4. The memorandum shall include a brief description to the extent to which the product will be underwritten. If the product is new, or there are changes to an existing product's underwriting standards, the underwriting manual shall be provided, unless the underwriting occurs on a "Yes/No" or "Reject" standard.

   The carrier shall state separately the effects of different types of underwriting: medical, financial or other.

   An example of an acceptable brief description is: "This policy form is subject to limited underwriting with yes/no questions. The expected impact is: duration 1 = .15; duration 2 = .05; duration 3 = .03 decrease in claim costs." Underwriting rate ups are considered rating factors and need to be filed and supported pursuant to Section 6.L., "Other Factors.

P. Actuarial Certification

An actuarial certification shall be submitted with all rate filings. An actuarial certification is a signed and dated statement made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, nor unfairly discriminatory. In addition, Medicare supplement rate filings shall include the certification required by Colorado Insurance Regulation 4-3-1 Section 14. In addition, long-term care rate filings shall include the certification requirements required by Colorado Insurance Regulation 4-4-1, Sections 10, 17 and 18. The Commissioner may require the submission of additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

Section 7 Additional Rate Filing Requirements for Long-Term Care Insurance

A. Actuarial Memorandum

1. The rate filing shall contain a compliant actuarial memorandum as specified in subsections A.2 and B. of this Section, including a narrative, except that the required 4-2-11 Rate Filing spreadsheet for purposes of this Section 7 actuarial memorandum is the 4-2-11 LTC Excel Template spreadsheet specified below and available in SERFF. Carriers shall supply all items that require a narrative as a separate document. The actuarial memorandum and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation and of Regulation 4-4-1.

2. The 4-2-11 LTC Excel Template spreadsheet template consists of the following sections

   a. Company info

b. Section A: Summary

c. Section D: Assumption or Merger

d. Section E: Law Changes

e. Section G: Retention

3. For additional details on filling out these sections, see the fuller explanations in the corresponding sections of Section 6.

B. Additional information which must be provided in the filing.

1. General

a. Long-term care insurance is regulated pursuant to §§ 10-19-101 to 115, C.R.S., and Colorado Insurance Regulations 4-2-11 and 4-4-1. If the requirements of both Colorado Insurance Regulation 4-4-1 and this regulation are not met, the filing may be considered incomplete and may be rejected or disapproved.

b. The Commissioner may require the submission of additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing. Long-term care filings require Review and Approval.

2. Reinsurance. The carrier shall provide an explanation of any reinsurance contracts on form including counterparty(s).

3. Distribution of in-force policies

a. The carrier shall provide distribution for each of nationwide and Colorado, at a minimum, elimination period, benefit period (especially lifetime vs. non-lifetime), daily (or monthly) benefit amount, inflation, and any optional riders available for purchase at the time of sale.

b. The carrier shall include a distribution of Colorado policies, by percentage, that are currently in any kind of paid-up status or that have premium schedules that will be paid-up before the end of the projections used in the filing for loss ratio demonstrations. The policies that shall be included are those that have elected any nonforfeiture option, that were sold under limited-payment agreements (10-pay, 20-pay, paid-up at 65, etc.), that have qualified for a lifetime waiver of premium without the policyholders being disabled themselves (e.g. survivor waiver of premium).

4. Credibility. The carrier shall include a commentary and analysis of how the credibility of the experience contributed to the development of the rate proposal. The carrier shall also provide an explanation of how claims cost expectations at older ages and later durations were developed if data was not fully credible at those ages and durations.

5. Assumptions

   a. The carrier shall provide evidence to support their current lapse, mortality and morbidity assumptions, including justification of the assumptions for the relevant benefit period (e.g., data may justify a rate change for lifetime benefits but not for limited period benefits). The carrier shall provide a summary of the most recent lapse, mortality and claims study. Also, the carrier shall provide actual to projected assumption analysis for lapse, mortality and morbidity.

   b. The carrier shall provide a claims retrospective test illustrating how claims paid compared to the Initial Disabled Life Reserve and Incurred But Not Reported Reserve set up.

   c. The carrier shall explain how the actuarial assumptions used in the rate filing proposal compare to those used in the most recent asset adequacy (reserve) testing. Specifically, the carrier shall highlight any significant differences between the assumptions underlying the rate change proposal and those included in Actuarial Guideline 51.

6. Experience and Projections

   a. General Requirements

      i. The experience period shall include consecutive data either no older than six (6) months prior to the filing date, or through the end of the year prior to the filing date.

      ii. All lifetime loss ratio projections shall contain a separate entry for estimated IBNR and Disabled Life Reserves claims included in incurred claims for each historical period (year or partial year) in the illustration. The projections shall also include historical life years, and future estimated life years associated with each future period.

      iii. A table with the annual investment rates applicable from date of initial sale to current date shall be provided.

      iv. The company shall provide the maximum valuation rate on policies sold.

      v. These projections shall include only active premium-paying nationwide policyholders.

      vi. The rate filing shall indicate if waived premiums are included in the premium and claim amounts of the required exhibits.

   b. Required Exhibits

      i. All lifetime loss ratio demonstrations shall include totals discounted at the maximum valuation rate. The carrier shall include loss ratio demonstrations for any portion of the distribution that has materially different experience or future assumptions than another or if the rate change percentage varies across the filing. Where applicable, experience and justification of any rate change shall be split by policy characteristics (benefit, issue age, etc.)

ii. A version of the lifetime loss ratio calculations shall be provided on an "if-known" premium basis, including totals discounted at maximum valuation rate, and totaling to original target loss ratio.

iii. A lifetime loss ratio calculation shall be provided on an "on-rate level premium" basis, including totals discounted at maximum statutory valuation rate.

7. The carrier shall indicate if they are still selling long-term care policies. If so the carrier shall provide a comparison of proposed rates to the long-term care products currently for sale.

8. State by State increases

a. The carrier shall include a distribution by state, including the premium volume and policy counts associated with each state that demonstrates the cumulative and current rate changes and status of rate filings.

b. The carrier shall include a history of the rate changes for this rate filing by policy and state since inception. This information shall include a listing by state of all prior change requests, receipts, effective date, amounts and status. The history shall be specific to the policy or policies identified in the rate filing.

9. Policies

a. The carrier shall provide the number of policies and lives ever issued a policy nationally and in Colorado.

b. The carrier shall provide the number of policies and lives remaining nationally and in Colorado.

c. The carrier shall provide the average attained and issue age nationally and in Colorado.

10. Policyholder Notice Requirements

a. The carrier shall provide notice to the policyholder of the rate change at least forty-five (45) days prior to the policyholder's rate change. This letter shall be included in the rate filing.

b. The carrier shall submit a copy of the proposed policyholder notice(s) corresponding to each rate change implemented over one year or multiple years, if applicable.

Section 8 Additional Rate Filing Requirements for Medicare Supplement Policies

A. Medicare supplement policies are regulated pursuant to §§ 10-18-101 to 109, C.R.S., and Colorado Insurance Regulation 4-3-1. If the requirements of both Colorado Insurance Regulation 4-3-1 and this regulation are not met, the filing may be considered incomplete and may be disapproved. Medicare supplement filings require Review and Approval. Rate filings for Medicare supplement policies shall be submitted on an annual basis. Additional rating requirements can be found in Colorado Insurance Regulation 4-3-1 Sections 10.E., 13, and 14. The Commissioner may require the submission of additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

1. Requirements for Medicare supplement New Business Rate Filings

   a. To assist carriers in submitting Medicare supplement new business rate filings in Colorado, the following requirements shall be followed. The carriers shall also follow the requirements found in Colorado Insurance Regulation 4-3-1.

   b. Carriers shall provide complete support for the development of starting claim costs and base rates, including experience relevant to the carrier and any manual claims costs used from third party consultants.

   c. When developing initial rates for Medicare supplement plans, carriers shall use the following supporting data:

      (1) Carrier's own fully credible Colorado Medicare supplement experience on similar plans.

      (2) Carrier's partially credible Colorado experience, and also similar national experience.

      (3) Carrier's own similar national experience when there is no Colorado experience.

      (4) Carrier has a parent or affiliated company and Colorado and/or national experience on similar Medicare supplement plans that can be utilized.

      (5) The carrier has no credible Colorado or national experience of its own or for any parent/affiliated company; therefore an outside actuarial database or studies must be utilized.

      (6) A reliable secondary source used to support partially credible data shall be provided, and the use of such data shall be justified. All detailed support from any model used shall be provided. If affiliated company experience is available on similar Medicare supplement policies in Colorado, or nationally, and is not being used in the rate setting, the experience is still required to be provided, and sufficient justification shall be included as to why such experience was not used in the calculation of the rates.

   d. A complete rate manual shall be provided. The rate manual shall include all rate tables, rating factors and formulas used to calculate the rate for any policyholder. Complete rating factor tables shall be provided for each factor applied to base rate tables in determining rates including:

      (1) Age factors;

      (2) Area factors, including what zip code or county definition of the area used;

      (3) Modal factors;

      (4) Tobacco/smoking factors;

      (5) Gender factors;

      (6) Family status (married/single);

(7) Underwriting class; and

(8) Change in rating methodology.

e. New business rate filings shall provide complete support for how the new business rating year's starting claim costs were developed, including all trend factors and other projection factors and adjustments applied.

f. The rate filing shall provide any competitive rate comparisons that were performed to determine how proposed rates compare to rates for similar plans in the Colorado market. The Division may utilize market level data in determining the appropriateness of the rates.

g. The rate filing shall provide actuarial support for the development of the claim trend, provide historical claim trend data and show adjustments in data for demographics, morbidity, and other factors. If available, the four (4) most recent years of monthly experience data used to evaluate historical trends shall be provided. Indicate any prospective unit cost or utilization adjustments made to the data to arrive at the final claim trend.

h. The rate filing shall include a lifetime loss ratio demonstration for all plans combined. This demonstration shall include the projected loss ratio in each policy year in the future, accounting for expected enrollment by year. The lifetime loss ratio shall be in addition to the durational loss ratio exhibit and shall be submitted in both PDF and Excel spreadsheet format.

i. Any future rate change request filings shall be based on the same lifetime loss ratio standard as originally submitted, unless there has been a material change in assumptions used to price the product. Changes to the lifetime loss ratio shall include adequate support and the rates shall not be implemented until approved by the Division. Future rate filings shall also include the actual and expected benefit ratios, and the ratio of actual-to-expected loss ratios for both the experience and rating periods.

j. Carriers shall demonstrate that the 'under age 65' rates are a maximum of 1.5 times the 'Age 65' rates for new plans being offered in the Colorado Medicare supplement market as required by Colorado Insurance Regulation 4-3-1 Section 10.E. The rate filing shall verify compliance with this requirement. The carrier shall maintain the relationship of 'Under age 65' rates being a maximum of 1.5 times the 'Age 65' rates for the entirety of the policy forms' lifetime.

k. The rate filing shall include the carrier's definition of 'residency'.

l. The rate filing shall include the methodology and justification used for converting an out-of-state Medicare supplement policy to a Colorado policy when the policyholder changes residency either out of Colorado or into Colorado. The methodology shall also include when the policyholder moves to another state and chooses to retain the Colorado Medicare supplement policy. The residency methodology shall also be included in the 'Premium Information' section of the 'Outline of Coverage".

2. Requirements for Medicare Supplement Existing Business Rate Filings

a. Medicare supplement rate change request filings and annual rate filings are required to meet the requirements of both Colorado Insurance Regulation 4-3-1 and this regulation. Rate filings that are not compliant with these regulations could be considered incomplete and the filing may be disapproved.

b. Medicare supplement rate request filings shall include the following specific items:

(1) A discussion of the credibility of the experience data used for calculating the rate request. The hierarchy for supporting data used in the development of claim costs in the rate filing is as follows:

(2) Carrier's own fully credible Colorado Medicare supplement experience.

(3) Carrier's partially credible Colorado experience.

(4) Carrier's own similar national experience to utilize when there is no Colorado experience.

(5) Carrier has a parent or affiliated company and Colorado and/or national experience on similar Medicare supplement plans that can be utilized.

(6) The carrier has no credible Colorado or national experience of its own, or for any parent/affiliated company; therefore an outside actuarial database or studies must be utilized.

(7) A reliable secondary source used to support partially credible data shall be provided, and the use of such data shall be justified. All detailed support from any model used shall be provided. If affiliated company experience is available on similar Medicare supplement policies in Colorado, or nationally, and is not being used in the rate setting, the experience is still required to be provided, and sufficient justification shall be included as to why such experience was not used for this rate setting.

This documentation shall be provided for all Colorado plans. Nationwide data shall also be provided if Colorado data is not fully credible.

c. Rate Manual

A complete rate manual shall be provided. The rate request filing shall include the rate manual that includes all rate tables, rating factors and formulas used to calculate the rate for any policyholder and includes the factors and formulas that have been revised. Complete rating factor tables shall be provided for each factor applied to base rate tables in determining rates including:

(1) Age factors;

(2) Area factors, including what zip code or county definition of area used;

(3) Modal factors;

(4) Tobacco/smoking factors;

(5) Gender factors;

(6) Family status (married/single);

(7) Underwriting class; and

(8) Change in rating methodology.

d. Claim Costs Developments: The rate request filing shall provide complete support for how the claim costs were developed, including all trend factors and other projection factors and adjustments applied.

e. Competitive Rate Comparison: A rate request filing shall provide all competitive rate comparisons that were performed to determine how the proposed rates compare to rates for similar plans in the Colorado market.

f. Claim Trend: A rate request filing shall provide actuarial support for the development of the claim trend, provide historical claim trend data and show adjustments in data for demographics, morbidity, and other factors. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be provided, if available. Indicate any prospective unit cost or utilization adjustments made to the data to arrive at the final claim trend.

g. Lifetime Loss Ratio: The rate filing shall include a lifetime loss ratio demonstration for all plans combined. The lifetime loss ratio shall be the same loss ratio as provided in the initial rate filing for the same plan, unless sufficient support is provided that requires a revision of the lifetime loss ratio. Sufficient support shall be provided in the rate filing supporting such a revision.

Any future rate change request filings shall be based on the same lifetime loss ratio standard as originally submitted, unless there has been a material change in assumptions used to price the product. Changes to the lifetime loss ratio shall include adequate support and shall not be implemented until requested and approved by the Division. Rate filings shall also include the actual and expected benefits ratios, and the ratio of actual-to-expected for both the experience and rating periods.

h. Experience

The experience shall be reported separately by plan, as well as combined by plan for the 1990 and 2010 Standardized plans, and totaled as all plans. This experience data shall be submitted on both a Colorado and nationwide basis. Include formulas for how the carrier arrives at projected earned premium and incurred claims for all future years.

i. Under Age Sixty-Five (65) Rates

(1) Verification shall be provided that indicates the ‘Under age 65’ rates do not exceed 1.5 times the ‘Age 65’ rates for new business plans entering the market. This maximum ratio of 1.5 shall follow plans throughout the form's lifetime for ‘Under age 65’ to ‘Age 65’ rates.

(2) If the 'Under age 65' rates are more than 1.5 times the 'age 65' rates, the rate increase shall not be more than the percent increase in the 'age 65' plus rates. The carrier shall maintain the relationship between the 'Under age 65' rates and the 'age 65' rates.

j. The rate filing shall include the carrier's definition of 'residency'.

k. The rate filing shall include the methodology and justification used for converting an out-of-state Medicare supplement policy to a Colorado policy when the policyholder changes residency either out of Colorado or into Colorado. The methodology shall also include when the policyholder moves to another state and chooses to retain the Colorado Medicare supplement policy. The residency methodology shall also be included in the 'Premium Information' section of the 'Outline of Coverage".

Section 9 Additional Rate Filing Requirements by Line of Business and by Market Type

The following subsections set forth the requirements by separate lines of business, which shall be complied with in addition to the above general requirements:

A. Individual

Renewal rates for individual health insurance plans shall not be affected by the health status or claims experience of the individual insured. A "claims experience factor", or any other part of the renewal rate calculation, based in whole or in part upon the health status or claims experience of the individual insured is prohibited.

B. Groups shall meet the requirements of valid groups as defined in this regulation. All non-employer groups shall be approved by the Division prior to issuance of coverage. An employer covering employees in a valid employer/employee relationship is a valid group and therefore does not require Division approval. All other groups shall be submitted to the Division for approval under SERFF Type of Insurance code (TOI) H21 – Other, using the Filing Type "Other – Non-employer group". This applies to new and existing groups. Detailed support shall be provided explaining how each non-employer group meets the requirements of a valid group. Banks, credit card holders, buying clubs and affinity groups do not meet the requirement of valid groups. Groups formed for the sole purpose of insurance are prohibited. The only out-of-state group health insurance policy that is exempt from Colorado laws is a single employer plan, under § 10-3-903(2)(h), C.R.S. All other groups shall meet the requirements described below:

1. Employer

Use of the Group Market Type "employer" classification requires that the policy shall be issued directly to the employer as the 'policyholder' covering at least ten (10) eligible employees of the employer as defined under § 10-16-214(1)(a), C.R.S. Eligible employee, as defined in § 10-16-102(18), C.R.S., means a full-time employee in a valid employer/employee relationship with the employer. Premiums may be paid by the employer from company revenues or if employees are required to contribute to the cost of their insurance deductions for this purpose may be made from their salaries. Terminated employees cannot be offered group coverage unless they opt to purchase COBRA or state continuation coverages. Division approval for this classification is not required.

2. Association

Use of the Group Market Type "Association" classification requires that the policy be issued directly to the association covering members of the association as defined in § 10-16-214(1)(b), C.R.S. Coverage under the policy cannot continue if the member ceases membership in the association. The association shall be formed and maintained in good faith for purposes other than obtaining insurance. Association by-laws and Articles of Incorporation shall be submitted in a separate filing for each association. Minimum coverage requirements of at least 25 members shall be met.

a. Multi-state associations shall meet the definition found at § 10-16-102(68), C.R.S.

b. Bona fide associations shall meet the definition found at § 10-16-102(6), C.R.S.

3. Under a policy issued to a person or organization to which a group life policy may be issued or delivered in the state as defined under § 10-16-214(1)(c), C.R.S. Be advised that Colorado law, under § 10-7-201, C.R.S., does not allow a group life policy to be delivered in Colorado if the group was formed for the sole purpose of obtaining insurance. Division approval is required for this type of group prior to the issuance of coverage.

4. Under a policy issued to a substantially similar group, such as a policy issued to an employer covering less than ten (10) full time employees in a valid employer/employee relationship. Employer groups covering less than ten (10) employees do not require submission to the Division for approval as a valid group. All other groups not meeting the definition of employer group shall be submitted to the Division for approval and shall provide adequate support for the validity of the group. Financial institutions, credit cardholders, buying clubs, and affinity groups do not meet Colorado requirements as valid groups.

C. Large Group Health Coverage Plans

Large group health coverage plan contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing shall contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes including trend continuation. Each filing shall also contain an example of how the large group health rates are calculated. While the final rate charged to the large group may differ from the initial quote, all rating variables shall be on file with the Division.

D. Disability Income

The filing shall demonstrate that investment income has been considered in the development of the rate. Group disability income plans shall also meet the requirements under § 10-16-214(3)(a)(V)(C), C.R.S.

E. Limited Service Licensed Provider Network (LSLPN)

Rates and premiums for products issued by an LSLPN shall be determined on a fixed prepayment basis. Therefore, no LSLPN product shall be issued on a cost-plus or retrospective rating basis.

Section 10 Prohibited Rating Practices

The Commissioner has determined, in accordance with § 10-16-107, C.R.S., that the following rating practices lead to excessive, inadequate or unfairly discriminatory rates and are prohibited:

A. Premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve. However, this requirement is not intended to prohibit the use of a premium schedule which provides for premiums to a specific age followed by a level premium, or the use of reasonable step rating;

B. The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income; and

C. For individual health coverage plans other than Medicare supplement, rates shall not vary due to the gender of the individual policyholder, enrollee, subscriber, or member for rates effective on or after January 1, 2011, pursuant to § 10-16-107(2), C.R.S

Section 11 Wellness Benefit Requirements

A. Wellness benefits must be paid to the insured and shall be paid on an indemnity basis. These benefits may be included in accident-only coverage, disability income coverage, or hospital indemnity coverage. If the policy includes wellness benefits, they must be fully disclosed and properly labeled on the front page of the policy and the certificate.

B. Wellness benefits may be included in the following types of coverage:

1. Accident-only coverage: If wellness benefits are included, the coverage must be labeled “Accident-only policy with wellness benefits”. Accident-only coverage and accident-only coverage with wellness benefits must not include medical expense benefits. This coverage must not include a coordination of benefits provision or any other provision that allows the policy to reduce its benefits with respect to any other coverage its covered person may have.

2. Disability income coverage: If wellness benefits are included, the coverage must be labeled “Disability income policy with wellness benefits”. Disability income policies and disability income policies with wellness benefits must not include annual doctor visits or outpatient coverage. If additional benefits are provided, such benefits must be periodic payment to replace income lost when the insured cannot work due to a sickness or injury. Loan payments and mortgage expense benefits must be filed as credit disability insurance.

3. Hospital indemnity coverage: If wellness benefits are included, the coverage must be labeled “Hospital indemnity policy with wellness benefits”. Hospital indemnity coverage and hospital indemnity coverage with wellness benefits must not include a coordination of benefits provision or any other provision that allows the coverage to reduce its benefits with respect to any other coverage its covered person may have.

Section 12 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 13 Incorporation by Reference

Actuarial Guideline 51, published by the National Association of Insurance Commissioners Center for Insurance Policy and Research shall mean Actuarial Guideline LI (AG 51), as published on the effective date of this regulation and does not include later amendments to, or editions of Actuarial Guideline 51 as published by the National Association of Insurance Commissioners Center for Insurance Policy and Research. A copy of Actuarial Guideline 51 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A charge for copies may apply. A copy may also be obtained online at the NAIC's website at https://naic.soutronglobal.net/Portal/Public/en-US/RecordView/Index/26732.

Section 14 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 15 Effective date

This regulation is amended effective July 30, 2024.

Section 16 History

Regulation 4-2-11, effective November 1, 1992.
Regulation Repealed and Re-promulgated, effective February 1, 1999.
Regulation amended effective January 1, 2001.
Regulation amended effective December 1, 2005.
Regulation amended effective December 1, 2007.
Emergency Regulation 08-E-4 was effective July 1, 2008.
Regulation amended effective October 1, 2008.
Regulation amended effective February 1, 2009.
Regulation amended effective July 1, 2009.
Regulation amended effective January 1, 2010.
Regulation 4-2-11 amended, effective May 1, 2010.
Regulation 4-2-11 amended, effective January 1, 2011.
Regulation 4-2-11 amended, effective January 1, 2012.
Regulation 4-2-11 amended, effective February 1, 2013.
Regulation 4-2-11 amended, effective October 1, 2013.
Regulation 4-2-11 Repealed and Repromulgated, effective February 1, 2020.
Amended regulation effective July 30, 2024.

Appendix A: Determination of Credibility Weights in Case of Nationwide Experience Not Reaching Full Credibility in Most Recent 3 Years

	Colorado experience			Nationwide experience		
Year	**# Claims**	**# Life Years**		**# Claims**	**# Life Years**	
2004	5	200		800	5,000	
2003	18	500		500	10,000	
2002	5	300		400	8,000	
2001	2	100		500	12,000	
2000	12	200		300	7,000	
	Cumulative Totals			Cumulative Totals		
Most recent # years	**# Claims**	**# Life Years**	**Min(Life years, Claims)**	**# Claims**	**# Life Years**	**Min(Life years, Claims)**
3	28	1,000	28	1,700	23,000	1,700
4	30	1,100	30	2,200	35,000	2,200
5	42	1,300	42	2,500	42,000	2,500

Colorado experience does not reach full credibility alone in the carrier's most recent 3 years.

Nationwide doesn't reach full credibility in 3 years,

but does reach full credibility in 4 years (Min(# Life years, # Claims)) > 2000.

Therefore, the most recent 4 years of experience is the experience basis for rating.

With Colorado experience as observation,

and Nationwide experience as the complement of credibility.

Most recent 4 years of experience:

Colorado credibility = SQRT(30/2000)

Nationwide weight (complement of credibility) = 1 - Colorado credibility

Regulation 4-2-13 Repealed in Full [eff. 01/01/2010]

Regulation 4-2-15 REQUIRED PROVISIONS IN CARRIER CONTRACTS WITH PROVIDERS, CARRIER CONTRACTS WITH INTERMEDIARIES NEGOTIATING ON BEHALF OF PROVIDERS, AND CARRIER CONTRACTS WITH INTERMEDIARIES CONDUCTING UTILIZATION REVIEWS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-16-121(5), and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to describe the entities subject to the provisions of § § 10-16-121, and 10-16-705, C.R.S., which concern the required provisions in insurance carrier's contracts with health care providers and intermediaries, and to establish how those entities shall meet the requirements of the above sections.

Section 3 Applicability

The provisions of this regulation shall apply to all contracts that concern the delivery, provision, payment or offering of care or services covered by a managed care plan that are entered into between a carrier and a provider or its representative, or between a carrier and an intermediary.

Section 4 Definitions

As used in this regulation, and unless the context requires otherwise:

A. "Carrier" is defined in § 10-16-102(8), C.R.S.

B. "Intermediary" is defined in § 10-16-102(40), C.R.S.

C. "Managed care plan" is defined in §10-16-102(43), C.R.S.

D. "Utilization management" is defined in § 10-16-1002(10), C.R.S.

E. "Utilization review" is defined in § 10-16-112(1)(b), C.R.S.

Section 5 Rules

A. Every contract between a carrier that has covered lives in Colorado and a provider or its representative that concerns the delivery, provision, payment or offering of care or services covered by a managed care plan that is issued, renewed, amended or extended shall contain provisions substantially similar to the following:

1. "No individual or group of providers covered by this contract shall be prohibited from protesting or expressing disagreement with a medical decision, medical practice of [name of carrier] or an entity representing or working for the carrier (e.g., a utilization review company)."

2. "[Name of carrier] or an entity representing or working for the carrier shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of an individual or group or providers covered by this contract."

3. "[Name of carrier] shall not terminate this contract because a provider covered by this contract expresses disagreement with a decision by [name of carrier] or an entity representing or working for such carrier to deny or limit benefits to a covered person or because the provider discusses with a current, former or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions or a plan, or a provider's personal recommendation regarding selection of a health plan based upon the provider's personal knowledge of the health needs of such patients."

B. Every contract between a carrier and an intermediary that concerns the delivery, provision, payment or offering of care or services covered by a managed care plan that is issued, renewed, amended or extended shall contain a provision requiring that the underlying contract authorizing the intermediary to negotiate and execute contracts with carriers, on behalf of providers, contain provisions substantially similar to the following:

1. "No individual or group of providers covered by any contract executed by [name of intermediary] shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of the carrier or an entity representing or working for such carrier (e.g. a utilization review company);"

2. "The carrier or an entity representing or working for such carrier shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of an individual or group of providers covered by any contract executed by [name of intermediary];"

3. "The carrier shall not terminate any contract executed by [name of intermediary] because any individual or group of providers covered by the contract:

a. Expresses disagreement with a decision by the carrier or an entity representing or working for such carrier to deny or limit benefits to a covered person,

b. Assists the covered person to seek reconsideration for the carrier's decision, or

c. Discusses with a current, former or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the needs of such patients."

C. Any contract entered into by a carrier with one or more intermediaries to conduct utilization management, utilization reviews, provider credentialing, administration of health insurance benefits, setting or negotiation of reimbursement rates, payment to providers, network development, or disease management programs, when issued, renewed, amended or extended shall contain provisions requiring the intermediary to:

1. Comply with the same standards, guidelines, medical policies, and benefit terms of the carrier; and

2. Indicate the name of the intermediary and the name of the carrier for which it is conducting the work when making any payment to a health care provider on behalf of the carrier.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this Regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process. Among others, the penalties provided for in §10-3-1108, C.R.S. may be applied.

Section 8 Effective Date

This regulation shall become effective on January 15, 2014.

Section 9 History

New regulation effective October 30, 1996.
Amended regulation effective December 1, 2009.
Amended regulation effective January 15, 2014.

Regulation 4-2-16 [Repealed eff. 01/01/2014]

Regulation 4-2-17 PROMPT INVESTIGATION OF HEALTH CLAIMS INVOLVING UTILIZATION REVIEW AND DENIAL OF BENEFITS AND RULES RELATED TO INTERNAL CLAIMS AND APPEALS PROCESSES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-1110, 10-16-109, and 10-16-113(2) and (10), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of §§ 10-3-1104(1)(h), 10-16-409(1)(a), and 10-16-113, C.R.S., in situations involving utilization review and certain denials of benefits for treatment, as well as rescission, cancellation, or denial of coverage based on an eligibility determination, as described herein. Among other things, § 10-3-1104(1)(h), C.R.S., requires carriers to adopt and implement reasonable standards for the prompt investigation of claims arising from health coverage plans; promptly provide a reasonable explanation of the basis in the health coverage plan in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and refrain from denying a claim without conducting a reasonable investigation based upon all available information.

This regulation is designed to provide minimum standards for handling appeals and grievances involving utilization review determinations, certain denials of benefits for treatments excluded by health coverage plans, and as otherwise required by § 10-16-113, C.R.S.

Section 3 Applicability

The provisions of this regulation shall apply to all health coverage plans, including, but not limited to, dental insurance policies. It does not apply to long-term care insurance policies as the requirements for the appeals process for that type of health coverage plan is covered under a separate regulation. This regulation shall not apply to automobile medical payment policies, worker's compensation policies, or property and casualty insurance. Where a decision concerning a claim is not based on utilization review, a carrier is not required to use the specific procedures outlined in this regulation. However, this regulation shall apply to a carrier's denial of a benefit because the treatment is excluded by the health coverage plan if the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply. Nothing in this regulation shall be construed to supplant any appeal or due process rights that a person may have under federal or state law.

Solely with respect to the requirements in sections 7.F.2. and 8.F.2., this regulation does not apply to a health maintenance organization which provides a majority of covered professional services through a single contracted medical group or to a nonprofit health maintenance organization operated by or under the control of the Denver Health and Hospital Authority created by Article 29 of Title 25 or any of its subsidiaries.

Section 4 Definitions

A. "Adverse determination" means, for the purposes of this regulation:

1. A determination by a carrier or its designee that a request for a prospective or retrospective benefit has been reviewed and, based upon the information provided, does not meet the carrier's requirement for medical necessity, or that the benefit is not appropriate, effective, efficient, is not provided in or at the appropriate health care setting or level of care, or is determined to be experimental or investigational, and is therefore denied, reduced, or terminated;

2. A denial for a benefit excluded by a health coverage plan for which the covered person is able to present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit;

3. A rescission or cancellation of coverage applied retroactively that is not attributed to a failure to pay premiums. However, a physician is not required to evaluate an appeal of this type of adverse determination; and

4. A denial of coverage to an individual based on an initial eligibility determination for all:

   a. Individual sickness and accident insurance policies issued by a carrier subject to Part 2 of Article 16 of Title 10; and

   b. Individual health care or indemnity contracts issued by a carrier subject to Parts 3 or 4 of Article 16 of Title 10.

   Section 4.A.4. does not apply to supplemental policies covering a specified disease or other limited benefit. A physician is not required to evaluate an appeal of this type of adverse determination.

B. "Ambulatory review" means, for the purposes of this regulation, a utilization review of health care services performed or provided in an outpatient setting.

C. "Applicable non-English language" means, for the purposes of this regulation, with respect to an address in any Colorado county to which a notice is sent, a non-English language that ten percent (10%) or more of the population residing in the county is only literate in as determined by the Secretary of the United States Department of Health and Human Services.

D. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

E. "Carrier's receipt" means, for the purposes of this regulation, the receipt date as date-stamped by the carrier in a legible manner; an electronically-formatted receipt date; a facsimile transmission date; or a receipt date imprinted on the document in some type of permanent manner. The earliest receipt date on the document will be considered the carrier's receipt date.

F. "Case management" means, for the purposes of this regulation, a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

G. "Clinical peer" means, for the purposes of this regulation, a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

H. "Complaint" means, for the purposes of this regulation, a written communication primarily expressing a grievance.

I. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

J. "Date of receipt of a notice" means, for the purposes of this regulation, the date that shall be calculated to be no less than three (3) calendar days after the date the notice is postmarked by the carrier.

K. "Designated representative" means, for the purposes of this regulation:

1. A person, including the treating health care professional or a person authorized by subsection 4.K.2., to whom a covered person has given express written consent to represent the covered person;

2. A person authorized by law to provide substituted consent for a covered person, including but not limited to a guardian, agent under a power of attorney, a proxy, or a designee of the Colorado Department of Health Care Policy and Financing; and/or

3. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

L. "Disability" means, for the purposes of this regulation, with respect to a covered person, a physical or mental impairment that substantially limits one or more of the major life activities of such covered person, in accordance with the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101.

M. "Discharge planning" means, for the purposes of this regulation, the formal process for determining, prior to discharge from a medical facility or service, the coordination and management of the care that a covered person receives following discharge from a medical facility or service.

N. "Emergency medical condition" means, for the purposes of this regulation, the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the covered person's health in serious jeopardy.

O. "Grievance" means, for the purposes of this regulation, a circumstance regarded as a cause for protest, including the protest of an adverse determination.

P. "Health care professional" means, for the purposes of this regulation, a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

Q. "Health care services" shall have the same meaning as found at § 10-16-102(33), C.R.S.

R. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.

S. "Life or limb threatening emergency" means, for the purposes of this regulation, any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

T. "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.

U. "Medical facility" means, for the purposes of this regulation, an institution providing health care services, or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

V. "Medical professional" means, for the purposes of this regulation, an individual licensed pursuant to the "Colorado Medical Practice Act", article 240 of title 12, C.R.S., or, for dental plans only, a dentist licensed pursuant to the "Dental Practice Law of Colorado", article 220 of title 12, C.R.S., acting within his or her scope of practice.

W. "Notice of the adverse determination" and "notice of the initial adverse determination", for the purposes of this regulation, do not include an explanation of benefits (EOB) form.

X. "Prior authorization" shall have the same meaning as found at § 10-16-112.5(7)(d), C.R.S.

Y. "Prospective review" and "prospective utilization review" mean, for the purposes of this regulation, a utilization review conducted prior to an admission or course of treatment requested by a covered person, designated representative, medical facility, or health care professional. It does not include prior authorizations required by a carrier.

Z. "Rescission" means, for the purposes of this regulation, the cancellation or discontinuance of coverage that has a retroactive effect. This includes a cancellation that treats a policy as void from the time of enrollment and a cancellation that voids benefits paid up to a year before the cancellation takes place. A rescission of coverage shall be treated as an adverse determination. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance is exclusively prospective, or the cancellation or discontinuance is retroactive only to the extent attributable to a failure to pay premiums or contributions toward the cost of coverage in a timely manner.

AA. "Retrospective review" and "retrospective utilization review" mean, for the purposes of this regulation, utilization review conducted after services have been provided to a covered person, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

AB. "Second opinion" means, for the purposes of this regulation, an opportunity or requirement to obtain a clinical evaluation by a health care professional other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the proposed health care service.

AC. "Voluntary second level review" means, for the purposes of this regulation, a request for a review of an adverse determination from a first-level appeal which is only available to persons covered under a group health coverage plan.

AD. "Stabilized" means, for the purposes of this regulation, with respect to an emergency medical condition or a life or limb threatening emergency, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred.

AE. "Urgent care request" means, for the purposes of this regulation:

1. A request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination that:

    a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or for a covered person with a physical or mental disability, creates an imminent and substantial limitation on his or her existing ability to live independently; or

    b. In the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

2. Except as provided in section 4.AE.3., in determining whether a request is to be treated as an urgent care request, a person acting on behalf of the carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

3. Any request that a health care professional with knowledge of the covered person's medical condition determines and states is an urgent care request within the meaning of section 4.AE.1. shall be treated as an urgent care request.

AF. "Utilization review" means, for the purposes of this regulation, a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, authorization, concurrent review, case management, discharge planning, and retrospective review. It also includes reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Section 5 Compliance Requirements

A. Pursuant to § 10-3-1104(1)(h)(IV), C.R.S., a carrier that does not use a procedure for investigating claims involving utilization review consistent with this regulation shall be deemed to be in violation of the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information.

B. Pursuant to § 10-3-1104(1)(h)(III), C.R.S., a carrier using standards in the review of claims involving utilization review that are not in compliance with the rules contained in this regulation shall be deemed to be in violation of the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier use reasonable standards for the prompt investigation of claims.

C. Pursuant to § 10-3-1104(1)(h)(II), C.R.S., a carrier that does not investigate claims involving utilization review within the time frames set out in this regulation shall be deemed to be in violation of the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly investigate claims.

D. Pursuant to § 10-3-1104(1)(h)(XIV), C.R.S., a carrier that does not follow the procedures for explaining the basis of a utilization review decision set forth in this regulation shall be deemed to be in violation of the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim.

E. Pursuant to § 10-3-1104(1)(h)(IV), C.R.S., a carrier that does not allow an appeal, consistent with the procedures set forth in this regulation, of a benefit denial for a treatment excluded by the health coverage plan when the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply shall be deemed to be in violation of the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information.

F. Carriers shall avoid conflicts of interest to ensure all benefit reviews and appeals are adjudicated in a manner designed to guarantee the independence and impartiality of the persons involved in making the decision. With respect to any person involved in the review of benefit requests and/or the review of appeals, decisions regarding hiring, compensation, termination, or promotion shall not be made based upon the likelihood that the person will support the denial of benefits.

Section 6 Form and Manner of Notices

A. Carriers shall provide all relevant notices in a culturally and linguistically appropriate manner as follows:

1. In the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the carrier; and

2. Shall provide, upon request, a notice in any applicable non-English language and shall allow the covered person the option of electing to receive all subsequent notices in the requested applicable non-English language.

B. Carriers shall provide oral language services in any applicable non-English language, providing assistance with answering questions about the filing of benefit requests and appeals.

C. Solely for the purposes of the requirements of section 6.A.2., the term “notice” does not include a carrier’s explanation of benefits form.

Section 7 Standard Utilization Review

A. A carrier shall establish written procedures in compliance with all of the requirements of this section for:

1. Reviewing prospective benefit requests received from a covered person, medical facility or a health care professional; and

2. Making and notifying the covered person, medical facility or the health care professional, as applicable, of utilization review decisions with respect to non-urgent benefit requests.

B. Prospective utilization review determinations.

1. Time period for determination and notification.

a. Subject to section 7.B.1.b., a carrier shall make the determination and notify the covered person and the covered person’s medical facility or health care professional of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person’s medical condition, but in no event later than fifteen (15) calendar days after the carrier’s receipt of the request. Whenever the determination is an adverse determination, the carrier shall make the notification of the adverse determination in accordance with section 7.E.

b. The time period for making a determination and notifying the covered person of the determination pursuant to section 7.B.1.a. may be extended one (1) time by the carrier for up to fifteen (15) calendar days, provided the carrier:

(1) Determines that an extension is necessary due to matters beyond the carrier’s control; and

(2) Notifies the covered person, prior to the expiration of the initial fifteen (15) calendar day time period, of the circumstances requiring the extension of time and the date by which the carrier expects to make a determination.

c. If the extension under section 7.B.1.b. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:

(1) Specifically describe the required information necessary to complete the request; and

(2) Give the covered person at least forty-five (45) calendar days from the date of receipt of a notice to provide the specified information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline will be extended to the next business day.

d. All coverage determinations shall include:

(1) A review of the covered person’s eligibility; and

(2) A review of the applicability of the health coverage plan's benefits, limitations and exclusions.

e. The authorization notice shall state that the service(s) and treatment(s) which are the subject of the standard utilization review request are covered services, subject to all of the terms and conditions of the policy, as long as:

(1) The covered person is still covered by the health coverage plan at the time the service(s) and treatment(s) are provided;

(2) The health care professional(s) and medical facility(ies) performing the authorized services are part of the carrier's network at the time of service unless otherwise specifically authorized; and

(3) Benefit limitations, such as annual visit or monetary limitations, which may apply to the approved service(s) and treatment(s) have not been exhausted.

f. Carriers may include beginning/end dates or the length of time the authorization is effective appropriate to the type of service being pre-authorized provided that they do not unnecessarily restrict the covered person's ability to schedule the services.

2. Failure to meet the carrier's filing procedures.

a. Whenever the carrier receives a prospective review request from a covered person that fails to meet the carrier's filing procedures, the carrier shall notify the covered person of this failure and provide in the notice information on the proper procedures to be followed for filing a request.

b. Required notice.

(1) The notice required under section 7.B.2.a. shall be provided as soon as possible, but in no event later than five (5) calendar days following the date of the failure.

(2) The carrier shall provide the notice in writing.

c. The provisions of section 7.B.2. shall apply only in the case of a failure that:

(1) Is a communication by a covered person that is received by a person or organizational unit of the carrier responsible for handling benefit matters; and

(2) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or medical facility and/or health care professional for which authorization is being requested.

3. For an adverse determination regarding a prospective review decision that occurs during a covered person's hospital stay or course of treatment, also known as concurrent review, the health care service or treatment that is the subject of an adverse determination shall continue to be covered according to the provisions of the health coverage plan until the covered person has been notified of the determination by the carrier.

4. The requirements of section 7.B. apply to all written requests involving utilization review received by the carrier which are submitted by a covered person or a medical facility and/or health care professional requesting a determination of coverage for a specific health care service or treatment for the covered person.

C. Retrospective utilization review determinations.

1. For retrospective utilization review determinations, a carrier shall make the determination and notify the covered person and the covered person's medical facility and/or health care professional of the determination within a reasonable period of time, but in no event later than thirty (30) calendar days after the carrier's receipt of the benefit request. Whenever the determination is an adverse determination, the carrier shall provide notice of the adverse determination to the covered person in accordance with section 7.E.

2. Time period for determination and notification.

a. The time period for making a determination and notifying the covered person of the determination pursuant to section 7.C.1. may be extended one (1) time by the carrier for up to fifteen (15) calendar days, provided the carrier:

(1) Determines that an extension is necessary due to matters beyond the carrier's control; and

(2) Notifies the covered person, prior to the expiration of the initial thirty (30) calendar day time period, of the circumstances requiring the extension of time and the date by which the carrier expects to make a determination.

b. If the extension under section 7.C.2.a. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:

(1) Specifically describe the required information necessary to complete the request; and

(2) Give the covered person at least forty-five (45) calendar days from the date of receipt of a notice to provide the specified information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline shall be extended to the next business day.

D. Calculation of time periods.

1. For purposes of calculating the time periods within which a determination is required to be made under sections 7.B. and 7.C., the time period shall begin on the date of the carrier's receipt of the request in accordance with the carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.

2. Extensions.

a. If the time period for making the determination under sections 7.B. or 7.C. is extended due to the covered person's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the carrier sends the notification of the extension to the covered person until the earlier of:

(1) The date on which the covered person responds to the request for additional information; or

(2) The date on which the specified information was to have been submitted.

b. If the covered person fails to submit the information before the end of the period of the extension, as specified in sections 7.B. or 7.C., the carrier may deny the authorization of the requested benefit.

E. Requirements for adverse determination notifications.

1. Except for the adverse determinations described section 7.E.2., a notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

a. An explanation of the specific medical basis for the adverse determination;

b. The specific reason or reasons for the adverse determination;

c. Reference to the specific plan provisions on which the determination is based;

d. A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

e. If the carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

f. If the adverse determination is based on a medical necessity, experimental or investigational treatment, or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

g. Information sufficient for the covered person to be able to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

h. If applicable, instructions for requesting:

(1) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in section 7.E.1.e.;

(2) The written statement of the scientific or clinical rationale for the adverse determination, as provided in section 7.E.1.f.; and/or

(3) The information necessary to identify the claim, as provided in section 7.E.1.g.;

i. A description of the carrier's review procedures and the time limits applicable to such procedures; and

j. An explanation of the right of the covered person to appeal an initial adverse determination with a description of the procedures for requesting an appeal.

(1) For individual health coverage plans, the notice shall include:

(a) An explanation of the right to a single level of internal appeal through a written appeal review or, unless it is an expedited appeal, the ability to appear in person or by telephone conference at a review meeting; and

(b) A description of the process to schedule a review meeting including the covered person's rights pursuant to section 12.

(2) For group health coverage plans, the notice shall advise that the covered person does not have the right to be present during the first level review.

2. For denials based on a contractual exclusion, the adverse determination notice shall include the health coverage plan's specific exclusion language and shall advise the covered person of the right to appeal the applicability of the exclusion by providing evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply.

3. A carrier shall provide the notice required under this section in writing, either on paper or electronically.

4. All written adverse determinations, except an adverse determination described in § 10-16-113(1)(b)(I)(C) and (E), C.R.S., shall be reviewed and signed by a licensed physician familiar with standards of care in Colorado. In the case of written denials of requests for covered benefits for dental care, a licensed dentist familiar with standards of care in Colorado may review and sign the written denial. Initial adverse determination notifications provided on an explanation of benefits form (EOB) are exempt from this requirement.

5. The notice of the initial adverse determination shall include information concerning the covered person's ability to request an internal and external expedited review on a concurrent basis. This information may be included in the letter or other notice advising the covered person of the finding of an adverse determination, or it may be included as a separate document within the same mailing.

F. Applicability.

1. The requirements of section 7 apply to all written requests involving standard utilization prospective reviews received by the carrier which are submitted by covered person, designated representative, a medical facility, and/or a health care professional requesting a determination of coverage for a specific health care service or treatment for the covered person.

2. Carriers' Requirements for Non-Urgent Prior Authorization Requests.

a. Time period for determination and notification.

(1) Carriers shall notify the medical facility or health care professional, as applicable, and the covered person within five (5) business days after the carrier's receipt of the request, that the request is approved, denied, or incomplete.

(2) If the request is incomplete, the carrier shall indicate the specific additional information consistent with the requirements of §§ 10-16-112.5(2)(a) and 10-16-112.5(4)(a)(III), C.R.S., required to process the request.

(a) The medical facility or health care professional, as applicable, shall submit the additional information within two (2) business days after receipt of the request for additional information. If the medical facility or health care professional, as applicable, fails to submit the required additional information, the prior authorization is not deemed granted.

(b) If additional information pursuant to the requirements of § 10-16-112.5(4)(a)(III), C.R.S., is required from the covered person, carriers shall give him or her at least forty-five (45) calendar days from the date of receipt of the notice to provide the specified information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline will be extended to the next business day.

(i) Carriers shall notify the medical facility or health care professional, as applicable, that the covered person has additional time to submit the required information.

(ii) The prior authorization request will not be deemed as granted during this time period.

(3) Carriers shall notify the medical facility or health care professional, as applicable, and the covered person that the request is approved or denied within five (5) business days after the carrier's receipt of the additional information required pursuant to section 7. F.2.a.(2) or the end of time period specified in section 7.F.2.a.(2)(b).

(4) The prior authorization request is deemed granted if a carrier fails to provide the notification as required by section 7.F.2.a.(1). except as provided in section 7.F.2.a.(2)(b). Carriers shall assign a unique authorization number to be utilized by the medical facility or health care professional, as applicable, for claim submission for a prior authorization that is deemed granted pursuant to this Section 7.F.2.a.(4).

b. Approval of the prior authorization request.

(1) All approvals shall include:

(a) A review of the covered person's eligibility; and

(b) A review of the applicability of the health coverage plan's benefits, limitations and exclusions; and

(c) A unique prior authorization number attributable to the request.

(2) The approval shall state that the service(s) and treatment(s) which are the subject of the prior approval request are covered services as long as the covered person is still covered by the same health coverage plan at the time the service(s) and treatment(s) are provided and shall include applicable requirements, if any, to use contracted medical facilities and health care professionals unless otherwise specifically authorized. The notice shall also reference any benefit limitations, such as annual visit or monetary limitations, which may apply to the approved service(s) and treatment(s).

c. Denial of the prior authorization request.

(1) If the carrier denies the prior authorization request, it shall comply with the requirements of section 7.E. as applicable;

(2) The carrier shall include information concerning any alternative treatment, test, procedure, or medication it requires; and

(3) The carrier shall assign and provide a unique prior authorization number attributable to the request as required by § 10-16-112.5(3)(c)(I), C.R.S.

(4) Section 7.F.2.c.(2) applies to prior authorization requests for drug benefits subject to § 10-16-124.5, C.R.S.

d. Upon approval, a prior authorization is valid for at least 180 days after the date of approval and continues for the duration of the authorized course of treatment unless:

(1) The prior authorization approval was based on fraud;

(2) The medical facility or health care professional, as applicable, never performed the services that were requested;

(3) The service provided did not align with the service that was authorized;

(4) The person receiving the service is no longer covered by the health coverage plan on or before the date the service was delivered; or

(5) The covered person's benefit maximums were reached on or before the date the service was delivered.

e. A change in a carrier's coverage or approval criteria for a previously approved health care service does not affect a covered person who received a prior authorization before the effective date of the change for the remainder of the covered person's plan year.

Section 8 Expedited Utilization Review

A. Procedures.

1. A carrier shall establish written procedures in compliance with all of the requirements of this section for:

a. Reviewing prospective urgent care benefit requests received from a covered person, medical facility or a health care professional; and

b. Making and notifying the covered person, medical facility or the health care professional, as applicable, of expedited utilization review decisions with respect to urgent care benefit requests.

For the purposes of Section 8, "covered person" includes the designated representative of a covered person.

2. Notification requirements.

a. As part of the procedures required under section 8.A.1., a carrier shall provide that, in the case of a failure by a covered person to follow the carrier's procedures for filing an urgent care request, the covered person shall be notified of the failure and the proper procedures to be followed for filing the request.

b. The notice required under section 8.A.2.a.:

(1) Shall be provided to the covered person as soon as possible but not later than twenty-four (24) hours after the carrier's receipt of the request; and

(2) Shall be in writing.

c. The provisions of section 8.A.2. apply only in the case of a failure that:

(1) Is a communication by a covered person that is received by a person or organizational unit of the carrier responsible for handling benefit matters; and

(2) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or medical facility and/or health care professional for which approval is being requested.

B. Urgent care requests.

1. Notification requirements for carrier determinations.

a. For an urgent care request, unless the covered person has failed to provide sufficient information for the carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the covered person's health coverage plan, the carrier shall notify the covered person and the covered person's medical facility and health care professional of the carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two (72) hours after the carrier's receipt of the request.

b. If the carrier's determination is an adverse determination, the carrier shall provide notice of the adverse determination in accordance with section 8.E.

c. All coverage determinations shall include:

(1) A review of the covered person's eligibility; and

(2) A review of the applicability of the health coverage plan's benefits, limitations and exclusions.

d. The authorization notice shall state that the service(s) and treatment(s) which are the subject of the urgent utilization review request are covered services, subject to all of the terms and conditions of the policy, as long as:

(1) The covered person is still covered by the health coverage plan at the time the service(s) and treatment(s) are provided;

(2) The health care professional(s) and medical facility(ies) performing the authorized services are part of the carrier's network at the time of service unless otherwise specifically authorized; and

(3) Benefit limitations, such as annual visit or monetary limitations, which may apply to the approved service(s) and treatment(s) have not been exhausted.

e. Carriers may include beginning/end dates or the length of time the authorization is effective appropriate to the type of service or treatment being pre-authorized provided that they do not unnecessarily restrict the covered person's ability to schedule the services.

2. Notification requirements for insufficient information.

a. If the covered person fails to provide sufficient information for the carrier to make a determination, the carrier shall notify the covered person either orally or, if requested by the covered person, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four (24) hours after the carrier's receipt of the request.

b. The carrier shall provide the covered person a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight (48) hours after notifying the covered person of the failure to submit sufficient information, as provided in section 8.B.2.a.

c. The carrier shall notify the covered person and the covered person's medical facility and health care professional of its determination with respect to the urgent care request as soon as possible, but in no event more than forty-eight (48) hours after the earlier of:

(1) The carrier's receipt of the requested specified information; or

(2) The end of the period provided for the covered person to submit the requested specified information.

d. If the covered person fails to submit the information before the end of the period of the extension, as specified in section 8.B.2.b., the carrier may deny the authorization of the requested benefit.

e. If the carrier's determination is an adverse determination, the carrier shall provide notice of the adverse determination in accordance with section 8.E.

C. Concurrent urgent care review requests.

1. For concurrent urgent care review requests involving a request by the covered person to extend the course of treatment beyond the initial period of time or the number of treatments authorized, if the request is made at least twenty-four (24) hours prior to the expiration of the authorized period of time or authorized number of treatments, the carrier shall make a determination with respect to the request and notify the covered person and the covered person's medical facility or health care professional of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than twenty-four (24) hours after the carrier's receipt of the request.

2. If the carrier's determination is an adverse determination, the carrier shall provide notice of the adverse determination in accordance with section 8.E. The health care service or treatment that is the subject of an adverse determination shall continue to be covered according to the provisions of the health coverage plan until the covered person has been notified of the determination by the carrier.

D. For purposes of calculating the time periods within which a determination is required to be made under sections 8.B. or 8.C., the time period shall begin on the date of the carrier's receipt of the request in accordance with the carrier's procedures established for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.

E. Adverse determination notification requirements.

1. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

a. An explanation of the specific medical basis for the adverse determination;

b. The specific reasons or reasons for the adverse determination;

c. Reference to the specific plan provisions on which the determination is based;

d. A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary;

e. If the carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

f. If the adverse determination is based on a medical necessity, experimental or investigational treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

g. Information sufficient for the covered person to be able to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

h. If applicable, instructions for requesting:

(1) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in section 8.E.1.e.;

(2) The written statement of the scientific or clinical rationale for the adverse determination, as provided in section 8.E.1.f.; and/or

(3) The information necessary to identify the claim, as provided in section 8.E.1.g.;

i. A description of the carrier's expedited review procedures and the time limits applicable to such procedures; and

j. An explanation of the right of the covered person to appeal an initial adverse determination with a description of the procedures for requesting an appeal.

(1) For individual health coverage plans, the notice shall include an explanation of the right to a single level of internal appeal through a written appeal review and, because it is an expedited appeal, the inability to appear in person or by telephone conference at a review meeting.

(2) For group health coverage plans, the notice shall advise that the covered person does not have the right to be present during the first level review.

2. Additional notification requirements.

a. A carrier may provide the notice required under this section orally, in writing, or electronically.

b. If notice of the adverse determination is provided orally, the carrier shall provide a written or electronic notice of the adverse determination within three (3) calendar days following the oral notification.

3. All written adverse determinations shall be reviewed and signed by a licensed physician familiar with standards of care in Colorado. In the case of written denials of requests for covered benefits for dental care, a licensed dentist familiar with standards of care in Colorado may review and sign the written denial.

4. The notice of the initial adverse determination shall include information concerning the covered person's ability to request an internal and external expedited review on a concurrent basis. This information may be included in the letter or other notice advising the covered person of the finding of an adverse determination, or it may be included as a separate document within the same mailing.

F. Applicability.

1. The requirements of section 8 apply to all written requests involving expedited utilization prospective reviews received by the carrier which are submitted by a covered person, designated representative, a medical facility, or a health care professional requesting a determination of coverage for a specific health care service or treatment for the covered person.

2. Carriers' Requirements for Urgent Prior Authorization Requests.

a. Time period for determination and notification.

(1) Carriers shall notify the medical facility or health care professional, as applicable, and the covered person within two (2) business days but not longer than seventy-two (72) hours after the carrier's receipt of the request, that the request is approved, denied, or incomplete.

(2) If the request is incomplete, the carrier shall indicate the specific additional information consistent with the requirements of §§ 10-16-112.5(2)(a) and 10-16-112.5(4)(a)(III), C.R.S., required to process the request.

(a) The medical facility or health care professional, as applicable, shall submit the additional information within two (2) business days after receipt of the request for additional information. If the medical facility or health care professional, as applicable, fails to submit the required additional information, the prior authorization is not deemed granted.

(b) If additional information pursuant with the requirements of § 10-16-112.5(4)(a)(III), C.R.S., is required from the covered person, carriers shall give him or her at least forty-eight (48) hours from the date of receipt of the notice to provide the specified information.

(i) Carriers shall notify the medical facility or health care professional, as applicable, that the covered person has additional time to submit the required information.

(ii) The prior authorization request will not be deemed as granted during this time period.

(3) Carriers shall notify the medical facility or health care professional, as applicable, and the covered person that the request is approved or denied within forty-eight (48) hours after the carrier's receipt of the additional information required pursuant to section 8.F.2.a.(2) or the end of time period specified in section 8.F.2.a.(2)(b).

(4) The prior authorization request is deemed granted if a carrier fails to provide the notification as required by section 8.F.2.a.(1) except as provided in section 8.F.2.a.(2)(b). Carriers shall assign a unique authorization number to be utilized by the medical facility or health care professional, as applicable, for claim submission for a prior authorization that is deemed granted pursuant to this Section 8.F.2.a.(4).

b. Approval of the prior authorization request.

(1) All approvals shall include:

(a) A review of the covered person's eligibility;

(b) A review of the applicability of the health coverage plan's benefits, limitations and exclusions; and

(c) A unique prior authorization number attributable to the request.

(2) The approval shall state that the service(s) and treatment(s) which are the subject of the prior approval request are covered services as long as the covered person is still covered by the same health coverage plan at the time the service(s) and treatment(s) are provided and shall include applicable requirements, if any, to use contracted medical facilities and health care professionals unless otherwise specifically authorized. The notice shall also reference any benefit limitations, such as annual visit or monetary limitations, which may apply to the approved service(s) and treatment(s).

c. Denial of the prior authorization request.

(1) If the carrier denies the prior authorization request, it shall comply with the requirements of section 8.E. as applicable;

(2) The carrier shall include information concerning any alternative treatment, test, procedure, or medication it requires; and

(3) The carrier shall assign and provide a unique prior authorization number attributable to the request as required by § 10-16-112.5(3)(c)(I), C.R.S.

(4) Section 8.F.2.c.(2) applies to prior authorization requests for drug benefits subject to § 10-16-124.5, C.R.S.

d. Upon approval, a prior authorization is valid for at least 180 days after the date of approval and continues for the duration of the authorized course of treatment unless:

(1) The prior authorization approval was based on fraud;

(2) The medical facility or health care professional, as applicable, never performed the services that were requested;

(3) The service provided did not align with the service that was authorized;

(4) The person receiving the service is no longer covered by the health coverage plan on or before the date the service was delivered; or

(5) The covered person's benefit maximums were reached on or before the date the service was delivered.

e. A change in a carrier's coverage or approval criteria for a previously approved health care service does not affect a covered person who received a prior authorization before the effective date of the change for the remainder of the covered person's plan year as long as the service(s) and treatment(s) are obtained from a contracted medical facility or health care professional, as applicable.

Section 9 Emergency Services

A. A carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent layperson having average knowledge of health care services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed. Under these same circumstances, a claim for emergency services necessary to screen and stabilize a covered person shall not be denied for failure by the covered person or the emergency service medical facility or health care professional to secure prior authorization.

B. With respect to care obtained from a non-contracted medical facility or health care professional within the service area of a managed care plan, a carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent layperson would have reasonably believed that use of a contracted medical facility or health care professional would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific medical facility or health care professional.

C. Health maintenance organizations shall also comply with the life or limb threatening emergency coverage provisions of § 10-16-407(2), C.R.S., in reviewing claims for emergency services necessary to screen and stabilize a covered person.

Section 10 Peer-to-Peer Conversation

A. In a case involving a prospective review determination, a carrier shall give the medical facility aor health care professional rendering the service an opportunity to request, on behalf of the covered person, a peer-to-peer conversation regarding an adverse determination by the reviewer making the adverse determination. Such a request may be made either orally or in writing.

B. The peer-to-peer conversation shall occur within five (5) calendar days of the carrier's receipt of the request and shall be conducted between the medical facility or health care professional rendering the health care service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination cannot be available within five (5) calendar days.

C. If the peer-to-peer conversation does not resolve the difference of opinion, the adverse determination may be appealed by the covered person. A peer-to-peer conversation is not a prerequisite to a first level review or an expedited review of an adverse determination.

D. For the purposes of § 10-3-1104(1)(i), C.R.S., a request for a peer-to-peer conversation shall not be considered a complaint.

Section 11 First Level Review

A. General requirements.

1. A carrier shall establish written procedures for the review of an adverse determination that does not involve an urgent care request in compliance with § 10-16-113, C.R.S., and this regulation. The procedures shall specify whether a first level review request must be in writing or may be submitted orally. The procedures shall also allow the covered person to identify the medical facility and health care professionals to whom the carrier shall send a copy of the review decision.

2. A first level review shall be available to, and may be initiated by, the covered person. For purposes of this section, "covered person" includes the designated representative of a covered person.

3. Pursuant to § 10-3-1104(1)(i), C.R.S., all written requests for a first level review shall be entered into the carrier's complaint record.

4. Within 180 calendar days after the date of receipt of a notice of an adverse determination sent pursuant to sections 7 or 8 or after the date of receipt of notification of a benefit denied due to a contractual exclusion, a covered person may file a grievance with the carrier requesting a first level review of the adverse determination. In order to secure a first level review after the receipt of the notification of a benefit denied due to a contractual exclusion, the covered person must be able to provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply. If the deadline for filing a request ends on a weekend or holiday, the deadline shall be extended to the next business day.

5. Full and fair review.

a. Before issuing a final internal adverse benefit determination based on new and/or additional evidence, the carrier shall provide the covered person, free of charge, the new and/or additional evidence considered, relied upon, or generated by the carrier in connection with the claim. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of the final internal adverse benefit determination is required to be provided pursuant to section 11.E. to give the covered person a reasonable opportunity to respond prior to that date.

b. Before issuing a final internal adverse benefit determination based on new and/or additional rationale, the carrier shall provide the covered person, free of charge, with the rationale considered, relied upon, or generated by the carrier in connection with the claim. Such rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of the final internal adverse benefit determination is required to be provided pursuant to section 11.E. to give the covered person a reasonable opportunity to respond prior to that date.

B. Individual health coverage plans.

1. Covered persons shall be provided a choice between a written appeal review and a review meeting for their first level appeal.

2. Written appeal reviews shall comply with the requirements of section 11.C.

3. Review meetings shall comply with the requirements of section 12. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review meeting.

4. The covered person is entitled to a single internal appeal review.

C. Conduct of first level written appeal reviews.

1. First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer(s), unless the reviewing physician is a clinical peer, except that, in the case of dental care, a dentist may evaluate the appeal, and the reviewing dentist shall consult with an appropriate clinical peer or peers. The physician, dentist, or clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions.

2. In conducting a review under this section, the reviewer(s) shall take into consideration all comments, documents, records, and other information regarding the request for services or benefits submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination. If the appeal is pursuant to § 10-16-113(1)(c), C.R.S., regarding the applicability of a contractual exclusion, the determination shall be made on the basis of whether the contractual exclusion applies to the denied benefit.

D. Covered person's rights for first level written appeal review for individual and group health coverage plans. A covered person is entitled to:

1. Submit written comments, documents, records, and other material relating to the request for benefits for the reviewer(s) to consider when conducting the review. For review of a benefit denial due to a contractual exclusion, the covered person shall provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply; and

2. Receive from the carrier, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the covered person's request for benefits. A document, record, or other information shall be considered "relevant" to a covered person's request for benefits if the document, record, or other information:

a. Was relied upon in making the benefit determination;

b. Was submitted, considered, or generated in the course of making the adverse determination, without regard to whether the document, record, or other information was relied upon in making the benefit determination;

c. Demonstrates that, in making the benefit determination, the carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as with other similarly-situated covered persons; and/or

d. Constitutes a statement of policy or guidance with respect to the health coverage plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

3. A covered person does not have the right to be present for the written appeal review.

E. Notification requirements.

1. A carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in section 11.E.2.

2. With respect to a request for a first level review of an adverse determination involving a prospective review request, the carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) calendar days after the date of the carrier's receipt of the grievance containing a request for the first level review.

3. With respect to a request for a first level review of an adverse determination involving a retrospective review request, the carrier shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) calendar days after the date of the carrier's receipt of a request for the first level review.

F. For purposes of calculating the time periods within which a determination is required to be made and notice provided under section 11.E.3., the time period shall begin on the date of the carrier's receipt of the grievance requesting the review provided in accordance with the carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.

G. The decision issued pursuant to section 11.E. shall set forth in a manner calculated to be understood by the covered person:

1. The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consulted. For the purposes of section 11, the physician and consulting clinical peers shall be called "the reviewers";

2. A statement of the reviewers' understanding of the covered person's request for a review of an adverse determination;

3. The reviewers' decision in clear terms; and

4. A reference to the evidence or documentation used as the basis for the decision.

H. A first level review decision involving an adverse determination issued pursuant to section 11.E. shall include, in addition to the requirements of section 11.G.:

1. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;

2. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant, as the term "relevant" is defined in section 11.D.2., to the covered person's benefit request;

3. If the reviewers relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

4. If the adverse determination is based on a medical necessity, experimental or investigational treatment, or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

5. Information sufficient for the covered person to be able to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

6. If applicable, instructions for requesting:

    a. A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in section 11.H.3.;

    b. The written statement of the scientific or clinical rationale for the determination, as provided in section 11.H.4.; and/or

    c. The information necessary to identify the claim, as provided in section 11.H.5.; and

7. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to section 5 of Colorado Insurance Regulation 4-2-21.

8. For group health coverage plans, a description of the process to obtain a voluntary second level review, including:

    a. The written procedures governing the voluntary second level review, including the required time frames for the review;

    b. The right of the covered person to:

        (1) Request the opportunity to appear in person before a health care professional (reviewer) or, if offered by the carrier, a review panel of health care professionals, who have appropriate expertise, who were not previously involved in the appeal, and who do not have a direct financial interest in the outcome of the review;

        (2) Receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable;

        (3) Present written comments, documents, records, and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting;

            (a) A copy of the materials the covered person plans to present or have presented on his or her behalf at the review meeting should be provided to the carrier at least five (5) calendar days prior to the date of the review meeting;

            (b) Any new material developed after the five-day deadline shall be provided to the carrier when practicable;

(4) Present the covered person's case to the reviewer or review panel;

(5) If applicable, ask questions of the reviewer or review panel; and

(6) Be assisted or represented by an individual(s) of the covered person's choice, including counsel, advocates, and health care professionals;

c. A statement that the carrier will provide to the covered person, upon request, sufficient information relating to the voluntary second level review to enable the covered person to make an informed judgment about whether to submit the adverse determination to a voluntary second level review, including a statement that the decision of the covered person as to whether or not to submit the adverse determination to a voluntary second level review will have no effect on the covered person's rights to any other benefits under the plan, the process for selecting the decision maker, and the impartiality of the decision maker.

d. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to section 5 of Colorado Insurance Regulation 4-2-21 if the covered person chooses not to request a voluntary second level review of the first level review decision involving an adverse determination.

Section 12 General Requirements for First Level and Voluntary Second Level Review Meetings

A. A carrier shall establish written procedures in compliance with all of the requirements of this section for a review process in which the covered person has the right to appear in person or by telephone conference at the review meeting before a health care professional (reviewer) or, if offered by the carrier, a review panel of health care professionals, selected by the carrier. The procedures shall allow the covered person to identify the medical facility and health care professional(s) to whom the carrier shall send a copy of the review decision. The purpose of the review meeting process is to give the covered person the opportunity to explain his or her grievance and to provide any relevant evidence in support of his or her claim for benefits.

B. For purposes of this section, "covered person" includes the designated representative of a covered person.

C. A complaint record entry shall be made for all review meeting requests, pursuant to § 10-3-1104(1)(i), C.R.S.

D. Covered person's review request filing requirements.

1. For individual health coverage plans, the requirements of section 11.A.4. apply.

2. For group health coverage plans, within sixty (60) calendar days after the date of receipt of a notice of a first level review adverse determination, the covered person may file a request with the carrier requesting a voluntary second level review of the adverse determination. If the deadline for filing a request ends on a weekend or holiday, the deadline shall be extended to the next business day.

E. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review meeting.

F. Carrier's requirements.

1. The adverse determination or, with respect to a voluntary second level review of a first level review decision, the denial shall be reviewed by a health care professional (reviewer) or, if offered by the carrier, a review panel of health care professionals, who have appropriate expertise in relation to the case presented by the covered person.

2. The reviewer or each review panel member, shall meet the following criteria:

   a. Were not previously involved in the appeal;

   b. Do not have a direct financial interest in the appeal or outcome of the review; and

   c. Are not a subordinate of any person previously involved in the appeal.

3. The reviewer or the review panel shall have the legal authority to bind the carrier to the reviewer's or review panel's decision.

G. The carrier's procedures for conducting a review meeting shall include the following:

1. The reviewer or review panel shall schedule and hold a review meeting within sixty (60) calendar days of the carrier's receipt of a request from a covered person for a review meeting. The covered person shall be notified in writing at least twenty (20) calendar days in advance of the review meeting date. The carrier shall not unreasonably deny a request for postponement of the review meeting made by a covered person even if the postponement causes the review meeting to occur beyond the sixty (60) calendar day requirement.

2. Notice requirements. The notice to the covered person of the review meeting date shall include:

   a. The right of the covered person to present written comments, documents, records, and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting.

   b. The right of the covered person to receive, upon request, a copy of the materials that the carrier intends to present at the review meeting at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable.

   c. The responsibility of the covered person to submit a copy of the materials that the covered person plans to present or have presented on his or her behalf at the review meeting to the carrier at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided to the carrier when practicable.

   d. The responsibility of the covered person to, within seven (7) calendar days in advance of the review meeting, inform the carrier if the covered person intends to have an attorney present to represent such person's interests. If the covered person decides to have an attorney present after the seven-day deadline, notice shall be provided to the carrier when practicable.

   e. The carrier shall use this notification to advise the covered person if it intends to have an attorney present to represent the interests of the carrier.

f. The carrier shall use this notification to advise the covered person that it will make an audio or video recording of the review meeting unless neither the covered person nor the carrier wants the recording made. The notice shall advise that this recording will be made available to the covered person and that if there is an external review, the audio or video recording shall be included in the material provided by the carrier to the reviewing entity unless the covered person specifically requests that it not be included.

3. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. Whenever a covered person has requested the opportunity to appear in person, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodation for disabilities. In cases where a face-to-face meeting is not practical for geographic reasons, a carrier shall offer the covered person the opportunity to communicate, at the carrier's expense, by telephone conference call. A carrier may also offer video conferencing or other appropriate technology.

4. In conducting the review meeting, if applicable, the reviewer or review panel shall take into consideration all comments, documents, records, and other information regarding the request for benefits submitted by the covered person without regard to whether the information was submitted or considered in reaching the first level review decision. If the appeal is pursuant to § 10-16-113(1)(c), C.R.S., regarding the applicability of a contractual exclusion, the determination shall be made on the basis of whether the contractual exclusion applies to the denied benefit.

5. Full and fair review.

a. Before issuing a final internal adverse benefit determination based on new and/or additional evidence, the carrier shall provide the covered person, free of charge, the new and/or additional evidence considered, relied upon, or generated by the carrier in connection with the claim. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of the final internal adverse benefit determination is required to be provided pursuant to section 12.G.6. to give the covered person a reasonable opportunity to respond prior to that date.

b. Before issuing a final internal adverse benefit determination based on new and/or additional rationale, the carrier shall provide the covered person, free of charge, with the rationale considered, relied upon, or generated by the carrier in connection with the claim. Such rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of the final internal adverse benefit determination is required to be provided pursuant to section 12.G.6. to give the covered person a reasonable opportunity to respond prior to that date.

6. The reviewer or review panel shall issue a written decision, as provided in section 12.H., to the covered person within seven (7) calendar days of completing the review meeting.

7. For purposes of calculating the time periods within which a review meeting is required to be scheduled, the time period shall begin on the date of the carrier’s receipt of the request for a review meeting provided in accordance with the carrier’s procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.

H. A decision issued pursuant to section 12.G. shall include:

1. The name(s), title(s), and qualifying credentials of the reviewer or the members of the review panel;

2. A statement of the reviewer's or the review panel's understanding of the covered person's request for review of an adverse determination;

3. The reviewer's or the review panel's decision in clear terms;

4. A reference to the evidence or documentation used as the basis for the decision;

5. For a decision issued involving an adverse determination:

   a. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;

   b. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant, as the term "relevant" is defined in section 11.D.2., to the covered person's benefit request;

   c. If the reviewer or review panel relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

   d. If the adverse determination is based on a medical necessity, experimental or investigational treatment, or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

   e. If applicable, instructions for requesting:

      (1) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in section 12.H.5.c.; and

      (2) The written statement of the scientific or clinical rationale for the determination, as provided in section 12.H.5.d.; and

   f. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to section 5 of Colorado Insurance Regulation 4-2-21.

Section 13 Expedited Review of an Adverse Determination

A. A carrier shall establish written procedures in compliance with all of the requirements of this section for the expedited review of urgent care requests or grievances involving an adverse determination. A carrier shall also provide an expedited review for a request for a benefit for a covered person who has received emergency services but has not been discharged from a medical facility. The procedures shall allow a covered person to request an expedited review under this section orally or in writing. The procedures shall also allow the covered person to identify a medical facility and health care professional(s) to whom the carrier shall send a copy of the review decision. Pursuant to § 10-16-113.5(7), C.R.S., a covered person requesting an expedited external review may request such review concurrently with a request for an expedited internal review.

B. An expedited review shall be available to, and may be initiated by, the covered person or the medical facility and/or health care professional acting on behalf of the covered person. For purposes of this section, “covered person” includes the designated representative of a covered person.

C. Pursuant to § 10-3-1104(1)(i), C.R.S., all written requests for an expedited review shall be entered into the carrier’s complaint record.

D. Expedited appeal evaluations.

1. Expedited appeals shall be evaluated by an appropriate clinical peer(s) in the same or similar specialty as would typically manage the case under review. For the purposes of this section, the clinical peer(s) shall be called “the reviewer(s)”. The clinical peer(s) shall not have been involved in the initial adverse determination.

2. In conducting a review under this section, the reviewer(s) shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by, or on behalf of, the covered person without regard to whether the information was submitted or considered in making the initial adverse determination.

E. Covered person’s rights. A covered person does not have the right to attend or to have a representative in attendance at the expedited review, but the covered person is entitled to:

1. Submit written comments, documents, records, and other materials relating to the request for benefits for the reviewer(s) to consider when conducting the review; and

2. Receive from the carrier, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person’s request for benefits, as described in section 11.D.2.

F. In an expedited review, all necessary information, including the carrier's decision, shall be transmitted between the carrier and the covered person or the medical facility and/or health care professional acting on behalf of the covered person by telephone, facsimile or similar expeditious method available.

G. In an expedited review, a carrier shall make a decision and notify the covered person or the medical facility and/or health care professional acting on the covered person's behalf as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the carrier’s receipt of the request. If the expedited review is a concurrent review and an adverse determination is made, the health care service or treatment shall continue to be covered according to the provisions of the health coverage plan until the covered person has been notified of the determination by the carrier.

H. A carrier shall provide a written confirmation of its decision concerning an expedited review within three (3) calendar days of providing notification of that decision, if the initial notification was not in writing.

I. In the case of an adverse determination, the written decision shall comply with the requirements specified in sections 11.G. and 11.H. of this regulation.

J. For purposes of calculating the time periods within which a decision is required to be made under section 13.G., the time period within which the decision is required to be made shall begin on the date of the carrier's receipt of the request in accordance with the carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.

K. In any case where the expedited review process does not resolve a difference of opinion between the carrier and the covered person or the medical facility and/or health care professional acting on behalf of the covered person, the covered person or the medical facility and/or health care professional acting on behalf of the covered person may request an independent external review.

L. Retrospective adverse determinations are not eligible for the expedited review process.

Section 14 Rescission and Initial Eligibility Determinations

A. The rescission of coverage and denials of coverage to an individual based on initial eligibility determinations are considered adverse determinations for the purposes of this regulation.

B. A carrier shall provide notice thirty (30) calendar days in advance of the policy rescission to each person covered by the policy.

C. An individual has the right to appeal a rescission or denial of coverage based on an initial coverage determination in accordance with sections 11 and 12 of this regulation. However, a physician or panel of health care professionals is not required to evaluate these appeals or consult with an appropriate clinical peer pursuant to § 10-16-113(4)(b)(II), C.R.S.

D. The carrier's rescission notification or denial of coverage based on an initial coverage determination do not have to be reviewed and signed by a physician.

Section 15 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 16 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 17 Effective Date

This amended regulation is effective on March 15, 2021.

Section 18 History

Originally promulgated effective July 1, 1997.
Amended effective April 1, 2000.
Amended effective April 1, 2004 to comply with ERISA claims/appeals procedures.
Amended effective October 1, 2004, to correct internal references and to provide clarification with respect to the expedited appeal.
Emergency Regulation 05-E-5 effective January 1, 2006.
Amended effective February 1, 2006.
Amended regulation effective November 1, 2010.
Amended regulation effective December 1, 2013.
Amended regulation effective June 1, 2019.
Amended regulation effective August 1, 2020.
Amended regulation effective March 15, 2021.

Regulation 4-2-18 [Repealed eff. 02/01/2019]

Regulation 4-2-19 [Repealed eff. 01/01/2014]

Regulation 4-2-20 CONCERNING THE SUMMARY OF BENEFITS AND COVERAGE FORM AND THE COLORADO SUPPLEMENT TO THE SUMMARY OF BENEFITS AND COVERAGE FORM

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-108.5(11)(b), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to coordinate the requirements of § 10-16-108.5(11), C.R.S. and certain provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the “Affordable Care Act” (ACA). This regulation also sets out procedures for carriers to make available the required Summary of Benefits and Coverage (SBC) and a Colorado Supplement to the Summary of Benefits and Coverage (COSSBC) Form for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer.

Section 3 Applicability

This regulation shall apply to all carriers offering or providing health benefit plans. This regulation includes student health insurance coverage as defined in § 10-16-102(65), C.R.S. This regulation excludes individual short-term policies as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found § 10-16-102(8), C.R.S.

B. “Conspicuously-visible font size” means, for the purposes of this regulation, a font of no less than twelve (12) points in size.

C. “COSSBC” means, for the purposes of this regulation, the Colorado Supplement to the Summary of Benefits and Coverage form, as referenced in Appendices A and B to this regulation.

D. “Glossary” means, for the purposes of this regulation, the uniform glossary required by the ACA as described in 45 C.F.R. § 147.200(c)(2).

E. “Health benefit plan” shall have the same meaning as found in § 10-16-102(32), C.R.S.

F. "Summary of Benefits and Coverage" or "SBC" means, for the purposes of this regulation, the form required by the ACA as described in 45 C.F.R. § 147.200(a).

Section 5 Rules

A. All carriers offering or providing health benefit plan coverage shall make available to a producer or person through electronic means or paper copy, a Summary of Benefits and Coverage ("SBC") form, and a completed copy of the Colorado Supplement to the Summary of Benefits and Coverage ("COSSBC") found in Appendix A, for each policy or contract for a health benefit plan that either covers a Colorado resident or is selected by a Colorado resident or such resident's employer for which the employee or participant is eligible.

B. The carrier shall maintain documentation that the requirements of Section 5.A. have been met.

C. For the SBC form, carriers must use the exact format found in the U.S. Department of Labor's 2021 edition of the SBC template. Carriers must follow the instructions found in the SBC "Instruction Guide for Individual Health Insurance Coverage" or "Instruction Guide for Group Coverage".

D. For the COSSBC form, the carrier must use the exact format found in Appendix A of this regulation. Carriers must follow the instructions for completing the COSSBC form found in Appendix B of this regulation. All boxes must be filled in. Carriers may only modify box dimensions, reduce margins, or use a portrait rather than a landscape page layout format. A carrier may also add its logo and form number to the form and print the form in color or black and white. Pursuant to § 10-3-1104(1)(a)(I), C.R.S., in completing the form, carriers shall not misrepresent the benefits, advantages, conditions, or terms of the policy.

E. Carriers shall provide an SBC form and a COSSBC form that is specific with respect to the particular provisions of the policy or contract within seven (7) business days of a potential policy or certificate holder expressing interest in a particular plan or such plan being selected as a finalist from which the ultimate selection will be made. Carriers shall also provide:

1. Other health benefit plan description materials, or enrollment application given to employees or members of a group, association or health care cooperative who have the option of selecting such an employer-sponsored, group-sponsored, association-sponsored, or cooperative-sponsored plan when they initially become eligible for coverage and thereafter during any open enrollment period;

2. The glossary, within seven (7) business days, if requested by any person or producer on behalf of any person, group, association, or health care cooperative, who is interested in coverage under or who is covered by a health benefit plan of the carrier. The request may be made orally or in writing to the carrier;

3. If written application materials are not distributed, the SBC form and the COSSBC form shall be provided no later than the first date on which the employee is eligible to enroll for coverage for the employee or dependent;

4. If there is any change in the information required to be on the SBC form and/or the COSSBC form between the time the application for coverage is received and the first day of coverage, the carrier shall update and provide a current form to the policy or certificate holder no later than the first day of coverage.

5. The notices, forms and information required by this subsection shall be provided no later than thirty (30) calendar days prior to the first day of coverage under the new plan year when the policy has an automatic renewal. If the policy has not been issued or renewed before such 30-day period, the notices, forms and information should be provided no later than seven (7) business days after issuance of the new policy or the receipt of written confirmation of intent to renew, whichever is earlier; and

6. The notices, forms and information required by this subsection shall be provided as soon as practicable, but in no event later than seven (7) business days following receipt of the application.

F. A carrier may avoid sending a duplicate SBC form and COSSBC form required in Section 5.A., if;

1. For group plans, the employer, plan administrator, association, health care cooperative or producer, has provided the SBC form and COSSBC form to the employee, dependent or member.

2. For individual policies, the SBC form and COSSBC form may be provided to one address provided on the application for coverage, unless any dependents are known to reside at a different address.

G. A carrier shall develop a separate SBC form and COSSBC form for each of its health benefit plans. These forms shall be filed according to the requirements of Colorado Insurance Regulation 4-2-41.

H. Each carrier shall include, in a conspicuously-visible font size, the English-language notice and the taglines required pursuant to 45 CFR § 92.8, paragraphs (a), (b), and (d).

I. The COSSBC form should not include attachments, except that a carrier may include:

1. A list of exclusions developed pursuant to Section 5.K. of this regulation;

2. Information on premiums;

3. Information on riders; and

4. Information that is statutorily required of marketing materials (e.g., for managed care plans, disclosure of the existence and availability of an access plan, as required pursuant to § 10-16-704(9), C.R.S.).

J. If a list of exclusions has not been attached to the COSSBC form pursuant to paragraph 5.I.1. a carrier shall make a list of policy exclusions available immediately upon request, but in no event more than seven (7) business days after the request, for each of its health benefit plans.

K. The COSSBC form developed for each health benefit plan shall be in a conspicuously-visible font size. Carriers are encouraged to utilize one of the following font types:

1. Arial Narrow;

2. Arial; or

3. Garamond.

L. Carriers must meet the following requirements for both the SBC form and the COSSBC form:

1. Include on each English version of the forms, a statement, in Spanish, in a conspicuously-visible font size, an offer to provide, upon request, a fully-translated version of these notices in Spanish and which clearly indicates how to access the alternate language services provided by the carrier;

2. Ensure that the SBC form and the COSSBC form are available in Spanish for all plans in Colorado, and provide them to the Division upon request; and

3. Once a request has been made by an individual, provide all subsequent forms to the policyholder in Spanish.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Incorporated Materials

45 C.F.R. § 147.200 published by the United States Government Printing Office shall mean 45 C.F.R. § 147.200 as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 147.200. A copy of 45 C.F.R. § 147.200 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202, or by visiting the United States Government Printing Office website at https://www.ecfr.gov. A certified copy of 45 C.F.R. § 147.200 may be requested from the Colorado Division of Insurance for a fee.

The 2021 edition of the Summary of Benefits and Coverage template published by the United States Department of Labor shall mean the 2021 edition of the Summary of Benefits and Coverage template as published on the effective date of this amended regulation and does not include later amendments to or editions of the 2021 edition of the Summary of Benefits and Coverage template. A copy of the 2021 edition of the Summary of Benefits and Coverage template may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202, or by visiting the United States Department of Labor website at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources. A certified copy of the 2021 edition of the Summary of Benefits and Coverage template may be requested from the Colorado Division of Insurance for a fee.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of a civil penalty, issuance of a cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation is effective on August 1, 2021.

Section 10 History

New regulation effective November 15, 1997.
Amended Sections 1, 2, 3, 4, 7, Appendix A, and Appendix B effective September 30, 1998.
Amended regulation effective January 1, 2004.
Amended regulation effective: January 1, 2005.
Amended regulation effective July 1, 2007.
Repealed and repromulgated effective September 1, 2012.
Amended regulation effective November 1, 2013.

Amended regulation effective March 15, 2017.
Amended regulation effective August 1, 2021.

Appendix A

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	
NAME OF PLAN	
1. Type of Policy	
2. Type of plan	
3. Areas of Colorado where plan is available.	

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	[EMBEDDED DEDUCTIBLE INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals. AGGREGATE DEDUCTIBLE INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid. FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid for any family member. The family deductible can be met by one or more individuals.]

5. Out-of-Pocket Maximum	[(EMBEDDED OUT-OF-POCKET) INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by [2] or more individuals.] [(AGGREGATE OUT-OF-POCKET) INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid at 100%. FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid at 100% for any family member. The family out-of-pocket can be met by one or more individuals.]
6. What is included in the In-Network Out-of-Pocket Maximum?	[Place the major categories that are subject to the network out-of-pocket here]
7. Is pediatric dental covered by this plan?	**[Yes, pediatric dental is subject to the medical deductible and out-of-pocket]** **[Yes, pediatric dental is subject to a separate $X deductible and $X/ individual or $X/ family out-of-pocket]** **[Yes, pediatric dental is covered at 100% of allowable charges.]** **[No, the plan does not include pediatric dental]**
8. What cancer screenings are covered?	

USING THE PLAN

	IN-NETWORK	**OUT-OF-NETWORK**
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?		
10. Does the plan have a binding arbitration clause?		

Questions: Call 1-800-[insert carrier's customer service number] or visit us at www.[insert carrier's web address].

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

Appendix B

**Instructions for Completing the
Colorado Supplement to the Summary of Benefits and Coverage Form**

[Insurance Company Name and Name of Plan]: Fill in the complete insurance company name on the first line and the name of the plan on the second line. Carriers may also include the following information, if they wish to do so, either at the top of the form, at the bottom of the page, or at the end of the document: carrier logo, group identification number, class or division, and effective date.

Question 1: Policy Type: Select one of the following choices only: (1) “Individual Policy”, (2) “Small Employer Group Policy”, (3) “Large Employer Group Policy”, (4) “Association Group Policy”.

Question 2: Type of Plan. Enter type of plan. Select one of the following choices only: (1) “Medical expense policy”, (2) “Preferred provider organization (PPO)”, (3) “Health maintenance organization (HMO)”, (4) “Point of service (POS)” (i.e., an HMO plan with some out-of-network benefits), (5) “Limited service licensed provider network (LSLPN) plan”, or (6) “Exclusive provider organization (EPO)”.

For HMOs that are marketing to small employers or employees of small employers outside of its geographic service area, the following statement must be added in bold, 10 point font caps:

“INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS.”

Question 3: Areas of Colorado Where Plan Is Available. Indicate where the plan itself is available. This question does not concern the residence of the potential enrollee. Select one of the following choices only: (1) “Plan is available throughout Colorado”; (2) “Plan is available only in the following areas: [fill in]”; or (3) “Plan is available throughout Colorado except in the following areas: [fill in].” A note should be added if the plan is marketed to employers or employees located across state or county lines.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Question 4: Annual Deductible Type. Insert the appropriate language for the type of deductible for the plan.

Question 5: Out-of-Pocket Type. Insert the appropriate language for the type of out-of-pocket for the plan.

Question 6: What is included in the In-Network Out-of-Pocket Maximum? Provide a list of the cost-sharing items, such as deductibles and copayments, that are included in the Out-of-Pocket Maximum.

Question 7: Is pediatric dental coverage included in this plan? Insert the appropriate answer, as specified in the template.

Question 8: What cancer screenings are covered? Provide a list of covered cancer screenings.

USING THE PLAN

Question 9: Provider Charges. In each column, select one of the following choices only: (1) “Yes” or (2) “No.” If the answer is “Yes”, a carrier may expand on the answer to note exceptions to this requirement.

Question 10: Binding Arbitration. Indicate, with a “Yes” or “No”, if the plan has binding arbitration.

QUESTIONS’ FOOTER

Questions: Carrier must insert the appropriate telephone number and website information.

Regulation 4-2-21 External Review of Benefit Denials of Health Coverage Plans

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-16-109, and 10-16-113.5(4)(d), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide standards for the external review process set forth in § 10-16-113.5, C.R.S., including the approval of independent external review entities. It is being amended to facilitate the implementation of certain provisions of recently enacted HB 13-1266.

Section 3 Applicability

The provisions of this regulation shall apply to all health coverage plans that base coverage decisions in whole or in part based on utilization reviews as defined in this regulation. This regulation shall not apply to automobile medical payment policies, worker's compensation policies or property and casualty contracts. Where a decision concerning a claim is in no way based on utilization review, a carrier is not required to use the specific procedures outlined in this regulation, except this regulation shall apply to a carrier's denial of a benefit because the treatment is excluded by the health coverage plan if the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply. This regulation also applies to carriers offering wellness and prevention programs that offer any incentive or reward for satisfying a standard related to a health risk factor. Nothing in this regulation shall be construed to supplant any appeal or due process rights that a person may have under federal or state law.

Section 4 Definitions

A. "Adverse determination" shall have the same meaning as found at § 10-16-113.5(2)(a), C.R.S., and shall include an adverse determination that, pursuant to Colorado Insurance Regulation 4-2-17, is eligible for an expedited external review to be conducted concurrently with an expedited internal appeal request. This definition shall also include a carrier's denial of a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor.

B. "Ambulatory review" means, for purposes of this regulation, a utilization review of health care services performed or provided in an outpatient setting.

C. "Business day" means, for purposes of this regulation, the days of the week between and including Monday through Friday, not including public holidays and weekends.

D. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

E. "Case management" means, for purposes of this regulation, a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

F. "Certification," as used in the definition of "utilization review," means, for purposes of this regulation, a determination by a carrier that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or efficiency.

G. "Clinical review criteria" means, for purposes of this regulation, the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a carrier to determine the necessity and appropriateness of health care services.

H. "Concurrent review" means, for purposes of this regulation, a utilization review conducted during a patient's hospital stay or course of treatment.

I. "Covered benefits" or "benefits," means, for purposes of this regulation, those health care services to which a covered person is entitled under the terms of a health coverage plan.

J. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S. For the purposes of this regulation, "covered person" includes the covered person's designated representative.

K. "De minimis" means, for the purposes of this regulation, any minor error or omission that does not substantively impact the rights of a covered person to request an external review of an adverse determination. The submission of a request on an incorrect form that contains all of the needed information is an example of a de minimis error. A carrier submitting a request to the Division in an untimely manner is not an example of a de minimis error.

L. "Designated representative" means, for purposes of this regulation:

1. A person, including the treating health care professional or a person authorized by paragraph 2. of this subsection J., to whom a covered person has given express written consent to represent the covered person in an external review; or

2. A person authorized by law to provide substituted consent for a covered person, including but not limited to a guardian, agent under a power of attorney, a proxy, or a designee of the Colorado Department of Health Care Policy and Financing (HCPF); or

3. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

M. "Discharge planning" means, for purposes of this regulation, the formal process for determining, prior to discharge from a facility or service, the coordination and management of the care that a patient receives following discharge from a facility or service.

N. "Disability" means, for purposes of this regulation, with respect to a covered person, a physical or mental impairment that substantially limits one or more of the major life activities of such covered person, in accordance with the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101.

O. "Expedited review" shall have the same meaning as found at § 10-16-113.5(2)(c), C.R.S.

P. "Facility" means, for purposes of this regulation, an institution providing health care services, or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Q. "Health care professional" means, for purposes of this regulation, a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

R. "Health care services" shall have the same meaning as found at § 10-16-102(33), C.R.S.

S. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.

T. Medical and scientific evidence" shall have the same meaning as found at § 10-16-113.5(2)(h), C.R.S.

U. "Prospective review" means, for purposes of this regulation, utilization review conducted prior to an admission or a course of treatment, also known as a "pre-service review".

V. "Protected health information" means health information:

1. That identifies an individual who is the subject of the information; or

2. With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

W. "Retrospective review" means, for purposes of this regulation, utilization review conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment, also known as a "post-service review".

X. "Second opinion" means, for purposes of this regulation, an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the necessity and appropriateness of the initial proposed health service.

Y. "Utilization review" means, for purposes of this regulation, a set of formal techniques designed to monitor the use of, or evaluate the necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Section 5 Notice and Disclosure of Right to External Review

A. Notification requirements.

1. A carrier shall notify the covered person in writing of the covered person's right to request an expedited internal and external review on a concurrent basis at the time the carrier sends written notice of the carrier's adverse determination following the covered person's urgent care request, as set forth in Colorado insurance regulation 4-2-17 Section 7. This information may be included in the written adverse determination notice itself, or it may be included as a separate document within the same mailing.

2. At the completion or exhaustion of the first level review or at the completion of the voluntary second level review:

a. A carrier shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in subparagraph b. of this paragraph 1. at the time the carrier sends written notice of the carrier's adverse determination following the first level or voluntary second level review as set forth in Colorado Insurance Regulation 4-2-17.

b. The carrier shall include in the required notice a copy of the description of both the standard and expedited external review procedures the carrier is required to provide pursuant to subsection B., including the provisions in the external review procedures that give the covered person the opportunity to submit new information and including any forms used to process an external review, as specified by the Division of Insurance (Division).

3. Following the denial of a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program, a carrier shall notify the covered person in writing of the covered person's right to request an external review, the procedures for making this request, and the timelines associated with an external review. These review requests are not eligible for the expedited external review process described in Section 9 of this regulation.

B. Disclosure requirements.

1. Each carrier shall include a description of the external review procedures in or attached to all health coverage plan materials dealing with the carrier's grievance procedures including but not limited to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.

2. The description required under paragraph 1. of this subsection B. shall include a notification of the availability of an external review process, the circumstances under which a covered person may use the external review process, the procedures for requesting an external review, and the timelines associated with an external review.

3. The description required under paragraph 1. of this subsection B. shall also include:

a. A notification of the covered person's ability to request a concurrent expedited external review when a request for an expedited internal review has been made; and

b. A notification that the carrier's failure to comply with any requirement of § § 10-16-113 and 10-16-113.5, C.R.S, or with any requirement of Colorado Insurance Regulation 4-2-17 or this regulation may deem the internal process exhausted and permit the covered person to request an independent external review.

C. There is no minimum dollar amount for a claim to be eligible for an external review.

Section 6 Request for External Review

A. Within four (4) months after the date of receipt of a notice of a carrier's adverse determination following the completion or exhaustion of the internal appeal process pursuant to Colorado Insurance Regulation 4-2-17, a covered person may file a written request for an external review with the carrier. For purposes of this subsection A., the date of receipt shall be calculated to be no less than three (3) calendar days after the date the notice is postmarked by the carrier. If the deadline for filing a request ends on a weekend or holiday, the deadline shall be extended to the next business day.

B. All requests for external review shall be made in writing to the carrier and must include a completed external review request form as specified by the Division.

C. A request for an external review may be made if an adverse determination has been made involving a recommended or requested medical service that is experimental or investigational if the treating physician certifies that the recommended or requested health care service or treatment will be less effective if not begun immediately, and:

1. The treating physician certifies that standard health care services or treatments have not improved the condition of the covered person or are not medically appropriate for the covered person; or

2. The treating physician certifies that there is no standard health care service or treatment available that is covered by the carrier that is more beneficial to the covered person than the recommended or requested health care service or treatment, and that the physician is a board-certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition.

The physician must also certify that scientifically valid studies support the heath care service or treatment subject to denial is likely to be more beneficial to the covered person than any available standard health care services or treatments.

D. A covered person requesting an expedited external review must include a request for an expedited review in the written request described in subsection A. and B. of this section 6.

E. All requests for external review shall include a signed consent form, authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review.

F. A request for external review submitted by the covered person may include new or additional information, if significantly different from information provided or considered during the internal appeals process, for consideration by the carrier and the independent external review entity.

G. A carrier's denial of a request for a standard external review, including but not limited to a de minimis error, shall be made in writing and include the specific reasons for the denial and shall provide information about appealing the denial of the request with the Division. A copy of the denial shall be sent to the Division at the same time it is sent to the covered person.

H. A carrier's denial of a request for an expedited external review, including but not limited to a de minimis error, shall be made in writing and transmitted electronically or by facsimile or any other available expeditious method. It must include the specific reasons for the denial and shall provide information about appealing the denial of the request with the Division. A copy of the denial must be sent to the Division at the same time it is sent to the covered person.

Section 7 Exhaustion of Internal Appeal Process

A. A request for an external review pursuant to Section 8 or 9 of this regulation may be made after the covered person has received the carrier's decision following the first level or voluntary second level review of an adverse determination as set forth in Colorado Insurance Regulation 4-2-17.

B. A request for an external review pursuant to Section 8 or 9 of this regulation may be made if the carrier fails to comply with any of the requirements of Section 10 of Colorado Insurance Regulation 4-2-17.

C. A request for an external review pursuant to Section 9 of this regulation may be made concurrent to an expedited request for a first level review in accordance with the requirements set forth in Colorado Insurance Regulation 4-2-17.

D. A carrier's denial of a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor is not subject to the internal appeal process requirements set forth in Colorado Insurance Regulation 4-2-17.

Section 8 Standard External Review

A. Carrier requirements.

1. Except as provided in paragraph 2. of this subsection A., the carrier, upon receipt of a complete request for an external review pursuant to Section 6 of this regulation, shall deliver a copy of the request to the Commissioner of Insurance within two (2) business days.

a. Whenever a carrier receives an incomplete standard request for external review that fails to meet the health carriers filing procedures, the carrier shall notify the covered person of this failure as soon as possible, but in no event later than five (5) days following the date the incomplete request was received.

b. Whenever a carrier receives an incomplete expedited request for external review that fails to meet the health carriers filing procedures, the carrier shall notify the covered person of this failure as soon as possible, but in no event later than twenty-four (24) hours after the incomplete request was received.

2. If the carrier, before the expiration of the deadline for sending notification to the Commissioner, reverses its adverse determination based on new or additional information submitted by the covered person pursuant to Section 6, subsection E., the carrier must notify the covered person within one (1) business day of its reversal, electronically, by facsimile, or by telephone followed by a written confirmation.

B. Division of Insurance requirements.

1. Within two (2) business days from the time a request for external review is received from the carrier, the Commissioner shall assign an independent external review entity to conduct the external review that has been approved pursuant to Section 11 of this regulation. The Commissioner shall randomly select an independent external review entity that does not have a conflict of interest, as described in Section 12. Upon assignment, the Commissioner shall notify the carrier, electronically or by facsimile, of the name and address of the independent external review entity to which the appeal should be sent.

2. After notice from the Commissioner pursuant to paragraph 1. of this subsection B., the carrier shall notify the covered person within one (1) business day electronically, by facsimile, or by telephone followed by a written confirmation. The notice shall include a written description of the independent external review entity that the Commissioner has selected to conduct the external review and information regarding how the covered person may provide the Commissioner with documentation regarding any potential conflict of interest of the independent external review entity as described in Section 12 of this regulation.

3. Within two (2) business days of receipt of notice from the carrier, the covered person may provide the Commissioner with documentation regarding a potential conflict of interest of the independent external review entity, electronically, by facsimile, or by telephone followed by a written confirmation. If the Commissioner determines that the independent external review entity presents a conflict of interest as described in § 10-16-113.5(4)(b), C.R.S., the Commissioner shall assign, within one (1) business day, a different independent external review entity to conduct the external review that has been approved pursuant to Section 11 of this regulation. Upon this reassignment, the Commissioner shall notify the carrier, electronically or by facsimile of the name and address of the new independent external review entity to which the appeal should be sent. The Commissioner will notify the covered person in writing of the Commissioner's determination regarding the potential conflict of interest, and the name and address of the new independent external review entity, if applicable.

4. Within five (5) business days of receipt of the notice from the carrier, the covered person may provide additional information to the independent external review entity that shall be considered during the review. The independent external review organization is not required to, but may, accept and consider additional information submitted after five (5) business days. The independent external review organization shall forward this information to the carrier within one (1) business day of receipt.

5. In reaching a decision, the independent external review entity is not bound by any decisions or conclusions reached during the carrier's utilization review process or the carrier's internal appeal process as set forth in Colorado Insurance Regulation 4-2-17.

C. Carrier requirements to provide documents and information.

1. Within five (5) business days from the date the carrier receives notice from the Commissioner pursuant to paragraph 1. of Section 8.B., the carrier shall deliver to the assigned independent external review entity the following documents and information considered in making the carrier's adverse determination including:

a. Any and all information submitted to the carrier by a health care professional or the covered person in support of:

(1) The request for coverage under the health coverage plan's procedures; or

(2) The request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program;

b. Any and all information used by the carrier during the internal appeal process to determine the medical necessity, medical appropriateness, medical effectiveness, or medical efficiency of the proposed treatment or service, including medical and scientific evidence and clinical review criteria;

c. A copy of any and all denial letters issued by the carrier concerning the case under review;

d. A copy of the signed consent form, authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review; and

e. An index of all submitted documents.

2. Within two (2) business days of receipt of the material specified in paragraph 1. of this subsection C., the independent external review entity shall deliver to the covered person the index of all materials that the carrier has submitted to the independent external review entity. The carrier shall provide to the covered person, upon request, all relevant information supplied to the independent external review entity that is not confidential or privileged under state or federal law concerning the case under review.

3. Independent external review entity notification requirements.

a. The independent external review entity shall notify the covered person, the health care professional of the covered person, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required pursuant to paragraph 1. of this subsection C. Within five (5) business days of such a request, the covered person or the health care professional of the covered person shall submit the additional information, or an explanation of why the additional information is not being submitted to the independent external review entity and the carrier.

b. If the covered person or the health care professional of the covered person fails to provide the additional information or the explanation of why additional information is not being submitted within the timeframe specified in subparagraph a. of this paragraph 3., the independent external review entity shall make a decision based on the information submitted by the carrier as required by paragraph 1. of this subsection C.

4. Failure of the carrier to provide documents and information.

   a. If the carrier fails to provide the required documents and information within the time specified in paragraph 1. of this subsection C., the independent external review entity may terminate the external review and make a decision to reverse the carrier's adverse determination.

   b. Immediately upon the reversal under subparagraph a. of this paragraph 4., the independent external review entity shall notify the covered person, the carrier, and the Commissioner.

5. Except as provided in paragraph 4. of this subsection C., failure by the carrier to provide the documents and information within the time specified in paragraph 1. of this subsection C. shall not delay the conduct of the external review.

D. The independent external review entity shall review all of the information and documents received pursuant to subsection C. of this Section 8.

E. Carrier's reconsideration of its adverse determination.

1. Upon receipt of the information permitted to be forwarded pursuant to Section 6.E. and subsection B.4. of this Section 8, the carrier may reconsider the adverse determination that is the subject of the external review.

2. Consideration of new information by the carrier of its adverse determination pursuant to paragraph 1. of this subsection E. shall not delay or terminate the external review.

3. The external review may only be terminated if the carrier decides to reverse its adverse determination and provide coverage or payment for the health care service or, for the purposes of participation in a wellness and prevention program, grant the request for an alternate standard or waiver of a standard that is the subject of the carrier's adverse determination.

4. Carrier notification requirements of reversal of adverse determination.

   a. Within one (1) business day of making the decision to reverse its adverse determination, as provided in paragraph 3., the carrier shall notify the covered person, the independent external review entity, and the Commissioner of its decision, electronically, by facsimile, or by telephone followed by a written confirmation.

   b. The independent external review entity shall terminate the external review upon receipt of the notice from the carrier sent pursuant to subparagraph a. of this paragraph 4.

F. In addition to the documents and information provided pursuant to subsection C. of this Section 8, the independent external review entity, to the extent the documents or information are available, shall review the following:

1. The covered person's medical records;

2. The attending health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the carrier, covered person, or the covered person's treating provider;

4. Any applicable clinical review criteria developed and used by the carrier; and

5. Medical and scientific evidence determined to be relevant and appropriate by the independent review entity.

G. The independent external review entity shall base its determination on an objective review of relevant medical and scientific evidence.

H. Independent external review entity notice requirements.

1. Within forty-five (45) calendar days after the date of receipt of the request for external review, the independent external review entity shall:

a. Make a decision to uphold or reverse the carrier's adverse determination, in whole or in part; and

b. Provide a written notification of its decision to the following:

(1) The covered person;

(2) The carrier;

(3) The physician or other health care professional of the covered person; and

(4) The Commissioner.

2. In addition to the requirements of § 10-16-113.5(11), C.R.S., the independent external review entity shall include in the notice sent pursuant to paragraph 1. of this subsection H.:

a. The date the independent external review entity received the assignment from the Commissioner to conduct the external review;

b. The date of its decision; and

c. An explanation that the external review decision is the final appeal available to the consumer under state insurance law.

3. Upon the carrier's receipt of the independent external review entity's notice of a decision pursuant to paragraph 1. of this subsection H. reversing its adverse determination, the carrier shall approve the coverage or, for the purposes of participation in a wellness and prevention program, grant the requested alternate standard or waiver of the standard that was the subject of the carrier's adverse determination.

a. For concurrent and prospective reviews, the carrier shall approve the coverage within one (1) business day.

b. For retrospective reviews, the carrier shall approve the coverage within five (5) business days.

c. The carrier shall provide written notice of the approval to the covered person or the covered person's designated representative within one (1) business day of the carrier's approval of coverage.

d. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.

Section 9 Expedited External Review

A. Request requirements.

1. Except as provided in subsections H. and I. of this Section 9, a covered person may make a request for an expedited external review with the carrier if the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this regulation would seriously jeopardize the life or health of the covered person, would jeopardize the covered person's ability to regain maximum function or, for persons with a disability, create an imminent and substantial limitation of their existing ability to live independently.

2. The covered person's or the covered person's designated representative's request for an expedited review must include a physician's certification that the covered person's medical condition meets the criteria in paragraph 1. of this subsection A.

3. Upon receipt of a request for an external review and the physician's certification pursuant to paragraph 1. and paragraph 2. of this subsection A., the carrier shall notify and send a copy of the request to the Commissioner within one (1) business day electronically or by telephone or facsimile or any other available expeditious method.

B. Division of Insurance requirements.

1. Within one (1) business day of the time the Commissioner receives a request for an expedited external review, the Commissioner shall randomly assign an independent external review entity that has been approved pursuant to Section 11 of this regulation to conduct the review and to make a decision regarding the carrier's adverse determination. The Commissioner shall select an independent external review entity that does not have a conflict of interest with the case, as described in Section 12. Upon assignment, the Commissioner shall inform the carrier of the name and address of the independent external review entity to which the appeal should be sent.

2. Within one (1) business day of notice from the Commissioner pursuant to paragraph 1. of this subsection B., the carrier shall notify the covered person, electronically, by facsimile, or by telephone followed by a written confirmation. The notice shall include a written description of the independent external review entity that the Commissioner has selected to conduct the independent review.

C. In reaching a decision, the independent external review entity is not bound by any decisions or conclusions reached during the carrier's utilization review process or the carrier's internal appeal process as set forth in Colorado Insurance Regulation 4-2-17.

D. Immediately upon receipt of the notification pursuant to subsection B., the carrier shall provide or transmit all necessary documents and information, as described in Section 8.C.1., considered in making its adverse determination to the independent external review entity electronically or by telephone or facsimile or any other available expeditious method.

E. In addition to the documents and information provided or transmitted pursuant to subsection D. of this Section 9, the independent external review entity, to the extent the information or documents are available, shall consider the following in reaching a decision:

1. The covered person's medical records;

2. The attending health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the carrier, covered person, or the covered person's treating provider;

4. Any applicable clinical review criteria developed and used by the carrier; and

5. Documents and information regarding medical and scientific evidence, to the extent the independent review entity considers them appropriate.

F. The independent external review entity shall base its determination on an objective review of relevant medical and scientific evidence.

G. Independent external review entity notice requirements.

1. Notwithstanding the requirements of § 10-16-113.5(11), C.R.S., within seventy-two (72) hours after the receipt of the assignment of the request for external review, the independent external review entity shall:

a. Make a decision to uphold or reverse the carrier's adverse determination, in whole or in part; and

b. Provide a notification of the decision to the following:

(1) The covered person;

(2) The carrier;

(3) The covered person's physician, or other health care professional; and

(4) The Commissioner.

2. If the notice provided pursuant to paragraph 1. of this subsection G. was not in writing, within forty-eight (48) hours after the date of providing that notice, the independent external review entity shall:

a. Provide written confirmation of the decision to the covered person, the carrier, and the Commissioner; and

b. Include the information set forth in Section 8.H.2. of this regulation.

3. Carrier's responsibility when the adverse determination is reversed by the independent external review entity.

a. Immediately upon the carrier's receipt of the independent external review entity's notice of a decision pursuant to paragraph 1. of this subsection G. reversing its adverse determination:

(1) The carrier shall approve the coverage that was the subject of its adverse determination; and

(2) The carrier shall provide written notice of the approval to the covered person or the covered person's designated representative.

b. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.

H. An expedited external review may not be requested for retrospective adverse determinations.

I. A carrier's denial of a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor is not eligible for an expedited external review.

Section 10 Binding Nature of External Review Decisions

A. An external review decision is binding on the carrier and the covered person except to the extent the carrier and covered person have other remedies available under federal or state law; however, the determination of the expert reviewer will create a rebuttable presumption in any subsequent action.

B. A covered person or the covered person's designated representative may not file a subsequent request for external review involving the same carrier's adverse determination for which the covered person has already received an external review decision pursuant to this regulation.

Section 11 Approval of Independent External Review Entities

A. The Commissioner shall approve independent external review entities eligible to be assigned to conduct external reviews under this regulation to ensure that an independent external review entity satisfies the minimum qualifications established under Section 12 of this regulation.

B. Application shall be made on a form specified by the Commissioner for approving independent external review entities to conduct external reviews.

C. Any independent external review entity wishing to be approved to conduct external reviews under this regulation shall submit a completed application form, including any documentation or information necessary for the Commissioner to determine if the independent external review entity satisfies the minimum qualifications established under Section 12 of this regulation.

D. Expiration of approval.

1. An approval is effective for two (2) years, unless the Commissioner determines before expiration of the approval that the independent external review entity is not satisfying the minimum qualifications established under Section 12 of this regulation.

2. Whenever the Commissioner determines that an independent external review entity no longer satisfies the minimum requirements established under Section 12 of this regulation, the Commissioner shall notify the independent external review entity that its approval has been withdrawn and remove the independent external review entity from the list of independent external review entities approved to conduct external reviews under this regulation that is maintained by the Commissioner pursuant to subsection E.

E. The Commissioner shall maintain and update, as necessary, a list of approved independent external review entities.

F. The Commissioner may rely on the accreditation status of an applicant independent external review entity as demonstration of fulfillment of any or all requirements of this Section.

Section 12 Minimum Qualifications for Independent External Review Entities

A. To be approved under Section 11 of this regulation to conduct external reviews, an independent external review entity shall meet the requirements of § 10-16-113.5(4), C.R.S., and shall:

1. Agree to maintain and provide to the Commissioner the information set out in Section 14 of this regulation; and

2. Submit to the Commissioner, with the application for approval as an independent external review entity, a schedule of reasonable fees to be charged to carriers for performance of external review, including administrative fees as described in Section 15.

B. The independent external review entity shall be accredited as an independent review organization by a nationally recognized private accrediting organization.

C. All expert reviewers assigned by an independent external review entity to conduct external reviews shall be physicians or other appropriate health care providers who meet the minimum qualifications and conflict of interest requirements described in § 10-16-113.5(2)(d), C.R.S.

Section 13 External Review Record Requirements

A. An independent external review entity assigned pursuant to Section 8 or 9 of this regulation to conduct an external review shall maintain written records in the aggregate and by carrier on all requests for external review for which it conducted an external review for the Division during a calendar year. The independent external review entity shall retain the written records required pursuant to this subsection for at least three (3) years.

B. Each carrier shall maintain written records in the aggregate and for each type (i.e., indemnity, preferred provider organization (PPO), health maintenance organization (HMO), and point-of-service (POS)) of health coverage plan offered by the carrier on all requests for external review that are filed with the carrier. The carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

Section 14 Funding of External Review

The carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost, consistent with the fee schedule the independent external review entity filed with the Commissioner, to the independent external review entity for conducting the external review. In the case of a carrier reversing a denial which is the subject of an external review after assignment of the review to independent external review entity, but prior to assignment of an expert reviewer, the carrier shall pay an administrative fee to the independent external review entity. Charges for the independent external review, when denial is reversed by the carrier prior to review completion but after assignment to an expert reviewer, shall be the full cost.

Section 15 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 16 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspension or revocation of license, subject to the requirements of due process.

Section 17 Effective Date

This amended regulation shall become effective on December 1, 2013.

Section 18 History

Originally promulgated with an effective date of April 1, 2000 for the approval process for independent expert review entities and an effective date of June 1, 2000 for the external review process.
Amended effective October 1, 2003 to delete reporting requirements since the Division of Insurance already tracks external review information.
Amended effective October 1, 2004, to clarify the options available after a covered person receives a final adverse determination.
Amended effective February 1, 2006.
Amended effective November 1, 2010.
Amended effective September 1, 2011.
Amended regulation effective December 1, 2013.

Regulation 4-2-22 [Repealed eff. 01/01/2014]

Regulation 4-2-23 PROCEDURE FOR PROVIDER-CARRIER DISPUTE RESOLUTION

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-109, and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish procedures for resolution of provider-carrier disputes, as required by § 10-16-705(13), C.R.S.

Section 3 Applicability

The provisions of this regulation shall apply to all carriers when they are providing health care services through managed care plans, except workers' compensation and auto insurance contracts.

Section 4 Definitions

A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.

C. "Necessary information", for the purposes of this regulation, consists of the following:

1. Each applicable date of service;

2. Subscriber or member name;

3. Patient name;

4. Subscriber or member number;

5. Provider name;

6. Provider tax identification number;

7. Dollar amount in dispute, if applicable;

8. Provider position statement explaining the nature of the dispute; and

9. Supporting documentation where necessary, e.g., medical records, proof of timely filing.

D. "Participating provider" shall have the same meaning as found at § 10-16-102(46), C.R.S.

E. "Provider-carrier dispute" means, for the purposes of this regulation, an administrative, payment, or other dispute between a participating provider and a carrier that does not involve a utilization review analysis and does not include routine provider inquiries that the carrier resolves in a timely fashion through existing informal processes.

F. "Provider-carrier dispute log" means, for the purposes of this regulation, a record of provider dispute resolution requests received by the carrier and maintained on a calendar year basis by the carrier.

1. At a minimum, the log shall include:

a. The date of receipt of the dispute resolution request;

b. The provider's name and tax identification number;

c. The subscriber or member name;

d. The subscriber or member number;

e. Patient name;

f. The date(s) of service;

g. The disputed amount(s), if applicable;

h. The nature of the dispute;

i. The date the request was closed;

j. Whether the request was pended for additional information; and

k. The outcome of the request.

2. All provider-carrier dispute logs which are produced, obtained by or disclosed to the Commissioner shall be given confidential or privileged treatment to the extent provided by law to protect the privacy of the patient and provider. Confidential or privileged information may not be made public by the Commissioner, except that access to such materials may be granted to the National Association of Insurance Commissioners ("NAIC"). Disclosure of such materials shall be made only upon the prior written agreement of the NAIC to hold such information confidential.

G. "Provider representative" means, for the purposes of this regulation, a person designated by a provider in writing, including other providers or an association of providers, to represent the provider's interest during the dispute resolution process.

H. "Utilization review" means, for the purposes of this regulation, a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include, without limitation, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Section 5 Rules

A. A carrier shall maintain written procedures for provider-carrier disputes. The procedures shall specify that requests for resolution of provider-carrier disputes must be in writing. All written requests for provider-carrier dispute resolution must be entered into a carrier's provider-carrier dispute log. The log shall be made available to the Commissioner within a reasonable time, upon request.

B. A carrier shall make a determination of a provider dispute resolution request within forty-five (45) calendar days of receipt of all necessary information. When the carrier does not receive all necessary information to make a decision, the carrier shall request, in writing and within thirty (30) calendar days of receipt of the provider dispute resolution request, the additional information needed. The carrier shall allow the provider thirty (30) calendar days from the date of the request for additional information to provide the requested information. If the provider does not respond within the thirty (30) day timeframe, the carrier shall close the request without further review. Further consideration of the closed provider dispute resolution request must begin with a new request by the provider.

C. Notification requirements.

1. For provider dispute resolution requests where all necessary information was provided, the carrier shall send written confirmation of receipt within thirty (30) calendar days of the dispute resolution request. The written confirmation must contain:

    a. A description of the carrier's dispute resolution procedures and timeframes;

    b. The procedures and timeframes for the provider or the provider's representative to present his/her rationale for the dispute resolution request; and

    c. The date by which the carrier must resolve the dispute resolution request.

2. In the instance where the provider dispute resolution request is resolved in accordance with the requirements of this regulation within thirty (30) calendar days, the notice required by section 5.E. shall constitute the notice required by this section 5.C.

3. In cases where the carrier does not receive all necessary information to make a decision, the carrier shall send, within thirty (30) calendar days of receipt of the provider dispute resolution request, a written notice to the provider that shall contain:

    a. A description of the additional necessary information required to review and respond to the request;

    b. The date, in accordance with section 5.B., that additional information must be provided by the provider; and

    c. A statement that failure to provide the requested information within thirty (30) calendar days from the carrier's request for additional information will result in the closure of the request with no further review.

4. In cases where the provider does not submit the additional necessary information required by the carrier and the carrier closes the request, the carrier shall notify the provider in writing that the case is closed and that further consideration of the closed dispute resolution request must begin with a new request by the provider.

D. A carrier shall offer the provider the opportunity to designate a provider representative in the dispute resolution process. The carrier shall allow the provider or the provider's representative the opportunity to present the rationale for the dispute resolution request in person. In cases where the provider determines that a face-to-face meeting is not practical, the carrier shall offer the provider the opportunity to utilize alternative methods such as teleconference or videoconference to present the rationale for the dispute resolution request. The carrier may require appropriate confidentiality agreements from the provider's representative(s) as a condition to participating in the dispute resolution process. The parties may mutually agree in writing to extend the timeframes beyond the forty-five (45) calendar days from receipt of all necessary information timeframe established by this regulation.

E. A carrier shall provide notification of the determination to the provider. In the event the determination is not in favor of the provider, the written notification shall include the principal reasons for the determination. The written notification shall contain:

1. The names and titles of the parties evaluating the provider-carrier dispute resolution request, and where the decision was based on a review of medical documentation, the qualifying credentials of the parties evaluating the provider-carrier dispute resolution request;

2. A statement of the reviewers' understanding of the reason for the provider's dispute;

3. The reviewers' decision in clear terms and the rationale for the carrier's decision; and

4. A reference to the evidence or documentation used as the basis for the decision.

F. All requirements in this regulation concerning written notification may be met by electronic means, including e-mail or facsimile, as long as confirmation of the transmission can be shown.

G. Nothing in this regulation shall be construed to supersede contract provisions that do not directly conflict with the terms of this regulation. For example, after a final determination is made by the carrier in accordance with the requirements set forth in this regulation, any further consideration of the request shall be handled in accordance with the contract provisions between the carrier and the provider, i.e., the request may be subject to mandatory arbitration as stated in the contract.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation is effective on July 1, 2018.

Section 9 History

New regulation, effective August 1, 2002.

Amended regulation effective September 1, 2011.
Amended regulation effective January 1, 2012.
Amended regulation effective December 15, 2013.
Amended regulation effective July 1, 2018.

Regulation 4-2-24 CONCERNING CLEAN CLAIM REQUIREMENTS FOR HEALTH CARRIERS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-16-109 and 10-1-109, C.R.S.

Section 2 Scope and Purpose

This regulation outlines the requirements to determine whether or not a claim will be considered a clean claim, as well as the requirements for carriers processing each as required for a prompt payment of claims.

Section 3 Applicability

This regulation applies to any entity that provides health coverage in this state including 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 Article 16 of the insurance laws of Colorado. This regulation also applies to those long-term care companies that submit claims on the CMS 1450 and CMS 1500 claim forms.

Section 4 Definitions

A. “Additional information” means, for the purposes of this regulation, information beyond what was submitted with the initial claim that is required to enable a carrier to determine its liability and resolve a claim.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. “Clean claim” means, for the purposes of this regulation, a claim for payment of health care expenses with all essential fields completed with correct and complete information required by the carrier to determine its liability.

D. “Essential field” means, for the purposes of this regulation, a field on a claim form, whether electronic or in any other form, that is not only required according to standards set forth by The Health Insurance Portability and Accountability Act (HIPAA), but is also necessary for the carrier to determine its liability and resolve the claim.

E. “Pended claim” means, for the purposes of this regulation, a claim which is held in an open or suspended status until requested additional information needed to resolve the claim is received or for at least thirty (30) days after a request for additional information is sent, whichever occurs first.

F. "Supplemental field" means, for the purposes of this regulation, a field on a claim form, whether electronic or in any other form, that is required or necessary only when it clarifies or quantifies the information in an essential field of a claim.

G. "Timely submit" means, for the purposes of this regulation, to provide to a carrier information or documentation requested within the time period required by § 10-16-106.5(4)(b), C.R.S.

H. "Unclean claim" means, for the purposes of this regulation, a claim for which information in the essential fields is missing, incorrect or incomplete, and additional information is needed by a carrier to determine its liability to resolve the claim.

Section 5 Rules

A. Clean claims shall be submitted in the appropriate format (electronic or paper) as required, must utilize the appropriate form (the American Dental Association Dental Claim Form, the CMS 1500 Form, or the CMS 1450 (UB-04) Form) or electronic equivalent, and shall include all essential fields necessary for the carrier to determine its liability and resolve the claim. In the case of a dispute over the status of a claim as clean or unclean, the Division shall make the final determination as to what fields are essential.

B. When all of the information or documentation necessary to resolve a claim is initially provided in the appropriate claim form or format that includes all of the essential fields and any supplementary fields needed for that claim, the claim shall be considered a clean claim and processed within the timeframes specified in § 10-16-106.5(4), C.R.S.

C. A carrier shall send a request for additional information necessary to resolve an unclean claim within thirty (30) calendar days after receipt of the claim pursuant to §10-16-106.5(4)(b), C.R.S.

D. A carrier shall pend an unclean claim, as defined in Section 4.H. of this regulation, and hold such claim in an open or suspended status until requested additional information needed to resolve the claim is received or for at least thirty (30) days after a request for additional information is sent, whichever occurs first.

E. A carrier shall not deny an unclean claim, as defined in Section 4.H. of this regulation, for lack of required or incorrect information without requesting the information needed to determine its liability and without allowing the required time period for the additional information to be submitted.

F. A claim shall not be considered unclean if the information provided in the required format is missing or incorrect unless that information is an essential field or is required by the carrier to determine its liability and resolve the claim.

G. A carrier shall pay interest as appropriate pursuant to § 10-16-106.5(5), C.R.S., when clean claims are not paid, denied, or settled within the specified time periods.

H. A carrier shall pay interest pursuant to § 10-16-106.5(5), C.R.S., when additional information necessary for resolving an unclean claim is not requested within the required time period or when the carrier denies an unclean claim without holding the claim in a pended status for at least thirty (30) days or until the information is received, following a request for additional information.

I. A carrier shall pay a penalty equal to twenty percent (20%) of the total amount ultimately allowed on all claims not paid, denied or settled within ninety (90) days after receipt of the claim.

Section 6 Additional Information

A. A claim with all required fields completed is not considered "clean" if additional information is needed in order to resolve the claim. Carriers may request additional information only if the carrier's claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow a determination of liability to be made.

B. When additional information is required, the carrier shall make the specific request in writing within thirty (30) calendar days after receipt of the claim. If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim. The specific information required shall be requested within thirty (30) calendar days after receipt of the claim form and identified for the provider upon request.

C. Additional information requested must be related to information in the essential fields of the claim. This applies even though the genesis of the request may be from other sources, e.g., if the carrier has other information that indicates the information in an essential field is incorrect, such as previous claims that indicate the treatment was for work-related injuries when the claim submitted indicates otherwise. Requests for additional information to determine if the treatment is medically necessary would be related to the fields specifying the services provided.

D. A carrier is not permitted to request additional information for the purpose of determining medical necessity when the claim form has all essential and supplementary fields correctly completed and the services were preauthorized pursuant to § 10-16-704(4), C.R.S.

E. The following circumstances are those for which additional information is generally required by most health carriers:

1. When the coverage is not primary, an explanation of benefits form from the primary payer;

2. When service/procedure codes indicate "unusual" procedural services or anesthesia, the medical records to justify medical necessity;

3. When surgical procedures utilize multiple surgeons or surgical assistants, the medical records to justify medical necessity;

4. When the procedure is a repeat procedure, the medical records to justify medical necessity;

5. When supplies and materials are ordered on an outpatient basis, the medical records and/or invoice to justify medical necessity or allowable fee; and

6. When services are billed using a "by report" or unlisted CPT code, the medical records to substantiate the claim.

F. If a managed care plan requires medical or other records on all claims for particular types of services/procedures or diagnosis codes, the carrier must clearly disclose such requirements in the provider contract, provider manual, or provider manual updates. If a carrier contracts with an intermediary, the carrier shall be responsible for making sure the intermediary provides such disclosure to contracted providers in a timely manner.

G. When requesting medical records, carriers must identify the particular component(s) of the medical record being requested or indicate the specific reason for the request, e.g., progress reports for most recent three months, or records to establish the medical necessity of the treatment provided. The records requested must be related to the service/procedure of the claim and limited to the minimum amount of information necessary. Requests for "all medical records" are not specific enough and would not be an acceptable request for claim adjudication.

H. Medical information requested from institutional providers shall be limited to the following:

1. History and physical reports;

2. Consultant reports;

3. Operative reports;

4. Discharge summaries;

5. Emergency department reports;

6. Diagnostic reports; and

7. Progress reports.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Incorporated Materials

The Centers for Medicare and Medicaid Services "CMS 1500 Form", published by the National Uniform Claim Committee shall mean "CMS 1500 Form" as published on the effective date of this regulation and does not include later amendments to or editions of the "CMS 1500 Form." The Centers for Medicare and Medicaid Services "CMS 1500 Form" may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Centers for Medicare and Medicaid Services Website at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html. Certified copies of The Centers for Medicare and Medicaid Services "CMS 1500 Form" are available from the Colorado Division of Insurance for a fee.

The Centers for Medicare and Medicaid Services "CMS 1450 (UB-04) Form", published by the National Uniform Billing Committee shall mean "CMS 1450 Form" as published on the effective date of this regulation and does not include later amendments to or editions of the "CMS 1450 Form." The Centers for Medicare and Medicaid Services "CMS 1450 Form" may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Centers for Medicare and Medicaid Services Website at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450.html. Certified copies of Tthe Centers for Medicare and Medicaid Services "CMS 1450 Form" are available from the Colorado Division of Insurance for a fee.

The American Dental Association "ADA Dental Claim Form," published by the American Dental Association shall mean "ADA Dental Claim Form" as published on the effective date of this regulation and does not include later amendments to or editions of the "ADA Dental Claim Form." The American Dental Association "ADA Dental Claim Form," may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting The American Dental Association Website at http://www.ada.org/7119.aspx. Certified copies of the American Dental Association "ADA Dental Claim Form" are available from the Colorado Division of Insurance for a fee.

Section 9 Enforcement

Non-compliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

This regulation is effective January 1, 2014.

Section 11 History

Emergency Regulation 02-E-7, effective July 2, 2002.
Temporary Regulation 02-T-7, effective October 1, 2002.
Regulation 4-2-24 effective February 1, 2003.
Amended Regulation 4-2-24 effective February 1, 2008.
Amended Regulation effective June 1, 2012.
Amended Regulation effective January 1, 2014.

Regulation 4-2-25 Repealed in Full [Eff. 04/01/2009]

Regulation 4-2-26 Repealed in Full [Eff. 11/01/2010]

Regulation 4-2-27 PROCEDURES FOR REASONABLE MODIFICATIONS TO INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-109, 10-16-103.4(7), and 10-16-105.1(6), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish procedures for the submission of reasonable modifications to grandfathered individual and small group health benefit plans, to non-grandfathered individual and small group health benefit plans, as outlined in § 10-16-105.1(5), C.R.S.

Section 3 Applicability

This regulation applies to all carriers seeking to make reasonable modifications to any individual or small group health benefit plan.

Section 4 Definitions

A. “ACA” or “PPACA” means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B. “Carrier” means, for the purposes of this regulation, a carrier as defined in § 10-16-102(8), C.R.S.

C. “Plan” means, for the purposes of this regulation, the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, specific cost-sharing amounts, provider network, and service area.

D. “Product” means, for the purposes of this regulation, a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a carrier offers in a state.

E. “Reasonable modification” means, for the purpose of this regulation, a modification to the benefits of a plan that is fair and reasonable, as determined by the Division of Insurance (Division), and does not necessitate the filing of a new plan.

F. “SERFF” means, for the purposes of this regulation, System for Electronic Rates and Forms Filing.

Section 5 Rules

A. Non-Grandfathered Plans

1. Federal or State Requirement Changes

a. A carrier may reasonably modify the benefits of a plan in accordance with a change in federal or state requirements if the reasonable modification is applied uniformly to all individual or small groups covered by the plan; and

b. The reasonable modification is made within a reasonable time period and is directly related to the change in federal or state requirement(s).

2. Other Types of Reasonable Modifications

a. Reasonable modifications are allowable if applied uniformly to all individual or small groups covered by the plan and if they meet all of the following criteria:

(1) The plan is offered by the same carrier;

(2) The plan is offered as the same network type (for example: health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);

(3) The plan continues to cover at least a majority of the same service area which must include a majority of the current counties, taking into consideration the population density of the counties that remain in the carriers' service area;

(4) The plan has the same cost-sharing structure as before the reasonable modification, except for any variation in cost-sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in § 10-16-103.4, C.R.S. A cost-share structure change includes the following and will not be allowed:

(a) Changing from copays to coinsurance when copays apply to the majority of services; or

(b) Changing from coinsurance to copays when coinsurance applies to the majority of services.

(4) Actuarial justification will be accepted if changes are made to maintain the plan's metal tier.

b. Potential reasonable modifications include, but are not limited to:

(1) Adding a benefit;

(2) Increasing out-of-pocket maximum to match federal limits; and/or

(3) Increasing or reducing deductibles or copays.

c. Potential unreasonable modifications may include, but are not limited to:

(1) Metal level changes;

(2) Removing a benefit; or

(3) Removing the availability to participate in a HSA.

d. If a carrier is changing a service area, or discontinuing plans in certain areas, a discontinuance filing must be submitted to the Division in accordance with the requirements found at § 10-16-105.1(2)(g), C.R.S., and notification must be given to policyholders in accordance with the requirements in Colorado Insurance Regulations 4-2-51 and 4-2-82.

B. Grandfathered Plans

1. Potential reasonable modifications may include, but are not limited to adding a benefit to comply with state or federal law.

2. Potential unreasonable modifications may include, but are not limited to:

a. Elimination of all or substantially all benefits to diagnose or treat a particular condition;

b. Increase in coinsurance percent requirement;

c. Increase in deductible or out-of-pocket requirements other than a copayment;

d. Increase in copayment requirements;

e. Decrease in contribution rate by employers and employee organizations, or decreases in contribution rate based on cost of coverage towards the cost of any tier of coverage for any similarly situated individuals by more than five (5) percentage points below the contribution rate for the coverage period that included March 23, 2010.

f. Changes in annual limits;

g. Addition of an annual limit;

h. Health plan that did not impose an overall annual or lifetime limit on the dollar value of all benefits then imposes an overall annual limit on the dollar value of benefits;

i. Adding a policy year, calendar year or lifetime limit to a benefit or plan that did not have a previous limit;

j. Decrease in limit for a plan or coverage with an annual limit;

k. Change in the cost-share structure. A cost-share structure change includes the following:

(1) Changing from copays to coinsurance when copays apply to the majority of services; or

(2) Changing from coinsurance to copays when coinsurance applies to the majority of services.

3. If any of the above potential unreasonable modifications are made to the plan it may lose its status as a grandfathered plan.

4. The removal of a benefit will be considered an unreasonable modification and that plan will no longer be considered a Grandfathered Plan.

5. If a carrier is changing a service area, or discontinuing plans in certain areas, a discontinuance filing must be submitted to the Division in accordance with the requirements found at § 10-16-105.1(2)(g), C.R.S., and notification must be given to policyholders in accordance with the requirements in Colorado Insurance Regulation 4-2-51.

Section 6 Requirements

A. Timing of reasonable modification request submissions.

1. The proposed reasonable modification request for non-grandfathered health benefit plans must be submitted annually on or before April 1st.

2. The proposed reasonable modification request for grandfathered plans must be submitted annually at least 180 days before the implementation date.

B. All reasonable modification requests must be submitted electronically through SERFF.

C. A separate filing must be submitted for each carrier. A single filing, which is made for more than one (1) carrier or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO, indemnity, point-of-service plan, exclusive provider organization or preferred provider organization.

D. SERFF Requirements for non-grandfathered health benefit plan

Carriers must complete and submit the following information in SERFF in order for a Reasonable Modification form filing submission to be considered complete:

1. Carriers must complete the Form Name, Form Number, Form Type, Action: Other, on the Form Schedule tab. All forms from the previously approved form filing must be listed.

2. Carriers must submit the following documents on the Supporting Documentation tab:

a. Cover Letter - A carrier must submit a cover letter addressed to the Commissioner in the format specified in Appendix A of this regulation. The cover letter must include:

(1) The market type of the plan (i.e. individual or small group);

(2) The grandfathered or non-grandfathered status of the plan;

(3) The effective date;

(4) The total number of Colorado groups and members affected; and

(5) The reason the plan(s) is/are being modified.

b. HIOS Plan Listing - A carrier must submit the relevant HIOS plan ID listings in the format specified in Appendix B of this regulation. The listings must be provided in an Excel spreadsheet and must include the following:

(1) The first column must contain the HIOS plan ID;

(2) The second column must contain the plan marketing name;

(3) The third column must contain the form number; and

(4) The fourth column must contain the status of the HIOS plan ID, using only one of the following terms:

(a) “Modifying”;

(b) “Continuing without Modification”; or

(c) “Discontinuing”.

(5) All HIOS plan IDs from the previous year must be identified in this spreadsheet which must not include any zero cost-share variant or silver cost-share variants.

(6) Plans identified as being continued without modifications or discontinued must not be modified.

c. Side-by-Side Comparison - A carrier must submit a “Side–by–Side Comparison” document, in the format specified in Appendix C of this regulation. This comparison document must be provided in an Excel spreadsheet and include the following column names:

(1) HIOS Plan ID;

(2) Plan Name;

(3) Form Number;

(4) Current Benefit;

(5) Proposed Benefit;

(6) Benefit Impact to AV;

(7) Total Actuarial Value, calculated with the new benefit year AV calculator, before the Changes;

(8) Total Actuarial Value after the Changes;

(9) Total Rate Impact of all Modified Benefits; and

(10) Comments.

d. Letter of Authority - If a carrier uses a third-party administrator or other entity to file on its behalf, a copy of the letter authorizing the third-party administrator to make the filings is required to be submitted with each filing. The filing must be submitted under the carrier's name and using the proper NAIC company code. In addition, the carrier shall ensure that the entity is aware of the requirements of this regulation.

E. SERFF Requirements for grandfathered health benefit plans

Carriers must complete and submit the following information in SERFF in order for a Reasonable Modification form filing submission for a grandfathered health benefit plan to be considered complete:

1. Carriers must complete the Form Name, Form Number, Form Type, Action: Other, on the Form Schedule tab. All forms from the previously approved form filing must be listed.

2. Carriers must submit the following documents on the Supporting Documentation tab:

a. Cover Letter - A carrier must submit a cover letter addressed to the Commissioner in the format specified in Appendix A of this regulation. The cover letter must include:

(1) The market type of the plan (i.e. individual, small group or large group);

(2) The grandfathered status of the plan;

(3) The effective date;

(4) The total number of Colorado groups and members affected; and

(5) The reason the plan(s) is/are being modified.

F. If a requested modification is not approved by the Division and the carrier elects to discontinue the plan, the carrier must file a discontinuance, in accordance with § 10-16-105.1, C.R.S., and Colorado Insurance Regulation 4-2-51.

G. A reasonable modification filing does not fulfill the requirements to file rates and forms in accordance with Colorado insurance laws and regulations.

Section 7 Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective on March 17, 2023.

Section 10 History

Regulation effective January 1, 2005.
Amended regulation effective May 1, 2010.
Amended regulation effective January 1, 2014.
Repealed and repromulgated regulation effective March 15, 2017.
Amended Regulation effective May 30, 2022
Amended regulation effective March 17, 2023.

Appendix A: Cover Letter Template

Date

Commissioner [Name]
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

RE: Proposed Reasonable Modifications to [Non-grandfathered][Grandfathered] Plans in the [Individual][Small Group] Market

Dear Commissioner [Name]:

Please accept this letter and its attachments as [Carrier name]'s reasonable modification submission for plans renewing effective [January 1, April 1, July 1, October 1], [Plan year] pursuant to § 10-16-105.1(5), C.R.S, Colorado Insurance Regulation 4-2-27 and the "Colorado PPACA Reasonable Modification Filing Procedures" for [plan year].

These plan modifications will affect [XX Colorado individuals] [XX individuals covered under XX Colorado small groups].

We are proposing to make the following changes:

[Enter either plan specific changes or range changes].

Attached please find:

- Exhibit of all [Year] plans;
- Side-by-side comparison;
- Policyholder letter.

Thank you for your consideration of this request.

Sincerely,

Appendix B: HIOS Plan ID Listings

HIOS Plan ID	Plan Marketing Name	Form Number	Status of Plan
[12345CO00100009]	[Sample Plan]	[CO16]	[Modifying]
[12345CO00100010]	[Sample Plan]	[CO16]	[Continuing without modification]
[12345CO00100011]	[Sample Plan]	[CO16]	[Discontinuing]

APPENDIX C: SIDE – BY – SIDE COMPARISON

HIOS Plan ID	Plan Name	Form Number	Benefit Name	Current Benefit	Proposed Benefit	Benefit Impact to AV	Total AV before Changes	AV after Change	Total Rate Impact of all Benefits	Comments
[12345CO00100009]	[Sample Plan]	[CO16]	[Office Visit Copay]	[$20 per visit]	[$30 per visit]	[-.14]	[81.39]	[80.98]	[-3.1%]	[Applicable comments]
[12345CO00100009]	[Sample Plan]	[CO16]	[In-Network Deductible]	[$6500.00]	[$6850.00]	[+.24]				[Applicable comments]
[12345CO00100009]	[Sample Plan]	[CO16]	[In-Network Out-of-Pocket]	[$6850.00]	[$7150.00]	[-.51]				[Applicable comments]

Regulation 4-2-28 CONCERNING THE PAYMENT OF EARLY INTERVENTION SERVICES FOR ELIGIBLE CHILDREN

Section 1 Authority

This regulation is being promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-16-104(1.3)(b)(II)(A), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide carriers the guidance necessary to facilitate the payment for early intervention services by private insurance sources and to comply with federal law.

Section 3 Applicability

This regulation applies to all carriers issuing and/or renewing individual and group health benefit plans.

Section 4 Definitions

A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. "Case management services" means, for the purposes of this regulation, the service coordination activities as defined in 34 CFR 303.34.

C. "Certified early intervention service broker" or "broker" means, for the purposes of this regulation, a community centered board or other entity designated by the Colorado Department of Human Services to perform the specified duties and functions in a particular designated service area and may include the Division of Community and Family Support acting as the broker for any service area until another broker has been designated.

D. "Division of Community and Family Support" means, for the purposes of this regulation, a division of the Colorado Department of Human Services.

E. "Early intervention services" shall have the same meaning as found at § 10-16-104(1.3)(a)(II), C.R.S., and includes monthly case management service costs and fees.

F. "Eligible child" shall have the same meaning as found at § 10-16-104(1.3)(a)(III), C.R.S.

G. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.

H. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S. For the purposes of this regulation, "health benefit plan" does not include short-term limited duration health insurance policies.

I. "Individualized family service plan" or "IFSP" shall have the same meaning as found at § 10-16-104(1.3)(a)(IV), C.R.S.

J. "Limited benefit health coverage" means, for the purposes of this regulation, any type of health coverage that is not provided by a health benefit plan.

K. "Registry" means, for the purposes of this regulation, a listing of early intervention service providers established by the designated area's certified early intervention service broker. The broker may provide early intervention services directly or may subcontract the provision of services to other qualified providers in the registry.

L. "Qualified early intervention service provider" or "qualified provider" shall have the same meaning as found at § 10-16-104(1.3)(a)(VI), C.R.S.

Section 5 Rules

A. Eligible early intervention services specified in the eligible child's IFSP shall meet the carrier's test of medically necessary services. Therefore, carriers shall arrange for the payment of claims for early intervention services provided to an eligible child received from qualified early intervention service providers listed in the registry.

B. The certified early intervention service broker will notify the carrier within ten (10) days of determining that a child, up to age three (3), is eligible for early intervention services. This notification will include, at a minimum:

1. The eligible child's name;

2. The eligible child's date of birth;

3. The policy number; and

4. The name of the primary insured or policyholder.

C. Trust Payments.

1. Upon the receipt of a new IFSP for an eligible child, carriers shall pay an amount equal to the annual monetary benefit, as established in section 5.E.3. of this regulation, into the trust established by the Colorado Department of Human Services (CDHS) as provided in § 27-10.5-709(1), C.R.S., within thirty (30) days of receipt of an invoice issued by CDHS.

2. For an eligible child covered by a plan subject to the requirements of section 5.E.1., 2., or 3.:

a. If funds remain in the trust after the required benefits and associated case management costs and fees have been paid, the trust will refund the balance to the carrier when it performs its reconciliation for the eligible child.

b. If the funds deposited are not enough to cover the services billed for the required number of visits, in accordance with section 5.E.1. or 2., and the associated case management costs and fees, the carrier will deposit an additional amount in increments of $1,000, as needed, until all required services and fees have been paid. Remaining funds will be refunded in accordance with section 5.C.2.a.

D. Eligible early intervention services do not include:

1. Non-emergency medical transportation;

2. Respite care;

3. Service coordination other than case management services; or

4. Assistive technology. However, assistive technology may be covered by the policy's durable medical equipment benefit provisions.

E. Benefit and payment requirements.

1. For non-grandfathered individual and group health benefit plans, coverage must be provided for no less than forty-five (45) visits annually for early intervention services and associated case management costs and fees, with no dollar limit imposed upon those visits.

2. For group grandfathered health benefit plans renewed on or after October 1, 2018, coverage must be provided for no less than forty-five (45) visits annually for early intervention services and associated case management costs and fees, with no dollar limit imposed upon those visits.

3. As of January 1, 2018, for individual grandfathered health benefit plans, the maximum annual monetary benefit payable for all eligible early intervention and case management costs and fees, is $7,168.00. Thereafter, on January 1 of each year, the maximum annual benefit payable will be adjusted in accordance with § 10-16-104(1.3)(b)(II)(B), C.R.S. The new maximum annual benefit amount will be published in a bulletin by the Colorado Division of Insurance.

4. Any covered benefit payable for the following services shall not be subject to the annual benefit amounts specified in sections 5.E.1., 2., and 3.:

a. Rehabilitation or therapeutic services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;

b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an IFSP; and

c. Assistive technology covered by the policy's durable medical equipment benefit provisions.

5. Qualified early intervention service providers that receive reimbursement in accordance with section 5.E.1., 2, or 3. shall accept such reimbursement as payment in full for services provided under § 10-16-104(1.3), C.R.S., and shall not seek additional reimbursement from either the primary policy or certificate holder or the carrier.

F. The Division of Community and Family Support will notify the carrier within ninety (90) days if a child is determined to no longer be eligible for early intervention services.

G. Short-term, accident, fixed indemnity, specified disease policies, disability income contracts, limited benefit health coverage plans, credit disability insurance and Medicare supplement policies are not required to provided the benefits set forth in § 10-16-104(1.3), C.R.S.

H. The carrier shall return requests for verification of eligibility of coverage of the eligible child to the certified early intervention service broker and/or trust within five (5) business days of receipt.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Incorporated Materials

Section 303.34 of Title 34 (Early Intervention Program for Infants and Toddlers with Disabilities), Code of Federal Regulations published by the Government Printing Office shall mean Section 303.34 of Title 34 as published on the effective date of this regulation and does not include later amendments to or editions of Section 303.34 of Title 34. A copy of Section 303.34 of Title 34 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of Section 303.34 of Title 34 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective on July 1, 2018.

Section 10 History

Emergency regulation 07-E-3 is effective December 3, 2007.
New regulation effective March 1, 2008.
Emergency regulation 09-E-01 is effective June 15, 2009.
Amended regulation effective October 1, 2009.
Amended regulation effective January 15, 2014.
Amended regulation effective July 1, 2018.

Regulation 4-2-29 CONCERNING THE RULES FOR STANDARDIZED CARDS ISSUED TO PERSONS COVERED BY HEALTH BENEFIT PLANS AND DENTAL COVERAGE PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-109, 10-16-135, and 10-16-165, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide carriers the guidance necessary to comply with the statutory requirements regarding the issuance and use of health benefit plan identification cards, pursuant to § 10-16-135, C.R.S, and to align state law with the requirements imposed by the No Surprises Act, part of the Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, §§ 101–118, 134 Stat. 1182 (2020), and codified in 42 U.S.C. § 300gg-111I. This regulation also provides carriers or prepaid dental plan organizations offering dental coverage plans the guidance necessary to comply with the statutory requirements regarding the issuance and use of dental coverage plan identification cards, pursuant to § 10-16-165, C.R.S.

Section 3 Applicability

This regulation applies to all individual and group health benefit plans issued or renewed by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes. The requirements of this regulation shall apply to identification cards issued to persons covered under health benefit plans, including, but not limited to, participants, beneficiaries, or enrollees (“members”) in a health benefit plan. This regulation applies to all carriers or prepaid dental plan organizations that issue dental coverage plans, as defined in § 10-16-165, C.R.S. These requirements do not apply to identification cards issued to persons covered by limited benefit health coverage.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Clear and conspicuous” means, for the purpose of this regulation, the placement of the required information will be set apart from other information listed to allow it to be easily located on the card.

C. “Dental coverage plan” shall have the same meaning as found at § 10-16-165(1)(b), C.R.S.

D. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

E. “Limited benefit health coverage” means, for the purpose of this regulation, any type of health coverage that is not provided by a health benefit plan, as defined in § 10-16-102(32)(a), C.R.S.

F. "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.

G. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.

H. "Prepaid dental plan organization" shall have the same meaning as found at § 10-16-102(53), C.R.S.

I. "Provider" shall have the same meaning as found at § 10-16-102(56), C.R.S.

Section 5 Health Benefit Plan Card Requirements

A. A new physical identification card shall be issued by a carrier:

1. When a person enrolls in a health benefit plan;

2. When a person's plan or benefit information changes;

3. Upon request of the member.

B. The card size must be approximately 2.125 inches by 3.370 inches, which is consistent with standard-sized credit cards, and must be made of plastic or be laminated.

C. The colors used for the card and font must be legible and conducive to black and white photocopying.

D. Carriers may provide members with digital identification cards. Digital identification cards must contain all information provided on the physical identification card, and cannot replace the issuance of physical identification cards as required by subsection A of this section.

E. The following information must appear on the front side of the identification card, in no less than 8 point font:

1. The legal name of the carrier underwriting the policy, but a "dba" may also be included;

2. The covered person's first name, middle initial (if applicable), and last name;

3. Any applicable policy, certificate, or group number, and the subscriber's or covered person's identifying number, as applicable, which is sufficient to identify the covered person with the policy;

4. The specific plan number or name;

5. The plan type, such as HMO (Health Maintenance Organization), POS (Point-of-Service), PPO (Preferred Provider Organization), EPO (Exclusive Provider Organization), or Indemnity (non-managed care plan);

6. Coverage levels for the following services. If all services are subject to the policy's deductible and applicable coinsurance, a notation of "Deductible and coinsurance apply" is sufficient; otherwise, the required copayments must be specified. If both a deductible and copayment apply, a notation of "Deductible applies" is sufficient, followed by the specified copayment amount.

a. Primary care;

b. Specialty care;

c. After hours/urgent care;

d. Emergency room; and

e. Inpatient hospital.

7. The designation “CO-DOI” must be placed on the card in a clear and conspicuous manner for health benefit plans regulated by the State of Colorado’s Division of Insurance.

F. The following information must appear on either the front or reverse side of the identification card at the carrier’s discretion, in no less than 8 point font:

1. Contact information for the carrier or plan administrator which includes:

a. Name and address for claim submissions;

b. Telephone number(s) and internet website address for member/customer service, through which a plan participant, beneficiary, or enrollee may seek customer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with the carrier for furnishing items and services under the plan;

c. If applicable, a statement that preauthorization or notification for hospitalization or other services may be required and the telephone number to obtain such preauthorization or to make such notification; and

d. If the carrier does not use its own managed care provider network, the logo, name of the network, website, or toll-free number where provider network information can be readily obtained.

2. Any deductible applicable to the plan;

3. Any out-of-pocket maximum limitation applicable to the plan;

4. “Card issued” date, which must be displayed in a clear and conspicuous manner.

G. The card may include other information at the carrier’s discretion including a member's pronouns, gender identity, or the name the member commonly uses, if different from their legal name.

H. Carriers may utilize commonly-known abbreviations or acronyms for the purposes of displaying the information required by Section 5.D.6., such as:

1. “PCP” to describe or refer to primary care provider benefits;

2. “SCP” to describe or refer to specialty care provider benefits;

3. “Urgent” to describe or refer to after hours/urgent care benefits;

4. “ER” to describe or refer to “emergency room” benefits;

5. “Hospital” to describe or refer to inpatient hospital benefits;

6. “Ded” or “deduct” to describe the application of the policy’s deductible; or

7. "Co-ins" to describe the application of the policy's coinsurance requirements.

I. Carriers choosing to utilize commonly known abbreviations or acronyms in accordance with Section 5.G. must provide an explanation of the abbreviations and/or acronyms displayed on the card in the information provided when the card is sent to the covered person.

Section 6 Dental Coverage Plan Card Requirements

A. A new physical or virtual identification card shall be issued by a carrier or prepaid dental plan organization:

1. When a person enrolls in a dental coverage plan;

2. When a person's plan or benefit information changes and the change affects data contained on the card;

3. Upon request of the member.

B. The size of a physical card must be approximately 2.125 inches by 3.370 inches, which is consistent with standard-sized credit cards, and must be made of plastic or be laminated.

C. The colors used for the card and font must be legible and conducive to black and white photocopying.

D. The following information must appear on the front side of the identification card, in no less than 8 point font:

1. The legal name of the carrier underwriting the policy, but a "dba" may also be included;

2. The covered person's first name, middle initial (if applicable), and last name;

3. Any applicable policy, certificate, or group number, and the subscriber's or covered person's identifying number, as applicable, which is sufficient to identify the covered person with the policy;

4. The designation "CO-DOI" must be placed on the card in a clear and conspicuous manner for dental plans regulated by the State of Colorado's Division of Insurance.

E. The following contact information for the carrier or plan administrator must appear on either the front or reverse side of the identification card, in no less than 8 point font:

1. Name and address for claim submissions.

2. Telephone number(s) and internet website address for member/customer service, through which a plan participant, beneficiary, or enrollee may seek customer assistance information.

F. The following information may be added at the carrier's discretion, in no less than 8-point font:

1. If applicable, a statement that preauthorization or notification for any services may be required and the telephone number to obtain such preauthorization or to make such notification; and

2. If the carrier does not use its own provider network, the logo, name of the network, website, or toll-free number where provider network information can be readily obtained.

3. A member's pronouns, gender identity, or the name the member commonly uses, if different from their legal name.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective on March 31, 2024.

Section 10 History

New regulation effective October 1, 2008.
Amended regulation effective July 1, 2009.
Amended regulation effective December 15, 2013.
Amended regulation effective September 1, 2017.
Amended regulation effective on January 1, 2022.
Amended regulation shall become effective on March 31, 2024.

Regulation 4-2-30 CONCERNING THE RULES FOR COMPLYING WITH MANDATED COVERAGE OF HEARING AIDS AND PROSTHETICS

Section 1 Authority

This regulation is being promulgated and adopted by the Commissioner of Insurance under the authority of § 10-1-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide health carriers the guidance necessary to comply with the requirement to provide coverage for prosthetics and hearing aids pursuant to § §10-16-104(14) and (19), C.R.S., respectively.

Section 3 Applicability

This regulation applies to all individual and group health benefit plans issued or renewed by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes.

Section 4 Definitions

A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

C. "Hearing aid" shall have the same meaning as found at § 10-16-102(38), C.R.S.

D. "Limited benefit health insurance" means, for the purpose of this regulation, a health policy, contract or certificate offered or marketed on an individual or group basis as supplemental health insurance that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles, copayments or coinsurance amounts not covered by a health benefit plan. "Limited benefit health insurance" does not include short-term limited duration health insurance policies, contracts or certificates; high deductible plans; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan".

E. "Minor child" shall have the same meaning as found at § 10-16-102(44), C.R.S.

Section 5 Rules

A. Hearing aids.

1. For the purposes of § 10-16-104(19), C.R.S., hearing aids do not meet the traditional definition of durable medical equipment; therefore, any benefits paid for a minor child's hearing aid(s) in accordance with the coverage mandated by Colorado law shall not be used to exhaust a health benefit plan's annual durable medical equipment maximum, if any.

2. The mandated coverage of hearing aids for a minor child shall be provided subject to the same annual deductible and/or copayment/coinsurance levels established for other covered benefits. Benefits shall be determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in § § 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

3. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. This requirement shall apply to each hearing aid if the minor child has two hearing aids.

B. For the purposes of §10-16-104(14), C.R.S., prosthetics do not meet the traditional definition of durable medical equipment; therefore, any benefits paid for prosthetics in accordance with the coverage mandated by Colorado law shall not be used to exhaust a health benefit plan's annual durable medical equipment maximum, if any.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective on December 15, 2013.

Section 9 History

Emergency Regulation 08-E-11 effective January 1, 2009.
New regulation 4-2-30 effective February 1, 2009.
Amended regulation, effective December 15, 2013.

Regulation 4-2-31 ANNUAL HEALTH REPORTING AND DATA RETENTION REQUIREMENTS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-109, 10-16-109 and 10-16-111(4), , C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to define uniform reporting, filing and data retention requirements for the hospital reimbursement rate report and the Annual Cost Report.

Section 3 Applicability

This regulation applies to all carriers, as defined in Section 4.B. of this regulation, operating in the state of Colorado with written health premium in the data year

Reporting of information is waived as shown for each report:

A. Hospital Reimbursement Rate Report

The following types of business are waived: Limited medical-payment plans (including disability income, accident only, specified or dread disease, hospital indemnity, vision only, and dental only), Medicare, Medicaid, long term care, and Medicare supplement insurance.

B. Annual Cost Report

The Division has been granted authority to waive the reporting requirement for carriers responding to the Colorado Health Cost Report so long as at least those representing the top ninety-two percent (92%) of earned premium market share respond. Companies required to respond will be contacted through email sent to the Market Conduct Contact on file with the National Association of Insurance Commissioners (NAIC).

The calculation determining which carriers are waived from being required to report will utilize Colorado-specific data in exhibits from the most recently-filed NAIC Annual Statement for carriers required to report to the NAIC at the time of each Annual Cost Report. Specific information on the annual waiver methodology can be found in Colorado Insurance Bulletin No. B-4.58.

Section 4 Definitions

A. "Average reimbursement rate" means, for the purposes of this regulation, the average of all reimbursement rates that a carrier paid, by MS-DRG code, to only hospitals/facilities reporting to the Colorado Hospital Association during the previous calendar year including both in-network and out-of-network facilities.

B. "Carrier", for the purposes of this regulation, shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. "Dividends" means, for purposes of this regulation, both policyholder and stockholder dividends.

D. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

E. MS-DRG" (Medicare Severity Diagnosis Related Group) is a code within a system developed for Medicare as part of its payment system to classify each hospital case into one of approximately 500 groups that is published by the Centers for Medicare and Medicaid Services in the FY 2017 Final Rule Tables, Table 5.

F. "Premium" means, for purposes of this regulation, the amount of money paid on behalf of the insured as a condition of receiving health care coverage. The premium paid normally reflects such factors as the carrier's expectation of the insured's future claim costs and the insured's share of the carrier's claims settlement, operational and administrative expenses, and the carrier's cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.

G. "Trend," means, for the purposes of this regulation, the rate of increase in costs for the reporting period.

Section 5 Hospital Reimbursement Rate Record Retention and Report

A. Pursuant to the Health Care Transparency Act, § 10-16-134, C.R.S., each carrier shall abide by the required reporting per 10 CCR 2505-5 §1.200.2.

B. Timing and Submission: The required data shall be filed on or before March 1 of each year.

Section 6 Annual Cost Report

A. Pursuant to § 10-16-111(4)(a), C.R.S., carriers subject to this regulation shall file an Annual Cost Report as described in this section. This report must comply with the requirements of this section.

B. Timing and Submission: All Annual Cost Reports shall be filed electronically in a format made available by the Division of Insurance via the Division's website on or before June 1 of each year.

C. Annual Cost Reports filed by carriers identified in Section 3 must contain, where applicable, all of the information in this subsection or be considered incomplete. The report shall include the following information for the previous calendar year unless an alternate date is specified.

1. The information required in this report identified in paragraph 2 of this subsection C. must be itemized in the following categories by market group size: individual on exchange, individual off exchange, small group on exchange, small group off exchange and large group.

2. The following information is to be reported from the carrier's annual financial statement or provided using the allocation method detailed in subsection D., or if not available, in the annual financial statement otherwise derived from company records:

    a. Number of Colorado Covered Lives as of 12-31 in the previous reporting calendar year;

    b. Number of Colorado Covered Lives as of 12-31 in the reporting calendar year;

    c. Number of Colorado individual Subscribers/certificate holders/policyholders as of 12-31 in the previous reporting calendar year;

    d. Number of Colorado individual Subscribers/certificate holders/policyholders as of 12-31 in the reporting calendar year;

    e. Number of Colorado groups/policies as of 12-31 in the previous reporting calendar year;

    f. Number of Colorado groups/policies as of 12-31 in the reporting calendar year;

    g. Number of member months;

    h. Direct Losses Incurred;

    i Colorado Direct Written Premium;

    j. Colorado Direct Earned Premium;

    k. Total Administrative Expenses; and

    l. Healthcare Cost Trend in the following categories:

        (1) Medical Trend due to provider price changes, utilization changes, medical cost shifting, new medical procedures and technology, and total medical trend; and

        (2) Prescription Drug Trend due to pharmaceutical price changes, utilization changes, medical cost shifting, introductions of new brand name and generic drugs, and total prescription drug trend.

3. Carriers shall report the following information from their annual financial statement or using the allocation method detailed in subsection D. or if not available in the annual financial statement otherwise derived from company records:

    a. Producer Commissions;

    b. Total Reserves on hand as of the end of December in the reporting calendar year;

    c. Salaries;

    d. Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses;

    e. Dividends paid to Colorado Policyholders;

f. Advertising and marketing expenditures;

g. Payments to legal counsel;

h. Paid lobbying expenditures;

i. Charitable contributions;

j. Investment income and realized capital gains or losses;

k. Net income;

l. Colorado state taxes, licenses, and fees;

m. Federal taxes;

n. Dividends paid to stockholders;

o. Surplus;

p. Capital;

q. Authorized control level risk based capital; and

r. Intermediaries: A list of each intermediary with whom the carrier has a contractual relationship, or a statement that the carrier does not have any intermediaries, including entity/individual name, business address, and business phone number.

4. Carriers shall report executive salaries, as reported on the carriers Supplemental Compensation Exhibit of the annual financial statement. Carriers must provide data from the Supplemental Compensation Exhibit of the carrier's annual financial statement including but not limited to, base salary, bonuses, stock awards, option awards, sign on payments, and severance payments.

5. National premium information including:

a. Major Medical Premium Earned;

b. Accident and Health Premium Earned;

c. Property and Casualty Premium Earned; and

d. Life Premium Earned

D. The information provided in subsection C. of this section shall be provided on a Colorado-only basis, with the exception of executive salaries as defined in subparagraph C.4 of this section. A carrier licensed in multiple jurisdictions may satisfy the requirements of subsection C. of this section by filing the Colorado-allocated portion of national data if the actual Colorado-only data is not otherwise available. The methods of allocation that should be used, if necessary, will be provided by the Division prior to the release of the report for completion.

E. If any of the items listed in subsection C. of this section are not applicable to the carrier, the carrier shall indicate in the filing which items are not applicable and the reason why such items are not applicable.

F. The information provided to the Division of Insurance in subsection C. of this section will be aggregated for all carriers and will be published on the Division of Insurance's website, www.dora.colorado.gov/insurance.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 8 Incorporated Materials

10 CCR 2505-5 §1.200.2 5 published by the Colorado Secretary of State, shall mean 10 CCR 2505-5 §1.200.2 5 as published on the effective date of this regulation and does not include later amendments to or editions of 10 CCR 2505-5 §1.200.2 5, 10 CCR 2505-5 §1.200.2 5 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202, or by visiting the Colorado Secretary of State website at https://www.sos.state.co.us/CCR. A certified copy of 10 CCR 2505-5 §1.200.2 5 may be requested from the Colorado Division of Insurance for a fee.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

This regulation shall become effective on January 15, 2021.

Section 11 History

Amended Regulation, Effective August 1, 2011.
Amended Regulation, Effective December 1, 2012.
Amended Regulation, Effective November 15, 2013.
Amended Regulation, Effective August 1, 2015.
Amended Regulation, Effective March 15, 2017.
Amended Regulation Effective January 15, 2021.

Regulation 4-2-32 STANDARDIZED ELECTRONIC IDENTIFICATION AND COMMUNICATION SYSTEMS GUIDELINES FOR HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-16-135, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to define the standardized electronic identification and communication systems to be used by carriers and providers of health benefit plans in Colorado, as required by § 10-16-135, C.R.S.

Section 3 Applicability

This regulation applies to all health benefit plan providers and carriers operating in the state of Colorado. Deadlines imposed in this regulation may be extended by the Commissioner under the circumstances listed in subsection 5.G. of this regulation.

Section 4 Definitions

A. “Carrier” shall have the same meaning as in § 10-16-102(8), C.R.S.

B. “CORE” means the Committee on Operating Rules for Information Exchange.

C. “CORE Phase I certified” means having followed all CORE certification guidelines and received a Phase I certification seal.

D. “CORE Phase II certified” means having followed all CORE certification guidelines and received a Phase II certification seal.

E. “Health benefit plan” shall have the same meaning as in § 10-16-102(32), C.R.S.

F. “Provider” shall have the same meaning as in § 10-16-102(56), C.R.S.

G. “HIPAA” means Health Insurance Portability and Accountability Act of 1996.

Section 5 Rules

A. All carriers licensed in this state as of January 1, 2013, shall be able to show the ability of their systems to allow real time data exchange including benefits eligibility, coverage determinations, and other appropriate provider-carrier transactions and interoperability following all CORE guidelines for data formats and system requirements.

B. Carriers licensed in this state after January 1, 2013, if not already having systems that allow real time data exchange including benefits eligibility, coverage determinations, and other appropriate provider-carrier transactions following all CORE guidelines, shall, within sixty (60) days of becoming licensed adjust their systems to follow all CORE guidelines for data formats and system requirements.

C. CORE Phase I certification shall be accepted as evidence of compliance with subsections 5.A. and 5.B. Those carriers using CORE certification to comply with the provisions of this rule shall be required to become CORE Phase II certified within one (1) year of completing certification for CORE Phase I.

D. All carriers and providers shall uniformly use the Council for Affordable Quality Healthcare-developed CORE data content and infrastructure rules in the exchange of HIPAA compliant healthcare information and infrastructure improvements.

E. When installing new operating systems after December 31, 2012, all carriers are required to use CORE certified systems for communications, those systems which meet CORE certification standards, or contract with a vendor who has applied by January 1, 2013 to be CORE certified.

F. Notwithstanding the above requirements, those systems used solely for internal integrated systems between a carrier and a provider group may be granted an exemption from this requirement so long as CORE certification standards of systems that provide information exchange functionality for carrier interactions related to consumers, out of network providers, and non-dedicated providers is maintained. No exemption exists until the Commissioner has reviewed a written request for exemption and has made a written finding that the exemption is granted.

G. A carrier or provider located in a rural area of the state, as determined by the Commissioner, may apply to the Commissioner for, and the Commissioner may grant, an extension of any of the deadlines imposed by this section if meeting a particular deadline would impose a financial hardship on the rural carrier or provider. The Commissioner may require the rural carrier or provider to submit documentation supporting the financial hardship claim.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Incorporated Materials

The “CORE Phase I Eligibility and Benefits Operating Rules Manual” published by the Council for Affordable Quality Healthcare shall mean “CORE Phase I Eligibility and Benefits Operating Rules Manual” as published on the effective date of this regulation. It does not include later amendments to or editions of “CORE Phase I Eligibility and Benefits Operating Rules Manual”. A copy of the “CORE Phase I Eligibility and Benefits Operating Rules Manual” may be examined at any state publications depository library. For additional information regarding how the “CORE Phase I Eligibility and Benefits Operating Rules Manual” may be obtained or examined, contact the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202.

The "CORE Phase II Policies and Operating Rules" published by the Council for Affordable Quality Healthcare shall mean "CORE Phase II Policies and Operating Rules" as published on the effective date of this regulation. It does not include later amendments to or editions of "CORE Phase II Policies and Operating Rules". A copy of the "CORE Phase II Policies and Operating Rules" may be examined at any state publications depository library. For additional information regarding how the "CORE Phase II Policies and Operating Rules" may be obtained or examined, contact the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective on January 1, 2014.

Section 10 History

New regulation effective October 1, 2010.
Amended regulation effective July 1, 2012.
Amended regulation effective January 1, 2014.

Regulation 4-2-33 [Repealed eff. 01/01/2014]

Regulation 4-2-34 SECTION NAMES AND THE PLACEMENT OF THOSE SECTIONS IN POLICY FORMS BY CARRIERS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-16-137(1), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to set forth the standardized format for section names and placement of those section names in policy forms issued by all carriers.

Section 3 Applicability

The requirements and provisions of this regulation apply to health benefit plans, limited benefit health insurance, short-term limited duration insurance policies, dental and vision policies issued or delivered on or after June 1, 2018.

This regulation does not apply to Medicare supplement, disability income, or travel insurance policies.

Section 4 Definitions

A. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. “Limited benefit health coverage” means, for the purposes of this regulation, any type of health coverage that is not provided by a health benefit plan, as found at § 10-16-102(32)(a), C.R.S.

D. “Managed care plan” shall have the same meaning as found at § 10-16-102(43), C.R.S.

E. “Short-term limited duration insurance policies” or “short-term policy” shall have the same meaning as found at § 10-16-102(60), C.R.S.

Section 5 Rules

A. Carriers shall use the section names in subsection 5.B., in the listed order, for health benefit plans, limited benefit health insurance, short-term polices, and dental and vision policy forms.

B. Section Names

1. Schedule of Benefits (Who Pays What);

2. Title Page (Cover Page);

3. Contact Us;

4. Table of Contents;

5. Eligibility;

6. How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans);

7. Benefits/Coverage (What is Covered);

8. Regarding limitations and exclusions:

   a. For health benefit plans: Limitations/Exclusions (What is Not Covered); or

   b. For all other plan types, including short-term policies: Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions);

9. Member Payment Responsibility;

10. Claims Procedure (How to File a Claim);

11. General Policy Provisions;

12. Termination/Nonrenewal/Continuation;

13. Appeals and Complaints;

14. Information on Policy and Rate Changes; and

15. Definitions.

C. Carriers may continue to use existing forms and instead publish a table of contents or directory which cross-references the proposed standard section names with those used in carrier's current forms for those policies issued prior to June 1, 2018.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation is effective June 1, 2018.

Section 9 History

New Regulation effective October 1, 2011.
Amended Regulation effective January 1, 2014.
Amended Regulation effective June 1, 2017.
Amended Regulation effective June 1, 2018.

Regulation 4-2-35 REQUIRED INFORMATION FOR CARRIERS TO PROVIDE ON EXPLANATION OF BENEFITS FORMS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-16-137(2), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to set forth the minimum required information for carriers to provide on an explanation of benefits form sent to covered persons.

Section 3 Applicability

The requirements and provisions of this regulation apply to health benefit plans, limited benefit health coverage, short-term limited duration health insurance policies, and dental plans issued or delivered on or after the effective date of this regulation.

This regulation does not apply to Medicare Supplement or disability income insurance.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

C. “Health benefit plans” shall have the same meaning as found at § 10-16-102(32), C.R.S.

D. “Limited benefit health coverage” means, for the purposes of this regulation, any type of health coverage that is not provided by a health benefit plan, as defined in § 10-16-102(32)(a), C.R.S.

E. “Protected health information” means, for the purposes of this regulation, health information:

1. That identifies an individual who is the subject of the information; or

2. With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

Section 5 Explanation of Benefits Form Information

Carriers shall include the following information on an Explanation of Benefits (EOB) form sent to covered persons:

A. Name of member.

B. Relationship of member to subscriber.

C. Subscriber/member's claim number.

D. Name of subscriber.

E. Provider name and whether the provider is in or out of network.

F. Date of service.

G. Type of service (emergency, inpatient, outpatient, etc.).

H. Denial information (with enough specificity to enable the member/subscriber to determine the reason for the denial). Additionally, the following notice shall accompany the denial:

"Notice: The diagnosis and treatment codes (and their meaning) related to the service that is the subject of this Explanation of Benefits (EOB) are available upon request made to the carrier."

I. Carrier contact information.

J. Explanation of appeal rights (Can be an attachment to EOB).

K. Notice "THIS IS NOT A BILL".

L. Claim payment calculation.

1. Financial Information:

a. Total billed amount; and

b. Amount allowed under the policy (if amount was less than billed amount include explanation: i.e. discounted due to network agreement, carrier's determination of reasonable and customary, out of network provider).

2. Breakdown of policy's cost-sharing requirements:

a. Subscriber/member's deductible amounts;

b. Subscriber/member's coinsurance amount or out-of-pocket amounts; and

c. Subscriber/member's copayment amounts.

M. Subscriber/member's financial liability.

1. "What you owe" (deductible + coinsurance + copayment + denied amounts the member/subscriber is liable for); and

2. "What we will pay".

N. Status of policy deductible, out-of-pocket amount, and policy maximums.

1. All deductible amounts applied to date;

2. All coinsurance amounts or out-of-pocket amounts applied to date, if applicable; and

3. Policy maximum amount, if applicable (annual out-of-pocket maximum or in the case of limited benefit health coverage, any annual limits for a specific benefit).

Section 6 Protected Health Information

For the purpose of an explanation of benefits form, carriers shall take reasonable steps to ensure that the protected health information (PHI) of any covered person is protected. This protection includes ensuring that any communications between the carrier and covered person remain confidential and private, as required under the Health Insurance Portability and Accountability Act (HIPAA). This protection of PHI includes, but is not limited to, developing a means of communicating confidentially with the covered person, in such a manner that PHI would not be sent to the primary policyholder without prior consent of the covered person and when the covered person is legally able to provide consent to treatment pursuant to Colorado law. This confidential means of communication shall be made available to the covered person upon request.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation is effective October 1, 2018.

Section 10 History

New Regulation effective October 1, 2011.
Amended Regulation effective January 1, 2014.
Amended Regulation effective October 1, 2018.

Regulation 4-2-36 [Repealed eff. 12/01/2013]

Regulation 4-2-37 REQUIRED INFORMATION FOR CARRIERS TO OBTAIN ON ALL FULL-LENGTH APPLICATIONS FOR INDIVIDUAL HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105.2(1.5), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish a standard affidavit form to be used upon application for an individual health benefit plan when a small employer intends on reimbursing an employee for any portion of the premium.

Section 3 Applicability

The requirements of this regulation apply to all carriers issuing individual health benefit plans on or after the effective date of this regulation. It does not apply to applications for short-term limited duration health insurance policies.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Eligible employee” shall have the same definition as found at § 10-16-102(18), C.R.S.

C. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

D. “Short-term limited duration health insurance policies” shall have the same meaning as found at § 10-16-102(60), C.R.S.

E. “Qualified small employer health reimbursement arrangement” and “QSEHRA” shall have the same meaning as found at 26 U.S.C. § 9831(d)(2).

Section 5 Rules

A. All full-length applications for individual health benefit plans must contain the questions provided in Appendix A, as supplemental form with a separate applicant signature.

B. If an applicant for an individual health benefit plan is required to submit an affidavit executed by the employer, the affidavit in Appendix B must be used.

1. The affidavit form must have been executed by the employer no earlier than ninety (90) calendar days prior to, or no later than ninety (90) calendar days after, the submission of the individual application to the carrier.

2. If the affidavit is beyond the ninety (90) calendar day time period, the carrier shall require a new affidavit be submitted with the full-length application.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective on March 1, 2019.

Section 9 History

Emergency regulation E-11-04 effective May 19, 2011.
New regulation effective September 1, 2011.
Amended regulation effective November 1, 2013.
Amended regulation effective March 1, 2019.

Appendix A: Required Questions

1. Will an employer of one hundred (100) or fewer eligible employees be paying for or reimbursing an employee through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for?

   ____ Yes ____ No

   If you answered “yes”, please continue. If you answered “no”, you may stop.

2. If the employer will be reimbursing an employee through a health reimbursement arrangement, does it qualify as a “qualified small employer health reimbursement arrangement” or QSEHRA *?

   ____ Yes ____ No

3. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve (12) months prior to the date of this application?

   ____ Yes ____ No

   If the answer to both questions 1 and 3 is “yes” and the answer to question 2 is ‘“no”, the applicant may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

   The applicant must submit a signed affidavit from the employer, IF:

   The answer to questions 1 and 2 is “yes” and the answer to question 3 is “no”

   OR

   The answer to question 1 is “yes” and the answer to questions 2 and 3 is “no”.

   The affidavit form to be executed by the employer is attached. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

   * Employers are required by 26 U.S.C. 9831(d)(4) to provide employees written notice regarding QSEHRAs.

Appendix B: Form of Affidavit

Employer's Name: _____

Employer's Address: _____

_____

The undersigned officer or principal of the employer identified above certifies that:

1. The employer is a small employer as defined in § 10-16-102(61), C.R.S., with one hundred (100) or fewer eligible employees;

2. The employer has either not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit or that it is using a qualified small employer health reimbursement arrangement (QSEHRA) to reimburse its employees' individual health insurance premiums.

A false certification may cause the rescission of the employee's individual health insurance policy and subject the employer to penalties for perjury and liability to the employee.

Signed: _____

Printed Name: _____

Position: _____

Date: _____

Regulation 4-2-38 CONTRACEPTIVE BENEFITS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-16-104(3)(a)(I) C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to implement Colorado insurance law and ensure carriers are providing coverage for contraception in policies in the same manner as any other sickness, injury, disease or condition is otherwise covered under the policy or contract.

Section 3 Applicability

The requirements and provisions of this regulation apply to all group sickness and accident insurance policies and health service contracts issued to an employer and all individual sickness and accident, health care or indemnity contracts under parts 2, 3 or 4 of Title 10.

This regulation does not apply to supplemental policies covering a specified disease or other limited benefits under § 10-16-102(32)(b), C.R.S.

Section 4 Definitions

For purposes of this regulation, the following terms are defined:

A. “Contraceptive” or “contraception” means a medically acceptable drug, device, or procedure used to prevent pregnancy in accordance with § 2-4-401, C.R.S.

B. “Emergency contraception” means a drug approved by the federal food and drug administration that prevents pregnancy after sexual intercourse, including but not limited to oral contraceptive pills; except that “emergency contraception” shall not include RU-486, mifepristone, or any other drug or device that induces a medical abortion, in accordance with § 25-3-110, C.R.S.

C. “Prescription drug” shall have the same meaning as defined in § 27-80-203(21), C.R.S.

Section 5 Rules

All group sickness and accident insurance policies and health service contracts issued to an employer and all individual sickness and accident insurance, health care or indemnity contracts shall provide contraceptive benefits in the same manner as any other sickness, injury, disease or condition is otherwise covered under the policy or contract.

A. Policies or contracts with prescription drug benefits shall cover prescription contraceptive drugs in the same manner as other prescription drugs are covered under the policy or contract. However, over-the-counter contraceptive drugs or devices for which a prescription is not required and which are not otherwise covered under the policy or contract, are not required to be covered.

B. Voluntary sterilization procedures are covered as a health care service as defined in § 10-16-102(33), C.R.S., in the same manner as any other sickness, injury, disease or condition is otherwise covered under the policy or contract.

C. Hormone injections for contraception shall be covered in the same manner as hormone injections for any other sickness, injury, disease or condition.

D. Emergency contraception is covered in the same manner as any other drug or device for any other sickness, injury, disease or condition is otherwise covered under the policy or contract.

E. The drugs RU-486, mifepristone, or any other drug or device that induces a medical abortion are not contraceptives or emergency contraceptives within the definitions of such terms and are not required to be covered under a contraceptive benefit.

F. Intrauterine devices (IUDs), subdermal implants, and the insertion, management and removal of such devices are covered in the same manner as health care services as defined in § 10-16-102(33), C.R.S. and devices as defined in § 27-80-203(10), C.R.S. to treat any other sickness, injury, disease or condition are otherwise covered under the policy or contract.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist order, and/or suspensions or revocations of certificates of authority. Among others, the penalties provided in § 10-3-1108, C.R.S., may be applied.

Section 8 Effective Date

This regulation shall become effective on January 1, 2012.

Section 9 History

New regulation effective January 1, 2012.

Regulation 4-2-39 CONCERNING PREMIUM RATE SETTING FOR NON-GRANDFATHERED INDIVIDUAL, SMALL AND LARGE GROUP HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-3-1110(1), 10-16-107 and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide the necessary guidance to carriers to ensure that health insurance rates comply with Colorado's health benefit plan rating laws.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing non-grandfathered individual, small group, and/or large group health benefit plans; health benefit plans subject to the laws of Colorado; student health insurance coverage; and stand-alone dental plans that provide for pediatric dental as an essential health benefit. This regulation excludes individual short-term health insurance policies, as defined in § 10-16-102(60), C.R.S. This regulation applies to all plans or rates not previously reviewed and approved by the Division.

Section 4 Definitions

A. "ACA" means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L.111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L 111-152.

B. "Actuarial Value" or "AV" means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a health benefit plan will cover, with calculations based on the provision of essential health benefits to a standard population.

C. "Benefits ratio" means, for the purposes of this regulation, the ratio of the value of the actual policy benefits, not including policyholder dividends, to the value of the actual premiums, not reduced by policyholder dividends, over the entire period for which rates are computed to provide coverage.

D. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

E. "Catastrophic plan" shall have the same meaning as found at § 10-16-102(10), C.R.S.

F. "Coordination of benefits" and "COB" mean, for the purposes of this regulation, a provision establishing an order in which policies pay the claims and permitting secondary policies to reduce the benefits so that the combined benefits of all plans do not exceed the total allowable expenses.

G. "Covered lives" mean, for the purposes of this regulation, the number of members, subscribers and dependents.

H. "CMS" means, for the purposes of this regulation, the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

I. "Dividends" mean, for the purposes of this regulation, both policyholder and stockholder dividends.

J. "Effective date" means, for the purposes of this regulation, the specific date that the filed or approved rates can be charged to an individual or group.

K. "Essential health benefit" and "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.

L. "Essential health benefits package" and "EHB package" shall have the same meaning as found at § 10-16-102(23), C.R.S.

M. "Excessive rates" mean, for the purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided, or if the rates include a provision for expenses that is unreasonably high in relation to the services rendered. In determining if the rate is excessive, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of any additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

N. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

O. "Expanded bronze plan" means, for the purposes of this regulation, a bronze plan that provides coverage for at least one (1) major service, other than preventive services, prior to meeting the deductible, or meets the requirements to qualify as a high deductible health plan under 26 U.S.C 223(c)(2), as established at 45 CFR 156.140(c) with a bronze actuarial value of 60%.

P. "Federal Actuarial Value Calculator" or AVC means, for the purposes of this regulation, the AV calculator required pursuant to 45 C.F.R. 156.135(a).

Q. "File and use" means, for the purposes of this regulation, a filing procedure that requires rates and rating data to be filed with the Division concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates. Under no circumstance shall the carrier provide insurance coverage using the rates until on or after the proposed effective date specified in the rate filing. Carriers may bill members but not require the member to remit premium prior to the proposed effective date of the rate change.

R. "Filed rate" means, for the purposes of this regulation, the index rate as adjusted for plan design and the case characteristics of age, geographic location, tobacco use and family size only. The "filed rate" does not include the index rate as further adjusted for any other case characteristic.

S. "Filing date" means, for the purposes of this regulation, the day the rate filing is received at the Division.

T. "Geographic area" means, for the purposes of this regulation, the geographic area selected by Colorado and approved by the federal government, to be used by carriers in the state of Colorado.

U. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.

V. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

W. "HHS" means, for the purposes of this regulation, the United States Department of Health and Human Services.

X. "HIOS" means, for the purposes of this regulation, CMS' Health Insurance and Oversight System.

Y. "IBNR" means, for the purposes of this regulation, incurred but not reported.

Z. "Inadequate rates" mean, for the purposes of this regulation, rates that are insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace. In determining if the rate is inadequate, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

AA. "Index rate" shall have the same meaning as found at § 10-16-102(39), C.R.S.

AB. "Induced Demand Factor" means, for the purposes of this regulation the anticipated induced demand associated with the health benefit plan's cost sharing (metal) level.

AC. "MHPAEA" shall have the same meaning as found at § 10-16-102(43.5), C.R.S.

AD. "Medical Loss Ratio" or "MLR" shall mean the medical loss ratio as set forth in 42 U.S.C. § 300gg-18(b)(1)(A).

AE. "New policy form" and "new policy form and/or product" mean, for the purposes of this regulation, a policy form that has substantially different new benefits or unique characteristics associated with risk or costs that are different from existing policy forms or revised policy forms. Examples include but are not limited to the following: A guaranteed issue policy form is different than an underwritten policy form; a managed care policy form is different than a non-managed care policy form; a direct written policy form is different from a policy sold using producers, etc.

AF. "NGF" means, for the purposes of this regulation, a non-grandfathered health benefit plan.

AG. "Plan" means, for the purposes of this regulation, the pairing of the health insurance coverage benefits under the product with a particular cost sharing structure, provider network, and service area.

AH. "Premium" shall have the same meaning as found at § 10-16-102(51), C.R.S.

AI. "Premium rate" means, for the purposes of this regulation, all moneys paid by an individual, or an employer and eligible employees, as a condition of receiving coverage from a carrier, including any fees or other contributions associated with obtaining or administering the health benefit plan.

AJ. "Product(s)" means, for the purposes of this regulation, a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, etc.) within a service area.

AK. "PMPM" means, for the purposes of this regulation, per-member, per-month.

AL. "Qualified actuary" means, for the purposes of this regulation, a member of the American Academy of Actuaries, or a person who has demonstrated to the satisfaction of the Commissioner that the person has sufficient educational background and who has not less than seven (7) years of recent actuarial experience relevant to the area of qualification, as defined in Colorado Insurance Regulation 1-1-1.

AM. "Rate" means, for the purposes of this regulation, the amount of money a carrier charges as a condition of providing health coverage. The rate charged normally reflects such factors as the carrier's expectation of the insured's future claim costs; the insured's share of the carrier's claim settlement; operational and general expenses; and the cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the contract.

AN. "Rate filing" means, for the purposes of this regulation, a filing that contains all of the items required in this regulation, and:

1. For individual products, the proposed base rates and all rating factors. The underlying rating assumptions shall be submitted. Support for all changes in existing rates, factors and assumptions shall be provided, including the continued use of previously filed trend factors. Support for new product offerings shall be provided; and

2. For group products, proposed base rates, the underlying rating factors and assumptions. Support for all changes in existing rates, factors and assumptions shall be provided, including the continued use of previously filed trend factors. Support for new product offerings shall be provided. Groups shall meet the definition contained in §§ 10-16-214(1) and 10-16-215, C.R.S.

AO. "Rate increase" shall have the same meaning as found at § 10-16-102(57), C.R.S., and includes increases in any current rate or factor used to calculate rates for new or existing policyholders, members, or certificate holders.

AP. "Rating period" shall have the same meaning as found at § 10-16-102(58), C.R.S.

AQ. "Renewed" means, for the purposes of this regulation, a plan renewed upon the occurrence of the earliest of: the annual anniversary date of issue; the date on which premium rates can be or are changed according to the terms of the plan; or the date on which benefits can be or are changed according to the terms of the plan. If the plan specifically allows for a change in premiums or benefits due to changes in state or federal requirements, and a change in the health benefit and standalone pediatric dental plan premiums or benefits that is solely due to changes in state or federal requirements, and is not considered a renewal in the plan, then such a change will not be considered a renewal for the purposes of this regulation.

AR. "Retention" means, for the purposes of this regulation, the sum of all non-claim expenses including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses as the percentage of total premium.

AS. "Review and Approval" means, for the purposes of this regulation, a filing procedure that requires a rate change be affirmatively approved by the Commissioner prior to distribution, release to producers, collection of premium, advertising, or any other use of the rate.

AT. "SERFF" means, for the purposes of this regulation, System for Electronic Rates and Forms Filing.

AU. "Silver plan variation" means, for the purposes of this regulation, the three (3) silver plan variations that shall be submitted to the Division for review to ensure compliance with § 45 CFR 156.420(a).

AV. "Stand-alone dental plan" or "SADP" means, for the purposes of this regulation, a dental plan that covers the pediatric dental benefits required by § 10-16-102(22)(b)(VII) and Colorado Insurance Regulation 4-2-42 Section 5.A.2.

AW. "Student health insurance coverage" shall have the same meaning as found at § 10-16-102(65), C.R.S.

AX. "Substantially different new benefit" means, for the purposes of this regulation, a new benefit which results in a change in the actuarial value of the existing benefits by 10% or more. The offering of additional cost-sharing options (i.e., deductibles and copayments) to what is offered as an existing product does not create a new benefit. Actuarial value is the change in benefit cost as developed when making other benefit relativity adjustments.

AY. "Trend" or "trending" means, for the purposes of this regulation, any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing. Trend used solely for restating historical experience from the experience period to the rating period, or which is used to project morbidity, is considered a rating assumption.

AZ. "Trend factor(s)" means, for the purposes of this regulation, rates or rating factors which vary over time or due to the duration that the insured has been covered under the policy or certificate, and which reflect any of the components of medical or insurance trend assumptions used in pricing. Medical trend includes changes in unit costs of medical services or procedures, medical provider price changes, changes in utilization (other than due to advancing age), medical cost shifting, and new medical procedures and technology. Insurance trend includes the effect of underwriting wear-off, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Rate filings shall be submitted on an annual basis to support the continued use of trend factors. Underwriting wear-off does not apply to guaranteed issue products.

BA. "Unfairly discriminatory rates" mean, for the purposes of this regulation, charging different rates for the same benefits provided to individuals, or groups, with like expectations of loss; or, if after allowing for practical limitations, differences in rates which fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

BB. "Unique Plan Design" means, for the purposes of the regulation, a plan which has benefits that are incompatible with the parameters of the federal Actuarial Value Calculator (AVC) and their materiality.

BC. "Use of the rates" or "using the rates" means, for the purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder including advertising, distributing rates or premiums to producers and disclosing premium quotes. Rates shall be filed with the Division and forms, as required by § 10-16-107.2, C.R.S., shall be filed prior to use. It does not include releasing information about the proposed rate change to other government entities or disclosing general information about the rate change to the public.

Section 5 General Rate Filing Requirements

A. Rate Filing Types

1. Review and Approval: Any proposed increase for health benefit plans or an annual rate increase of 5% or more for dental insurance, which is any increase in any base rate, any rating factor, or the continuation of trend, is subject to review and approval by the Commissioner and shall be filed with the Division.

   To determine if the filing is subject to review and approval, calculations shall reflect both the twelve (12) month cumulative impact of trend and any changes to rating factors or base rates.

2. File and Use: Any new product, or existing product that does not contain a proposed increase, is not subject to review and approval by the Commissioner and shall be filed with the Division.

   To determine if the filing is subject to file and use, calculations shall reflect both the twelve (12) month cumulative impact of trend and any changes to rating factors or base rates. If there is an annual cumulative decrease in rates during the filed rating period, then the filing would be considered as file and use.

B. Timing and General Rate Filing Requirements

1. Carrier Requirements

   a. Carriers shall submit rate filings for review and approval to the Commissioner at least sixty (60) days prior to the proposed effective date of the rates.

   b. For new products and annual filings that are not experiencing a rate increase, carriers shall submit file and use rate filings at least one day prior to the effective date.

   c. Filings that are resubmissions of previously withdrawn, rejected or disapproved rate filings shall be considered new filings.

2. Rate Filing Deadlines

   a. Rate Review Deadlines

      (1) The filing shall be reviewed for completeness and, if found incomplete, the Commissioner may reject or disapprove the filing within the first thirty (30) calendar days of the review period. If the Commissioner has not rejected or disapproved the filing on or before the thirtieth (30) day, the filing shall be considered complete.

(2) If the Commissioner reviews the filing for substantive content, any deficiencies identified shall be corrected on a prospective basis. Any rate deficiency identified, including but not limited to the requirements of § 10-16-107(3), C.R.S., may be subject to a penalty if the violation is determined to be willful. Violations may include, but are not limited to, rates that are found to be excessive, inadequate or unfairly discriminatory.

(3) For rates subject to review and approval, if the Commissioner does not approve or disapprove a rate filing within sixty (60) days of the filing date, the carrier may implement and reasonably rely on the rates.

b. The Division will utilize the following, as provided in § 2-4-108, C.R.S.:

(1) To determine the start of the thirty (30) and sixty (60) calendar day period, the day after the filing date will be utilized. For example, if a filing is submitted in SERFF on June 1, the review period will begin on June 2, regardless of the day of the week.

(2) If the thirtieth (30) or sixtieth (60) calendar day falls on a Saturday, Sunday, or legal holiday, the review period will be extended to the next business day which is not a Saturday, Sunday, or legal holiday. For example, if the 60-day expires on July 4, the review period will be extended to July 5, as long as July 5 falls on a business day.

3. Rate Filing Guidelines and Review Guidelines

a. General Rate Filing Requirements

(1) Rates on all health insurance policies, riders, contracts, endorsements, certificates, and other evidence of health care coverage, shall be filed with the Division prior to the marketing, issuance or deliverance of coverage.

(2) All carriers shall submit a compliant rate filing whenever the rates to be charged to new policyholders or certificate holders differ from the rates on file with the Division. Included in this requirement are the following changes:

(a) Periodic recalculation of experience;

(b) Change in rate calculation methodology;

(c) Changes in the trend; and/or

(d) Other changes in rating assumptions.

(3) All carriers shall submit a compliant rate filing on at least an annual basis to support the continued use of trend factors which change on a pre-determined basis. Trend factors which change on a predetermined basis can be continued for no more than a period of twelve (12) months. To continue the use of trend factors that change on a predetermined basis, a filing shall be submitted for that particular form with an effective date within one (1) year of the implementation of the most recent approved rate filings.

(4) All carriers shall submit a compliant rate filing when the rates are changed on an existing product even if the rate change pertains to new business only.

(5) All carriers shall submit a compliant rate filing within sixty (60) calendar days after Commissioner approval of the assumption, acquisition or merger of a block of business.

(6) Each line of business requires a separate rate filing. Rate filings shall not be combined with form filings.

(7) All carriers are expected to review their experience on a regular basis, no less than annually, and file revisions, as appropriate and in a timely manner, to ensure that rates are not excessive, inadequate or unfairly discriminatory and to avoid filing large rate changes.

(8) Carriers shall not represent an existing product to be a new policy form, or product, unless it fits the definition set forth in Section 4.X. of this regulation.

(9) A separate filing shall be submitted for each carrier. A single filing made for more than one carrier, or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/Indemnity/Point of Service plan.

(10) Small group health benefit plan rate filings shall not be combined with either individual or large group health benefit rate filings.

b. General Elements of Rate Filings

(1) All rate filings shall be filed electronically in SERFF using a format made available by the Division, unless exempted by rule for an emergency situation as determined by the Commissioner.

(2) The rate filing shall demonstrate that the proposed rates are not excessive, inadequate, or unfairly discriminatory.

(3) The rate filing shall contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate.

(4) The rate filing shall contain Colorado experience.

(5) If Colorado experience is partially credible, similar coverage and/or nationwide experience shall also be submitted in the rate filing.

(6) For an acquisition or merger, the acquiring or assuming carrier shall provide support for the rating factors, even if there is no change in the rating factors. The new filing shall demonstrate that the rating assumptions are still appropriate.

(7) The Form Schedule tab in SERFF shall be completed for all rate filings. This tab shall list all policies, riders, endorsements, or certificates affected by the rate filing. Actual forms shall not be attached to the rate filing.

(8) The Effective Date Requested field on the General Information tab in SERFF shall be completed with a specific date. Using a notation such as "On Approval" is not a valid response.

(9) The Commissioner may require submission of any relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

c. Rate Filing Disapproval: The Commissioner shall disapprove the rate filing if any of the following apply:

(1) The benefits provided are not reasonable in relation to the premiums charged;

(2) The rate filing contains rates that are excessive, inadequate, unfairly discriminatory;

(3) The data and/or actuarial support do not justify the requested rate increase;

(4) The rate filing is incomplete;

(5) The data in the filing fails to adequately support the proposed rates;

(6) The rate filing fails to demonstrate compliance with MHPAEA; or

(7) Otherwise does not comply with the provisions of this regulation.

4. Rate Usage Guidelines

a. Review and Approval

(1) If the Commissioner approves the rate filing within sixty (60) calendar days, as specified in Section 5.B.2.a. of this regulation, the carrier may utilize the rates for business effective on the effective date or later. Under no circumstances shall the carrier provide insurance coverage using the rates until on or after the proposed effective date specified in the rate filing.

(2) Carriers are permitted to bill and require payment for new rates prior to the effective date requested; however, carriers shall not use the new rates, bill or require payment from consumers with an effective date prior to the effective date requested.

b. File and Use: Carriers shall not use the rates sooner than the day after the filing date. Correction of any deficiency shall be on a prospective basis.

c. Withdrawn, Rejected or Disapproved Filings: Rates for filings that are withdrawn, rejected or disapproved shall not be used or distributed. Use of rates in rate filings that are withdrawn, rejected or disapproved shall constitute a violation of Colorado law.

d. Rates Not on File

(1) Any rates or rating factors that are not on file with the Division shall not be used.

(2) Failure to file a compliant rate filing shall render the carrier as using unfiled rates and the Division will take appropriate action as allowed by Colorado law.

(3) Rates not on file with the Division, including the continued use of rates beyond one year, are deemed to be unfiled rates, which is a violation of Colorado law under § 10-16-107, C.R.S.

5. Confidentiality

a. All rate filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S.

b. The Division does not consider the following as confidential; including, but not limited to:

(1) Rates

(2) All base rating factors applied to develop an individual's, a family's, a university's or an employer's rates

(3) All required experience period data, including trend data

(4) Support for general expenses for detailed expense categories as needed to verify expense loads

(5) Required information in the actuarial memorandum

c. The entire filing, including the actuarial memorandum, cannot be held as confidential.

d. There shall be a separate SERFF component for the confidential exhibits, which shall be indicated as such by the confidential icon in SERFF.

e. A "Confidentiality Index" shall be completed if the carrier desires confidential treatment of any information submitted. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected.

6. Interest and Penalty Payments:

Any interest and penalty payments that a carrier makes pursuant to § 10-16-106.5(5), C.R.S., shall not be included in the carrier's experience used for rate setting.

Section 6 Individual and Small Group Rate Filing Requirements

A. Actuarial Memorandum Requirements

The rate filing shall contain a compliant actuarial memorandum, which is comprised of two (2) parts: a narrative, and a completed Regulation 4-2-39 Excel Template, supplied by the Division in SERFF. The Excel template is provided in SERFF, labeled “Regulation 4-2-39 Template.” Carriers are required to use the version in SERFF at the time of submission. Carriers shall supply all items that require a narrative as a separate document in PDF format. The narrative shall contain complete support for any calculated item or provide adequate details. The actuarial memorandum and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. Only the rate manual shall be attached to the Rate/Rule tab in SERFF.

1. Summary: The memorandum shall contain a summary that includes, but is not limited to, the following:

   a. Reason(s) for the rate filing: A statement as to whether this is a new product offering; a rate revision to an existing product, which includes rates applicable to new business only; or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated. This information shall be included in the narrative.

   b. Requested Rate Action: Identify the rate increase or decrease amount for all appropriate items. This shall include at a minimum of the following:

      (1) Base Rate Change

      (2) Trend Requested

      (3) Benefit Factor Change

      (4) Area Factor Change

      (5) MHPAEA Compliance

      (6) Law and Regulation Changes

      This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

   c. Overall Rate Action: Identify the overall, minimum, and maximum rate percentage changes. This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

   d. Marketing Method(s): Select all marketing methods used for the filed form. This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

   e. Market Type(s): This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

      (1) Select the appropriate market type(s). Identify if the product will be sold to associations, trusts, etc., this shall be noted in the narrative.

(2) Small Groups shall not use any health status-related factor in determining the premium or contribution for any enrolled individual and/or his or her dependent. However, the prohibition in this subsection shall not be construed to prevent the carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for adherence to programs of health promotion or disease prevention if otherwise allowed by state or federal law.

f. Premium Classification: Select all attributes upon which the premium rates vary. This section shall comply with all rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas. This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

g. Product Descriptions: Describe the benefits provided by the policy, or contract in the narrative. This section shall include Essential Health Benefits (EHBs) and list any substitution of benefits or any additional benefits provided above the required EHB. This information shall be included in the narrative.

h. Policy or Contract: All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

i. Age Basis: Select the appropriate age basis used for the forms. This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

j. Renewability Provision: All health benefit plans are guaranteed renewable. Carriers shall select "guaranteed renewable." This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

k. Rate Change Distribution: Complete the Rate Distribution table. This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

2. Rate History:

The memorandum shall include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) approvals immediately prior to the filing date, including the effective date of each rate change. Rate changes shall include the impact of trend.

a. This chart shall contain the following information: the filing number (SERFF tracking number), the effective date of each rate change, the average increase or decrease in rate, the minimum and maximum increase, and the cumulative rate change for the past twelve (12) months.

b. This chart shall contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.

c. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable. This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

3. Retention Schedule:

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. The memorandum shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.

a. Retention Percentage:

The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financial statements, with an explanation for any variations between retention loads used and actual experience for each component. Carriers shall provide justification if any component has changed since the carrier's previous rate filing. Specific retention components shall include at least the following:

(1) General expenses;

(2) Commissions and other acquisition expenses (may be separated);

(3) Taxes;

(4) ACA fees;

(5) Health Insurance Affordability Fee required pursuant to § 10-16-1205, C.R.S.; and Colorado Insurance Regulation 4-2-76.

i) Two and one-tenth percentage of premiums collected by for-profit carriers. For-profit carriers shall use exactly 2.10% (§ 10-16-1205(1)(a)(I)(B), C.R.S.)

ii) One and fifteen hundredths percentage of premiums collected by non-profit carriers. Non-profit carriers shall use exactly 1.15% (§ 10-16-1205(1)(a)(I)(A), C.R.S.)

(6) Other assessments;

(7) Profit and contingencies

(8) Exchange fees; and

(9) Quality Improvement

b. Retention loads shall be spread out across all rates in the NGF pool using the same rating factor. Retention rating factors shall not vary between on-Exchange and off-Exchange plans. Differences in expenses due to Exchange fees shall be spread out across all NGF pooled plans.

c. Carriers shall indicate pre-tax and post-tax levels and shall indicate how investment income has been accounted for in the setting of profit margins. Material investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

d. Administrative and Other Fees: Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Reasonable late payment penalties may be imposed by a small group carrier if the policy discloses the carrier's right to, the amount of, and circumstances under which late payment penalties will be imposed.

e. The carrier shall comply with the following minimum benefit ratio guidelines.

Individual Health Benefit Plans	80%
Small Group Health Benefit Plans	80%

This information shall be provided in both the narrative and the "Regulation 4-2-39 Template" spreadsheet.

4. Federal Medical Loss Ratio

This information shall be provided in both the narrative and in the "Regulation 4-2-39 Template" spreadsheet.

a. Medical carriers shall provide a calculation of the federal medical loss ratio (MLR) for the two (2) most recently completed calendar years and a projected MLR for the current calendar year showing all allowable adjustments in the numerator and denominator.

b. The carrier shall indicate all adjustments allowed in the minimum MLR calculation that will be used to reach the minimum required MLR.

c. Pursuant to 42 U.S.C. § (b)(1)(A)(ii), the federal minimum MLR requirement is 80% for Individual and Small Group markets.

d. Carriers shall apply all allowable adjustments in the MLR calculation. Note that meeting the federal MLR minimum level does NOT satisfy rating requirements in the State of Colorado. The Division reviews the federal MLR as part of effective rate review to assist CMS with monitoring and enforcement of rebate calculations.

e. For the purposes of determining whether a carrier is meeting the MLR requirements, a carrier shall provide a list of other plans under its legal entity that will be pooled with the plan in the rate filing for purposes of determining whether the federal minimum MLR will be met.

5. Trend:

The memorandum shall describe the trend factor assumptions used in pricing. These trend factor assumptions shall each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported. This information shall be provided in the narrative. In addition, the following information shall be included in the Regulation 4-2-39 Template:

a. The "Regulation 4-2-39 Template" contains a tab for a summary of trend assumptions. Medical trend assumptions shall be listed separately, and are defined as:

(1) Medical provider price increases;

(2) Utilization changes;

(3) Medical cost shifting;

(4) New medical procedures and technology; and

(5) Other insurance trend, which means, for the purposes of this section, the combined effect of any other items impacting medical trend that are not captured in items (1) – (4), including the effect of deductible leveraging, anti-selection resulting from rate increases and discontinuance of new sales, and the impact on trend due to anticipated demographic changes. The components of the medical trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other insurance trend. Other insurance trend shall be fully justified in the rate filing, and described in the narrative.

b. Pharmaceutical trend assumptions shall be listed separately, and are defined as:

(1) Pharmaceutical price increases;

(2) Pharmacy utilization changes;

(3) Effect of cost shifting;

(4) Introduction of new drugs; and

(5) Other pharmaceutical trend, which means, for the purposes of this section, the combined effect of any other items impacting pharmacy trend that are not captured in items (1) – (4), including the effect of pharmaceutical deductible leveraging. The components of the pharmacy trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other pharmaceutical trend. Other pharmaceutical trend shall be fully justified in the rate filing, and described in the narrative.

c. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be included in the "Regulation 4-2-39 Template".

(1) This experience may include data from the plan being rated or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

(2) Provided loss data shall be on an incurred basis, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date.

d. Pharmacy data shall be shown separately from the medical data.

e. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

f. The provided claims experience shall include the following separate data elements for each month:

(1) Actual medical (non-pharmacy) paid on incurred claims;

(2) Total medical incurred claims (including estimated IBNR claims);

(3) Actual pharmacy paid on incurred claims;

(4) Total pharmacy incurred claims (including estimated IBNR claims);

(5) Average covered lives for medical; and,

(6) Average covered lives for pharmacy.

g. Data elements shall be aggregated into 12-month annual periods, with yearly PMPM data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified in the "Regulation 4-2-39 Template" spreadsheet.

6. Credibility:

The memorandum shall discuss the credibility of the Colorado data; the Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards shall be met within a maximum of three (3) years if the proposed rates are based on claims experience. If the carrier's Colorado data is not fully credible, partial credibility shall be used, with the following guidelines:

a. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period.

b. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

c. The proposed rates shall be based upon as much Colorado data as possible. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard.

d. The partially-credible Colorado data and collateral data used to support partially-credible data shall be provided. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

e. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data shall include a discussion as to how the rating methodology was modified for the partially credible data.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet. If the full credibility standard is not met, explanations of the use of partially-credible or aggregated data and resulting changes to rating methodology shall be provided in the narrative.

7. Experience:

The memorandum shall include earned premium, loss experience, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. Experience shall be provided for the specific company filing prior to being combined with another company for credibility purposes.

a. Medical and pharmacy experience shall be provided separately for incurred claims and number of claims.

b. Premium and number of policyholders may be combined for medical and pharmacy experience.

c. National or other relevant experience shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

d. If the purpose of the filing is to introduce a new product in Colorado, the product shall be substantially different from an existing product. Nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

e. Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a “new product,” as defined in this regulation.

f. Rates shall be supported by the most recent experience available, with as much weight as possible placed upon the Colorado experience. Data used to support rates shall be included in the filing. For both renewal filings and new business filings, the experience period shall include consecutive data no older than six (6) months prior to the filing date.

g. The loss experience shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Capitation payments shall be considered as claim or loss payments. The carrier shall also provide information on how the number of claims was calculated.

This information shall be provided in the “Regulation 4-2-39 Template” spreadsheet.

8. Side-by-side Comparison:

Each memorandum shall include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison shall include five (5) columns: the first containing the category; the second containing the HIOS Plan ID number; the third containing the current rate, rating factor, or rating variable; the fourth containing all proposed rates, rating factors, or rating variables that are changing; and the fifth containing the percentage increase or decrease of each proposed change. If the proposed rating factor(s) are new, the memorandum shall specifically state this and provide detailed support for each of the rating factors.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

9. Benefits Ratio Projections:

The memorandum shall contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison shall be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations shall be included.

If the filing is for a new product, the expected projected premiums and projected incurred claims shall be provided.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

10. Out of Network Claims Payment

For the experience period, the carrier shall provide the following Out of Network claims data:

a. Total number of claims;

b. Aggregate amount of billed charges;

c. Aggregate amount of that would have been paid in the absence of §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

d. Aggregate amount that was paid due to §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

e. Premium impact of the difference between (c) and (d) for the projection period.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

11. Effect of Law Changes:

The actuarial memorandum shall identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s) in the previous 12 months. All applicable requirements shall be listed, including those with no rating impact. This quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

This information shall be included in the narrative.

The rating impact for each law or regulation charge shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

12. Assumption, Acquisition or Merger:

Identify whether the products included in the rate filing are part of an assumption, acquisition, or merger of policies from/with another carrier. If so, the memorandum shall include the full name of the carrier(s) from which the policies were assumed, acquired or merged, and the date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.B.3.b.6 for assumption, acquisition or merger rate filing requirements.

This information shall be included in the narrative.

13. Rating Period:

Identify the period for which the rates will be effective, including both the Effective and End Date. The date shall concur with the Effective Date Requested field in SERFF. The maximum rating period is one (1) year.

a. Individual Market: Individual health benefit plan rates shall be filed annually, by a date specified by the Commissioner, with an effective date of January 1. The rating period shall be twelve (12) months and premiums cannot change through the year.

b. Small Group Market: Small group health benefit plan rates shall be filed annually, by a date specified by the Commissioner, with an effective date of January 1. Rating periods shall not be more than twelve (12) months. A carrier shall treat all health benefit plans issued or renewed in the same calendar quarter as having the same rating period. Rates in the annual filing may be trended quarterly. Small group health benefit plan rates shall be filed no more frequently than quarterly.

This information shall be included in the narrative.

14. Coordination of Benefits and/or Subrogation:

The memorandum shall reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

This information shall be included in the narrative.

15. Complete Explanation as to how the Proposed Rates were Determined:

The memorandum shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if support for each rating assumption is found to be inadequate.

This explanation may be on an aggregate expected loss basis or a PMPM basis, but it shall completely explain how the proposed rates were determined. The memorandum shall adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums. This information shall be included in the narrative, with additional exhibits as necessary to fully demonstrate how the rates were developed.

a. Rate Development Requirements

(1) Carriers shall develop a single market-wide index rate for the individual and small group NGF plans it offers. The index rate for a market segment (individual or small group) shall be based on the total combined EHB claims experience of all enrollees in all NGF plans in the respective individual and small group single risk pool.

(2) After setting the Index Rate, the carrier shall make market-wide adjustments for each of the following:

(a) The expected aggregated payments and charges under the federal risk adjustment program;

(b) The expected reimbursements from the Colorado Reinsurance Program under § 10 16 1105, C.R.S.; and

(c) The Exchange user fees.

(3) The premium rate for any given plan shall not vary from the resulting adjusted market-wide Index Rate, except for the following factors:

(a) The actuarial value and cost-sharing structure of the plan;

(b) The plan's provider network;

(c) Delivery system characteristics;

(d) Utilization management practices;

(e) Plan benefits in addition to EHB; and

(f) With respect to catastrophic plans - the expected impact of specific eligibility categories for those plans.

(4) The Index Rate, the market-wide adjustment to the Index Rate, and the plan-specific adjustments shall be actuarially justified and implemented transparently, consistent with federal and state rate review processes.

b. Market Wide Index Rate

(1) Market-wide index rate (average rate) shall be:

(a) Based on EHB claims experience of all enrollees in all NGF health benefit plans in the risk pool, where carriers shall provide EHBs and essential health care benefit packages,

(b) Adjusted for risk adjustment/reinsurance payments and charges, and Exchange user fees; and

(c) Index rates may be developed separately for supplemental stand-alone benefits, and all such similar benefits are pooled for setting the respective index rate.

(2) Rates on an individual policy issued on or after January 1, 2015, are only guaranteed through December 31 of that year. All members will receive new rates on January 1 of the following year. For example, an individual enrolling on October 1, 2022 would have his or her rates in effect until December 31, 2022, and would then be subject to the new rates effective on January 1, 2023.

c. Market Wide Index Rate Development

(1) Average Projected Benefit Cost Per-Member-Per-Month

(a) The index rate shall initially be set by determining the average benefit cost of all NGF members in the pool in the state. Carriers are expected to consider all of the usual data adjustments and methods in developing the PMPM cost, from their experience, including the following:

(b) Credibility: Carriers shall determine the credibility levels of the experience being used and adjust appropriately. Carriers shall always discuss actuarial justification for credibility of the data being used.

(c) Typical methods to deal with experience deemed to be less than 100% credible would be:

(i) Supplement the Colorado experience with similar national business; or

(ii) Supplement small employer business with other Colorado experience with similar characteristics (membership, network, plan designs).

(2) Large Claims: Complete explanation of how large claims impact the line of business. Discuss the methods for adjusting data by pooling large claims above a threshold and apply pooling charges.

(3) Carriers shall support and provide estimates for the IBNR claims portion of total incurred claims.

(4) Risk Adjustment Payments: For NGF individual and small employer business, carriers shall consider estimates of risk adjustment payment transfers either to or from HHS. Carriers with risk profiles of members indicating higher than market risks shall consider adjusting the index rate to reflect receiving payments from the risk adjustment program.

(5) In developing the health cost trend, costs shall be projected to the applicable rating period, assuming an actuarially justifiable health cost trend. For individual business, index rates shall not be trended monthly or quarterly through any rating period, and index rates shall be the same for each month during a rating period. For small employer business, index rates may increase quarterly to reflect trend.

(6) Adjustments for Demographic Mix, Benefit Mix, and Area: Other projected population changes from the experience period to the rating period shall include considerations of newly uninsured policyholders entering the market and grandfathered members moving into NGF products.

(7) Adjustments for underwriting wear-off may be made due to members who were previously underwritten.

d. Benefit Factor Adjustments to the Index Rate

(1) The adjusted index rate as developed from the process in Section 6.N.1. may be modified for each plan design by reflecting benefit cost adjustments due to the different benefit plan designs.

(a) Differences in the rates for different benefit plans, for enrollees with the same case characteristics of age, geographic location, family size, and tobacco use shall be attributable to plan design only.

(b) Benefit factors shall not reflect the health status of members assumed to be enrolled in any particular plan, and shall not reflect claims experience of members in a particular plan.

(c) The benefit cost relativity between plans shall only reflect the true benefit differences due to different member cost sharing levels and plan design features. Using this method, a carrier's benefit factor for a plan design relative to the benefit factor for a richer (leaner) plan design shall be higher (lower).

(2) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans shall be reflected.

e. Acceptable Case Characteristic Factor Categories

(1) Carriers will be allowed to adjust premiums only for the following factors: self-only or family enrollment, geographic area, age, and tobacco. These factors apply to products offered both inside and outside the Exchange, and for both individual and small group products.

(2) Rates may vary based on whether a plan covers an individual or a family. 42 U.S.C. § 300gg provides that, with respect to family coverage, the rating variation permitted for age and tobacco use shall be applied based on the portion of the premium attributable to each family member covered under a plan.

(3) The per-member rating methodology under 45 CFR § 147.102(c)(1) shall apply. Per-member rating requires that the age and tobacco use factors be apportioned to each family member, and no more than three (3) covered children under the age of 21 whose per-member rates can be taken into account in determining the family premium.

(4) Health status and claims experience shall not be used as case characteristics

f. Individual Plan Design

The actuarial value of each plan shall be calculated at the individual level in accordance with 45 C.F.R. § 156.135. Carriers shall not calculate the AV at the family level.

g. Geographic Factors

A complete explanation as to how the geographic factors were developed shall be provided. Health claims may be used in the process of developing geographic factors. As stated in the ACA, rating factors shall not reflect differences in member health status. Geographic rating factors shall only reflect differences in the costs of delivery and shall not include differences for population morbidity by geographic area. Geographic factors shall be actuarially justified and verified to have been set based upon the above criteria.

If a carrier uses geographic location to calculate rates, then it shall use the nine (9) mandatory categories in the following table.

Rating Area	County
Rating Area 1	Boulder
Rating Area 2	El Paso, Teller
Rating Area 3	Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park
Rating Area 4	Larimer
Rating Area 5	Mesa
Rating Area 6	Weld
Rating Area 7	Pueblo
Rating Area 8 (East)	Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Phillips, Prowers, Rio Grande, Saguache, Sedgwick, Washington, Yuma
Rating Area 9 (West)	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit

For a small employer in Colorado, the applicable area factor for each employee is based on the principal business location of the small employer, rather than the residence of each employee.

For an individual policy, the applicable area factor applied to rates for each member is based on the location of the primary policyholder rather than the residence of each family member.

h. Age Factors

Carriers are required to follow the federal age bands. Age factors and age bands shall be determined based on an enrollee's age on the date of policy issuance or renewal and shall not exceed the 3:1 age ratio. For individuals who are added to the plan or coverage on a date other than the date of policy issuance or renewal, the enrollee's age is determined as of the date such individuals are added or enrolled in the coverage.

Children: A single age band covering children 0 through 14 years of age, where all premium rates are the same.

Children and Adults: One-year age bands starting at age 15 and ending at age 63.

Older adults: A single age band covering individuals 64 years of age and older, where all premium rates are the same.

The following are the federal age band requirements:

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-14	0.765	31	1.159	48	1.635
15	0.833	32	1.183	49	1.706
16	0.859	33	1.198	50	1.786
17	0.885	34	1.214	51	1.865
18	0.913	35	1.222	52	1.952
19	0.941	36	1.230	53	2.040
20	0.970	37	1.238	54	2.135
21	1.000	38	1.246	55	2.230
22	1.000	39	1.262	56	2.333
23	1.000	40	1.278	57	2.437
24	1.000	41	1.302	58	2.548
25	1.004	42	1.325	59	2.603
26	1.024	43	1.357	60	2.714
27	1.048	44	1.397	61	2.810
28	1.087	45	1.444	62	2.873
29	1.119	46	1.500	63	2.952
30	1.135	47	1.563	64 and Older	3.000

i. Tobacco Use Rate

(1) Carriers may vary tobacco rating by age (for example, a younger enrollee may be charged a lower tobacco use rate than an older enrollee) provided the tobacco use rate does not exceed the non-tobacco use rate by more than 1.15:1.

(2) Carriers in the individual and small group market may remove the tobacco rating factor (as described in 42 U.S.C. § 300gg) for individuals participating in a wellness program.

(3) "Tobacco use" is defined at 45 CFR § 147.102(a)(1)(iv) as the use of a tobacco product or products four (4) or more times per week within, but no longer than, the past six (6) months by legal users of tobacco products (generally those 21 years and older). It includes all tobacco products and clarifies that the term tobacco use does not include religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives). Tobacco use shall be defined by carriers in terms of the time since the individual's last use of a tobacco product.

j. Family Size Categories

(1) All adults can be rated based on their age.

(2) Up to 3 children (oldest), under the age of 21 can be rated. This includes child only coverage.

k. Morbidity

Other projected population changes from the experience period to the rating period shall include considerations of newly insureds entering the market and grandfathered members moving into NGF products. For any morbidity factor used, a complete explanation of development shall be provided.

l. Exchange User Fees

The development of the plan cost and index rate shall include market-wide adjustments for Exchange user fees.

Carriers shall make a market-wide adjustment to the index rate for Exchange user fees. This will ensure that Exchange user fees are spread evenly across the market, inside and outside the Exchange, and protecting against adverse selection.

m. Calculating Actuarial Value

The ACA requires carriers offering NGF health plans inside and outside of the Exchange in the individual and small group markets to assure that any offered plan meets a distinct level of coverage, or actuarial value (AV), specified in section 1302 of the ACA: bronze, expanded bronze, silver, gold, or platinum (also known as "metal tiers"). Carriers may also offer catastrophic-only coverage to certain eligible individuals.

AV standards will help consumers compare health benefit plans by providing information about relative plan generosity. The AV standard of a health benefit plan is determined using the following calculation:

$$\frac{\text{(Total Overall Health Costs – Total Enrollee Cost Sharing)}}{\text{Total Overall Health Costs}}$$

AV shall be calculated based on the provision of EHB to a standard population and is presented as a percentage. Additionally, AV determines a health benefit plan's metal level tier. The ACA directs that NGF individual and small group plans inside and outside the Exchanges meet specific AV targets (or be a catastrophic plan):

Bronze = 60% AV

Silver = 70% AV

Gold = 80% AV

Platinum = 90% AV

These targets allow for a de minimis range of -4% / +2% points

On-Exchange individual silver plans are allowed a de minimis range of -2% / +2%

An acceptable de minimis range of -4% / +5% points is allowed for an expanded bronze plan.

An acceptable de minimis range of -1%/+1% points is allowed for a silver plan variation.

n. Calculating the Actuarial Value

(1) To satisfy actuarial value (AV) requirements, carriers are required to use the federal AVC in accordance with 45 C.F.R. § 156.135. In order to assist with this calculation, the SERFF Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. In addition, upon submission of a QHP application, HHS recalculates this value to validate that a carrier's plan designs meet AV requirements.

(2) The AVC will be integrated with SERFF so that the Division can evaluate plans for compliance with AV standards on an automated basis. Carriers will first complete the Plans and Benefits Template and submit the information through SERFF; the Plans and Benefits Template will directly populate the AVC to determine a plan's AV and corresponding metal tier. A plan's results from the AVC will be displayed automatically in SERFF.

(3) Carriers will determine AV in accordance with 45 C.F.R. § 156.135. The AVC will guarantee plans with the same cost sharing structure will have the same actuarial value (regardless of plan discounts or utilization estimates).

(4) If a carrier determines that a material aspect of its plan design cannot be accommodated by the AVC, 45 C.F.R. § 156.135allows for alternative calculation methods supported by certification of an actuary.

o. Calculating the Actuarial Value of Unique Plan Designs.

(1) Although the AVC has been designed to accommodate the vast majority of plan designs, there is the possibility that the AVC will not be able to accommodate a small percentage of plan designs. Under 45 CFR § 156.135(b), carriers with plan designs that are not compatible with the AVC shall use an alternate method to calculate AV, as described below. For example, the following types of plan designs would not be compatible with the AVC.

Example 1: A plan with coinsurance rates that increase with out-of-pocket spending, such as a plan design with 10 percent (10%) coinsurance for the first $1,000 in consumer spending after the deductible, 20 percent (20%) coinsurance for the next $1,000 in consumer spending, and 40 percent (40%) coinsurance up to a $6,350 out-of-pocket maximum. This plan design would not be compatible because the current AVC can accommodate only a single coinsurance rate for each benefit.

Example 2: A plan with a multi-tiered provider or hospital network with substantial amounts of utilization expected in tiers other than the two (2) lowest-priced tiers. This plan design would not be compatible because the current AVC does not take into account utilization beyond the second network tier when computing AV.

Generally, a plan design that includes different cost sharing for services not included in the AVC would be considered compatible with the AVC. For example, advanced imaging is a single cost-sharing entry in the AVC; a plan design would not be considered incompatible because it assigns different copayment amounts to different types of imaging (e.g., MRI versus CT). Similarly, because the AVC does not consider quantitative or qualitative limits for any benefit, the application of limits to a particular benefit would generally not necessitate one of the alternative methods for AV calculation.

(2) To account for plan designs that are incompatible and ensure that requiring the use of the AVC allows for plan innovation, 45 CFR § 156.135(b) provides two (2) alternative methods of calculating AV for plans that cannot meaningfully fit within the parameters of the AVC.

Carriers issuing such plans shall:

(a) Make adjustments to certain key plan design features to enter a modified plan design that fits into the parameters of the AVC, and have an actuary certify that the plan design appropriately fits into the parameters of the AVC; or

(b) Use the AVC to determine the AV for plan provisions that do fit within its parameters, and then have an actuary calculate appropriate adjustments to the AVC-generated AV to account for remaining plan features. For example, a carrier with reference pricing for prescription drugs could use the AVC to determine the AV for the medical benefits in its plan and then make adjustments to reflect its prescription drug benefits.

Both of the AV calculation methods for evaluating incompatible plans designs shall be certified by a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies. If a carrier uses either of the two (2) alternate methods for calculating AV just described, the carrier shall submit an actuarial certification.

p. Induced Demand Factor

Induced Demand Factors may be reflected in the development of the AV and Cost Sharing Benefit Design in the URRT. The Induced Demand Factors shall be determined by inputting the actuarial value (AV) determined by the federal AVC into the formula below:

$$\text{Induced Demand Factor} = 1.24 - AV + AV^2$$

q. Small Group Composite Rating

(1) Small group carriers may offer small group rates calculated using a four-tier family rate and, in addition or in the alternative, may offer small groups individual rates calculated for each employee pursuant to Section 6 N. of this regulation. If a small group carrier offers composite rating, the carrier shall offer the small group the choice of both individually-rated employees and composite rates, at initial application and each renewal.

(2) If a small group carrier offers both rating methodologies for a plan, the small group carrier shall ensure that:

(a) Both methods are offered to every small group, with differences between methodologies clearly explained in writing: or

(b) Every small group shall be given a written option to indicate in check-off form, or other similar form, in the application or renewal application, that:

(i) Both rating methods need to be presented;

(ii) Only rates for individual employees need to be presented; or

(iii) Only the composite rate needs to be presented.

(3) Small group carriers may offer small groups four-tier composite rates as an alternative to rates calculated individually for each employee. If the small group carrier offers composite rating, the carrier shall make the same offer for all plans.

(4) Calculating Composite Rates

(a) The total premium charged to the small group shall be calculated using the per-member methodology in Section 6 of this regulation. Age, geographic area and tobacco use (if applicable) are determined at the time coverage is issued to the group. The small group's total premium is equal to the sum of the premiums for each covered employee and his/her covered spouse and/or dependents.

(b) Once the small group's total premium has been calculated, it shall be allocated to covered employees based on the tier factor applicable to each employee's family composition. All carriers will use the following standard tier definitions and factors:

(i) Employee Only = 1.00

(ii) Employee and Spouse = 2.00

(iii) Employee and Child(ren) = 1.85

(iv) Employee, Spouse, and Child(ren) = 2.85

(c) Any allowable tobacco use factor shall be allocated separately to the corresponding individual employee or dependent, so the average Employee Only premium does not include any tobacco factor.

(5) A small group's total composite premium shall equal the sum of the per-member premiums for all covered employees and dependents. In addition, once the composite premiums are computed at the beginning of the plan year, they shall not vary during the plan year, regardless of any census changes within the group.

(6) If the small group carrier offers composite rating, the Colorado alternative tiered-composite premium methodology will be required to be offered to all small groups without regard to size.

(7) Small group carriers may decide which plans will offer composite premiums and which plans will not.

(8) Small group carriers offering plans on the Exchange's Small Employer Health Options Program (SHOP) are not required to include the option of composite rating for those small group plans offered on the SHOP, unless and until the Exchange implements the ability for small group carriers to utilize composite rating

16. Actuarial Certification:

An actuarial certification shall be submitted with all filings. An actuarial certification is a signed and dated statement within the sixty (60) days prior to the submission of the filing made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

B. Rating Manual Requirements:

A rating manual shall be submitted to the Division for all products. All changes to the rating manual shall be filed with the Division in an appropriate rate filing. Rate pages and rate manual shall be attached to the Rate/Rule Schedule tab in SERFF.

Premium rounding and truncation rules shall be provided in the rate manual for all rate filings.

Rating factors shall be calculated and displayed to four (4) decimal points.

This information shall be provided as a spreadsheet, separate from the Division "Regulation 4-2-39 Template".

C. Other Rate Filing Requirements:

1. Format: All required reports and documentation shall be submitted through SERFF in a searchable PDF format.

2. Submission Requirements for Rate Filings: Carriers shall complete and submit the following information in SERFF in order for a rate filing submission to be considered complete:

a. Carriers shall complete all SERFF required data fields.

b. Carriers shall list all forms associated with the rate filing under the Form Schedule Tab.

(1) Carriers shall complete all data fields (Form Name, Form Number, Form Type, Action, Readability Score) under this tab.

(2) Carriers shall attach copies of the actual form documents as part of a rate filing.

c. Carriers shall attach a copy of the Rate Tables/Manual under the Rate/Rule Schedule Tab.

d. Carriers shall attach copies of the following documents under the Supporting Documentation Tab in the Filing (Non-Binder) section in SERFF:

(1) If a carrier uses a third party to submit a rate and/or form filings on their behalf, a Letter of Authority, which shall be attached under the Supporting Documentation Tab in SERFF.

(2) A copy of the Colorado Actuarial Memorandum, which includes all elements contained in Section 6 of this regulation.

(3) The following documents required by CMS, in accordance with 45 C.F.R. § 154.215:

(a) Part I – Unified Rate Review Template;

(b) Part II – Consumer Justification Narrative shall be completed for all rate increases, but is optional for new plans;

(c) Part III – Actuarial Memorandum.

(4) Any applicable justification or attestations forms specified by the Division.

e. Carriers shall attach copies of the following documents required by CMS under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF

(1) Part I - the Unified Rate Review Template; and

(2) Part II - Consumer Justification Narrative, which shall be completed for all rate increases, but optional for new plans.

3. The Supplemental Template shall be completed for all Individual and Small Group rate filings. The Supplemental template will be available in SERFF and will be labeled "Supplemental Template." Carriers are required to use the version in SERFF at the time of submission.

4. Colorado Option Plans

Carriers shall use the Division's Colorado Option Standardized Plans Actuarial Value Certification document, which includes AV screenshots from the current federal AVC and a discussion of the methodology used to determine the final AVs. Carriers submit the AV Certification document in the rate filing to demonstrate this reliance.

Section 7 Large Group Rate Filing Requirements

A. Actuarial Memorandum Requirements

The rate filing shall contain a compliant actuarial memorandum, which is comprised of two (2) parts: a narrative and a completed Regulation 4-2-39 Excel Template, supplied by the Division in SERFF. The Excel template is provided in SERFF, labeled "Regulation 4-2-39 Template." Carriers are required to use the version in SERFF at the time of submission. Carriers shall supply all items that require a narrative as a separate document in PDF format. The narrative shall contain complete support for any calculated item or provide adequate details. The actuarial memorandum and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. Only the rate manual shall be attached to the Rate/Rule tab in SERFF.

1. Summary: The memorandum shall contain a summary that includes, but is not limited to, the following:

a. Reason(s) for the rate filing:

A statement as to whether this is a new product offering; a rate revision to an existing product, which includes rates applicable to new business only; or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated.

This information shall be included in the narrative.

b. Requested Rate Action:

Identify the rate increase or decrease amount for all appropriate items.

This shall include at a minimum of the following:

(1) Base Rate Change

(2) Trend Requested – Trend factors that directly affect the rates (i.e. rating factors that are applied throughout the rating period) are part of the requested increase.

(3) Trend factors of this type shall be reflected anywhere that a requested change is reported.

(4) Benefit Factor Change

(5) Area Factor Change

(6) MHPAEA Compliance

(7) Law and Regulation Changes

This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

c. Overall Rate Action:

Identify the overall, minimum, and maximum rate percentage changes.

This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

d. Marketing Method(s):

Select all marketing methods used for the filed form.

This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

e. Market Type(s):

Select the appropriate market type(s). Identify if the product will be sold to associations, trusts, etc., this shall be noted in the narrative.

Large groups shall not use any health status-related factor in determining the premium or contribution for any enrolled individual and/or his or her dependent. However, the prohibition in this subsection shall not be construed to prevent the carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for adherence to programs of health promotion or disease prevention if otherwise allowed by state or federal law.

This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

f. Premium Classification:

Select all attributes upon which the premium rates vary. This section shall comply with all rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

g. Product Descriptions:

Describe the benefits provided by the policy, or contract in the narrative. This description shall include major categories of the policy to include but not limited to office visits, inpatient hospital stays, radiology, and pathology.

This information shall be included in the narrative.

h. Policy or Contract:

All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

i. Age Basis:

Select the appropriate age basis used for the forms.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

j. Renewability Provision:

All health benefit plans are guaranteed renewable. Carriers shall select “guaranteed renewable”.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

k. Rate Change Distribution:

Complete the Rate Change Distribution table.

This information shall be provided in the “Regulation 4-2-39 Template” spreadsheet.

2. Rate History:

The memorandum shall include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) approvals immediately prior to the filing date, including the effective date of each rate change. Rate changes shall include the impact of trend.

a. This chart shall contain the following information: the filing number (SERFF tracking number), the effective date of each rate change, the average increase or decrease in rate, the minimum and maximum increase, and the cumulative rate change for the past twelve (12) months.

b. This chart shall contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.

c. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

3. Retention Schedule:

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. The memorandum shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.

a. Retention Percentage: The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financial statements, with an explanation for any variations between retention loads used and actual experience for each component. Carries shall provide justification if any component has changed since the carrier's previous rate filing. Specific retention components shall include at least the following:

(1) General expenses;

(2) Commissions and other acquisition expenses (may be separated);

(3) Taxes;

(4) ACA fees;

(5) Health Insurance Affordability Fee pursuant to § 10-16-1205, C.R.S.; and Colorado Insurance Regulation 4-2-76.

i) Two and one-tenth percentage of premiums collected by for-profit carriers. For-profit carriers shall use exactly 2.10% (§ 10-16-1205(1)(a)(I)(B), C.R.S.)

ii) One and fifteen hundredths percentage of premiums collected by non-profit carriers. Non-profit carriers shall exactly use 1.15% (§ 10-16-1205(1)(a)(I)(A), C.R.S.)

(6) Other assessments; and

(7) Profit and contingencies

b. Carriers shall indicate pre-tax and post-tax levels and shall indicate how investment income has been accounted for in the setting of profit margins. Material investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

c. The carrier shall comply with the following minimum benefit ratio guidelines.

Large Group Health Benefit Plans	85%
Expatriate Health Plans	75%

This information shall be provided in both the narrative and in the "Regulation 4-2-39 Template" spreadsheet.

4. Federal Medical Loss Ratio

a. For the purposes of determining whether a carrier is meeting the federal MLR requirements, a carrier shall provide a list of other plans under its legal entity that will be pooled with the plan in the rate filing for purposes of determining whether the federal minimum MLR will be met.

b. Medical carriers shall provide a calculation of the MLR for the two (2) most recently completed calendar years and a projected MLR for the current calendar year, showing all allowable adjustments in the numerator and denominator.

c. The carrier shall indicate all adjustments allowed in the MLR calculation that will be used to reach the minimum required MLR.

d. Pursuant to 42 U.S.C. §300gg-18(b)(1)(A)(i), the federal minimum MLR requirement is 85% for Large Group markets.

e. Carriers shall apply all allowable adjustments in the MLR calculation. Note that meeting the federal MLR minimum level does NOT satisfy rating requirements in the State of Colorado. The Division reviews the federal MLR as part of effective rate review to assist CMS with monitoring and enforcement of rebate calculations.

This information shall be provided in both the narrative and in the "Regulation 4-2-39 Template" spreadsheet.

5. Trend:

The memorandum shall describe the trend factor assumptions used in pricing. These trend factor assumptions shall each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported. Trend factors shall not automatically renew. Continued use of trend factors shall be filed and adequately supported annually. This information shall be provided in the narrative. In addition, the following information shall be included in the Division-provided Regulation 4-2-39 Template:

a. The "Regulation 4-2-39 Template" contains a tab for a summary of trend assumptions. Medical trend assumptions shall be listed separately, and are defined as:

(1) Medical provider price increases;

(2) Utilization changes;

(3) Medical cost shifting;

(4) New medical procedures and technology; and

(5) Other insurance trend, which means, for the purposes of this section, the combined effect of any other items impacting medical trend that are not captured in items (1) – (4), including the effect of deductible leveraging, anti-selection resulting from rate increases and discontinuance of new sales, and the impact on trend due to anticipated demographic changes. The components of the medical trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other insurance trend. Other insurance trend shall be fully justified in the rate filing, and described in the narrative.

b. Pharmaceutical trend assumptions shall be listed separately, and are defined as:

(1) Pharmaceutical price increases;

(2) Pharmacy utilization changes;

(3) Effect of cost shifting;

(4) Introduction of new drugs; and

(5) Other pharmaceutical trend, which means, for the purposes of this section, the combined effect of any other items impacting pharmacy trend that are not captured in items (1) – (4), including the effect of pharmaceutical deductible leveraging. The components of the pharmacy trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other pharmaceutical trend. Other pharmaceutical trend shall be fully justified in the rate filing, and described in the narrative.

c. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be included in the “Regulation 4-2-39 Template”.

(1) This experience may include data from the plan being rated or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

(2) Provided loss data shall be on an incurred basis, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date.

d. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

e. The provided claims experience shall include the following separate data elements for each month:

(1) Actual medical (non-pharmacy) paid on incurred claims;

(2) Total medical incurred claims (including estimated IBNR claims);

(3) Actual pharmacy paid on incurred claims;

(4) Total pharmacy incurred claims (including estimated IBNR claims);

(5) Average covered lives for medical; and,

(6) Average covered lives for pharmacy.

f. Data elements shall be aggregated into 12-month annual periods, with yearly PMPM data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified.

6. Credibility:

The memorandum shall discuss the credibility of the Colorado data; the Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards shall be met within a maximum of three (3) years if the proposed rates are based on claims experience. If the carrier's Colorado data is not fully credible, partial credibility shall be used, with the following guidelines:

a. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period.

b. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

c. The proposed rates shall be based upon as much Colorado data as possible. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard.

d. The partially-credible Colorado data and collateral data used to support partially-credible data shall be provided. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

e. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data shall include a discussion as to how the rating methodology was modified for the partially credible data.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet. If the full credibility standard is not met, explanations of the use of partially-credible or aggregated data and resulting changes to rating methodology shall be provided in the narrative.

7. Experience:

The memorandum shall include earned premium, loss experience, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. Experience shall be provided for the specific company filing prior to being combined with another company for credibility purposes.

a. Medical and pharmacy experience shall be provided separately for incurred claims and number of claims.

b. Premium and number of policyholders may be combined for medical and pharmacy experience.

c. National or other relevant experience shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

d. If the purpose of the filing is to introduce a new product in Colorado, the product shall be substantially different from an existing product. Nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

e. Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a "new product," as defined in this regulation.

f. Rates shall be supported by the most recent experience available, with as much weight as possible placed upon the Colorado experience. Data used to support rates shall be included in the filing. For both renewal filings and new business filings, the experience period shall include consecutive data no older than six (6) months prior to the filing date.

g. The loss experience shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Capitation payments shall be considered as claim or loss payments. The carrier shall also provide information on how the number of claims was calculated.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

8. Side-by-side Comparison:

Each memorandum shall include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison shall include five (5) columns: the first containing the category; the second containing the plan name, number or description; the third containing the current rate, rating factor, or rating variable; the fourth containing all proposed rates, rating factors, or rating variables that are changing; and the fifth containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum shall specifically state this and provide detailed support for each of the rating factors.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

9. Benefits Ratio Projections:

The memorandum shall contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison shall be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations shall be included.

If the filing is for a new product, the expected projected premiums and projected incurred claims shall be provided.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

10. Out of Network Claims Payment

For the experience period, the carrier shall provide the following Out of Network claims data:

a. Total number of claims;

b. Aggregate amount of billed charges;

c. Aggregate amount of that would have been paid in the absence of §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

d. Aggregate amount that was paid due to §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

e. Premium impact of the difference between (c) and (d) for the projection period.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

11. Effect of Law Changes:

The memorandum shall identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable mandates shall be listed, including those with no rating impact. This quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

This information shall be included in the narrative.

The rating impact for each law change shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

12. Assumption, Acquisition or Merger:

Identify whether the products included in the rate filing are part of an assumption, acquisition, or merger of policies from/with another carrier. If so, the memorandum shall include the full name of the carrier(s) from which the policies were assumed, acquired or merged, and the date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.B.3.b.6 for assumption, acquisition or merger rate filing requirements.

This information shall be included in the narrative.

13. Rating Period:

Identify the period for which the rates will be effective, including both the Effective and End Date. The date shall concur with the Effective Date Requested field in SERFF. The maximum rating period for products using trend is one (1) year.

This information shall be included in the narrative.

14. Coordination of Benefits and/or Subrogation:

The memorandum shall reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

This information shall be included in the narrative.

15. Complete Explanation as to how the Proposed Rates were Determined:

The memorandum shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if support for each rating assumption is found to be inadequate.

This explanation may be on an aggregate expected loss basis or a PMPM basis, but it shall completely explain how the proposed rates were determined. The memorandum shall adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

a. Base Rate Development

A complete explanation as to how the base rate was developed shall be provided. Carriers may utilize actual claims experience in developing the base rate. The base rate shall be actuarially justified and implemented transparently, consistent with state rate review processes.

The memorandum's narrative shall clearly reference all other rating factors and definitions used, including but not limited to the area factors, age factors, gender factors, etc. Carriers shall provide support for the use of each of these factors in the rate filing. The same level of supports for changes to any of these factors shall be included in all renewal rate filings. In addition, each carrier shall review each of these rating factors every five (5) years, at minimum, and provide detailed support for the continued use of each of these factors in a rate filing.

This information shall be included in the narrative.

b. Geographic Factors

A complete explanation as to how the geographic factors were developed shall be provided. Health claims may be used in the process of developing geographic factors. Carriers shall identify counties and zip codes, if zip codes are utilized, of each service area if a state-wide network is not used.

The following guidelines shall be followed whenever zip codes are used in determining a carrier's rating factors:

(1) All zip codes in the 800-802 three-digit zip code groups are considered part of the Denver metropolitan areas and shall receive the same rating factor, with the following possible exceptions:

(a) The following zip codes in Elbert County: 80101, 80106, 80107, 80117;

(b) The following zip codes in Arapahoe County: 80102, 80103, 80105, 80136

(c) The following zip codes in El Paso County: 80132, 80133;

(d) The following zip codes in Boulder County: 80025, 80026, 80027, 80028

(2) In addition, the following zip codes outside the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor as the 800-802 three-digit zip code groups:

(a) The following zip codes in Jefferson County; 80401 – 80403, 80419, 80433, 80437, 80439, 80453, 80454, 80457, 80465; and

(b) The following zip codes in Adams County: 80614, 80640

(3) All zip codes in the 809 three-digit zip code group are considered part of the Colorado Springs metropolitan area and shall receive the same rating factor. In addition, the following zip codes in El Paso County, which lie outside the 809 three-digit zip code group shall be considered part of the Colorado Springs metropolitan area and shall receive the same rating factor as the 809 three-digit zip code group: 80809, 80817, 80819, 80829, 80831, 80840, and 80841.

If a carrier uses area rating factors which are based in whole or in part upon the zip code, and does not follow these guidelines, the carrier may be found to have rates that are unfairly discriminatory.

The use of any rating factors based upon zip codes which fail to equitably adjust for different expectations of loss is prohibited. Areas of the state with like expectations of loss shall be treated in a similar manner. Also, policyholders utilizing the same provider groups shall be rated in a like manner. The use of zip codes in determining rating factors can result in inequities.

Carriers shall review the appropriateness of area factors at least every five (5) years and provide detailed support for the continued use of the factors in rating filings and upon request.

Geographic factors shall be actuarially justified and verified to have been set based upon the above criteria.

c. Age

Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve are prohibited. However, this requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating.

d. Benefit Factors

The base rate may be modified for each plan design by reflecting benefit cost adjustments due to the different benefit plan designs. Benefit factors shall not reflect the health status of members assumed to be enrolled in any particular plan, and shall not reflect claims experience of members in a particular plan. The benefit cost relativity between plans shall only reflect the true benefit differences due to different member cost sharing levels and plan design features.

A complete explanation as to how the benefit factors were developed shall be provided.

e. Morbidity

Other projected population changes from the experience period to the rating period shall include consideration of newly insured policyholders entering the market and grandfathered members moving into NGF products. For any morbidity factor used, a complete explanation of development shall be provided.

f. Large Claims

Complete explanation of how large claims impact the line of business. Discuss the methods for adjusting data by pooling large claims above a threshold and apply pooling charges.

g. Network Factor Adjustments

The rate may be modified to reflect cost differences between different provider networks. Network factors shall not be developed to reflect health status or claims experience of members included in the different networks. Factors shall be set assuming each network has the same average member risk profile and levels of member health. Therefore, claims experience shall not be directly used as the basis for setting a network factor. Network factors shall reflect the following estimated cost differences between networks:

(1) Differences in reimbursement levels and discounts between providers;

(2) Differences in the utilization management of members, including tighter control of referrals, stricter managed care, disease management and wellness programs, etc.; and

(3) Other delivery system characteristics of a network.

h. Determining Minimum Value

(1) A group health plan provides minimum value (MV) if the total allowed costs of benefits paid by the plan is no less than 60%.

(2) An individual eligible for coverage in an employer-sponsored plan that provides MV is not eligible for premium tax credits.

(3) A group health plan may determine if it provides MV using the following methods:

(a) The Minimum Value Calculator pursuant to 45 C.F.R. § 156.145(a)(1); or

(b) A safe harbor established by HHS and the Internal Revenue Service pursuant to 45 C.F.R. § 156.145(1)(2); or

(c) Certification by an actuary if neither is suitable.

This information shall be included in the narrative.

16. Actuarial Certification

An actuarial certification shall be submitted with all filings. An actuarial certification is a signed and dated statement within the sixty (60) days prior to the submission of the filing made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory

B. Transition Credits

1. Carriers are required to comply with §10-3-1104(1)(g) C.R.S. regarding transition payments. In particular:

a. The carrier shall include any transition payment in the contract signed by an employer group.

(1) Carriers should provide the amount of transition credits awarded during the experience period of the rate filing in both dollar amounts and as a percent of premium,

(2) Carriers should estimate the amount of transition credits anticipated during the rating period of the rate filing,

(3) Carriers may be asked to provide additional justification for transition credits in a rate filing, and

(4) Carriers should show where the transition credits are allocated within the classification of expenses (i.e. general expenses, commissions).

C. Rating Manual Requirement:

A rating manual shall be submitted to the Division for each new product. All changes to the rating manual shall be filed with the Division in an appropriate rate filing. Rate pages and rate manual shall be attached to the Rate/Rule Schedule tab in SERFF.

Premium rounding and truncation rules shall be provided in the rate manual for all rate filings.

Rating factors shall be calculated and displayed to four (4) decimal points.

This information shall be provided as a spreadsheet, separate from the Division "Regulation 4-2-39 Template".

D. Record Retention:

Large group health benefit plan contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing shall contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing shall contain an example of how rates are calculated. While the final rate charged to the large group may differ from the initial quote, all rating variables shall be on file with the Division.

Although it is not necessary to submit a separate rate filing for each large group policy issued, each carrier shall retain detailed records for each large group policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each group insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate shall be identified in the detail material and lie within the range identified in the rate filing on file with the Division. The carrier shall make all such information available for review by the Commissioner upon request.

The rates for subgroups shall be determined in an actuarially sound manner using credible data. The methodology for determining these rates shall be on file with the Division and any changes in the methodology shall be filed with the Division.

E. Prohibited Rating Practice

The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income.

Section 8 Student Health Insurance Rate Filing Requirements

A. Actuarial Memorandum Requirements

The rate filing shall contain a compliant actuarial memorandum, which is comprised of two (2) parts: a narrative and a completed Regulation 4-2-39 Excel Template, supplied by the Division in SERFF. The Excel template is provided in SERFF, labeled “Regulation 4-2-39 Template.” Carriers are required to use the version in SERFF at the time of submission. Carriers shall supply all items that require a narrative as a separate document in PDF format. The narrative shall contain complete support for any calculated item or provide adequate details. The actuarial memorandum and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. Only the rate manual shall be attached to the Rate/Rule tab in SERFF.

1. Summary: The memorandum shall contain a summary that includes, but is not limited to, the following:

    a. Reason(s) for the rate filing:

A statement as to whether this is a new product offering; a rate revision to an existing product, which includes rates applicable to new business only; or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated.

This information shall be included in the narrative.

b. Requested Rate Action:

Identify the rate increase or decrease amount for all appropriate items.

This shall include at a minimum of the following:

(1) Base Rate Change

(2) Trend Requested

(3) Benefit Factor Change

(4) Area Factor Change

(5) MHPAEA Compliance

(6) Law and Regulation Changes

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

c. Overall Rate Action:

Identify the overall, minimum, and maximum rate percentage changes.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

d. Marketing Method(s):

Select all marketing methods used for the filed form.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

e. Market Type(s):

Select the appropriate market type(s).

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

f. Premium Classification:

Select all attributes upon which the premium rates vary. This section shall comply with all rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas.

This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

g. Product Descriptions:

Describe the benefits provided by the policy, or contract in the narrative. This description shall include major categories of the policy to include but not limited to office visits, inpatient hospital stays, radiology, and pathology.

This information shall be included in the narrative.

h. Policy or Contract:

All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

i. Age Basis:

Select the appropriate age basis used for the forms.

This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

j. Renewability Provision:

All health benefit plans are guaranteed renewable. Carriers shall select "guaranteed renewable."

This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

k. Rate Change Distribution:

Complete the Rate Change Distribution table.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

2. Rate History:

The memorandum shall include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) approvals immediately prior to the filing date, including the effective date of each rate change. Rate changes shall include the impact of trend.

a. This chart shall contain the following information: the filing number (SERFF tracking number), the effective date of each rate change, the average increase or decrease in rate, the minimum and maximum increase, and the cumulative rate change for the past twelve (12) months.

b. This chart shall contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.

c. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

3. Retention Schedule:

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. The memorandum shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.

a. Retention Percentage:

The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financial statements, with an explanation for any variations between retention loads used and actual experience for each component. Carriers shall provide justification if any component has changed since the carrier's previous rate filing. Specific retention components shall include at least the following:

(1) General expenses;

(2) Commissions and other acquisition expenses (may be separated);

(3) Taxes;

(4) ACA fees;

(5) Health Insurance Affordability Fee pursuant to§ 10-16-1205, C.R.S., and Colorado Insurance Regulation 4-2-76.

i) Two and one-tenth percentage of premiums collected by for-profit carriers. For-profit carriers shall use exactly 2.10% (§ 10-16-1205(1)(a)(I)(B), C.R.S.)

ii) One and fifteen hundredths percentage of premiums collected by non-profit carriers. Non-profit carriers shall exactly use 1.15% (§ 10-16-1205(1)(a)(I)(A), C.R.S.)

(6) Other assessments; and

(7) Profit and contingencies.

b. Carriers shall indicate pre-tax and post-tax levels and shall indicate how investment income has been accounted for in the setting of profit margins. Material investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

c. The carrier shall comply with the following minimum benefit ratio guidelines.

Student Health Insurance Coverage	80%

This information shall be provided in both the narrative and in the "Regulation 4-2-39 Template" spreadsheet.

4. Federal Medical Loss Ratio

   a. For the purposes of determining whether a carrier is meeting the federal MLR requirements, a carrier shall provide a list of other plans under its legal entity that will be pooled with the plan in the rate filing for purposes of determining whether the federal minimum MLR will be met.

   b. Medical carriers shall provide a calculation of the MLR for the two (2) most recently completed calendar years and a projected MLR for the current calendar year, showing all allowable adjustments in the numerator and denominator.

   c. The carrier shall indicate all adjustments allowed in the MLR calculation that will be used to reach the minimum required MLR.

   d. Pursuant to 42 U.S.C. § (b)(1)(A)(ii), the federal minimum MLR requirement is 80% for Student Health.

   e. Carriers shall apply all allowable adjustments in the MLR calculation. Note that meeting the federal MLR minimum level does NOT satisfy rating requirements in the State of Colorado. The Division reviews the federal MLR as part of effective rate review to assist CMS with monitoring and enforcement of rebate calculations.

   This information shall be provided in both the narrative and in the "Regulation 4-2-39 Template" spreadsheet.

5. Trend:

   The memorandum shall describe the trend factor assumptions used in pricing. These trend factor assumptions shall each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported. This information shall be provided in the narrative. In addition, the following information shall be included in the Division "Regulation 4-2-39 Template":

   a. The "Regulation 4-2-39 Template" contains a tab for a summary of trend assumptions. Medical trend assumptions shall be listed separately, and are defined as:

      (1) Medical provider price increases;

      (2) Utilization changes;

      (3) Medical cost shifting;

      (4) New medical procedures and technology; and

(5) Other insurance trend, which means, for the purposes of this section, the combined effect of any other items impacting medical trend that are not captured in items (1) – (4), including the effect of deductible leveraging, anti-selection resulting from rate increases and discontinuance of new sales, and the impact on trend due to anticipated demographic changes. The components of the medical trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other insurance trend. Other insurance trend shall be fully justified in the rate filing, and described in the narrative.

b. Pharmaceutical trend assumptions shall be listed separately, and are defined as:

(1) Pharmaceutical price increases;

(2) Pharmacy utilization changes;

(3) Effect of cost shifting;

(4) Introduction of new drugs; and

(5) Other pharmaceutical trend, which means, for the purposes of this section, the combined effect of any other items impacting pharmacy trend that are not captured in items (1) – (4), including the effect of pharmaceutical deductible leveraging. The components of the pharmacy trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other pharmaceutical trend. Other pharmaceutical trend shall be fully justified in the rate filing, and described in the narrative.

c. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be included in the “Regulation 4-2-39 Template”.

(1) This experience may include data from the plan being rated or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

(2) Provided loss data shall be on an incurred basis, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date.

d. Pharmacy data shall be shown separately from the medical data.

e. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

f. The provided claims experience shall include the following separate data elements for each month:

(1) Actual medical (non-pharmacy) paid on incurred claims;

(2) Total medical incurred claims (including estimated IBNR claims);

(3) Actual pharmacy paid on incurred claims;

(4) Total pharmacy incurred claims (including estimated IBNR claims);

(5) Average covered lives for medical; and,

(6) Average covered lives for pharmacy.

g. Data elements shall be aggregated into 12-month annual periods, with yearly PMPM data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified.

6. Credibility:

The memorandum shall discuss the credibility of the Colorado data; the Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards shall be met within a maximum of three (3) years if the proposed rates are based on claims experience. If the carrier's Colorado data is not fully credible, partial credibility shall be used, with the following guidelines:

a. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period.

b. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

c. The proposed rates shall be based upon as much Colorado data as possible. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard.

d. The partially-credible Colorado data and collateral data used to support partially-credible data shall be provided. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

e. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data shall include a discussion as to how the rating methodology was modified for the partially credible data.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet. If the full credibility standard is not met, explanations of the use of partially-credible or aggregated data and resulting changes to rating methodology shall be provided in the narrative.

7. Experience:

The memorandum shall include earned premium, loss experience, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. Experience shall be provided for the specific company filing prior to being combined with another company for credibility purposes.

a. Medical and pharmacy experience shall be provided separately for incurred claims and number of claims.

b. Premium and number of policyholders may be combined for medical and pharmacy experience.

c. National or other relevant experience shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

d. If the purpose of the filing is to introduce a new product in Colorado, the product shall be substantially different from an existing product. Nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

e. Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a "new product," as defined in this regulation.

f. Rates shall be supported by the most recent experience available, with as much weight as possible placed upon the Colorado experience. Data used to support rates shall be included in the filing. For both renewal filings and new business filings, the experience period shall include consecutive data no older than six (6) months prior to the filing date.

g. The loss experience shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Capitation payments shall be considered as claim or loss payments. The carrier shall also provide information on how the number of claims was calculated.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

8. Side-by-side Comparison:

Each memorandum shall include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison shall include five (5) columns: the first containing the category; the second containing the plan name, number or description; the third containing the current rate, rating factor, or rating variable; the fourth containing all proposed rates, rating factors, or rating variables that are changing; and the fifth containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum shall specifically state this and provide detailed support for each of the rating factors.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

9. Benefits Ratio Projections:

The memorandum shall contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison shall be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations shall be included.

If the filing is for a new product, the expected projected premiums and projected incurred claims shall be provided.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

10. Out of Network Claims Payment

For the experience period, the carrier shall provide the following Out of Network claims data:

a. Total number of claims;

b. Aggregate amount of billed charges;

c. Aggregate amount of that would have been paid in the absence of §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

d. Aggregate amount that was paid due to §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

e. Premium impact of the difference between (c) and (d) for the projection period

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

11. Effect of Law Changes:

The memorandum shall identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable mandates shall be listed, including those with no rating impact. This quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

This information shall be included in the narrative.

The rating impact for each law change shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

12. Assumption, Acquisition or Merger:

Identify whether the products included in the rate filing are part of an assumption, acquisition, or merger of policies from/with another carrier. If so, the memorandum shall include the full name of the carrier(s) from which the policies were assumed, acquired or merged, and the date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.B.3.b.6 for assumption, acquisition or merger rate filing requirements.

This information shall be included in the narrative.

13. Rating Period:

Identify the period for which the rates will be effective, including both the Effective and End Date. The date shall concur with the Effective Date Requested field in SERFF. The maximum rating period for products using trend is one (1) year.

This information shall be included in the narrative.

14. Coordination of Benefits and/or Subrogation:

The memorandum shall reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

This information shall be included in the narrative.

15. Complete Explanation as to how the Proposed Rates were Determined:

The memorandum shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if support for each rating assumption is found to be inadequate.

This explanation may be on an aggregate expected loss basis or a PMPM basis, but it shall completely explain how the proposed rates were determined. The memorandum shall adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

a. Base Rate Development

A complete explanation as to how the base rate was developed shall be provided. Carriers may utilize actual claims experience in developing the base rate. The base rate shall be actuarially justified and implemented transparently, consistent with state rate review processes.

The memorandum's narrative shall clearly reference all other rating factors and definitions used, including but not limited to the area factors, age factors, gender factors, etc. Carriers shall provide support for the use of each of these factors in the rate filing. The same level of supports for changes to any of these factors shall be included in all renewal rate filings. In addition, each carrier shall review each of these rating factors every five (5) years, at minimum, and provide detailed support for the continued use of each of these factors in a rate filing.

This information shall be included in the narrative.

b. Geographic Factors

A complete explanation as to how the geographic factors were developed shall be provided. Health claims may be used in the process of developing geographic factors. Carriers shall identify counties and zip codes, if zip codes are utilized, of each service area if a state-wide network is not used.

The following guidelines shall be followed whenever zip codes are used in determining a carrier's rating factors:

(1) All zip codes in the 800-802 three-digit zip code groups are considered part of the Denver metropolitan areas and shall receive the same rating factor, with the following possible exceptions:

(a) The following zip codes in Elbert County: 80101, 80106, 80107, 80117;

(b) The following zip codes in Arapahoe County: 80102, 80103, 80105, 80136;

(c) The following zip codes in El Paso County: 80132, 80133;

(d) The following zip codes in Boulder County: 80025, 80026, 80027, 80028.

(2) In addition, the following zip codes outside the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor as the 800-802 three-digit zip code groups

(a) The following zip codes in Jefferson County; 80401 – 80403, 80419, 80433, 80437, 80439, 80453, 80454, 80457, 80465; and

(b) The following zip codes in Adams County: 80614, 80640

(3) All zip codes in the 809 three-digit zip code group are considered part of the Colorado Springs metropolitan area and shall receive the same rating factor. In addition, the following zip codes in El Paso County, which lie outside the 809 three-digit zip code group shall be considered part of the Colorado Springs metropolitan area and shall receive the same rating factor as the 809 three-digit zip code group: 80809, 80817, 80819, 80829, 80831, 80840, and 80841.

If a carrier uses area rating factors which are based in whole or in part upon the zip code, and does not follow these guidelines, the carrier may be found to have rates that are unfairly discriminatory.

The use of any rating factors based upon zip codes which fail to equitably adjust for different expectations of loss is prohibited. Areas of the state with like expectations of loss shall be treated in a similar manner. Also, policyholders utilizing the same provider groups shall be rated in a like manner. The use of zip codes in determining rating factors can result in inequities.

Carriers shall review the appropriateness of area factors at least every five (5) years and provide detailed support for the continued use of the factors in rating filings and upon request.

Geographic factors shall be actuarially justified and verified to have been set based upon the above criteria.

c. Age

Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve are prohibited. However, this requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating.

d. Benefit Factors

The base rate may be modified for each plan design by reflecting benefit cost adjustments due to the different benefit plan designs. Benefit factors shall not reflect the health status of members assumed to be enrolled in any particular plan, and shall not reflect claims experience of members in a particular plan. The benefit cost relativity between plans shall only reflect the true benefit differences due to different member cost sharing levels and plan design features.

A complete explanation as to how the benefit factors were developed shall be provided.

e. Morbidity

Other projected population changes from the experience period to the rating period shall include consideration of newly insured policyholders entering the market and grandfathered members moving into NGF products. For any morbidity factor used, a complete explanation of development shall be provided.

f. Large Claims

Complete explanation of how large claims impact the line of business. Discuss the methods for adjusting data by pooling large claims above a threshold and apply pooling charges.

g. Network Factor Adjustments

The rate may be modified to reflect cost differences between different provider networks. Network factors shall not be developed to reflect health status or claims experience of members included in the different networks. Factors shall be set assuming each network has the same average member risk profile and levels of member health. Therefore, claims experience shall not be directly used as the basis for setting a network factor. Network factors shall reflect the following estimated cost differences between networks:

(1) Differences in reimbursement levels and discounts between providers;

(2) Differences in the utilization management of members, including tighter control of referrals, stricter managed care, disease management and wellness programs, etc.; and

(3) Other delivery system characteristics of a network.

h. Determining Minimum Value

(1) A group health plan provides minimum value (MV) if the total allowed costs of benefits paid by the plan is no less than 60%.

(2) An individual eligible for coverage in an employer-sponsored plan that provides MV is not eligible for premium tax credits.

(3) A group health plan may determine if it provides MV using the following methods:

(a) The Minimum Value Calculator pursuant to 45 C.F.R. § 156.145(a)(1); or

(b) A safe harbor established by HHS and the Internal Revenue Service pursuant to 45 C.F.R. § 156.145(a)(2); or

(c) Certification by an actuary if neither is suitable.

This information shall be included in the narrative.

16. Actuarial Certification

An actuarial certification shall be submitted with all filings. An actuarial certification is a signed and dated statement within the sixty (60) days prior to the submission of the filing made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory

B. Transition Credits

1. Carriers are required to comply with §10-3-1104(1)(g) C.R.S. regarding transition payments. In particular:

a. The carrier shall include any transition payment in the contract signed by a college, university, or other institution of higher education.

(1) Carriers should provide the amount of transition credits awarded during the experience period of the rate filing in both dollar amounts and as a percent of premium,

(2) Carriers should estimate the amount of transition credits anticipated during the rating period of the rate filing,

(3) Carriers may be asked to provide additional justification for transition credits in a rate filing, and

(4) Carriers should show where the transition credits are allocated within the classification of expenses (i.e. general expenses, commissions).

C. Rating Manual Requirement:

A rating manual shall be submitted to the Division for each new product. All changes to the rating manual shall be filed with the Division in an appropriate rate filing. Rate pages and rate manual shall be attached to the Rate/Rule Schedule tab in SERFF.

Premium rounding and truncation rules shall be provided in the rate manual for all rate filings.

Rating factors shall be calculated and displayed to four (4) decimal points.

This information shall be provided as a spreadsheet, separate from the Division "Regulation 4-2-39 Template".

D. Record Retention:

Student health insurance contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each student health insurance rate filing shall contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing shall contain an example of how the rates are calculated. While the final rate charged to the college, university, or other institution of higher education may differ from the initial quote, all rating variables shall be on file with the Division.

Carriers shall submit final rates for each college, university, or other institution of higher education that have been negotiated at least 60 days prior to implementation of those rates. Carriers shall retain detailed records for each college, university, or other institution of higher education policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each college, university, or other institution of higher education policy insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate shall be identified in the detail material and lie within the range identified in the rate filing on file with the Division. The carrier shall make all such information available for review by the Commissioner upon request.

The rates for subgroups shall be determined in an actuarially sound manner using credible data. The methodology for determining these rates shall be on file with the Division and any changes in the methodology shall be filed with the Division.

E. Prohibited Rating Practice

The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income.

Section 9 Stand-Alone Dental Rate Filing Requirements

A. Actuarial Memorandum Requirements

The rate filing shall contain a compliant actuarial memorandum, which is comprised of two (2) parts: a narrative and a completed Regulation 4-2-39 Excel Template, supplied by the Division in SERFF. The Excel template is provided in SERFF, labeled “Regulation 4-2-39 Template.” Carriers are required to use the version in SERFF at the time of submission. Carriers shall supply all items that require a narrative as a separate document in PDF format. The narrative shall contain complete support for any calculated item or provide adequate details. The actuarial memorandum and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. Only the rate manual shall be attached to the Rate/Rule tab in SERFF.

1. Summary: The memorandum shall contain a summary that includes, but is not limited to, the following:

    a. Reason(s) for the rate filing:

A statement as to whether this is a new product offering; a rate revision to an existing product, which includes rates applicable to new business only; or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated.

This information shall be included in the narrative.

b. Requested Rate Action:

Identify the rate increase or decrease amount for all appropriate items.

This shall include at a minimum of the following:

(1) Base Rate Change

(2) Trend Requested

(3) Benefit Factor Change

(4) Area Factor Change

(5) Law and Regulation Changes

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

c. Overall Rate Action:

Identify the overall, minimum, and maximum rate percentage changes.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

d. Marketing Method(s):

Select all marketing methods used for the filed form.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

e. Market Type(s):

Select the appropriate market type(s). Identify if the product will be sold to associations, trusts, etc., this shall be noted in the narrative.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

f. Premium Classification:

Select all attributes upon which the premium rates vary. This section shall comply with all rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

g. Product Descriptions:

Describe the EHB benefit provided by the policy or contract in the narrative. For non-grandfathered individual and small group stand-alone dental plans, this section shall also list any additional benefits provided.

This information shall be included in the narrative.

h. Policy or Contract:

All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

i. Age Basis:

Select the appropriate age basis used for the forms.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

j. Renewability Provision:

Select all renewability provisions used for the forms.

This information shall be included in the “Regulation 4-2-39 Template” spreadsheet.

k. Rate Change Distribution:

Complete the Rate Change Distribution table.

This information shall be provided in the “Regulation 4-2-39 Template” spreadsheet.

2. Rate History:

The memorandum shall include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) approvals immediately prior to the filing date, including the effective date of each rate change. Rate changes shall include the impact of trend.

a. This chart shall contain the following information: the filing number (SERFF tracking number), the effective date of each rate change, the average increase or decrease in rate, the minimum and maximum increase, and the cumulative rate change for the past twelve (12) months.

b. This chart shall contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.

c. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

3. Retention Schedule:

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. The memorandum shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.

a. Retention Percentage: The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financial statements, with an explanation for any variations between retention loads used and actual experience for each component. Carriers shall provide justification if any component has changed since the carrier's previous rate filing. Specific retention components shall include at least the following:

(1) General expenses;

(2) Commissions and other acquisition expenses (may be separated);

(3) Taxes;

(4) ACA fees;

(5) Other assessments;

(6) Exchange fees; and

(7) Profit and contingencies

b. Retention loads shall be spread out across all rates in the NGF pool using the same rating factor. Retention rating factors shall not vary between on-Exchange and off-Exchange plans. Differences in expenses due to Exchange fees shall be spread out across all NGF pooled plans.

c. Carriers shall indicate pre-tax and post-tax levels and shall indicate how investment income has been accounted for in the setting of profit margins. Material investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

d. Administrative and Other Fees:

Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Reasonable late payment penalties may be imposed by a small group carrier if the policy discloses the carrier's right to, the amount of, and circumstances under which late payment penalties will be imposed.

e. The carrier shall comply with the following minimum benefit ratio guidelines.

Stand-Alone Dental (SADP)	65%

This information shall be provided in both the narrative and in the "Regulation 4-2-39 Template" spreadsheet.

4. Trend:

The memorandum shall describe the trend factor assumptions used in pricing. These trend factor assumptions shall each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported. This information shall be provided in the narrative. In addition, the following information shall be included in the Regulation 4-2-39 Template:

a. The "Regulation 4-2-39 Template" contains a tab for a summary of dental trend assumptions. Dental trend assumptions shall be listed separately, and are defined as:

(1) Dental provider price increases;

(2) Utilization changes;

(3) Dental cost shifting;

(4) New dental procedures and technology; and

(5) Other insurance trend, which means, for the purposes of this section, the combined effect of any other items impacting dental trend that are not captured in items (1) – (4), including the effect of deductible leveraging, anti-selection resulting from rate increases and discontinuance of new sales, and the impact on trend due to anticipated demographic changes. The components of the dental trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other insurance trend. Other insurance trend shall be fully justified in the rate filing, and described in the narrative.

b. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be included in the "Regulation 4-2-39 Template" if available.

(1) This experience may include data from the plan being rated or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

(2) Provided loss data shall be on an incurred basis, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date.

c. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

d. The provided claims experience shall include the following separate data elements for each month:

(1) Actual dental paid on incurred claims;

(2) Total dental incurred claims (including estimated IBNR claims); and,

(3) Average covered lives for dental.

e. Data elements shall be aggregated into 12-month annual periods, with yearly PMPM data, and year-over-year PMPM trends. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified.

5. Credibility:

The memorandum shall discuss the credibility of the Colorado data; the Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards shall be met within a maximum of three (3) years if the proposed rates are based on claims experience. If the carrier's Colorado data is not fully credible, partial credibility shall be used, with the following guidelines:

a. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period.

b. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

c. The proposed rates shall be based upon as much Colorado data as possible. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard.

d. The partially-credible Colorado data and collateral data used to support partially-credible data shall be provided. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

e. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data shall include a discussion as to how the rating methodology was modified for the partially credible data.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet. If the full credibility standard is not met, explanations of the use of partially-credible or aggregated data and resulting changes to rating methodology shall be provided in the narrative.

6. Experience:

The memorandum shall include earned premium, loss experience, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. Experience shall be provided for the specific company filing prior to being combined with another company for credibility purposes.

a. National or other relevant experience shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

b. If the purpose of the filing is to introduce a new product in Colorado, the product shall be substantially different from an existing product. Nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

c. Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a "new product," as defined in this regulation.

d. Rates shall be supported by the most recent experience available, with as much weight as possible placed upon the Colorado experience. Data used to support rates shall be included in the filing. For both renewal filings and new business filings, the experience period shall include consecutive data no older than six (6) months prior to the filing date.

e. The loss experience shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Capitation payments shall be considered as claim or loss payments. The carrier shall also provide information on how the number of claims was calculated.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

7. Side-by-side Comparison:

Each memorandum shall include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison shall include five (5) columns: the first containing the category; the second containing the plan name, number, or description; the third containing the current rate, rating factor, or rating variable; the fourth containing all proposed rates, rating factors, or rating variables that are changing; and the fifth containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum shall specifically state this and provide detailed support for each of the rating factors.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

8. Benefits Ratio Projections:

The memorandum shall contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison shall be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations shall be included.

If the filing is for a new product, the expected projected premiums and projected incurred claims shall be provided.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

9. Effect of Law Changes:

   The memorandum shall identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable mandates shall be listed, including those with no rating impact. This quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

   This information shall be included in the narrative.

   The rating impact for each law change shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

10. Assumption, Acquisition or Merger:

    Identify whether the products included in the rate filing are part of an assumption, acquisition, or merger of policies from/with another carrier. If so, the memorandum shall include the full name of the carrier(s) from which the policies were assumed, acquired or merged, and the date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.B.3.b.6 for assumption, acquisition or merger rate filing requirements.

    This information shall be included in the narrative.

11. Rating Period:

    Identify the period for which the rates will be effective, including both the Effective and End Date. The date shall concur with the Effective Date Requested field in SERFF. The maximum rating period is one (1) year.

    a. Individual Market: Individual rates shall be filed no more frequently than annually. The rating period shall be twelve (12) months and premiums cannot change through the year.

    b. Small Group Market: Small group rates shall be filed no more frequently than quarterly. An annual rate filing, with an effective date of January 1, shall be made each year by a date specified by the Commissioner. Rating periods shall not be more than twelve (12) months. A carrier shall treat all health benefit plans issued or renewed in the same calendar quarter as having the same rating period. Rates in the annual filing may be trended quarterly.

    This information shall be included in the narrative.

12. Coordination of Benefits and/or Subrogation:

    The memorandum shall reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

    This information shall be included in the narrative.

13. Complete Explanation as to how the Proposed Rates were Determined:

The memorandum shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if support for each rating assumption is found to be inadequate.

The explanation may be on an aggregate expected loss basis or a PMPM basis, but it shall completely explain how the proposed rates were determined. The memorandum shall adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

a. Base Rate Development

A complete explanation as to how the base rate was developed shall be provided. Carriers may utilize actual claims experience in developing the base rate. The base rate shall be actuarially justified and implemented transparently, consistent with state rate review processes.

b. Rating Factors

The memorandum's narrative shall clearly reference all rating factors and definitions used. Carriers shall provide support for the use of each of the rating factors in the rate filing. The same level of support for changes to any of these factors shall be included in all renewal rate filings. In addition, each carrier shall review each of these rating factors every five (5) years, at minimum, and provide detailed support for the continued use of each of these factors in a rate filing. Rates shall not vary by gender.

This information shall be included in the narrative.

14. Actuarial Certification:

An actuarial certification shall be submitted with all filings. An actuarial certification is a signed and dated statement within the sixty (60) days prior to the submission of the filing made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

B. Stand-alone Dental Plan Requirements

1. QHPs in an Exchange may omit the pediatric dental EHB if an SADP on the Exchange offers pediatric dental EHB coverage.

2. SADP offering pediatric dental EHB coverage shall provide coverage up to age 19.

3. The standardized rating regions that apply to the medical QHPs do not apply to SADPs. Each dental carrier can determine its area adjustment factors and how to vary such factors by geographic locations. If zip codes are used to establish the area adjustment factors, no zip code smaller than a three (3) digit zip code shall be used when establishing an area.

4. The standard rating tiers and child factors applicable to the medical QHP do not apply to SADP. The dental carrier can develop a rating structure that conforms to federal and state laws.

5. The pediatric dental EHB coverage offered by a SADP shall be offered without annual and lifetime limits. Such limits may be used for benefits offered in addition to pediatric dental essential health benefits as well as for adult dental benefits.

6. The AV calculation for all SADPs shall include a summary statement and certification signed and dated by a qualified actuary.

7. SADPs offering pediatric dental coverage as an EHB on-the-exchange shall be exchange certified stand-alone dental plans. Stand-alone dental plans offered off-the-exchange shall be approved by the Division.

8. New filings shall be submitted in accordance with the ACA rate filing requirements for Colorado.

C. Rating Manual Requirements:

A rating manual shall be submitted to the Division for each new product. All changes to the rating manual shall be filed with the Division in an appropriate rate filing. Rate pages and rate manual shall be attached to the Rate/Rule Schedule tab in SERFF.

Premium rounding and truncation rules shall be provided in the rate manual for all rate filings.

Rating factors shall be calculated and displayed to four (4) decimal points.

This information shall be provided as a spreadsheet, separate from the Division “Regulation 4-2-39 Template”.

D. Prohibited Rating Practice

The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income.

Section 10 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 11 Incorporated Materials

45 CFR § 147.102 shall mean 45 CFR § 147.102 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 147.102. A copy of 45 CFR § 147.102 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 CFR § 147.102 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 CFR §156.135 shall mean 45 CFR §156.135 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 CFR §156.135. A copy of 45 CFR §156.135 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 CFR §156.135 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 CFR §147.145 shall mean 45 CFR §147.145 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 CFR §147.145. A copy of 45 CFR §147.145 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 CFR §147.145 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 154.215 shall mean 45 CFR §154.215 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 154.215. A copy of 45 C.F.R. § 154.215 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 154.215 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 CFR § 154.220 shall mean 45 CFR § 154.220 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 154.220. A copy of 45 CFR § 154.220 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 CFR § 154.220 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 156.145 shall mean 45 C.F.R. § 156.145 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.145. A copy of 45 C.F.R. § 156.145 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.145 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 CFR §156.420 shall mean 45 CFR §156.420 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 CFR §156.420. A copy of 45 CFR §156.420 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 CFR §156.420 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 12 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 13 Effective Date

This regulation shall become effective on May 30, 2023.

Section 14 History

Regulation effective October 1, 2013.
Amended regulation effective April 15, 2014.
Amended regulation effective August 15, 2014.
Amended regulation effective January 1, 2016.
Emergency regulation effective August 1, 2017.
Amended regulation effective December 1, 2017.
Emergency regulation effective June 13, 2018.
Amended regulation effective October 15, 2018.
Repealed and Repromulgated regulation effective May 15, 2021.
Amended regulation effective May 30, 2023.

Regulation 4-2-40 CONCERNING THE ELEMENTS OF CERTIFICATION FOR CERTAIN LIMITED BENEFIT HEALTH PLANS, CREDIT LIFE AND HEALTH, PRENEED FUNERAL CONTRACTS, EXCESS/STOP-LOSS INSURANCE FORMS, SICKNESS AND ACCIDENT INSURANCE, AND OTHER LIMITED BENEFIT HEALTH PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance (Commissioner) under the authority of §§ 10-1-109(1), 10-3-1110,10-16-107.2(1),(2),(3), 10-16-107.3(4), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to promulgate rules applicable to the filing of new and/or revised policy forms, new policy form listings, annual reports of policy forms, and certifications of policy forms and contracts, other than health benefit plan forms.

Section 3 Applicability

This regulation applies to all insurers and other entities authorized to conduct business in Colorado who are required to fully execute and file a certification form and complete the Form Schedule Tab in the System for Electronic Rate and Form Filing (SERFF). This includes insurers and other entities who provide insurance for sickness accident, credit disability, credit -health, credit - life, accident-only, specified disease, intensive care, organ and tissue transplant, dental, and disability income. This also includes insurers and other entities who provide hospital indemnity, travel, vision, long-term care, preneed funeral contracts, accidental death and dismemberment, hospital/surgical/medical, and prescription drug. This also includes excess/stop-loss insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act" (ERISA). This regulation does not change the certification requirements for preneed funeral contract sellers who utilize Colorado's prototype preneed funeral contracts. This rule does not apply to health benefit plans, including student health insurance coverage, short-term limited duration health insurance policies, or to Medicare supplement plans.

Section 4 Definitions

A. "ACA" means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B "Accident-only" means, for the purposes of this regulation, coverage for death, dismemberment, disability, or hospital and medical care caused by or necessitated as the result of an accident or specified kinds of accidents.

C. "Annual Report for credit insurance" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF and including the documents and information listed in Section 8.B. of this regulation.

D. "Annual Report for health coverage plans" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF, including the documents and information listed in Section 6.B. of this regulation.

E. "Annual Report for preneed contracts" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF, including the documents and information listed in Section 9.B. of this regulation.

F. "Certification" means, for the purposes of this regulation, the form that contains the necessary elements of certification, as determined by the Commissioner, which has been signed by the designated officer of the entity.

G. "Contract seller" must have the same meaning as found at § 10-15-102(6), C.R.S.

H. "Covered person" must have the same meaning as found at § 10-16-102(15), C.R.S.

I. "Credit Insurance" must have the same meaning as found at § 10-10-103(2), C.R.S.

J. "Disability income policy" means, for the purposes of this regulation, a policy that provides periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury.

K. "Effective date" means, for the purposes of this regulation, the specific date that the filed or approved forms can be offered to an individual or a group.

L. "Entity" means, for the purposes of this regulation, any organization that provides sickness and accident insurance, credit insurance, preneed funeral contracts, or excess/stop-loss coverage in this state. For the purpose of this regulation, "entity" includes insurers providing health coverage through fraternal benefit societies, health maintenance organizations, nonprofit hospital and health service corporations, sickness and accident insurance companies, and any other entities providing a plan of health insurance or health benefits subject to Colorado insurance laws and regulations.

M. "Excess/stop-loss insurance" means, for the purposes of this regulation, the excess/stop-loss insurance provided in conjunction with self-insured employer benefit plans under ERISA, which comply with the requirements set forth in § 10-16-119, C.R.S.

N. "Health benefit plan" must have the same meaning as found at § 10-16-102(32), C.R.S.

O. "Health coverage" means, for the purposes of this regulation, services included in furnishing to any individual medical, mental, dental, optometric care or hospitalization or nursing home care or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human physical or mental illness or injury, other than health benefit plans.

P. "Health coverage plan" must have the same meaning as found at § 10-16-102(34), C.R.S. For the purposes of this regulation, the term "health coverage plan" does not include health benefit plans.

Q. "Hospital indemnity policy" means, for the purposes of this regulation, a supplemental policy that provides a stated daily, weekly or monthly payment while the covered person is hospitalized regardless of expenses incurred and regardless of whether or not other insurance is in force.

R. "Limited benefit health coverage" means, for the purposes of this regulation, any type of health coverage that is not a health benefit plan.

S. "New policy form or new product" means, for the purposes of this regulation, a policy form that has substantially different new benefits or unique characteristics associated with risk or cost that are different from existing policy forms. For example: A guaranteed issue policy form is different than an underwritten policy form, a managed care policy form is different than a non-managed care policy form and a direct written policy form is different from a policy sold using producers.

T. "Officer of the entity" means, for the purposes of this regulation, the president, vice-president, assistant vice-president, corporate secretary, assistant corporate secretary, chief executive officer (CEO), chief financial officer (CFO), chief operating officer (COO), funeral director, general counsel or actuary who is a corporate officer, or any officer appointed by the Board of Directors.

U. "Plan" means, for the purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.

V. "Policy of sickness and accident insurance" must have the same meaning as found at § 10-16-102(50), C.R.S.

W. "Pre-existing condition" means, for the purposes of this regulation, an injury, sickness, or pregnancy for which a person has incurred charges, received medical treatment, consulted a health care professional or taken prescription drugs within the 12 months preceding the coverage effective date under a limited benefit health plan.

X. "Product(s)" means, for the purposes of this regulation, the services covered as a package under a policy form by an entity, which may have several cost-sharing options and riders as options.

Y. "Program" means, for the purposes of this regulation, the title of an entity's insurance program, product or preneed funeral contract.

Z. "Revised policy form" means, for the purposes of this regulation, an existing form previously submitted to the Division, which has been revised or modified. Entities may be required to submit redline copies.

AA. "SERFF" means, for the purpose of this regulation, the NAIC System for Electronic Rate and Form Filing.

AB. "Signature" includes an electronic signature as found at § 24-71.3-102(8), C.R.S.

AC. "Specified disease or illness coverage" means, for the purposes of this regulation, the payment of benefits for the diagnosis and treatment of a specifically named disease, illness, or diseases. Benefits can be paid as expense incurred, per diem, or principal sum.

AD. "Substantially different new benefit" means, for the purposes of this regulation, a new benefit offering that results in a change in the original policy. The offering of additional cost-sharing options (i.e. deductibles and copayments) to what is offered on an existing product does not create a new benefit.

AE. "Wellness benefits" means, for the purposes of this regulation, health benefits offered outside of the specifically defined line of coverage, such as annual preventive care and health screening, including laboratory services, x-ray services and similar services.

Section 5 Rules for Form Filings

Any new and/or revised policies, riders, contracts, application forms, certificates or other evidences of coverage associated with all limited benefit health plans, credit, life and health, preneed funeral contracts, excess/stop-loss insurance, sickness and accident insurance, and other limited benefit health plans must be filed with the Division of Insurance (Division) prior to issuance of the policy, rider, contract, application form, certificate, or other evidence of coverage. All form filings must be submitted electronically by licensed entities. Failure to supply the information required in this Section 5 will render the filing incomplete. All form filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S.

New plan designs under an existing product or policy form must be filed and must identify the difference in benefits and state if the benefits have been previously offered under the policy form and then later removed. Entities must not represent an existing policy form to be a new policy form, if the policy form is not being issued in connection with a substantially different new benefit. For entities who have opted to discontinue a previous form, new policy forms cannot have similar names or form numbers to any discontinued plan forms.

All form filings must be submitted electronically in SERFF by licensed entities. This section summarizes the general SERFF requirements for all form filings and the standardized format for the certification of all forms. This section must apply to each new product form introduced, to an existing form that is being modified or amended, and to the submission of form certifications. A separate filing must be submitted for each "Type of Insurance Code (TOI)" that best describes the product line. If a filing is submitted under an incorrect TOI code or Sub-TOI code, it will be rejected or disapproved as this field cannot be changed after submission in SERFF.

A. SERFF General Information Tab

1. SERFF Effective Date Requested: This date must be at least thirty-one (31) days after the submission date of the filing and must be reflected in "MM/DD/YYYY" format. For excess/stop-loss insurance and preneed forms, entities may use the filing submission date. The SERFF pre-populated "On Approval" term shall not be used.

2. SERFF Requested Filing Mode: "File and Use" ("Informational" filings are not allowed in Colorado and may be rejected).

3. SERFF Filing Type: Use "Form" for all form filings and "Annual" for annual form certifications.

4. SERFF Group Market Type: If identified as an association, blanket, discretionary group, trust or labor union, the Division requires that ALL non-employer groups must be approved by the Division prior to the group becoming involved with the solicitation of the product form being filed. The By-laws and Articles of Incorporation or Articles of Association, trust agreement, and any other documentation that would help the Division determine the validity of the group, must be submitted with the filing prior to solicitation of association members and issuance of coverage. These documents, for the potential groups, must be submitted for review by the Division through SERFF using the SERFF TOI code "H21 Health – Other" and filing type "Other". Additional information may be requested by the Division during the review process.

B. SERFF Form Schedule Tab

Identify all forms that pertain to the filing and complete all fields including the "Readability Score," demonstrating compliance with § 10-16-107.3, C.R.S. The actual forms must be attached for Hospital Indemnity and other Indemnity products filed using TOI codes H14 and H23, H25G – Similar Supplemental Coverage, and for health excess/stop-loss insurance. A separate "Forms List" under the "Supporting Documentation" Tab is not required.

C. SERFF Supporting Documentation Tab

1. Letter of authority. When an entity uses a third-party to submit a form filing on its behalf a letter of authority must be filed.

2. Red-lined copies of revised forms. For products that require the filing of the actual forms, or when red-lined copies are requested, all changes to previously filed forms should include a red-lined copy of the original document(s) and include revised form numbering and edition dating to distinguish the new revised form from the previously filed form.

3. Colorado certification form. A fully-executed Colorado certification form specific to the product and filing type as specified in Sections 6, 8, 9 and 10 must be filed. Applicable Colorado certification forms are attached in the appendices of this regulation.

   The elements of certification as determined by the Commissioner, which must be included in the "Colorado - Certification Form" and "Colorado - Certification Form for Annual Reports" applicable to the product being certified, are as follows:

   a. The name of the entity or contract seller;

   b. A statement that the officer signing the certification form has carefully reviewed items being certified and identified on the Form Schedule Tab in SERFF;

c. A statement that the officer signing the certification form has read and understands each applicable law, regulation, and bulletin;

d. A statement that the officer signing the certification form is aware of applicable penalties for certification of a noncompliant form or contract;

e. The name and title of the officer signing the certification form and the date the certification form was signed. Signatures must be dated within the sixty (60) days prior to the submission of the filing;

f. The original or valid electronic signature of the officer. Signature stamps, photocopies, or a signature on behalf of the officer are not acceptable. Electronic signatures must be in compliance with § 24-71.3-101 et seq., C.R.S., and applicable regulations; and

g. If the individual signing the certification is other than the president, vice-president, assistant vice-president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation must be included which documents that this individual has been appointed as an officer of the organization by the Board of Directors. This documentation must be submitted with every filing.

Section 6 Rules for Form Filings and Annual Form Filings for Certain Limited Benefit Health Plans, Sickness and Accident Insurance, and other Limited Benefit Health Plans

A. Form Filings

All new and revised policies, riders, contracts, application forms, certificates or other evidence of coverage associated with all limited benefit plans, sickness and accident insurance, and other limited benefit health plans must be filed with the Division. All form filings must be submitted electronically by licensed entities as specified in Section 5, with the following specific requirements:

1. The SERFF “Effective Date Requested” field must be completed and must be at least thirty-one (31) days after the filing submission date.

2. Entities must file a fully-executed “Colorado Health Coverage Certification Form for Listing of New and/or Revised Policy Forms (Form Health),” described in Section 5.C.2 of this regulation. An officer of the entity must sign and date the Certification Form provided in Appendix A.

B. Annual Form Certifications

No later than December 31 of each year, each entity subject to the provisions of this regulation must file an annual report of policy forms as specified in Section 5, with the following additional specific requirements:

1. Insurance entities must use SERFF TOI code “H21 – Health – Other” and Health Maintenance Organizations must use “HOrg03 Health – Other.” All health lines of business should be submitted in one (1) Annual Form Certification filing.

2. The SERFF Filing Type must be “Annual Certification.”

3. The SERFF “Effective Date Requested” field is not required to be completed.

4. The Form Schedule Tab must list all policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements, riders, and/or health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms. This must include all forms for policies for which premiums were collected during the year ending on December 31 of the reporting year. The Form Schedule Tab must be completed as follows:

   a. Form Name;

   b. Form Number;

   c. Form Type, select the appropriate form type;

   d. Action, select "Other"; and

   e. Action Specific Data, select "Other" and list "Annual Form Certification."

5. Listing of the readability score and attaching the actual forms is not required.

6. Entities must file a fully-executed "Colorado Health Coverage Certification Form for Annual Reports (Form Health Annual)," described in Section 5.C.2. of this regulation. An officer of the entity must sign and date the Certification Form provided in Appendix B.

Section 7 Required Attestations and Notices for Limited Benefit Health Coverage

A. All entities issuing limited benefit health coverage must include the following statement in BOLD type on the policy's and certificate's face page, and on the front page of the application:

"THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES."

B. All entities issuing dental policies that do not provide pediatric dental coverage as mandated by the ACA, must include the following statement in BOLD type on the policy's and certificate's face page, and on the front page of the application:

"THIS POLICY DOES NOT INCLUDE COVERAGE OF PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE ACA. COVERAGE OF PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE IN THE STATE OF COLORADO AND CAN BE PURCHASED AS A STAND-ALONE PLAN. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR CONNECT FOR HEALTH COLORADO TO PURCHASE EITHER A PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE OR AN EXCHANGE-QUALIFIED STAND-ALONE DENTAL PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE."

This notice requirement does not apply to large group stand-alone dental plans.

Section 8 Rules for Form Filings and Annual Reports for Credit Life and Health Products

A. Form Filings

Any new and/or revised forms for credit life and health products must be filed at least thirty-one (31) days prior to use as specified in Section 5. with the following additional specific requirements:

1. The SERFF TOI code beginning with "CR" appropriate for the credit health product being presented must be used.

2. The SERFF "Effective Date Requested" field must be completed.

3. Entities must file a fully-executed "Colorado Credit Insurance Policy Certification Form for Annual Reports and Listings of New and/or Revised Policy Forms (Form CI)" available in Appendix C of this regulation.

   An officer of the entity must sign and date the certification provided on the Form provided in Appendix C.

B. Annual Reports

No later than July 1 of each year, each credit insurer must file an annual report for credit insurance, listing policy forms as specified in Section 5, with the following specific requirements:

1. SERFF TOI code "CR07.000 - Credit Other" must be used.

2. The SERFF Filing Type must be "Annual Certification."

3. The SERFF "Effective Date Requested" field is not required to be completed.

Section 9 Rules for Form and Annual Report Filings for Preneed Funeral Contracts

A. Form Filings

Preneed funeral contract sellers must file compliant forms, prior to, or concurrently with, the use of the form by a contract seller, as specified in Section 5. with the following specific requirements:

1. Use SERFF TOI codes "ML02 Multi-Line - Other"

2. The SERFF "Effective Date Requested" field must be completed. Use the submission date of the filing on preneed forms which are filed concurrently to the date of use.

3. The actual forms to be used must be attached to the Form Schedule Tab in SERFF. Red-lined versions of any revised forms must be attached to the Supporting Documentation Tab in SERFF.

4. Contract sellers must file a fully-executed "Colorado Preneed Certification Form for Annual Reports and Listings of New and/or Revised Contracts (Form PN)" described in Section 5.C.2 of this regulation.

   An officer of the entity must sign and date the Certification Form provided in Appendix D.

B. Annual Reports

No later than July 1 of each year, each preneed contract entity must file an annual report for preneed contracts, listing policy forms as specified in Section 5, with the following additional specific requirements:

1. SERFF TOI code “ML02 Multi-Line - Other” must be used.

2. The SERFF Filing Type must be “Annual Certification.”

3. The SERFF “Effective Date Requested” field is not required to be completed.

Section 10 Rules for Filing Excess/Stop-Loss Insurance Forms

Excess/stop-loss insurance, used in conjunction with self-insured employer benefit plans under ERISA, does not require the filing of an annual form certification.

Any new and/or revised forms for excess/stop-loss insurance must be filed prior to use as specified in Section 5, with the following additional specific requirements:

A. Use SERFF TOI code “H12 Health – Excess/Stop-Loss”

B. The SERFF “Effective Date Requested” field must be completed. Use the submission date of the filing on forms which are filed concurrently to the date of use.

C. The actual forms to be used must be attached to the Form Schedule Tab in SERFF. Red-lined versions of any revised forms must be attached to the Supporting Documentation Tab in SERFF.

D. Entities must file a fully-executed “Colorado Health Excess/Stop-Loss Insurance for Self-Insured Employer Benefit Plans Under ERISA Certification Form (Form Colorado Health Excess/Stop-Loss),” described in Section 5.C.2 of this regulation, for each form filing.

An officer of the entity must sign and date the Certification Form provided in Appendix E.

Section 11 Wellness Benefits

A. Wellness benefits must be paid to the insured and shall be paid on an indemnity basis. These benefits may only be included in accident-only coverage, disability income coverage, or hospital indemnity coverage. If the policy includes wellness benefits, they must be fully disclosed and properly labeled on the front page of the policy and the certificate.

B. Wellness benefits may only be included in the following types of coverage:

1. Accident-only coverage: If wellness benefits are included, the coverage must be labeled “Accident-only policy with wellness benefits”. Accident-only coverage and accident-only coverage with wellness benefits must not include medical expense benefits. This coverage must not include a coordination of benefits provision or any other provision that allows the policy to reduce its benefits with respect to any other coverage its covered person may have.

2. Disability income coverage: If wellness benefits are included, the coverage must be labeled “Disability income policy with wellness benefits”. Disability income policies and disability income policies with wellness benefits must not include annual doctor visits or outpatient coverage. If additional benefits are provided, such benefits must be periodic payment to replace income lost when the insured is unable to work as the result of a sickness or injury. Loan payment and mortgage expense benefits must be filed as credit disability insurance.

3. Hospital indemnity coverage: If wellness benefits are included, the coverage must be labeled “Hospital indemnity policy with wellness benefits”. Hospital indemnity coverage and hospital indemnity coverage with wellness benefits must not include a coordination of benefits provision or any other provision that allows the coverage to reduce its benefits with respect to any other coverage its covered person may have.

Section 12 Prohibited Practices

Policies must not misrepresent their benefits by including coverages that are not specifically included benefits for that type of product. Consumers must be notified that some types of policies must not coordinate benefits with health coverage policies.

A. Carriers shall not apply pre-existing condition limitations to any insured that is more restrictive than a twelve month look back period.

B. Policies that are not health coverage plans (such as accidental death and dismemberment (AD&D) coverage, accident-only, credit, and travel) must not coordinate benefits with any other policies.

C. Accident-only policies must not include “sickness” benefits. If additional accident-related benefits are provided, such benefits must be accident-related medical benefits, and must be fully disclosed and properly labeled. Accident-only policies must not include a coordination of benefits provision or any other provision that allows it to reduce its benefits with respect to any other coverage its covered person may have.

D. Disability income policies must not include annual doctor visits or outpatient coverage. If additional benefits are provided, such benefits must be periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury, and must be fully disclosed and properly labeled. Policies must not misrepresent the benefits of an insurance policy by including coverages that are not specifically defined by the line of business. Loan payments and mortgage expense benefits must be filed as credit disability insurance. Group disability income policies must comply with § 10-16-214(3)(a)(V)(C), C.R.S.

E. Hospital Indemnity policies must not include medical expense coverage. If additional indemnity benefits are provided they must be indemnity benefits provided while the covered person is confined to a hospital, and must be fully disclosed and properly labeled. Outpatient benefits and other non-hospital-related coverages do not meet this definition. Hospital indemnity policies must not include a coordination of benefits provision, or any other provision that allows the policy to reduce its benefits with respect to any other coverage the covered person may have. Hospital indemnity products must be filed using the H14 TOI code in SERFF. Carriers wishing to offer indemnity products that include other permissible benefits such as hospital indemnity, accident, sickness, and outpatient benefits must specifically identify the benefits covered in the policy title and must be filed using the H23 TOI code in SERFF.

F. Specified disease or illness (such as cancer-only) policies, hospital indemnity, or other fixed indemnity insurance must not coordinate benefits with any other policies and must be provided under a separate policy or certificate.

G. Policies that include limited-scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community-based care must not coordinate benefits with any other policies. However, limited scope vision and dental benefits may coordinate benefits with each other.

H. Entities must not represent any policy form as compliant with the ACA, and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152. Entities must not use similar names or form numbers as plans that are compliant with the ACA. Using terms such as, but not limited to, Health Savings Account (HSA), High Deductible Health Plan (HDHP) or any reference to a metal level, are not permitted. Use of metal-level terms in plan names, or in the marketing and advertising of plans that do not provide "minimum essential coverage," is prohibited.

I. Any entity selling any type of limited benefit health coverage, with or without bundled coverages or coordination of benefits, that is marketed as a substitute for, an alternative to, a replacement of, or as equivalent to an ACA-compliant health benefit plan, or including services that do not meet the definition for the line of business for that product, is prohibited.

Section 13 Readability

A. Pursuant to § 10-16-107.3, C.R.S., entities writing health coverage plans, limited benefit health insurance, dental plans, or long-term care plans, must include the Flesch-Kincaid grade level or the Flesch Read Ease score in the SERFF filing. The Flesch-Kincaid grade level must not exceed the tenth (10th) grade level or the Flesch Read Ease score must not be less than fifty (50).

B. Entities may choose either the Flesh-Kincaid grade level formula or the Flesh Read Ease formula to generate a readability score. However, once a formula has been selected from these two (2) formulas, the selected formula must be used consistently for all text being scored for that particular policy.

C. All policies, as well as riders, amendments, endorsements, applications, and other forms that are made a part of the policy, evidence of coverage, or certificate of coverage, must comply with the readability score and must either be scored as a separate form, or as part of the policy with which they may be used.

D. Cancellation notices, renewal notices, disclosure forms, and notices of reductions in coverage do not require a readability score.

E. Entities must provide all policy forms in a manner that is accessible and timely to individuals living with disabilities, or with limited English proficiency.

Section 14 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 15 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 16 Effective Date

This regulation shall become effective on June 14, 2022.

Section 17 History

Originally issued as Final Regulation 1-1-6 effective June 1, 1994.
Amended Regulation 1-1-6 effective February 1, 2002.
Amended Regulation 1-1-6 effective June 1, 2003.
Sections 1, 2, 3, 8 and 9 amended effective February 1, 2004.
Amended Regulation effective January 1, 2012.
Regulation 1-1-6 repealed in full October 1, 2013.
Regulation effective October 1, 2013.
Repealed and Repromulgated regulation effective September 1, 2018.
Amended regulation effective June 14, 2022.

Appendix A - FORM HEALTH

COLORADO HEALTH COVERAGE CERTIFICATION FORM FOR LISTINGS OF NEW AND/OR REVISED POLICY FORMS

I, THE UNDERSIGNED OFFICER OF _____,
(Name of Entity)

AM KNOWLEDGEABLE OF HEALTH COVERAGES; HAVE CAREFULLY REVIEWED THE CONTENTS OF THE POLICY FORMS, APPLICATIONS, SUBSCRIPTION CERTIFICATES, MEMBERSHIP CERTIFICATES OR OTHER EVIDENCES OF HEALTH CARE COVERAGE IDENTIFIED ON THE FORM SCHEDULE TAB IN SERFF WHICH IS HEREBY FILED WITH THE COLORADO COMMISSIONER OF INSURANCE;

HAVE READ AND UNDERSTAND EACH OF THE APPLICABLE COLORADO LAWS, REGULATIONS, AND BULLETINS;

AM AWARE OF THE PENALTIES FOR CERTIFICATION OF A NONCOMPLYING FORM OR CONTRACT; AND

CERTIFY, TO THE BEST OF MY GOOD FAITH KNOWLEDGE AND BELIEF, THAT THE NEW POLICY FORMS, REVISED FORMS, APPLICATION FORMS (TO INCLUDE ANY HEALTH QUESTIONNAIRES USED AS PART OF THE APPLICATION PROCESS), ENDORSEMENTS AND RIDERS FOR ANY SICKNESS, ACCIDENT, AND/OR HEALTH INSURANCE POLICY, CONTRACT, CERTIFICATE, OR OTHER EVIDENCE OF COVERAGE ISSUED OR DELIVERED TO ANY POLICYHOLDER, CERTIFICATE HOLDER, ENROLLEE, SUBSCRIBER, OR MEMBER IN COLORADO PROVIDE ALL APPLICABLE MANDATED COVERAGES IDENTIFIED IN THE FORM SCHEDULE TAB IN SERFF AND ARE IN FULL COMPLIANCE WITH ALL COLORADO INSURANCE LAWS AND REGULATIONS, AND COPIES OF THE RATES AND THE CLASSIFICATION OF RISKS OR SUBSCRIBERS PERTAINING THERETO ARE FILED WITH THE COMMISSIONER.

_____ _____
(***Original*** Signature of Officer*) (Title of Officer*)

_____ _____
(Printed Name of Officer*) (Date)

**If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation shall be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. Electronic signatures are not acceptable UNLESS provided through a signature verification provider such as VeriSign.*

FORM REVISED 6-14-2022

Appendix B - FORM HEALTH ANNUAL

COLORADO HEALTH COVERAGE CERTIFICATION FORM
FOR ANNUAL REPORTS

I, THE UNDERSIGNED OFFICER OF _____,
(Name of Entity)

AM KNOWLEDGEABLE OF HEALTH COVERAGES; HAVE CAREFULLY REVIEWED THE CONTENTS OF THE POLICY FORMS, APPLICATION FORMS, SUBSCRIPTION CERTIFICATES, MEMBERSHIP CERTIFICATES OR OTHER EVIDENCES OF HEALTH CARE COVERAGE IDENTIFIED ON THE FORM SCHEDULE TAB IN SERFF WHICH IS HEREBY FILED WITH THE COLORADO COMMISSIONER OF INSURANCE;

HAVE READ AND UNDERSTAND EACH OF THE APPLICABLE COLORADO LAWS, REGULATIONS, AND BULLETINS;

AM AWARE OF THE PENALTIES FOR CERTIFICATION OF A NONCOMPLYING FORM; AND

CERTIFY, TO THE BEST OF MY GOOD FAITH KNOWLEDGE AND BELIEF, THAT FOR THE ANNUAL REPORT OF ALL POLICY FORMS (TO INCLUDE ANY HEALTH QUESTIONNAIRES USED AS PART OF THE APPLICATION PROCESS), ENDORSEMENTS OR RIDERS FOR ANY SICKNESS, ACCIDENT, LIMITED BENEFIT PLAN AND/OR HEALTH INSURANCE POLICY, CONTRACT, CERTIFICATE, OR OTHER EVIDENCE OF COVERAGE CURRENTLY IN USE AND ISSUED OR DELIVERED TO ANY POLICYHOLDER, CERTIFICATE HOLDER, ENROLLEE, SUBSCRIBER, OR MEMBER IN COLORADO, INCLUDING THE TITLES OF THE PROGRAMS OR PRODUCTS AFFECTED BY THE FORMS IDENTIFIED IN THE FORM SCHEDULE TAB IN SERFF, PROVIDE ALL APPLICABLE MANDATED COVERAGES AND ARE IN FULL COMPLIANCE WITH ALL COLORADO INSURANCE LAWS AND REGULATIONS, AND COPIES OF THE RATES AND THE CLASSIFICATION OF RISKS OR SUBSCRIBERS PERTAINING THERETO ARE FILED WITH THE COMMISSIONER.

_____ _____
(***Original*** Signature of Officer*) (Title of Officer*)

_____ _____
(Printed Name of Officer*) (Date)

**If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation must be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. Electronic signatures are not acceptable UNLESS provided through a signature verification provider such as VeriSign.*

FORM REVISED 6-14-2022

Appendix C - FORM CI

COLORADO *CREDIT INSURANCE* POLICY CERTIFICATION FORM
FOR ANNUAL REPORTS AND LISTINGS OF NEW AND/OR REVISED POLICY FORMS

I, THE UNDERSIGNED OFFICER OF _____,
(Name of Entity)

AM KNOWLEDGEABLE OF CREDIT INSURANCE;

HAVE CAREFULLY REVIEWED THE CONTENTS OF THE NEW AND/OR REVISED POLICIES FOR CREDIT INSURANCE, CERTIFICATES OF INSURANCE, NOTICES OF PROPOSED INSURANCE, APPLICATIONS FOR INSURANCE, ENDORSEMENTS, AND RIDERS IDENTIFIED ON THE FORM SCHEDULE TAB IN SERFF WHICH IS HEREBY FILED WITH THE COLORADO COMMISSIONER OF INSURANCE;

HAVE READ AND UNDERSTAND EACH OF THE APPLICABLE COLORADO LAWS, REGULATIONS, AND BULLETINS;

AM AWARE OF THE PENALTIES FOR CERTIFICATION OF A NONCOMPLYING FORM; AND

CERTIFY, TO THE BEST OF MY GOOD FAITH KNOWLEDGE AND BELIEF, THAT THE POLICY FORMS IDENTIFIED ON THE FORM SCHEDULE TAB IN SERFF OR ANNUAL REPORT FILED WITH THIS CERTIFICATION, POLICY FORM, CERTIFICATE OF INSURANCE, NOTICE OF PROPOSED INSURANCE, APPLICATION FOR INSURANCE, ENDORSEMENT, OR RIDER IN USE ARE IN FULL COMPLIANCE WITH ALL COLORADO INSURANCE LAWS AND REGULATIONS, AND COPIES OF THE RATES AND THE CLASSIFICATION OF RISKS OR SUBSCRIBERS PERTAINING THERETO ARE FILED WITH THE COMMISSIONER.

_____ _____
(***Original*** Signature of Officer*) (Title of Officer*)

_____ _____
(Printed Name of Officer*) (Date)

**If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation shall be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. Electronic signatures are not acceptable UNLESS provided through a signature verification provider such as VeriSign.*

FORM REVISED 6-14-2022

Appendix D - FORM PN

COLORADO PRENEED CERTIFICATION FORM
FOR ANNUAL REPORTS AND LISTINGS OF NEW AND/OR REVISED CONTRACTS

NOTE: PROTOTYPE CONTRACTS ARE EXCLUDED FROM THIS REQUIREMENT

I, THE UNDERSIGNED OFFICER OF _____,
(Name of Contract Seller)

AM KNOWLEDGEABLE OF PRENEED FUNERAL CONTRACTS;

HAVE CAREFULLY REVIEWED THE CONTENTS OF THE CONTRACTS IDENTIFIED ON THE FORM SCHEDULE TAB IN SERFF WHICH IS HEREBY FILED WITH THE COLORADO COMMISSIONER OF INSURANCE;

HAVE READ AND UNDERSTAND EACH OF THE APPLICABLE COLORADO LAWS, REGULATIONS, AND BULLETINS;

AM AWARE OF THE PENALTIES FOR CERTIFICATION OF A NONCOMPLYING CONTRACT; AND

CERTIFY THAT, TO THE BEST OF THE CONTRACT SELLER'S GOOD FAITH KNOWLEDGE AND BELIEF, EACH PRENEED FUNERAL CONTRACT OR FORM OF ASSIGNMENT IDENTIFIED ON THE FORM SCHEDULE TAB IN SERFF IS IN FULL COMPLIANCE WITH ALL COLORADO INSURANCE LAWS AND REGULATIONS AND THAT COPIES OF THE RATES AND THE CLASSIFICATION OF RISKS OR SUBSCRIBERS PERTAINING THERETO ARE FILED WITH THE COMMISSIONER.

_____ _____
(***Original*** Signature of Authorized Representative*) (Title of Authorized Representative*)

_____ _____
(Printed Name of Officer*) (Date)

**If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation shall be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. Electronic signatures are not acceptable UNLESS provided through a signature verification provider such as VeriSign.*

FORM REVISED 6-14-2022

Appendix E - FORM COLORADO HEALTH EXCESS/STOP-LOSS

COLORADO HEALTH EXCESS/STOP-LOSS INSURANCE FOR SELF-INSURED EMPLOYER BENEFIT PLANS UNDER ERISA CERTIFICATION FORM

I, THE UNDERSIGNED OFFICER OF _____,

(Name of Entity)

AM KNOWLEDGEABLE OF HEALTH EXCESS/STOP-LOSS INSURANCE FOR SELF-INSURED EMPLOYER BENEFIT PLANS UNDER ERISA;

HAVE CAREFULLY REVIEWED THE CONTENTS OF THE POLICY FORMS ATTACHED TO THIS CERTIFICATION, TOGETHER WITH THE EXCESS/STOP-LOSS FOR ERISA PLAN GUIDES, COPIES OF WHICH ARE HEREBY PLACED ON FILE WITH THE COLORADO COMMISSIONER OF INSURANCE;

HAVE READ AND UNDERSTAND EACH OF THE APPLICABLE COLORADO LAWS, REGULATIONS, AND BULLETINS;

AM AWARE OF THE PENALTIES FOR CERTIFICATION OF A NONCOMPLYING FORM; AND

CERTIFY, TO THE BEST OF MY GOOD FAITH KNOWLEDGE AND BELIEF, THE NEW POLICY FORMS, APPLICATION FORMS (TO INCLUDE ANY HEALTH QUESTIONNAIRES USED AS PART OF THE APPLICATION PROCESS), ENDORSEMENTS AND RIDERS FOR ANY SICKNESS, ACCIDENT, AND/OR HEALTH INSURANCE POLICY, CONTRACT, CERTIFICATE, OR OTHER EVIDENCE OF COVERAGE ISSUED OR DELIVERED TO ANY POLICYHOLDER, CERTIFICATE HOLDER, ENROLLEE, SUBSCRIBER, OR MEMBER IN COLORADO, PROVIDE ALL APPLICABLE MANDATED COVERAGES AND ARE IN FULL COMPLIANCE WITH ALL COLORADO INSURANCE LAWS AND REGULATIONS, AND COPIES OF THE RATES AND THE CLASSIFICATION OF RISKS OR SUBSCRIBERS PERTAINING THERETO ARE FILED WITH THE COMMISSIONER.

_____ _____
(***Original*** Signature of Officer*) (Title of Officer*)

_____ _____
(Printed Name of Officer*) (Date)

**If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation shall be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. Electronic signatures are not acceptable UNLESS provided through a signature verification provider such as VeriSign.*

FORM REVISED 6-14-2022

Regulation 4-2-41 CONCERNING THE ELEMENTS FOR FORM FILINGS FOR HEALTH BENEFIT PLANS, ACA-COMPLIANT STAND-ALONE DENTAL PLANS, STUDENT HEALTH INSURANCE COVERAGE, AND SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICIES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-3-1110, 10-16-107.2(3), 10-16-107.3(1)(b), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to promulgate rules applicable to the form filing requirements for health benefit plans, ACA-compliant stand-alone dental plans, student health insurance coverage, and short-term limited duration health insurance policies.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing individual, small group, and/or large group non-grandfathered, and grandfathered health benefit plans, ACA-compliant stand-alone dental plans that provide for pediatric dental as an essential health benefit, student health insurance coverage, and short-term limited duration health insurance policies subject to Colorado insurance laws.

This regulation excludes certain limited benefit plans, non-ACA-compliant stand-alone dental plans, credit life and health policies, preneed funeral contracts, excess/stop loss insurance forms, and sickness and accident insurance other than health benefit plans.

Section 4 Definitions

A. “ACA” means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B. “ACA-compliant stand-alone dental plan” or “ACA-compliant SADP” means, for the purposes of this regulation, a plan, separate from a medical plan, which provides the pediatric dental Essential Health Benefits required under the Affordable Care Act, and which has its own cost sharing and deductibles separate from a medical plan.

C. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

D. "Certification" means, for the purpose of this regulation, a certification form, which contains elements of certification as determined by the Commissioner, signed by a designated officer of the carrier.

E. "Connect for Health Colorado" shall have the same meaning as "exchange" as found at § 10-16-102(26), C.R.S.

F. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

G. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.

H. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.

I. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

J. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.

K. "New policy form or product" means, for the purposes of this regulation, a policy form that has "substantially different new benefits" or unique characteristics associated with risk or cost that are different from existing policy forms. For example: A guaranteed-issue policy form is different than an underwritten policy form; a managed care policy form is different than a non-managed care policy form; a direct written policy form is different from a policy sold using producers, etc.

L. "Officer" means, for the purposes of this regulation, the president, vice-president, assistant vice-president, corporate secretary, chief executive officer (CEO), chief financial officer (CFO), chief operating officer (COO), assistant corporate secretary, funeral director, general counsel or actuary who is a corporate officer, or any officer appointed by the board of directors.

M. "Plan" means, for the purpose of this regulation, the specific benefits and cost-sharing provisions available to a covered person.

N. "Pre-existing condition" means, for the purposes of this regulation, an injury, sickness, or pregnancy for which a person has incurred charges, received medical treatment, consulted a health care professional or taken prescription drugs within the twelve (12) months preceding the coverage effective date under a short-term policy.

O. "Product(s)" means, for the purpose of this regulation, the services covered as a package under a policy form by a carrier, which may have several cost-sharing options and riders as options.

P. "Program" means, for the purpose of this regulation, the title of a carrier's health coverage program or product.

Q. "Revised policy form" means, for the purpose of this regulation, an existing form previously submitted to the Division that has been revised or modified.

R. "SERFF" means, for the purpose of this regulation, the NAIC System for Electronic Rate and Form Filings.

S. "Short-term limited duration health insurance policies" or "short-term policy" shall have the same meaning as found at § 10-16-102(60), C.R.S.

T. "Signature" includes an electronic signature as found at § 24-71.3-102(8), C.R.S.

U. "Student health insurance coverage" shall have the same meaning as found at § 10-16-102(65), C.R.S.

V. "Substantially different new benefit" means, for the purpose of this regulation, a new benefit that results in a change in the actuarial value or premium. The offering of additional cost sharing options (i.e. deductibles, coinsurance, copayments, and maximum out-of-pocket amounts) to what is offered as an existing product does not constitute a substantially different new benefit.

Section 5 Rules for Form Filings

Any new and/or revised policies, riders, contracts, application forms, certificates, or other evidence of health coverage associated with health insurance coverage shall be filed with the Division of Insurance (Division). All form filings shall be submitted electronically by licensed entities.

If a carrier uses the optional method of electronic dissemination of newly issued or revised policy forms or endorsements, the carrier shall comply with Colorado's Uniform Electronic Transactions Act (UETA) § 24-71.3-101, et seq., C.R.S.

Carriers shall not represent an existing policy form to be a new policy form if the policy form is not being issued in connection with a substantially different new benefit. For carriers who have opted to discontinue a previous form, new policy forms cannot have similar names or form numbers to any discontinued plan forms.

For the policies, evidences of coverage, certificates and other applicable forms, carriers shall use the section names as specified in Colorado Insurance Regulation 4-2-34. Failure to supply the information required in Section 5 of this regulation will render the filing incomplete. All form filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S.

A. General SERFF Requirements for All Form Filings

1. At least thirty-one (31) days prior to using any new form or revised form, each carrier, subject to the provisions of this regulation, shall file a fully-executed "Colorado Health Coverage Certification Form for Listing of New and/or Revised Policy Forms (Form Health)", available in Appendix A and SERFF, and complete the Form Schedule Tab in SERFF according to the following requirements.

   A separate filing must be submitted for each "Type of Insurance Code (TOI)" that best describes the product line. If a filing is submitted under an incorrect TOI code or Sub-TOI code, it will be rejected or disapproved as this field cannot be changed after submission in SERFF. Each type of insurance shall have a separate form filing. Form filings must not be combined with rate filings. A separate filing shall be submitted for each carrier. A single filing made for more than one carrier, or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/indemnity point-of-service plan, each carrier shall submit a separate form filing.

   a. SERFF General Information Tab

      (1) SERFF Effective Date Requested: This date must be at least thirty-one (31) days after the submission date of the filing or as specified below and must be reflected in "MM/DD/YYYY" format. The SERFF pre-populated "On Approval" term shall not be used.

      (2) SERFF Requested Filing Mode: "File and Use"

(3) SERFF Filing Type: Use “Form” for all form filings and “Annual Certification” for annual form certifications.

b. SERFF Form Schedule Tab

The listing shall include any new or revised policy forms and/or application forms for the specific insurance types listed below, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, with a description of the form, unique form number for new forms, including the edition date for revised forms, the title of the program or product affected by the form, and the readability score where required pursuant to § 10-16-107.3, C.R.S. The actual forms must be attached as specified.

c. SERFF Supporting Documentation Tab

(1) Colorado Health Coverage Certification Form for Listing of New and/or Revised Policy Forms (Form Health), fully executed in the format prescribed in Section 7. This form is available in Appendix A and in SERFF.

(2) Carriers submitting any revised documents must submit a redlined version showing all changes that were made. In the initial submission, the redlines must show the changes made from documents approved the previous year. Redline documents showing changes made in response to objections must be submitted with objection responses.

(3) Letter of Authority (if a carrier uses a third party to submit a form filing on its behalf).

B. Additional Specific Requirements for Form Filings for Individual and Small Group Non-Grandfathered ACA-Compliant Health Benefit Plans and ACA-Compliant SADPs

1. For filings for individual or small group non-grandfathered filings, all form documents shall be included in the SERFF filing. All form documents must include page numbers.

2. All non-grandfathered health benefit plan form filings shall be submitted separately from grandfathered health benefit plan form filings.

3. Unless otherwise noted, carriers offering individual and small group health benefit plans shall follow the filing requirements in this regulation for plans offered inside and outside of Connect for Health Colorado.

4. Variability: Carriers shall submit one base (“master” level) document, accompanied by a statement of variability, for all policy forms, per the following requirements:

a. Cost sharing information, including deductibles, coinsurance, copayments, and maximum out-of-pocket amounts, must be bracketed as variable amounts to include the entire possible range of amounts for plans at all metal levels (as defined in Colorado Insurance Regulation 4-2-39);

b. Bracketed language must include all options and must be identified in a statement of variability. Form filings that do not include an adequate explanation of bracketed ranges and language may be rejected;

c. Special requirements for the Evidence of Coverage (EOC), Summary of Benefit and Coverage (SBC), and Colorado Supplement to the SBC (COSSBC) forms, if applicable:

(1) For health benefit plans:

(a) The EOC, SBC, and COSSBC documents attached under the Form Schedule Tab in SERFF, as required in Section 5.B.5.a.,will be reviewed by the Division for compliance with state and federal law. The Division will allow carriers to use variable language in these documents at the level of the Benefits Package, as defined by the Federal Plans and Benefits Template in the Plan Management (Binder) section in SERFF; and

(b) For plans offered through Connect for Health Colorado ("on-exchange"), following the Division's review, and at the time requested by the Division, the EOC, SBC, and COSSBC documents shall be attached under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF. These documents must be produced and submitted at the variant-specific level, as defined in 45 C.F.R. § 156.420, and as directed by the Division. These documents will be posted on the Connect for Health Colorado website. For plans offered through Connect for Health Colorado, all SBCs, COSSBCs and EOCs must be submitted in English and in Spanish.

(2) For ACA-compliant SADPs

(a) The EOC documents attached under the Form Schedule Tab in SERFF, as required in Section 5.B.5.b.,will be reviewed by the Division for compliance with state and federal law. The Division will allow carriers to use variable language in these documents at the level of the Benefits Package, as defined by the Federal Plans and Benefits Template in the Plan Management (Binder) section in SERFF; and

(b) For plans offered through Connect for Health Colorado, following review, and at the time requested by the Division, the EOC documents shall be attached under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF. The Spanish EOCs must be available upon request but are not required to be submitted to the Division. Connect for Health Colorado provides the information for preparation and submittal of SBCs.

5. SERFF Submission Requirements

Carriers shall complete and submit the following information on the SERFF Form Schedule tab in order for a form filing submission to be considered complete:

a. Health benefit plan carriers shall complete the Form Name, Form Number, Form Type, Action, and Readability Score data fields on the Form Schedule Tab, and attach copies of the following documents:

(1) Evidence of Coverage (EOC);

(2) Summary of Benefits and Coverage (SBC);

(3) Colorado Supplement to the SBC;

(4) Uniform Application; and

(5) Any additional policy forms.

(6) No riders or endorsements are permitted.

b. SADP carriers shall complete the Form Name, Form Number, Form Type, Action, Readability Score data fields on the Form Schedule Tab. The following form documents shall be included in the SERFF filing.

(1) Evidence of Coverage (EOC); and

(2) Any additional policy forms.

(3) No riders or endorsements are permitted.

C. Additional Specific Requirements for Form Filings for Large Group and Grandfathered Health Benefit Plans

1. All grandfathered health benefit plan form filings shall be submitted separately from non-grandfathered health benefit plan form filings.

2. Carriers shall complete the Form Name, Form Number, Form Type, Action, Readability Score data fields on the SERFF Form Schedule Tab. Copies of the actual form documents should not be attached unless requested by the Division:

a. Evidence of Coverage (EOC);

b. Summary of Benefits and Coverage (SBC);

c. Applications; and

d. Policy forms, riders and endorsements.

D. Additional Specific Requirements for Form Filings for Student Health Insurance Coverage

1. As student health insurance policies meet the definition of health benefit plans pursuant to § 10-16-102(32), C.R.S., they are required to provide coverage of the essential health benefits as listed in Section 5 of Colorado Insurance Regulation 4-2-42, except for pediatric dental, and coverage of applicable mandated benefits pursuant to § 10-16-104, C.R.S.

2. Carriers shall complete the Form Name, Form Number, Form Type, Action, Readability Score data fields on the SERFF Form Schedule Tab. Copies of the actual form documents shall be attached:

a. Evidence of Coverage (EOC);

b. Summary of Benefits and Coverage (SBC); and

c. Applications.

3. Variability: Carriers shall submit one base document, accompanied by a statement of variability, for all policy forms, per the following requirements:

    a. Cost sharing information, including deductibles, coinsurance, copayments, and maximum out-of-pocket amounts, should be bracketed as variable amounts to include the entire possible range of amounts; and

    b. Bracketed language shall be complete and options shall be identified in a statement of variability. Form filings that do not include an adequate explanation of bracketed ranges and language may be rejected.

E. Additional Specific Requirements for Form Filings for Short-Term Limited Duration Health Insurance Policies

1. As short-term policies meet the definition of health benefit plans pursuant to § 10-16-102(32), C.R.S., except the requirement to cover pre-existing conditions, they are required to provide coverage of the applicable mandated benefits pursuant to § 10-16-104, C.R.S. and the essential health benefits, found at § 10-16-102(22)(b), C.R.S.

2. Carriers shall complete all SERFF required data fields.

3. Carriers shall complete the Form Name, Form Number, Form Type, Action, Readability Score data fields on the SERFF Form Schedule Tab, and attach copies of the following documents, with page numbers:

    a. Evidence of Coverage (EOC); and

    b. Application.

    c. Summary of Benefits and Coverage documents shall not be used.

4. Variability: Carriers shall submit one base document, accompanied by a statement of variability, for all policy forms, per the following requirements:

    a. Cost sharing information, including deductibles, coinsurance, copayments, and maximum out-of-pocket amounts, should be bracketed as variable amounts to include the entire possible range of amounts; and,

    b. Bracketed language shall be complete and options shall be identified in a statement of variability. Form filings that do not include an adequate explanation of bracketed ranges and language may be rejected.

5. Carriers shall not represent any policy form as compliant with the ACA. Carriers shall not use similar names or form numbers for any plan that is compliant with the ACA. Using terms such as, but not limited to, Health Savings Account (HSA), High Deductible Health Plan (HDHP) or any reference to a metal level, are not permitted.

6. Disclaimers Required for Form Filings for Short-Term Limited Duration Health Insurance Policies

a. All carriers issuing short-term policies must include the following statement in BOLD type on the first page of all forms, marketing materials and applications:

"THIS SHORT-TERM 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.

THIS SHORT-TERM POLICY IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE.

b. In addition, carriers shall include the following question in all applications:

"HAVE YOU OR ANY OTHER PERSON TO BE INSURED BEEN COVERED UNDER TWO OR MORE NONRENEWABLE SHORT-TERM POLICIES DURING THE PAST TWELVE (12) MONTHS? IF "YES", THEN THIS POLICY CANNOT BE ISSUED. YOU MUST WAIT SIX (6) MONTHS FROM THE DATE OF YOUR LAST SUCH POLICY TO APPLY FOR A SHORT-TERM POLICY."

Section 6 Rules for Annual Form Certification

No later than December 31 of each year, each carrier subject to the provisions of this regulation shall file an annual report of policy forms, as specified in § 10-16-107.2 C.R.S. This filing shall include a fully executed "Colorado Health Coverage Certification Form for Annual Reports (Form Health Annual)", available in Appendix B, and the completed Form Schedule Tab in SERFF.

The carrier shall complete the Form Schedule Tab in SERFF which must include all policy forms, application forms, endorsements or riders, and/or health policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms. Listing the readability score and attaching the actual forms is not required.

Section 7 Certification Requirements

One of the following specific certification forms shall be submitted for form filings as specified in Sections 5 and 6 above. The certification for new and revised policy forms shall be the "Colorado Health Coverage Certification Form for Listing of New and/or Revised Policy Forms (Form Health)", found in Appendix A of this regulation. The certification for annual form certifications shall be the "Colorado Health Coverage Certification Form for Annual Reports (Form Health Annual)", found in Appendix B. The elements of both of these certifications are as follows:

A. The name of the carrier;

B. A statement that the officer signing the certification form is knowledgeable of the health coverage insurance being certified;

C. A statement that the officer signing the certification form has carefully reviewed the policy forms, subscription certificates, membership certificates, or other evidences of health care coverage identified on the Form Schedule Tab in SERFF;

D. A statement that the officer signing the certification form has read and understands each applicable law, regulation and/or bulletin; and

E. A statement that the officer signing the certification form is aware of applicable penalties for certification of a noncomplying form or contract.

F. A statement that the officer signing the certification form certifies:

1. For the “Listing of New and/or Revised Policy Forms” for health benefit plans, ACA-compliant SADPs, student health insurance coverage, and short-term limited duration health insurance policies, that the certifying officer has reviewed, signed and placed on file, and to the best of the officer's good faith, knowledge and belief, that the submitted forms provide all applicable mandated coverages and are in full compliance with all Colorado laws and regulations, and that copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the Commissioner. The submitted forms shall include:

a. New and/or revised policy forms;

b. Application forms (to include any health questionnaires used as part of the application process used by large group plans only);

c. Endorsements and riders for any health benefit plan, student health insurance coverage, and/or short-term policy (endorsements and riders are not allowed on ACA-compliant plans); and

d. Contracts, certificates, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado.

2. For “Annual Report for Health Coverage Plan” for health benefit plans, ACA-compliant SADPs, and short-term policies, the documents identified in the Form Schedule Tab in SERFF, provide all applicable mandated coverages, and are in full compliance with all Colorado laws and regulations.

G. The name and title of the officer signing the certification form and the date the certification form was signed. Signatures shall be dated within the sixty (60) days prior to the submission of the filing;

H. The original or valid electronic signature of the officer. Signature stamps, photocopies or a signature on behalf of the officer are not acceptable. Electronic signatures must be in compliance with § 24-71.3-101 et seq, C.R.S. and applicable regulations; and

I. If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel or an actuary that is also a corporate officer, documentation shall be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. This documentation is to be submitted with all filings.

Section 8 Readability Score

A. Carriers writing health benefit plans shall include the Flesch-Kincaid grade level or the Flesch Read Ease score in the electronic filing. The Flesch-Kincaid grade level shall not exceed the tenth (10th) grade level or the Flesch Read Ease score shall not be less than fifty (50).

B. Carriers may choose either the Flesch-Kincaid grade level formula or the Flesch Read Ease formula to generate a readability score. However, once a formula has been selected from these two (2) formulas, the selected formula shall be used consistently for all text being scored for that particular policy form.

C. All policies, amendments, application forms, endorsements or riders, and other forms that are made a part of the policy by a carrier must either be scored as a separate form, or as part of the policy with which they will be used.

D. For the purposes of the readability score, amendments, application forms, endorsements or riders that are made part of the policy, evidence of coverage, or certificate of coverage, shall comply with the readability score. Cancellation notices, renewal notices, disclosure forms, and notices of reductions in coverage do not require a readability score.

E. Carriers shall provide all policy forms in a manner that is accessible and timely to individuals living with disabilities, or with limited English proficiency.

Section 9 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 10 Incorporated Materials

45 C.F.R. § 156.420 published by the Government Printing Office shall mean 45 C.F.R. § 156.420 as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.420. A copy of 45 C.F.R. § 156.420 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.420 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 11 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 12 Effective Date

This regulation shall become effective on August 30, 2023.

Section 13 History

Regulation effective October 1, 2013.
Revised regulation effective April 15, 2014.
Repealed and Re-promulgated regulation effective September 1, 2018.
Amended regulation effective August 30, 2023.

Appendix A - FORM HEALTH

COLORADO HEALTH COVERAGE CERTIFICATION FORM FOR LISTING OF NEW AND/OR REVISED POLICY FORMS

I, THE UNDERSIGNED OFFICER OF _____,
(Name of Entity)

AM KNOWLEDGEABLE OF HEALTH COVERAGES; HAVE CAREFULLY REVIEWED THE CONTENTS OF THE POLICY FORMS, APPLICATIONS, SUBSCRIPTION CERTIFICATES, MEMBERSHIP CERTIFICATES OR OTHER EVIDENCES OF HEALTH CARE COVERAGE IDENTIFIED ON THE FORM SCHEDULE TAB IN SERFF WHICH IS HEREBY FILED WITH THE COLORADO COMMISSIONER OF INSURANCE;

HAVE READ AND UNDERSTAND EACH OF THE APPLICABLE COLORADO LAWS, REGULATIONS, AND BULLETINS;

AM AWARE OF THE PENALTIES FOR CERTIFICATION OF A NONCOMPLYING FORM OR CONTRACT; AND

CERTIFY, TO THE BEST OF MY GOOD FAITH KNOWLEDGE AND BELIEF, THAT THE NEW POLICY FORMS, REVISED FORMS, APPLICATION FORMS (TO INCLUDE ANY HEALTH QUESTIONNAIRES USED AS PART OF THE APPLICATION PROCESS), ENDORSEMENTS AND RIDERS FOR ANY SICKNESS, ACCIDENT, AND/OR HEALTH INSURANCE POLICY, CONTRACT, CERTIFICATE, OR OTHER EVIDENCE OF COVERAGE ISSUED OR DELIVERED TO ANY POLICYHOLDER, CERTIFICATE HOLDER, ENROLLEE, SUBSCRIBER, OR MEMBER IN COLORADO PROVIDE ALL APPLICABLE MANDATED COVERAGES IDENTIFIED IN THE FORM SCHEDULE TAB IN SERFF AND ARE IN FULL COMPLIANCE WITH ALL COLORADO INSURANCE LAWS AND REGULATIONS, AND COPIES OF THE RATES AND THE CLASSIFICATION OF RISKS OR SUBSCRIBERS PERTAINING THERETO ARE FILED WITH THE COMMISSIONER.

_____ _____
(***Original*** Signature of Officer*) (Title of Officer*)

_____ _____
(Printed Name of Officer*) (Date)

** If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation must be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. Electronic signatures are not acceptable UNLESS provided through a signature verification provider such as VeriSign.*

FORM REVISED 6-14-2022

Appendix B - FORM HEALTH ANNUAL

COLORADO HEALTH COVERAGE CERTIFICATION FORM FOR ANNUAL REPORTS

I, THE UNDERSIGNED OFFICER OF _____,
(Name of Entity)

AM KNOWLEDGEABLE OF HEALTH COVERAGES; HAVE CAREFULLY REVIEWED THE CONTENTS OF THE POLICY FORMS, APPLICATION FORMS, SUBSCRIPTION CERTIFICATES, MEMBERSHIP CERTIFICATES OR OTHER EVIDENCES OF HEALTH CARE COVERAGE IDENTIFIED ON THE FORM SCHEDULE TAB IN SERFF WHICH IS HEREBY FILED WITH THE COLORADO COMMISSIONER OF INSURANCE;

HAVE READ AND UNDERSTAND EACH OF THE APPLICABLE COLORADO LAWS, REGULATIONS, AND BULLETINS;

AM AWARE OF THE PENALTIES FOR CERTIFICATION OF A NONCOMPLYING FORM; AND

CERTIFY, TO THE BEST OF MY GOOD FAITH KNOWLEDGE AND BELIEF, THAT FOR THE ANNUAL REPORT OF ALL POLICY FORMS (TO INCLUDE ANY HEALTH QUESTIONNAIRES USED AS PART OF THE APPLICATION PROCESS), ENDORSEMENTS OR RIDERS FOR ANY SICKNESS, ACCIDENT, LIMITED BENEFIT PLAN AND/OR HEALTH INSURANCE POLICY, CONTRACT, CERTIFICATE, OR OTHER EVIDENCE OF COVERAGE CURRENTLY IN USE AND ISSUED OR DELIVERED TO ANY POLICYHOLDER, CERTIFICATE HOLDER, ENROLLEE, SUBSCRIBER, OR MEMBER IN COLORADO, INCLUDING THE TITLES OF THE PROGRAMS OR PRODUCTS AFFECTED BY THE FORMS IDENTIFIED IN THE FORM SCHEDULE TAB IN SERFF, PROVIDE ALL APPLICABLE MANDATED COVERAGES AND ARE IN FULL COMPLIANCE WITH ALL COLORADO INSURANCE LAWS AND REGULATIONS, AND COPIES OF THE RATES AND THE CLASSIFICATION OF RISKS OR SUBSCRIBERS PERTAINING THERETO ARE FILED WITH THE COMMISSIONER.

_____ _____
(***Original*** Signature of Officer*) (Title of Officer*)

_____ _____
(Printed Name of Officer*) (Date)

** If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation must be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. Electronic signatures are not acceptable UNLESS provided through a signature verification provider such as VeriSign.*

FORM REVISED 6-14-2022

Regulation 4-2-42 CONCERNING ESSENTIAL HEALTH BENEFITS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109, 10-16-103.4 and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for the required inclusion of the essential health benefits in individual and small group health benefit plans in accordance with Article 16 of Title 10 of the Colorado Revised Statutes, and the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the "Affordable Care Act" (ACA).

Section 3 Applicability

This regulation shall apply to all carriers offering individual and small group health benefit plans subject to the individual and group laws of Colorado and the requirements of the ACA. The requirements of this regulation do not apply to grandfathered health benefit plans.

Section 4 Definitions

A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. "Essential health benefits" and "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.

C. "Essential health benefits package" shall have the same meaning as found at § 10-16-102(23), C.R.S.

D. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

E. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.

F. "Habilitative services" means, for the purposes of this regulation, services that help a person retain, learn or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's EHB benchmark plan.

G. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

Section 5 Essential Health Benefits

A. Carriers offering non-grandfathered individual and small group health benefit plans inside or outside of the Exchange must include the essential health benefits package.

1. Carriers must provide benefits that are substantially equal to Colorado's EHB-benchmark plan in the following thirteen (13) categories:

a. Ambulatory patient services, which must include, at a minimum:

(1) Primary care to treat an illness or injury;

(2) Specialist visits;

(3) Outpatient surgery;

(4) Chemotherapy services;

(5) Radiation therapy;

(6) Home infusion therapy;

(7) Home health care;

(8) Outpatient diagnostic laboratory, x-ray, and pathology services;

(9) Sterilization;

(10) Treatment of cleft palate and cleft lip conditions; and

(11) Oral anti-cancer medications.

b. Emergency services, which must include, at a minimum:

(1) Emergency room – facility and professional services;

(2) Ambulance services; and

(3) Urgent care treatment services.

c. Hospitalization services, which must include:

(1) Inpatient medical and surgical care;

(2) Organ and tissue transplants (transplants may be limited to specified organs);

(3) Chemotherapy services;

(4) Radiation services;

(5) Anesthesia services; and

(6) Hospice care.

d. Laboratory and radiology services, which must include:

(1) Laboratory tests, x-ray, and pathology services; and

(2) Imaging and diagnostics, such as MRIs, CT scans, and PET scans.

e. Maternity and newborn care services, including state and federally required benefits for hospital stays in connection with childbirth, which must include:

(1) Pre-natal and postnatal care;

(2) Delivery and inpatient maternity services; and

(3) Newborn well child care.

f. Behavioral health, mental health, and substance use disorder treatment services, which are provided in a manner no less extensive than the coverage provided for any physical illness, pursuant to § 10-16-104(5.5), C.R.S.

g. Pediatric services, which must include:

(1) Preventive care services;

(2) Immunizations;

(3) One (1) comprehensive routine eye exam per year, to age nineteen (19),

(4) Prescribed vision hardware, such as eyeglasses, lenses, or contact lenses, no less than one pair or one set every two (2) years for plans issued and renewed on or after January 1, 2017, to age nineteen (19);

(5) Routine hearing exams to age nineteen (19);

(6) Hearing aids to age eighteen (18), pursuant to § 10-16-104(19), C.R.S.; and

(7) Children's dental anesthesia, pursuant to § 10-16-104(12), C.R.S.

h. Prescription drugs, which must include:

(1) Retail services;

(2) Mail services (home delivery);

(3) All contraceptive methods approved by the Food and Drug Administration (FDA); and

(4) To meet the EHB requirement for prescription drug benefits, carriers must offer coverage that includes at least the greater of:

(a) One (1) drug in every United States Pharmacopeia (USP) category and class; or

(b) The same number of prescription drugs in each category and class as the EHB-benchmark plan.

i. All preventive services required by state and/or federal mandate, which are not subject to deductibles, copayments, or coinsurance, include, but are not limited to:

(1) Services related to contraception, including, but not limited to FDA-approved methods, and including the services related to follow-up and management of side effects, counseling for continued adherence, and device removal; and

(2) Age-appropriate immunizations and vaccines for children, adolescents, and adults in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP).

(3) Mental health wellness exam, at least one (1) visit per year for plans issued and renewed on or after January 1, 2023.

j. Rehabilitative and habilitative services and devices, which must include:

(1) No less than twenty (20) visits per calendar year, per therapy, for physical, speech, and occupational therapy for:

(a) Habilitative services; and

(b) Rehabilitative services.

Habilitative and rehabilitative service visits are cumulative, such that a carrier must provide, at a minimum, no less than sixty (60) visits for habilitative services, and no less than sixty (60) visits for rehabilitative services per calendar year.

(2) Cardiac rehabilitation services;

(3) Pulmonary rehabilitation services;

(4) Durable medical equipment;

(5) Arm and leg prosthetics;

(6) Inpatient and outpatient habilitative services;

(7) No less than one hundred (100) days of skilled nursing services annually;

(8) No less than two (2) months of inpatient rehabilitation annually, and no less than sixty (60) days;

(9) Autism spectrum disorder services; and

(10) Physical, occupational, and speech therapy for congenital defects for children up to age six (6), as required by § 10-16-104(1.7), C.R.S.

k. Medically necessary bariatric surgery services, for plans issued and renewed on or after January 1, 2017.

l. Infertility services, for plans issued and renewed on or after January 1, 2017, which must include:

(1) X-ray and laboratory procedures;

(2) Services for diagnosis and treatment of involuntary infertility; and

(3) Artificial insemination.

m. Chiropractic care, up to twenty (20) visits per year, at a minimum, for plans issued and renewed on or after January 1, 2017, which must include:

(1) Diagnosis and evaluation; and

(2) Medically necessary lab and x-ray services required for chiropractic services and musculoskeletal disorders.

n. Acupuncture care, up to six (6) visits per year, at a minimum, for plans issued and renewed on or after January 1, 2023.

o. Medically necessary gender affirming care for gender dysphoria, for plans issued and renewed on or after January 1, 2023, which must include:

(1) Hormone therapy;

(2) Genital and non-genital surgical procedures;

(3) Blepharoplasty (eye and lid modification);

(4) Face/forehead and/or neck tightening;

(5) Facial bone remodeling for facial feminization;

(6) Genioplasty (chin width reduction);

(7) Rhytidectomy (cheek, chin, and neck);

(8) Cheek, chin, nose implants;

(9) Lip lift/augmentation;

(10) Mandibular angle augmentation/creation/reduction (jaw);

(11) Orbital recontouring;

(12) Rhinoplasty (nose reshaping);

(13) Laser or electrolysis hair removal; and

(14) Breast/Chest augmentation, reduction, construction.

2. Carriers seeking to include pediatric dental EHB coverage within a health benefit plan, or carriers offering a stand-alone pediatric dental plan that meets EHB requirements, must include the following eligible services, subject to plan benefit limitations, in order to meet the EHB requirements for pediatric dental coverage:

a. Diagnostic and preventive procedures, which must include:

(1) Oral exams and evaluations;

(2) Full mouth, intra-oral, and panoramic x-rays;

(3) Bitewing x-rays;

(4) Routine cleanings;

(5) Fluoride treatments;

(6) Space maintainers;

(7) Sealants; and

(8) Palliative treatment.

b. Basic restorative services, which must include:

(1) Amalgam fillings;

(2) Resin and composite filings;

(3) Crowns;

(4) Pin retention; and

(5) Sedative fillings.

c. Oral surgery, consisting of extractions.

d. Endodontics, consisting of:

(1) Surgical services; and

(2) Root canal therapy.

e. Medically necessary orthodontia and medically necessary prosthodontics for the treatment of cleft lip and cleft palate.

f. Implants, denture repair and realignment, dentures and bridges, non-medically necessary orthodontia, and periodontics are not considered a part of the pediatric dental EHB.

3. Benefits that are excluded from EHB, even though they may be covered by the EHB-benchmark plan, include:

a. Routine non-pediatric dental services;

b. Routine non-pediatric eye exam services;

c. Long-term/custodial nursing home care benefits; and

d. Non-medically necessary orthodontia.

4. Although the EHB-benchmark plan provides coverage for abortion services, no health benefit plan must cover such services as part of the requirement to cover EHB.

5. Carriers offering stand-alone non-pediatric dental plans that are offered in conjunction with a health benefit plan, or are offered as a stand-alone policy, need not comply with the requirements of Section 5.A.2. of this regulation.

6. Carrier compliance with the provision of EHBs shall include coverage of behavioral, mental health and substance use disorders that is in compliance with §§ 10-16-102(43.5) and 10-16-104(5.5), C.R.S., and all Colorado insurance regulations concerning mental health parity.

C. Drug/Formulary Review

Carriers must submit their formularies to the Division annually, by June 30 of each year. If a formulary changes by more than five percent (5%) in a calendar year, the carrier must submit a filing to the Division supporting that its formulary has the required number of drugs in each category to comply with the EHB requirement.

Section 6 Incorporation by Reference

The age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices, as published by the Advisory Committee on Immunization Practices shall mean age-appropriate immunization and vaccine schedules as published on the effective date of this regulation and do not include later amendments to, or editions of, the age-appropriate immunization and vaccine schedules. The age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Advisory Committee on Immunization Practices website at http://www.cdc.gov/vaccines/schedules/hcp/index.html. Certified copies of the age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices are available from the Colorado Division of Insurance for a fee.

Colorado's EHB benchmark plan shall mean Colorado's EHB benchmark plan, as published on the effective date of this regulation and does not include later amendments to, or editions of, Colorado's EHB benchmark plan. Colorado's EHB benchmark plan may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Division of Insurance website at https://www.colorado.gov/pacific/dora/node/100216. Certified copies of Colorado's EHB benchmark plan are available from the Colorado Division of Insurance for a fee.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date t

This regulation shall become effective on June 30, 2022.

Section 10 History

Regulation effective October 1, 2013.
Amended regulation effective March 15, 2015.
Amended regulation effective April 1, 2016.
Amended regulation effective November 1, 2016.
Amended regulation effective January 1, 2020.
Amended regulation effective June 30, 2022.

Regulation 4-2-43 ENROLLMENT PERIODS RELATING TO INDIVIDUAL AND GROUP HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-105(2)(b), 10-16-105.7(1)(e), 10-16-105.7(3)(a)(II)(G), 10-16-105.7(3)(b)(II)(F), 10-16-105.7(3)(c), 10-16-108.5(8), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules governing enrollment periods for individual and group health benefit plans in accordance with Article 16 of Title 10 of Colorado Revised Statutes and the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the "Affordable Care Act" (ACA).

Section 3 Applicability

This regulation shall apply to all carriers offering individual and/or group health benefit plans subject to the individual and/or group laws of Colorado and the requirements of the ACA.

Section 4 Definitions

A. "Calendar year" means, for the purpose of this regulation, a year beginning on January 1 and ending on December 31.

B. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. "Creditable coverage" shall have the same meaning as found at § 10-16-102(16), C.R.S.

D. "Days" mean, for the purpose of this regulation, calendar days, not business days.

E. "Designated beneficiary agreement" shall have the same meaning as found at § 15-22-103(2), C.R.S.

F. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

G. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

H. "Provider" shall have the same meaning as found at § 10-16-102(56), C.R.S.

I. "Qualified health plan" or "QHP" means, for the purposes of this regulation, a health benefit plan that has been reviewed and approved by the Division of Insurance as meeting the standards necessary to be considered an ACA-compliant health benefit plan.

J. "Qualified individual" means, for the purpose of this regulation, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

K. "Short-term limited duration health insurance policy" or "short-term policy" shall have the same meaning as found at § 10-16-102(60), C.R.S.

Section 5 Individual Enrollment Periods

A. Carriers offering individual health benefit plans must accept every eligible individual who applies for coverage, agrees to make the required premium payments, and to abide by the reasonable provisions of the plan, although carriers may choose to restrict enrollment to open or special enrollment periods.

B. Carriers offering individual health benefit plans must display continuously and prominently on their website:

1. Notice of open enrollment dates;

2. Notice of special enrollment for qualifying and triggering events;

3. Notice of the enrollment periods for each qualifying and triggering event; and

4. Instructions on how to enroll.

C. Open enrollment periods.

1. Pursuant to 45 C.F.R. § 155.410(e)(4)(i), the open enrollment period for plans effective on or after January 1 shall begin on November 1 of the prior year and extend through January 15 of the immediately following year.

2 Carriers must ensure that coverage is effective on January 1 for health benefit plans purchased on or before December 15 of the open enrollment period.

3. Individual health benefit plans purchased beginning December 16 through January 15 shall be effective no later than February 1 of the plan year.

4. The benefit year for individual health benefit plans purchased during the annual open enrollment period is a calendar year.

5. During open enrollment periods, carriers must offer guarantee-issue child-only health benefit plans to all applicants under the age of 21.

D. Special enrollment periods.

Carriers must establish special enrollment periods for individuals who experience triggering events, pursuant to § 10-16-105.7, C.R.S.

1. Following a triggering event, a carrier must provide a special enrollment period of sixty (60) days, except for individuals under Section 5.D.4.h.9 who will have a special enrollment period of up to twenty (20) months, beginning on April 1, 2023 through November 30, 2024.

2. When an individual is notified or becomes aware of a triggering event that will occur in the future, they may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the date of the triggering event, unless otherwise noted in Section 5.D.4., with coverage beginning no earlier than the day the triggering event occurs, to avoid a gap in coverage. The individual may be required to provide written documentation to support the date of the triggering event. The effective date of this enrollment must comply with the coverage effective dates found in Section 5.D.6. of this regulation.

3. When a qualified individual is notified or becomes aware of a triggering event that will occur in the future, they may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the date of the triggering event, with coverage beginning no earlier than the day the triggering event occurs, to avoid a gap in coverage. The individual may be required to provide written documentation to support the date of the triggering event. The effective date of this enrollment must comply with the coverage effective dates found in Section 5.D.6. of this regulation.

4. Triggering events are:

    a. An individual or their dependent involuntarily losing existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a premium. Such individual or dependent may apply for enrollment in a new health benefit plan during the sixty (60) calendar days before or after the effective date of the loss of coverage. Dependent coverage cannot be terminated, on the basis of age, before the end of the plan year in which the dependent attains age 26;

    b. An individual or their dependent loses pregnancy-related Medicaid coverage. The date of the loss of coverage is the last day the consumer would have pregnancy-related Medicaid coverage;

    c. When an Exchange enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the Exchange enrollee, or their dependent, dies;

    d. An individual or their dependent losing other coverage as described under Section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. § 301 et seq.). Such individual or dependent may apply once during a calendar year for enrollment in a new health benefit plan during the sixty (60) calendar days before and after the effective date of the loss of coverage;

    e. An individual gaining a dependent or becoming a dependent through marriage, civil union, birth, adoption, or placement for adoption, placement in foster care, through a child support order or other court order, or by entering into a designated beneficiary agreement if the carrier offers coverage to designated beneficiaries;

    f. An individual's or their dependent's enrollment or non-enrollment in a health benefit plan that is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or the Exchange;

    g. An individual or their dependent demonstrating to the Commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual or their dependent;

    h. A qualified individual who:

(1) Becomes newly eligible, or an Exchange enrollee who is newly eligible or ineligible, for the federal advance premium tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange;

(2) Has a dependent enrolled in the same qualified health plan who is determined to be newly eligible or ineligible for the federal advance premium tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange;

(3) Becomes newly eligible, or their dependent becomes newly eligible, for enrollment in a QHP through the Exchange because they have been released from incarceration;

(4) Was previously ineligible for federal premium tax credit solely because of a household income below one hundred percent (100%) of the Federal Poverty Level and who, during the same timeframe, was ineligible for Medicaid because they were living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the qualified individual becoming newly eligible for advance payments of the federal premium tax credit;

(5) Is enrolled, or has a dependent enrolled, in an eligible employer-sponsored plan and is determined to be newly eligible for the federal advance premium tax credit based in part on a finding that such individual is ineligible for coverage in an eligible employer-sponsored plan that provides minimum creditable coverage, including as a result of their employer discontinuing or changing coverage within the next sixty (60) days, provided the enrollee is able to terminate their existing coverage. This enrollee may apply for enrollment in a new health benefit plan during the sixty (60) calendar days before and after the effective date of the loss of coverage;

(6) Is found eligible for financial assistance for health coverage by Connect for Health Colorado, having indicated by the tax deadline on a Colorado Individual Income Tax Form that they are interested in learning more about free or reduced health coverage.

(7) Did not receive timely notice of an event that triggers eligibility for a special enrollment period, and otherwise was reasonably unaware that a triggering event described in Section 5.D.4 occurred, the Exchange must allow the individual, their dependent to select a new plan within sixty (60) days of the date that they knew, or reasonably should have known, of the occurrence of the triggering event; or

(8) Becomes eligible, or their dependent becomes eligible for the federal advance premium tax credit and whose household income is expected to be no greater than 150 percent of the federal poverty level, may enroll in a QHP or change from one QHP to another one time per month.

(9) Beginning April 1, 2023 through November 30, 2024, becomes ineligible under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101, et seq., C.R.S.) or a dependent becomes ineligible under the Child Health Plan Plus (CHP+) due to the provisions of the Consolidated Appropriations Act, 2023, Pub. L. No. 117-164.

i. An individual or their dependent gaining access to other creditable coverage as a result of a permanent change in residence;

j. A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Child Health Plan Plus (CHP+);

k. An individual becoming ineligible under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.);

l. An individual, who was not previously a citizen, a national, or a lawfully present individual, gaining such status;

m An Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq.), or their dependent on the same application, may enroll in a qualified health plan or change from one qualified health plan to another one (1) time per month;

n. An individual or their dependent currently enrolled in an individual or group non-calendar year health benefit plan may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the effective date of the involuntary loss of coverage, which is the last day of the plan or policy year, or the sixty (60) calendar days after the effective date of the involuntary loss of coverage;

o. An individual who is a victim of domestic abuse or spousal abandonment, as defined by 26 C.F.R. § 1.36B-2(b)(2), including a dependent or unmarried victim within a household, who is enrolled in creditable coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment;

p. An individual who is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

q. An individual or their dependent who applies for coverage during the annual open enrollment period or due to a triggering event, and is assessed as potentially eligible for Medicaid or the Child Health Plan Plus (CHP+), and is determined ineligible for Medicaid or CHP+ either after open enrollment has ended or more than sixty (60) days after the triggering or qualifying event, or applies for coverage through a State Medicaid or CHP+ agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHP+ after open enrollment has ended;

r. An individual, or their dependent, who has purchased an off-Exchange plan, adequately demonstrates to the Commissioner that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP, including adequate demonstration by other individuals for the benefit of the individual or their dependent;

s. An individual, or their dependent, who has purchased an on-Exchange plan, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP, including adequate demonstration by other individuals for the benefit of the individual or their dependent;

t. An individual, or their dependent, adequately demonstrates to the Exchange, in accordance with 45 C.F.R. § 155.420(d)(9), that the individual meets other exceptional circumstances as the Exchange may provide;

u. An individual who has purchased a short-term limited duration health insurance policy in the past twelve (12) months and is unable, at the end of their policy term, to purchase another short-term policy from the same carrier due to that short-term policy carrier ceasing its sales of all short-term policies in Colorado on or after April 1, 2019. Such individuals may apply for enrollment in a new individual health benefit plan in accordance with Section 5.D.1. and 2. of this regulation, or during the sixty (60) calendar days after the effective date of this regulation; or

v. In the event, an individual, or their dependent, is enrolled in COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the qualified individual's or dependent's COBRA continuation coverage or government subsidies completely cease. The triggering event is the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.

w. Beginning January 1, 2024, an individual who does not have existing credible coverage receives written certification from a provider acting within the provider's scope of practice that the individual is pregnant.

x. An individual becomes eligible, or their dependent becomes eligible for financial assistance and whose household income is expected to be no greater than 150 percent of the federal poverty level can enroll at any month.

5. Special Enrollment Period Eligibility Verification and Prior Coverage Requirements

a. Carriers may establish a special enrollment period eligibility verification process to confirm that an individual applying for coverage through a special enrollment period is eligible for the requested special enrollment period. Carriers may delay the processing of an application or any enrollment documents or premium payments until after completion of verification of eligibility for the requested special enrollment period.

(1) For special enrollment period eligibility verification, carriers shall make the list of required documentation, relevant premium payment information, and the verification process and deadlines available on their website in a conspicuous manner, and encourage individuals to provide the required documentation with their request for a special enrollment.

(2) A carrier shall notify the applicant within fourteen (14) days of receipt of the application if the applicant did not provide sufficient documentation necessary to verify eligibility for the special enrollment period requested. The notice shall include information that a failure to provide the documentation will result in a denial of enrollment, and that coverage will not be issued until the required documentation confirming eligibility for the special enrollment period has been received.

(3) Individuals shall have no less than thirty (30) days from the date of the insufficient documentation notice to provide a carrier with sufficient documentation to establish eligibility for the requested special enrollment period.

(4) Carriers must make a verification determination within fourteen (14) days of receiving sufficient documentation in order to make an eligibility determination. If the verification determination is not made within the fourteen (14) day period, the individual shall be deemed verified and coverage shall be issued.

(5) A carrier must provide written notice to the individual of the outcome of the verification determination.

(6) The carrier may retroactively terminate or cancel an individual's enrollment if the carrier determines that the individual committed fraud or intentionally misrepresented their eligibility for a special enrollment period.

(7) A carrier is not required to provide thirty (30) days notice prior to denying, terminating, or cancelling an individual determined not to be eligible for a special enrollment period.

(8) A carrier shall notify an individual determined ineligible for a special enrollment period for an on-Exchange plan that they may appeal that decision with the Exchange, and the carrier shall respond to documentation requests from the Exchange concerning an appeal within seven (7) days of receiving that request.

(9) A carrier shall notify an individual determined ineligible for a special enrollment period for an off-Exchange plan that they may appeal that decision with the carrier and that they may appeal a carrier's final determination to the Division once the carrier's internal appeal process has been completed.

b. A carrier shall provide written confirmation of an individual's loss of creditable coverage to that individual within ten (10) business days of receiving such a request. The written confirmation must include the date of the loss of coverage and the reason for the loss of coverage.

c. The following documents shall constitute proof of a triggering event and sufficient documentation of eligibility for a special enrollment period:

(1) Evidence of gaining or becoming a dependent shall be considered sufficient if the individual produces one of the following documents:

(a) A marriage license, civil union certificate or common law documentation, if the gaining or becoming a dependent occurs due to marriage or civil union;

(b) A birth certificate, adoption documents, or foster care documents, if the gaining or becoming a dependent occurs due to birth, adoption, placement for adoption, or placement in foster care; or

(c) A court order or designated beneficiary documents, if the gaining or becoming a dependent occurs due to a court order.

(2) Evidence of losing a dependent or no longer being considered a dependent shall be considered sufficient if the individual produces:

(a) A copy of the death certificate or the obituary.

(b) Copies of the final divorce or separation documents.

(c) Proof of age and evidence of loss of creditable coverage when an individual turns 26 and loses coverage under a parent's health benefit plan at the end of the plan year.

(3) Evidence of a change in citizenship or immigration status shall be considered sufficient if the individual produces official documentation of the change.

(4) The following triggering events shall be confirmed by self-attestation:

(a) Evidence of an involuntary loss of credible coverage;

(b) Evidence of a permanent change in residence;

(c) Evidence of a material violation of a carrier's contract confirming eligibility for a special enrollment from the Division;

(d) Evidence of a status as American Indian/Native American; or

(e) Evidence of the termination of a short-term policy with an expiration date on or after April 1, 2019, that indicates that the carrier has exited the market, which includes, but is not limited to, written communication from the carrier or from a broker; or

(f) Evidence of the cessation of subsidies for COBRA or state continuation coverage.

(5) Evidence of pregnancy shall be considered sufficient if the individual provides written certification from a provider acting within the provider's scope of practice that the individual is pregnant.

(6) Any other documentation reasonably sufficient to verify eligibility for the special enrollment period requested.

d. Individuals eligible for a special enrollment period under Section 5.D.4.h.9. shall attest that they are currently not enrolled in a health benefit plan. Verbal attestation is sufficient for purposes of determining eligibility for this special enrollment period. Carriers shall not require additional verification or attestation beyond the eligibility and enrollment information provided by the Exchange. Carriers shall not require written documentation for verification of this special enrollment period and may waive the verbal attestation requirement.

e. Prior coverage requirements.

(1) For special enrollment period requests due to marriage or civil union, carriers may require that at least one individual demonstrate that they possessed minimum essential coverage for at least one (1) or more days during the sixty (60) days immediately preceding the date of the special enrollment period triggering event.

(2) For special enrollment period requests due to a permanent move, the requesting individual must demonstrate that they possessed minimum essential coverage for at least one (1) or more days during the sixty (60) days immediately preceding the date of the permanent move.

(3) If the requesting individual is unable to demonstrate that they possessed minimum essential coverage, carriers may require the requesting individual to demonstrate:

(a) They lived outside of the United States or in a United States territory for one (1) or more days during the sixty (60) days immediately preceding the date of the special enrollment period triggering event;

(b) They are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act; or

(c) They lived for one (1) or more days during the sixty (60) days preceding the qualifying event or during his or her most recent preceding enrollment period in a service area where no qualified health plan was available through the Exchange.

f. The special enrollment period eligibility verification requirements do not apply to the special enrollment period found in Section 5.D.4.h.6.

6. Coverage effective dates will be:

a. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage must be effective on either:

(1) The date of the event; or

(2) The first day of the month following the birth, adoption, placement for adoption, or placement in foster care, if requested by the primary individual policyholder.

b. In the case of an involuntary loss of existing creditable coverage in accordance with Section 5.D.4.a. of this regulation, coverage shall become effective either:

(1) On the first day of the month following the triggering event if plan selection is made on or before the effective date of the triggering event;

(2) In accordance with the effective dates specified in Section 5.D.6.g of this regulation if a plan selection is made after the effective date of the triggering event; or

(3) At the option of the Exchange, on the first day of the month following plan selection when plan selection is made after a triggering event.

c. In the case of gaining a dependent or becoming a dependent through a court order, coverage shall become effective either:

(1) On the date the court order is effective; or

(2) In accordance with the effective dates specified in Section 5.D.6.g of this regulation at the election of the primary individual policyholder.

d. The effective date of coverage for triggering events found in Section 5.D.4.f. and g. of this regulation must be an appropriate date based upon the circumstances of the special enrollment period.

e. Beginning January 1, 2024, the effective date of coverage for individuals who are pregnant is the first day of the month in which the individual receives written certification of the pregnancy, unless the individual elects to have coverage effective on the first day of the month following the date that the individual makes a plan selection.

f. Beginning April 1, 2023 through November 30, 2024, the effective date of coverage for individuals who qualify under Section 5.D.4.h.9. is no later than the first day of the month following plan selection.

g. In the case of all other triggering events where individual coverage is selected, coverage shall become effective no later than the first day of the following month.

Section 6 Group Enrollment Periods

A. Carriers that offer small group health benefit plans must guarantee-issue small group health benefit plans throughout the year to any eligible small group that applies for a plan, agrees to make the required premium payments, and abide by the reasonable provisions of the plan, except as noted below.

B. Special enrollment periods for small employers.

1. For small employers that are unable to comply with employer contribution or group participation rules at the time of initial application, carriers may limit the availability of coverage to a special enrollment period that begins on November 15 and ends on December 15 of each year.

2. Coverage must be effective consistent with the dates listed below, unless the initial premium payment is not received by the carrier's cut-off date.

a. Carriers cannot establish a waiting period of more than ninety (90) days.

b. If a fully completed application that includes plan selection is received by the carrier, the first effective day of the health benefit plan will be no later than the first day of the following month.

C. Special enrollment periods for employees of small and large employer group plans.

1. Carriers must establish special enrollment periods in the group health benefit plan for individuals who experience any of the following qualifying events pursuant to § 10-16-105.7(3)(b)(II), C.R.S.:

a. Loss of coverage due to:

(1) The death of a covered employee;

(2) The termination or reduction in the number of hours of the employee's employment;

(3) The covered employee becoming eligible for benefits under Title XVIII of the Federal Social Security Act (42 U.S.C. § 301 et seq.); or

(4) The divorce or legal separation from the covered employee's spouse or partner in a civil union.

b. Becoming a dependent through marriage, civil union, birth, adoption, or placement for adoption, or placement in foster care;

c. Becoming a dependent of a covered person by entering into a designated beneficiary agreement, or pursuant to a court or administrative order mandating that the individual be covered;

d. Losing other creditable coverage due to:

(1) Termination of employment or eligibility for coverage, regardless of eligibility for COBRA or state continuation;

(2) A reduction in the number of hours of employment;

(3) Involuntary termination of coverage; or

(4) Reduction or elimination of his or her employer's contributions toward the coverage.

e. Losing coverage under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.) and then requesting coverage under an employer's group health benefit plan within sixty (60) days of the loss of coverage;

f. An employee or dependent becoming eligible for premium assistance under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.) or the Child Health Plan Plus (CHP+); or

g. A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Child Health Plan Plus (CHP+), and the parent or legal guardian requests enrollment of the dependent in a health benefit plan within sixty (60) days of the disenrollment or determination of ineligibility.

2. Individuals in the group market shall have a thirty (30) day special enrollment period that begins on the date the qualifying event occurs, except as provided in Section 6.C.1.e, and g. of this regulation, which provide a sixty (60) day special enrollment period.

3. When an individual in the group market is notified or becomes aware of a qualifying event that will occur in the future, they may apply for coverage during the thirty (30) calendar days prior to the effective date of the qualifying event, with coverage beginning no earlier than the day the qualifying event occurs to avoid a gap in coverage. The individual must be able to provide written documentation to support the effective date of the qualifying event at the time of enrollment. The effective date of this enrollment must comply with the coverage effective dates found in Section 6.C.4. of this regulation.

4. Coverage effective dates.

   a. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage must be effective on the date of the event.

   b. In the case of marriage, civil union, or other qualifying events, coverage must be effective no later than the first day of the following month after the date the Exchange or the carrier receives a completed enrollment form.

5. An individual, beginning April 1, 2023 through November 30 2024, becomes ineligible under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101, et seq., C.R.S.) or a dependent becomes ineligible under the Child Health Plan Plus (CHP+) due to the provisions of the Consolidated Appropriations Act, 2023, Pub. L. No. 117-164.

D. For small employer group plans, dependent coverage cannot be terminated, on the basis of age, before the end of the plan year in which the dependent attains age 26.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Incorporated materials

26 C.F.R. §1.36B-2(b)(2), published by Government Printing Office shall mean 26 C.F.R. § 1.36B-2(b)(2) as published on the effective date of this regulation and does not include later amendments to or editions of 26 C.F.R. § 1.36B-2(b)(2). A copy of 26 C.F.R. § 1.36B-2(b)(2) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 26 C.F.R. § 1.36B-2(b)(2) may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 155.410(e)(4)(i) published by Government Printing Office shall mean 45 C.F.R. § 155.410(e)(4)(i) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 155.410(e)(4)(i). A copy of 45 C.F.R. § 155.410(e)(4)(i) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 45 C.F.R. § 155.410(e)(4)(i) may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 155.420(d)(9), published by Government Printing Office shall mean 45 C.F.R. § 155.420(d)(9) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 155.420(d)(9). A copy of 45 C.F.R. § 155.420(d)(9) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 45 C.F.R. § 155.420(d)(9) may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at www.ecfr.gov.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

This regulation shall become effective on July 30, 2024.

Section 11 History

Emergency regulation 13-E-13 effective October, 31, 2013.
Regulation effective February 1, 2014.
Amended regulation effective August 15, 2014.
Amended regulation effective November 1, 2015.
Emergency regulation 17-E-01 effective August 1, 2017.
Amended regulation effective December 1, 2017.
Emergency regulation 18-E-04 effective September 5, 2018.
Amended regulation effective January 1, 2019.
Amended regulation effective September 1, 2019.
Amended regulation effective January 15, 2022.
Amended regulation effective June 1, 2023.
Amended regulation effective January 1, 2024.
Amended regulation effective July 30, 2024.

Regulation 4-2-44 [Repealed eff. 01/01/2016]

Regulation 4-2-45 UNIFORM INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLAN APPLICATIONS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-107.5(1), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to promulgate rules concerning the uniform individual and small group health benefit plan applications.

Section 3 Applicability

This regulation applies to all carriers offering individual and small group health benefit plans that are subject to Colorado insurance laws accepting applications for coverage on or after January 1, 2025. This includes carriers offering coverage under Parts 2, 3, and 4 of Article 16 of Title 10 of the Colorado Revised Statutes.

Section 4 Definitions

A. “Exchange” shall have the same meaning as found at § 10-16-102(26), C.R.S.

B. “Uniform Individual Application” means, for purposes of this regulation, the individual application developed and published by the Division of Insurance (Division) for use by carriers in collecting information from an applicant to determine what plans are appropriate for the applicant to consider.

C. “Uniform Small Group Application” means, for purposes of this regulation, the small group application developed and published by the Division of Insurance (Division) for use by carriers in collecting information from employees to determine what plans are appropriate for the employee to consider.

Section 5 Rules

A. Carriers must comply with the following requirements concerning electronic and non-electronic applications:

1. All carriers offering individual health benefit plans outside of the Exchange must use the Uniform Individual Application when collecting enrollment information from consumers. The Uniform Individual Application can be found in Appendix A of this regulation.

2. All carriers offering individual health benefit plans within the Exchange will use the Uniform Individual Application for the non-electronic collection of enrollment information from consumers.

3. All carriers offering small group health benefit plans must use the Uniform Small Group Application when collecting enrollment information from employees and their dependents.

   a. This application will be utilized by the Exchange as the non-electronic enrollment application for small group employees in the Small Business Health Options Program (SHOP).

   b. The Uniform Small Group Application can be found in Appendix B of this regulation.

4. Carriers may not alter, modify, or change the uniform applications developed by the Division.

5. Carriers may not add logos or other graphics or text to the uniform applications except where designated on the uniform applications found in Appendix A and Appendix B.

6. A carrier shall not deny an application for a health benefit plan solely on the basis of an applicant electing to not provide a Social Security Number, Tax Identification Number, or Alternative Identification Number.

B. The Exchange may require additional information, through the use of an electronic application or a supplemental questionnaire, to collect information to comply with federal law for on-Exchange products.

C. Carriers shall make electronic and non-electronic applications available in Spanish.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective on January 1, 2025.

Section 9 History

New regulation effective October 15, 2013.
Amended regulation effective November 1, 2020.
Amended regulation effective November 1, 2021.
Amended regulation effective January 1, 2025.

Appendix A

[CARRIER LOGO]

COLORADO UNIFORM **INDIVIDUAL** APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.connectforhealthco.com.

COVERAGE INFORMATION					
Application Type: (check all that apply)	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*				
Is the applicant purchasing this plan using a reimbursement arrangement (if applicable):	☐ Yes ☐ No	If so, what type:	☐ HRA	☐ ICHRA	☐ QSEHRA
Special Enrollment Period Qualifying event: ☐ Loss of Coverage ☐ Birth/Adoption/Placement for Adoption ☐ Marriage ☐ Other:_____ Date of Event:_____					
Requested Effective Date:	_____/_____/_____(MM/DD/YYYY)				

* Proof of eligibility for special enrollment will be required – information available on the DOI website at: https://www.colorado.gov/pacific/dora/division-insurance

PRIMARY APPLICANT/INSURED INFORMATION					
Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.					
First Name:		Middle Initial:		Last Name:	
SSN/TIN/ALT ID #: (Optional)		Date of Birth:	/ /	Current Age:	Gender: ☐ M ☐ F ☐ X
SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out this field shall not be a reason to deny an application for coverage.					
Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different, can be P.O. Box):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	
Are you (check one): ☐ Single ☐ Married ☐ Common Law ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Under 21					
Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No This question is being asked as American Indians and Alaskan Natives have an enhanced ability to enroll in health benefit plans.					
Tell us about your race. *This information is confidential and will only be used to help us improve service to all Coloradans. We use this information to make sure everyone gets fair access to coverage. Providing this information will not impact eligibility, plan options, or costs.*					
What is your race? (Select all that apply) *(optional)* ☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American ☐ Hispanic/Latino ☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ White/European ☐ Not Listed or Other: _____ ☐ Prefer not to answer					

ADDITIONAL APPLICANTS					
Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26 (older if medically disabled) are applying for coverage. If a dependent child is applying as an individual rather than as part of a family, list the child as the primary applicant. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet. SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out that field shall not be a reason to deny an application for coverage.					
Name (First, MI, Last)	SSN/TIN/ALT ID #:	Gender	Relationship	Disability Y/N	Birth Date (MM/DD/YY)
		☐ M ☐ F ☐ X	SPOUSE/PARTNER	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	

		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (If no, complete below)

Child(ren)'s Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 and different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."
Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

MEDICARE/MEDICAID INFORMATION		
Is any applicant enrolled in Medicare?	☐ Yes	☐ No
Name of person covered by Medicare: _____. **For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.**		
Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program?	☐ Yes	☐ No
Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect which coverage is primary and/or applicant's eligibility for APTC.		

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐ Yes ☐ No

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this application is accepted? ☐ Yes ☐ No

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain:_____

CERTIFICATION OF DENTAL INSURANCE COVERAGE Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado or for consumers without children under the age of nineteen (19)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required to provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐ Yes ☐ No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:
Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print):	Name (print):
Agent ID # (NPN):	Agent ID #(NPN):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐ Yes ☐ No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	Date

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://doi.colorado.gov. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Primary Applicant: _____ Date Signed: _____

Appendix B

COLORADO UNIFORM EMPLOYEE APPLICATION FOR **SMALL GROUP** HEALTH BENEFIT PLANS

This form is designed for an employee's initial application for coverage. Please contact your agent or the carrier to determine if this form should be used in other situations once the group is enrolled with the carrier.

COVERAGE INFORMATION				
Application Type:	☐ New Coverage	☐ Change/Modification to Existing Policy	☐ Open Enrollment	☐ Special Enrollment*
Special Enrollment Period Qualifying event: ☐ Loss of Coverage ☐ Birth/Adoption/Placement for Adoption ☐ Marriage ☐ Other:_____ Date of Event:_____				

* Proof of eligibility for special enrollment will be required – information on special enrollment periods is available at: https://www.colorado.gov/pacific/dora/division-insurance

EMPLOYER INFORMATION			
Employee Name:		Employer Name:	
Proposed Effective Date:		Group Number (if known):	

EMPLOYEE INFORMATION					
Employee Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.					
First Name:		Middle Initial:		Last Name:	
SSN/TIN/ALT ID #: Not filing out this field shall not be a reason to deny an application for coverage		Date of Birth:	/ /	Current Age:	Gender: ☐ M ☐ F ☐ X
Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different, can be P.O. Box):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	Home / Work
First day of employment?		How many hours, on average, do you work each week?		Work Phone:	
Are you (check one): ☐ Single ☐ Married ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Designated Beneficiary ☐ Widow/Widower ☐ Common Law ☐ Designated Beneficiary - A common law or designated beneficiary certification may be required by the carrier					
Are you on COBRA or State Continuation?	☐ Yes	☐ No	Start Date:		Stop Date:

It should be noted that American Indians and Alaskan Natives have an enhanced ability to enroll in individual health benefit plans under the Affordable Care Act.

Tell us about your race. *This information is confidential and will only be used to help us improve service to all Coloradans. We use this information to make sure everyone gets fair access to coverage. Providing this information will not impact eligibility, plan options, or costs.*

What is your race? (Select all that apply) *(optional)*

☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American ☐ Hispanic/Latino ☐ Middle Eastern/North African
☐ Native Hawaiian/Pacific Islander ☐ White/European ☐ Not Listed or Other: _____ ☐ Prefer not to answer

TYPE OF HEALTH COVERAGE

List all dependents (spouse/partner and child(ren)) applying for coverage. If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).

Please select the type of health insurance coverage for which you are applying:	☐ Employee Only	☐ Employee & Spouse	☐ Employee & Child	☐ Employee & Family

Name of plan selected: _____

Dependent Information- List all dependents to be covered					
Name (First, MI, Last)	SSN/TIN/ALT ID # (can leave blank):	Gender	Relationship	Disability Y/N	Birth Date (MM/DD/YY)
		☐ M ☐ F ☐ X	SPOUSE/PARTNER	☐ Yes ☐ No	

		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	

Employee Name:	Employer Name:

TOBACCO USE	
Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used." Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.	
Name of Person	Used Tobacco Products
	☐ Yes ☐ No
	☐ Yes ☐ No

EMPLOYEE/DEPENDENT WAIVER OF COVERAGE

Complete this section ONLY if you are not enrolling yourself or your spouse/partner or dependents. Waiver must be completed for all of your dependents to be eligible for enrollment on this plan in the event of changing circumstances. I understand that I am eligible to apply for group health coverage through my employer. I do NOT want, and hereby waive, group health coverage for:

	Name (Last, First, MI)	Birth Date (Mo/Day/Year)
Employee		
Spouse/Partner		
Dependent 1		
Dependent 2		
Dependent 3		
Dependent 4		
Dependent 5		
Dependent 6		

I am waiving group health coverage for myself and/or the dependents listed above because (check all that apply, copy of ID card may be required):	
☐	I am covered under my spouse/partner's group policy
☐	My spouse/partner is covered under another plan (including this plan, if spouse/partner is also an employee)
☐	My dependents are covered under another plan
☐	I wish to continue other coverage obtained through an Individual Plan or Medicare
Other (Please explain):	

WAIVER: I certify that I have been given the opportunity to apply for group health coverage and decline to enroll as indicated above, on behalf of myself, my spouse/partner and my dependent child(ren). I understand that by signing this waiver, I, my spouse/partner, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the carrier(s) into waiving or declining the group health coverage. If in the future I apply for coverage, I, my spouse/partner, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement of coverage for up to 12 months.

I understand that if I am declining enrollment for myself, my spouse/partner, or my dependent child(ren) because of other health coverage, I may, in the future, be able to enroll myself, my spouse/partner, or my dependent child(ren) in this plan, as required by law, provided that I request enrollment within
30 days after my other health coverage ends or a qualifying event occurs. If I do not request enrollment within 30 days of the above events, I understand that I may not be able to enroll for coverage until my company's Open Enrollment period. I understand that I can obtain information related to my enrollment eligibility from my employer or small group health carrier.

Signature of Employee:_____ Date Signed:_____

Employee Name:	Employer Name:

MEDICARE INFORMATION								
If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet). A copy of your ID card may be required.								
Are you, your spouse/partner or your child(ren) covered by:								
Medicare Part A?	☐ Yes	☐ No	Medicare Part B?	☐ Yes	☐ No	Medicare Part D?	☐ Yes	☐ No
If "Yes," reason for Medicare:	☐ 65+	Effective Date:		☐ Disability	Effective Date:			
	☐ End-stage Renal Disease (ESRD)	Effective Date:		☐ Disability and ESRD	Effective Date:			
Name of person covered by Medicare:								

CURRENT MEDICAL COVERAGE		
Will you, your spouse/partner, or your dependent child(ren) listed in this application have other health insurance coverage that will be in effect at the same time as the coverage you are applying for on this application?	☐ Yes	☐ No

Your information will help the small employer carrier(s) to coordinate benefits with any other group health coverage you may have.

Name	Carrier Name Carrier Phone Number	Plan Name Group Number Subscriber ID#	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Type of Coverage (See Key Below)

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only; D = Dental Coverage Only O=Other, please explain:_____

This is being asked to determine if there will be coordination of benefits if any of the individuals on the application have existing coverage

PRIMARY CARE PHYSICIAN SELECTION, IF APPLICABLE				
This section should be completed only if the small employer group insurance for which you are applying requires the selection of a primary care provider. A selection should be made for each individual applying for such coverage. The provider information may be listed in the provider materials that are supplied by each carrier to your employer. Use additional sheets if necessary.				
Covered Person's Name	Medical Plan	Primary Care Physician Name:	Primary Care Physician Address: (optional)	Is this your current provider?

Employee Name:	Employer Name:
CERTIFICATION OF DENTAL INSURANCE COVERAGE Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado or for consumers without children under the age of nineteen (19)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required to provide proof that you have obtained coverage before this policy will be approved
TERMS – CONDITIONS- DISCLOSURES	

I acknowledge that I have read all sections of this Colorado Uniform Employee Application for Small Employer Group Health Coverage (Application), and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance agents have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any Colorado small employer carrier's other rights or requirements.

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado small employer carrier(s) under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. I agree that no coverage will be effective until the date specified by the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s).

I understand and agree that any information obtained in connection with this Application will be used by Colorado small employer carrier(s) to determine eligibility for coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes, including arbitration when required and as allowed by law. Please refer to any arbitration provisions in the group contract(s).

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY APPLICABLE HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO ANY SMALL EMPLOYER THAT APPLIES FOR THE PLAN AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS, AND SATISFIES THE OTHER PROVISIONS OF THE HEALTH BENEFIT PLAN.

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at https://www.colorado.gov/pacific/dora/division-insurance. For questions regarding coverage or enrollment please see your employer.

Signature of Employee: _____ Date Signed: _____

Regulation 4-2-46 CONCERNING PREMIUM RATE SETTING FOR GRANDFATHERED INDIVIDUAL, SMALL GROUP, AND LARGE GROUP HEALTH BENEFIT PLANS AND STUDENT HEALTH COVERAGE

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109(1), 10-16-107 and 10-16-109, C.R.S. (2012).

Section 2 Scope and Purpose

The purpose of this regulation is to establish and implement rules for setting premiums for grandfathered individual, small group and large group plans. Article 16, as it existed prior to the effective date of HB 13-1266, applies to grandfathered health benefit plans, unless grandfathered health benefit plans are specifically addressed in Article 16 as amended by House Bill 13-1266.

Section 3 Applicability

This regulation shall apply to all carriers that have grandfathered individual, small group, large group health benefit plans, and/or student health insurance plans, in Colorado. This regulation concerns grandfathered individual, small and large group health benefit plans, to include student health coverage.

Section 4 Definitions

A. “Administrative ratio” means, for purposes of this regulation, the ratio of actual total administrative expenses, not including policyholder dividends, to the value of the actual earned premiums, not reduced by policyholder dividends, over the specified period, which is typically a calendar year.

B. “Benefits ratio” shall have the same meaning as found at § 10-16-102(5.3), C.R.S. (2012). Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits ratio calculations must be displayed without the inclusion of active life reserves.

C. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S. (2012).

D. “Covered lives” means, for purposes of this regulation, the number of members, subscribers and dependents.

E. "Dividends" means, for purposes of this regulation, both policyholder and stockholder dividends.

F. "Excessive rates" means, for purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided or if the rates include a provision for expenses that is unreasonably high in relation to the services rendered. In determining if the rate is excessive, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of whatever relevant information the Commissioner deems necessary in determining whether to approve or disapprove a rate filing.

G. "Filed rate" means, for purposes of this regulation, the index rate as adjusted for plan design and the case characteristics of age, geographic location, and family size only. The "filed rate" does not include the index rate as further adjusted for any other case characteristic (See Section 7.A. of this regulation).

H. "File and use" means, for purposes of this regulation, a filing procedure that requires rates and rating data to be filed with the Division of Insurance (Division) concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates. Under no circumstance shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date. Carriers may bill members but not require the member remit premium prior to the proposed implementation date of the rate change.

I. "Filing date" means, for purposes of this regulation, the date that the rate filing is received at the Division.

J. "Grandfathered plan" means, for purposes of this regulation, a health benefit plan provided to an individual, employer, or other group by a carrier on or before March 23, 2010, for as long as it maintains that status in accordance with federal law, and includes an extension of coverage under an individual or employer health benefit plan that existed 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.

K. "Health benefit plan" shall have the same meaning as found at § 10-16-102(21), C.R.S. (2012).

L. "Implementation date" means, for purposes of this regulation, the date that the filed or approved rates can be charged to an individual or group.

M. "Inadequate rates" means, for purposes of this regulation, rates that are clearly insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace. In determining if the rate is inadequate, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of whatever relevant information the Commissioner deems necessary in determining whether to approve or disapprove a rate filing.

N. "Lifetime loss ratio" means, for the purposes of this regulation:

1. A ratio equal to:

a. The sum of the accumulated value of policy benefits from the inception of the policy form(s) to the end of the experience period and the present value of expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage; divided by:

b. The sum of the accumulated value of earned premiums from the inception of the policy form(s) to the end of the experience period and the present value of expected earned premium over the entire future period for which the proposed rates are expected to provide coverage.

2. The lifetime loss ratio should be calculated on an incurred basis as the ratio of accumulated and expected future incurred losses to accumulated and expected future earned premiums. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits or loss ratio calculations must be displayed without the inclusion of active life reserves.

3. An appropriate rate of interest should be used in calculating the accumulated values and the present values of incurred losses and earned premiums.

4. Any policy form or forms for which the benefits ratio in any policy duration is expected to differ more than 10% from the lifetime loss ratio shall be assumed to have been priced on a "lifetime loss ratio standard", for purposes of this regulation.

O. "Metropolitan statistical area" or "MSA" means, for purposes of this regulation, a relatively freestanding area of the state determined by one or more large population nuclei, together with adjacent communities, that have a high degree of economic and social integration with the nuclei. Each MSA is not closely associated with another MSA. An MSA is a statistical standard developed for use by the Federal Office of Management and Budget, following a set of officially published standards, including, but not limited to, the acceptable underlying population base.

P. "On-rate-level premium" means, for purposes of this regulation, the premium that would have been generated if the present rates had been in effect during the entire period under consideration.

Q. "Plan" means, for purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.

R. "Premium" means, for purposes of this regulation, the amount of money paid by the insured member, subscriber, or policyholder as a condition of receiving health care coverage. The premium paid normally reflects such factors as the carrier's expectation of the insured's future claim costs and the insured's share of the carrier's claims settlement, operational and administrative expenses, and the carrier's cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract

S. "Primary metropolitan statistical area" or "PMSA" means, for purposes of this regulation, a possible subcategory of an MSA, which has a million or more persons living in that MSA. The PMSA consists of a large urbanized county or cluster of counties that demonstrate very strong internal economic and social links, in addition to close ties, to other portions of the larger area. Each PMSA is also determined by the Federal Office of Management and Budget following a set of officially published standards, including, but not limited to, the acceptable underlying population base.

T. "Prior approval" means, for purposes of this regulation, a filing procedure that requires a rate change to be affirmatively approved by the Commissioner prior to distribution, release to agents, collections of premium, or any other use of the rate. Under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing. After the rate filing has been approved by the Commissioner, carriers may bill members but not require the member remit premium prior to the proposed implementation date of the rate change.

U. "Product(s)" means, for purposes of this regulation, the services covered as a package under a policy form by a carrier, which may have several cost-sharing options and riders as options.

V. "Qualified actuary" means, for purposes of this regulation, an actuary who meets the requirements of Colorado Insurance Regulation 1-1-1.

W. "Rate" means, for purposes of this regulation, the amount of money a carrier charges as a condition of providing health care coverage. The rate charged normally reflects such factors as the carrier's expectation of the insured's future claim costs, and the insured's share of the carrier's claim settlement, operational and administrative expenses, and cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.

X. "Rate filing" means, for purposes of this regulation, a filing that contains all of the items required in this regulation, and

1. For individual products, the proposed base rates and all rating factors, the underlying rating assumptions, and support for changes in these rates, factors and assumptions; and

2. For group products, the underlying rating factors and assumptions, and support for changes in these factors and assumptions.

Y. "Rate increase" shall have the same meaning as found at § 10-16-102(36.5), C.R.S. (2012).

Z. "Rating period" shall have the same meaning as found at § 10-16-102(38), C.R.S. (2012).

AA. "Renewed" means, for the purposes of this regulation, a health benefit plan renewed upon the occurrence of the earliest of: the annual anniversary date of issue; the date on which premium rates can be or are changed according to the terms of the plan; or, the date on which benefits can be or are changed according to the terms of the plan. If the health benefit plan specifically allows for a change in premiums or benefits due to changes in state or federal requirements and a change in the health benefit plan premiums or benefits that is solely due to changes in state or federal requirements is not considered a renewal in the health care coverage contract, then such a change will not be considered a renewal for the purposes of this regulation.

AB. "Retention" means, for the purposes of this regulation, the sum of all non-claim expenses including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses as percentage of total premium (or 100% minus the lifetime loss ratio, for products priced on a lifetime loss ratio standard).

AC. "SERFF" means, for the purposes of this regulation, System for Electronic Rate and Form Filings.

AD. "Student health insurance coverage" means, for the purpose of this regulation, a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education that 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, or does not condition eligibility for health insurance coverage on any health-status-related factor related to a student or a dependent of a student.

AE. "Trend" or "trending" means, for purposes of this regulation, any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing.

AF. "Trend factors" means, for purposes of this regulation, rates or rating factors which vary over time or due to the duration that the insured has been covered under the policy or certificate, and that reflect any of the components of medical or insurance trend assumptions used in pricing. Medical trend includes changes in unit costs of medical services or procedures, medical provider price changes, changes in utilization (other than due to advancing age), medical cost shifting, and new medical procedures and technology. Insurance trend includes the effect of underwriting wear-off, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Underwriting wear-off means the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wear-off does not apply to guaranteed issue products. Trend factors include inflation and durational factors.

AG. "Unfairly discriminatory rates" means, for purposes of this regulation, charging different rates for the same benefits provided to individuals, or groups, with like expectations of loss; and/or, if after allowing for practical limitations, differences in rates fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

AH. "Use of the rates" means, for purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder. It does not include releasing information about the proposed rating change to other government entities or disclosing general information about the rate change to the public.

AI. "Wellness and prevention program" shall have the same meaning as found at § 10-16-136(7)(b), C.R.S.(2012).

Section 5 Requirements to Maintain Grandfathered Status and Recordkeeping

A. A carrier must retain in its files all necessary documentation to support its determination that a policyholder's plan is grandfathered. The information must be sufficient to demonstrate that the carrier's determination of grandfathered status as determined by the requirements of 45 C.F.R. §147.140, is credible.

B. A carrier's documentation supporting the grandfathered plan designation must be made available to the Commissioner or the U.S. Department of Health and Human Services for review and examination upon request, and retained for a period of not less than ten (10) years. For each plan, the records supporting the carrier's determination must also be made available to participants and beneficiaries upon request.

C. A carrier's documentation must establish for each grandfathered plan that since March 23, 2010:

1. The plan was not amended to eliminate all or substantially all the benefits to diagnose or treat a particular condition. A list of all plan benefit amendments that eliminate benefits and the date of the amendment is the minimum level of acceptable documentation that must be available to support this criteria;

2. The cost-sharing percentage requirements for the plan, if applicable, were not increased after March 23, 2010. A list of each cost-sharing percentage that has been in place for a grandfathered plan, beginning with the cost-sharing percentage on March 23, 2010, is the minimum level of acceptable documentation that must be available to support this criteria;

3. The fixed cost-sharing requirements other than copayments did not increase by a total percentage measured from March 23, 2010 to the date of change that is more than the sum of medical inflation plus fifteen percent (15%). A list of the fixed cost-sharing requirements other than copayments that apply to a grandfathered plan beginning on March 23, 2010, and a record of any increase, the date and the amount of the increase, is the minimum level of documentation that must be available to support this criteria;

4. Copayments did not increase by an amount that exceeds the greater of:

    a. A total percentage measured from March 23, 2010 to the date of change that is more than the sum of medical inflation plus fifteen percent (15%); or

    b. Five dollars ($5.00), adjusted annually for medical inflation measured from March 23, 2010. A record of all copayments beginning on March 23, 2010 applicable to a grandfathered plan, and any changes in the copayment since that date is the minimum level of documentation that must be available to support this criterion.

5. The employer's contribution rate toward any tier of coverage for any class of similarly situated individuals did not decrease by more than five percent (5%) below the contribution rate in place on March 23, 2010, expressed as a percentage of the total cost of coverage. The total cost of coverage must be determined using the methodology for determining applicable COBRA premiums. If the employer's contribution rate is based on a formula such as hours worked, a decrease of more than five percent (5%) in the employer's contributions under the formula will cause the plan to lose grandfathered status. The carrier must retain a record of the employer's contribution rate for each tier of coverage, and any changes in that contribution rate, beginning March 23, 2010 as the minimum level of documentation that must be available to support this criteria;

6. On or after March 23, 2010, the plan was not amended to impose an overall annual limit on the dollar value of benefits that was not in the applicable plan documents on March 23, 2010;

7. On or after March 23, 2010, the plan was not amended to adopt an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit for all benefits that was in effect on March 23, 2010; and

8. The plan was not amended to decrease the dollar value of the annual limit, regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits.

D. In addition to documentation establishing that none of the prohibited changes described in subsection C. of this section have occurred, a carrier must also make available to the Commissioner upon request the following information for each grandfathered plan:

1. Enrollment records of new employees and members added to the plan on or after March 23, 2010;

2. Underwriting rules and guidelines applied to enrollees on or after March 23, 2010; and

3. Proof of notification to the individual or group of its plan's grandfathered status designation for each year for which the status is claimed.

E. A change to a plan, adopted pursuant to a legally binding contract, state insurance department filing or written plan amendment on or before March 23, 2010, but that became effective after March 23, 2010, is permitted without negating a plan's grandfathered status. If the plan change resulted from a merger, acquisition or similar business action where one of the principal purposes is covering new individuals from the merged or acquired group under a grandfathered health plan, the plan may not be designated as grandfathered.

F. A carrier may delegate the administrative functions related to documenting or determining grandfathered status designation to a third party. Such delegation does not relieve the carrier of its obligation to ensure that the designation is correctly made, that replacement plans are issued in a timely and compliant manner as required by state or federal law, and that all requisite documentation is kept by the carrier.

G. If the Commissioner determines that a carrier incorrectly designated a group plan as grandfathered, the plan is non-grandfathered, and must be discontinued and replaced with a plan that complies with all relevant market requirements within thirty (30) calendar days. This section does not preclude additional enforcement action.

H. A carrier must designate whether a plan is grandfathered or non-grandfathered as required by the Colorado State SERFF filing instructions.

Section 6 General Rate Filing Requirements

All grandfathered individual, small group, and large group health benefit rate filings must be filed electronically in a format made available by the Division, unless exempted by rule for an emergency situation as determined by the Commissioner. Failure to supply the information required in Sections 6, 7, 8 and 11, as applicable, of this regulation will render the filing incomplete. Incomplete filings are not reviewed for substantive content. If the carrier fails to comply with these requirements, the carrier will be notified that the filing has been returned as incomplete. Complete filings will have all the relevant general requirements, rate and policy forms information filled out in the electronically submitted rate filing. If a filing is returned due to lack of completeness, the rates may not be used or distributed. All filings that are not returned or disapproved on or before the 30th calendar day after receipt will be considered complete. Filings may be reviewed for substantive content, and if reviewed, any deficiency will be identified and communicated to the filing carrier on or before the 45th calendar day after receipt. Correction of any rate filing deficiency, including deficiencies identified after the 45th calendar day, will be required on a prospective basis, and no penalty will be applied for a non-willful violation identified in this manner. Nothing in this regulation shall render a rate filing subject to prior approval by the Commissioner that is not otherwise subject to prior approval as provided by statute.

A. General Requirements

1. Prior Approval: Any proposed rate increase is subject to prior approval by the Commissioner and must be filed with the Division at least sixty (60) calendar days prior to the proposed implementation or use of the rates.

   a. If the Commissioner approves the rate filing within sixty (60) calendar days after the filing date, the carrier may use the rates immediately upon approval; however, under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing.

   b. A carrier who provides insurance coverage under the rates before the proposed implementation date will be considered as using unfiled rates and the Division will take appropriate action as defined by Colorado law.

   c. After the rate filing has been approved by the Commissioner, carriers may bill members but may not require that members remit premium prior to the proposed implementation date of the rate change.

   d. If the Commissioner does not approve or disapprove the rate filing within sixty (60) calendar days after the filing date, the carrier may implement and make use of the rates.

   e. Under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing.

2. Existing law also defines a rate increase to be an increase in the current rate. Any rate filing that would include increasing any base rate or rating factor used to calculate premium rates that results in an overall increase in the current rate to any existing policyholder or certificate holder renewing during the proposed rating period of the filing would be considered a prior approval filing.

   To determine prior approval, calculations should reflect the 12-month accumulative impact of trend and any changes to rating factors or base rates. Calculations should not reflect a particular policyholder's movement within each rating table (i.e., change in family status, move to a new region, etc.). Trend factors do not renew automatically and must be filed annually. Any continued use of any trend factor for more than twelve (12) months is subject to prior approval.

   The Commissioner may require the submission of whatever relevant information the Commissioner deems necessary in determining whether to approve or disapprove a rate filing. Corrections of any deficiency identified after the 60th calendar day will be required on a prospective basis and no penalty will be applied for a non-willful violation identified in this manner if the rates are determined to be excessive, inadequate or unfairly discriminatory. All filings must be filed with the Rates and Forms Section of the Division. The Commissioner shall disapprove the rate filing if any of the following apply:

   a. The benefits provided are not reasonable in relation to the premiums charged;

b. The rate filing contains rates that are excessive, inadequate, unfairly discriminatory, or otherwise does not comply with the provisions of Sections 6, 7, 8, 9, 10 and 11, as applicable, of this regulation. In determining if the rate is excessive or inadequate, the Commissioner may consider profits, dividends, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice;

c. The actuarial reasons and data do not justify the requested rate increase; or

d. The rate filing is incomplete.

3. File and Use: Any rate filing not specified in paragraph 1. of this subsection is classified as file and use. Existing law allows for file and use rate filings to be implemented upon submission to the Division and correction of any deficiency shall be on a prospective basis. All filings not returned on or before the 30th day after receipt will be considered complete.

   To determine file and use, calculations should reflect the 12-month accumulative impact of trend and any changes to rating factors or base rates. If there is an annual cumulative decrease in rates for all policyholders during the filed rating period then the filing would be file and use.

   If a rate change has been implemented or used without being filed with the Division, corrective actions may be ordered, including civil penalties, refunds to policyholders, and/or rate credits. Under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date. A carrier who provides insurance coverage under the rates before the proposed implementation date will be considered as using unfiled rates and the Division would take appropriate action as defined by Colorado law. Carriers may bill members but not require the member remit premium prior to the proposed implementation date of the rate change. All filings must be filed with the Rates and Forms Section of the Division.

4. Required Submissions:

   a. All carriers must submit a compliant rate filing whenever the rates charged to renewing policyholders, or certificate holders differ from the rates on file with the Division. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or change(s) in trend or other rating assumptions. Failure to file a rate filing that is compliant with this regulation in these instances will render the carrier as using unfiled rates and the Division will take appropriate action as allowed by Colorado law.

   b. All carriers must submit a compliant rate filing on an annual basis, at minimum, to support the continued use of trend factors, which change on a predetermined basis. The rate filing must contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate. The rate filing shall contain all of the items required in this regulation. The rate filing must demonstrate that the rate is not excessive, inadequate or unfairly discriminatory. Note: Trend factors which change on a predetermined basis can be continued for no more than twelve (12) months. To continue the use of trend factors that change on a predetermined basis, a filing must be made for that particular form with an implementation or effective date on or before the one-year anniversary of the implementation or effective date of the most recent rate filing for that form.

c. All carriers must submit a rate filing within sixty (60) calendar days after Commissioner approval of the assumption or acquisition of a block of business. This rate filing should provide detailed support for the rating factors the assuming or acquiring carrier proposes to use, even if the rating factors are not changing. The new filing must demonstrate that the rating assumptions continue to be appropriate.

d. Each line of business requires a separate rate filing. Rate filings should not be combined with form filings.

e. All carriers are expected to review their experience on a regular basis, no less than annually, and file rate revisions, as appropriate, in a timely manner to ensure that rates are not excessive, inadequate or unfairly discriminatory, and to avoid filing large rate changes.

f. The Form Schedule tab in SERFF must be completed for all rate and form filings. This tab must list policies, riders, endorsements, or certificates referenced in the rate filing. Do not attach the actual forms to a rate filing.

5. Withdrawn, Returned, or Disapproved Filings: Filings that have either been withdrawn by the filer, returned by the Division as incomplete or disapproved as unjustified, and subsequently are resubmitted, will be considered as new filings. If a filing is withdrawn, returned, or disapproved, the rates may not be used or distributed. Nothing in this regulation shall render a rate filing subject to prior approval by the Commissioner that is not otherwise subject to prior approval as provided by statute.

6. Carrier Specific: A separate filing must be submitted for each carrier. A single filing, which is made for more than one carrier or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/indemnity point-of-service plan.

7. Submission of Rate Filings: All grandfathered individual and large group health benefit plan rate filings must be filed electronically in a format made available by the Division, unless exempted by rule for an emergency situation as determined by the Commissioner. If the carrier fails to comply with these requirements, the carrier will be notified that the filing has been returned as incomplete. Complete filings will have all the relevant general requirements, rate and policy forms information filled out in the electronically submitted rate filing. If a filing is returned due to lack of completeness, the rates may not be used or distributed.

8. Required Inclusions: Rate filings require the submission of an actuarial memorandum in the format specified in Section 7 of this regulation. A response must be provided for each element contained in Section 7. The level of detail and the degree of consistency incorporated in the experience records of the carrier are vital factors in the presentation and review of rate filings. Every rate filing shall be accompanied by sufficient information to support the reasonableness of the rate. Valid carrier experience should be used to justify grandfathered plans. Actual Colorado experience must be submitted with changes to existing products. In addition, the Commissioner may request additional information used by the carrier to support the rate change request.

9. Confidentiality: All rate filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. The Division does not consider such items as rates, rating factors, rate histories, or side-by-side comparisons of rates or retention components to be confidential. The entire filing, including the actuarial memorandum, cannot be held as confidential. There should be a separate SERFF component for confidential exhibits, and such component must be indicated as confidential in SERFF. Non-confidential information, such as the actuarial memorandum, must be in a separate SERFF component.

10. A "Confidentiality Index" must be completed if the carrier desires confidential treatment of any information submitted, as required in this regulation. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected. It should be noted that HMOs are not afforded automatic confidential treatment of any rate filings; and, therefore, must complete a Confidentiality Index.

B. Actuarial Certification

Each rate filing shall include a signed and dated statement by a qualified actuary, which attests that, in the actuary's opinion, the rates are not excessive, inadequate or unfairly discriminatory.

C. Wellness and prevention programs: A carrier offering individual and/or small group health coverage in this state may offer incentives or rewards to encourage the individual and other covered persons under the plan to participate in wellness and prevention programs, pursuant to § 10-16-136, C.R.S.(2012), and shall be subject to the following:

1. The incentives or rewards shall be made to all participants in the program and may include, but are not limited to: premium discounts or rebates; modifications to copayment, deductible, or coinsurance amounts; the absence of a surcharge; the value of a benefit that would otherwise not be provided; or, a combination of these incentives or rewards.

2. The program shall be voluntary and a penalty shall not be imposed on a covered person for not participating.

3. The carrier shall not use the wellness and prevention programs, or incentives or rewards under such programs, to increase rates or premiums for any individuals covered by the carrier's plans.

4. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:

   a. Does not shift costs to individuals that decline to participate in the program; and

   b. Is reasonably related to the program.

5. For wellness and prevention programs providing incentives or rewards based upon satisfaction of a standard related to a health risk factor:

   a. The carrier shall provide in each filing, proof that the wellness program has been accredited by a nationally recognized nonprofit entity that accredits wellness programs pursuant to § 10-16-136(3.7), C.R.S.;

   b. The carrier shall document that the wellness program is scientifically proven to improve health and that the incentives are not provided based on an individual's actual health status; and

c. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:

(1) Does not exceed 20% of the premium; and

(2) Is not a subterfuge for discriminating based upon a health status-related factor.

6. The carrier shall include any information required by the Commissioner to ensure that the filed rates, in conjunction with the incentives and rewards available under the wellness program, are not excessive, inadequate, or unfairly discriminatory.

Section 7 Actuarial Memorandum

The rate filing must contain an actuarial memorandum. To ensure compliance with this regulation, each of the following sections must be provided in the memorandum in the designated order shown below, or in an alternate template supplied by the Division. A response must be provided for each element under this section. The actuarial memorandum must be attached to the Supporting Documents tab in SERFF, and must be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the Actuarial Certification requirements of this regulation. Do not attach the actuarial memorandum, supporting documents, or actuarial certification to the Rate/Rule tab in SERFF.

A. Summary: A brief written summary of the filing including, but not limited to, the following:

1. Reason(s) for the Rate Filing: A statement that this is a rate revision and the reason for the revision shall be included.

2. Requested Rate Action: The overall rate increase or decrease should be listed. The listed rate change, the average change in each rate component and the change in renewal date by effective month must be provided. The submission must also list the twelve (12) month renewal with changes by component and the averages by component.

3. Marketing Method(s): A brief description of the marketing method used for the filed form should be listed. (Agency/Broker, Internet, Direct Response, Other)

4. Premium Classification: The section should state all attributes upon which the premium rates vary.

5. Product Descriptions: This section should describe the benefits provided by the policy.

6. Policy/Rider or Contract: This section must include a listing of all policies/riders or contracts impacted by the submission.

7. Age Basis: A statement as to whether the premiums will be charged on an issue age, attained age, renewal age or other basis and the issue age range of the form, as applicable, should be specified.

8. Renewability Provision: All health plans are guaranteed renewable.

B. Assumption or Acquisition: The memorandum must state whether or not the products included in the rate filing are part of an assumption or acquisition of policies from/with another carrier. If so, the memorandum must include the full name of the carrier/carriers from which the policies were assumed, acquired or merged, and the effective date of the assumption or acquisition, and the SERFF Tracking Number of the assumption of the acquisition, or assumption rate filing. Commissioner approval of the assumption or acquisition of a block of business is required. See Section 6.A.4.c. for acquisition or assumption rate filing requirements.

C. Rating Period: The memorandum must identify the period for which the rates will be effective. At a minimum, the proposed implementation date of the rates must be provided. If the length of the rating period is not clearly identified, it will be assumed to be for twelve (12) months, starting from the proposed implementation date.

D. Effect of Law Changes: The memorandum should identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in law(s) or regulation(s), including federal, state or local. All applicable benefit mandates should be listed, including those with no rating impact. This quantification must include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

E. Rate History: The memorandum must include a chart showing the rate changes implemented including the implementation date of each rate change in at least the three (3) years immediately prior to the date of the filing. This chart must contain the following information: the filing number (State or SERFF tracking number); the implementation date of each rate change; the average rate increase or decrease; and the minimum and maximum rate increase and cumulative rate change for the past twelve (12) months. The cumulative effect of all rate filings, submitted in the prior year, on renewal rates should be specified. The rate history should be provided on both a Colorado basis, as well as an average nationwide basis, if applicable.

F. Coordination of Benefits: Each rate filing must reflect the actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

G. Relation of Benefits to Premium: The memorandum must adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period. This relationship will be presumed to be reasonable if the carrier complies with the following:

1. Retention Percentage: The actuarial memorandum must list and adequately support each specific component of the retention percentage. The support for a health benefit plan must include a comparison of the most recent levels experienced for each component as shown in the carrier’s financial statements, with an explanation for any variations between retention loads used and actual experience for each component.

    a. If the product was not initially priced using a lifetime loss ratio standard, the retention percentage is equal to the sum of all non-claim components of the rate including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses.

    b. Each of these specific components must be expressed as a percentage of the earned premium, and should sum to the total carrier retention percentage. Each component should reflect the average assumption used in pricing. Ranges for each assumption and flat dollar amounts are not permitted. The component for profit/contingencies should reflect the target load for profit and contingencies, and not the expected results or operating margin.

The Commissioner will evaluate each component for reasonableness and consistency with other similar rate filings. Any change in these components from the previous rate filing must be adequately supported. It should be noted that broad groupings of these components are not permitted.

2. Benefits Ratio Guidelines: The Commissioner uses these percentages as guidelines for the acceptability of the carrier's targeted benefits ratio.

   a. All rate filings justifying the relationship of benefits to premium using one of these guidelines must list the components of the retention percentage, as defined in subsection G.1. of this section. The Commissioner will evaluate these components for reasonableness. Policy forms priced at, or above, these benefit ratios may be unacceptable if one or more of the retention components is not supported.

   b. The Division recommended benefits ratio guidelines are as listed below. Targeted benefits ratios below these guidelines shall be actuarially justified.

      Benefits Ratio Guidelines

Comprehensive Major Medical (Individual)	80%
Comprehensive Major Medical (Small Group)	80%
Comprehensive Major Medical (Large Group)	85%
Student Health Insurance Coverage	80%

   c. The benefits ratio guideline for conversion products shall be at least 125%. Adequate support shall be submitted if the benefits ratio is below the 125% guideline.

   d. For individual products issued to HIPAA eligible individuals the premiums for these products are, at most, two times the premiums for the underlying, underwritten product.

H. Lifetime Loss Ratio for Individual Health Benefit Plans: The memorandum must state whether or not the product was priced initially using a lifetime loss ratio standard. If the product was priced using a lifetime loss ratio standard, then any subsequent rate change request must be based on the same lifetime loss ratio standard unless there has been a material change in assumptions used to price the product, including changes in regulations covering the product. Changes to the lifetime loss ratio must be identified and clearly supported. The lifetime loss ratio standard shall consider the effects of investment income. Any subsequent rate change request shall consider the variance in the expected benefit ratios over the duration of the policy. The rate filing must include the average policy duration in years as of the endpoint of the experience period and the expected benefits ratio, as originally priced, for each year of the experience period. The rate filing must also include a chart showing actual and expected benefits ratios for both the experience and rating periods. For each year of the experience period the chart must show the actual and expected benefits ratios, and the ratio of these two (2) benefits ratios. For each year of the rating period, the chart must show the projected and expected benefits ratios, and the ratio of these two (2) benefits ratios. It is expected that the carrier is pricing these products to achieve a benefits ratio greater than or equal to the expected benefits ratio for the rating period.

I. Provision for Profit and Contingencies. The memorandum must identify the provision percentage for profit and contingencies, and how this provision is included in the final rate. Material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process. Detailed support must be provided for any proposed load.

J. Complete Explanation as to How the Proposed Rates were Determined: The memorandum must contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if adequate support for each rating assumption is not provided. This explanation may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis, but must completely explain how the proposed rates were determined. The memorandum must adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

K. Trend: The memorandum must describe the trend factor assumptions used in pricing. These trend factor assumptions must each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported. Trend factors do not renew automatically. Continued use of trend factors must be supported annually. This must be provided in an Excel spreadsheet.

1. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be provided if available. This experience may include data from the plan being rated, or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

2. Provided loss data must be on an incurred basis, with pharmacy data shown separately from medical data, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and “incurred but not reported” (IBNR) reserves) as of the valuation date. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

3. The provided claims experience shall include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims; total medical incurred claims (including estimated IBNR claims); actual pharmacy paid on incurred claims; total pharmacy incurred claims (including estimated IBNR claims); average covered lives for medical; and, average covered lives for pharmacy.

4. Data elements shall be aggregated into 12-month annual periods, with yearly PMPM data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified. The trend assumptions shall be quantified into two (2) categories: medical and insurance, as defined below:

    a. Medical trend means, for the purposes of this section, the combined effect of medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology.

    b. Insurance trend means, for the purposes of this section, the combined effect of underwriting wear-off, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Note: medical trend must be determined or assumed before insurance trend can be determined. Underwriting wear-off means the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wear-off does not apply to guaranteed issue products.

    Major service categories are Hospital Inpatient, Outpatient, Physician, Pharmacy, Other.

L. Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three (3) years, if the proposed rates are based on claims experience.

1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers) must be provided and the applicability of the use of such data must be discussed. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is SQRT {(# life years or claims)/full credibility standard}. Colorado data must still be provided.

2. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data should include a discussion as to how the rating methodology was modified for the partially credible data.

M. Data Requirements: The memorandum must include, at a minimum, earned premium data, loss experience data, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. This must be provided in an Excel spreadsheet.

1. Pharmacy claims data should be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.

National or other relevant data shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates, rating factors, rating methodology and trend.

3. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. Data used for support rates must be included in the filing. For renewal filings, the experience period must include consecutive data no older than six (6) months prior to the filing (submission) date. For renewal filings the experience period must include consecutive data no older than nine months prior to the rate effective implementation date.

4. The loss data must be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Premiums, and/or exposure data, must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information on how the number of claims was calculated.

N. Side-by-Side Comparison: Each memorandum must include a “side-by-side comparison” identifying any proposed change(s) in rates. This comparison should include three columns: the first containing the current rate, rating factor, or rating variable; the second containing the proposed rate, rating factor, or rating variable; and the third containing the percentage increase or decrease of each proposed change(s).

O. Benefits Ratio Projections: The memorandum must contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison should be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should be included. This must be provided in an Excel spreadsheet.

P. Other Factors: The memorandum must clearly display or clearly reference all other rating factors and definitions used, including the area factors, age factors, etc., and provide support for the use of each of these factors in the new rate filing. The same level of support for changes to any of these factors must be included in all renewal rate filings. In addition, the Commissioner expects each carrier to review each of these rating factors every five (5) years, at minimum, and provide detailed support for the continued use of each of these factors in a rate filing. This must be provided in an Excel spreadsheet.

Section 8 Premium Rate Setting for Small Group Health Benefit Plans

A. Calculating Premium Rates Adjusted for Case Characteristics

1. Index Rate: Each carrier offering a health benefit plan to small employers in Colorado shall develop a single index rate for all small group plans it offers. This single index rate is identical to a community rate for the carrier's universe of small group plans offered for renewal. It should be calculated using the experience for all small group plans. The premium rate charged during a rating period, applicable to all small employers, shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this Section 8.

2. Plan Design Adjustment: The index rate may be adjusted to reflect differences attributable to different plan designs. If the carrier elects to make this adjustment, the carrier should calculate a rate adjustment factor for each small group plan design. Differences in the rates for different benefit plans, for persons with the same case characteristics of age, geographic location and family size, shall be attributable to plan design only.

3. Acceptable Case Characteristic Factor Categories: For all small employer policies, carriers choosing to modify the unique index rate by the use of case characteristics must utilize one or more of the categories listed below. Carriers shall develop a rating factor for each category, which is actuarially based.

a. Age: If a carrier uses age to calculate rates, then it shall use the following twelve (12) mandatory age categories. Rates must be based on employee age only, not employee and spouse ages.

Mandatory Age Categories
Children ages newborn through age 19 (or through age 24 if the child is a full-time student covered as a dependent), excluding emancipated minors
Emancipated minors and persons ages 20 through 24
Age 25 through 29
Age 30 through 34
Age 35 through 39
Age 40 through 44
Age 45 through 49
Age 50 through 54
Age 55 through 59
Age 60 through 64
Age 65 and older: Medicare is primary payer
Age 65 and older: Medicare is secondary payer

b. Geographic Location: If a carrier uses geographic location to calculate rates, then it shall use the nine (9) mandatory categories listed below. In determining that these geographic location categories best serve the public interest, the Commissioner considered the key issues of accessibility, availability, consumer choice and the cost of health care in all areas of the state. Public and consumer input was solicited, received, and evaluated. The Commissioner determined that these area groupings best serve the public interest by maximizing consumer choice options and health care availability in all areas of the state at the lowest possible cost and will ensure that the rates charged are not excessive, inadequate or unfairly discriminatory. The appropriate population base for these categories is the base as determined by the federal government in establishing MSAs, except for the last two categories listed below. No MSA exists for these counties and consequently, these counties were grouped by population size. Carriers may, with prior written approval of the Commissioner, establish one (1) or more additional categories by further subdividing the last two (2) categories.

Rates must be based on the primary physical location of the small employer's business, except that an employer with multiple business locations in separate geographic categories may be provided with separate rates for each physical business location. There cannot be a separate factor for a small employer's out-of-state employees, if any. These individuals shall be rated as if they are working in the small employer's primary physical business location.

Mandatory Geographic Location Categories
1. Boulder County (known as the Boulder-Longmont PMSA)
2. Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson counties (known as the Denver MSA)
3. Weld County (known as the Greeley PMSA)
4. El Paso County (known as the Colorado Springs MSA)
5. Larimer County (known as the Fort Collins-Loveland MSA)
6. Mesa County (known as the Grand Junction MSA)
7. Pueblo County (known as the Pueblo MSA)
8. Counties in Colorado with a population of 20,000 or fewer residents: Alamosa, Archuleta, Baca, Bent, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, Lake, Las Animas, Lincoln, Mineral, Moffat, Otero, Ouray, Park, Phillips, Pitkin, Prowers, Rio Blanco, Rio Grande, Saguache, San Juan, San Miguel, Sedgwick, Washington, and Yuma counties. (Such counties may be grouped into one or more geographic location categories based on differences in medical costs of the carrier with the prior written approval of the Commissioner.)
9. All other Colorado counties: Delta, Eagle, Elbert, Fremont, Garfield, La Plata, Logan, Montezuma, Montrose, Morgan, Routt, Summit, and Teller counties. (Such counties may be grouped into one or more geographic location categories based on differences in medical costs of the carrier with the prior written approval of the Commissioner.)

PMSA = Primary Metropolitan Statistical Area

MSA = Metropolitan Statistical Area

(1) Geographic rating factors must be determined on the same basis, reflect the relative differences in expected costs, and produce rates that are not excessive, inadequate, or unfairly discriminatory in such geographic areas. For example, a geographic factor of 1.2 for the Colorado Springs MSA and a factor of 1.0 for the Denver MSA would imply that costs can reasonably be expected to be 20% higher in the Colorado Springs MSA than they are in the Denver MSA. All changes in the geographic rating factors must be supported on this basis.

(2) Approval to subdivide categories eight and nine above into two (2) or more subcategories must be obtained in advance. The material provided to support the subdivision(s) shall be based upon statistically-credible data using the Division of Insurance's credibility standard and/or other actuarially-determined standards. The Division's credibility standard is 2,000 life-years and 2,000 claims per year. (See Section 7.L. of this regulation).

c. Family Size: If a carrier uses family size to calculate rates, then it shall use the four (4) mandatory categories listed below. If age is also used as a rating factor, rates must be based on employee age only, not employee and spouse ages.

Mandatory Family Size Categories
1 Adult
2 Adults
1 Adult plus any number of children who are dependents of the primary insured or for whom the primary insured is legally required to provide health insurance coverage.
2 Adults plus any number of children who are dependents of the primary insured or for whom the primary insured is legally required to provide health insurance coverage.

d. Tobacco Use: If a carrier reflects tobacco usage in the calculation of rates, then it must do so according to the following requirements found at § 10-16-105(8.5)(a)(I)(B), C.R.S. (2012):

(1) The carrier shall provide a wellness and prevention program;

(2) Any individual who participates in the program shall be given the lower rate;

(3) Any rate adjustment attributable to an individual (and all similarly situated individuals) based upon tobacco usage shall be applied to that individual (and all similarly situated individuals), and shall not be distributed to the entire group; and

(4) The carrier shall use one of the following three (3) allowable rate adjustments:

(a) An increase of up to fifteen percent (15%) for tobacco use; or

(b) A decrease of up to fifteen percent (15%) for nonuse of tobacco.

(c) A discount of up to ten percent (10%) for refraining from smoking for more than twelve (12) consecutive months prior to the effective date or renewal date of the small group policy, pursuant to § 10-16-105(13)(c), C.R.S. (2012).

e. Standard Industrial Classifications: If the carrier uses the standard industrial classifications pursuant to § 10-16-105(8.5)(a)(I)(A), C.R.S., (2012), to calculate rates, only one (1) factor is permitted for each small group. No enrolled employee should be charged directly for any such adjustment.

f. All rating adjustments due to the application of any of these case characteristics must be applied consistently in the calculation of all small employers' rates. Any adjustments made due to standard industrial classification should be applied uniformly to the rates charged for all employees enrolled under each small group policy.

g. All rate filings must contain adequate and acceptable detailed information as to how the rating factors used for tobacco use is determined and the combined maximum and minimum effect of applying the rating factor.

h. Health status and claims experience may not be used as case characteristics. A health questionnaire, requesting reasonable information, may be used to obtain information about the health status of group enrollees. However, the health questionnaire may not be used in any way to determine the premium rate or any rating factor that is used in the determination of the premium rate that is charged to the group, except as provided in subparagraph d. of this paragraph.

4. Wellness and Prevention Programs: A carrier may make available wellness and prevention programs as provided for under Section 6.C. of this regulation.

B. Rating Period

The rating period for all small group health plans shall be twelve (12) months unless:

1. A carrier specifies in its rate filings a different rating period, which shall be the same for all of its small group health benefit plans issued or renewed in the same calendar month; and

2. The carrier clearly disclosed in all its small employer solicitation and sales materials exactly what the different rating period was.

C. Administrative and Other Fees

Carriers and producers shall not charge any fees in addition to premium. Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Such charges must be built into the index rate and are not an allowable rate adjustment factor. Reasonable late payment penalties may be imposed by a carrier if the policy discloses the carrier's right to, the amount of, and circumstances under which late payment penalties will be imposed.

Section 9 Use of Composite Rates for Small Group Health Benefit Plans

A. Carriers may offer the small employer rates calculated by use of the following methods subject to the following restrictions:

1. Four-tier family, age-banded rates calculated pursuant to Section 8 of this regulation; or

2. A choice between four-tier, age-banded rates, calculated pursuant to Section 8 of this regulation, and composite rates. It shall be construed that the carrier has offered the small employer a choice between the two (2) methods if, at initial application and at each renewal:

a. Both methods are offered to the small employer, with the differences clearly explained in writing; or

b. The small employer is given a written option to indicate that:

(1) Both rating methods need be presented;

(2) Only age-banded rates need be presented; and

(3) Only the composite rate need be presented. This indication may be a check-off on the application or renewal form or other similar form that complies with this section.

B. Carriers may offer small employers composite rates as an alternative to four-tier, age-banded rates calculated pursuant to Section 8 of this regulation if all of the following conditions are met:

1. The carrier makes the same offer across its entire book of Colorado small group business where an employer has ten (10) or more eligible employees. If the carrier makes this offer to all small employers having ten (10) or more eligible employees, then the carrier may also offer composite rates to small employers having fewer than ten (10) eligible employees. The carrier must establish a pre-determined minimum size for offering composite rates. The same offer must be made available to all small employers having at least this pre-determined number of eligible employees.

2. The carrier must clearly state on its application and renewal forms for all of its small group products the differences between age-banded and composite rates and that either:

   a. The minimum number of eligible employees for calculating composite rates is ten (10) and that all small employers with ten (10) or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates, and have the right to see them calculated either or both ways; or

   b. If the number of minimum eligible employees is less than ten (10), the carrier shall state the minimum number and that all small employers with at least this minimum number of eligible employees are entitled to a choice of composite rates or four-tier, age-banded rates, and have the right to see them calculated either or both ways.

3. Calculating Composite Rates.

   Renewing Groups: At renewal, composite rates must be calculated for each small employer group based on enrollment as of the date of the renewal calculation, or as of the effective date for the renewal rates, which shall be consistent for all small employers. A second quote, subsequent to the date of the renewal calculation, may be calculated if the demographics of the small group have changed significantly since the date of the original renewal quote, and the carrier recalculates the composite rates in all similar circumstances. If the carrier retains the right to revise the original calculation, this right must be clearly disclosed. Despite changes in the demographic composition of the small employer group, composite rates shall be set, as of the renewal date, for a particular small employer for the entire rating period.

4. The carrier uses the same composite rating methodology for all small employers. The carrier may offer composite rates on a two-tier (i.e. employee and employee plus dependents), three-tier or four-tier composition basis. If the carrier elects to offer these three (3) choices, it is at the employer's sole discretion whether the composite rates are set on the two-tier, three-tier, or four-tier family composition basis. However, the basis for the calculation of initial premiums before composite rating for a particular employer must be based on four-tier family, age-banded rates calculated pursuant to Section 8 of this regulation.

5. At the time of the initial application by the small employer, the composite rating and four-tier family, age-banded rating for a particular small employer must result in identical total premium collections due from that employer for the first month of the rating period. At renewal, the composite rating method and four-tier family, age-banded rating methods for each small employer must result in identical total premium amounts as of the date of the renewal calculation. Assuming there is no change in the demographic composition of the small employer group, composite rating and four-tier family, age-banded rating for a particular employer must result in identical total premium collections due from that employer for a given rating period.

C. Nothing in this section shall be construed to require carriers to provide anything other than four-tiered, age-banded rates.

Section 10 Rate Filings for Small Group Health Benefit Plans

The provisions of § 10-16-107, C.R.S. (2012) and this regulation shall apply to the filing of rates for grandfathered small employer health benefit plans. Expected rate increases for small employer health benefit plans shall be submitted for approval to the Division of Insurance at least sixty (60) calendar days prior to the proposed implementation of the rate.

Section 11 Additional Rate Filing Requirement by Line of Business

The following subsections set forth the requirements by separate lines of business, which must be complied with in addition to the above general requirements:

A. Wellness and Prevention Programs: A carrier offering an individual health coverage plan or a small group plan in this state may offer incentives or rewards to encourage the individual or small group and other covered persons under the plan to participate in wellness and prevention programs, pursuant to §10-16-136, C.R.S. (2012), and shall be subject to the following:

1. The incentives or rewards shall be made to all participants in the program and may include, but are not limited to: premium discounts or rebates; modifications to copayment, deductible, or coinsurance amounts; the absence of a surcharge; the value of a benefit that would otherwise not be provided; or, a combination of these incentives or rewards.

2. Incentives or rewards provided under the program shall not be based upon the size or composition of the small group.

3. The program shall be voluntary and a penalty shall not be imposed on a covered person or small group for not participating.

4. The carrier shall not use the wellness and prevention programs, or incentives or rewards under such programs, to increase rates or premiums for any individuals or small groups covered by the carrier's plans.

5. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:

   a. Does not shift costs to individuals or small groups that decline to participate in the program; and

   b. Is reasonably related to the program.

6. For wellness and prevention programs providing incentives or reward which are based upon satisfaction of a standard related to a health risk factor:

   a. The carrier shall provide in each filing proof that the wellness program has been accredited by a nationally recognized nonprofit entity that accredits wellness programs pursuant to § 10-16-136(3.7), C.R.S., (2012);

   b. The carrier shall document that the wellness program is scientifically proven to improve health and that the incentives are not provided based on an individual's actual health status; and

c. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:

(1) Does not exceed 20% of the premium; and

(2) Is not a subterfuge for discriminating based upon a health status-related factor.

d. For purposes of small group plans, the incentives or rewards attributable to the individual (and all similarly situated individuals) shall be applied to that individual (and all similarly situated individuals), and shall not be distributed to the entire group.

7. The carrier shall include any information as required by the Commissioner to ensure that the filed rates, in conjunction with the incentives and rewards available under the wellness program, are not excessive, inadequate, or unfairly discriminatory.

B. Large Group Health Coverage Plans (to include Student Health Insurance Coverage): Large group health coverage plan contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing must contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing should also contain an example of how the large group health rates are calculated. While the final rate charged the large group may differ from the initial quote, all rating variables must be on file with the Division.

Although it is not necessary to submit a separate rate filing for each large group policy issued, each carrier must retain detailed records for each large group policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each group insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate should be identified in the detail material and lie within the range identified in the rate filing on file with the Division. The carrier shall make all such information available for review by the Commissioner upon request. All such requests will be made at least three (3) business days prior to the date of review.

The rates for subgroups must be determined in an actuarially sound manner using credible data. The methodology for determining these rates must be on file with the Division and any changes in the methodology must be filed with the Division.

C. Valid Multi-State Association Groups: Pursuant to § 10-16-107(6), C.R.S. (2012), any health benefit plan issued before March 10, 2010 for any valid multi-state association under § 10-16-214(2), C.R.S. (2012), shall not use any health status-related factor in determining the premium or contribution for any enrolled individual and/or their dependent. However, the prohibition in this subsection shall not be construed to prevent the carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for adherence to programs of health promotion or disease prevention if otherwise allowed by state or federal law.

Section 12 Prohibited Rating Practices

The Commissioner has determined that certain rating activities lead to excessive, inadequate or unfairly discriminatory rates, and are unfair methods of competition and/or unfair or deceptive acts or practices in the business of insurance. Therefore, in accordance with § 10-16-107, C.R.S. (2012) and § 10-3-1110(1), C.R.S., the following are prohibited:

A. Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve. However, this requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating;

B. The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income;

C. For individual health benefit plans, rates shall not vary due to the gender of the individual policyholder, enrollee, subscriber, or member for rates effective on or after January 1, 2011, pursuant to § 10-16-107(1.5)(b), C.R.S. (2012); and

D. For individual health benefit plans, the use of any rating factors based upon zip codes which fail to equitably adjust for different expectations of loss. It is the expectation of the Commissioner that areas of the state with like expectations of loss must be treated in a similar manner. Also, policyholders utilizing the same provider groups should be rated in a like manner. The use of zip codes in determining rating factors can result in inequities. Unless different rating factors can be justified based upon different provider groups or other actuarially sound reasons, the following guidelines shall be followed whenever zip codes are used in determining a carrier's rating factors:

1. All zip codes in the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor, with the following possible exceptions:

    a. The following zip codes in Elbert County: 80101, 80106, 80107, 80117.

    b. The following zip codes in Arapahoe County: 80102, 80103, 80105, 80136.

    c. The following zip codes in El Paso County: 80132, 80133.

    d. The following zip codes in Boulder County: 80025, 80026, 80027, 80028.

2. In addition, the following zip codes outside the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor as the 800-802 three-digit zip code groups:

    a. The following zip codes in Jefferson County: 80401-80403, 80419, 80433, 80437, 80439, 80453, 80454, 80457, 80465.

    b. The following zip codes in Adams County: 80614, 80640.

3. All zip codes in the 809 three-digit zip code group are considered part of the Colorado Springs metropolitan area and shall receive the same rating factor. In addition, the following zip codes in El Paso County, which lie outside the 809 three-digit zip code group shall be considered part of the Colorado Springs metropolitan area and shall receive the same rating factor as the 809 three-digit zip code group: 80809, 80817, 80819, 80829, 80831, 80840, 80841.

   If a carrier uses area rating factors which are based in whole or in part upon the zip code, and does not follow these guidelines, the carrier may be found to have rates that are unfairly discriminatory. The Commissioner would prefer that a carrier use federal MSA's, rather than zip codes, in their rating structure. The Commissioner expects carriers to review the appropriateness of area factors at least every five years and provide detailed support for the continued use of the factors in rate filings and upon request.

E. For individual health benefit plans, renewal rates shall not be affected by the health status or claims experience of the individual insured. A "claims experience factor," or any other part of the renewal rate calculation, which is based in whole or in part upon the health status or claims experience of the individual insured is prohibited.

Section 13 Incorporated Materials

45 CFR § 147.140 published by the Government Printing Office shall mean 45 CFR § 147.140 as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 147.140. A copy of the 45 CFR § 147.140 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the 45 CFR § 147.140 may be requested from the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 14 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 15 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 16 Effective Date

This regulation shall become effective January 1, 2016.

Section 17 History

New regulation effective December 1, 2013.
Amended regulation effective January 1, 2016.

Regulation 4-2-47 CONCERNING THE REQUIRED BENEFIT FOR APPLIED BEHAVIOR ANALYSIS THERAPY FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS FOR A CHILD

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-16-104(1.4)(b) and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements for the benefit provided by carriers for applied behavior analysis (ABA) therapy for the treatment of autism spectrum disorders in children.

Section 3 Applicability

This regulation shall apply to all carriers offering individual and/or group health benefit plans subject to the individual and group laws of Colorado and the requirements of the Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (ACA). This regulation shall not apply to grandfathered health benefit plans. This regulation replaces Emergency Regulation 13-E-16 in its entirety.

Section 4 Definitions

A. “Applied behavior analysis” or “ABA” shall have the same meaning as found at § 10-16-104(1.4)(a)(I), C.R.S., and § 10-16-104(1.4)(a)(XII)(b), C.R.S.

B. “Autism services provider” shall have the same meaning as found at § 10-16-104(1.4)(a)(II), C.R.S.

C. “Autism spectrum disorders” shall have the same meaning as found at § 10-16-104(1.4)(a)(III), C.R.S.

D. “Grandfathered health benefit plans” shall have the same meaning as found at § 10-16-102(31), C.R.S.

E. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

F. “Treatment for autism spectrum disorders” shall have the same meaning as found at § 10-16-104(1.4)(a)(XII), C.R.S.

Section 5 Rules

A. All health benefit plans subject to this regulation must provide coverage for the assessment, diagnosis, and treatment of autism spectrum disorders for children.

B. All health benefit plans subject to this regulation issued or renewed on or after May 15, 2014 must provide coverage for annual ABA therapy to treat autism spectrum disorders in children, which must provide, at a minimum:

1. Five hundred fifty (550) ABA sessions annually for children from birth through age eight (8);

2. One hundred eighty-five (185) ABA sessions annually for children aged nine (9) to nineteen (19);

3. Sessions will be will be calculated in twenty-five (25) minute increments; and

4. Sessions eligible for this benefit must be performed by an autism services provider.

C. Pursuant to § 10-16-104(1.4)(b)(I), C.R.S., at a minimum, all carriers with health benefit plans subject to this regulation must provide coverage annually for ABA therapy that is equivalent to what was required prior to May 13, 2013.

1. In the event that five hundred fifty (550) annual ABA sessions for a child from birth through age eight (8) does not provide the same coverage for ABA therapy as would have been required prior to May 13, 2013, all carriers with health benefit plans subject to this regulation shall increase the number of visits or sessions in order to provide the equivalent of the minimum number of visits or sessions as would have been required prior to May 13, 2013.

2. In the event that one hundred eighty-five (185) annual ABA sessions for a child aged nine (9) to nineteen (19) does not provide the same coverage for ABA therapy as would have been required prior to May 13, 2013, all carriers with health benefit plans subject to this regulation shall increase the number of visits or sessions in order to provide the equivalent of the minimum number of visits or sessions as would have been required prior to May 13, 2013.

D. Nothing in this regulation requires or permits a carrier to reduce benefits provided for autism spectrum disorders if a health benefit plan already provides coverage that exceeds the requirements of § 10-16-104(1.4), C.R.S., and this regulation.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process

Section 8 Effective Date

This regulation shall become effective on May 15, 2014.

Section 9 History

Emergency regulation 13-E-15 effective November 1, 2013.
Emergency regulation 13-E-16 effective December 31, 2013.
New regulation effective May 15, 2014.

Regulation 4-2-48 CONCERNING GRACE PERIODS FOR POLICYHOLDERS RECEIVING ADVANCE PAYMENT TAX CREDITS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-106.5(8)(b), and 10-16-140(4), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements for grace periods for health benefit plans offered on the Exchange for policyholders that receive the federal Advance Payment Tax Credits (APTC), and where the policyholder of the plan is delinquent in the payment of monthly premiums.

Section 3 Applicability

The provisions of this regulation shall apply to all individual health benefit plans issued or renewed on or after the effective date of this regulation for policyholders that receive federal Advance Payment Tax Credits. This regulation does not apply to grandfathered health benefit plans.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Exchange” shall have the same meaning as found at § 10-16-102(26), C.R.S.

C. “Grandfathered health benefit plan” shall have the same meaning as found at § 10-16-102(31), C.R.S.

D. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

Section 5 Rules

A. All individual health benefit plans shall contain a provision that the policyholder is entitled to a three (3) month grace period beginning the first month premium has not been received, as long as the policyholder has previously paid at least one (1) full month’s premium during the current benefit year.

B. During the three (3) month grace period, the health benefit plan shall remain in force, and the carrier:

1. Shall pay all appropriate claims for services rendered to the policyholder during the first month of the grace period; and

2. May pend claims for services rendered to the policyholder during the second and third month of the grace period.

3. If a carrier is unable to pend pharmacy claims during the second and third months of the three (3) month grace period, a carrier may deny those pharmacy claims. The carrier shall be required to reimburse a policyholder directly if a claim is filed for the denied pharmacy benefits once all delinquent premium payments have been received.

4. A carrier must continue to comply with the requirements set forth in §§ 10-16-704(4), 10-16-704(4.5), and 10-16-705(12), C.R.S.

C. If the policyholder's portion of the premium payment becomes delinquent, the carrier shall provide notice:

1. To the policyholder advising of the premium payment delinquency, including a description of the three (3) month grace period, and that the delinquency applies to all persons covered under the policy;

2. To the policyholder, at least 30 days in advance, of the carrier's intent to terminate coverage due to non-payment of premium in accordance with §§ 10-16-222, 10-16-325, and 10-16-429, C.R.S., including a statement that such a termination does not qualify as a special enrollment period during which the policyholder can enroll in another health benefit plan;

3. To the policyholder that they may be required to pay all amounts owed for services incurred after the first month of the three (3) month grace period, including repayment of APTC received during the grace period;

4. To providers with pended claims incurred in the second and/or third month of the policyholder's grace period that the claims may be denied if no further premium payments are received from the policyholder; and

5. To the U.S. Department of Health and Human Services (HHS) of policyholder non-payment.

These notices, except for the notice found in paragraph 4, shall be provided regardless of whether or not claims are incurred during the three (3) month grace period. The notice in paragraph 4 in Section 5.C. of this regulation must only be provided if claims are incurred during the three (3) month grace period.

D. The carrier must continue to collect advance payments of the premium tax credit on behalf of the policyholder during the three (3) month grace period.

E. The carrier shall return the advance payments of the premium tax credit collected during the second and third month of the three (3) month grace period if all delinquent premium payments have not been received by the end of the third month.

F. If a policyholder receiving APTC does not pay all outstanding premiums during the three (3) month grace period, the carrier must terminate coverage in accordance with §§ 10-16-222, 10-16-325, and 10-16-429, C.R.S.

G. The carrier must receive all past-due premium from the policyholder prior to allowing the policyholder to change to another plan offered by the carrier.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this Regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective on July 1, 2014.

Section 9 History

New regulation effective July 1, 2014.

Regulation 4-2-49 CONCERNING THE DEVELOPMENT AND IMPLEMENTATION OF A UNIFORM DRUG BENEFIT PRIOR AUTHORIZATION PROCESS, THE REQUIRED DRUG APPEALS PROCESS, AND THE COVERAGE OF CERTAIN OPIOID DEPENDENCE AND OTHER SUBSTANCE USE DISORDER TREATMENT DRUGS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-124.5(3)(a), and 10-16-124.5(3)(c), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements, process, and form to be utilized by carriers and contracted pharmacy benefit management firms for the prior authorization process for prescription drug benefits, and to adopt the changes mandated by House Bill 19-1269.

Section 3 Applicability

Except as noted, the provisions of this regulation shall apply to all carriers that market individual and group health benefit plans in the state of Colorado which provide prescription drug benefits. Except as required by Sections 5.A. and 5.B., the provisions of this regulation do not apply to non-profit health maintenance organizations with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group.

Section 4 Definitions

A. “Adverse determination” shall have the same meaning as found at § 10-16-113(1)(b), C.R.S.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S., and shall, for the purposes of this regulation, include a pharmacy benefit management firm contracted by a carrier.

C. “Covered person” or “patient” means, for the purposes of this regulation, the person entitled to receive benefits or services under a health benefit plan.

D. “Drug benefit” means, for the purposes of this regulation, the provision of a drug used to treat a covered medical condition of a covered person.

E. “FDA” means, for the purposes of this regulation, the Food and Drug Administration in the United States Department of Health and Human Services.

F. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

G. "Health maintenance organization" shall have the same meaning as found at § 10-16-102(35), C.R.S.

H. "Non-grandfathered" means, for the purposes of this regulation, a health benefit plan that does not qualify as a grandfathered health benefit plan as defined in § 10-16-102(31), C.R.S.

I. "Pharmacy benefit management firm" shall have the same meaning as found at § 10-16-102(49), C.R.S.

J. "Prescribing provider" shall have the same meaning as found at § 10-16-124.5(8)(a), C.R.S.

K. "Small group health benefit plan" means, for the purposes of this regulation, a health benefit plan sold to a small employer as defined in § 10-16-102(61)(b) C.R.S.

L. "Urgent prior authorization request" shall have the same meaning as found at § 10-16-124.5(8)(b), C.R.S.

Section 5 Rules

A. All carriers issuing individual and group health benefit plans shall make available and provide coverage for, without prior authorization, a five (5) day supply of at least one (1) of the FDA-approved drugs prescribed for the treatment of opioid dependence. This requirement is limited to a first request within a twelve (12) month period.

B. Special Exception Processes for Non-formulary Drug Authorization Requests for Non-Grandfathered Individual and Small Group Health Benefit Plans

1. Carriers shall have standard and expedited exception processes that allow a covered person, the covered person's designee, or the covered person's prescribing provider (or other prescriber) to request and gain access to clinically-appropriate drugs not otherwise covered by his or her health benefit plan pursuant to 45 C.F.R. § 156.122(c) and this Section 5.B.

2. Standard Exception Requests

a. A carrier shall make its determination on a standard exception request and shall notify the covered person or the covered person's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than seventy-two (72) hours following receipt of the request.

b. A carrier that grants a standard exception request shall provide coverage of the non-formulary drug for the duration of the prescription, including refills, as long as the covered person remains covered under the individual or small group health benefit plan.

3. Expedited Exception Requests

a. A carrier shall have a process for a covered person, the covered person's designee, or the covered person's prescribing physician (or other prescriber) to request an expedited review based on exigent circumstances. Exigent circumstances exist when a covered person is suffering from a health condition that may seriously jeopardize the covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug.

b. A carrier shall make its coverage determination on an expedited exception request and shall notify the covered person or the covered person's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than twenty-four (24) hours following receipt of the request.

c. A carrier that grants an exception based on exigent circumstances shall provide coverage of the non-formulary drug for the duration of the exigency, as long as the covered person remains covered under the individual or small group health benefit plan.

4. External Exception Request Reviews

a. If the carrier denies a request for a standard exception under Section 5.B.2. or for an expedited exception under Section 5.B.3., it shall have a process for the covered person, the covered person's designee, or the covered person's prescribing physician (or other prescriber) to request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

b. A carrier shall ensure that the independent review organization makes its determination on the external exception request and notifies the covered person or the covered person's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than seventy-two (72) hours following its receipt of the request, if the original request was a standard exception request under Section 5.B.2. or no later than twenty-four (24) hours following its receipt of the request, if the original request was an expedited exception request under Section 5.B.3.

c. If the independent review organization overturns the carrier's denial of a standard exception request, the carrier shall provide coverage of the non-formulary drug for the duration of the prescription as long as the covered person remains covered under the individual or small group health benefit plan.

d. If the independent review organization overturns the carrier's denial of an expedited exception request, the carrier shall provide coverage of the non-formulary drug for the duration of the exigency as long as the covered person remains covered under the individual or small group health benefit plan.

C. A prior authorization process for a drug benefit, as developed by a carrier, shall:

1. Be made available electronically to the prescribing provider;

2. Make the following information available and accessible in a centralized location on the carrier's or its designated pharmacy benefit management firm's website:

a. The prior authorization requirements and restrictions, including, but not limited to:

(1) The prescribing provider's obligation to respond to requests for additional information; and

(2) When requests will be deemed "approved" or "denied";

b. An alphabetical list of drugs, including both brand name and scientific name, that require prior authorization, including the clinical criteria and supporting references that will be used in making a prior authorization determination;

c. Written clinical criteria that include the criteria for reauthorization of a previously approved drug, if applicable, after the previous approval period has expired; and

d. The standard form for prior authorization for a drug benefit, provided in Appendix A of this regulation.

3. Include evidence-based guidelines to be used by the carrier when making prior authorization determinations;

4. Allow for, but not require, the electronic submission of prior authorization requests for a drug benefit to the carrier.

D. Urgent prior authorization requests.

1. For requests not subject to Section 5.B., a carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy, if applicable, within one (1) business day of receiving an urgent prior authorization request. Carriers shall include appropriate information on the expedited appeals process related to urgent care situations as required by § 10-16-113, C.R.S., and its associated regulation with any denial of an urgent prior authorization request.

a. If additional information is required to process an urgent prior authorization request, the carrier must advise the prescribing provider of any and all information needed within one (1) business day of receiving the request.

b. If additional information is required to process an urgent prior authorization request, the prescribing provider shall submit the information requested by the carrier within two (2) business days of receiving such a request from the carrier.

c. If the additional information requested from the prescribing provider is not received within two (2) business days of the prescribing provider receiving such a request, the request shall be deemed denied. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy, if applicable, with a confirmation of the denial within one (1) business day of the date the request was deemed denied.

d. Once the requested additional information is received, the carrier shall make a determination in accordance with Section 5.D.1., of this regulation.

2. If a carrier does not request additional information or provide notification of approval or denial, as required by Section 5.D.1., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy, if applicable, with a confirmation of the deemed approval within one (1) business day of date the request was deemed approved.

E. Non-urgent prior authorization requests.

1. For requests not subject to Section 5.B., a carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy, if applicable, within two (2) business days of receiving a non-urgent prior authorization request that has been submitted through the carrier’s electronic pre-authorization system.

a. If additional information is required, the carrier must advise the prescribing provider of any and all information needed within two (2) business days of receiving the non-urgent prior authorization request.

b. If additional information is required to process a non-urgent prior authorization request, the prescribing provider shall submit the information requested by the carrier within two (2) business days of receiving such a request from the carrier.

c. If the additional information requested from the prescribing provider is not received within two (2) business days of the prescribing provider receiving such a request, the request shall be deemed denied. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy, if applicable, with a confirmation of the denial within two (2) business days of the date the request was deemed denied.

d. Once the requested additional information is received, the carrier shall make a determination in accordance with Section 5.E.1. or Section 5.E.2., of this regulation, as applicable.

2. A carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy, if applicable, within three (3) business days of receiving a non-urgent prior authorization request that has been submitted via facsimile, electronic mail, or verbally with associated written confirmation.

3. If a carrier does not request additional information or provide notification of approval or denial within:

a. Two (2) business days of the receipt of an electronically filed non-urgent prior authorization request, as required by Section 5.E.1., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy, if applicable, with a confirmation of the deemed approval within two (2) business days of the date the request was deemed approved; or

b. Three (3) business days of the receipt of a non-urgent prior authorization request that has been submitted via facsimile, electronic mail, or verbally with associated written confirmation, as required by Section 5.E.2., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy, if applicable, with a confirmation of the deemed approval within two (2) business days of the date the request was deemed approved.

F. When notifying a prescribing provider of a prior authorization approval, a carrier shall include:

1. A unique prior authorization number attributable only to that drug benefit approval request;

2. Specifications for the particular approved drug benefit, and the source and date of the clinical criteria used to make the determination for each particular drug;

3. The next date for review of the approved drug benefit; and

4. A link to the current criteria that will need to be submitted in order to reapprove the current prior authorization.

G. When notifying a prescribing provider of a prior authorization denial, a carrier shall include a notice to the prescribing provider, and dispensing pharmacy, if provided, that the covered person has the right to appeal the adverse determination pursuant to §§ 10-16-113 and 10-16-113.5, C.R.S., and their associated regulations.

H. For approval of requests not subject to Section 5.B., the prior authorization approval is valid for at least one hundred eighty (180) days after the date of approval.

I. If a prior authorization request is submitted electronically, verbally, via facsimile, or electronic mail, the response to that request shall be made through the same medium, or in a manner specifically requested by the provider.

J. Beginning January 1, 2020, any carrier that provides prescription drug benefits for the medication-assisted treatment of substance use disorders shall not impose any prior authorization requirements for any FDA-approved medication on the carrier's formulary.

Section 6 Form

All carriers shall utilize the uniform prior authorization form found in Appendix A of this regulation.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Incorporated Materials

45 C.F.R. § 156.122(c), published by Government Printing Office shall mean shall mean 45 C.F.R. § 156.122(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.122(c). A copy of 45 C.F.R. § 156.122(c) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 45 C.F.R. § 156.122(c) may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at www.ecfr.gov.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

This regulation shall become effective on October 1, 2019.

Section 11 History

New regulation effective July 15, 2014.
Amended regulation effective January 1, 2019.
Amended regulation effective October 1, 2019.

APPENDIX A

[CARRIER LOGO]
[CARRIER NAME]

UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:

[CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM CONTACT INFORMATION]

As of January 1, 2020, no prior authorization requirements may be imposed by a carrier for any FDA-approved prescription medication on its formulary which is approved to treat substance use disorders.

☐ **Urgent** [1]	☐ **Non-Urgent**		
Requested Drug Name:			
Is this drug intended to treat opioid dependence?		**Yes** ☐	**No** ☐
If **Yes,** is this a first request within a 12-month period for prior authorization for this drug? *** If Yes, prior authorization is not required for a 5-day supply of any FDA-approved drug for the treatment of opioid dependence and there is no need to complete this form.** *** If No, as of January 1, 2020, a prior authorization is not required for prescription medications on the carrier's formulary and there is no need to complete this form.**		**Yes*** ☐	**No** ☐

Patient Information:	**Prescribing Provider Information:**
Patient Name:	Prescriber Name:
Member/Subscriber Number:	Prescriber Fax:
Policy/Group Number:	Prescriber Phone:
Patient Date of Birth (MM/DD/YYYY):	Prescriber Pager:
Patient Address:	Prescriber Address:
Patient Phone:	Prescriber Office Contact:
Patient Email Address:	Prescriber NPI:
	Prescriber DEA:
Prescription Date:	Prescriber Tax ID:
	Specialty/Facility Name (If applicable):
	Prescriber Email Address:

Prior Authorization Request for Drug Benefit:	☐ New Request	☐ Reauthorization	
Patient Diagnosis and ICD Diagnostic Code(s):			
Drug(s) Requested (with J-Code, if applicable):			
Strength/Route/Frequency:			
Unit/Volume of Named Drug(s):			
Start Date and Length of Therapy:			
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:			
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]			
For use in clinical trial? (If yes, provide trial name and registration number):			
Drug Name (Brand Name and Scientific Name)/Strength:			
Dose:	Route:		Frequency:
Quantity:	Number of Refills:		
Product will be delivered to:	☐ Patient's Home	☐ Physician Office	☐ Other:
Prescriber or Authorized Signature:			Date:
Dispensing Pharmacy Name and Phone Number:			

☐ **Approved**	☐ **Denied**

	If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or could subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request.

Regulation 4-2-50 CONCERNING PEDIATRIC DENTAL COVERAGE REQUIREMENTS

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109 and 10-16-103.4(7), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish a requirement that carriers cannot sell a health benefit plan to consumers with children under the age of nineteen (19) in the individual or small group market inside or outside the Exchange that does not contain pediatric dental essential health benefit (EHB) coverage without obtaining reasonable assurance that such coverage has been purchased.

Section 3 Applicability

This regulation shall apply to all insurance carriers who offer individual and small group health benefit plans, and/or stand-alone dental plans, issued or renewed on or after January 1, 2025, in the state of Colorado.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Clear and conspicuous” means, for the purposes of this regulation, and with respect to a disclosure, that the disclosure is reasonably understandable and designed to call attention to the nature and significance of the information it contains. A disclosure is considered designed to call attention to the nature and significance of the information in it if the carrier:

1. Uses a typeface and type size that are easy to read;

2. Provides wide margins and ample line spacing;

3. Uses boldface, italics, underscoring, or capitals for key words and phrases; and

4. In a form that combines the disclosure with other information, uses a plain-language heading to call attention to the disclosure portion of the document, and uses a type size that is greater than the type size predominantly used in the rest of the document.

C. “Essential health benefits” and “EHB” shall have the same meaning as found at § 10-16-102(22), C.R.S.

D. “Exchange” shall have the same meaning as found at § 10-16-102(26), C.R.S.

E. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

F. "Patient Protection and Affordable Care Act" and "ACA" mean, for the purposes of this regulation, the Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

Section 5 Rules

A. Pediatric dental coverage is one of the ten (10) essential health benefits (EHB) that must be covered by health benefit plans subject to the requirements of the ACA.

B. Obtaining pediatric dental coverage.

1. Carriers selling individual and small group health benefit plans must ensure that consumers with children under the age of nineteen (19) purchasing their health plans obtain pediatric dental EHB coverage.

2. Carriers shall give consumers notice if the plan they have selected for purchase does not include the required pediatric dental EHB coverage.

3. Carriers shall provide a clear and conspicuous notice to consumers on their websites or with all pediatric dental plan marketing materials describing how out-of-pocket maximums for stand-alone pediatric dental plans are treated differently than out-of-pocket maximums for dental plans that are provided with, or contained within, a health benefit plan. This notice shall also be provided to consumers as a separate document that is included with the dental plan policy documents given to policyholders.

4. Carriers must be reasonably assured that the required pediatric dental EHB coverage has been purchased through one of the following methods:

a. The purchase of a health benefit plan which contains the required pediatric dental EHB coverage;

b. The purchase of a health benefit plan which provides the required pediatric dental EHB coverage through a contractual arrangement with a dental carrier; or

c. The purchase of a stand-alone dental plan that provides the required pediatric dental EHB coverage.

C. In order for a carrier to sell an individual or small group health benefit plan that does not include coverage of the pediatric dental EHB, the carrier must be reasonably assured that a consumer with children under the age of nineteen (19) has or will purchase such coverage. Reasonable assurance may be obtained by one or more of the following:

1. Obtaining a certification from the consumer that they have purchased pediatric dental EHB coverage; or

2. Obtaining an attestation as supplied on the individual application that the consumer has or will purchase pediatric dental EHB coverage.

D. Supplying only the notice as required in Section 6 of this regulation does not constitute reasonable assurance.

Section 6 Notices for No-Adult-Benefit Pediatric Dental Plans

A. Carriers must provide notice to consumers purchasing pediatric-only dental EHB coverage, whether in a stand-alone dental policy or as part of a health benefit plan, that such coverage does not provide any dental benefits to individuals age nineteen (19) or older.

B. The required notice shall be prominently displayed on the first page of the policy form and shall be contained in all marketing materials for that policy.

C. The required notice shall consist of the following language::

"This policy does not provide any dental benefits to individuals age nineteen (19) or older. This policy is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. If you want adult dental benefits, you will need to buy a plan that has adult dental benefits. This plan will not pay for any adult dental care, so you will have to pay the full price of any care you receive."

Section 7 Severability

If any provisions of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation is effective January 1, 2025.

Section 10 History

Regulation effective July 15, 2014.
Regulation 4-2-50 amended, regulation effective April 15, 2015.
Amended regulation effective January 1, 2025.

Regulation 4-2-51 CARRIER DISCONTINUANCE OR MARKET EXIT OF HEALTH BENEFIT PLANS OR STUDENT HEALTH INSURANCE COVERAGE POLICIES

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109, 10-16-105.1(6)(a), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish standards for carriers in discontinuing health benefit plans or student health insurance coverage policies and for carriers exiting a Colorado market segment pursuant to the requirements of Colorado law.

Section 3 Applicability

This regulation shall apply to individual, small group, and large group health benefit plans and student health insurance coverage policies subject to the health insurance laws of Colorado.

Section 4 Definitions

A. “Carrier” shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Creditable coverage” shall, for purposes of this regulation, have the same meaning as found at § 10-16-102(16), C.R.S.

C. “Effective date” shall, for the purposes of this regulation, mean the effective date of the company’s discontinuance or exit.

D “Enrollee” shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(20).

E. “Exchange” shall, for the purposes of this regulation, have the same meaning as set forth in § 10-16-102(26), C.R.S.

F. "Grandfathered health benefit plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(31), C.R.S.

G. "Health benefit plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(32), C.R.S.G.

H. "Market Exit" shall, for the purposes of this regulation, mean a discontinuance of all of a carrier's health benefit plans or student health insurance coverage policies.

I. "Market Segment" shall, for the purposes of this regulation, mean the individual, small group, large group or student health insurance coverage.

J. "SERFF" shall, for the purposes of this regulation, mean System for Electronic Rate and Form Filing.

K. "Small group plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(63), C.R.S.

L. "Student health insurance coverage" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(65), C.R.S.

Section 5 Discontinuance of Individual and Small Group Health Benefit Plans

A. Prior to discontinuing any grandfathered or non-grandfathered individual or small group health benefit plans, a carrier must notify the Division of such discontinuance by submitting a filing to the Division. All filings must be submitted electronically via SERFF by a licensed entity. Failure to supply the required information specified in this regulation will render the filing incomplete, and such a filing may be rejected. A separate filing must be sent for each Line of Business being discontinued. The SERFF filing should be submitted as:

1. Type of Filing "Other"; and

2. Type of Insurance (TOI) code H21, or for HMO's code HOrg03.

B. A carrier that elects to non-renew or discontinue individual or small group health benefit plans must do so in accordance with the requirements found at § 10-16-105.1(2)(g), C.R.S. The carrier must offer enrollees the following options to purchase other coverage:

1. Any other individual health benefit plan or small group health benefit plan from the carrier in the same county;

2. A plan from another carrier in the same market segment; or

3. A new plan through Connect for Health Colorado.

C. The carrier must provide the Commissioner with at least 135 days notice prior to the discontinuance date.

D. The carrier must provide notice of the decision not to renew or continue coverage at least ninety (90) days prior to the date of nonrenewal or discontinuance as follows:

1. For individual health benefit plans, notice must be provided to each policyholder, including any enrollees;

2. For small group health benefit plans, notice must be provided to the group policy holder or employer.

F. Carriers offering individual health benefit plans must provide coverage on a calendar year basis, from January 1 to December 31, and must not discontinue plans mid-year.

G. Carriers must include notice to the policyholder of eligibility for special enrollment periods, as established pursuant to § 10-16-105.7, C.R.S. and Colorado Insurance Regulation 4-2-43, with the nonrenewal or discontinuance notice.

H. Carriers must provide notice in accordance with Colorado Insurance Regulation 4-2-82.

Section 6 Discontinuance of Large Group Health Benefit Plans and Student Health Insurance Coverage

Large group carriers and student health insurance carriers must use the following guidelines when discontinuing large group health benefit plans or student health insurance coverage plans to ensure adequate consumer protection.

A. When a large group or student health coverage carrier is discontinuing a particular plan, but is remaining in the large group market or student health insurance market, the carrier must provide notice of the decision to discontinue to each policyholder, certificate holder, participant, and beneficiary covered by the plan, no less than ninety (90) days prior to discontinuation. The notice found in Colorado Insurance Regulation 4-2-82 must be utilized. Additional communication with the policyholders and certificate holders regarding their enrollment options is not prohibited.

B. All filings must be submitted electronically via SERFF by a licensed entity. Failure to supply the required information specified in this regulation will render the filing incomplete, and such a filing could be rejected. A separate filing must be submitted for each market segment whereby a health benefit plan or student health insurance policy is being discontinued. The SERFF filing must be submitted as:

1. Type of Filing “Other”; and

2. Type of Insurance (TOI) code H21 – Other, or for HMOs HOrg03 – Other.

C. The large group and student health insurance coverage carrier must offer policyholders the option to purchase any other large group or student health benefit plan(s), respectively, currently offered by the carrier or purchasing a plan from another carrier.

D. The large group or student health insurance coverage carrier must act uniformly without regard to the claims experience of the policyholders or any health status-related factor relating to any policyholder, certificate holder, participant, or beneficiary covered, or new participants or beneficiaries that may become eligible for such coverage.

E. With respect to the discontinuance of a particular large group health benefit plan(s), the carrier must notify the Insurance Commissioner before providing the notification required in subsection A. above at least 135 days prior to the discontinuance date.

Section 7 Market Exits of Individual, Small Group, Large Group and Student Health Insurance Coverage Policies

A. Carriers must file a market exit filing with the Division prior to notification of that exit to policyholders or enrollees. The filing must be submitted electronically via SERFF by a licensed entity. Failure to supply the required documentation may render the filing incomplete and may result in the filing being disapproved. A separate filing must be submitted for each market segment the carrier wishes to exit from. The SERFF filing must be submitted as:

1. Type of Filing "Other"; and

2. Type of Insurance (TOI) code H21 – Other or for HMOs HOrg03 – Other.

B. The carrier must notify the Division at least 225 days prior to the market exit.

C. The carrier must supply the policyholder and enrollees with notice at least 180 days prior to the market exit.

D. The carrier must use the notification as found in Colorado Insurance Regulation 4-2-82.

E. A carrier that exits a market segment must continue coverage through the first renewal period not to exceed twelve (12) months after the notice provided pursuant to § 10-16-105.1(2)(h)(II)(A), C.R.S.

F. A carrier that exits a market segment must not write any new health benefit plans or student health insurance coverage policies of the same type that the carrier exited for a period of five (5) years after the date of the notice to the Commissioner pursuant to § 10-16-105.1(2)(h)(II)(B), C.R.S.

Section 8 Required SERFF Filing Elements

Carriers shall provide the following information via SERFF to the Division when discontinuing plans:

A. The Form Schedule Tab in SERFF must be completed with the lead form number, form name, form number, edition date, form type, and action for each policy form that is being discontinued. Listing the readability score and attaching the actual forms is not required.

B. Copies of all proposed policyholder notices for Division review.

C. A letter addressed to the Commissioner that contains a summary of the carrier's discontinuance or market exit actions must be attached in the Supporting Documentation tab in SERFF and must contain the following information:

1. Implementation date of the discontinuance or exit from the market;

2. The reason for the carrier's action;

3. The market segment being exited or discontinued;

4. The plans or policies affected by the discontinuance or market exit;

4. Number of people affected;

5. Grandfathered/Non-Grandfathered status; and

6. A statement as to whether the plans are grandfathered or non-grandfathered.

D. The form found in Appendix A of this regulation must be completed and included with any discontinuance or market exit filing. Carriers must utilize the format in Appendix A and submit the data in Excel format.

E. The form found in Appendix B of this regulation must be completed and included with any discontinuance or market exit filing. Carriers must utilize the format in Appendix B and submit the data in Excel format. Carriers must include all 64 Colorado counties. For individual and small group plans, carriers must submit the HIOS IDs and the Exchange status of each of the plans.

Section 9 Severability

If any provisions of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 10 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 11 Effective Date

This regulation shall become effective May 30, 2022.

Section 12 History

New regulation effective August 15, 2014.
Amended regulation effective August 1, 2015.
Amended regulation effective May 30, 2022.

APPENDIX A – HEALTH BENEFIT PLAN DISCONTINUANCES SUMMARY DATA TEMPLATE (WITH EXAMPLES):

Health Benefit Plan Discontinuances Summary **[Insert Carrier Name]**					
Effective Date	Market Segment	People Affected	Reason for Action	Grandfathered Status	Comments
6/30/14	Individual	6	Discontinuance of Specific Health Benefit Plan §10-16-105.1(2)(g)	Non-grandfathered	
7/1/14	Small Group	29	Exiting the Market §10-16-105.1(2)(h)	Grandfathered	
8/1/14	Individual	1,256	Exiting the Market §10-16-105.1(2)(h)	Non-grandfathered	
7/13/15	Large Group	214	Discontinuance of Specific Health Benefit Plan §10-16-105.1(2)(g)	Grandfathered	
1/1/16	Student Health Insurance Coverage	1,823	Exiting the Market §10-16-105.1(2)(h)	Non-grandfathered	
Total		3,328			

APPENDIX B – HEALTH BENEFIT PLAN DISCONTINUANCES OR MARKET BY COUNTY DATA TEMPLATE (WITH EXAMPLES):

	DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:				
SERFF FILING #:	COUNTY TOTAL:	111111	222222	333333	
NAIC #:		44444	55555	66666	
PLAN/PRODUCT NAME:		Plan X	Plan Y	Plan Z	
ADAMS COUNTY	5		2	3	
ALAMOSA COUNTY					
APAPAHOE COUNTY	9		3	6	
ARCHULETA COUNTY					
BACA COUNTY					
BENT COUNTY					
BOULDER COUNTY	106		6	100	
BROOMFIELD COUNTY	45		2	43	
CHAFFEE COUNTY	1	1			
CHEYENNE COUNTY					
CLEAR CREEK COUNTY	1			1	
CONEJOS COUNTY					
COSTILLA COUNTY					
CROWLEY COUNTY	1			1	
CUSTER COUNTY					
DELTA COUNTY					
DENVER COUNTY	208		8	200	
DOLORES COUNTY	1			1	
DOUGLAS COUNTY	50			50	
EAGLE COUNTY	1			1	
EL PASO COUNTY	3			3	
ELBERT COUNTY					

APPENDIX B– HEALTH BENEFIT PLAN DISCONTINUANCES OR MARKET EXIT DATA TEMPLATE BY COUNTY (WITH EXAMPLES) CONTINUED:

	DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:				
SERFF FILING #:	COUNTY TOTAL:	111111	222222	333333	
NAIC #:		44444	55555	66666	
PLAN/PRODUCT NAME:		Plan X	Plan Y	Plan Z	
FREMONT COUNTY	11		2	9	
GARFIELD COUNTY					
GILPIN COUNTY					
GRAND COUNTY	153		3	150	
GUNNISON COUNTY					
HINSDALE COUNTY					
HUERFANO COUNTY	46		6	40	
JACKSON COUNTY	32		2	30	
JEFFERSON COUNTY	1	1			
KIOWA COUNTY					
KIT CARSON COUNTY	1			1	
LA PLATA COUNTY					
LAKE COUNTY					
LARIMER COUNTY	1			1	
LAS ANIMAS COUNTY					
LINCOLN COUNTY					
LOGAN COUNTY	133		8	125	
MESA COUNTY	1			1	
MINERAL COUNTY	60			60	
MOFFAT COUNTY	1			1	
MONTEZUMA COUNTY	3			3	
MONTROSE COUNTY					
MORGAN OOUNTY					

APPENDIX B – HEALTH BENEFIT PLAN DISCONTINUANCES OR MARKET EXIT DATA TEMPLATE BY COUNTY (WITH EXAMPLES) CONTINUED:

	DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:				
SERFF FILING #:	COUNTY TOTAL:	111111	222222	333333	
NAIC #:		44444	55555	66666	
PLAN/PRODUCT NAME:		Plan X	Plan Y	Plan Z	
OTERO COUNTY	14		2	12	
OURAY COUNTY					
PARK COUNTY	48		3	45	
PHILLIPS COUNTY					
PITKIN COUNTY					
PROWERS COUNTY	156		6	150	
PUEBLO COUNTY	13		2	11	
RIO BLANCO COUNTY	1	1			
RIO GRAND COUNTY					
ROUTT COUNTY	1			1	
SAGUACHE COUNTY					
SAN JUAN COUNTY					
SAN MIGUEL COUNTY	1			1	
SEDGWICK COUNTY					
SUMMIT COUNTY					
TELLER COUNTY	128		8	120	
WASHINGTON COUNTY	1			1	
WELD COUNTY	75			75	
YUMA COUNTY	1			1	
OUT OF STATE	3			3	
TOTAL:	**1316**	**3**	**63**	**1250**	

Regulation 4-2-52 [Repealed eff. 02/01/2019]

Regulation 4-2-53 NETWORK ADEQUACY STANDARDS AND REPORTING REQUIREMENTS FOR ACA-COMPLIANT HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-104(5.5)(b), 10-16-109, 10-16-704(1.5), 10-16-708, 10-16-1304(2)(c), and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide carriers offering Affordable Care Act (ACA)-compliant health benefit plans with standards and guidance on Colorado filing requirements for health benefit plan network adequacy filings, and requirements for Colorado Option Standardized Plan as specified in Colorado Insurance Regulation 4-2-80, including the applicable requirements found in Section 10-16-104(5.5), C.R.S. These standards shall serve as the measurable requirements used by the Division to evaluate the adequacy of carrier networks.

Section 3 Applicability

This regulation applies to all carriers offering ACA-compliant individual and/or group health benefit plans subject to the individual, small group, and/or large group laws of Colorado. This regulation includes student health insurance coverage. This regulation excludes individual short-term limited duration health insurance policies as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. “ACA” means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. “Counties with Extreme Access Considerations” or “CEAC” means, for the purposes of this regulation, counties with a population density of less than ten (10) people per square mile, based on U.S. Census Bureau population and density estimates.

D. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

E. “Dentist” and “dental provider” means, for the purposes of this regulation, a dental provider who is skilled in and licensed to practice dentistry for patients in all age groups and is responsible for the diagnosis, treatment, management, and overall coordination of services to meet the patient’s oral health needs.

F. “Embedded” means, for the purposes of this regulation, dental benefits provided as part of a health benefit plan, which may or may not be subject to the same deductible, coinsurance, copayment and out-of-pocket maximum of the health benefit plan.

G. “Emergency services” shall have the same meaning as found in § 10-16-704(19)(e)(I), C.R.S.

H. “Enrollment” means, for the purposes of this regulation, the number of covered persons enrolled in a specific health plan or network.

I. “Essential community provider” or “ECP” means, for the purposes of this regulation, a provider, including health care providers defined in § 25.5-5-403(2), C.R.S., § 25.5-8-103(6), C.R.S., and at 45 C.F.R. § 156.235(c), that serves predominantly low-income, medically underserved individuals,

J. “Health benefit plan” shall, for the purposes of this regulation, have the same meaning as found in § 10-16-102(32), C.R.S.

K. “Home health services” shall, for the purposes of this regulation, have the same meaning as found in § 25.5-4-103(7), C.R.S.

L. “Managed care plan” shall have the same meaning as found at § 10-16-102(43), C.R.S.

M. “Mental health, behavioral health, and substance use disorder care” means, for the purposes of this regulation, health care services for a behavioral, mental health, and substance use disorder as defined by § 10-16-104(5.5)(d), C.R.S., provided by mental health, behavioral health, and substance use disorder care providers.

N. “Mental health, behavioral health, and substance use disorder care providers” for the purposes of this regulation, and for the purposes of network adequacy measurements, means a provider offering health care services for a behavioral, mental health, and substance use disorder as defined by § 10-16-104(5.5)(d), C.R.S., and includes but is not limited to psychiatrists, psychologists, psychotherapists, licensed clinical social workers, psychiatric practice nurses, licensed addiction counselors, opioid treatment programs, inpatient and residential behavioral health facilities, licensed marriage and family counselors, and licensed professional counselors.

O. “Network” shall have the same meaning as found at § 10-16-102(45), C.R.S.

P. “Primary care” means, for the purposes of this regulation, health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care provider.

Q. "Primary care provider" or "PCP" means, for the purposes of this regulation, a participating health care professional designated by the carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person. For the purposes of network adequacy measurements, PCPs for adults and children includes physicians (pediatrics, general practice, family medicine, internal medicine, geriatrics, obstetrician/gynecologist), physician assistants, and nurse practitioners supervised by, or collaborating with, a primary care physician.

R. "SERFF" means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filings.

S. "Specialist" means, for the purposes of this regulation, a physician or non-physician health care professional who:

1. Focuses on a specific area of physical, mental health, behavioral health, substance use disorder care or a group of patients; and

2. Has successfully completed required training and is recognized by the state in which they practice to provide specialty care.

"Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

T. "Standardized plan" shall have the same meaning as found in § 10-16-1303(14) C.R.S.

U. "Student health insurance coverage" shall have the same meaning as found in § 10-16-102(65), C.R.S.

V. "Substance use disorder care provider" for purposes of this regulation, means a provider offering health care services for a substance use disorder, including the recurring use of alcohol and/or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities.

W. "Telehealth" shall have the same meaning as found in § 10-16-123(4)(e), C.R.S.

X. "Urgent care facility" means, for the purposes of this regulation, a facility or office that generally has extended hours, may or may not have a physician on the premises at all times, and is only able to treat minor illnesses and injuries. An urgent care facility does not typically have the facilities to handle an emergency condition, which includes life or limb threatening injuries or illnesses, as defined under emergency services.

Section 5 Reporting Requirements

A. Network adequacy filings shall be filed with the Division through SERFF prior to use and annually thereafter. Specific SERFF filing requirements are in Section 11.

B. The following four (4) measurement standards shall be used to evaluate a carrier's network adequacy:

1. Compliance with network adequacy filing instructions published by the Division;

2. Compliance with network adequacy definitions contained in this regulation;

3. Compliance with the measurement details contained in this regulation; and

4. Compliance with the reporting methodologies contained in this regulation.

C. Attestations of adequate networks, for each network, including networks for Colorado Option Standardized Plans, shall be provided on the "Colorado Carrier Network Adequacy Summary and Attestation Form" submitted as part of the network adequacy form filing.

Section 6 Network Adequacy Standards

The following access to service and waiting time standards shall be met in order to comply with network adequacy requirements:

Service Type	**Time Frame**	**Time Frame Goal**
Emergency Care – Medical, Behavioral, Mental Health, and Substance Use	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care – Medical, Behavioral, Mental Health and Substance Use	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 7 calendar days	Met ≥ 90% of the time
Initial Non-Emergency Behavioral Health, Mental Health and Substance Use Disorder Care, initial appointments	Within 7 calendar days	Met ≥ 90% of the time
Follow-up Non-Emergency Behavioral Health, Mental Health and Substance Use Disorder Care appointments	Within 7 calendar days	Met ≥ 90% of the time
Prenatal Care	Within 7 calendar days	Met ≥ 90% of the time
Primary Care Access to after-hours care	Office number answered 24 hours/ 7 days a week by answering service or instructions on how to reach a physician	Met ≥ 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met ≥ 90% of the time
Specialty Care - non urgent	Within 30 calendar days	Met ≥ 90% of the time

Section 7 Availability Standards

A. "Provider to enrollee" ratios for different provider types shall be reported in the filed "Enrollment Document". Carriers shall also report on the Enrollment Document in SERFF the total number of lives and counts for the following types of providers/facilities: PCPs, specialists, obstetricians, gynecologists, OBGYNs, pediatricians, behavioral health, mental health and substance abuse disorder providers and facilities, pharmacy, hospitals, and urgent care facilities.

B. The standards listed below shall be used to measure network adequacy, along with geographic access standards, in counties with "large metro, metro and micro" status, as defined in Appendix A, for the specific provider types listed in Section 7.D. of this regulation.

C. The carrier shall attest that it is compliant with the "provider to enrollee" ratios standards in Section 7.D. of this regulation

D. The following "provider to enrollee" ratio availability standards shall be met in order to comply with network adequacy requirements:

Provider/Facility Type	**Large Metro**	**Metro**	**Micro**
Primary Care	1:1000	1:1000	1:1000
Pediatrics	1:1000	1:1000	1:1000
OB/GYN	1:1000	1:1000	1:1000
Mental health, and behavioral health providers	1:1000	1:1000	1:1000
Substance use disorder care providers	1:1000	1:1000	1:1000

Section 8 Geographic Access Standards

A. The carrier shall attest that at least one (1) of each of the providers and facilities listed below is available within the maximum road travel distance of any enrollee in each specific carrier's network

B. Geographic access standards may require that an enrollee cross county or state lines to reach a provider.

C. Network Adequacy Geographic Access Standards by Provider Type:

Individual Provider Specialty Types	**Geographic Type**				
	Large Metro	**Metro**	**Micro**	**Rural**	**CEACs**
	Maximum Distance (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)
Primary Care	5	10	20	30	60
Gynecology, OB/GYN	5	10	20	30	60
Pediatrics - Routine/Primary Care	5	10	20	30	60
Allergy and Immunology	15	30	60	75	110
Cardiothoracic Surgery	15	40	75	90	130
Cardiology	10	20	35	60	85
Chiropractor	15	30	60	75	110
Dermatology	10	30	45	60	100
Emergency Medicine	10	30	60	60	100

Individual Provider Specialty Types	Geographic Type				
	Large Metro	**Metro**	**Micro**	**Rural**	**CEACs**
	Maximum Distance (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)
Endocrinology	15	40	75	90	130
ENT/Otolaryngology	15	30	60	75	110
Gastroenterology	10	30	45	60	100
General Surgery	10	20	35	60	85
Gynecology only	15	30	60	75	110
Infectious Diseases	15	40	75	90	130
Licensed Addiction Counselor	10	30	45	60	100
Licensed Clinical Social Worker	10	30	45	60	100
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurosurgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100
Oncology - Radiation	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Optometry for routine pediatric vision services	15	30	60	75	110
Orthopedic Surgery	10	20	35	60	85
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	5	10	20	30	60
Physical Medicine and Rehabilitative Medicine	15	30	60	75	110
Plastic Surgery	15	40	75	90	130
Podiatry	10	30	45	60	100
Psychiatry	10	30	45	60	100
Psychology	10	30	45	60	100
Pulmonology	10	30	45	60	100
Rheumatology	15	40	75	90	130
Urology	10	30	45	60	100
Vascular Surgery	15	40	75	90	130
OTHER MEDICAL PROVIDER	15	40	75	90	130
Dentist	15	30	60	75	110

Individual Provider Specialty Types	Geographic Type				
	Large Metro	**Metro**	**Micro**	**Rural**	**CEACs**
	Maximum Distance (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)
Pharmacy	5	10	20	30	60
Acute Inpatient Hospitals	10	30	60	60	100
Cardiac Surgery Program	15	40	120	120	140
Cardiac Catheterization Services	15	40	120	120	140
Critical Care Services – Intensive Care Units (ICU)	10	30	120	120	140
Outpatient Dialysis	10	30	50	50	90
Surgical Services (Outpatient or ASC)	10	30	60	60	100
Skilled Nursing Facilities	10	30	60	60	85
Diagnostic Radiology	10	30	60	60	100
Mammography	10	30	60	60	100
Physical Therapy	10	30	60	60	100
Occupational Therapy	10	30	60	60	100
Speech Therapy	10	30	60	60	100
Inpatient and Residential Behavioral Health Facility Services	15	45	75	75	140
Orthotics and Prosthetics	15	30	120	120	140
Outpatient Infusion/Chemotherapy	10	30	60	60	100
Urgent Care Facilities	10	30	60	60	100
Opioid Treatment Program	10	30	60	60	100
OTHER FACILITIES	15	40	120	120	140

Section 9 Essential Community Provider Standards

A. ACA-compliant individual and small group health benefit plans, including those with embedded dental benefits, are required to have a sufficient number and geographic distribution of essential community providers (ECPs), where available. ECP standards do not apply to large group health benefit plans or student health insurance coverage.

B. Carriers shall ensure the inclusion of a sufficient number of ECPs to ensure reasonable and timely access to a broad range of ECP providers for low-income, medically underserved individuals in their service areas.

C. There are four (4) ECP standards for carrier ECP submissions:

1. General ECP Standard. Carriers utilizing this standard shall demonstrate in their "Essential Community Provider/Network Adequacy Template" in SERFF that at least 35 percent (35%), as specified by Colorado and CMS, of available ECPs in each plan's service area participate in the plan's network. This standard applies to all carriers except those who qualify for the alternate ECP standard.

2. Alternate ECP Standard. Carriers utilizing this standard shall demonstrate in their "Essential Community Provider/Network Adequacy Template" in SERFF, that they have the same number of ECPs as defined in the general ECP standard (calculated as 35 percent (35%) of the ECPs in the carrier's service area), but the ECPs should be located within Health Professional Shortage Areas (HPSAs) or five-digit ZIP codes in which 30 percent (30%) or more of the population falls below 200 percent (200%) of the federal poverty level (FPL). An alternate ECP standard carrier is one that provides a majority of covered professional services through physicians it employs or through a single contracted medical group.

3. General ECP Standard for Colorado Option Standardized Plans Networks as specified in Colorado Insurance Regulation 4-2-80, as applicable.

4. Alternate ECP Standard for Colorado Option Standardized Plans Networks as specified in Colorado Insurance Regulation 4-2-80, as applicable.

Section 10 Network Adequacy Requirements for Plans with Embedded Dental Benefits

Health benefit plans that offer embedded dental coverage shall report all aspects of network adequacy required in Section 11 of this regulation for dental providers included in carrier networks. If the dental provider is not within the carrier's medical network, the carrier shall include network adequacy reporting for the separate dental network(s) within the medical network adequacy filing. Network adequacy standards and reporting requirements for ACA-compliant stand-alone dental plans are specified in Colorado Insurance Regulation 4-2-57.

A. The carrier shall attest that at least one (1) dentist or dental provider listed below is available within the maximum road travel distance for each geographic type, as defined in Appendix A, for at least 90% of its enrollees in each Colorado county within the carrier's service area:

Geographic Type					
Provider Type	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Distance (Miles)	**Maximum Distance** (Miles)	**Maximum Distance** (Miles)	**Maximum Distance** (Miles)	**Maximum Distance** (Miles)
Dentist or Dental Provider	15	30	60	75	110

B. Geographic accessibility in some circumstances, may require that an enrollee cross county or state lines to reach an in-network provider.

Section 11 Requirements for Annual Network Adequacy Reporting for ACA-Compliant Individual, Small Group, and Large Group Health Benefit Plans, and Student Health Insurance Coverage Plans

Network adequacy reporting shall consist of network adequacy form and binder (if appropriate) filings submitted in SERFF. These filings shall be filed using the filing instructions for the appropriate ACA-compliant managed care plans in Sections 11.A and 11.B. Carriers shall report each network, including networks for Standardized Plans, if applicable, that provides managed care services for a carrier's individual, small group, large group, and student health insurance coverage plans.

A. Network Adequacy Filings for ACA-Compliant Individual and Small Group Health Benefit Plans

Network adequacy filings for networks associated with ACA-compliant individual and small group health benefit plans, including networks for Standardized Plans, shall be filed during the annual health benefit plan certification process, and shall consist of two (2) sections, the "Essential Community Providers/Network Adequacy" (ECP/NA) template filing in the Plan Management (Binder) section in SERFF, and a network adequacy form filing, filed with a SERFF "type of insurance" (TOI) code NA01.004. Each network that is included in any of a carrier's Binder filings, including networks for Standardized Plans, shall be included in the carrier's ECP/NA template filing and in the carrier's network adequacy form filing. Templates in SERFF and filing instructions specified on the Division's website shall be used.

1. Elements of the Binder Filing

a. All carriers shall submit network provider and facility listings on the "Essential Community Provider/Network Adequacy" (ECP/NA) template in the Binder filing in SERFF for each network. All ECPs in each network, including networks for Standardized Plans, must be included in this template. The templates must be completed and filed as described in SERFF and in the Division filing instructions on the Division website.

b. The "ECP Write-in Worksheet", if applicable, shall be filed on the "Supporting Documentation" tab of the Binder filing.

c. If a carrier does not meet the 35% ECP standard during the carrier binder validation or Division review process, the carrier shall submit a copy of the "Colorado ECP Justification Template" on the Supporting Documentation tab of the Binder in SERFF.

d. If the carrier does not meet the Colorado Option Standardized Plans ECP standards as specified in Colorado Insurance Regulation 4-2-80, the carrier shall submit a copy of the "Colorado ECP Justification Template" on the Supporting Documentation tab of the Binder in SERFF.

2. Elements of the Network Adequacy Form Filing

The network adequacy form filing shall include the following items and attached on the "Supporting Documentation" tab.

a. Carriers shall submit network access plans for each network, including networks for Colorado Option Standardized Plans, pursuant to § 10-16-704(9), C.R.S., and each Colorado Option Standardized Plan network in accordance with Colorado Insurance Regulation 4-2-80. Network access plan standards and reporting requirements are provided in Colorado Insurance Regulations 4-2-54 and 4-2-80.

b. Carriers shall submit an "Enrollment Document" in SERFF containing separate spreadsheets (tabs) for each network. Counts used for this document shall be based on the projected enrollment of all members in the carrier's individual, small group, and large group health benefit plans, and the student health insurance coverage plans utilizing that specific network.

c. The carrier shall provide screen shots from the provider directory(ies) showing:

(1) Master (entry) page of the carrier's website, directing users to the provider directory(ies);

(2) Introduction screen of the provider directory;

(3) The directory's general information, such as inclusion criteria, description of tiering (if applicable), customer service contact information, date of last revision(s), and directory disclosures;

(4) Simple search screen;

(5) A page of a provider directory produced from a search; and

(6) Detail screen for at least one (1) provider and one (1) facility.

d. The carrier shall submit the completed "Carrier Individual/Small Group Network Adequacy Summary and Attestation Form" in SERFF as described in Section 12.

B. Large Group Health Benefit Plans and Student Health Insurance Coverage Plans

Network adequacy reporting for large group health benefit plans and/or student health insurance coverage plans shall be contained in network adequacy filings separate from individual and small group filings, submitted annually to the Division. The annual submittal date is at the carrier's discretion.

Large group health benefit plans and student health insurance coverage plan network adequacy filings shall consist of one (1) or more network adequacy form filings, filed with SERFF "type of insurance" (TOI) code NA01.004. Each network (i.e. HMO, PPO, EPO, etc.) that is utilized by the carrier for large group health benefit plans or student health insurance coverage plans shall be reported in network adequacy form filings. Copies of the templates and filing instructions to be used for network adequacy filings for large group and student plans are in SERFF and on the Division's website. Requirements specified in Colorado Insurance Regulation 4-2-80 are not applicable to large group health benefit plans and student health insurance coverage plans.

The form filing will include the following items, all attached on the "Supporting Documentation" tab:

1. Carriers shall submit network adequacy access plans for each network, pursuant to § 10-16-704(9), C.R.S. and Colorado Insurance Regulation 4-2-54;

2. Carriers shall submit an "Enrollment Document" in SERFF containing separate spreadsheets (tabs) for each network. Counts used for this document shall be based on the projected enrollment of all members in the carrier's large group health benefit plans or student health insurance coverage plans utilizing that specific network.3. The carrier shall provide screen shots from the provider directory(ies) showing:

a. The master (entry) page of the carrier's website, directing users to the provider directory(ies);

b. The introduction screen of the provider directory;

c. The directory's general information, such as inclusion criteria, description of tiering (if applicable), customer service contact information, date of last revisions, and directory disclosures;

d. The simple search screen;

e. A page of a provider directory produced from the search; and

f. A detail screen for at least one (1) provider and one (1) facility.

3. All carriers must submit the "Network Provider Listing" and the "Network Facility Listing" for each network included in the network adequacy filing. For network adequacy filings that do not utilize a network reported for an individual or small group ACA plan in the last 12 months, the carrier shall submit a "Network Provider Listing" and a "Network Facility Listing." Copies of the templates and instructions for completing the listing documents are in SERFF and on the Division's website. If the carrier uses a network in a filing that has been reported in a network adequacy filing for an individual or small group ACA plan within the last twelve (12) months, the provider and network facility listings need not be duplicated. In these cases, the carrier must identify the network name, filing number, and date of the filing for each network that has already been reviewed on the "Carrier Large Group/Student Network Adequacy Summary and Attestation Form".

4. The carrier shall submit the completed "Carrier Large Group/Student Network Adequacy Summary and Attestation Form" in SERFF as described in Section 12.

Section 12 Required Attestations

A. A carrier shall attest that each of its health benefit plans will maintain a provider network(s) that meets the standards contained in this regulation, and that each provider network is sufficient in number and types of providers, including providers that specialize in mental health and substance use services, to assure that the services will be accessible without unreasonable delay.

B. A carrier shall attest that each of its individual and/or small group health benefit plans include in its provider network(s) a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in its service areas. This specific attestation is not applicable to networks only serving large group health benefit plans or student health insurance coverage plans.

C. In addition to the attestations required in subsections 12.A and 12.B, a carrier offering Standardized Plans shall attest that any network used for Standardized Plans meets the requirements of Section 8 of Colorado Insurance Regulation 4-2-80. This specific attestation does not apply to networks only serving large group health benefit plans or student health insurance coverage plans.

D. Each applicable attestation, including attestations for Colorado Option Standardized Plans network, shall be made on the applicable "Carrier Network Adequacy Summary and Attestation Form" submitted with the network adequacy form filing in SERFF. Network adequacy filings for individual and small group ACA-compliant plans shall include a completed, signed and dated "Carrier Individual/Small Group Network Adequacy Summary and Attestation Form." Network adequacy filings for large group and student health insurance coverage ACA-compliant plans shall include a completed, signed and dated "Carrier Large Group/Student Network Adequacy Summary and Attestation Form."

Section 13 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 14 Incorporated Materials

45 C.F.R. § 156.235(c) published by the Government Printing Office shall mean 45 C.F.R. § 156.235(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.235(c). A copy of 45 C.F.R. § 156.235(c) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.235(c) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 15 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 16 Effective Date

This regulation shall be effective on June, 30, 2023.

Section 17 History

New regulation effective January 1, 2017
Amended regulation effective July 1, 2018.
Emergency regulation effective September 10, 2019.
Amended regulation effective January 1, 2020.
Amended regulation effective June, 30, 2023.

APPENDIX A – DESIGNATING COUNTY TYPES

The county type, Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations (CEAC), is a significant component of the network access criteria. CMS uses a county type designation methodology that is based upon the population size and density parameters of individual counties.

Density parameters are foundationally based on approaches taken by the U.S. Census Bureau in its delineation of "urbanized areas" and "urban clusters", and the Office of Management and Budget (OMB) in its delineation of "metropolitan" and "micropolitan". A county must meet both the population and density thresholds for inclusion in a given designation. For example, a county with population greater than one million and a density greater than or equal to 1,000 persons per square mile (sq. mile) is designated Large Metro. Any of the population-density combinations listed for a given county type may be met for inclusion within that county type (i.e., a county would be designated "Large Metro" if any of the three Large Metro population-density combinations listed in the following table are met; a county is designated as "Metro" if any of the five Metro population-density combinations listed in the table are met; etc.).

Population and Density Parameters

County Type	Population	Density
Large Metro	≥ 1,000,000	≥ 1,000/sq. mile
---	500,000 – 999,999	≥ 1,500/ sq. mile
---	Any	≥ 5,000/ sq. mile
Metro	≥ 1,000,000	10 – 999.9/sq. mile
---	500,000 – 999,999	10 – 1,499.9/sq. mile
---	200,000 – 499,999	10 – 4,999.9/sq. mile
---	50,000 – 199,999	100 – 4,999.9/sq. mile
---	10,000 – 49,999	1,000 – 4,999.9/sq. mile
Micro	50,000 – 199,999	10 – 99.9 /sq. mile
---	10,000 – 49,999	50 – 999.9/sq. mile
Rural	10,000 – 49,999	10 – 49.9/sq. mile
---	<10,000	10 – 4,999.9/sq. mile
CEAC	Any	<10/sq. mile

COLORADO COUNTY DESIGNATIONS

County	Classification
Adams	Metro
Alamosa	Rural
Arapahoe	Metro
Archuleta	Rural
Baca	CEAC
Bent	CEAC
Boulder	Metro
Broomfield	Metro
Chaffee	Rural
Cheyenne	CEAC
Clear Creek	Rural
Conejos	CEAC
Costilla	CEAC
Crowley	CEAC
Custer	CEAC
Delta	Rural
Denver	Large Metro
Dolores	CEAC
Douglas	Metro
Eagle	Micro
Elbert	Rural
El Paso	Metro

County	Classification
Fremont	Rural
Garfield	Micro
Gilpin	Rural
Grand	CEAC
Gunnison	CEAC
Hinsdale	CEAC
Huerfano	CEAC
Jackson	CEAC
Jefferson	Metro
Kiowa	CEAC
Kit Carson	CEAC
Lake	Rural
La Plata	Micro
Larimer	Metro
Las Animas	CEAC
Lincoln	CEAC
Logan	Rural
Mesa	Micro
Mineral	CEAC
Moffat	CEAC
Montezuma	Rural
Montrose	Rural

County	Classification
Morgan	Rural
Otero	Rural
Ouray	CEAC
Park	CEAC
Phillips	CEAC
Pitkin	Rural
Prowers	CEAC
Pueblo	Micro
Rio Blanco	CEAC
Rio Grande	Rural
Routt	Rural
Saguache	CEAC
San Juan	CEAC
San Miguel	CEAC
Sedgwick	CEAC
Summit	Micro
Teller	Rural
Washington	CEAC
Weld	Metro
Yuma	CEAC

Regulation 4-2-54 NETWORK ACCESS PLAN STANDARDS AND REPORTING REQUIREMENTS FOR ACA-COMPLIANT HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-704(1.5), 10-16-708, 10-16-1304(2)(c), and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide carriers offering ACA-compliant health benefit plans with standards and guidance on Colorado filing requirements for health benefit plan network access plan filings and requirements for Colorado Option Standardized Plans as specified in Colorado Insurance Regulation 4-2-80. These standards shall serve as the measurable requirements used by the Division to evaluate the adequacy of carrier network access plan filings.

Section 3 Applicability

This regulation applies to all carriers offering ACA-compliant individual, group health benefit plans and/or student health insurance coverage subject to the individual, small group, and/or large group laws of Colorado. This regulation excludes individual short-term limited duration health insurance policies as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. “ACA” or means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

D. “Emergency medical condition” shall have the same meaning as found at § 10-16-704(19)(d), C.R.S.

E. “Emergency services” shall have the same meaning as found at § 10-16-704(19)(e)(I), C.R.S.

F. "Enrollment" means, for the purposes of this regulation, the number of covered persons enrolled in a specific health plan or network.

G. "Essential community provider" and "ECP", mean, for the purpose of this regulation, a provider, including health care providers defined in § 25.5-5-403(2), C.R.S., § 25.5-8-103(6), C.R.S., and at 45 C.F.R. § 156.235(c), that serves predominantly low-income, medically underserved individuals.

H. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

I. "Health maintenance organization" shall have the same meaning as found at § 10-16-102(35), C.R.S.

J. "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.

K. "Material change" means, for the purposes of this regulation, changes in the carrier's network of providers or type of providers available in the network to provide health care services or specialty health care services to covered persons that may render the carrier's network non-compliant with one or more network adequacy standards. Types of changes that could be considered material include:

1. A significant reduction in the number of primary or specialty care for physical health, mental health, behavioral health, or substance use disorder providers available in a network;

2. A reduction in a specific type of provider such that a specific covered service is no longer available;

3. A change to the tiered, multi-tiered, layered or multi-level network plan structure; and

4. A change in inclusion of a major health system that causes the network to be significantly different from what the covered person initially purchased.

L. "Mental health, behavioral health, and substance abuse disorder care" means, for the purposes of this regulation, health care services for a behavioral, mental health, and substance use disorder as defined by section § 10-16-104(5.5)(d), C.R.S., provided by mental health, behavioral health, and substance use disorder care providers.

M. "Mental health, behavioral health, and substance abuse disorder care providers" for the purposes of this regulation, and for the purposes of network adequacy measurements, means a provider offering health care services for a behavioral, mental health, and substance use disorder as defined by section 10-16-104(5.5)(d), C.R.S., and includes but is not limited to psychiatrists, psychologists, psychotherapists, licensed clinical social workers, psychiatric practice nurses, licensed addiction counselors, opioid treatment programs, inpatient and residential behavioral health facilities, licensed marriage and family counselors, and licensed professional counselors.

N. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.

O. "Primary care" means, for the purposes of this regulation, health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care provider.

P. "Primary care provider" or "PCP" means, for the purposes of this regulation, a participating health care professional designated by the carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person. For the purposes of network adequacy measurements, PCPs for adults and children include physicians (pediatrics, general practice, family medicine, internal medicine, geriatrics, obstetrics/gynecology), physician assistants, and nurse practitioners supervised by, or collaborating with, a primary care physician.

Q. SERFF means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filings.

R. "Specialist" means, for the purposes of this regulation, a physician or non-physician health care professional who:

1. Focuses on a specific area of physical health, mental health, behavioral health or substance use disorder for a group of patients; and

2. Has successfully completed required training and is recognized by the state in which they practice to provide specialty care.

"Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

S. "Standardized plan" shall have the same meaning as found in § 10-16-1303(14) C.R.S.

T. "Telehealth" shall have the same meaning as found in § 10-16-123(4)(e), C.R.S.

Section 5 Network Access Plan Standards

A. Network access plans are used by carriers to describe their policies and procedures for maintaining and ensuring that their networks are sufficient and consistent with state and federal requirements. These plans, along with other documents, are filed with the Division annually and are available upon request to consumers. Carriers shall submit current network access plans to the Division through SERFF with the annual network adequacy form filing specified in Colorado Insurance Regulation 4-2-53.

B. Carriers shall file, maintain, and make available on their website, an access plan for each network that the carrier offers in Colorado.

C. Carriers shall prepare an access plan prior to offering a new network plan, and shall notify the Division of any material change to any existing network plan within fifteen (15) business days after the change occurs, including a reasonable timeframe, pursuant to § 10-16-704(2.5), C.R.S., within which it will file an update to an existing access plan.

D. Carriers shall make the access plans, absent confidential information pursuant to § 24-72-204, C.R.S., available and shall provide them to any interested party upon request.

E. All health benefit plan form documents and marketing materials of a carrier shall clearly disclose the existence and availability of the access plan.

F. All rights and responsibilities of the covered person shall be included in the policy provisions, regardless of whether or not such provisions are also specified in the access plan.

G. Carriers shall prepare and file an access plan prior to offering a new network, and shall update an existing access plan whenever the carrier makes any material change to an existing network.

H. An access plan submitted by a carrier offering a health benefit plan that is a managed care plan shall demonstrate that the carrier meets all requirements in Section 6.

Section 6 Network Access Plan Reporting Requirements

The carrier shall address the following in the network access plan for each network offered by the carrier:

A. Establishing that the carrier's network has an adequate number of providers and facilities within a reasonable distance, as defined in Colorado Insurance Regulation 4-2-53;

B. The specific provider and facility types that will be measured and reported by the carrier. Those provider and facility types include, but are not limited to, the following:

1. Acute care hospital services;

2. Primary care providers (PCP);

3. Providers who may be available through the use of telehealth;

4. Pharmacy providers, within a reasonable distance and/or delivery time, and can include retail and/or mail-order pharmacy providers; and

5. Other provider and facility types;

C. The carrier's documented quantifiable and measureable process for monitoring and assuring the sufficiency of the network in order to meet the health care needs of populations enrolled in its managed care plans on an ongoing basis;

D. Information regarding how a carrier builds its provider network, including a description of the network and the criteria used to select and/or tier providers;

E. The carrier's quality assurance standards which must be adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care;

F. The carrier's process and communication to consumers to assure that a covered person is able to obtain a covered benefit, at the in-network benefit level, from a non-participating provider should the carrier's network prove to not be sufficient within the appointment wait time and distance standards required by Colorado Insurance Regulation 4-2-53, Section 6;

G. The carrier's process to ensure that covered services or treatment rendered at a network facility, including ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at a network facility, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider; and

H. The carrier's process for monitoring access to physician specialist services for emergency room care, anesthesiology, radiology, hospitalist care, pathology, and laboratory services at its participating facilities.

I. For Colorado Option Standardized Plan networks, all Network Access Plan reporting requirements listed in Colorado Insurance Regulation 4-2-80, Section 7.

Section 7 Network Access Plan Procedures for Referrals

The network access plan for each network offered by the carrier shall include procedures for making referrals both within its networks and outside of its networks pursuant to § 10-16-704(9)(b), C.R.S., and shall include the following:

A. A comprehensive listing, made available to covered persons and primary care providers, of the carrier's network of participating providers and facilities;

B. A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a health maintenance organization may offer variable deductibles, coinsurance and/or copayments to encourage the selection of certain providers;

C. Timely referrals for access to specialty care;

D. A process for expediting the referral process when indicated by the covered persons medical condition;

E. A provision that referrals approved by the carrier cannot be retrospectively denied except for fraud or abuse;

F. A provision that referrals approved by the carrier cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse; and

G. The carrier's process for covered persons to access services outside the network when necessary.

Section 8 Network Access Plan Disclosures and Notices

A. In the network access plan for each network offered, a carrier shall explain its method for informing covered persons of the plan's services and features through disclosures and notices to policyholders.

B. Required disclosures to covered persons, pursuant to § 10-16-704(9), C.R.S., shall include:

1. The carrier's grievance procedures, which shall be in conformance with Division regulations concerning prompt investigation of health claims involving utilization review and grievance procedures;

2. The extent to which specialty medical services, including but not limited to physical therapy, occupational therapy, and rehabilitation services are available;

3. The carrier's procedures for providing and approving emergency and non-emergency medical care;

4. The carrier's process for choosing and changing network providers;

5. The carrier's documented process to address the needs, including access and accessibility of services, of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities;

6. The carrier's documented process to identify the potential needs of special populations; and

7. The carrier's methods for assessing the health care needs of covered persons, tracking and assessing clinical outcomes from network services, assessing needs on an on-going basis, assessing the needs of diverse populations, and evaluating consumer satisfaction with services provided.

Section 9 Network Access Plans and Coordination and Continuity of Care

A. A carrier shall address its process for ensuring the coordination and continuity of care for its covered persons in the network access plan, pursuant to § 10-16-704(9)(h) and (j), C.R.S., for each network offered by the carrier.

B. The process for ensuring the coordination and continuity of care shall include, but is not limited to, the following:

1. The carrier's documented process for ensuring the coordination and continuity of care for covered persons referred to specialty providers;

2. The carrier's documented process for ensuring the coordination and continuity of care for covered persons using ancillary services, including social services and other community resources;

3. The carrier's documented process for ensuring appropriate discharge planning;

4. The carrier's process for enabling covered persons to change primary care providers;

5. The carrier's proposed plan and process for providing continuity of care in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The proposed plan and process shall include an explanation of how covered persons shall be notified in the case of a provider contract termination, the carrier's insolvency, or of any other cessation of operations, as well as how policyholders impacted by such events will be transferred to other providers in a timely manner; and

6. A carrier shall file and make available upon request the fact that the carrier has a "hold harmless" provision in its provider contracts, prohibiting contracted providers from balance-billing covered in compliance with § 10-16-705(3), C.R.S.

Section 10 Annual Network Access Plan Reporting and Attestations

A. Network access plans shall be submitted in network adequacy form filings in SERFF for each network offered, including networks for Colorado Option Standardized Plans. The data provided in the network access plans shall be specific to each network in a carrier's service area.

B. For networks including Colorado Option plans, in addition to the reporting requirements in this regulation, network access plan attestations and requirements in Colorado Insurance Regulation 4-2-80 shall be submitted in network adequacy filings in SERFF.

C. The following attestations shall be made on the "Carrier Network Adequacy Summary and Attestation Template" submitted with the form filing in SERFF.

1. Carrier attests that each of its managed care health benefit plans will maintain a provider network(s) that is sufficient in number and types of providers, including providers that specialize in mental health, behavioral health, and substance use care services, to assure that the services will be accessible without unreasonable delay.

2. Carrier attests that each of its managed care health benefit plans include in its provider network(s) a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in their service areas.

3. If the carrier does not immediately meet network adequacy standards, the carrier will include an attestation adequately addressing how it plans to meet network adequacy standards specified in section 5 of this regulation. Such changes shall be implemented and filed by the carrier in accordance with the reasonable schedule established by the carrier and reviewed by the Division.

Section 11 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 12 Incorporated Materials

45 C.F.R. § 156.235(c) published by the Government Printing Office shall mean 45 C.F.R. § 156.235(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.235(c). A copy of 45 C.F.R. § 156.235(c) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.235(c) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 13 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 14 Effective Date

This amended regulation shall be effective on June 30, 2023.

Section 15 History

New regulation effective January 1, 2017.
Amended regulation effective on July 1, 2018.
Amended regulation effective June 30, 2023.

Regulation 4-2-55 STANDARDS AND REPORTING REQUIREMENTS FOR ACA-COMPLIANT HEALTH BENEFIT PLAN PROVIDER DIRECTORIES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-704(1.5), 10-16-708, 10-16-146, 10-16-1304(2)(c), and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish standards and requirements for carrier ACA-compliant health benefit plan provider directories. These standards shall serve as the measurable requirements used by the Division to evaluate the adequacy of carrier provider directories.

Section 3 Applicability

This regulation applies to all carriers offering ACA-compliant individual and/or group health benefit plans that are subject to the individual, small group, and/or large group laws of Colorado, including Standardized Plans. This regulation excludes individual short-term policies as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. Affordable Care Act, “ACA” means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S., and shall include a carrier’s designee.

C. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

D. “Essential community provider” or “ECP” means, for the purpose of this regulation, a provider, including health care providers defined in § 25.5-5-403(2), C.R.S., § 25.5-8-103(6), C.R.S., and at 45 C.F.R. § 156.235(c), that serves predominantly low-income, medically underserved individuals.

E. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

F. "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.

G. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.

H. "Primary care" means, for the purposes of this regulation, health care services for a range of common physical, mental, or behavioral health conditions provided by a physician or non-physician primary care provider.

I. "Primary care provider" or "PCP" means, for the purposes of this regulation, a participating health care professional designated by the carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person. For the purposes of network adequacy measurements, PCPs for adults and children include physicians (pediatrics, general practice, family medicine, internal medicine, geriatrics, obstetrics/gynecology) and physician assistants and nurse practitioners supervised by, or collaborating with, a primary care physician.

J. "Provider" shall have the same meaning as found at § 10-16-102(56).

K. "Provider directory" means, for the purposes of this regulation, a comprehensive listing, produced and maintained by the carrier, or it's designee, made available to covered persons, the public, and primary care providers, of the plan's participating providers and facilities in each of the carrier's networks.

L. "SERFF" means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filings.

M. "Specialty care" means, for the purposes of this regulation, health care services that are not primary care and focus on a specific area of physical, mental, or behavioral health, or a specific group of patients.

N. "Standardized plan" shall have the same meaning as found in § 10-16-1303(14) C.R.S.

Section 5 Provider Directories

A. Provider directories shall be maintained by the carrier. Screen shots of the provider directory must be filed in SERFF in the annual network adequacy form filing.

B. Provider directories maintained by the carriers shall meet all of the following requirements:

1. A carrier shall post electronically a current and accurate provider directory for each of its networks, with the information and search functions as described in Appendix A, no less than monthly;

2. When making the provider directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a network through a clearly identifiable link or tab without requiring an individual to create or access an account or requiring the entry of a policy or contract number. The carrier shall include on the public electronic provider directory notice that the directory is available in the 15 most common languages spoken by individuals with limited English proficiency in Colorado;

3. The carrier shall include a disclosure in the provider directory of the carrier's response protocols as specified in Section 11, and a disclosure of the date of the most recent update for electronic directories, or the date of printing for printed directories. This disclosure shall state that the information included in the provider directory is accurate, to the best of the carrier's knowledge, as of the date of updating/printing, and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website, or call the carrier's customer service telephone number, to obtain current provider directory information;

4. A carrier shall provide a print copy of the requested pertinent portion of the current provider directory with the information described in Appendix A, Item 3, to a covered person within five (5) business days of the request;

5. A carrier shall provide information on how to file a complaint with the Division or with the carrier related to the accuracy of the provider directory and/or the provider experience:

6. A carrier shall include, in both the electronic and print versions of the provider directory, the following general information for each of its provider networks:

    a. A description of the criteria the carrier has used to build its provider network;

    b. If applicable, a description of the criteria the carrier has used to tier providers;

    c. If applicable, a description of how the carrier designates the different provider tiers or levels in the network and identifies (e.g., by name, symbols or grouping) which tier or level the following are placed in:

        (1) Each specific provider;

        (2) Each specific hospital; and

        (3) Each specific other type of facility in the network.

    d. A note that an authorization or referral may be required to access some providers; and

    e. A description of available translation and interpreter services in languages other than English for individuals with limited English proficiency, and how to access them.

7. A carrier shall make it clear, in both its electronic and print directories, which provider directory applies to a particular managed care network plan, such as including the specific name of the managed care network plan as marketed and issued in this state;

8. The carrier shall include, in both its electronic and print directories, customer service contact information by electronic means such as email, text or social media and, telephone number and an electronic link that covered persons or the general public may use to notify the carrier of inaccurate provider directory information;

9. For the items of information required in a provider directory pursuant to Appendix A pertaining to a health care professional, a hospital or a facility other than a hospital, the carrier shall make available, through the provider directory, the source of the information and any limitations;

10. A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency. A provider directory shall also be available in Spanish; and

11. The carrier shall respond as soon as practicable and, in no case later than one business day after receiving a request from a covered person through a telephone call or electronic, web-based, or Internet-based means, on whether a provider or facility has a contractual relationship to furnish items and services under the covered person's plan. The carrier shall retain the communication in the covered person's file for at least two years following the response.

Section 6 Requirements for Provider Directory Updates and Audits

A. The carrier shall update each electronic network provider directory at least monthly. Current provider directories shall be made available to the Commissioner, upon request. The carrier shall update the provider directory within two business days of receiving updated information from a provider or facility:

1. When the provider or facility begins a network agreement with a plan or with a carrier with respect to certain coverage;

2. When the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage; and

3. When there are material changes to the content of provider directory information of the provider or facility.

B. No less frequently than quarterly, the carrier shall audit at least twenty percent (20%) of the providers contained in its provider directories for accuracy and update that provider directory based upon its findings.

C. Audits shall be conducted such that all entries in a provider directory will be audited at least once every eighteen (18) months. Documentation of the process and findings of all audits and the information required by this regulation shall be retained for no less than thirty-six (36) months and shall be made available to the Commissioner upon request.

Section 7 Materially Inaccurate Information in Provider Directories

A. A covered person who has demonstrated that he or she reasonably relied upon materially inaccurate information contained in a carrier's provider directory and received services from what the covered person believed to be an in-network provider. The covered person will only be required to pay the amount that he or she would have paid, had the services been delivered by an in-network provider under the carrier's network plan.

B. A covered person will be considered to have demonstrated that he or she reasonably relied upon a carrier's provider directory if a covered person has confirmed that a provider is contained in a carrier's provider directory at the time the appointment was made. .

C. Carriers shall maintain an archive of all provider directory updates for a period of at least one hundred and eighty (180) days which must be provided to the Commissioner upon request.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 9 Incorporated Materials

45 C.F.R. § 156.235(c) published by the Government Printing Office shall mean 45 C.F.R. § 156.235(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.235(c). A copy of 45 C.F.R. § 156.235(c) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.235(c) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 10 Enforcement

Noncompliance with this Regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 11 Effective Date

This amended regulation shall be effective on July 15, 2023.

Section 12 History

New regulation effective January 1, 2017
Amended regulation effective July 1, 2018
Amended regulation effective July 15, 2023.

Appendix A - Provider Directory Contents

Provider directory filings made on or after the date of this regulation will be required to meet the following requirements.

1. The carrier shall make available through an electronic provider directory, for each network, the following information in a searchable format. Specific requirements for fields and searchability criteria are defined in the network adequacy filing instructions provided annually by the Division.

   A. For health care professionals:

      (1) Name;

      (2) Gender;

      (3) Participating office location(s);

      (4) Accessibility of the provider's office and examination rooms for persons with disabilities;

      (5) If the provider offers extended and weekend hours;

      (6) Specialty, if applicable;

      (7) Medical group affiliations, if applicable;

      (8) Participating facility affiliations, if applicable;

      (9) Languages spoken other than English, if applicable;

      (10) Tiers and network plans to which the provider belongs, if applicable; and

      (11) Whether accepting new patients.

   B. For hospitals:

      (1) Hospital name;

      (2) Hospital type (i.e. acute, rehabilitation, children's, cancer);

      (3) Participating hospital location; and

      (4) Hospital accreditation status.

   C. For facilities, other than hospitals, by type:

      (1) Facility name;

      (2) Facility type;

      (3) Types of services performed;

      (4) If the facility is an ECP; and

(5) Participating facility location(s).

2. For the electronic provider directories, for each network, a health carrier shall make available the following, non-searchable, information in addition to all of the information available under item 1. above:

A. For health care professionals:

(1) Contact information (telephone number(s), and if available, e-mail addresses, website URLs, etc.);

(2) Board certification(s); and

B. For hospitals and facilities other than hospitals: Telephone number(s), e-mail addresses, website URLs, etc., if applicable.

3. The carrier shall make available in print, upon request, the following provider directory information for the applicable network:

A. For health care professionals:

(1) Name;

(2) Contact information (telephone number(s), and if available, e-mail addresses, website URLs, etc.);

(3) Participating office location(s);

(4) Specialty, if applicable;

(5) Languages spoken other than English, if applicable; and

(6) Whether accepting new patients.

B. For hospitals:

(1) Hospital name;

(2) Hospital type (i.e. acute, rehabilitation, children's, cancer); and

(3) Participating hospital location and telephone number.

C. For facilities, other than hospitals, by type:

(1) Facility name;

(2) Facility type;

(3) Types of services performed;

(4) If the facility is an ECP; and

(5) Participating facility location(s), telephone number(s), e-mail addresses, website URLs, if applicable.

Regulation 4-2-56 CONCERNING CONTINUITY OF CARE REQUIREMENTS FOR ACA-COMPLIANT HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-705 and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide carriers offering ACA-compliant health benefit plans with the continuity of care requirements for health benefit plans. Continuity of care protections apply when a provider leaves or is terminated from a plans network; a Medicaid enrollee transfers to a commercial plan; or an enrollee's coverage is not renewed because the carrier is no longer offering any health benefit plans for which the individual is eligible.

Section 3 Applicability

This regulation applies to all carriers offering ACA-compliant individual and/or group health benefit plans subject to the individual, small group, and/or large group laws of Colorado. This regulation excludes individual short-term policies as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. "ACA" means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B. "Active course of treatment" means, for the purposes of this regulation:

1. An ongoing course of treatment for a life-threatening condition;

2. An ongoing course of treatment for a serious acute health condition, chronic health condition, or life-limiting illness;

3. the entire pregnancy through the postpartum period;

4. An ongoing course of treatment for a health condition, whether physical health, mental health, behavioral health, or substance use disorder, for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes;

5. Inpatient care; or

6. Scheduled to undergo non elective surgery, including the receipt of post operative care with respect to the surgery.

C. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

D. "Health condition" means, for the purposes of this regulation, an illness, injury, impairment, or condition of a physical, behavioral, or mental health nature, or that involves substance abuse.

E. "Life-threatening health condition" means, for the purpose of this regulation, a disease or health condition for which likelihood of death is probable unless the course of the disease or health condition is interrupted.

F. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.

G. "Primary care" means, for the purposes of this regulation, health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care provider.

H. "Primary care provider" or "PCP" means, for the purposes of this regulation, a participating health care professional designated by the carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person. For the purposes of network adequacy measurements, PCPs for adults and children include physicians (pediatrics, general practice, family medicine, internal medicine, geriatrics, obstetrics/gynecology) and physician assistants and nurse practitioners supervised by, or collaborating with, a primary care physician.

I. "Serious acute health condition, chronic health condition, or life-limiting illness" means, for the purpose of this regulation, a disease or health condition requiring complex on-going care which the covered person is currently receiving, including, but not limited to, chemotherapy, post-operative visits or radiation therapy.

J. "Transferring enrollee" shall have the same meaning as found at § 10-16-705(4.5)(a)(IV), C.R.S.

Section 5 Continuity of Care Requirements

Carriers shall ensure sufficient continuity of care provisions for their policyholders. Carriers shall include their processes on continuity of care provisions in their network access plans, as required by Insurance Regulation 4-2-54, Section 9.

A. A carrier and participating provider shall provide at least sixty (60) days written notice to each other before a provider is removed or leaves the network without cause.

B. When a primary care provider is being removed, leaving the network, or is being non-renewed, all covered persons who are patients of that primary care provider shall be notified by the carrier, in writing, by first class mail and by electronic mail, prior to termination. When the provider gives or receives the notice in accordance with Section 5.A. of this regulation, the provider shall supply the carrier with a list of those patients of the provider that are covered by a plan of the carrier. The carrier shall supply the provider with a list of the provider's patients that are covered by the carrier.

C. Notice to policyholders:

1. For covered persons, irrespective of whether it is for cause or without cause or due to non-renewal of a contract, the carrier shall make a good faith effort to provide both written notice of a provider's removal, leaving, or non-renewal from the network, and the provider information contained in Section 5.F. of this regulation, within fifteen (15) working days of receipt or issuance of a notice provided in accordance with Section 5.A. of this regulation. This notice shall be provided to all covered persons who are identified as patients by the provider, are on a carrier's patient list for that provider, or who have been seen by the provider being removed or leaving the network within the previous twelve (12) months. This notice shall be provided by first class mail, and by electronic mail, when possible.

2. For transferring enrollees, the carrier shall notify the transferring enrollee, in plain language, by first-class mail, and by electronic mail, when possible, at the time of enrollment, that the enrollee may request continued transition care from an out-of-network provider. The transferring enrollee or enrollee's provider must notify the carrier of the need for continued transitional care within thirty (30) days after the transferring enrollees effective date of coverage. The carrier shall make a good faith effort to provide the provider information contained in Section 5.F. of this regulation, within fifteen (15) working days of receipt of a request for care.

D. A covered person must have been undergoing treatment, or have been seen at least once in the previous twelve (12) months, by the provider being removed or leaving the network for that covered person to be considered in an active course of treatment. A transferring enrollee must have been undergoing treatment or have been seen at least once in the previous twelve (12) months by the out-of-network provider.

E. A carrier shall establish reasonable procedures to transition the covered person or transferring enrollee who is in an active course of treatment to a participating provider in a manner that provides for continuity of care when a covered person's provider leaves or is removed from the network or when a transferring enrollee enrolls in the carrier's network.

F. A carrier shall make available to the covered person or transferring enrollee a list of available participating providers who are accepting new patients in the same geographic area and specialty provider type, or a referral to a provider if there is no participating provider available, who is of the same provider or specialty type. The carrier shall provide information about how the covered person or transferring enrollee may request continuity of care as required by this regulation.

G. A carrier's transition procedures shall provide that:

1. A carrier shall review requests for continuity of care made by the covered person or transferring enrollee or the covered person's or transferring enrollee's authorized representative and ensure a timely transfer, without a gap in coverage, after the continuity of care period.

2. The continuity of care period shall extend through the entire pregnancy and postpartum period.

3. The continuity of care period for covered persons and transferring enrollees who are undergoing an active course of treatment shall extend to the earlier of:

a. The termination of the course of treatment by the covered person or transferring enrollee or the treating provider;

b. Ninety (90) days after the effective date of the provider's departure or termination from the network, unless the carrier's Medical Director determines that a longer period is necessary;

c. The date that care is successfully transitioned to a participating provider;

d. Benefit limitations under the plan are met or exceeded; or

e. The care is no longer medically necessary.

H. For the duration of the continuity of care period, in addition to the provisions of Section 5.G. of this regulation, a continuity of care request may only occur when the provider departing or terminated from the network:

1. Agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the carrier for that patient as provided in the original provider contract, or by the new payment and terms agreed upon and executed between the provider and the carrier; and

2. Agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the provider were still a participating provider.

I. The obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the in-network relationship is extended to provide continuity of care.

J. For the duration of the continuity of care period, in addition to the provisions of Section 5.G of this regulation, a continuity of care request from a transferring enrollee may only occur when the out-of-network provider:

1. Agrees in writing to accept the carrier's standard in-network reimbursement rate and adhere to the carriers' terms and conditions, quality of care standard and protocols, referral process, and reporting standards that apply to comparable in-network providers; and

2. Agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the provider were an in-network provider.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This amended regulation shall be effective on January 1, 2025.

Section 9 History

New regulation effective January 1, 2017.
Amended regulation effective July 1, 2018.
Amended regulation effective January 1, 2025.

Regulation 4-2-57 NETWORK ADEQUACY STANDARDS AND REPORTING REQUIREMENTS FOR ACA-COMPLIANT STAND-ALONE DENTAL MANAGED CARE PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-704(1.5), and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide carriers offering ACA-compliant stand-alone dental managed care plans with standards and guidance on Colorado filing requirements for managed care dental plan network adequacy filings. These standards shall serve as the measurable requirements used by the Division to evaluate the adequacy of carrier networks.

Section 3 Applicability

This regulation applies to all carriers marketing, issuing, and renewing ACA-compliant stand-alone dental managed care plans, including individual and small group dental managed care plans, subject to the individual and small group laws of Colorado. ACA-compliant health benefit plans with embedded dental benefits are excluded from this regulation.

Section 4 Definitions

A. Affordable Care Act or “ACA” means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. “Counties with Extreme Access Considerations” or “CEAC” means, for the purposes of this regulation, counties with a population density of less than ten (10) people per square mile, based on U.S. Census Bureau population and density estimates (see Appendix A).

D. "Covered person" means, for the purposes of this regulation, a person entitled to receive benefits or services under a dental managed care plan.

E. "Dentist" and "Dental Provider" mean, for the purposes of this regulation, a dental provider who is skilled in and licensed to practice dentistry for patients in all age groups and is responsible for the diagnosis, treatment, management, and overall coordination of services to meet the patient's oral health needs.

F. "Dental managed care plan" means, for the purposes of this regulation, a dental plan that covers dental benefits obtained through a network of contracted dental providers.

G. "Embedded" means, for the purposes of this regulation, dental benefits provided as part of a health benefit plan, which may or may not be subject to the deductible, coinsurance, copayment and out-of-pocket maximum of the health benefit plan.

H. "Enrollment" means, for the purposes of this regulation, the number of covered persons enrolled in a specific dental plan or network.

I. "Essential community provider" or "ECP" means, for the purposes of this regulation, a provider, including health care providers defined in § 25.5-5-403(2), C.R.S., § 25.5-8-103(6), C.R.S., and at 45 C.F.R. § 156.235(c), that serves predominantly low-income, medically underserved individuals.

J. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

K. "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.

L. "Material change" means, for the purposes of this regulation, changes in the dental carrier's network of providers or type of providers available in the network to provide dental services or specialty dental services to covered persons that render the carrier's network non-compliant with one or more network adequacy standards.

M. "Network" means, for the purposes of this regulation, a group of participating providers providing services under a dental managed care plan. Any subdivision or subgrouping of a network is considered a network if covered individuals are restricted to any benefit tiering for covered benefits under the dental managed care plan.

N. "Participating provider" shall have the same meaning as found at § 10-16-102(46), C.R.S.

O. "SERFF" means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filings.

P. "Specialist" means, for the purposes of this regulation, a licensed provider in dentistry who has obtained additional education and/or certification to practice specialized treatment, such as pediatric, oral surgery, endodontics, periodontics, and orthodontics.

Q. "Stand-alone dental plan" or "SADP" means, for the purposes of this regulation, a plan, separate from a managed care plan, which provides the pediatric dental essential health benefits required under the Affordable Care Act, and which has its own cost sharing and deductibles separate from a managed care plan.

Section 5 Rules

A. Network adequacy filings for ACA-compliant individual and small group SADPs shall be filed with the Division through the "SERFF" prior to use and annually thereafter.

B. Network adequacy filings for ACA-compliant SADPs shall consist of the documents listed in Section 8. Filing instructions for preparation of these documents will be published on the Division's website on an annual basis.

C. The "ACA-Compliant Dental Carrier Network Adequacy Summary and Attestation Form" shall be submitted as part of the network adequacy form filing, described below.

Section 6 Dental Network Adequacy Standards

A. The carrier shall attest that at least one (1) dentist or dental provider listed below is available within the maximum road travel distance for each geographic type, as defined in Appendix A, for at least 90% of its enrollees in each Colorado county within the carrier's network.:

Geographic Type					
Provider Type	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Distance (Miles)	Maximum Distance (Miles)	Maximum Distance (Miles)	Maximum Distance (Miles)	Maximum Distance (Miles)
Dentist or Dental Provider	15	30	60	75	110

B. Geographic access standards may require that an enrollee cross county or state lines to reach a dentist or dental provider.

Section 7 Essential Community Provider Standards for ACA-Compliant Individual and Small Group Stand-Alone Dental Plans

A. Carriers issuing ACA-Compliant SADPs in the individual and small group markets are required to have a sufficient number and geographic distribution of ECPs, where available.

B. Carriers shall ensure the inclusion of a sufficient number of ECPs to ensure reasonable and timely access to a broad range of ECPs for low-income, medically underserved individuals in their service areas.

C. Carriers shall meet one (1) of the two (2) federal ECP standards for carrier ECP submissions, and the carrier shall submit one (1) of the following ECP standards to the Division for review:

1. General ECP Standard. Carriers utilizing this standard shall demonstrate in their "ECP/Network Adequacy Template" in SERFF that at least thirty-five percent (35%) of available ECPs in each plan's service area participate in the plan's network. This standard applies to all carriers except those who qualify for the alternate ECP standard; or

2. Alternate ECP Standard. The Centers for Medicare & Medicaid Services (CMS) defines a carrier that provides a majority of covered professional services through physicians it employs or through a single contracted medical group as subject to the Alternate ECP Standard. Carriers utilizing this standard shall demonstrate in their "ECP/Network Adequacy Template" and justifications, that they have the same number of ECPs as defined in Section 7.C.1. Carriers utilizing the Alternate ECP standard shall certify that their ECPs are located within Health Professional Shortage Areas (HPSAs) or five-digit ZIP codes in which thirty percent (30%) or more of the population falls below 200 percent (200%) of the federal poverty level (FPL).

Section 8 Annual Dental Network Adequacy Reporting Requirements for Individual and Small Group ACA-Compliant Stand-Alone Dental Plans

A. Individual and small group ACA-compliant SADP network adequacy filings shall be filed in SERFF during the annual health benefit plan certification process, and shall consist of two (2) sections, the Essential Community Providers/Network Adequacy (ECP/NA) Template filing in the Plan Management (Binder) section in SERFF, and a network adequacy form filing filed with a SERFF "type of insurance" (TOI) code NA01.004. Each network that is included on the network templates filed in any of a carrier's binder filings shall be included in the carrier's ECP/Network Adequacy Template filing. Templates in SERFF and filing instructions on the Division's website shall be used.

B. Elements of the Binder Filing.

1. All carriers shall submit network provider and facility listings on the "ECP/Network Adequacy Template" in the binder filing in SERFF. All ECPs in each network shall be included in this template. The templates shall be completed and filed as described in SERFF and in the Division filing instructions, on the Division's website.

2. The "ECP Write-in Worksheet", if applicable, shall be filed on the "Supporting Documentation" tab of the binder filing.

3. If a carrier does not meet the 35% ECP standard during the carrier binder validation or Division review process, the carrier shall submit a copy of the "Colorado ECP Justification Template" on the Supporting Documentation tab of the binder in SERFF.

C. Elements of the Network Adequacy Form Filing.

1. All carriers shall submit a "Network Access Plan" for each network in SERFF, pursuant to § 10-16-704(9), C.R.S., as described in Appendix B. Network access plans shall be used by carriers to describe their policies and procedures for maintaining and ensuring that their networks are sufficient and consistent with state and federal requirements.

a. Carriers shall prepare and file an access plan prior to offering a new dental network, and shall update an existing access plan, within fifteen (15) business days, whenever the carrier makes any material change to an existing dental network, and shall file the current access plan with the Division not less often than annually.

b. A carrier shall make the access plans, absent confidential information, available and shall provide them within five (5) business days of request.

c. All of a carrier's dental managed care plans and the associated marketing materials shall clearly disclose the existence and availability of the access plan.

d. All rights and responsibilities of the covered person under the dental managed care plan shall be included in the contract provisions of the dental managed care plan, regardless of whether or not such provisions are also specified in the access plan.

e. Network access plans and confidentiality.

(1) All network access plans submitted in the network adequacy form filing shall be open to public inspection, unless a carrier asserts that specific information contained in the access plan should be held confidential pursuant to § 24-72-204, C.R.S.

(2) If a carrier asserts that specific information contained in the network access plan is to be held confidential, a second network access plan must be filed with the Division that redacts the potentially confidential information. Statutory justifications for each redaction made must also be filed with the redacted network access plan.

(3) Redacted network access plans shall be filed as separate SERFF components on the "Supporting Documentation" tab.

(4) Redacted network access plans shall be made available through access to SERFF network adequacy filings on the Division website, and on the carrier's website.

2. All carriers shall submit a "Confidential Dental Enrollment Document," in SERFF containing separate spreadsheets (tabs) for each network. Confidential Enrollment documents shall be submitted in an Excel format using the "DOI Dental Enrollment Document Template" in SERFF. Counts used for this document shall be based on the projected enrollment of all members in the carrier's individual, small group and large group dental plans utilizing that specific network.

3. Provider directories are comprehensive listings, produced and maintained by the carrier, made available to covered persons and the public, of the plan's participating providers in each of the carrier's networks. Provider directories maintained by a carrier or its designee shall meet the general provider directory requirements, as applicable to dental managed care plans, required in § 10-16-704 C.R.S. and Colorado Insurance Regulation 4-2-55. Provider directories shall be updated no less frequently than monthly. Documentation (screen shots) of provider directories for each carrier shall be filed with the Division annually.

The carrier shall provide screen shots from the provider directory(ies) showing: (1) Master (entry) page of the carrier's website, directing users to the provider directory(ies); (2) Introduction screen of the provider directory; (3) The directory's general information, such as inclusion criteria, description of tiering (if applicable), customer service contact information, date of last revision(s), and directory disclosures; (4) Simple search screen; (5) A page of a provider directory produced from a search; and (6) Detail screen for at least one (1) provider and one (1) facility.

4. The carrier shall submit the completed "ACA Compliant Dental Network Adequacy Summary and Attestation Form" in SERFF as described in Section 9.

Section 9 Required Attestations

A. A carrier shall attest that each of its dental managed care plans will maintain a provider network(s) that meets the standards contained in this regulation, and that each provider network is sufficient in number and types of providers, to assure that the services will be accessible without unreasonable delay.

B. A carrier shall attest that each of its ACA-compliant dental managed care plans will include in its provider network(s) a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in their service areas.

C. A carrier shall attest that each of its dental benefit plans will maintain adequate provider directories for each network.

D. Attestations for individual and small group ACA-compliant dental plans shall be made on the "ACA-Compliant Dental Carrier Network Adequacy Summary and Attestation Form" submitted with the network adequacy form filing. This document is available in SERFF and at the Division website. Instructions for its completion are also found ar the Division website.

Section 10 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 11 Incorporated Materials

45 CFR § 156.235(c) published by the Government Printing Office shall mean 45 CFR § 156.235(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 156.235(c). A copy of 45 CFR § 156.235(c) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 CFR § 156.235(c) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 12 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process

Section 13 Effective Date

This amended regulation shall become effective on July 15, 2023.

Section 14 History

New regulation effective January 1, 2017.
Amended regulation effective June 1, 2018.
Amended regulation effective July 15, 2023.

APPENDIX A – DESIGNATING COUNTY TYPES

The county type, Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations (CEAC), is a significant component of the network access criteria. The Centers for Medicare and Medicaid Services (CMS) uses a county type designation methodology that is based upon the population size and density parameters of individual counties.

Density parameters are foundationally based on approaches taken by the U.S. Census Bureau in its delineation of "urbanized areas" and "urban clusters", and the Office of Management and Budget (OMB) in its delineation of "metropolitan" and "micropolitan". A county must meet both the population and density thresholds for inclusion in a given designation. For example, a county with population greater than one million and a density greater than or equal to 1,000 persons per square mile (sq. mile) is designated "Large Metro." Any of the population-density combinations listed for a given county type may be met for inclusion within that county type (i.e., a county would be designated "Large Metro" if any of the three (3) Large Metro population-density combinations listed in the following table are met; a county is designated as "Metro" if any of the five (5) Metro population-density combinations listed in the table are met; etc.).

Population and Density Parameters

County Type	Population	Density
Large Metro	≥ 1,000,000	≥ 1,000/sq. mile
---	500,000 – 999,999	≥ 1,500/ sq. mile
---	Any	≥ 5,000/ sq. mile
Metro	≥ 1,000,000	10 – 999.9/sq. mile
---	500,000 – 999,999	10 – 1,499.9/sq. mile
---	200,000 – 499,999	10 – 4,999.9/sq. mile
---	50,000 – 199,999	100 – 4,999.9/sq. mile
---	10,000 – 49,999	1,000 – 4,999.9/sq. mile
Micro	50,000 – 199,999	10 – 99.9 /sq. mile
---	10,000 – 49,999	50 – 999.9/sq. mile
Rural	10,000 – 49,999	10 – 49.9/sq. mile
---	<10,000	10 – 4,999.9/sq. mile
CEAC	Any	<10/sq. mile

COLORADO COUNTY DESIGNATIONS

County	Classification	County	Classification	County	Classification
Adams	Metro	Fremont	Rural	Morgan	Rural
Alamosa	Rural	Garfield	Micro	Otero	Rural
Arapahoe	Metro	Gilpin	Rural	Ouray	CEAC
Archuleta	Rural	Grand	CEAC	Park	CEAC
Baca	CEAC	Gunnison	CEAC	Phillips	CEAC
Bent	CEAC	Hinsdale	CEAC	Pitkin	Rural
Boulder	Metro	Huerfano	CEAC	Prowers	CEAC
Broomfield	Metro	Jackson	CEAC	Pueblo	Micro
Chaffee	Rural	Jefferson	Metro	Rio Blanco	CEAC
Cheyenne	CEAC	Kiowa	CEAC	Rio Grande	Rural
Clear Creek	Rural	Kit Carson	CEAC	Routt	Rural
Conejos	CEAC	Lake	Rural	Saguache	CEAC
Costilla	CEAC	La Plata	Micro	San Juan	CEAC
Crowley	CEAC	Larimer	Metro	San Miguel	CEAC
Custer	CEAC	Las Animas	CEAC	Sedgwick	CEAC
Delta	Rural	Lincoln	CEAC	Summit	Micro
Denver	Large Metro	Logan	Rural	Teller	Rural
Dolores	CEAC	Mesa	Micro	Washington	CEAC
Douglas	Metro	Mineral	CEAC	Weld	Metro
Eagle	Micro	Moffat	CEAC	Yuma	CEAC
Elbert	Rural	Montezuma	Rural		
El Paso	Metro	Montrose	Rural		

APPENDIX B – DENTAL NETWORK ACCESS PLAN INSTRUCTIONS

The carrier shall address the following in the network access plan for each dental network offered by the carrier:

1. Network Composition, Identification of Provider Criteria

    a. The factors a carrier uses to build its dental provider network, including a description of the network; and

    b. The carrier's quality assurance standards, which shall be adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care criteria used to select and/or tier providers.

2. Network Standards and Adequacy

    a. The carrier's criteria for assessing network adequacy;

    b. A statement verifying the carrier's adequate networks; and

    c. The carrier's description of specific actions to be taken, including remedies, timeframes, schedule for implementation, and proposed notification and communications with the Division, providers and policyholders, if a network is found to be inadequate.

3. Network Monitoring and Corrective Action Processes

    a. The carrier's documented quantifiable and measurable process for monitoring and assuring the sufficiency of the network in order to meet the managed care needs of populations enrolled in dental managed care plans on an ongoing basis; and

    b. The carrier's process to assure that a covered person is able to obtain a covered benefit at the in-network level of benefit from a non-participating provider should the carrier's network prove to not be sufficient.

4. Referral Process

    a. A comprehensive listing, made available to covered persons and medical/dental providers, of the carrier's network participating providers;

    b. A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a managed care plan may offer variable deductibles, coinsurance and/or copayments to encourage the selection of certain providers;

    c. A managed care plan that offers variable deductibles, coinsurance, and/or copayments shall provide adequate and clear disclosure, as required by law, of variable deductibles and copayments to policyholders, and the amount of any deductible or copayment shall be reflected on the benefit card provided to the enrollees;

    d. Timely referrals for access to specialty care;

    e. A process for expediting the referral process when indicated by the health condition;

f. A provision that referrals approved by the carrier cannot be retrospectively denied except for fraud or abuse;

g. A provision that referrals approved by the carrier cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse; and

h. The carrier's process allowing covered persons to access services outside the network when necessary.

5. Communications

A carrier shall address its method for informing policyholders of the plan's services and features through disclosures and notices to policyholders in the network access plan for each network offered by the carrier.

6. Patients with Special Needs

The carrier's documented process to address the needs, including access and accessibility of services, of policyholders with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and/or mental disabilities.

7. Grievance and Appeal Procedures

The carrier's grievance procedures, which shall be in conformance with Division rules concerning prompt investigation of claims involving utilization review and grievance procedures.

8. Coordination and Continuity of Care

Carriers shall ensure sufficient continuity of care provisions for their policyholders.

a. A carrier and participating provider shall provide at least sixty (60) days written notice to each other before a provider is removed or leaves the network without cause.

b. Irrespective of whether it is for cause or without cause or due to non-renewal of a contract, the carrier shall make a good faith effort to provide both written notice of a provider's removal, leaving, or non-renewal from the network, and the provider information contained in regulation, within fifteen (15) working days of receipt or issuance of a notice provided in accordance with this regulation. This notice shall be provided to all covered persons who are identified as patients by the provider, are on a carrier's patient list for that provider, or who have been seen by the provider being removed or leaving the network within the previous six (6) months.

c. A covered person shall have been undergoing treatment, or have been seen at least once in the previous twelve (12) months, by the provider being removed or leaving the network for that covered person to be considered in an active course of treatment.

d. A carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care when a covered person's provider leaves or is removed from the network.

e. A carrier shall make available to the covered person a list of available participating providers who are accepting new patients in the same geographic area and specialty provider type, or a referral to a provider if there is no participating provider available, who is of the same provider or specialty type. The carrier shall provide information about how the covered person may request continuity of care as required by this regulation.

f. A carrier's transition procedures shall provide that:

(1) A carrier shall review requests for continuity of care made by the covered person or the covered person's authorized representative;

(2) Requests for continuity of care shall be reviewed by the carrier's Medical/Dental Director after consultation with the treating provider. This requirement applies to:

(a) Patients who meet the applicable criteria listed in this regulation; and

(b) Who are under the care of a provider who has not been removed or leaving the network for cause;

(3) The continuity of care period for covered persons what are undergoing an active course of treatment shall extend to the earlier of:

(a) The termination of the course of treatment by the covered person or the treating provider;

(b) Ninety (90) days after the effective date of the provider's departure or termination from the network, unless the carrier's Medical/Dental Director determines that a longer period is necessary;

(c) The date that care is successfully transitioned to a participating provider;

(d) Benefit limitations under the plan are met or exceeded;

(e) The date that the coverage is terminated; or

(f) The care is no longer medically necessary.

g. In addition to the provisions of item 8 of Appendix B of this regulation, a continuity of care request may only be granted when the provider departing or terminated from the network:

(1) Agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the carrier for that patient as provider in the original provider contract, or by the new payment and terms agreed upon and executed between the provider and the carrier; and

(2) Agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the provider were still a participating provider.

h. The obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the in-network relationship is extended to provide continuity of care.

Regulation 4-2-58 NON-DISCRIMINATORY COST-SHARING AND TIERING REQUIREMENTS FOR PRESCRIPTION DRUGS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-3-1110, 10-16-103.6(2), 10-16-108.5(8), 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for carriers regarding non-discriminatory cost-sharing and tiering requirements for prescription drugs.

Section 3 Applicability

This regulation applies to all Affordable Care Act-compliant individual and small employer health benefit plans issued or renewed on or after January 1, 2023. This regulation does not apply to catastrophic plans, grandfathered plans, large group health benefit plans, Health Savings Account (HSA)-qualified high deductible health benefit plans, limited benefit plans or short-term limited duration health insurance policies.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Catastrophic plan” shall have the same meaning as found at § 10-16-102(10), C.R.S.

C. “Exchange” shall have the same meaning as found at § 10-16-102(26), C.R.S.

D. “Grandfathered health benefit plan” and “grandfathered plan” shall have the same meaning as found at § 10-16-102(31), C.R.S.

E. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

F. “Limited benefit health plans” means, for the purposes of this regulation, any type of health coverage that is not provided by a health benefit plan, as defined in § 10-16-102(32)(a), C.R.S.

G. “Meaningful difference” means, for the purposes of this regulation, ten percent (10%) or greater.

H. "Medical service drugs" means, for the purposes of this regulation, prescription drugs that are administered by a physician or other provider in the provider's office or other outpatient setting and covered under the plan's medical benefits. Medical Service Drugs are not generally covered under the plan's pharmacy benefits.

I. "Preventive care drugs" means, for the purposes of this regulation, drugs designated as preventive under state or federal law.

J. "Service area" means, for the purposes of this regulation, the geographic area a carrier offers a plan or plans. Service areas may be limited to specific zip codes, counties or may be statewide.

K. "Short-term limited duration health insurance policy" and "short-term policy" shall have the same meaning as found at § 10-16-102(60), C.R.S.

L. "Small employer" shall have the same meaning as found at § 10-16-102(61), C.R.S.

Section 5 Drug Tiering and Non-Discriminatory Plan Design

A. Individual and small employer carriers shall not discriminate against individuals based on health status or claims experience. Carriers shall not encourage or direct individuals or small employers to refrain from filing an application for coverage because of health status or claims experience by ensuring that:

1. No more than fifty percent (50%) of drugs on a formulary used to treat a specific condition are placed in the highest cost tier;

    a. Carriers shall use the RxCUI to evaluate the fifty percent (50%) requirement specified in Section 5.A.1.;

    b. The primary category and class for each drug will be utilized when calculating the fifty percent (50%) requirement; secondary uses and off-label usage shall not be included in the calculation; and

    c. Drugs not included on a carrier's formulary shall not be considered as part of the fifty percent (50%) requirement calculation, including any drugs approved as part of the exception process.

2. The most recent clinical studies shall be used in developing formularies to ensure consumers have access to screening and treatment in a timely manner.

B. Carriers may use appropriate disease management or utilization reviews as part of a formulary design.

C. Carriers shall use "Rx Copay" at the end of the marketing names for the copayment plans.

D. Carriers shall list all preventive care drugs in the first (1st) tier of the formulary Carriers shall not apply any cost sharing (e.g. deductibles, copayments or coinsurance) to preventive drugs.

E. Carriers shall list all drugs considered medical service drugs that the carrier has included in the formulary on a separate tier.

F. Carriers may list other drugs in any other tier offered.

Section 6 Required Drug Copayment-only Payment Structures

For each of a carrier's service areas, no fewer than twenty-five percent (25%) of the plans offered for each metal level (Platinum, Gold, Silver and Bronze) must contain a copayment-only payment structure for all drug tiers. Carriers shall not apply the deductible or any coinsurance amount for these plans.

A. The highest allowable copayment for the highest cost drug tier(s) must be no greater than 1/12th of the plan's "individual" annual out-of-pocket maximum.

B. Copayments between the two highest cost tiers shall have a meaningful difference of at least ten percent (10%).

C. For all tiers, carriers shall not employ benefit designs that will have the effect of discouraging individuals with significant prescription needs from enrolling in certain health benefit plans.

D. Cost-sharing arrangements that utilize coinsurance up to a capped dollar amount maximum are not considered copayments and cannot be used to meet the all-copayment structure requirement.

E. Carriers must meet the requirements of Section 6 separately for plans offered on the Exchange and plans that are offered off the Exchange.

Section 7 Required Methodology

In order to determine compliance with the copayment requirements, carriers shall use the following calculation methodology:

A. The numerator shall contain the count of all plans that have a copayment-only payment structure for all drug tiers for each metal level in a service area.

B. The denominator shall contain the count of all plans, including plans with a copayment or coinsurance benefit, for each metal level in a service area. Catastrophic plans, grandfathered plans, large group plans and high deductible health plans that are HSA-qualified shall not be included in the total.

C. This calculation shall be completed and submitted separately for plans that are offered on the Exchange and for plans offered off the Exchange.

D. Plans that are marketed both on and off the Exchange must be included in the separate calculations for on-Exchange plans and off-Exchange plans.

E. Carriers that market all plans on the Exchange and off of the Exchange shall submit one calculation.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

This regulation shall become effective on January 14, 2023.

Section 11 History

New regulation effective June 1, 2018.
Amended regulation effective June 1, 2021.
Amended regulation effective January 14, 2023.

Regulation 4-2-59 CONCERNING PREMIUM RATE SETTING FOR SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICIES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-1110, 10-16-107 and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide the necessary guidance to carriers on the rate filing requirements for short-term limited duration health insurance policies.

Section 3 Applicability

This regulation applies to all carriers that issue short-term limited duration health insurance policies for policies that are marketed and/or issued on or after the effective date of this regulation. This regulation excludes limited benefit plans, non-grandfathered health benefit plans, grandfathered health benefit plans and any other policy which does not meet the definition of a short-term limited duration health insurance policy.

Section 4 Definitions

A. “Benefits ratio” shall have the same meaning as found at § 10-16-102(5), C.R.S.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. "Covered lives" means, for the purposes of this regulation, the number of enrollees, subscribers and dependents covered by the issued short-term limited duration health insurance policy.

D. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

E. "Effective date" means, for the purposes of this regulation, the date the coverage is effective.

F. "Excessive rates" means, for the purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided or if the rates include a provision for expenses that is unreasonably high in relation to the services rendered. In determining if the rate is excessive, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

G. "File and use" means, for the purposes of this regulation, a filing procedure that does not require approval by the Commissioner prior to distribution, release to producers, collection of premium, advertising, or any other use of the rate.

H. "Filing date" means, for the purposes of this regulation, the day the rate filing is received by the Division.

I. "Geographic area" means, for the purposes of this regulation, the geographic areas established by the Commissioner by rule that are to be used by short-term limited duration health insurance carriers in the state of Colorado.

J. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

K. "Implementation date" means, for the purposes of this regulation, the specific date that the filed or approved rates can be charged to an individual.

L. "Inadequate rates" means, for the purposes of this regulation, rates that are insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace. In determining if the rate is inadequate, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

M. "New policy form" and "new policy form and/or product" mean, for the purposes of this regulation, a policy form that has "substantially different new benefits" or unique characteristics associated with risk or costs that are different from existing policy forms. For example: A guaranteed issue policy form is different than an underwritten policy form, a managed care policy form is different than a non-managed care policy form, a direct written policy form is different from a policy sold using producers, etc.

N. "On-rate-level premium" means, for the purposes of this regulation, the premium that would have been generated if the present rates had been in effect during the entire period under consideration.

O. "Plan" means, for the purpose of this regulation, the specific benefits and cost-sharing provisions available to a covered person.

P. "Pre-existing condition" means, for the purposes of this regulation, an injury, sickness, or pregnancy for which a person has incurred charges, received medical treatment, consulted a health care professional or taken prescription drugs within the 12 months preceding the coverage effective date under a short-term policy.

Q. "Product(s)" means, for the purposes of this regulation, the services covered as a package under a policy form by a carrier, which may have several cost-sharing options and riders as options.

R. "Qualified actuary" means, for the purposes of this regulation, a member of the American Academy of Actuaries, or a person who has demonstrated to the satisfaction of the Commissioner that the person has sufficient educational background and who has not less than seven (7) years of recent actuarial experience relevant to the area of qualifications, as defined in Colorado Insurance Regulation 1-1-1.

S. "Rate" means, for the purposes of this regulation, the amount of money a carrier charges as a condition of providing health coverage. The rate charged normally reflects such factors as the carrier's expectation of the insured's future claim costs; the insured's share of the carrier's claim settlement; operational and administrative expenses; and the cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the contract.

T. "Rate filing" means, for purposes of this regulation, a filing that contains all of the items required in this regulation, including the proposed base rates and all rating factors, the underlying rating assumptions, support for new product offerings and for all changes in existing rates, factors and assumptions utilized, including the continued use of trend factors.

U. "Retention" means, for the purposes of this regulation, the sum of all non-claim expenses including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses as the percentage of total premium.

V. "Review and approval" or "prior approval" means, for the purposes of this regulation, a filing procedure that requires a rate change to be affirmatively approved by the Commissioner prior to distribution, release to producers, collection of premium, advertising, or any other use of the rate.

W. "SERFF" means, for the purposes of this regulation, the System for Electronic Rates and Forms Filing.

X. "Short-term limited duration health insurance policy" or "short-term policy" shall have the same meaning as found at § 10-16-102(60), C.R.S.

Y. "Substantially different new benefit" means, for the purposes of this regulation, adding or deleting a benefit from the package. The offering of additional cost sharing options (i.e. deductibles and copayments) to what is offered as an existing product does not create a new policy form.

Z. "Trend" or "trending" means, for the purposes of this regulation, any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing.

AA. "Trend factors" means, for purposes of this regulation, rates or rating factors which vary over time or due to the duration that the insured has been covered under the policy or certificate, and which reflect any of the components of medical or insurance trend assumptions used in pricing.

AB. "Unfairly discriminatory rates" means, for the purposes of this regulation, charging different rates for the same benefits provided to individuals, or groups, with like expectations of loss; or if after allowing for practical limitations, differences in rates which fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

AC. "Use of the rates" means, for the purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder including advertising, distributing rates or premiums to producers, and disclosing premium quotes. It does not include releasing information about the proposed rating change to other government entities or disclosing general information about the rate change to the public.

Section 5 General Rate Filing Requirements

A. Rate Filing Types

1. Review and Approval

Any proposed increase, which is any increase in any base rate, any rating factor, or the continuation of trend factors, is subject to prior approval by the Commissioner, and shall be filed with the Division.

To determine if the filing is subject to review and approval, calculations shall reflect both the twelve (12) month cumulative impact of trend and any changes to rating factors or base rates.

2. File and Use

Any new product, or existing product that does not contain a proposed increase, is not subject to prior approval by the Commissioner, and shall be filed with the Division.

To determine if the filing is subject to file and use, calculations shall reflect the twelve (12) month cumulative impact of trend and any changes to rating factors or base rates. If there is an annual cumulative decrease in rates during the filed rating period, then the filing would be considered as file and use.

B. Timing and General Rate Filing Requirements

1. Carrier Requirements

a. Carriers shall submit rate filings for review and approval to the Commissioner at least sixty (60) days prior to the proposed implementation date of the rates.

b. For new products and annual filings that are not experiencing a rate increase, carriers shall submit file and use rate filings at least one day prior to the implementation date.

c. Filings that are resubmissions of previously withdrawn, rejected or disapproved rate filings shall be considered new filings.

2. Rate Filing Deadlines

a. Rate Review Deadlines

(1) The filing shall be reviewed for completeness and, if found incomplete, the Commissioner may reject or disapprove the filing within the first thirty (30) calendar days of the review period. If the Commissioner has not rejected or disapproved the filing on or before the thirtieth (30) day, the filing shall be considered complete.

(2) If the Commissioner reviews the filing for substantive content, any deficiencies identified shall be corrected on a prospective basis. Any rate deficiency identified will be subject to a penalty if the violation is determined to be willful. Violations may include, but are not limited to, rates that are found to be excessive, inadequate or unfairly discriminatory.

(3) If the Commissioner does not approve or disapprove a rate filing within sixty (60) days of the filing date, the carrier may implement and reasonably rely on the rates. Carriers may be required to correct the rates on a prospective basis if the Commissioner determines that the rates are excessive, inadequate or unfairly discriminatory. No penalty will be applied for a non-willful violation identified in this manner.

b. The Division will utilize the following, as provided in § 2-4-108, C.R.S.:

(1) To determine the start of the thirty (30) and sixty (60) calendar day period, the day after the filing date will be utilized. For example, if a filing is submitted in SERFF on June 1, the review period will begin on June 2, regardless of the day of the week.

(2) If the thirtieth (30) or sixtieth (60) calendar day falls on a Saturday, Sunday, or legal holiday, the review period will be extended to the next business day which is not a Saturday, Sunday, or legal holiday. For example, if the 60-day period expires on July 4, the review period will be extended to July 5, as long as July 5 falls on a business day.

3. Rate Filing Guidelines and Review Guidelines

a. General Rate Filing Requirements

(1) Rates on all health insurance policies, riders, contracts, endorsements, certificates, and other evidence of health care coverage, shall be filed with the Division prior to the marketing, issuance or deliverance of coverage.

(2) All carriers shall submit a compliant rate filing whenever the rates to be charged to new policyholders differ from the rates on file with the Division. Included in this requirement are the following changes:

(a) Periodic recalculation of experience;

(b) Change in rate calculation methodology;

(c) Changes in the trend; and/or

(d) Other changes in rating assumptions.

(3) All carriers shall submit a compliant rate filing on at least an annual basis to support the continued use of trend factors which change on a predetermined basis. Trend factors which change on a predetermined basis can be continued for no more than a period of twelve (12) months. To continue the use of trend factors that change on a predetermined basis, a filing shall be submitted for that particular form with an implementation date within one (1) year of the implementation of the most recent approved rate filing.

(4) All carriers shall submit a compliant rate filing when the rates are changed on an existing product even if the rate change pertains to new business only.

(5) All carriers shall submit a compliant rate filing within sixty (60) calendar days after Commissioner approval of the merger, assumption or acquisition of a block of business.

(6) Each line of business requires a separate rate filing. Rate filings shall not be combined with form filings.

(7) All carriers are expected to review their experience on a regular basis, no less than annually, and file revisions, as appropriate and in a timely manner, to ensure that rates are not excessive, inadequate or unfairly discriminatory and to avoid filing large rate changes.

(8) Carriers shall not represent an existing product to be a new policy form, or product, unless it fits the definition set forth in Section 4.M. of this regulation.

(9) A separate filing shall be submitted for each carrier. A single filing made for more than one carrier, or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/Indemnity/Point of Service plan.

b. General Elements of Rate Filings

(1) All rate filings shall be filed electronically in a format made available by the Division, unless exempted by rule for an emergency situation as determined by the Commissioner.

(2) The rate filing shall demonstrate that the proposed rates are not excessive, inadequate, or unfairly discriminatory.

(3) The rate filing shall contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate.

(4) The rate filing shall contain Colorado experience in the actuarial memorandum.

(5) If Colorado experience is partially credible, similar coverage and/or nationwide experience shall also be submitted.

(6) For a merger or acquisition, the assuming or acquiring carrier shall provide support for the rating factors, even if there is no change in the rating factors. The new filing shall demonstrate that the rating assumptions are still appropriate.

(7) The Form Schedule tab in SERFF shall be completed for all rate filings. This tab shall list all policies, riders, endorsements, or certificates affected by the rate filing. Actual forms shall not be attached to the rate filing.

(8) The Implementation Date Requested field on the General Information tab in SERFF shall be completed with a specific date. Using a notation such as “On Approval” is not a valid response.

(9) The Commissioner may require submission of any relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

c. Rate Filing Disapproval Requirements

The Commissioner shall disapprove the rate filing if any of the following apply:

(1) The benefits provided are not reasonable in relation to the premiums charged;

(2) The rate filing contains rates that are excessive, inadequate, unfairly discriminatory, or otherwise does not comply with the provisions of this regulation;

(3) The data and/or actuarial support do not justify the requested rate increase;

(4) The rate filing is incomplete; or

(5) The data in the filing fails to adequately support the proposed rates.

4. Rate Usage Guidelines

a. Review and Approval

(1) If the Commissioner approves the rate filing within sixty (60) calendar days, the carrier may utilize the rates for business effective on the implementation date or later. Under no circumstances shall the carrier provide insurance coverage using the rates until on or after the proposed implementation date specified in the rate filing.

(2) Carriers are permitted to bill and require payment for new rates prior to the implementation date; however, carriers shall not use the new rates, bill or require payment from consumers with an effective date prior to the implementation date.

b. File and Use

Current law allows for file and use rate filings to be used no sooner than the day after the filing date. Correction of any deficiency shall be on a prospective basis.

c. Withdrawn, Rejected or Disapproved Filings

Rates for filings that are withdrawn, rejected or disapproved shall not be used or distributed. Use of rates in rate filings that are withdrawn, rejected or disapproved shall constitute a violation of Colorado law.

d. Rates Not on File

(1) Any rates or rating factors that are not on file with the Division shall not be used.

(2) Failure to file a compliant rate filing shall render the carrier as using unfiled rates and the Division will take appropriate action as allowed by Colorado law.

5. Confidentiality

a. All rate filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S.

b. The Division does not consider the following as confidential:

(1) Rates;

(2) Rating factors; and

(3) Information required for inclusion in the actuarial memorandum.

c. The entire filing, including the actuarial memorandum, cannot be held as confidential.

d. There shall be a separate SERFF component for the confidential exhibits, which shall be indicated as such by the confidential icon in SERFF.

e. A “Confidentiality Index” shall be completed if the carrier desires confidential treatment of any information submitted. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected.

Section 6 Actuarial Memorandum

The rate filing shall contain a compliant actuarial memorandum, which is comprised of two (2) parts: a narrative and an Excel spreadsheet. To ensure compliance with this regulation, the Division will supply an Excel template for the items required to be submitted in Excel. Carriers shall supply all items that require a narrative as a separate document in PDF format. The narrative shall contain complete support for any calculated item or provide adequate details. The actuarial memorandum and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. Only the rate manual shall be attached to the Rate/Rule tab in SERFF.

A. Summary

The memorandum shall contain a summary that includes, but is not limited to, the following:

1. Reason(s) for the Rate Filing

A statement as to whether or not this is a new product offering; a rate revision to an existing product, which includes rates applicable to new business only; or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated.

This information shall be included in the narrative.

2. Requested Rate Action

The overall rate increase or decrease shall be listed. The listed rate change and the average change in each rate component shall be provided. The submission shall also list the twelve (12) month changes by component and the averages by component.

This information shall be included in an Excel spreadsheet. See Appendix B for the required format.

3. Marketing Method(s)

A brief description of the marketing method used for the filed form shall be listed. (Agency/Broker, Internet, Direct Sale, Other).

This information shall be included in an Excel spreadsheet. See Appendix B for the required format.

4. Premium Classification

This section shall state all attributes upon which the premium rates vary. Plans may vary premium rates utilizing the following factors when actuarially justified:

a. Benefit factors;

b. Family composition (individual or family);

c. Geographic rating area;

d. Age, except that it may not vary by more than three (3) to one (1) for adults; and

e. Tobacco use.

This information shall be included in an Excel spreadsheet. See Appendix B for the required format.

5. Product Descriptions

This section shall describe the benefits provided by the policy, rider or contract.

This information shall be included in the narrative.

6. Policy/Rider or Contract

All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

7. Age Basis

This section shall state that the premiums will be charged on an issue-age basis.

This information shall be included in an Excel spreadsheet. See Appendix B for the required format.

8. Renewability Provision

These policies are not renewable.

B. Assumption, Acquisition or Merger

Identify whether or not the products included in the rate filing are part of an assumption, acquisition or merger of policies from/with another carrier. If so, the memorandum shall include the full name of the carrier(s) from which the policies were assumed, acquired or merged, and the date of the assumption, acquisition or merger, and the SERFF tracking number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.B.3. for assumption, acquisition or merger rate filing requirements.

This information shall be included in the narrative.

C. Rating Period

Identify the period for which the rates will be effective. At a minimum, the proposed implementation date of the rates shall be provided. If the length of the rating period is not clearly identified, it will be assumed to be for twelve (12) months, starting from the proposed implementation date.

Premiums may change throughout the year for trend only and shall not be changed during the contract term, except for changes made by the policyholder.

This information shall be included in the narrative.

D. Underwriting

Short-term limited duration health insurance policies are subject to guaranteed issue requirements of § 10-16-105(1)(a)(I), C.R.S. Underwriting shall only be used in determining pre-existing conditions that will be excluded under the policy.

This information shall be contained in the narrative.

E. Effect of Law Changes

Identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable mandates shall be listed, including those with no rating impact. This quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

This information shall be contained in the narrative.

F. Rate History

Include a chart showing, at a minimum, any rate changes that have been implemented in the three (3) approvals immediately prior to the filing date, including the implementation date of each rate change. Rate changes shall include the impact of trend.

1. This chart shall contain the following information: the filing number (SERFF tracking number); the implementation date of each rate change; the average increase or decrease in rate; the minimum and maximum rate change and; the cumulative rate change for the past twelve (12) months.

2. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable.

This information shall be provided in an Excel spreadsheet. See Appendix C for the required format.

G. Subrogation

The memorandum shall reflect actual loss experience net of any savings associated with subrogation.

A statement confirming this shall be contained in the narrative.

H. Relation of Benefits to Premium

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. The memorandum shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period. The carrier shall comply with the following benefits ratio guidelines:

1. Retention Percentage: The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financial statements, with an explanation for any variations between retention loads used and actual experience for each component.

2. Carriers shall have, at a minimum, an eighty percent (80%) loss ratio for short-term policies.

This shall be provided in both the narrative and an Excel spreadsheet. See Appendix D for the required format.

I. Provision for Profit and Contingencies

Carriers shall indicate pre-tax and post-tax levels and shall indicate how investment income has been accounted for in the setting of profit margins. Material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

This shall be provided in both the narrative and an Excel Spreadsheet. See Appendix E for the required format.

J. Complete Explanation as to How the Proposed Rates were Determined

The memorandum shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may reject a rate filing if support for any rating assumption is found to be inadequate.

This explanation may be on an aggregate expected loss basis or a per-member-per-month (PMPM) basis, but it shall completely explain how the proposed rates were determined. The memorandum shall adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

1. Base Rate

A complete explanation as to how the base rate was developed shall be provided. The base rate shall not include any other factors and shall be adjusted to exclude any benefit, geographic, age or other factors used in calculating the premium. Carriers may utilize actual claims experience in developing the base rate.

The base rate shall be actuarially justified and implemented consistent with state rate review processes.

2. Geographic Area Rating Factors

A complete explanation as to how geographic area rating factors (area factors) were developed shall be provided. Health claims may be used in the process of developing area factors. Area factors shall not reflect differences in enrollee health status. Area factors shall reflect only differences in the costs of delivery and shall not include differences for population morbidity by geographic area. Area factors shall be actuarially justified and verified to have been set based upon the above criteria.

3. Benefit Factors

Benefit factors shall be provided when such factors affect the final rate. A complete explanation as to how benefit factors were developed shall be provided. The benefit factors shall be actuarially supported and the support shall be provided.

4. Morbidity

Other projected population changes from the experience period to the rating period shall include considerations of demographic changes over the course of the year, and the impact of the exclusion of any pre-existing condition. For any morbidity factor used, a complete explanation of development shall be provided.

This information shall be included in the narrative.

K. Trend

The memorandum shall describe the trend factor assumptions used in pricing. These trend factor assumptions shall be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported. Trend factors do not renew automatically, continued use of trend factors shall be supported annually.

1. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be provided if available. This experience may include data from the plan being rated or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

2. Provided loss data shall be on an incurred basis, with pharmacy data shown separately from medical data, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g. case, bulk and incurred but not reported (IBNR) reserves) as of the valuation date. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

3. The provided claims experience shall include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims; total medical incurred claims (including estimated IBNR claims); actual pharmacy paid on incurred claims; total pharmacy incurred claims (including estimated IBNR claims); average covered lives for medical; and, average covered lives for pharmacy.

4. Data elements shall be aggregated into twelve (12) month annual periods, with yearly “per member, per month” (PMPM) data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified. The trend assumptions shall be quantified into two (2) categories, medical and insurance, as defined below:

    a. Medical trend in Appendix F1 (1A to 1F) means, for the purposes of this section, the combined effect of medical provider price increases, utilization changes, medical cost shifting, new medical procedures and technology, and other insurance trend. Medical trend includes changes in unit costs of medical services or procedures, medical provider price changes, changes in utilization (other than due to advancing age), medical cost shifting, and new medical procedures and technology. Insurance trend includes anti-selection resulting from rate increases and discontinuance of new sales.

    b. Insurance trend in Appendix F1 (1E) means, for the purposes of this section, the combined effect of any other items impacting medical trend that are not captured in items (1A) through (1D) of Appendix F1, including the the impact on trend due to anticipated demographic changes. The components of the medical trend noted as (1A) through (1D) in Appendix F1 shall be determined or assumed before determining the impacts of the other insurance trend items included in (1E), which shall be fully justified in the rate filing.

c. Pharmaceutical trend in Appendix F1 (2A to 2F) means, for the purposes of this section, the combined effect of pharmaceutical price increases, pharmacy utilization changes, cost shifting, introduction of new drugs, and other pharmaceutical trend.

d. Other pharmaceutical trend in Appendix F1 (2E), means, for the purposes of this section, the combined effect of any other items impacting pharmaceutical rates that are not captured in items (2A) through (2D) of Appendix F1.

The assumptions shall be presented in the narrative, and the data shall be provided in an Excel spreadsheet. See Appendix F1, Appendix F2 and Appendix F3 for the required format.

5. Trend factors that directly affect the rates (i.e. rating factors that are applied throughout the rating period) are part of the requested increase. Trend factors of this type shall be reflected anywhere that a requested change is reported (all SERFF Rate/Rule Schedule tab items, rating factors included in the rate pages, Side-by-Side Comparison). Trend factors do not renew automatically and shall be requested annually. Trend factors include inflation factors. Rate filings shall be submitted on an annual basis with adequate support for the continued use of trend factors.

6. Rates not on file with the Division, including the continued use of trend factors beyond one year, are deemed to be unfiled rates, which is a violation of Colorado law under § 10-16-107, C.R.S.

This information shall be provided in both the narrative and Excel spreadsheet. See Appendices F1 through F3 for the required format.

L. Credibility

The memorandum shall discuss the credibility of the Colorado data; the Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards shall be met within a maximum of three (3) years if the proposed rates are based on claims experience. If the carrier's Colorado data is not fully credible, partial credibility shall be used, with the following guidelines:

1. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period.

2. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

3. The proposed rates shall be based upon as much Colorado data as possible. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard.

4. The partially-credible Colorado data and collateral data used to support partially-credible data shall be provided. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

5. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially-credible data shall include a discussion as to how the rating methodology was modified for the partially credible data.

This shall be provided in an Excel spreadsheet. If the full credibility standard is not met, explanations of the use of partially-credible or aggregated data and resulting changes to rating methodology shall be provided in the narrative. See Appendix G for the required format.

M. Experience

The memorandum shall include earned premium, loss experience, actual benefits ratio, average covered lives and number of claims submitted on a Colorado-only basis for at least three (3) years.

1. Pharmacy claims data shall be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.

2. National or other relevant data shall be provided to support the rates, if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

3. If the purpose of the filing is to introduce a new product to Colorado, nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

4. Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a “new product,” as defined in this regulation.

5. Rates shall be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. Data used to support rates shall be included in the filing. The experience period shall include consecutive data no older than six (6) months prior to the filing date.

6. The loss data shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g. case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Premiums, and/or exposure data, shall be stated on both an actual and on-rate-level basis. Capitation payments shall be considered as claim or loss payments. The carrier shall also provide information on how the number of claims was calculated.

This shall be provided in an Excel spreadsheet. See Appendix H for the required format.

N. Side-by-side Comparison

Each memorandum shall include a “side-by-side comparison” identifying any proposed change(s) in rates. This comparison shall include four (4) columns: the first containing the category, the second containing the current rate, rating factor, or rating variable; the third containing the proposed rate, rating factor, or rating variable; and the fourth containing the percentage increase or decrease of each of the proposed change(s). If the proposed rating factor(s) are new, the memorandum shall specifically state this and provide detailed support for each of the rating factors.

This information shall be provided in an Excel worksheet. See Appendix I for the required format.

O. Benefits Ratio Projections

The memorandum shall contain a section projecting the benefits ratio over the rating period, both with and without the requested changes. The comparison shall be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested change. The corresponding projection calculations shall be included.

If the filing is for new product, the expected projected premiums and projected incurred claims shall be provided.

This information shall be provided in Excel spreadsheet. See Appendix J for the required format.

P. Rating Manuals

A rating manual shall be submitted to the Division for each new product. All changes to the rating manual shall be filed with the Division in an appropriate rate filing. Rate pages and rate manual shall be attached to the Rate/Rule Schedule tab in SERFF.

Q. Actuarial Certification

An actuarial certification shall be submitted with all filings. An actuarial certification is a signed and dated statement made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

Section 7 Premium Rate Setting

A. Calculating Premium Rates Adjusted for Case Characteristics

1. Base Rate

Each carrier offering a short-term limited duration health insurance policy to individuals in Colorado shall develop a single base rate for all individual short-term policies it offers. The base rate shall be based on:

a. The claims experience of all enrollees in all short-term policies in the risk pool.

b. The premium rate charged during a rating period shall be based upon this base rate, adjusted for case characteristics and coverage as allowed in this section.

2. Benefit Design Adjustment

The base rate may be adjusted to reflect differences attributable to different benefit designs. Differences in the rates for different benefit plans, for persons with the same case characteristics of age, geographic location and family size, shall be attributable to benefit design only. Using this methodology, a carrier's rates for a plan with leaner benefits shall be lower than the rates for a plan with more benefits.

3. Acceptable Case Characteristics Factor Categories

a. Carriers shall adjust premiums only for the following factors: self-only or family enrollment, geographic area, age, and tobacco.

b. Rates may vary based on whether a plan covers an individual or a family. The rating variation permitted for age and tobacco use shall be applied based on the portion of the premium attributable to each family member covered under a policy.

c. Age and tobacco use factors shall be apportioned to each family member.

d. Geographic area rating factors shall not vary by benefit selections; there shall only be one (1) set of area factors for each rate filing. Geographic area rating factors are separate from network factor rating adjustments and may not vary by network.

For example, a particular carrier's geographic area rating factors might be:

Geographic Area	Rating Factor
Boulder MSA	0.89
Denver MSA	1.03
Greeley MSA	0.98
Colorado Springs MSA	1.02
Fort Collins MSA	1.01
Grand Junction MSA	0.95
Pueblo MSA	1.05
East Non-MSA	1.27
West Non-MSA	0.99

The Denver area factor does not have to be set to 1.0. Carriers typically scale their area factors so that they are revenue neutral when applied within their rating formulas. Health claims may be used in the process of developing area factors. Rating factors must not reflect differences in member health status. Area factors must be actuarially justified and verified to have been set based upon the above criteria.

Geographic Location: If a carrier uses geographic location to calculate rates, then it shall use the nine (9) mandatory categories in the following table.

Rating Area	County
Rating Area 1	Boulder
Rating Area 2	El Paso, Teller
Rating Area 3	Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park
Rating Area 4	Larimer
Rating Area 5	Mesa
Rating Area 6	Weld
Rating Area 7	Pueblo
Rating Area 8 (East)	Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Phillips, Prowers, Rio Grande, Saguache, Sedgwick, Washington, Yuma
Rating Area 9 (West)	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit

The applicable area factor applied to rates for each member is based on the location of the primary policyholder rather than the residence of each family member.

e. Age factors and age bands shall be determined based on an enrollee's age on the date of policy issuance. For individuals who are added to the policy on a date other than the date of policy issuance, the enrollee's age is determined as of the date such individuals are added or enrolled in the coverage.

Carriers may establish age factors and age bands that differ from other lines of business. Adequate support shall be provided for any age factors and age bands.

f. Tobacco Use Rate

(1) Carriers may vary tobacco rating by age (for example, a younger enrollee may be charged a lower tobacco use rate than an older enrollee) provided the tobacco use rate does not exceed the non-tobacco use rate contained in § 10-16-107(5)(a)(I)(D), C.R.S.

(2) Carriers may remove the tobacco rating factor for individuals participating in a wellness program.

(3) "Tobacco use" is defined, for the purposes of this section, as the use of a tobacco product or products four (4) or more times per week within, but no longer than, the past six (6) months by legal users of tobacco products (generally those 18 years and older). It includes all tobacco products and does not include religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives). Tobacco use shall be defined by carriers in terms of the time since the individual's last use of a tobacco product.

B. Base rates shall not be adjusted more frequently than monthly.

C. Carriers shall not vary the rates for any reason during the term of the contract, except for the following:

1. Changes in the family composition;

2. Changes in the geographic area of the policyholder;

3. Changes in tobacco use;

4. Changes to the plan requested by the policyholder; and/or

5. Other changes required by federal law or regulations or otherwise expressly permitted by state law or Commissioner rule.

D. Administrative and Other Fees

Separate administrative, processing, enrollment, and other special charges are prohibited. Reasonable late payment penalties may be imposed by a carrier if the policy discloses the carrier's right to, the amount of, and circumstances under which late payment penalties will be imposed.

E. Cost Sharing Limitation

Plans may set a limit on cost sharing (commonly referred to as a maximum out-of-pocket limit) as part of the benefits package offered.

F. Benefit Factor Adjustments to the Base Rate

The adjusted base rate as developed from the process in Section 6. J.1. may be modified for each plan characteristic by reflecting benefit cost adjustments due to selection of different plan options. Differences in the plan options for persons with the same case characteristics of age, geographic location, family size, and tobacco use shall be attributable to plan design only. Benefit factors shall not reflect the health status of enrollees assumed to be enrolled in any particular benefit option and shall not reflect claims experience of enrollees on a similarly selected plan. The benefit cost relativity between plan options shall only reflect the true benefit differences due to different enrollee cost-sharing levels and plan design features. Using this method, a carrier's benefit factor for a plan design relative to the benefit factor for a leaner (richer) plan design shall be lower (higher).

G. Retention Factor Adjustments to the Base Rate

1. Carriers shall adjust the base rate to include all retention from expenses, fees and profits that will be loaded into rates. Retention loads shall be spread out across all rates in the short-term policies using the same rating factor(s).

2. At the minimum, carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financials, and identify and justify loads by specific retention components that include at least the following:

   a. Administrative expenses;

   b. Commissions and other acquisition expenses (may be separated);

   c. Taxes;

   d. Other assessments; and

   e. Profit and contingencies.

H. Required Health Benefits

As short-term policies meet the definition of health benefit plans pursuant to § 10-16-102(32), C.R.S., except the requirement to cover pre-existing conditions, they are required to provide coverage of the applicable mandated benefits pursuant to § 10-16-104, C.R.S. and the essential health benefits, found at § 10-16-102(22)(b), C.R.S.

Section 8 Rate Filings

A. The provisions of § 10-16-107, C.R.S. and this regulation shall apply to the filing of rates for short-term limited duration health insurance policies. Expected rate increases for short-term policies shall be submitted for approval to the Division of Insurance at least sixty (60) days prior to the proposed rate implementation date.

B. Filings for short-term policies shall not be combined with any other filing. Additionally, they shall be filed separately by type of coverage (indemnity, preferred provider organization, or health maintenance organization).

C. Rates shall be filed no less frequently than annually.

Section 9 Prohibited Rating Practices

The Commissioner has determined, in accordance with § 10-16-107, C.R.S., that the following rating practices lead to excessive, inadequate or unfairly discriminatory rates and are prohibited:

A. Premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve. However, this requirement is not intended to prohibit use of a premium schedule which provides for premiums to a specific age followed by a level premium, or the use of reasonable step rating;

B. The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increase number of billings and/or the loss of interest income; and

C. Pursuant to § 10-16-107(2)(b), C.R.S., short-term policy rates shall not vary due to the gender of the individual policyholder, enrollee, subscriber, or member.

Section 10 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 11 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 12 Effective Date

This regulation shall become effective on April 1, 2019.

Section 13 History

New regulation effective September 1, 2018.
Amended regulation effective April 1, 2019.

APPENDIX A RATE FILING REQUIREMENTS

A. Format: All required reports and documentation shall be submitted through SERFF in a searchable PDF format. All tables identified in Section 6 of this regulation shall also be submitted in an Excel format (in addition to the searchable PDF).

B. Submission Requirements for New Rate Filings: Carriers shall complete and submit the following information in SERFF in order for a rate filing submission to be considered complete:

1. Carriers shall complete all SERFF required data fields.

2. Carriers shall list all forms associated with the rate filing under the Form Schedule Tab.

    a. Carriers shall complete all data fields (Form Name, Form Number, Form Type, Action) under this tab.

    b. Carriers shall not attach copies of the actual form documents as part of a rate filing.

3. Carriers shall attach a copy of the Rate Tables/Manual under the Rate/Rule Schedule Tab.

4. Carriers shall attach copies of the following documents under the Supporting Documentation Tab in the Filing (Non-Binder) section in SERFF:

    a. If a carrier uses a third party to submit a rate filing on its behalf, a Letter of Authority shall be attached under the Supporting Documentation tab in SERFF.

    b. A copy of the Colorado actuarial memorandum, which includes all elements contained in Section 6 of this regulation.

    c. Any applicable justification or attestations forms specified by the Division.

APPENDIX B: SUMMARY

Summary		
1. Reason(s):	Provide a narrative describing the exact reasons for the filing.	
2. Requested Rate Action (Enter the percentage for each factor changing):		Base Rate Change
		Age
		Area Factor Change
		Benefit Factor Change
		Family Composition
		Tobacco
		Trend
		Other (Please Specify):
3. Overall Rate Action:		Average Total Change
		Minimum
		Maximum
4. Marketing Method(s) (Select all that apply):	☐	Agency / Broker
	☐	Internet
	☐	Direct Sale
	☐	Other (Please Specify):
5. Premium (Select all that apply):	☐	Age
	☐	Family Composition
	☐	Tobacco
	☐	Geographic Area
	☐	Benefit
	☐	Other (Please Specify):
6. Product Description(s):	Provide a narrative describing the benefits.	

7. Policy/Rider Impacted	Complete the Form Schedule Tab with all applicable policy and/or contract forms affected.		
8. Age Basis (Select all that apply):	☐	Issue Age	
	☐	Not Utilized	
	☐	Other (Please Specify):	
9. Renewability Provision:	☐	Non-Renewable	

APPENDIX C: RATE HISTORY

RATE HISTORY					
Provide rate changes made in at least the last three (3) approved filings (If available)					
☐ N/A New Filing					
COLORADO					
		% OF CHANGE			
SERFF Tracking Number	**Implementation Date**	**Minimum**	**Average**	**Maximum**	**Cumulative for past 12 Months**

NATIONWIDE		
Implementation Date	**Average % of change**	**Cumulative for past 12 Months**

Additional Information:				

Appendix D: Relation of Benefits to Premium

Relation of Benefits to Premium	
Description	**Percentage**
(1) Commissions	
(2) General Expenses	
(3) Premium Taxes	
(4) Pre-Tax Profit/Contingencies	
(5) Investment Income (express as a negative number)	
(6) Other	
(7) Total Retention (1+2+3+4+5+6)	
Targeted Loss Ratio [(1-(7))]	

APPENDIX E: PROVISION FOR PROFIT AND CONTINGENCIES

Provision for Profit and Contingencies	
(1) Post-Tax Provision for Profit and Contingencies	
(2) Investment Income (expressed as a negative number)	
(3) Federal Income Tax	
(4) Pre-tax Profit and Contingencies, including Investment Income* (4) = (1) – (2) + (3)	

*Equal to line (4) from previous table – Relation of Benefits to Premium

APPENDIX F1: TREND

TREND	
MEDICAL TREND	**Trend (%)**
(1A) Medical provider price increase	
(1B) Utilization changes	
(1C) Medical cost shifting	
(1D) Medical procedures and new technology	
(1E) Other Insurance Trend	
(1F) Medical Trend Total Product of (1A) - (1E)	
PHARMACEUTICAL TREND (IF APPLICABLE)	
(2A) Price increases	
(2B) Utilization changes	
(2C) Cost shifting	
(2D) Introduction of new brand and generic drugs	
(2E) Other Pharmaceutical Trend	
(2F) Pharmaceutical Trend Total Product of (2A) - (2E)	
TOTAL AVERAGE ANNUALIZED TREND (1F) and (2F) weighted proportionately by the mix of carrier's business	

APPENDIX F2: MONTHLY HISTORICAL TREND

Enter Your Member and Claim Information for the most Recent 4 Years. If your plan has less than 4 years of data then enter the amount since plan inception.													
The most recent month should be within 6 months of the date that you filed rates. Enter the most recent month in Row# 48.													
Dental carriers please only complete the medical portion of this template.													
Month Through Which Claims are Paid:													
		HISTORICAL DATA											
		Medical			**Pharmacy**			**Medical 12-Month**		**Pharmacy 12-Month**		**Total 12-Month**	
Row #	**Month**	**Members**	**Total Incurred Claims**	**Estimated IBNR Claims**	**Members**	**Total Incurred Claims**	**Estimated IBNR Claims**	**PMPM**	**PMPM Trend**	**PMPM**	**PMPM Trend**	**PMPM**	**PMPM Trend**
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													

12													
13													
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45													
46													
47													
48													

		Medical			**Pharmacy**			**One Year Trends**					
Start Month	**End Month**	**Total Member Months**	**Total Incurred Claims**	**Estimated IBNR Claims**	**Total Member Months**	**Total Incurred Claims**	**Estimated IBNR Claims**	**Medical**		**Pharmacy**		**Total**	
								PMPM	**Trend**	**PMPM**	**Trend**	**PMPM**	**Trend**
Three Year Annualized Trend													

APPENDIX F3: MONTHLY NORMALIZED TREND

Enter Your Member and Claim Information for the most Recent 4 Years. If your plan has less than 4 years of data then enter the amount since plan inception.

The most recent month should be within 6 months of the date that you filed rates. Enter the most recent month in Row# 48.

Dental carriers please only complete the medical portion of this template.

Month Through Which Claims are Paid:

		NORMALIZED DATA											
		Medical			Pharmacy			Medical 12-Month		Pharmacy 12-Month		Total 12-Month	
Row #	Month	Members	Total Incurred Claims	Estimated IBNR Claims	Members	Total Incurred Claims	Estimated IBNR Claims	PMPM	PMPM Trend	PMPM	PMPM Trend	PMPM	PMPM Trend
1													
2													
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48													

		Medical			**Pharmacy**			**One Year Trends**					
Start Month	**End Month**	**Total Member Months**	**Total Incurred Claims**	**Estimated IBNR Claims**	**Total Member Months**	**Total Incurred Claims**	**Estimated IBNR Claims**	**Medical**		**Pharmacy**		**Total**	
								PMPM	**Trend**	**PMPM**	**Trend**	**PMPM**	**Trend**
Three Year Annualized Trend													

APPENDIX G: CREDIBILITY

Credibility				
1. Credibility Calculation				
Colorado Experience:		**Other Experience:**		
Life Years		**Life Years**		
Number of Claims		**Number of Claims**		
		Above data is for (please specify):		
		National		
		Manual Rate (please specify)		
		Other Product (please specify)		
Colorado Credibility Weighting Assigned				
Other Experience Credibility Weighting Assigned				
2. Number of years of data used to calculation above credibility percentage:	☐ 1 Year ☐ 2 Years ☐ 3 Years			
3. Provide a narrative if aggregated data meets the Colorado credibility requirement and how the rating methodology was modified for the partially credible data, if applicable.				

APPENDIX H: EXPERIENCE

EXPERIENCE							
Colorado-only basis for at least 3 years. **Include** national, regional or other appropriate basis, if the Colorado data is not fully credible. The experience period shall include consecutive data no older than 6 months prior to the proposed effective date.							
COLORADO MEDICAL EXPERIENCE							
Experience is for:	☐Existing Product		☐Comparable Product		☐Other		
Year*	**Earned Premium**	**Incurred Claims**	**Estimated IBNR Claims**	**Total Estimated Incurred Claims**	**Loss Ratio**	**Average Covered Lives**	**Number of Claims**
20xx							
20xx							
20xx							
20xx							
***This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY**							

COLORADO MEDICAL FOR EXPERIENCE PERIOD USED IN SETTING RATES									
Date		**Paid Through Date**	**Earned Premium**	**Incurred Claims**	**Estimated IBNR Claims**	**Total Estimated Incurred Claims**	**Loss Ratio**	**Average Covered Lives**	**Number of Claims**
From	**To**								
Blocks of Business Included in Experience:									

COLORADO PHARMACY EXPERIENCE							
Experience is for:	☐Existing Product		☐Comparable Product		☐Other		
Year*	**Earned Premium****	**Incurred Claims**	**Estimated IBNR Claims**	**Total Estimated Incurred Claims**	**Loss Ratio**	**Average Covered Lives**	**Number of Claims**
20xx							
20xx							
20xx							
20xx							
***This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY**							

COLORADO PHARMACY FOR EXPERIENCE PERIOD USED IN SETTING RATES									
Date		**Paid Through Date**	**Earned Premium**	**Incurred Claims**	**Estimated IBNR Claims**	**Total Estimated Incurred Claims**	**Loss Ratio**	**Average Covered Lives**	**Number of Claims**
From	**To**								
Blocks of Business Included in Experience:									

COLORADO TOTAL EXPERIENCE							
Experience is for:	☐Existing Product		☐Comparable Product		☐Other		
Year*	**Earned Premium**	**Incurred Claims**	**Estimated IBNR Claims**	**Total Estimated Incurred Claims**	**Loss Ratio**	**Average Covered Lives**	**Number of Claims**
20xx							
20xx							
20xx							
20xx							
***This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY**							

	COLORADO TOTAL FOR EXPERIENCE PERIOD USED IN SETTING RATES								
Date		**Paid Through Date**	**Earned Premium**	**Incurred Claims**	**Estimated IBNR Claims**	**Total Estimated Incurred Claims**	**Loss Ratio**	**Average Covered Lives**	**Number of Claims**
From	**To**								
Blocks of Business Included in Experience:									

	OTHER EXPERIENCE						
Experience is for:	☐Existing Product	☐Comparable Product	☐National	☐Other	(Check all that apply)		
Year	**Earned Premium**	**Incurred Claims**	**Total Estimated Incurred Claims**	**Total Estimated IBNR Claims**	**Loss Ratio**	**Average Covered Lives**	**Number of Claims**
20xx							
20xx							
20xx							
20xx							
Experience Period:	**From:**		**To:**				
Additional Information:							

**If pharmacy premium cannot be calculated separately from medical premium leave the pharmacy premium blank.

APPENDIX I: SIDE BY SIDE COMPARISON

O. SIDE-BY-SIDE COMPARISON			
If the proposed rating factor(s) are new, the memorandum shall specifically so state, and provide detailed support for each of the factors.	☐ N/A New Product		
Category Description	**Current Rate/ Rating Factor/ Rating Variable**	**Proposed Rate/ Rating Factor/Rating Variable**	**Percentage Increase/ Decrease**
If the above table is not used, please identify the location of the Side-by-Side Comparison in the rate filing:			
Description and detailed support for new rating factor(s):			
Additional Information:			

APPENDIX J: PROJECTED BENEFITS RATIO

PROJECTED EXPERIENCE FOR RATING PERIOD			
	Premiums (1)	**Incurred Claims (2)**	**Benefits Ratio (2 / 1)**
Projected Experience Without Rate Change			
Projected Experience With Rate Change			
Additional Information:			

Regulation 4-2-60 CONCERNING NETWORK ADEQUACY FILINGS FOR SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICIES, NON-AFFORDABLE CARE ACT MEDICAL PLANS, DENTAL PLANS, VISION PLANS, PHARMACY PLANS, AND ANY OTHER MANAGED CARE HEALTH COVERAGE PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-109, and 10-16-704, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide the necessary guidance to carriers on network adequacy filing procedures for short-term limited duration health insurance policies, non-ACA medical plans, dental plans, vision plans, pharmacy plans, and other managed care health coverage plans.

Section 3 Applicability

This regulation applies to all carriers that issue short-term limited duration health insurance policies, non-ACA medical plans, dental plans, vision plans, pharmacy plans, and any other managed care health coverage plans that are not health benefit plans as defined in § 10-16-102(32), C.R.S., for plans that are issued on or after the effective date of this regulation. This regulation does not apply to non-grandfathered health benefit plans, grandfathered health benefit plans, and ACA-compliant dental plans.

Section 4 Definitions

A. "ACA" means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B. "Active course of treatment" means, for the purposes of this regulation:

1. An ongoing course of active treatment for a life-threatening condition;

2. An ongoing course of treatment for a serious acute health condition, chronic health condition, or life limiting illness;

3. The second or third trimester of pregnancy through the postpartum period; or

4. An ongoing course of treatment for a health condition, whether physical health, mental health, behavioral health, or substance use disorder, for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

C. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

D. "Counties with Extreme Access Considerations" or "CEAC" means, for the purposes of this regulation, counties with a population density of less than ten (10) people per square mile, based on U.S. Census Bureau population and density estimates.

E. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

F. "Dentist" and "Dental Provider" mean, for the purposes of this regulation, a dental provider who is skilled in and licensed to practice dentistry for patients in all age groups and is responsible for the diagnosis, treatment, management, and overall coordination of services to meet the patient's oral health needs.

G. "Emergency services" shall have the same meaning as found at § 10-16-704(19)(e)(I), C.R.S.

H. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.

I. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

J. "Health care services" shall have the same meaning as found at § 10-16-102(33), C.R.S.

K. "Health condition" means, for the purposes of this regulation, an illness, injury, impairment, or condition of a physical, behavioral, or mental health nature, or that involves substance use.

L. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.

M. "Life-threatening health condition" means, for the purposes of this regulation, a disease or health condition for which likelihood of death is probable unless the course of the disease or health condition is interrupted.

N "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.

O. "Material change" means, for the purposes of this regulation, changes in the carrier's network of providers or type of providers available in the network to provide health care services or specialty health care services to covered persons that renders the carrier's network non-compliant with one or more network adequacy standards. Types of changes that could be considered material include:

1. A significant reduction in the number of primary or specialty care physicians available in a network;

2. A reduction in a specific type of provider such that a specific covered service is no longer available;

3. A change to the tiered, multi-tiered, layered or multi-level network plan structure; and

4. A change in inclusion of a major health system that causes the network to be significantly different from what the covered person initially purchased.

P. "Mental health, behavioral health, and substance use disorder care," means for the purposes of this regulation, health care services for a range of common mental or behavioral health conditions, or substance use disorders provided by a physician or non-physician professionals.

Q. "Mental health, behavioral health, and substance use disorder care providers", for the purposes of this regulation, and for the purposes of network adequacy measurements, means a provider offering health care services for a behavioral, mental health, and substance use disorder as defined by § 10-16-104(5.5)(d), C.R.S., and includes but is not limited to psychiatrists, psychologists, psychotherapists, licensed clinical social workers, psychiatric practice nurses, licensed addiction counselors, opioid treatment programs, inpatient and residential behavioral health facilities, licensed marriage and family counselors, and licensed professional counselors.

R. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.

S. "Other Vision provider" means, for the purposes of this regulation, a provider of vision services, other than ophthalmologists and optometrists, including opticians, and other vision hardware providers.

T. "Plan" means, for the purpose of this regulation, the specific benefits and cost-sharing provisions available to a covered person.

U. "Primary care" means, for the purposes of this regulation, health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care provider.

V. "Primary care provider" or "PCP" means, for the purposes of this regulation, a participating health care professional designated by the carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person. For the purposes of network adequacy measurements, PCPs for adults and children includes physicians (pediatrics, general practice, family medicine, internal medicine, geriatrics, obstetrician/gynecologist); and physician assistants and nurse practitioners supervised by, or collaborating with, a primary care physician.

W. "Provider directory" means, for the purposes of this regulation, a comprehensive listing, produced and maintained by the carrier, or it's designee, made available to covered persons, the public, and primary care providers, of the plan's participating providers and facilities in each of the carrier's networks.

X. "SERFF" means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filings.

Y. "Serious acute health condition, chronic health condition, or life-limiting illness" means, for the purposes of this regulation, a disease or health condition requiring complex on-going care which the covered person is currently receiving, including, but not limited to, chemotherapy, post-operative visits or radiation therapy.

Z. "Short-term limited duration health insurance policy" or "short-term policy" shall have the same meaning as found at § 10-16-102(60), C.R.S.

AA. "Specialist" means, for the purposes of this regulation, a physician or non-physician health care professional who:

1. Focuses on a specific area of physical, mental or behavioral health or a group of patients; and

2. Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

"Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

AB. "Specialty care" means, for the purposes of this regulation, health care services that are not primary care and focus on a specific area of physical, mental, or behavioral health, or a specific group of patients.

AC. "Telehealth" shall have the same meaning as found at § 10-16-123(4)(e), C.R.S.

AD. "Urgent care" means, for the purposes of this regulation, a facility or office that generally has extended hours, may or may not have a physician on the premises at all times, and is only able to treat minor illnesses and injuries. An urgent care facility does not typically have the facilities to handle an emergency condition, which includes life or limb threatening injuries or illnesses, as defined under emergency services.

Section 5 Network Adequacy Reporting Requirements

A. Each network that is used by carriers for short-term limited duration health insurance non-ACA medical, dental, vision, pharmacy, and any other health coverage managed care plans must be included in the carrier's "Network Adequacy" filing. Carriers must submit all filings through SERFF prior to use and annually thereafter.

B. The following measurement standards will be used to evaluate a carrier's network adequacy:

1. Compliance with network adequacy definitions and reporting methodologies contained in this regulation;

2. Compliance with the following two (2) measurement standards as they apply to each type of plan contained in this regulation;

a. Network Adequacy Access to Service and Waiting Time Standards; and

b. Applicable Geographic Access Standards.

C. Network Adequacy filings for plans specified in this regulation must include all of the documents listed in Section 8 of this regulation.

D. Attestations to adequate networks, for each network, must be provided pursuant to Required Attestations found in Section 8.D of this regulation.

Section 6 Network Adequacy Access to Service and Waiting Time Standards

A. The following access to service and waiting time standards must be met by all carriers filing short-term limited duration and non-ACA medical managed care plans subject to this regulation in order to comply with network adequacy requirements, if the service is covered:

Service Type	Time Frame	Time Frame Goal
Emergency Care – Medical, Behavioral, Substance Use	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care – Medical, Behavioral, Mental Health and Substance Use	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 7 calendar days	Met ≥ 90% of the time
Initial Non-Emergency Behavioral Health, Mental Health and Substance Use Disorder Care, initial appointments	Within 7 calendar days	Met ≥ 90% of the time
Follow-up Non-Emergency Behavioral Health, Mental Health and Substance Use Disorder Care appointments	Within 7 calendar days	Met ≥ 90% of the time
Prenatal Care	Within 7 calendar days	Met ≥ 90% of the time
Primary Care Access to after-hours care	Office number answered 24 hrs./ 7 days a week by answering service or instructions on how to reach a physician	Met ≥ 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met ≥ 90% of the time
Specialty Care – non urgent	Within 60 calendar days	Met ≥ 90% of the time

B. The following access to services and waiting time standards must be met by all carriers filing non-ACA dental, vision, pharmacy, and all other managed care health coverage plans subject to this regulation, if service is covered:

Service Type	**Time Frame**	**Time Frame Goal**
Emergency Care – if covered	24 hours a day, 7 days a week	Met 100% of the time
Access to after-hours care	Office number answered 24 hrs./ 7 days a week by answering service or instructions on how to reach a physician	Met ≥ 90% of the time
Non-urgent, Routine, Preventive visit/well visits	Within 30 calendar days	Met ≥ 90% of the time
Specialty Care – non urgent	Within 60 calendar days	Met ≥ 90% of the time

Section 7 Geographic Access Standards

Colorado uses the "County Types" designations and methodology defined by the Centers for Medicare & Medicaid Services (CMS) (see Appendix A of this regulation).

A. The carrier must attest that at least one (1) of each of the provider and facility types, appropriate to the specific type of plan listed below, is available within the maximum road travel distance, of any enrollee in each specific carrier's network.

1. For short-term limited duration plans, non-ACA medical plans, any other managed care health coverage plans not listed in Section 7.A.2 - provider types and maximum road travel distances are listed in Appendix A.

2. Dental plans:

	Geographic Type				
Provider Type – the plan provides access to at least one dental provider for at least 90% of the enrollees	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)
Dentist	15	30	60	75	110

3. Vision plans:

	Geographic Type				
Provider Type – the plan provides access to at least one vision provider from the following list for at least 90% of the enrollees	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)
Ophthalmology	10	20	35	60	85
Optometry	10	20	35	60	85
Other Vision Providers	10	20	35	60	85

4. Pharmacy plans:

	Geographic Type				
Provider Type – the plan provides access to at least one pharmacy provider for at least 90% of the enrollees	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)
Pharmacy	5	10	20	30	60

B. Geographic access standards may require that a policyholder cross county or state lines to reach a provider.

Section 8 Requirements for Annual Network Adequacy Reporting

Annual network adequacy filings must include all of the following documents, attached to the "Supporting Documentation" tab in SERFF. Network adequacy filings must be filed using the SERFF TOI code NA001.004. The data provided in the documents specified in this section, must apply to each network (i.e. HMO, PPO, EPO, etc.) in the carrier's service area. Networks that are not service area specific may be rejected.

A. Network Access Plan

All carriers offering short-term limited duration health insurance, non-ACA medical, dental, vision, pharmacy, and any other managed care health coverage plans utilizing one or more networks must submit access plans for each network they utilize, pursuant to § 10-16-704(9), C.R.S., and this regulation. Network access plans are public-facing documents used by carriers to describe their policies and procedures for maintaining and ensuring that their networks are sufficient and consistent with state and federal requirements. All policies and marketing materials of a carrier must clearly disclose the existence and availability of the network access plan, if a network is being used.

1. A carrier must:

a. Prepare and file an access plan prior to offering a new managed care network;

b. File the current access plan with the Division not less often than annually; and

c. Update an existing access plan, within fifteen (15) business days whenever the carrier makes any material change to an existing network.

2. Network access plans and confidentiality.

a. All network access plans submitted in the network adequacy form filing shall be open to public inspection, unless a carrier asserts that specific information contained in the access plan should be held confidential pursuant to § 24-72-204, C.R.S.

b. If a carrier asserts that specific information contained in the network access plan is to be held confidential, a second network access plan must be filed with the Division that redacts the potentially confidential information. Statutory justifications for each redaction made must also be filed with the redacted network access plan.

c. Redacted network access plans shall be filed as separate SERFF components on the "Supporting Documentation" tab.

d. Redacted network access plans shall be made available through access to SERFF network adequacy filings on the Division of Insurance's (Division's) website, and on the carrier's website.

3. A network access plan submitted by a carrier offering a health coverage plan subject to this regulation, utilizing a managed care network, must follow the Network Access Plan Instructions listed in Appendices B or C, specific to the type of health coverage plan. The network access plan must demonstrate that the carrier:

a. Has an adequate network that it is actively maintaining;

b. Explains how the network is built, maintained and assessed;

c. Informs consumers of the plan's network services and features; and

d. Provides a documented process and plan for coordination and continuity of care appropriate to the type of health plan.

4. All rights and responsibilities of the covered person under the short-term limited duration health insurance, non-ACA medical, dental, vision, pharmacy, and any other managed care health coverage plan subject to this regulation must be included in the contract provisions of the policy, regardless of whether or not such provisions are also specified in the access plan.

B. Provider Listings

All carriers must submit the Network Provider Listing and the Network Facility Listing found in Appendix D for each network being reported in the network adequacy filing, if applicable. Copies of the templates and instructions for provider and network facility listing documents are provided in SERFF and on the Division's website. If the carrier uses a network that has been reported in an ACA-compliant network adequacy filing within the last twelve (12) months, the provider and network facility listings need not be duplicated. In these cases, the carrier must identify the network name, filing number and date of the filing for each network that has already been reviewed pursuant to the Required Attestations found in Section 8.D of this regulation.

C. Provider Directories

Provider directories are comprehensive listings, produced and maintained by the carriers, made available to covered persons and the public, of the plan's participating providers in each of the carrier's networks. Provider directories must meet all of the following requirements:

1. A carrier must post electronically a current and accurate provider directory for each of its network plans with the information and search functions as described in Appendix E of this regulation, updated no less frequently than monthly;

2. When making the directory available electronically, the carrier must ensure that the general public is able to view all of the current providers for a network through a clearly identifiable link or tab without requiring an individual to create or access an account or requiring the entry of a policy or contract number;

3. The carrier must include a disclosure in the directory of the date of the most recent update for electronic directories or the date of printing for printed directories. This disclosure must state that the information included in the directory is accurate, to the best of the carrier's knowledge, as of the date of updating/printing, and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website, or call the carrier's customer service telephone number, to obtain current provider directory information;

4. A carrier must provide a print copy of the requested pertinent portion of the current provider directory with the information described in Section 8.C.5. to a covered person with five (5) business days of the request;

5. A carrier must include, in both the electronic and print directory, the following general information for each of its provider networks:

a. A description of the criteria the carrier has used to build its provider network;

b. A description of the criteria the carrier has used to tier providers, if applicable;

c. If applicable, a description of how the carrier designates the different provider tiers or levels in the network and identifies (e.g. by name, symbols or grouping) which tier or level the following are placed in:

(1) Each specific provider;

(2) Each specific hospital; and

(3) Each specific other type of facility in the network.

d. If applicable, a note that an authorization or referral may be required to access some providers.

6. A carrier must make it clear, in both its electronic and print directories, which provider directory applies to a particular network plan, such as including the specific name of the network plan as marketed and issued in this state;

7. The carrier must include, in both its electronic and print directories, customer service contact information by electronic means such as email, text, or social media and, telephone number and an electronic link that covered persons or the general public may use to notify the carrier of inaccurate provider directory information;

8. A provider directory, whether in electronic or print format, must accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency. A provider directory must also be available in Spanish;

9. The carrier must provide provider directory updates and audits as follows:

a. The carrier must update each electronic network provider directory at least monthly. Current directories must be made available to the Commissioner, upon request;

b. No less frequently than annually, the carrier must audit at least fifty percent (50%) of the providers contained in its provider directories for accuracy and update that directory based upon its findings; and

c. Documentation of the process and findings of all audits and the information required by this regulation shall be retained for no less than thirty-six (36) months and must be made available to the Commissioner upon request.

10. Materially Inaccurate Information in Provider Directories

a. In circumstances where the Commissioner finds that a covered person has demonstrated that he or she reasonably relied upon materially inaccurate information contained in a carrier’s provider directory and received services from what the covered person believed to be an in-network provider:

(1) The Commissioner may require the carrier to cover services or treatment at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider for up to thirty (30) days after the services or treatment were initially provided; and

(2) Unless the covered person chooses otherwise, once the materially inaccurate information has been identified, the carrier shall transition the covered person to an in-network provider.

b. A covered person who has demonstrated that he or she reasonably relied upon materially inaccurate information contained in a carrier's provider directory and received services from what the covered person believed to be an in-network provider must only be required to pay the amount that he or she would have paid, had the services been delivered by an in-network provider under the carrier's network plan.

c. A covered person will be considered to have demonstrated that he or she reasonably relied upon a carrier's provider directory if a covered person has confirmed that a provider is contained in a carrier's provider directory no more than thirty (30) days prior to receiving care.

d. Carriers must maintain an archive of all provider directory updates for a period of at least one hundred and eighty (180) days and which must be provided to the Commissioner upon request.

11. The carrier must provide screen shots from its publicly-accessible website provider directory(ies) showing:

a. Master (entry) page of the carrier's web-site, directing users to the provider directory(ies);

b. Introduction screen of the provider directory;

c. Directory general information, such as inclusion criteria, description of tiering (if applicable), customer service contact information, date of last revisions, and directory disclosures;

d. Simple search screen;

e. A page of a provider directory produced from a search; and

f. Detail screen for at least one (1) provider and one (1) facility, if applicable.

D. Required Attestations

Attestations shall be made on the applicable "Carrier Network Adequacy Summary and Attestation Form" submitted with the network adequacy form filing in SERFF. The two Carrier Network Adequacy Summary and Attestation Forms applicable to this regulation are Colorado-specific, consumer-facing, fillable Excel documents found on SERFF and on the Division's website. The first tab of these Attestation Forms provides the instructions for completing the summary and attestation forms.

1. A carrier shall attest that each of its managed care health coverage plans will maintain a provider network(s) that meets the standards contained in this regulation, and that each provider network is sufficient in applicable number and types of providers to assure that the services will be accessible without unreasonable delay.

2. If a network does not meet Colorado access to service and waiting time standards or geographic access standards, the carrier must explain/describe specific items not meeting the standards, and actions to be taken, including remedies, timeframes, schedule for implementation, and proposed notification and communications with the Division, providers, policyholders, and enrollees. Instructions to provide these explanations are specified in the Summary and Attestation Forms and instructions.

3. The carrier shall attest that it files, maintains, and makes available, a network access plan for each of its networks that meets the standards of, and is maintained as specified in Section 8.A. of this regulation, and that each of its health plan networks includes the continuity of care requirements, specified in item 8. of Appendix B or Appendix C of this regulation, to ensure sufficient continuity of care for its policyholders and/or enrollees.

4. The carrier shall attest that each of its health plan networks will maintain a provider directory(ies) for each network that meets the standards of, and is maintained as specified in Section 8.C. of this regulation.

5. The carrier shall provide the signature and date signed of an authorized officer of the filing entity. If the individual signing the attestation is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary who is also a corporate officer, include documentation that shows that the Board of Directors has appointed this individual as an officer of the organization. The signature must be an original signature of an authorized officer of the filing entity. Electronic signatures are not acceptable unless provided through a signature verification provider such as VeriSign.

Section 9 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 10 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 11 Effective Date

This regulation shall become effective on June 14, 2024.

Section 12 History

New regulation effective September 1, 2018.
Amended Regulation effective June 14, 2024.

APPENDIX A - DESIGNATING COUNTY TYPES AND GEOGRAPHIC ACCESS STANDARDS

The county type, Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations (CEAC), is a significant component of the network access criteria. CMS uses a county type designation methodology that is based upon the population size and density parameters of individual counties.

Density parameters are foundationally based on approaches taken by the U.S. Census Bureau in its delineation of "urbanized areas" and "urban clusters", and the Office of Management and Budget (OMB) in its delineation of "metropolitan" and "micropolitan". A county must meet both the population and density thresholds for inclusion in a given designation. For example, a county with population greater than one million and a density greater than or equal to 1,000 persons per square mile (sq. mile) is designated Large Metro. Any of the population-density combinations listed for a given county type may be met for inclusion within that county type (i.e., a county would be designated "Large Metro" if any of the three (3) Large Metro population-density combinations listed in the following table are met; a county is designated as "Metro" if any of the five (5) Metro population-density combinations listed in the table are met; etc.).

Population and Density Parameters

County Type	Population	Density
Large Metro	≥ 1,000,000	≥ 1,000/sq. mile
---	500,000 – 999,999	≥ 1,500/ sq. mile
---	Any	≥ 5,000/ sq. mile
Metro	≥ 1,000,000	10 – 999.9/sq. mile
---	500,000 – 999,999	10 – 1,499.9/sq. mile
---	200,000 – 499,999	10 – 4,999.9/sq. mile
---	50,000 – 199,999	100 – 4,999.9/sq. mile
---	10,000 – 49,999	1,000 – 4,999.9/sq. mile
Micro	50,000 – 199,999	10 – 99.9 /sq. mile
---	10,000 – 49,999	50 – 999.9/sq. mile
Rural	10,000 – 49,999	10 – 49.9/sq. mile
---	<10,000	10 – 4,999.9/sq. mile
CEAC	Any	<10/sq. mile

COLORADO COUNTY DESIGNATIONS

County	Classification	County	Classification
Adams	Metro	Kit Carson	CEAC
Alamosa	Rural	Lake	Rural
Arapahoe	Metro	La Plata	Micro
Archuleta	Rural	Larimer	Metro
Baca	CEAC	Las Animas	CEAC
Bent	CEAC	Lincoln	CEAC
Boulder	Metro	Logan	Rural
Broomfield	Metro	Mesa	Micro
Chaffee	Rural	Mineral	CEAC
Cheyenne	CEAC	Moffat	CEAC
Clear Creek	Rural	Montezuma	Rural
Conejos	CEAC	Montrose	Rural
Costilla	CEAC	Morgan	Rural
Crowley	CEAC	Otero	Rural
Custer	CEAC	Ouray	CEAC
Delta	Rural	Park	CEAC
Denver	Large Metro	Phillips	CEAC
Dolores	CEAC	Pitkin	Rural
Douglas	Metro	Prowers	CEAC
Eagle	Micro	Pueblo	Micro
Elbert	Rural	Rio Blanco	CEAC
El Paso	Metro	Rio Grande	Rural
Fremont	Rural	Routt	Rural
Garfield	Micro	Saguache	CEAC
Gilpin	Rural	San Juan	CEAC
Grand	CEAC	San Miguel	CEAC
Gunnison	CEAC	Sedgwick	CEAC
Hinsdale	CEAC	Summit	Micro
Huerfano	CEAC	Teller	Rural
Jackson	CEAC	Washington	CEAC
Jefferson	Metro	Weld	Metro
Kiowa	CEAC	Yuma	CEAC

Network Adequacy Geographic Access Standards by Provider or Facility Type:

	Large Metro	**Metro**	**Micro**	**Rural**	**CEAC**
Specialty	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)
Primary Care	5	10	20	30	60
Gynecology, OB/GYN	5	10	20	30	60
Pediatrics - Routine/Primary Care	5	10	20	30	60
Allergy and Immunology	15	30	60	75	110
Cardiothoracic Surgery	15	40	75	90	130
Cardiovascular Disease	10	20	35	60	85
Chiropractic	15	30	60	75	110
Dermatology	10	30	45	60	100
Emergency Medicine	10	30	60	60	100
Endocrinology	15	40	75	90	130
ENT/Otolaryngology	15	30	60	75	110
Gastroenterology	10	30	45	60	100
General Surgery	10	20	35	60	85
Gynecology only	15	30	60	75	110
Infectious Diseases	15	40	75	90	130
Licensed Addiction Counselor	10	30	45	60	100
Licensed Clinical Social Worker	10	30	45	60	100
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurosurgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100

	Large Metro	Metro	Micro	Rural	CEAC
Specialty	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)
Oncology - Radiation	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Optometry for routine vision services	10	20	35	60	85
Other Vision Provider	10	20	35	60	85
Orthopedic Surgery	10	20	35	60	85
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	5	10	20	30	60
Physical Medicine and Rehabilitative Medicine	15	30	60	75	110
Plastic Surgery	15	40	75	90	130
Podiatry	10	30	45	60	100
Psychiatry	10	30	45	60	100
Psychology	10	30	45	60	100
Pulmonology	10	30	45	60	100
Rheumatology	15	40	75	90	130
Urology	10	30	45	60	100
Vascular Surgery	15	40	75	90	130
Other Medical Provider	15	40	75	90	130
Dentist	15	30	60	75	110
Pharmacy	5	10	20	30	60
Acute Inpatient Hospital	10	30	60	60	100
Cardiac Surgery Program	15	40	120	120	140
Cardiac Catheterization Services	15	40	120	120	140

	Large Metro	**Metro**	**Micro**	**Rural**	**CEAC**
Specialty	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)
Critical Care Services – Intensive Care Units (ICU)	10	30	120	120	140
Outpatient Dialysis	10	30	50	50	90
Surgical Services (Outpatient or ASC)	10	30	60	60	100
Dental Surgical Services (Outpatient or ASC)	10	30	60	60	100
Vision Surgical Services (Outpatient or ASC)	10	30	60	60	100
Skilled Nursing Facility	10	30	60	60	85
Diagnostic Radiology	10	30	60	60	100
Mammography	10	30	60	60	100
Physical Therapy	10	30	60	60	100
Occupational Therapy	10	30	60	60	100
Speech Therapy	10	30	60	60	100
Inpatient and Residential Behavioral Health Facility	15	45	75	75	140
Orthotics and Prosthetics	15	30	120	120	140
Outpatient Infusion/Chemotherapy	10	30	60	60	100
Urgent Care Facilities	10	30	60	60	100
Other Facilities	15	40	120	120	140

APPENDIX B - NETWORK ACCESS PLAN INSTRUCTIONS FOR SHORT-TERM LIMITED DURATION AND NON-ACA MEDICAL HEALTH COVERAGE PLAN NETWORKS

The carrier must address the following in the network access plan for each network offered by the carrier for short-term limited duration plans and non-ACA medical health coverage plans:

1. Network Identification, Composition and Adequacy

    a. Description of the network(s), including name, coverage area, and the composition (types of providers and facilities) of the network(s); and

    b. A statement of the adequacy of the network(s).

2. Identification of Provider Acceptance Criteria, and Network Standards

    a. The factors a carrier uses to build its provider network;

    b. The carrier's criteria and process for assessing network adequacy;

        1) Quality assurance standards used to measure network adequacy, which must be adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care criteria used to select and/or tier providers;

        2) Documented quantifiable and measurable process for monitoring and assuring the sufficiency of the network to meet the managed care needs of populations enrolled in plans on an ongoing basis;

    c. The carrier's description of how telehealth is used (or not used) to meet healthcare needs and network adequacy standards; and

    d. The carrier's description of specific actions to be taken, including remedies, timeframes, schedule for implementation, and proposed notification and communications with the Division, providers, policyholders, and enrollees, if a network is found to be inadequate.

3. Policyholder and/or Enrollee Network Communications and Corrective Action Processes

    The carrier must inform policyholders and/or enrollees of the plan's network services and features through this Network Access Plan and other documents, disclosures and notices provided to policyholders and/or enrollees. This section of the Network Access Plan will identify these items and reference where the items are explained in other documents.

    a. An explanation of Provider Directories, including availability, accessibility, and updating process;

    b. The carrier's process for policyholders to access and use the network, including

        1) How to use network providers and facilities, and selection and changing primary care providers, if applicable;

        2) Availability and access to appropriate specialists, including an explanation of the referral process, if used. The Referral Process shall include:

            a. A comprehensive listing, made available to covered persons and medical providers, of the carrier's network participating providers and facilities;

b. A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a managed care plan may offer variable deductibles, coinsurance and/or copayments to encourage the selection of certain providers; and

c. A managed care plan that offers variable deductibles, coinsurance, and/or copayments must provide adequate and clear disclosure, as required by law, of variable deductibles and copayments to enrollees, and the amount of any deductible or copayment must be reflected on the benefit card provided to the enrollees;

(1) Timely referrals for access to specialty care;

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

(3) A provision that referrals approved by the carrier cannot be retrospectively denied except for fraud or abuse;

(4) A provision that referrals approved by the carrier cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse; and

(5) The carrier's process allowing covered persons to access services outside the network when necessary.

3) The carrier's process to assure that a covered person is able to obtain a covered benefit at the in-network level of benefit from a non-participating provider should the carrier's network prove to not be sufficient.

4) The carrier's process to address the needs, including access and accessibility of services, of policyholders and/or enrollees with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and/or mental disabilities.

5) The carrier must briefly describe its grievance and appeals procedures, provide contact information and provide the location of where these procedures are fully described.

4. Coordination and Continuity of Care Provisions

a. A carrier and participating provider shall provide at least sixty (60) days written notice to each other before a provider is removed or leaves the network without cause.

b. When a primary care provider is being removed, leaving the network, or is being non-renewed, all covered persons who are patients of that primary care provider must be notified by the carrier, in writing, prior to termination. When the provider gives or receives the notice in accordance with this regulation, the provider shall supply the carrier with a list of those patients of the provider that are covered by a plan of the carrier. The carrier must supply the provider with a list of the provider's patients that are covered by the carrier.

c. Irrespective of whether it is for cause or without cause or due to non-renewal of a contract, the carrier must make a good faith effort to provide both written notice of a provider's removal, leaving, or non-renewal from the network, and the provider information contained in regulation, within fifteen (15) working days of receipt or issuance of a notice provided in accordance with this regulation. For short-term policies, this notice must be provided to all covered persons who are identified as patients by the provider, or who have been seen by the provider being removed or leaving the network within the period since the effective date of the policy for the covered person. For all other policies, this notice must be provided to all covered persons who are identified as patients by the provider, are on a carrier's patient list for that provider, or who have been seen by the provider being removed or leaving the network within the previous six (6) months.

d. A covered person, in a short-term policy, must have been undergoing treatment, or have been seen at least once during the effective period of the policy, by the provider being removed or leaving the network for that covered person to be considered in an active course of treatment.

e. For all other policies, a covered person must have been undergoing treatment, or have been seen at least once in the previous twelve (12) months, by the provider being removed or leaving the network for that covered person to be considered in an active course of treatment.

f. A carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care when a covered person's provider leaves or is removed from the network.

g. A carrier must make available to the covered person a list of available participating providers who are accepting new patients in the same geographic area and specialty provider type, or a referral to a provider if there is no participating provider available, who is of the same provider or specialty type. The carrier must provide information about how the covered person may request continuity of care as required by this regulation.

h. A carrier's transition procedures must provide that:

(1) A carrier shall review requests for continuity of care made by the covered person or the covered person's authorized representative;

(2) Requests for continuity of care must be reviewed by the carrier's Medical Director after consultation with the treating provider. This requirement applies to:

(a) Patients who meet the applicable criteria listed in this regulation; and

(b) Who are under the care of a provider who has not been removed or leaving the network for cause;

(3) Any decisions made with respect to a request for continuity of care are subject to the plan's internal and external grievance and appeal processes in accordance with applicable state and federal laws and regulations;

(4) The continuity of care period for covered persons that are undergoing an active course of treatment shall extend to the earlier of:

(a) The termination of the course of treatment by the covered person or the treating provider;

(b) Ninety (90) days after the effective date of the provider's departure or termination from the network, unless the carrier's Medical Director determines that a longer period is necessary;

(c) The date that care is successfully transitioned to a participating provider;

(d) Benefit limitations under the plan are met or exceeded;

(e) The date that the coverage is terminated; or

(f) The care is no longer medically necessary.

i. In addition to the provisions of item 4. of Appendix B of this regulation, a continuity of care request may only be granted when the provider departing or terminated from the network:

(1) Agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the carrier for that patient as provided in the original provider contract, or by the new payment and terms agreed upon and executed between the provider and the carrier; and

(2) Agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the provider were still a participating provider.

j. The obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the in-network relationship is extended to provide continuity of care.

k. Nothing in this item 4. of Appendix B shall prohibit a carrier from excluding conditions from continuity of care provisions that are not covered due to a pre-existing condition exclusion.

APPENDIX C - NETWORK ACCESS PLAN INSTRUCTIONS FOR DENTAL, VISION, PHARMACY, AND OTHER MANAGED CARE HEALTH COVERAGE PLAN NETWORKS

The carrier must address the following in the network access plan for each network offered by the carrier for dental, vision, pharmacy, and other non-medical plans:

1. Network Identification, Composition and Adequacy

    a. Description of the network(s), including name, coverage area, and the composition (types of providers and facilities) of the network(s); and

    b. A statement of the adequacy of the network(s).

2. Identification of Provider Acceptance Criteria, and Network Standards

    a. The factors a carrier uses to build its provider network;

    b. The carrier's criteria and process for assessing network adequacy;

        1) Quality assurance standards used to measure network adequacy, which must be adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care criteria used to select and/or tier providers;

        2) Documented quantifiable and measurable process for monitoring and assuring the sufficiency of the network to meet the managed care needs of populations enrolled in plans on an ongoing basis;

    c. The carrier's description of how telehealth is used (or not used) to meet dental, vision, pharmacy, or other health coverage plan needs and network adequacy standards; and

    d. The carrier's description of specific actions to be taken, including remedies, timeframes, schedule for implementation, and proposed notification and communications with the Division, providers, policyholders, and enrollees, if a network is found to be inadequate.

3. Policyholder Network Communications and Corrective Action Processes

    The carrier must inform policyholders and/or enrollees of the plan's network services and features through this Network Access Plan and other documents, disclosures and notices provided to policyholders and/or enrollees. This section will explain the following items and identify/reference where these items are explained in other documents.

    a. An explanation of Provider Directories, including availability, accessibility, and updating process;

    b. The carrier's process for policyholders to access and use the network, including

        1) How to use network providers and facilities, and selection and changing primary providers, if applicable;

        2) Availability and access to appropriate specialists, including an explanation of the referral process, if used;

3) The carrier's process, including contact information, to assure that a covered person is able to obtain a covered benefit at the in-network level of benefit from a non-participating provider should the carrier's network prove to not be sufficient;

4) The carrier's process to address the needs, including access and accessibility of services, of policyholders and/or enrollees with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and/or mental disabilities;

5) The carrier must briefly describe its grievance and appeal procedures, contact information, and where these procedures are fully described.

4. Coordination and Continuity of Care Provisions

a. The carrier must make a good faith effort to provide notice of a provider's removal, leaving, or non-renewal from the network, within fifteen (15) working days of receipt or issuance of a notice provided in accordance with this regulation. This notice must be provided to all covered persons who are identified as patients by the provider, are on a carrier's patient list for that provider, or who have been seen by the provider being removed or leaving the network within the previous six (6) months.

b. A carrier must make available to the covered person a list of available participating providers who are accepting new patients in the same geographic area and specialty provider type, or a referral to a provider if there is no participating provider available, who is of the same provider or specialty type. The carrier must provide information about how the covered person may request continuity of care as required by this regulation.

c. If a covered person has been undergoing treatment, at least once in the previous twelve (12) months, by the provider being removed or leaving the network, that covered person is considered to be in an active course of treatment.

d. A carrier shall establish reasonable procedures, including time frame, to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care when a covered person's provider leaves or is removed from the network.

e. The carrier shall print in the Network Access Plan it's obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the in-network relationship is extended to provide continuity of care.

APPENDIX D - PROVIDER AND FACILITY LISTING INSTRUCTIONS

All carriers MUST submit a separate network provider listing and a network facility listing **for each network** that is included in the filing. This listing must include a complete set of providers and facilities for each network. If a provider/facility is in multiple networks, they must be listed in the file for each network. Network provider and network facility listings must be submitted in Excel (.xls or .xlsx) format. These listings must be completed as described below.

NOTE: The provider listing submitted to the Division as part of the network adequacy filing is a separate document from the provider directory maintained by the carrier.

If the carrier uses a network that has been reported in an ACA-compliant network adequacy filing within the last twelve (12) months, the provider and facility listings need not be duplicated. In these cases, the carrier must identify the network name, filing number and date of the filing for each network that has already been reviewed.

The provider and facility listings submitted to the Division must be in the Division-format Excel documents, which are available on SERFF and on the Division website.

NETWORK PROVIDER LISTING

The following fields are required:

Heading:

- **Company Legal Name** – Name used on General Information tab for the filing.
- **NAIC Company Code**
- **Network Name**

Fields:

- First Name of Provider: Only the first name.
- Middle Initial of Provider: Only the middle initial.
- Last Name of Provider: Only the last name.
- Specialty Type (Area of medicine**):** Select the specialty type from the drop down menu, (derived from the list provided in Appendix A). If the specialty is not included on the list, please list as “Other.”
- Street Address: Only a number and a street name. No other information will be allowed in this field, including suite numbers, unit numbers, building numbers, building names and # symbols. An example of what is accepted here is “123 Main Street.” An unacceptable address would be “123 Main Street Suite 3.”
- Street Address 2 (Suite, building name, etc.): Any additional address information, such as unit names, suite numbers, building names and floor numbers.
- City: Only the city.
- State: The full name of the state, no abbreviations (e.g. Colorado not CO).
- County: The county name only (e.g. Kit Carson not Kit Carson County).
- Zip: Only the five or nine-digit zip code.
- National Provider Identifier (NPI): Unique 10-digit identification number issued to health care providers by the Centers for Medicare and Medicaid (CMS).
- Accepting New Patients (Y/N): Indicate whether provider is currently accepting new patients.

NETWORK FACILITY LISTING

The required fields for the facilities listing are:

Heading:

- Company Name: Name used on General Information tab for the filing.
- NAIC Company Code
- Network Name

Fields:

- Facility Name: This field must contain only the name of the facility.
- Facility Type: Select from the drop down menu. The types of facilities are categorized according to the list in Appendix A. If the facility type is not included on the list, please use “other” for the facility type.
- Street Address: Only a number and a street name. No other information will be allowed in this field, including suite numbers, unit numbers, building numbers, building names and # symbols. An example of what is accepted here is “123 Main Street.” An unacceptable address would be “123 Main Street Suite 3”.
- Street Address 2 (Suite, building name, etc.): This field should contain any additional address information, such as unit names, suite numbers, and floor numbers.
- City: Only the city.
- State: Only the full name of the state, no abbreviations (e.g. Colorado not CO).
- County: Only the county name (e.g. Kit Carson not Kit Carson County).
- Zip: The five or nine-digit zip code only.
- National Provider Identifier (NPI): Unique 10-digit identification number issued to health care providers by the Centers for Medicare & Medicaid Services (CMS).

Dental and Vision carriers are not required to submit network facility listing as part of their network adequacy filings.

APPENDIX E - PROVIDER DIRECTORY CONTENTS

Provider directory filings made on or after the date of this regulation will be required to meet the following requirements, and carriers are strongly encouraged to prepare and meet these requirements as soon as possible.

1. The carrier shall make available through an electronic provider directory, for each network, the information in this subsection in a searchable format. At a minimum, consumers should be able to search provider directories by provider or facility name, address (at least county and/or zip code), specialty type, and network. Carriers are strongly encouraged to have many searchable fields.

    A. For health care professionals:

        (1) Name;

        (2) Gender;

        (3) Participating office location(s);

        (4) Specialty, if applicable;

        (5) Medical group affiliations, if applicable;

        (6) Participating facility affiliations, if applicable;

        (7) Languages spoken other than English, if applicable;

        (8) Tiers and network plans to which the provider belongs, if applicable; and

        (9) Whether accepting new patients.

    B. For hospitals:

        (1) Hospital name;

        (2) Hospital type (i.e. acute, rehabilitation, children's, cancer);

        (3) Participating hospital location; and

        (4) Hospital accreditation status.

    C. For facilities, other than hospitals, by type:

        (1) Facility name;

        (2) Facility type;

        (3) Types of services performed; and

        (4) Participating facility location(s).

2. For the electronic provider directories, for each network, a health carrier shall make available the following, non-searchable, information in addition to all of the information available under Section 1. above:

A. For health care professionals:

(1) Contact information (telephone number(s), and if available, e-mail addresses, website URLs, etc.); and

(2) Board certification(s

B. For hospitals and facilities other than hospitals: Telephone number(s), e-mail addresses, website URLs, etc., if applicable.

3. The carrier shall make available in print, upon request, the following provider directory information for the applicable network:

A. For health care professionals:

(1) Name;

(2) Contact information (telephone number(s), and if available, e-mail addresses, website URLs, etc.);

(3) Participating office location(s);

(4) Specialty, if applicable;

(5) Languages spoken other than English, if applicable; and

(6) Whether accepting new patients.

B. For hospitals:

(1) Hospital name;

(2) Hospital type (i.e. acute, rehabilitation, children's, cancer); and

(3) Participating hospital location and telephone number.

C. For facilities, other than hospitals, by type:

(1) Facility name;

(2) Facility type;

(3) Types of services performed; and

(4) Participating facility location(s), telephone number(s), e-mail addresses, website URLs, if applicable.

Regulation 4-2-61 CONCERNING THE PAYMENT PARAMETERS FOR THE COLORADO REINSURANCE PROGRAM

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, and 10-16-1104(1)(i), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the payment parameters, including the attachment point, coinsurance rate, and program cap, for the Colorado reinsurance program. Establishing these payment parameters ensures that carriers are able to file rates that reflect the impact of the reinsurance program on claims costs. This regulation replaces Colorado Emergency Regulation 19-E-01 in its entirety.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing non-grandfathered individual health benefit plans on or after the effective date of this regulation and that are subject to the individual health benefit plan laws of Colorado.

Section 4 Definitions

A. “Attachment point” shall have the same meaning as found at § 10-16-1103(1), C.R.S.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. “Coinsurance rate” shall have the same meaning as found at § 10-16-1103(3), C.R.S.

D. “Eligible carrier” shall have the same meaning as found at § 10-16-1103(5), C.R.S.

E. “Geographic area” means, for the purposes of this regulation, the geographic rating area selected by Colorado and approved by the federal government, to be used by carriers in the state of Colorado.

F. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

G. “Payment parameters” shall have the same meaning as found at § 10-16-1103(9), C.R.S.

H. “Reinsurance cap” shall have the same meaning as found at § 10-16-1103(10), C.R.S.

I. “Reinsurance payment” shall have the same meaning as found at § 10-16-1103(11), C.R.S.

J. “Reinsurance program” shall have the same meaning as found at § 10-16-1103(12), C.R.S.

Section 5 Payment Parameters for the 2020 Plan Year Reinsurance Program

A. Reinsurance payments shall only be made to an eligible carrier for those individual health benefit plan claims that meet the payment parameters established in this regulation.

B. Colorado has established nine (9) geographic areas for health benefit plans that are contained in the following table:

Geographic Area	County
Geographic Area 1	Boulder
Geographic Area 2	El Paso, Teller
Geographic Area 3	Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park
Geographic Area 4	Larimer
Geographic Area 5	Mesa
Geographic Area 6	Weld
Geographic Area 7	Pueblo
Geographic Area 8 (East)	Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Phillips, Prowers, Rio Grande, Saguache, Sedgwick, Washington, Yuma
Geographic Area 9 (West)	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit

C. Attachment Points

1. Geographic areas five and nine shall have an attachment point of $30,000.

2. Geographic areas four, six, seven, and eight shall have an attachment point of $30,000.

3. Geographic areas one, two, and three shall have an attachment point of $30,000.

D. Coinsurance Rates

1. Geographic areas five and nine shall have a coinsurance rate of eighty-five percent (85%).

2. Geographic areas four, six, seven, and eight shall have a coinsurance rate of fifty percent (50%).

3. Geographic areas one, two, and three shall have a coinsurance rate of forty-five percent (45%).

E. Reinsurance Caps

1. Geographic area five and nine shall have a reinsurance cap of $400,000.

2. Geographic areas four, six, seven, and eight shall a reinsurance cap of $400,000.

3. Geographic areas one, two, and three shall have a reinsurance cap of $400,000.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective October 1, 2019.

Section 9 History

Emergency regulation 19-E-01 effective May 31, 2019.
Regulation effective October 1, 2019.

Regulation 4-2-62 CONCERNING INSURANCE UNFAIR PRACTICES ACT PROHIBITIONS ON DISCRIMINATION BASED UPON SEXUAL ORIENTATION OR GENDER IDENTITY

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-1110, and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish requirements to ensure compliance with the prohibitions on discrimination in health coverage based upon an individual's sexual orientation. Such discrimination shall be considered an unfair method of competition and an unfair or deceptive act or practice in the business of insurance as found at § 10-3-1104(1)(f), C.R.S.

Section 3 Applicability

The provisions of this regulation shall apply to all carriers that market policies of sickness and accident insurance and/or health coverage plans in in the state of Colorado.

Section 4 Definitions

A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S., and shall, for the purposes of this regulation, include a pharmacy benefit management firm contracted by a carrier.

B. "Policy" means, for the purpose of this regulation, both a health coverage plan, as defined at § 10-16-102(34), C.R.S., and a policy of sickness and accident insurance, as defined at § 10-16-102(50), C.R.S.

C. "Sexual orientation" shall have the same meaning as found at § 2-4-401(13.5), C.R.S.

Section 5 Rules

A. Carriers shall not engage in unfair discrimination due to sexual orientation or gender identity between individuals of the same class in:

1. The amount of premium charged for any policy of sickness and accident insurance or health coverage plan;

2. The amount of any policy fees, or rates charged for any policy of sickness and accident insurance or health coverage plan;

3. The benefits payable under such policy;

4. The terms or conditions of the policy; and

5. Any other manner that may be perceived as discriminatory.

B. Carriers shall not inquire about or make an investigation concerning, directly or indirectly, an applicant's, a proposed insured, or a beneficiary's sexual orientation or gender identity in an application for coverage.

C. Carriers shall not use information about gender, marital status, medical history, or occupation to determine sexual orientation or gender identity.

D. Carriers shall not use sexual orientation or gender identity in the underwriting process or when making a determination of insurability.

E. Carriers are prohibited from denying, canceling, limiting, or refusing to issue or renew a policy because of a person's sexual orientation or gender identity. A carrier shall not:

1. Impose any differential in premium rates or charges with regard to an applicant or covered person's sexual orientation or gender identity;

2. Designate an individual's sexual orientation or gender identity as a pre-existing condition for the purpose of denying or limiting coverage; and

3. Deny, exclude, or otherwise limit coverage for medically necessary services, in accordance with generally accepted professional standards of care, based upon a person's sexual orientation or gender identity.

F. The violation of any of the provisions in Section 5.A. through E. shall be considered unfair discrimination, an unfair method of competition and an unfair or deceptive act or practice in the business of insurance, pursuant to § 10-3-1104(1)(f), C.R.S.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective on April 1, 2019.

Section 9 History

New regulation effective April 1, 2019.

Regulation 4-2-63 CONCERNING MEANINGFUL DIFFERENCE STANDARDS FOR HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § 10-1-109(1), 10-16-108.5(8) and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish requirements to ensure that there is meaningful difference between health benefit plans being offered by a carrier, which in turn promotes the fair marketing of health benefit plans and a competitive health insurance market.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing non-grandfathered individual and small group health benefit plans on or after the effective date of this regulation, and health benefit plans subject to the individual and small group laws of Colorado. This regulation does not apply to the cost sharing variants of individual silver metal level plans, as defined in 45 CFR § 156.420, to the Colorado Standardized Health Benefit Plan, as defined in § 10-16-1303(14) C.R.S. and implemented by Colorado Insurance Regulation 4-2-81, or to individual short-term health insurance policies, as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

C. “Metal tier” means, for the purposes of this regulation, one of the four different health benefit plan levels of coverage found at § 10-16-103.4(2), C.R.S.

D. “Service area” means, for the purposes of this regulation, the area designated by a carrier in which a health benefit plan is offered for sale.

Section 5 Meaningful Difference Standards

A. All individual or small group health benefit plans offered for sale in Colorado must be meaningfully different from any other individual or small group health benefit plans offered by the same carrier within the same service area and same metal tier.

B. An individual or small group health benefit plan is considered meaningfully different from another individual or small group health benefit plan in the same service area and same metal tier if there are one (1) or more material differences between the plan and other plan offerings among the following characteristics:

1. To be considered meaningfully different with regards to cost sharing, a health benefit plan within a carrier's service area shall differ in at least one (1) of the following:

   a. Having either an integrated or non-integrated medical and drug deductible;

   b. Having multiple in-network tiers rather than only one;

   c. Having at least a five-percent (5%) difference in the maximum-out-of-pocket limit; or

   d. Having at least a five-percent (5%) difference in the deductible.

2. To be considered meaningfully different with regards to provider networks, a health benefit plan within a carrier's service area shall have unique provider networks;

3. The covered benefits provided by a health benefit plan differ from the other health benefit plans within that service area and metal tier;

4. Plan type, such as PPO, HMO, and EPO;

5. Child-only versus non-child-only plan offerings; or

6. Health Savings Account-eligible or non-Health Savings Account-eligible.

C. If the plan offerings at a particular metal tier, within a county are limited, as determined by the Commissioner, plans submitted for approval in that particular metal level within that county may not be subject to the meaningful difference requirement set forth in Section 5.B of this regulation.

D. If two (2) or more plans within a carrier's service area do not differ based upon at least one (1) of the factors listed in Section 5.B. of this regulation, one (1) of those plan filings may not be approved after Division review.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This amended regulation shall be effective May 30, 2022.

Section 9 History

New regulation effective June 1, 2019.
Amended regulation effective May 30, 2022.

Regulation 4-2-64 CONCERNING MENTAL HEALTH PARITY IN HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109, 10-16-104(5.5)(b), 10-16-107(3)(a)(IV), 10-16-109, 10-16-113(10), 10-16-147(3), and 10-16-166(3), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements, processes, and forms to be utilized by carriers to ensure compliance with §§ 10-16-104(5.5) and 10-16-147, C.R.S., and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA as defined at § 10-16-102(43.5), C.R.S.).

This regulation adopts and reiterates the requirements of 45 C.F.R. 146.136(c)(4) and successor regulation 45 C.F.R 146.137(a)-(c) in accordance with § 10-16-104(5.5)(a)(V)(A), C.R.S. This regulation also adopts and reiterates the requirements of 45 C.F.R. 146.136(c)(2) and (c)(3) and successor regulations in accordance with § 10-16-104(5.5)(a)(V)(A), C.R.S.

Section 3 Applicability

This regulation applies to health benefit plans subject to the individual and group laws of Colorado, including non-grandfathered plans, short-term limited duration health insurance policies, and student health insurance coverage. This regulation does not apply to limited benefit plans, which are exempted from the definition of “health benefit plan” set forth in § 10-16-102(32)(b), C.R.S., and exclusions for coverage of specific mandated benefits as found at § 10-16-104, C.R.S.

The provisions of this regulation shall become effective consistent with the applicability requirements set forth in 45 C.F.R. § 146.136, 45 C.F.R. § 146.137, and 45 C.F.R. § 147.160. However, any requirements based only on Colorado law and annual Colorado reporting requirements shall become effective on the effective date of this regulation.

Section 4 Definitions

A. “Aggregate lifetime dollar limit” means, for the purposes of this regulation, a dollar limitation on the total amount of specified benefits that may be paid under a health benefit plan for any coverage unit.

B. "American Society of Addiction Medicine (ASAM) Criteria" means, for the purposes of this regulation, ASAM Criteria for Addictive, Substance-related, and Co-Occurring Conditions as referenced in § 10-16-104(5.5)(a)(I)(B), C.R.S.

C. "Annual dollar limit" means, for the purposes of this regulation, a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a health benefit plan for any coverage unit.

D. "Autism spectrum disorder" shall have the same meaning as defined at § 10-16-104(1.4)(a)(III), C.R.S.

E. "Behavioral health benefits" means, for the purposes of this regulation, the benefits supplied for items or services for behavioral health conditions.

F. "Behavioral, mental health, and substance use disorder" shall have the same meaning as defined at § 10-16-104(5.5)(d), C.R.S.

G. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

H. "Colorado Option Standardized Plan" or "Standardized Plan" shall have the same meaning as defined at § 10-16-1303(14), C.R.S.

I. "Diagnostic and Statistical Manual of Mental Disorders (DSM)" shall have the same meaning as the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders defined in 45 C.F.R. § 146.136(a)(2).

J. "Evidentiary standards" are any evidence, sources, or standards that a health benefit plan or carrier considered or relied upon in designing or applying a factor with respect to a non-quantitative treatment limitation, including specific benchmarks or thresholds. Evidentiary standards may be empirical, statistical, or clinical in nature, and include: sources acquired or originating from an objective third party, such as recognized medical literature, professional standards and protocols (which may include comparative effectiveness studies and clinical trials), published research studies, payment rates for items and services (such as publicly available databases of the "usual, customary and reasonable" rates paid for items and services), and clinical treatment guidelines; internal carrier data, such as claims or utilization data or criteria for assuring a sufficient mix and number of network providers; and benchmarks or thresholds, such as measures of excessive utilization, cost levels, time or distance standards, or network participation percentage thresholds.

K. "Factors" are all information, including processes and strategies (but not evidentiary standards), that a health benefit plan or carrier considered or relied upon to design a non-quantitative treatment limitation, or to determine whether or how the non-quantitative treatment limitation applies to benefits under the plan or coverage. Examples of factors include, but are not limited to: provider discretion in determining a diagnosis or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; claim types with a high percentage of fraud; quality measures; treatment outcomes; severity or chronicity of condition; variability in the cost of an episode of treatment; high cost growth; variability in cost and quality; elasticity of demand; and geographic location.

L. "FDA" means, for the purposes of this regulation, the Food and Drug Administration in the United States Department of Health and Human Services.

M. "Financial requirements" means, for the purposes of this regulation, the deductibles, copayments, coinsurance, or out-of-pocket maximums imposed under a health benefit plan. Financial requirements do not include aggregate lifetime or annual dollar limits.

N. "Health benefit plan" shall have the same meaning as defined at § 10-16-102(32), C.R.S.

O. "International Statistical Classification of Diseases and Related Health Problems" or "ICD)" shall have the same meaning as the World Health Organization's International Classification of Diseases defined in 45 C.F.R. § 146.136(a)(2).

P. "Material difference" means, for the purposes of this regulation, data-driven differences in access between mental health and substance use disorder benefits compared to medical and surgical benefits based on all relevant facts and circumstances.

Q. "Medical/surgical benefits" for health benefit plans shall have the same meaning as 45 C.F.R. § 146.136(a)(2).

R. "Mental health benefits" for health benefit plans shall have the same meaning as 45 C.F.R. § 146.136(a)(2), except for generally recognized independent standards of current medical practice shall also include The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood as referenced in § 10-16-104(5.5)(d)(I)(C), C.R.S.

S. "Medication-Assisted Treatment (MAT)" shall have the same meaning as found at § 23-21-803(4), C.R.S.

T. "MHPAEA" shall have the same meaning as found at § 10-16-102(43.5) C.R.S.

U. "Participating provider" shall have the same meaning as found at § 10-16-104(46), C.R.S.

V. "Prior authorization" shall have the same meaning as found at § 10-16-112.5(7)(d), C.R.S.

W. "Processes" are actions, steps, or procedures that a health benefit plan or carrier uses to apply a non-quantitative treatment limitation, including actions, steps, or procedures established by the health benefit plan or carrier as requirements in order for a participant or beneficiary to access benefits, including through actions by a participant's or beneficiary's authorized representative or a provider or facility. Examples of processes include, but are not limited to: procedures to submit information to authorize coverage for an item or service prior to receiving the benefit or while treatment is ongoing (including requirements for peer or expert clinical review of that information); provider referral requirements that are used to determine when and how a participant or beneficiary may access certain services; and the development and approval of a treatment plan used in a concurrent review process to determine whether a specific request should be granted or denied. Processes also include the specific procedures used by staff or other representatives of a health benefit plan or carrier (or the service provider of a health benefit plan or carrier) to administer the application of non-quantitative treatment limitations, such as how a panel of staff members applies the non-quantitative treatment limitation (including the qualifications of staff involved, number of staff members allocated, and time allocated), consultations with panels of experts in applying the non-quantitative treatment limitation, and the degree of reviewer discretion in adhering to criteria hierarchy when applying a non-quantitative treatment limitation.

X. "Provider" shall have the same meaning as found at § 10-16-104(56), C.R.S.

Y. "SERFF" means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filing.

Z. "Short-term limited duration health insurance policy" and "short-term policy" shall have the same meaning as found at § 10-16-102(60), C.R.S.

AA. "Step therapy" shall have the same meaning as found at § 10-16-145(1)(g), C.R.S.

AB. "Strategies" are practices, methods, or internal metrics that a health benefit plan or carrier considers, reviews, or uses to design a non-quantitative treatment limitation. Examples of strategies include, but are not limited to: the development of the clinical rationale used in approving or denying benefits; the method of determining whether and how to deviate from generally accepted standards of care in concurrent reviews; the selection of information deemed reasonably necessary to make medical necessity determinations; reliance on treatment guidelines or guidelines provided by third-party organizations in the design of a non-quantitative treatment limitation; and rationales used in selecting and adopting certain threshold amounts to apply a non-quantitative treatment limitation, professional standards and protocols to determine utilization management standards, and fee schedules used to determine provider reimbursement rates, used as part of a non-quantitative treatment limitation. Strategies also include the method of creating and determining the composition of the staff or other representatives of a health benefit plan or carrier (or the service provider of a health benefit plan or carrier) that deliberates, or otherwise makes decisions, on the design of non-quantitative treatment limitations, including the health benefit plan or carrier's methods for making decisions related to the qualifications of staff involved, number of staff members allocated, and time allocated; breadth of sources and evidence considered; consultations with panels of experts in designing the non-quantitative treatment limitation; and the composition of the panels used to design a non-quantitative treatment limitation.

AC. "Student health insurance coverage" and "student health policy" shall have the same meaning as found at § 10-16-102(65), C.R.S.

AD. "Substance use disorder benefits" means for health benefit plans shall have the same meaning as 45 C.F.R. § 146.136(a)(2), except for generally recognized independent standards of current medical practice shall also include The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood as referenced in § 10-16-104(5.5)(d)(I)(C), C.R.S.

AE. "Treatment limitations" include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and non-quantitative treatment limitations (such as standards related to network composition), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See Section 7 of this regulation for an illustrative, non-exhaustive list of non-quantitative treatment limitations.) A complete exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

Section 5 Required Coverage

A. Preventive Care and Access to Coverage

1. Pursuant to § 10-16-104(18)(b)(I), C.R.S., carriers must provide coverages for the total cost (without deductibles, copayments, or coinsurance) for the following:

   a. An unhealthy alcohol use screening for adults;

   b. A preventive screening for depression in adolescents and adults; and

   c. Perinatal maternal counseling interventions for persons at risk.

2. These benefits may be provided by a primary care provider, behavioral health care provider as defined at § 25-1.5-502(1.3), C.R.S., or mental health professional licensed or certified pursuant to Article 245 of Title 12.

B. Court-Ordered Treatment

1. Carriers shall provide coverage for court-ordered medically necessary services for behavioral, mental health, and substance use disorders, as specified in § 10-16-104.8, C.R.S., and for substance use disorders, as specified in § 10-16-104.7, C.R.S.

2. Nothing in this Section 5.B. prohibits a carrier from using appropriate disease management or utilization review protocols, as long as the protocols are no more stringent or restrictive than medical/surgical disease management or utilization review protocols.

C. Carriers shall provide coverage for medication-assisted treatment of substance use disorders as specified in § 10-16-148, C.R.S.

1. Carriers shall place at least one covered prescription medication approved by the FDA for the treatment of substance use disorder on the lowest tier of the drug formulary developed and maintained by the carrier.

2. Carriers shall not impose prior authorization requirements on any prescription medication approved by the FDA for the treatment of substance use disorders.

3. Carriers shall not impose any step therapy requirements as a prerequisite for coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

4. Carriers shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medications and services were court ordered.

D. A carrier that provides coverage under a health benefit plan for a drug used to treat a substance use disorder shall not require prior authorization, as defined in § 10-16-112.5(7)(d), for a drug based solely on the dosage amount.

E. Every health benefit plan subject to the requirements of § 10-16-104(5.5), C.R.S., shall:

1. Establish procedures to authorize treatment with a nonparticipating provider if a covered service is not available within established time and distance standards and within a reasonable period after a service is requested, and with the same coinsurance, deductible, or copayment requirements as would apply if the services were provided by a participating provider, and at no greater cost to the covered person than if the services were obtained at or from a participating provider;

2. If a covered person obtains a covered service from a nonparticipating provider because the covered service is not available within established time and distance standards, reimburse treatment or services for behavioral, mental health, or substance use disorders required to be covered pursuant to § 10-16-104(5.5), C.R.S., that are provided by a nonparticipating provider using the same methodology the carrier uses to reimburse covered medical services provided by nonparticipating providers and, upon request, provide evidence of the methodology to the covered person or provider.

F. For the treatment of substance use disorders, carriers shall use the American Society of Addiction Medicine (ASAM) criteria for the placement, medical necessity, and utilization management determinations, as specified in § 10-16-104(5.5)(a)(I)(B), C.R.S.

G. Carriers shall not utilize the body mass index (BMI), ideal body weight (IBW), or any other standard requiring an achieved weight when determining medical necessity or the appropriate level of care for an individual diagnosed with an eating disorder, including but not limited to bulimia nervosa, atypical anorexia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and other specified feeding and eating disorders as defined in the DSM.

The following factors, at a minimum, must be considered when determining medical necessity or the appropriate level of care for an individual diagnosed with an eating disorder:

1. The individual's eating behaviors;

2. The individual's need for supervised meals and support interventions;

3. Laboratory results, including but not limited to, the individual's heart rate, renal or cardiovascular activity, and blood pressure;

4. The recovery environment; and

5. Co-occurring disorders the individual may have.

H. Carriers shall provide meaningful benefits for any mental health or substance use condition in every benefit classification in which medical/surgical benefits are provided. A carrier does not provide meaningful benefits unless it provides benefits for a core treatment for that condition or disorder in each classification in which the plan provides benefits for a core treatment for one or more medical conditions or surgical procedures. A core treatment for a condition or disorder is a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice.

Section 6 Financial Requirements and Quantitative Treatment Limitations

A. All health benefit plans subject to the individual and group laws of Colorado must comply with the financial requirements and quantitative treatment limitations specified in 45 C.F.R. 146.136(c)(2) and (c)(3).

B. A health benefit plan that provides both medical/surgical benefits and mental health or substance use disorder benefits shall not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. A carrier shall not impose any financial requirement or treatment limitation that is applicable only with respect to mental health or substance use disorder benefits and not to any medical/surgical benefits in the same benefit classification.

C. A carrier shall not sell a health benefit plan or short term policy that fails to comply with Section 6 of this regulation, as specified in 45 C.F.R. § 146.136(c).

D. Calculation of Substantially All and Predominant Level Benefits

1. Carriers shall not use any financial requirement or quantitative treatment limitation unless the carrier can provide verification that the following conditions have been met:

a. Substantially All Test

(1) A type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two thirds of all medical/surgical benefits in that classification.

(2) For the purposes of this regulation, benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation.

(3) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

b. Predominant Level Test

(1) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under Section 6.D.1.a, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

(2) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan (or health insurance issuer) may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(3) Carriers must follow the examples set forth 45 C.F.R. § 146.136 regarding the predominant level test.

c. Portion Based on Plan Payments

The determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative.

d. Classification for Certain Thresholds

For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied.

For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. The rules of this paragraph apply for any other thresholds at which the rate of the plan payment changes.

2. Substantially All and Predominant Level Test Requirements

a. The expected claim payments shall be based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year. If a carrier has sufficient plan-level claims data for a reasonable projection of expected claim payments, such claims data shall be used for the analysis.

Other reasonable claims data may be used to project expected claim payments only if there is insufficient plan-level claims data. The assumptions used in choosing a data set and making projections shall be submitted to the Division if plan-level claims data are not used.

A reasonable and credible method shall be used to project the expected claim payments for medical/surgical benefits when performing the financial requirement or quantitative treatment limitation analysis. The method shall use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice.

b. Carriers shall not consider estimated claims payments associated with behavioral, mental health, or substance use disorder benefits in the calculation.

c. Carriers shall consider all estimated claims payments applying to the deductible and out-of-pocket maximum when calculating the deductible and out-of-pocket maximum applicability in determining if the deductible and out-of-pocket maximum apply to substantially all of the claims.

E. Allowed Benefit Classifications

1. If a plan provides any benefits for a mental health condition or substance use disorder in any classification of benefits described in Section 6.E.2., it must provide meaningful benefits for that mental health condition or substance use disorder in every classification in which medical/surgical benefits are provided. For purposes of this paragraph, whether the benefits provided are meaningful benefits is determined in comparison to the benefits provided for mental conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the plan (or coverage) provides benefits for one or more medical conditions or surgical procedures. A plan (or coverage does not provide meaningful benefits under this paragraph unless it provides benefits for a core treatment for that condition or disorder in each classification in which the plan (or coverage) provides benefits for a core treatment for one or more medical conditions or surgical procedures. For purposes of this paragraph, a core treatment for a condition or disorder is a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice. If there is no core treatment for a covered mental health condition or substance use disorder with respect to a classification, the plan (or coverage) is not required to provide benefits for a core treatment for such condition or disorder in that classification (but must provide benefits for such condition or disorder in every classification in which medical/surgical benefits are provided). In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical surgical benefits and to mental health or substance use disorder benefits. To the extent that a plan (or health insurance coverage) provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, the rules of this paragraph apply separately with respect to that classification for all financial requirements or treatment limitations. The following classification of benefits are the only classifications used in applying the rules of this paragraph, in addition to the permissible sub-classifications described in Section 6.F.

2. The substantially all/predominant level test must be applied separately to the following six (6) classifications of benefits:

   a. Inpatient In-Network;

   b. Inpatient Out-of-Network;

   c. Outpatient In-Network;

   d. Outpatient Out-of-Network;

   e. Emergency care; and

   f. Prescription drugs.

F. Special Rules

Unless specifically permitted under this paragraph, sub-classifications are not permitted when applying the rules of paragraph D of this section.

1. If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in Section 7 (relating to requirements for non-quantitative treatment limitations) and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the plan satisfies the parity requirements of this paragraph with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

2. Multiple In-Network Tiers. If a carrier provides benefits through multiple tiers of in-network providers (such as an in- network tier of preferred providers with more generous cost-sharing to members than a separate in-network tier of participating providers), the carrier may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules in Section 7 (such as quality performance and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or mental health or substance use disorder benefits. After the sub-classifications are established, the carrier may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph D of this section.

3. Sub-classifications permitted for office visits, separate from other outpatient services. For purposes of applying the financial requirement and treatment limitation rules of Section 6, a health benefit plan or carrier may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this paragraph. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph D of this section. Sub-classifications other than these special rules, such as separate sub-classifications for generalists and specialists, are not permitted. The two sub-classifications permitted under this paragraph are:

    a. Office visits (such as physician visits), and

    b. All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

G. No separate cumulative financial requirements or cumulative quantitative treatment limitations

A carrier may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.

H. Parity requirements with respect to aggregate lifetime and annual dollar limits.

1. Plan with no limit or limits on less than one-third of all medical/surgical benefits.

   If a plan (or health insurance coverage) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

2. Plan with a limit on at least two-thirds of all medical/surgical benefits.

   If a plan (or health insurance coverage) includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either-

   a. Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health benefits or substance use disorder benefits; or

   b. Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively m on medical/surgical benefits.

3. Determining one-third and two-thirds of all medical/surgical benefits.

   For purposes of this paragraph H, the determination of whether the portion of medical/surgical benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

4. Plans not described in paragraph H.1. or H.2.of this section

   a. In general, a group health plan that is not described in paragraph H.1. or H.2.of this section with respect to aggregate lifetime or annual dollar limits on medical/surgical benefits, must either:

      (1) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance us disorder benefits; or

(2) Impose an aggregate of annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph. In addition, for purposes for determining weighted averages, any benefits that re not within a category that is subject to a separately-designed dollar limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

b. For purposes of this paragraph H.4., the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph H.3. for determining one-third or two-thirds of all medical surgical benefits.

5. Nothing in this section shall prohibit a carrier from:

a. Providing some benefits that are subject to the deductible and other benefits that are not subject to the deductible within the same classification; or

b. Applying, separately, a deductible or out-of-pocket maximum that differs between the in-network and out-of-network benefit levels, as long as the same deductible or out-of-pocket that applies to behavioral, mental health, or substance use disorder benefits applies to medical/surgical benefits.

Section 7 Non-Quantitative Treatment Limitations

A. All health benefit plans subject to the individual and group laws of Colorado must comply with the non-quantitative treatment limitation requirements of 45 C.F.R. 146.136(c)(4) and successor regulation 45 C.F.R 146.137(a)-(c).

B. Carriers may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification that is more restrictive, as written or in operation, than the predominant nonquantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification. For purposes of this Section 7.B., a nonquantitative treatment limitation is more restrictive than the predominant nonquantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification if the health benefit plan or carrier fails to meet the requirements of Section 7.C. or D. In such a case, the health benefit plan or carrier will be considered to violate MHPAEA, and the nonquantitative treatment limitation may not be imposed by the health benefit plan or carrier with respect to mental health or substance use disorder benefits in the classification.

C. Requirements related to design and application of a nonquantitative treatment limitation.

1. A health benefit plan or carrier may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the health benefit plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the limitation with respect to medical/surgical benefits in the classification.

2. Prohibition on discriminatory factors and evidentiary standards.

   For the purposes of determining comparability and stringency under Section 7.C.1, a health benefit plan or carrier may not rely upon discriminatory factors or evidentiary standards to design a non-quantitative treatment limitation to be imposed on mental health or substance use disorder benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits.

   a. Information, evidence, sources, or standards are considered to be biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits if, based on all the relevant facts and circumstances, the information, evidence, sources, or standards systematically disfavor access or are specifically designed to disfavor access to mental health or substance use disorder benefits as compared to medical/surgical benefits. For the purposes of this paragraph C.2.a, relevant facts and circumstances may include, but are not limited to, the reliability of the source of the information, evidence, sources, or standards, including any underlying data; the independence of the information, evidence, sources, and standards relied upon; the analyses and methodologies employed to select the information and the consistency of their application; and any known safeguards deployed to prevent reliance on skewed data or metrics. Information, evidence, sources, or standards are not considered biased or not objective for this purpose if the health benefit plan or carrier has taken the steps necessary to correct, cure, or supplement any information, evidence, sources, or standards that would have been biased or not objective in the absence of such steps.

   b. For purposes of Section 7.C.2, historical plan data or other historical information from a time when the plan or coverage was not subject to MHPAEA or was not in compliance with MHPAEA are considered to be biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits, if the historical plan data or other historical information systematically disfavor access or are specifically designed to disfavor access to mental health or substance use disorder benefits as compared to medical/surgical benefits, and the health benefit plan or carrier has not taken the steps necessary to correct, cure, or supplement the data or information.

c. For purposes of Section 7.C.2, generally recognized independent professional medical or clinical standards and carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate mental health and substance use disorder benefits are not information, evidence, sources, or standards that are biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits. However, health benefit plans and carriers must comply with Section 7, as applicable, with respect to such standards or measures that are used as the basis for a factor or evidentiary standard used to design or apply a non-quantitative treatment limitation.

D. Required use of outcome data.

1. To ensure that a nonquantitative treatment limitation applicable to mental health or substance use disorder benefits in a classification, in operation, is no more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical/surgical benefits in the classification, a health benefit plan or carrier shall collect and evaluate relevant data in a manner reasonably designed to assess the impact of the non-quantitative treatment limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits and carefully consider the impact as part of the health benefit plan's or carrier's evaluation. As part of its evaluation, the health benefit plan or carrier shall not disregard relevant outcomes data that it knows or reasonably should know suggest that a non-quantitative treatment limitation is associated with material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits.

a. Relevant data generally. For the purposes of Section 7.D.1, relevant data could include, as appropriate, but are not limited to, the number and percentage of claims denials and any other data relevant to the nonquantitative treatment limitation required by Colorado law or private accreditation standards.

b. Relevant data for nonquantitative treatment limitations related to network composition. In addition to the relevant data set forth in Section 7.D.1.a, relevant data for nonquantitative treatment limitations related to network composition could include, as appropriate, but are not limited to, in-network and out-of-network utilization rates (including data related to provider claims submissions), network adequacy matric (including time and distance data, and data on providers accepting new patients), and provider reimbursement rates (for comparable services and as benchmarked to a reference standards).

c. Unavailability of data

(1) If a health benefit plan or carrier newly imposes a non-quantitative treatment limitation for which relevant data is initially temporarily unavailable and the health benefit plan or carrier therefore cannot comply with Section 7.D.1, the health benefit plan or carrier must include in its comparative analysis, as required by Section 10.C.12., a detailed explanation of the lack of relevant data, the basis for the health benefit plan's or carrier's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed. Such health benefit plan or carrier also must comply with Section 7.D.1 as soon as practicable once relevant data becomes available.

(2) If a health benefit plan or carrier imposes a non-quantitative treatment limitation for which no data exist that can reasonably assess any relevant impact of the non-quantitative treatment limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits, the health benefit plan or carrier must include in its comparative analysis, as required by this Section 10.C.12., a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the non-quantitative treatment limitation's impact, why the nature of the non- quantitative treatment limitation prevents the health benefit plan or carrier from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the non-quantitative treatment limitation complies with Section 7. If a health benefit plan or carrier becomes aware of data that can reasonably assess any relevant impact of the non-quantitative treatment limitation, the health benefit plan or carrier must comply with Section 7.D.1.as soon as practicable.

(3) Sections 7.D.1.c.(1)-(2) of this section shall only apply in very limited circumstances and, where applicable, shall be construed narrowly.

2. Material differences. To the extent the relevant data evaluated under Section 7.D.1. suggest that the non-quantitative treatment limitation contributes to material differences in access benefits in a classification, such differences will be considered a strong indicator that the health benefit plan or carrier violates this Section 7.

a. Where the evaluated relevant data. suggest that the non-quantitative treatment limitation contributes to material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits in a classification, the health benefit plan or carrier must take reasonable action, as necessary, to address the material differences to ensure compliance, in operation, with Section 7. and must document the actions that have been or are being taken by the health benefit plan or carrier to address material differences in access to mental health or substance use disorder benefits, as compared to medical/surgical benefits, as required by Section 10.C.12.

b. For purposes of this Section 7.D.2, relevant data are considered to suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits if, based on all relevant facts and circumstances, and taking into account the considerations outlined in this Section 7.D.2.b, the difference in the data suggests that the nonquantitative treatment limitation is likely to have a negative impact on access to mental health or substance use disorder benefits compared to medical/surgical benefits.

(1) Relevant facts and circumstances, for purposes of this Section 7.D.2.b may include, but are not limited to, the terms of the nonquantitative treatment limitation at issue, the quality or limitations of the data, casual explanations and analyses, evidence as to the recurring or non-recurring nature of the results, and the magnitude of any disparities.

(2) Differences in access to mental health or substance use disorder benefits attributable to generally independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent fraud or abuse that minimize the negative impact on access to appropriate mental health and substance use disorder benefits, which are used as the basis for a factor or evidentiary standard used to design or apply a nonquantitative treatment limitation, are not considered to be material for purposes of this Section 7.D.2. To the extent a health benefit plan or carrier attributes any differences in access to the application of such standards or measures, the health benefit plan or carrier must explain the bases for that conclusion in the documentation prepared under Section 10.C.12.

3. Nonquantitative treatment limitations related to network composition. For purposes of applying Section 7.D with respect to nonquantitative treatment limitations related to network composition, a health benefit plan or carrier must collect and evaluate relevant data in a manner reasonably designed to assess the aggregate impact of all such nonquantitative treatment limitations on access to mental health and substance use disorder benefits and medical/surgical benefits. Examples of possible actions that a health benefit plan or carrier could take to comply with the requirement under this Section 7.D.2.a to take reasonable action, as necessary, to address any material differences in access with respect to non-quantitative treatment limitations related to network composition to ensure compliance with Section 7, include, but are not limited to:

   a. Strengthening efforts to recruit and encourage a broad range of available mental health and substance use disorder providers and facilities to join the carrier's network of providers, including taking actions to increase compensation or other inducements, streamline credentialing processes, or contact providers reimbursed for items and services provided on an out-of-network basis to offer participation in the network;

   b. Expanding the availability of telehealth arrangements to mitigate any overall mental health and substance use disorder provider shortages in a geographic area

   c. Providing additional outreach and assistance to participants and beneficiaries enrolled in the health benefit plan or coverage to assist them in finding available in-network mental health and substance use disorder providers and facilities; and

   d. Ensuring that provider directories are accurate and reliable.

E. Illustrative, non-exhaustive list of non-quantitative treatment limitations. Non-quantitative treatment limitations include, but are not limited to:

1. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether the treatment is experimental or investigative.

2. Utilization management protocols, including but not limited to prior authorization, concurrent review, and retrospective review.

3. Step therapy, fail-first, or the refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective.

4. Exclusions based on failure to complete a course of treatment.

5. Restrictions based on:

   a. Geographic location;

   b. Facility type;

   c. Provider specialty; and

   d. Other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

6. Formulary design for prescription drugs.

7. Network tier design (when the plan has multiple network tiers).

8. Standards related to network composition, including but not limited to:

   a. Standards for provider and facility admission to participate in a network or for continued network participation, including recruitment, retention, and contract negotiation processes;

   b. Methods for determining reimbursement rates;

   c. Credentialing standards, and

   d. Procedures for ensuring the network includes an adequate number of providers and facilities to provide services under the plan or coverage;

9. Methods for determining out-of-network rates, such as allowed amounts; usual, customary, and reasonable charges; or application of other external benchmarks for out-of-network rates.

F. Non-Quantitative Treatment Limitation Examples

1. Pursuant to § 10-16-104(5.5)(a)(V)(A), C.R.S, carriers must comply with the non-quantitative treatment limitation illustrative examples set forth in 45 C.F.R. § 146.136.

2. Carriers shall not use the following medical management processes or strategies when applying limitations to behavioral, mental health, and substance use disorder benefits:

   a. The carrier routinely approves a number of days without a treatment plan for medical/surgical inpatient, in-network, services, but approves, on a routine basis, a lesser number of days without a treatment plan for behavioral, mental health, and substance use disorders, inpatient-in-network.

   b. The carrier applies concurrent review to inpatient, in-network stays with various lengths of stay due to the medical condition, but reviews all behavioral, mental health, and substance use disorder inpatient, in-network stays using a more restrictive review criteria, reviewing the stay more frequently in all cases than commonly used for medical/surgical benefits.

   c. Location of Services

(1) The carrier allows for out-of-state treatment of medical/surgical services, but does not permit out-of-state treatment for behavioral, mental health, and substance use disorder services; or

(2) Permits access to an out-of-network hospital for medical/surgical services, but does not permit access to a non-network hospital for behavioral, mental health, and substance use disorders, when the plan covers non-network services.

d. The carrier does not apply a payment reduction penalty to outpatient medical/surgical services that do not have prior authorization, but applies a penalty to outpatient behavioral, mental health, and substance use disorder benefits when no prior authorization has been obtained.

e. Employee Assistance Programs (Group Plans Only)

In the event that an employer maintains both a major medical plan and an Employees Assistance Program, and the Employee Assistance Program provides a limited number of mental health or substance use disorder counseling sessions that are not significant benefits in the nature of medical care, the carrier requires that the member utilize the available Employee Assistance Program benefits prior to utilizing the behavioral, mental health, and substance use disorder benefits under the group plan. The carrier does not require the member to utilize the Employee Assistance Program for any medical/surgical benefits prior to utilizing the group plan.

f. Within the same classification, the carrier applies more restrictive prior authorization requirements in operation for mental health, behavioral health, and substance use disorder benefits than medical/surgical benefits.

g. Within the same classification, the carrier applies more restrictive peer-to-peer review medical necessity standards in and/or deviates from independent professional medical and clinical standards in operation for mental health, behavioral health, and substance use disorder benefits than for medical/surgical benefits.

h. Within the same classification, the carrier applies incomparable and more stringent methods for determining reimbursement rates in operation for mental health, behavioral health, and substance use disorder benefits than for medical/surgical benefits.

i. Within the same classification, the carrier uses more restrictive network admission standards for mental health, behavioral health, and substance use disorder providers than for medical/surgical benefits providers.

j. Within the same classification, in operation, the carrier's exclusions for experimental or investigative treatment are more restrictive when applied to behavior analysis (ABA) therapy for autism spectrum disorder than for a comparable medical/surgical condition.

3. Within the same prescription drug classification, carriers shall not use the following pharmacy benefit design when applying limitations to behavioral, mental health, and substance use disorder benefits:

a. Carrier formulary design for coverage of prescription drugs for medical/surgical conditions is based on FDA approval, clinical studies, peer-reviewed medical literature, recommendations of experts with necessary training and experience and other medical decision criteria which are routinely provided, whereas the exclusion of behavioral, mental health, and substance use disorder drugs is only based on the side effects reported as a part of clinical studies.

b. A carrier regularly provides coverage for medical/surgical prescription drugs on all four (4) tiers of a four (4) tier formulary design, but places all drugs for the treatment of behavioral, mental health, and substance use disorders on the two (2) highest tiers, without regard to it being generic, preferred brand name or non-preferred brand name.

4. Carriers shall not use the following network designs when applying limitations to behavioral, mental health, and substance use disorder benefits for the inpatient, in-network and outpatient, in-network classifications:

a. The carrier regularly allows licensed non-M.D. providers into the network who treat medical/surgical conditions while not permitting licensed non-M.D. providers into the network who primarily treat behavioral, mental health, or substance use disorders.

b. The carriers regularly admits into the network and reimburses for pre-licensure, provisional, and/or delegated medical/surgical providers, while not admitting into the network and reimbursing for pre-licensure, provisional, and/or delegated mental health, behavioral health, and substance use disorder providers.

c. The carrier regularly negotiates rates with a medical/surgical provider while not regularly negotiating rates with behavioral, mental health, and substance use disorder providers.

5. The items in this section are not an exhaustive list of non-quantitative treatment limitation violations.

Section 8 Denial of Benefits for Behavioral, Mental Health or Substance Use Disorders

A. Carriers shall provide consumers with written notice of the denial when denying benefits for the treatment of behavioral, mental health, or substance use disorders that explicitly provides the reason for denial.

B. Carriers shall provide the following language on any adverse determination of benefits for behavioral, mental health, or substance use disorders as required by § 10-16-113, C.R.S.:

"This plan is subject to the protections provided under the Mental Health Parity and Addiction Equity Act (MHPAEA). Coverage provided for mental health and substance use disorders must be comparable to services covered under the medical benefits available on this plan. If you believe that your rights under MHPAEA have been violated, you may contact the Office of the Ombudsperson for Behavioral Health Access to Care at 303-866-2789 or at ombuds@bhoco.org, or the Division, at Colorado Division of Insurance, Consumer Services, 1560 Broadway, Ste. 850, Denver, CO 80202, dora_insurance@state.co.us or 303-894-7490 or 800-930-3745 (in-state, toll-free).

You may also request a copy of the medical necessity criteria for any behavioral, mental health, or substance use disorder benefits, and it will be provided to you at no additional cost."

Section 9 Annual Filings to the Commissioner

A. As part of their annual health benefit plan filings, carriers shall provide the financial requirements and quantitative treatment limitation annual compliance documents, as detailed in this section.

B. Timing and Format of Filings

1. Carriers offering plans in the non-grandfathered individual and small group markets shall submit fully completed "Financial Requirements Attestation" and "Financial Requirements and Quantitative Treatment Limitation Classification" documents by the date designated by the Division for annual filings. Carriers are required to use the template provided in SERFF to complete the "Financial Requirements Attestation" and "Financial Requirements and Quantitative Treatment Limitation Classification" submissions.

2. Carriers offering plans in the non-grandfathered large group, student health policy, and short-term limited duration policy lines of business shall submit fully completed the "Financial Requirements Attestation" and "Financial Requirements and Quantitative Treatment Limitation Classifications" documents no later than March 1 of each year and prior to the submission of any rates, as applicable, for an upcoming plan year.

3. Carriers shall submit the completed "Financial Requirements Attestation" and "Quantitative Treatment Limitation Classifications" in SERFF as an "Annual MHPAEA Compliance Statement" filing. This filing shall be submitted separately from any rate, form, annual certification, binder or network adequacy filing.

4. Carriers shall use "On Approval" for the "Implementation Date" in SERFF.

5. Carriers shall use "File and Use" for the "Requested Filing Mode" in SERFF.

6. Carriers shall provide a filing description, including the plan year the filing will support.

C. Attestations

Carriers shall attest that all plans meet the requirements of § 10-16-104(5.5), C.R.S., and Colorado Insurance Regulation 4-2-64, in that all benefits associated with behavioral, mental health and substance use disorder meet all of the requirements of Colorado and federal law. Carriers must also attest to the following:

1. The plan meets the requirements of Section 6 of this regulation concerning financial requirements and quantitative treatment limitations.

2. The plan meets the requirements of Section 7 of this regulation concerning non-quantitative treatment limitations;

3. The coverage for autism spectrum disorders may not be subject to copayments, coinsurance, or deductibles that are less favorable than those applied to physical illness for the following services:

a. Evaluation and assessment services;

b. Habilitative benefits, including occupational therapy, physical therapy and speech therapy;

c. Rehabilitative benefits, including occupational therapy, physical therapy and speech therapy;

d. Pharmacy care and medication, if covered by the health benefit plan;

e. Psychiatric care;

f. Psychological care, including family counseling; and

g. Therapeutic care.

4. The expected claim payments utilize a reasonable and credible method to determine the estimated claim payments associated with the medical/surgical benefits that are subject to a financial requirement or quantitative treatment limitation. The method utilized must conform to the Actuarial Standards of Practice.

5. The attestation shall be signed by an actuary and the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, chief executive officer, chief financial officer, chief operating officer, general counsel or other person, with documentation showing that the person has been appointed a company officer by the board of directors.

D. Quantitative Treatment Limitation Classifications:

1. Carriers shall provide Quantitative Treatment Limitation Classifications for the following plans:

a. For individual and small group plans, carriers shall provide the required calculations for plans identified by the Division, which are chosen upon submission of reasonable modifications filings. The Division may increase the number of plans reviewed upon binder submissions. Carriers shall be notified of such via SERFF.

b. For large group, student health policies and short-term limited duration policies, carriers shall provide the required calculations for the top ten (10) plan designs or top twenty percent (20%) of plan designs by premium volume, whichever is greater provided.

2. Carriers shall provide the classification of all benefits, except emergency room and prescription drugs, provided by the plan as: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; or outpatient, out-of-network. If the carrier sub-classifies the outpatient benefits, the carrier shall specify which of the outpatient benefits is considered an “Office Visit” or is included in the “All Other Outpatient Items and Services” category. Carriers shall not subclassify outpatient benefits using any other classes other than “Office Visits” and “All Other Outpatient Items and Services.”

3. Carriers shall provide the copay or coinsurance amount that applies to each of the benefits. Carriers shall also identify whether the deductible, if any, applies to the benefit.

4. Carriers shall provide the expected claims payments for all medical/surgical benefits provided by the plan.

5. Carriers shall not include expected claim payments for any behavioral, mental health, or substance use disorder benefits in the Quantitative Treatment Limitation Classification, including applied behavioral analysis therapy for autism spectrum disorders.

6. If the carrier utilizes multiple in-network tiers, the carrier shall supply two (2) versions of the "Quantitative Treatment Limitation Classifications" worksheet, identifying the template to which the tier applies.

E. The signatures required by this Section 9 must be an original or valid electronic signature of the person signing. Signature stamps, photocopies or a signature on behalf of the authorized signer are not acceptable. Electronic signatures shall be in compliance with § 24-71.3-101 et seq., C.R.S., and applicable regulations.

Section 10 Annual Reporting to the Commissioner

A. Carriers shall submit each of the treatment limitation templates as listed in this Section 10 to the Commissioner annually.

B. Timing and Format of Reporting

1. Carriers offering plans in the non-grandfathered individual, small group, and large group markets, student health policies, and short-term limited duration policy lines of business will submit the following, fully-completed reports no later than March 1 of each year. Data will be collected and reported to the Division that pertains to the January 1 through December 31 reporting period annually in the following templates:

   a. NQTL Identification and Classification (includes Medical Management)

   b. NQTL Verifications

   c. Prior Authorization and Concurrent Review

   d. Out-of-Network and Gap Exception Utilization Data

   e. Provider Network Engagement and Availability

   f. Office Visit In-Network Allowed Rates Analysis

   g. Provider Credentialing

   h. Confidential Network Development Medicare

   i. ASAM Criteria Utilization

   j. Eating Disorder BMI/IBW

   k. Pharmacy Medical Management

   l. Colorado NQTL Comparative Analysis Six-Step Reporting

2. Carriers shall submit the completed reports using the templates provided in SERFF as an "Annual MHPAEA Compliance Statement" filing. This filing shall be submitted separately from any rate, form, annual certification, binder or network adequacy filing. Carriers are required to provide a comprehensive inventory of covered services within each classification or sub-classification of benefits for each health benefit plan offered by the carrier during the reporting period.

3. Carriers shall use "On Approval" for the "Implementation Date" in SERFF.

4. Carriers shall use “File and Use” for the “Requested Filing Mode” in SERFF.

5. Carriers shall provide a filing description, including the plan or benefit year of the data being reported.

C. Non-Quantitative Treatment Limitation Reporting Templates

1. NQTL Identification and Classification (includes Medical Management)

a. Carriers shall complete and provide the template to identify all non-quantitative treatment limitations as required by C.R.S. § 10-16-147(2)(c).

b. Carriers must complete one template for each applicable market level for all plans within that market level that use the same processes, standards, and benefit classification structure for application of non-quantitative treatment limitations. The carrier must list each covered service, classifying it as medical/surgical, mental health, or substance use disorder, and specify the applicable NQTLs for each benefit classification or subclassification.

2. NQTL Verifications

a. Carriers shall complete one NQTL Verification template for each market offered by the carrier, including a separate NQTL verification template for Colorado Option Standardized Plans offered in the individual and small group markets.

b. Carriers shall provide the following data by medical/surgical, behavioral health, mental health or substance use disorder category and by classification.

(1) Processed claim counts for covered benefits and

(2) Non-duplicate, unique claim counts. Carriers shall specify the reasons for claim actions, categorized by Claim Adjustment Group Codes and Claim Adjustment Reasons Codes.

3. Prior Authorization and Concurrent Review

a. Carriers shall complete a Prior Authorization and Concurrent Review Data template for each applicable market level and including data for all plans within that market level that use the same processes, standards, and benefit classification structure.

b. Carriers shall provide the number of all in-network and out-of-network prior authorization requests and concurrent reviews requested, irrespective of service delivery or claims submission, during the reporting period.

c. Carries shall categorize the review requests as medical/surgical, mental health, or substance use disorder based on the requested review of the primary diagnosis.

d. Carrier shall provide the outcomes of prior authorization review requests and concurrent review requests.

4. Out-of-Network and Gap Exception Utilization Data

a. Carriers shall complete one Out-of-Network and Gap Exception Utilization Data template for each network offered by the Carrier, including the Colorado Option Standardized Plans networks.

b. Carriers shall provide claims data for in-network, out-of-network, and network gap exception claims submitted.

5. Provider Network Engagement and Availability

a. Carriers shall complete one Provider Network Engagement and Availability template for each network offered by the Carrier, including the Colorado Option Standardized Plans networks.

b. Carriers shall report data on the number and types of providers listed as participating in the network at any time during the reporting period. Carriers shall report claim submission data during the reporting period for in-network providers.

6. Office Visit In-Network Allowed Rates Analysis

a. Carriers shall complete one Office Visit In-Network template for each network offered by the Carrier, including the Colorado Option Standardized Plans networks.

b. Carriers shall report weighted average allowed amounts for in-network Mental Health/Substance Use Disorder providers and Medical/Surgical providers using claims data from January 1 to December 31 of the calendar year preceding the filing submission date by CPT code, including:

(1) 99213

(2) 99214

(3) 90834

(4) 90837

c. Carriers shall also provide their Standard Provider Fee Schedule(s) for the specific CPT codes applicable during the same review period.

7. Provider Credentialing

a. Carriers shall complete one Provider Credentialing template for each applicable market level and include all plans within that market level that use the same processes and standards, for application of the NQTLs of Provider Credentialing

b. Carriers shall report the total number of initial provider credentialing and recredentialing applications received during the reporting period.

c. For all credentialing and recredentialing applications, carriers shall report the total number of pending applications, closed applications, outcome types, and processing times.

8. Confidential Network Development Medicare

a. Carriers shall complete one Confidential Network Development Medicare template for each network offered by the Carrier, including the Colorado Option Standardized Plans networks.

b. Carriers shall provide allowable rates for all medical/surgical, mental health, and substance use disorder benefits by provider type and service location by the following:

(1) Weighted average

(2) 25th, 50th, 75th, and 95th percentiles

(3) 50th percentile as percentage of Medicare allowable amount

c. Carriers shall report the weighted average allowed reimbursement rates based on in-network claims by procedure code, and the 25th, 50th, 75th and 95th percentiles of the allowed amounts for procedure codes.

d. Carriers shall utilize the Medicare Physician Fee Schedule (MPFS) for the reporting period year as a basis for professional fee Medicare allowable amounts.

e. Carriers shall provide an explanation of the method utilized to determine Medicare allowable amounts for facility services.

9. ASAM Criteria Utilization

a. Carriers shall complete an ASAM Criteria Utilization template for each applicable market level for all plans within that market level that use the same processes and standards related to ASAM medical necessity criteria.

b. Carriers shall provide information regarding compliance with § 10-16-104(5.5)(a)(I)(B), C.R.S. It shall include the following:

(1) Utilization of the treatment identified in § 10-16-104(5.5)(a)(I)(B), C.R.S., in policy and operation, in accordance with generally accepted standards of care;

(2) Modifications to the treatment identified in § 10-16- 104(5.5)(a)(I)(B), C.R.S., and rationale for such;

(3) Utilization of criteria in addition to the treatment identified in § 10- 16-104(5.5)(a)(I)(B), C.R.S., and rationale for such;

(4) Application of the treatment identified in § 10-16- 104(5.5)(a)(I)(B), C.R.S., at various levels of care and review;

(5) Reviewing training and preparedness to assess the treatment identified in § 10-16-104(5.5)(a)(I)(B), C.R.S., in medical determinations; and

(6) Information regarding claim handling of substance use disorder benefits.

10. Eating Disorder BMI/IBW

a. Carriers shall complete an Eating Disorder BMI/IBW template at each applicable market level for all plans within that market level that use the same processes and standards related to eating disorder medical necessity criteria.

b. Carriers shall attest to and validate compliance with §§ 10-16-166(1) and (2), C.R.S., including the absence of body mass index (BMI) or ideal body weight (IBW) criteria utilization or any other standard requiring an achieved weight when determining medical necessity or the appropriate level of care for an individual diagnosed with an eating disorder.

c. Carriers shall include the minimum factors set forth in § 10-16-166(2), C.R.S. used when determining medical necessity of the appropriate level of care for an individual diagnosed with an eating disorder.

11. Pharmacy Medical Management

a. Carriers shall complete a Pharmacy Medical Management template for each applicable market level and include data for all plans within that market level that use the same processes and standards for pharmacy medical management.

b. Carriers shall provide the number of all in-network and out-of-network requests for pharmaceuticals regardless of whether the medication was dispensed or claim was submitted, during the reporting period.

c. Carriers shall categorize the review requests as medical/surgical, mental health, or substance use disorder based on the medication's indication and use.

d. Carriers shall further define and report on the reasons for pharmacy request denials including prior authorization denials, and formulary exception denials.

12. Colorado NQTL Comparative Analysis Six-Step Reporting

a. Carriers shall provide the Colorado NQTL Comparative Analysis Six-Step Reporting template to demonstrate performance and documentation of the Comparative Analysis required by 42 U.S.C. § 300gg-26(a)(8)(A), 45 C.F.R. 146.137(c), and § 10-16-147(2)(d), C.R.S. Carriers shall provide one template for each NQTL specific to each applicable benefit classification and may include all plans within the market that utilize the same processes, standards, and benefit classification structure. If the carriers' plans in the same market utilize different processes, standards, or benefit classification structures, then separate templates must be submitted. The analysis in the template must address all non-quantitative treatment limitations within each benefit classification or subclassification identified by the carrier in the NQTL Identification and Classification (includes Medical Management) Template, and must include, at minimum, the following non-quantitative treatment limitations as written and in operation:

(1) Medical necessity criteria

(2) Prior authorization

(3) Concurrent review

(4) Provider reimbursement

(5) Network development and adequacy

(6) Network admission and credentialing

(7) Retrospective review

(8) Fail first and step therapy

(9) Facility/Provider Type Restrictions

(10) Geographic Restrictions

b. Carriers shall explain the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to benefits for behavioral health, mental health, and substance use disorders benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to medical/surgical benefits within the corresponding classification of benefits.

c. Carriers are required to complete the templates identified in Section 10.C.2 of this regulation and address any comparative disparities in the in-operation comparative analysis related to the specific NQTL.

d. The Comparative Analysis submission shall, at minimum:

(1) Provide a detailed definition of the NQTL and describe the specific coverage terms, plan language, and procedures as applied to mental health, substance use disorder, and medical or surgical benefits.

(2) Provide a listing of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies. Carriers shall list all pertinent plan documents that outline the application of the NQTLs.

(3) Identify the factors relied upon in the design and application of NQTLs to the services in the specific benefit classification or subclassification for both mental health/substance use disorder and medical/surgical benefits;

(4) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each non-quantitative treatment limitation;

(5) Provide a comprehensive assessment and comparative analyses, including any results of the analyses, performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, as written, and the written processes and strategies used to apply to each non-quantitative treatment limitation for benefits for behavioral, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to design and apply to each non-quantitative treatment limitation, as written, and the written processes and strategies used to apply to each non-quantitative treatment limitation for medical and surgical benefits;

(6) Provide a comprehensive assessment and comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply to each non-quantitative treatment limitation, in operation, for benefits for behavioral, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply to each non-quantitative treatment limitation, in operation, for medical and surgical benefits; and

(7) Disclose the specific findings and conclusions reached by the carrier that the results of the analyses indicate that each health benefit plan offered by the carrier complies with § 10-16-104(5.5), C.R.S., and the MHPAEA.

e. Carriers shall have the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, chief executive officer, chief financial officer, chief operating officer, general counsel or other person, with documentation showing that the person has been appointed a company officer by the board of directors certify that the information contained in the comparative analyses is accurate and in compliance with this regulation.

f. The signatures required by this Section 10 must be an original or valid electronic signature of the person signing. Signature stamps, photocopies or a signature on behalf of the authorized signer are not acceptable. Electronic signatures shall be in compliance with § 24-71.3-101 et seq., C.R.S., and applicable regulations.

Section 11 Confidentiality

A. All mental health parity filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. The Division does not consider such items as the calculations of “substantially all” and “predominant” tests; narratives regarding any review standard the carrier may use; the attestations; or any other such documents as required in this regulation as confidential. Carriers must submit the confidential exhibits separately in SERFF, which must be indicated as such by the confidential icon in SERFF. Non-confidential information must be in a separate SERFF component.

B. Nothing in this section shall prohibit a carrier from redacting information in public documents that is confidential. Carriers shall submit a redacted and unredacted version of any documents.

C. The Division considers the information submitted in the Non-Quantitative Treatment Limitations: Confidential Network Development Questionnaire as confidential, pursuant to § 24-72-204, C.R.S.

D. A “Confidentiality Index” must be completed if the carrier desires confidential treatment of any information submitted, as required in this regulation. The Division will evaluate the reasonableness of any requests for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected.

Section 12 Incorporation by Reference

Actuarial Standards of Practice shall mean the Actuarial Standards of Practice as published by the Actuarial Standards Boards on the effective date of this regulation and does not include later amendments to or editions of the Actuarial Standards of Practice. Actuarial Standards of Practice may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of Actuarial Standards of Practice may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A charge for certification may apply. A copy may also be obtained online at http://www.actuarialstandardsboard.org/standards-of-practice/.

45 C.F.R. § 146.136 shall mean 45 C.F.R. § 146.136 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 146.136. A copy of 45 C.F.R. § 146.136 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 146.136 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 146.137 shall mean 45 C.F.R. § 146.137 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 146.137. A copy of 45 C.F.R. § 146.137 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 146.137 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 147.160 shall mean 45 C.F.R. § 147.160 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 147.160. A copy of 45 C.F.R. § 147.160 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 147.160 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 13 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 14 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in § 10-3-1108, C.R.S., may be applied.

Section 15 Effective Date

This regulation shall become effective on January 30, 2025, except as follows:

A. The requirements in Sections 5.H. and 6.E relating to the provision of meaningful benefits pursuant to 45 C.F.R. § 146.136(c)(2)(ii)(A) shall become effective for health benefit plans issued on or after January 1, 2026.

B. The requirements in Section 7.C.2, addressing the prohibition on discriminatory factors and evidentiary standards in the design and application of non-quantitative treatment limitations, pursuant to 45 C.F.R. § 146.136(c)(4)(i)(B), and § 146.137(c)(2)(ii)(C) shall become effective for health benefit plans issued on or after January 1, 2026.

C. The requirements in Section 7.D, pertaining to the required use and evaluation of outcome data under 45 C.F.R. § 146.136(c)(4)(iii), § 146.137 (c)(5)(i)(C) and (D), and (c)(5)(ii) through (v) shall become effective for health benefit plans issued on or after January 1, 2026.

D. Until the applicability dates set forth in the section, health benefit plans and carriers shall continue to comply with Regulation 4-2-64 effective June 1, 2021.

Section 16 History

Emergency regulation 19-E-02 effective June 13, 2019.
Emergency regulation 19-E-04 effective October 10, 2019.
Regulation effective February 1, 2020.
Amended Regulation effective June 1, 2021.
Amended Regulation effective January 30, 2025.

Regulation 4-2-65 CONCERNING THE ESTABLISHMENT OF A CARRIER PAYMENT ARBITRATION PROGRAM FOR OUT-OF-NETWORK PROVIDERS S

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, and 10-16-704(15)(b), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements for a carrier payment dispute arbitration program; to ensure that out-of-network providers seeking arbitration concerning payment received from a carrier utilize a standard arbitration request form; and to establish qualification requirements for arbitrators who participate in this arbitration program. These requirements are being established pursuant to HB 19-1174. This regulation replaces Colorado Emergency Regulation 19-E-05 in its entirety.

Section 3 Applicability

This regulation applies to all carriers offering individual, small group and large group health benefit plans that will receive claims from out-of-network providers incurred on or after January 1, 2020 that are subject to the insurance laws of Colorado.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Commissioner” means, for the purposes of this regulation, the Commissioner of Insurance or his or her designee.

C. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

D. “De-identified” means, for the purposes of this regulation, the removal of all information that can be used to identify the patient from whose medical record the health information was derived.

E. “Out-of-network provider” means, for the purposes of this regulation, a provider in this state that has not entered into a contract with a carrier or with its contractor or subcontractor to provide health care services to covered persons.

F. “Payment” means, for the purposes of this regulation, the amount the carrier determines to be the total allowable charge for the covered services prior to the application of the managed care plan’s in-network deductible, coinsurance, and/or copayment requirements.

G. "Provider" shall have the same meaning as found at § 10-16-102(56), C.R.S.

H. "Qualified arbitrator" means, for the purposes of this regulation, an arbitrator who has submitted an application to the Commissioner for inclusion in the list of arbitrators maintained by the Division for the purposes of carrier payment arbitration program for out-of-network providers , and who has met the qualifications contained in Section 6 of this regulation and § 10-16-704(15)(b), C.R.S.

Section 5 Arbitration Process and Timelines

A. An out-of-network provider may request arbitration within ninety (90) calendar days of receipt of the payment, notice of payment, or remittance advice, as applicable, for a claim if the out-of-network provider:

1. Believes that the payment made by a carrier pursuant to §§ 10-16-704(3), 10-16-704 (5.5), or 25-3-122(3), C.R.S., as applicable, was not sufficient based upon the complexity and circumstances of the services provided; and

2. Sent a claim for a covered service to the carrier within one hundred eighty (180) calendar days after the receipt of insurance information, if required by § 25-3-122(3), C.R.S.

B. A request for arbitration is initiated when a request for arbitration has been filed by the out-of-network provider or facility with the Commissioner and the carrier using the form found in Appendix A of this regulation, and is sent to a specific email address established by the carrier for this purpose.

C. The Commissioner shall appoint a qualified arbitrator within thirty (30) calendar days after the receipt of a request for arbitration by an out-of-network provider when an informal settlement teleconference has not been requested.

D. The out-of-network provider and the carrier may agree to participate in an informal settlement teleconference prior to the appointment of a qualified arbitrator. If the carrier does not agree to participate in a settlement teleconference, the out-of-network provider will notify the Division within three (3) business days of the carrier's refusal to participate. If the carrier does agree to participate:

1. The informal settlement teleconference shall be held within thirty (30) calendar days of the request for arbitration;

2. The out-of-network provider and the carrier shall notify the Commissioner of the outcome of the informal settlement teleconference within five (5) business days of the conclusion of the teleconference and shall:

a. Advise whether or not the teleconference resulted in a settlement;

b. If a settlement was reached, provide the details of that settlement; and/or

c. If a settlement was not reached, request the appointment of an arbitrator.

E. The Commissioner shall appoint a qualified arbitrator within fifteen (15) calendar days of receiving notice that an informal settlement teleconference was unsuccessful.

F. Once the parties to the arbitration have been notified of the appointment of a qualified arbitrator by the Commissioner, each party to the arbitration must submit its final offer, and the reasoning for that offer in writing to the appointed arbitrator within thirty (30) calendar days of receipt of the notification. Any patient information submitted to the arbitrator in support of the offer being made shall be de-identified to ensure that protected health information is not disclosed.

G. If either the carrier or the out-of-network provider does not provide a final offer to the appointed arbitrator within the thirty (30) calendar days, the arbitrator must select the offer that has been received by the arbitrator.

H. If neither the carrier nor the out-of-network provider provide a final offer to the appointed arbitrator within the thirty (30) calendar days, the arbitration shall be considered complete, and the payment initially made to the out-of-network provider shall be considered to be payment in full by both parties.

I. If the carrier disagrees that the managed care plan under which the payment was made is subject to the requirements of § 10-16-704(15), C.R.S., or that the out-of-network provider complied with the requirements of Section 5.A.1., it shall have two (2) business days to provide the Commissioner with the documentation to support its determination. If the Commissioner agrees, both parties and the arbitrator shall be advised of the termination of the arbitration process within two (2) business days of the receipt of the carrier's documentation.

J. The appointed arbitrator shall make its decision and notify the parties to the arbitration and the Commissioner, in writing utilizing the form found in Appendix B of this regulation, within forty-five (45) calendar days after the date of the arbitrator's appointment. The arbitrator's decision and notification shall include a description of the reasoning for the arbitrator's decision.

K. The party whose final offer amount was not selected by the arbitrator shall pay the arbitrator's expenses and fees within thirty (30) calendar days of receiving an invoice from the arbitrator. If the provider is responsible for paying for the arbitration after the decision has been made fails to pay for the arbitration when required, no further requests for arbitration will be accepted from that provider until any past-due payments have been resolved.

L. If the informal teleconference settlement or the arbitrator's decision requires the carrier to make an additional payment:

1. The carrier shall re-adjudicate the relevant claim(s) within thirty (30) calendar days of the informal teleconference settlement or the arbitrators decision or be subject to the payment of interest and penalties in accordance with § 10-16-106.5, C.R.S.; and

2. The carrier shall notify the covered person of any change to his or her deductible, coinsurance, and/or copayment calculations and provide information regarding the out-of-network provider's responsibility to refund any overpayment pursuant to §§ 12-30-113(2) and 25-3-122(2), C.R.S.

M. If the informal teleconference settlement or arbitrator's decision does not require the carrier to make an additional payment:

1. The carrier shall notify the covered person of the outcome of the arbitration and advise the covered person that the out-of-network provider is prohibited from billing the covered person directly except for the covered person's required deductible, coinsurance, and/or copayment obligations.

2. The carrier's notification shall also advise the covered person of the requirement for the out-of-network provider to reimburse him or her within sixty (60) calendar days after the date the out-of-network provider is notified by the carrier of an overpayment if the covered person has paid the out-of-network provider more than amounts due related to the covered person's deductible, coinsurance, and/or copayment for the covered service.

N. The arbitrator's decision is final and binding on both parties and only applies to the covered person's services identified in the arbitration request unless the parties agree otherwise.

O. Information submitted to the Division and/or an arbitrator appointed by the Commissioner pursuant to § 10-16-704(15), C.R.S., shall be considered confidential pursuant to § 24-72-204(3), C.R.S.

Section 6 Arbitrator Qualifications and Selection

A. The Division shall post a list of qualified arbitrators on its website.

B. In order for an arbitrator to apply for consideration for inclusion on the list of qualified arbitrators, the following qualifications must be met:

1. Provide evidence of having completed arbitration training by the American Arbitration Association or the American Health Lawyers Association, or a similar entity;

2. Demonstrate good standing with the state agency that licenses, registers or otherwise regulates attorneys in the states in which he or she practices;

3. Demonstrate experience in health care billing and health care reimbursement rates;

4. Demonstrate and certify that neither they nor their family members have a professional affiliation with any of the following:

a. A carrier or a professional association of carriers;

b. A health care facility or a professional association of health care facilities; and

c. Health care providers or a professional association of health care providers;

5. Provide a schedule of expenses and fees to be used for arbitrations; and

6. Agree to comply with the requirements of § 10-16-704(15) C.R.S.

C. The Commissioner shall randomly select a qualified arbitrator to conduct an initiated arbitration from the list of qualified arbitrators maintained by the Division. If the selected arbitrator is currently involved in an ongoing arbitration, another arbitrator shall be selected by the Commissioner.

D. Once a qualified arbitrator has been selected, the Division will contact the arbitrator and identify the parties involved in the request for arbitration. Prior to finalizing the appointment to conduct the arbitration, the arbitrator must attest to the Commissioner that they or a family member do not have:

1. A personal conflict of interest with any parties to the arbitration;

2. Any professional conflict of interest with any parties to the arbitration; nor

3. A financial conflict of interest with any parties to the arbitration.

If any conflicts of interest exist between the arbitrator and the parties to the arbitration, the arbitrator shall disclose those conflicts of interest to the Commissioner within three (3) business days of being contacted by the Commissioner to oversee an arbitration, and another qualified arbitrator shall be selected.

E. The qualified arbitrator shall demonstrate that there are no conflicts of interest in the arbitration by submitting an attestation to the Commissioner. Once the attestation has been received by the Commissioner and reviewed, the Commissioner will provide final approval of the appointment to the arbitrator, and notify the parties that the arbitration can begin.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective April 15, 2020.

Section 10 History

Emergency regulation effective December 20, 2019.
Regulation effective April 15, 2020.

Appendix A

COLORADO
Department of Regulatory Agencies
Division of Insurance

Division of Insurance Out-of-Network Provider Arbitration Request Form

Date of Request: (Must be within ninety (90) calendar days after receipt of the payment, notice of payment, or remittance advice.)		Patient's plan is regulated by the Division: *(See information on back.)* Yes ☐ No ☐ **If "no", do not submit this request.**
Name and Contact Information of Provider or Facility Requesting Arbitration:		
The Entity Requesting Arbitration is a:	Out-of-Network Health Care Facility ☐	License Type:
	Out-of-Network Health Care Provider ☐	Specialty Type:
Description of Health Care Services Provided (including any applicable CPT codes):		
Group/Plan #:		
Claim Number(s):		
Date(s) of Service:		
Amount billed by Out-of-Network Health Care Provider or Out-of-Network Facility:	Carrier-determined Eligible Amount for Covered Services:	Date payment, notice of payment, or remittance advice received: *(Attach a copy of the notice to this form.)*
Name and Contact Information of Carrier Identified for Arbitration:		
I will be initiating an informal settlement teleconference with the carrier prior to initiation of the arbitration process and I will notify the Division within three (3) business days if the carrier declines my request for a settlement teleconference.		Yes ☐ No ☐

Please review important information on the back of this form prior to submitting this request.

1. Only claim payments made in connection with health insurance plans regulated by the Division of Insurance have access to the arbitration process. Examples of health insurance plans that are not included are:

   - Medicare and Medicaid
   - Federal employee benefit plans
   - Plans issued to employers headquartered in another state
   - Plans with are self-funded by employers under ERISA

   Please check for a "CO-DOI" notification listed on the patient's ID card prior to submitting this request as it means this plan is regulated by the Division.

2. The out-of-network emergency services facility and/or out-of-network provider providing emergency services or services at an in-network facility may submit this request if it is believed that the payment made for the covered services was not sufficient given the complexity and circumstances of the services provided to the patient.

3. If the facility/provider and the carrier agree to participate in an informal settlement teleconference prior to the start of arbitration, it will be scheduled and must be completed within thirty (30) calendar days of this request.

4. If no informal settlement teleconference has been agreed to, both the facility/provider and carrier will be provided with the contact information for the appointed arbitrator. Both parties will have thirty (30) calendar days to submit their final offer and their argument supporting the final offer in writing given the complexity and circumstance of the services provided to the patient.

5. The arbitrator will issue a written decision to both parties within forty-five (45) calendar days of appointment, choosing the facility's, the provider's or the carrier's final offer. This decision is final and binding on both parties and only applies to the services (claims) identified in the arbitration request unless the parties agree otherwise.

6. The party whose final offer amount was not selected shall pay the arbitrator's expenses and fees within thirty (30) calendar days of receipt of the invoice.

Appendix B

COLORADO
Department of Regulatory Agencies
Division of Insurance

Division of Insurance Arbitration Decision and Reporting Form

Upon decision, a copy of this form is to be sent by the Arbitrator to the Carrier, the requesting Out-of-Network Provider/Facility and the Division of Insurance	
Arbitrator Name:	Division's Arbitration Tracking Number:
Date of Arbitrator Appointment:	Date of Arbitration Decision:
Is additional payment being requested because the out-of-network provider/facility believes that the amount allowed for the covered services was not sufficient given the ***complexity and circumstances of the services provided to the patient***? ☐ YES ☐ NO	
Decision Found for: ☐ Out-of-Network Health Care Facility ☐ Out-of-Network Health Care Provider ☐ Carrier	
The decision was reached through: ☐ Arbitrator's decision ☐ Closed due to lack of communication from the parties involved	
Provider/Facility Name:	Carrier Name:
Provider Specialty:	
Facility License Type:	
Date(s) of Service for Arbitrated Claim:	
Claim Number(s):	
Initial Carrier-determined Allowable Amount for Covered Services:	
Amount billed by Out-of-Network Provider or Facility:	
Final Offer of Carrier for Allowable Amount for Covered Services:	
Date Received:	

Reason(s) Provided by Carrier for Final Offer's Allowable Amount:

Final Offer Requested by Out-of-Network Provider/Facility:	
Date Received:	

Reason(s) Provided by Out-of-Network Provider or Facility for Final Allowable Amount Requested:

Arbitrator's Decision
Final Allowable Amount :
Reason(s) for Arbitrator's Decision:

Fee charged in accordance with arbitrator's filed fee schedule and basis used for fee determination:	

Name and Contact Information of Arbitrator:
I certify that I have no personal or professional conflict of interest with either party involved in this arbitration.

Signature	Date

The Arbitrator's fee must be paid within thirty (30) calendar days by the:

Carrier ☐ Provider/Facility ☐

Important Information for the Carrier

The carrier shall notify the covered person of any change to his or her deductible, coinsurance, and/or copayment calculations and provide information regarding the out-of-network provider's responsibility to refund any overpayment pursuant to §§ 12-30-113(2)(a) and 25-3-122(2), C.R.S.

The carrier shall notify the covered person of the outcome of the arbitration and advise the covered person that the out-of-network provider is prohibited from billing the covered person directly except for the covered person's required in-network deductible, coinsurance, and/or copayment obligations.

The carrier's notification shall also advise the covered person of the requirement for the out-of-network provider to reimburse him or her within sixty (60) calendar days after the date the out-of-network provider is notified by the carrier of an overpayment if the covered person has paid the out-of-network provider more than amounts due related to the covered person's deductible, coinsurance, and/or copayment for the covered service(s).

Important Information for the Provider/Facility

Providers and facilities shall not bill or collect a payment from the covered person for any outstanding balance for covered services not paid by the carrier except for the applicable in-network deductible, coinsurance, or copayment amount required to be paid by the covered person.

If the provider or facility received a payment from the covered person for amounts the covered person is not responsible for pursuant to § 10-16-704(3)(b) or (5.5), C.R.S., or due to an additional payment made by the carrier as a result of this arbitration, it shall reimburse the covered person within sixty (60) calendar days after the date the overpayment is reported to it.

A provider or facility that fails to reimburse a covered person as required by §§ 12-30-113(2) or 25-3-122(2)(a), C.R.S., shall pay interest on the overpayment as required by §§ 12-30-113(2)(b) or 25-3-122(2)(b), C.R.S.

Regulation 4-2-66 CONCERNING THE PAYMENT METHODOLOGY FOR NON-CONTRACTED SERVICE AGENCIES THAT PROVIDE EMERGENCY AMBULANCE SERVICES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-704(5.5)(d)(II)(A), and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish a payment methodology to be utilized by carriers to pay non-contracted service agencies that provide emergency ambulance services pursuant to HB 19-1174. This payment methodology does not apply to a publicly-funded fire agency.

Section 3 Applicability

This regulation applies to carriers offering individual, small group and large group health benefit plans that will receive claims incurred on or after January 1, 2020 from non-contracted services agencies which provide emergency ambulance services and who are subject to the requirements of § 10-16-704(5.5), C.R.S.

Section 4 Definitions

A. “Ambulance service” shall have the same meaning as found at § 25-3.5-103(3), C.R.S.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

D. “Geographic area” means, for the purposes of this regulation, the geographic area established by the Division for out-of-network reimbursements pursuant to § 10-16-704(3)(d)(VI)(A), C.R.S., and contained in Appendix A of this regulation.

E. “Medicare reimbursement rate” shall have the same meaning as found at § 10-16-704(3)(d)(VI)(B), C.R.S.

F. “Non-contracted service agency” means, for the purposes of this regulation, a service agency that does not have a contract with a carrier to provide emergency ambulance services.

G. “Publicly-funded fire agency” means, for the purposes of this regulation, an ambulance service provider that has been established as part of a fire protection district, health services district, municipality, special tax district, or other government entity.

H. "Service agency" shall have the same meaning as found at § 25-3.5-103(11.5), C.R.S.

Section 5 Payment Methodology Rules

A. Carriers shall reimburse a non-contracted service agency that provides emergency ambulance services to a covered person at three hundred twenty-five percent (325%) of the Medicare reimbursement rate for the same service provided in the same geographic area, including mileage.

B. A non-contracted service agency that does not meet the definition of a publicly-funded fire agency, but does contract with a fire department, fire protection district, health services district, municipality, special tax district, or other government entity to provide emergency ambulance services on their behalf shall be reimbursed in accordance with the terms of that contract.

C. A non-contracted service agency shall remain subject to Section 5.D. of this regulation if it contracts with a fire department, fire protection district, health services district, municipality, special tax district, or other government entity to provide emergency ambulance services and is prohibited from billing the covered person, except as permitted in Section 5.D. of this regulation.

D. Covered persons shall only be responsible for the applicable in-network deductible, coinsurance, and/or copayment they would be required to pay for in-network emergency ambulance services.

E. Payment made in compliance with Section 5.A. of this regulation shall be considered payment in full for the covered services provided, except for any in-network deductible, coinsurance and/or copayment amount required to be paid by the covered person.

F. An ambulance service provider must demonstrate to a carrier that it meets the definition of a publicly-funded fire agency found at Section 4.G. of this regulation in order to be exempt from the requirements found in this regulation.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective April 15, 2020.

Section 9 History

Emergency regulation effective December 20, 2019.
Regulation effective April 15, 2020.

Appendix A: Zip Code to DOI Geographic Area Crosswalk

Zip Code	DOI Region	Location	Zip Code	DOI Region	Location	Zip Code	DOI Region	Location	Zip Code	DOI Region	DOI	Zip Code	DOI Region	DOI
80025	1	Boulder	80117	3	Denver	80538	4	Ft. Collins	81045	8	East	81420	9	West
80026	1	Boulder	80118	3	Denver	80539	4	Ft. Collins	81046	8	East	81422	9	West
80027	1	Boulder	80120	3	Denver	80541	4	Ft. Collins	81047	8	East	81423	9	West
80301	1	Boulder	80121	3	Denver	80545	4	Ft. Collins	81049	8	East	81424	9	West
80302	1	Boulder	80122	3	Denver	80547	4	Ft. Collins	81050	8	East	81425	9	West
80303	1	Boulder	80123	3	Denver	80549	4	Ft. Collins	81052	8	East	81426	9	West
80304	1	Boulder	80124	3	Denver	80553	4	Ft. Collins	81054	8	East	81427	9	West
80305	1	Boulder	80125	3	Denver	81501	5	Grand Junction	81055	8	East	81428	9	West
80306	1	Boulder	80126	3	Denver	81502	5	Grand Junction	81057	8	East	81429	9	West
80307	1	Boulder	80127	3	Denver	81503	5	Grand Junction	81058	8	East	81430	9	West
80308	1	Boulder	80128	3	Denver	81504	5	Grand Junction	81059	8	East	81431	9	West
80309	1	Boulder	80129	3	Denver	81505	5	Grand Junction	81062	8	East	81432	9	West
80310	1	Boulder	80130	3	Denver	81506	5	Grand Junction	81063	8	East	81433	9	West
80314	1	Boulder	80131	3	Denver	81507	5	Grand Junction	81064	8	East	81434	9	West
80455	1	Boulder	80134	3	Denver	81520	5	Grand Junction	81067	8	East	81435	9	West
80466	1	Boulder	80135	3	Denver	81521	5	Grand Junction	81071	8	East	81601	9	West
80471	1	Boulder	80136	3	Denver	81522	5	Grand Junction	81073	8	East	81602	9	West
80481	1	Boulder	80137	3	Denver	81523	5	Grand Junction	81076	8	East	81610	9	West
80501	1	Boulder	80138	3	Denver	81524	5	Grand Junction	81077	8	East	81611	9	West
80502	1	Boulder	80150	3	Denver	81525	5	Grand Junction	81081	8	East	81612	9	West
80503	1	Boulder	80151	3	Denver	81526	5	Grand Junction	81082	8	East	81615	9	West
80510	1	Boulder	80155	3	Denver	81527	5	Grand Junction	81084	8	East	81620	9	West
80516	1	Boulder	80160	3	Denver	81624	5	Grand Junction	81087	8	East	81621	9	West
80533	1	Boulder	80161	3	Denver	81630	5	Grand Junction	81089	8	East	81623	9	West
80540	1	Boulder	80162	3	Denver	81643	5	Grand Junction	81090	8	East	81625	9	West
80544	1	Boulder	80163	3	Denver	81646	5	Grand Junction	81091	8	East	81626	9	West
80106	2	Colorado Springs	80165	3	Denver	80504	6	Greeley	81092	8	East	81631	9	West
80132	2	Colorado Springs	80166	3	Denver	80514	6	Greeley	81101	8	East	81632	9	West
80133	2	Colorado Springs	80201	3	Denver	80520	6	Greeley	81102	8	East	81633	9	West
80808	2	Colorado Springs	80202	3	Denver	80530	6	Greeley	81120	8	East	81635	9	West
80809	2	Colorado Springs	80203	3	Denver	80534	6	Greeley	81123	8	East	81636	9	West
80813	2	Colorado Springs	80204	3	Denver	80542	6	Greeley	81124	8	East	81637	9	West
80814	2	Colorado Springs	80205	3	Denver	80543	6	Greeley	81125	8	East	81638	9	West
80816	2	Colorado Springs	80206	3	Denver	80546	6	Greeley	81126	8	East	81639	9	West
80817	2	Colorado Springs	80207	3	Denver	80550	6	Greeley	81129	8	East	81640	9	West
80819	2	Colorado Springs	80208	3	Denver	80551	6	Greeley	81130	8	East	81641	9	West
80829	2	Colorado Springs	80209	3	Denver	80603	6	Greeley	81131	8	East	81642	9	West
80831	2	Colorado Springs	80210	3	Denver	80610	6	Greeley	81132	8	East	81645	9	West
80832	2	Colorado Springs	80211	3	Denver	80611	6	Greeley	81133	8	East	81647	9	West
80833	2	Colorado Springs	80212	3	Denver	80612	6	Greeley	81135	8	East	81648	9	West
80840	2	Colorado Springs	80214	3	Denver	80615	6	Greeley	81136	8	East	81649	9	West

Zip Code	DOI Region	Location
80841	2	Colorado Springs
80860	2	Colorado Springs
80863	2	Colorado Springs
80864	2	Colorado Springs
80866	2	Colorado Springs
80901	2	Colorado Springs
80902	2	Colorado Springs
80903	2	Colorado Springs
80904	2	Colorado Springs
80905	2	Colorado Springs
80906	2	Colorado Springs
80907	2	Colorado Springs
80908	2	Colorado Springs
80909	2	Colorado Springs
80910	2	Colorado Springs
80911	2	Colorado Springs
80912	2	Colorado Springs
80913	2	Colorado Springs
80914	2	Colorado Springs
80915	2	Colorado Springs
80916	2	Colorado Springs
80917	2	Colorado Springs
80918	2	Colorado Springs
80919	2	Colorado Springs
80920	2	Colorado Springs
80921	2	Colorado Springs
80922	2	Colorado Springs
80923	2	Colorado Springs
80924	2	Colorado Springs
80925	2	Colorado Springs
80926	2	Colorado Springs
80927	2	Colorado Springs
80928	2	Colorado Springs
80929	2	Colorado Springs
80930	2	Colorado Springs
80931	2	Colorado Springs
80932	2	Colorado Springs
80933	2	Colorado Springs
80934	2	Colorado Springs
80935	2	Colorado Springs
80936	2	Colorado Springs
80937	2	Colorado Springs
80938	2	Colorado Springs
80939	2	Colorado Springs
80941	2	Colorado Springs

Zip Code	DOI Region	Location
80215	3	Denver
80216	3	Denver
80217	3	Denver
80218	3	Denver
80219	3	Denver
80220	3	Denver
80221	3	Denver
80222	3	Denver
80223	3	Denver
80224	3	Denver
80225	3	Denver
80226	3	Denver
80227	3	Denver
80228	3	Denver
80229	3	Denver
80230	3	Denver
80231	3	Denver
80232	3	Denver
80233	3	Denver
80234	3	Denver
80235	3	Denver
80236	3	Denver
80237	3	Denver
80238	3	Denver
80239	3	Denver
80241	3	Denver
80243	3	Denver
80244	3	Denver
80246	3	Denver
80247	3	Denver
80248	3	Denver
80249	3	Denver
80250	3	Denver
80251	3	Denver
80252	3	Denver
80256	3	Denver
80257	3	Denver
80259	3	Denver
80260	3	Denver
80261	3	Denver
80262	3	Denver
80263	3	Denver
80264	3	Denver
80265	3	Denver
80266	3	Denver

Zip Code	DOI Region	Location
80620	6	Greeley
80621	6	Greeley
80622	6	Greeley
80623	6	Greeley
80624	6	Greeley
80631	6	Greeley
80632	6	Greeley
80633	6	Greeley
80634	6	Greeley
80638	6	Greeley
80639	6	Greeley
80642	6	Greeley
80643	6	Greeley
80644	6	Greeley
80645	6	Greeley
80646	6	Greeley
80648	6	Greeley
80650	6	Greeley
80651	6	Greeley
80652	6	Greeley
80729	6	Greeley
80732	6	Greeley
80742	6	Greeley
80754	6	Greeley
81001	7	Pueblo
81002	7	Pueblo
81003	7	Pueblo
81004	7	Pueblo
81005	7	Pueblo
81006	7	Pueblo
81007	7	Pueblo
81008	7	Pueblo
81009	7	Pueblo
81010	7	Pueblo
81011	7	Pueblo
81012	7	Pueblo
81019	7	Pueblo
81022	7	Pueblo
81023	7	Pueblo
81025	7	Pueblo
81069	7	Pueblo
80649	8	East
80653	8	East
80654	8	East
80701	8	East

Zip Code	DOI Region	DOI
81138	8	East
81140	8	East
81141	8	East
81143	8	East
81144	8	East
81146	8	East
81148	8	East
81149	8	East
81151	8	East
81152	8	East
81154	8	East
81155	8	East
81201	8	East
81211	8	East
81212	8	East
81215	8	East
81221	8	East
81222	8	East
81223	8	East
81226	8	East
81227	8	East
81228	8	East
81232	8	East
81233	8	East
81236	8	East
81240	8	East
81242	8	East
81244	8	East
81248	8	East
81252	8	East
81253	8	East
81290	8	East
80423	9	West
80424	9	West
80426	9	West
80428	9	West
80429	9	West
80430	9	West
80434	9	West
80435	9	West
80442	9	West
80443	9	West
80446	9	West
80447	9	West
80451	9	West

Zip Code	DOI Region	DOI
81650	9	West
81652	9	West
81653	9	West
81654	9	West
81655	9	West
81656	9	West
81657	9	West
81658	9	West

Zip Code	DOI Region	Location
80942	2	Colorado Springs
80944	2	Colorado Springs
80946	2	Colorado Springs
80947	2	Colorado Springs
80949	2	Colorado Springs
80950	2	Colorado Springs
80951	2	Colorado Springs
80960	2	Colorado Springs
80962	2	Colorado Springs
80970	2	Colorado Springs
80977	2	Colorado Springs
80995	2	Colorado Springs
80997	2	Colorado Springs
80001	3	Denver
80002	3	Denver
80003	3	Denver
80004	3	Denver
80005	3	Denver
80006	3	Denver
80007	3	Denver
80010	3	Denver
80011	3	Denver
80012	3	Denver
80013	3	Denver
80014	3	Denver
80015	3	Denver
80016	3	Denver
80017	3	Denver
80018	3	Denver
80019	3	Denver
80020	3	Denver
80021	3	Denver
80022	3	Denver
80023	3	Denver
80024	3	Denver
80030	3	Denver
80031	3	Denver
80033	3	Denver
80034	3	Denver
80035	3	Denver
80036	3	Denver
80037	3	Denver
80038	3	Denver
80040	3	Denver
80041	3	Denver

Zip Code	DOI Region	Location
80271	3	Denver
80273	3	Denver
80274	3	Denver
80281	3	Denver
80290	3	Denver
80291	3	Denver
80293	3	Denver
80294	3	Denver
80299	3	Denver
80401	3	Denver
80402	3	Denver
80403	3	Denver
80419	3	Denver
80420	3	Denver
80421	3	Denver
80422	3	Denver
80425	3	Denver
80427	3	Denver
80432	3	Denver
80433	3	Denver
80436	3	Denver
80437	3	Denver
80438	3	Denver
80439	3	Denver
80440	3	Denver
80444	3	Denver
80448	3	Denver
80449	3	Denver
80452	3	Denver
80453	3	Denver
80454	3	Denver
80456	3	Denver
80457	3	Denver
80465	3	Denver
80470	3	Denver
80474	3	Denver
80475	3	Denver
80476	3	Denver
80601	3	Denver
80602	3	Denver
80614	3	Denver
80640	3	Denver
80820	3	Denver
80827	3	Denver
80830	3	Denver

Zip Code	DOI Region	Location
80705	8	East
80720	8	East
80721	8	East
80722	8	East
80723	8	East
80726	8	East
80727	8	East
80728	8	East
80731	8	East
80733	8	East
80734	8	East
80735	8	East
80736	8	East
80737	8	East
80740	8	East
80741	8	East
80743	8	East
80744	8	East
80745	8	East
80746	8	East
80747	8	East
80749	8	East
80750	8	East
80751	8	East
80755	8	East
80757	8	East
80758	8	East
80759	8	East
80801	8	East
80802	8	East
80804	8	East
80805	8	East
80807	8	East
80810	8	East
80812	8	East
80815	8	East
80818	8	East
80821	8	East
80822	8	East
80823	8	East
80824	8	East
80825	8	East
80826	8	East
80828	8	East
80834	8	East

Zip Code	DOI Region	DOI
80459	9	West
80461	9	West
80463	9	West
80467	9	West
80468	9	West
80469	9	West
80473	9	West
80477	9	West
80478	9	West
80479	9	West
80480	9	West
80482	9	West
80483	9	West
80487	9	West
80488	9	West
80497	9	West
80498	9	West
81121	9	West
81122	9	West
81128	9	West
81137	9	West
81147	9	West
81157	9	West
81210	9	West
81220	9	West
81224	9	West
81225	9	West
81230	9	West
81231	9	West
81235	9	West
81237	9	West
81239	9	West
81241	9	West
81243	9	West
81251	9	West
81301	9	West
81302	9	West
81303	9	West
81320	9	West
81321	9	West
81323	9	West
81324	9	West
81325	9	West
81326	9	West
81327	9	West

80042	3	Denver	80835	3	Denver	80836	8	East	81328	9	West
Zip Code	**DOI Region**	**Location**	**Zip Code**	**DOI Region**	**Location**	**Zip Code**	**DOI Region**	**Location**	**Zip Code**	**DOI Region**	**DOI**
80044	3	Denver	80511	4	Ft. Collins	80861	8	East	81329	9	West
80045	3	Denver	80512	4	Ft. Collins	80862	8	East	81330	9	West
80046	3	Denver	80513	4	Ft. Collins	81020	8	East	81331	9	West
80047	3	Denver	80515	4	Ft. Collins	81021	8	East	81332	9	West
80101	3	Denver	80517	4	Ft. Collins	81024	8	East	81334	9	West
80102	3	Denver	80521	4	Ft. Collins	81027	8	East	81335	9	West
80103	3	Denver	80522	4	Ft. Collins	81029	8	East	81401	9	West
80104	3	Denver	80523	4	Ft. Collins	81030	8	East	81402	9	West
80105	3	Denver	80524	4	Ft. Collins	81033	8	East	81403	9	West
80107	3	Denver	80525	4	Ft. Collins	81034	8	East	81410	9	West
80108	3	Denver	80526	4	Ft. Collins	81036	8	East	81411	9	West
80109	3	Denver	80527	4	Ft. Collins	81038	8	East	81413	9	West
80110	3	Denver	80528	4	Ft. Collins	81039	8	East	81414	9	West
80111	3	Denver	80532	4	Ft. Collins	81040	8	East	81415	9	West
80112	3	Denver	80535	4	Ft. Collins	81041	8	East	81416	9	West
80113	3	Denver	80536	4	Ft. Collins	81043	8	East	81418	9	West
80116	3	Denver	80537	4	Ft. Collins	81044	8	East	81419	9	West

Regulation 4-2-67 CONCERNING CARRIER DISCLOSURES FOR EMERGENCY AND NON-EMERGENCY OUT-OF-NETWORK SERVICES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-704(12)(b) and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish requirements for carriers to provide disclosures concerning a covered person's financial responsibility for emergency and non-emergency services rendered by out-of-network providers.

Section 3 Applicability

This regulation applies to carriers offering individual, small group and large group health benefit plans whose members may receive services from out-of-network providers on or after January 1, 2022, which are subject to the requirements of §§ 10-16-704(3) and 10-16-704(5.5), C.R.S.

Section 4 Definitions

A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

C. "Emergency services" shall have the same meaning as found at § 10-16-704(19)(e)(I), C.R.S.

D. "Health care services" shall have the same meaning as found at § 10-16-102(33), C.R.S.

E. "Out-of-network provider" means, for the purposes of this regulation, a provider in this state that has not entered into a contract with a carrier or with its contractor or subcontractor to provide health care services to covered persons.

F. "Participating provider" shall have the same meaning as found at § 10-16-102(46), C.R.S.

G. "Preauthorization" means, for the purposes of this regulation, a pre-service or pre-treatment confirmation provided by a carrier, at the request of a covered person and/or his or her healthcare provider, indicating that the service(s) and/or treatment(s) being considered by the covered person will be covered by his or her health plan.

H. "Prior authorization" shall have the same meaning as found at § 10-16-112.5(7)(d), C.R.S.

I. "Provider" shall have the same meaning as found at § 10-16-102(56), C.R.S.

J. "Publicly available" means, for the purposes of this regulation, searchable on the carrier's public website, displayed in a manner that is easily accessible, without barriers, and that ensures that the information is accessible to the general public, including that it is findable through public search engines. The carrier's public website must be accessible free of charge, without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information.

Section 5 Disclosure Requirements

A. When a covered person has incurred a claim for emergency or non-emergency health care services from an out-of-network provider, and the claim is subject to the requirements of §§ 10-16- 704(3) or 10-16-704(5.5), C.R.S., the carrier shall provide the disclosure contained in Appendix A as a separate document with any explanation of benefits form (EOB) that is provided to the covered person related to the payment and/or denial of an incurred claim subject to this regulation.

B. The disclosure contained in Appendix A of this regulation shall be made publicly available on a carrier's website in a clear and conspicuous manner.

C. Carriers shall make the disclosure contained in Appendix A available in Spanish and available in languages other than English upon request to the carrier.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective November 30, 2022.

Section 9 History

Emergency regulation effective December 20, 2019.
Regulation effective April 15, 2020.
Regulation effective November 30, 2022.

Appendix A: Emergency and Non-emergency Services Disclosure

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, please contact your insurance company at the number on your ID card, or the Division of Insurance at 303-894-7490, 1-800-930-3745, or DORA_Insurance@state.co.us.

Visit the CMS No Surprises Act website for more information about your rights under federal law.

Visit DOI Out-of-Network website for more information about your rights under Colorado state law.

Ambulance Information: Balance billing claims related to services provided by air ambulances are governed by federal law. Services provided by ground ambulances are regulated by Colorado state law and do not allow private companies to balance bill. However, you may be balance billed for emergency services you receive if the ambulance service provider is a publicly funded fire agency or if the ambulance services are for a non-emergency, such as ambulance transport between hospitals, that is not a post-stabilization service.

Regulation 4-2-68 CONCERNING PRESCRIPTION INSULIN DRUG COST SHARING AND LIMITATIONS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, and 10-16-151(5), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the conditions under which health coverage plans implement the requirements found at § 10-16-151, C.R.S.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing health coverage plans that provide coverage for prescription insulin drugs in the State of Colorado issued or renewed on or after January 1, 2020. This regulation applies to Health Saving Account-qualified (HSA-qualified) high deductible health plans, but it does not apply to catastrophic plans or grandfathered health benefit plans.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Catastrophic plan” shall have the same meaning as found at § 10-16-102(10), C.R.S.

C. “Grandfathered health benefit plan” shall have the same meaning as found at § 10-16-102(31), C.R.S.

D. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

E. “Health coverage plan” shall have the same meaning as found at § 10-16-102(34), C.R.S.

Section 5 Cost-Sharing Requirements and Limitations

A. Carriers that provide coverage for prescription insulin drugs shall cap the total amount that an individual is required to pay for all covered prescription insulin drugs at an amount not to exceed $100 for the individual’s entire thirty (30) day supply, regardless of the amount or type of insulin needed to fill the covered person’s prescription or the number of insulin prescriptions.

B. Carriers may reduce prescription insulin drug cost-sharing to an amount less than $100 per thirty (30) day supply.

C. Carriers may charge an individual up to $300 for a ninety (90) day supply of all of their prescription insulin. Carriers shall not charge any additional copayments, deductibles or coinsurance for an additional fill of those same prescriptions in that ninety (90) day period if the fill is to ensure the covered person has sufficient insulin available until the next ninety (90) day period begins.

D. Pursuant to IRS Notice 2019-45, HSA-qualified high deductible health plans are permitted to provide benefits for insulin without a deductible; therefore, they shall comply with the requirements of this section and § 10-16-151, C.R.S.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Incorporated Materials

IRS Notice 2019-45 published by Internal Revenue Service shall mean IRS Notice 2019-45 as published on the effective date of this regulation and does not include later amendments to or editions of IRS Notice 2019-45. A copy of IRS Notice 2019-45 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202, or by visiting the Internal Revenue Service website at https://www.irs.gov/pub/irs-drop/n-19-45.pdf. Certified copies of IRS Notice 2019-45, published by the Internal Revenue Service are available from the Colorado Division of Insurance for a fee.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective March 17, 2023.

Section 10 History

Emergency regulation effective December 23, 2019.
Regulation effective April 15, 2020.
Amended regulation effective March 17, 2023.

Regulation 4-2-69 [Repealed eff. 10/01/2020]

Regulation 4-2-71 CONCERNING CARRIER CARE MANAGEMENT PROTOCOLS FOR THE COLORADO REINSURANCE PROGRAM

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, and 10-16-1105(5), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to amend the carrier submission requirements for the Reinsurance Program Care Management Protocols, pursuant to § 10-16-1105(5), C.R.S. Care Management Protocols are intended to promote more cost-effective health care and to be fair to federal taxpayers by restraining growth in federal health care spending commitments. Eligible Carriers are required to submit Care Management Protocols to confirm their strategies for managing claims within the Colorado Reinsurance Program Payment Parameters.

Section 3 Applicability

This regulation applies to all eligible carriers that participate in the Colorado Reinsurance Program pursuant to Title 10, article 16, part 11.

Section 4 Definitions

A. “Attachment Point” shall have the same meaning as found at § 10-16-1103(1), C.R.S.

B. “Benefit Year” shall have the same meaning as found at § 10-16-1103(2), C.R.S.

C. “Care Protocols” means the strategy an Eligible Carrier implements to manage claims within the Reinsurance Payment Parameters and promote more cost-effective health care, pursuant to § 10-16-1105(5), C.R.S.

D. “Eligible Carrier” shall have the same meaning as found at § 10-16-1103(5), C.R.S.

E. “Health Care Provider” means a hospital, physician group, or other medical provider entity licensed or certified by the Department of Public Health and environment pursuant to § 25-1.5-103.

F. “Payment Parameters” shall have the same meaning as found at § 10-16-1103(9), C.R.S.

G. “Reinsurance Program” shall have the same meaning as found at § 10-16-1103(12), C.R.S.

H. “SERFF” means the System for Electronic Rates and Forms Filing.

Section 5 Care Management Protocol Requirements

A. Eligible Carriers must develop and implement Care Management Protocols that promote cost-effective care and manage claims costs for enrollees whose claims are expected to exceed the Reinsurance Program Attachment Point. The Division of Insurance (Division) publishes the Reinsurance Program Payment Parameters, including the Attachment Point, on or before March 15th annually for the following program year.

B. Beginning in 2020, Eligible Carriers shall file the Reinsurance Care Management Protocol Assessment (available in SERFF) for the applicable benefit year with their annual rate filings, submitted to the Division per the requirements of § 10-16-107, C.R.S. Care Management Protocols describe Eligible Carriers' strategies for managing high-cost claims and providing effective care management for members whose claims costs are expected to exceed the Reinsurance Program Attachment Point.

1. Eligible Carriers must use the Reinsurance Care Management Protocol Assessment form (available in SERFF) to submit information to the Division to fulfill this requirement.

2. Eligible Carriers must identify enrollees whose claims are expected to fall within the Payment Parameters.

    a. Carriers must identify reinsurance-eligible individuals prospectively, when possible, based on claims history.

    b. In cases where prospective identification of reinsurance-eligible individuals is not possible (e.g. new enrollee with no claims history, or unexpected claims costs due to emergency care), carriers must have care management strategies in place with contracted providers to implement as needed for enrollees whose claims become reinsurance-eligible.

    c. Carriers must describe any efforts to include social determinants of health in their member risk stratification models, as well as any other efforts to address health equity issues among reinsurance-eligible members through Care Management Protocols.

3. Eligible Carriers must implement strategies with contracted providers to manage care costs and utilization for enrollees whose claims are expected to fall within the Payment Parameters.

    a. Carriers must describe the care management services and activities they require contracted providers or other entities to perform for the impacted enrollee population.

    b. Carriers must describe how they track care management services and activities performed by contracted providers or other entities.

    c. Carriers must note any significant differences in care management strategies or services performed by geographic region.

4. Eligible Carriers must describe any payments made to contracted providers or other entities for the provision of care management services and activities.

5. Eligible Carriers must estimate the annual savings to the Colorado Reinsurance Program they expect to generate through their Care Management Protocols. “Savings” are generally defined as the difference between a carrier’s estimated total reinsurance payment amount with Care Management Protocols implemented and the estimated reinsurance payment amount without them.

6. Eligible Carriers must include in their submission of the Reinsurance Care Management Protocol Assessment any contracts (e.g. participation agreements, provider agreements, etc.), actuarial analysis or data, and other documentation that support the Eligible Carriers’ responses to the Assessment.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This amended regulation shall be effective June 15, 2021.

Section 9 History

New regulation effective August 15, 2020.
Amended regulation effective June 15, 2021.

Regulation 4-2-72 CONCERNING STRATEGIES TO ENHANCE HEALTH INSURANCE AFFORDABILITY

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-107(3.5), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of the regulation is to establish standards for health insurance carriers to enhance the affordability of their products by implementing payment system reforms. These reforms reduce overall health care costs by increasing utilization of primary and preventive care and value-based alternative payment models. The regulation establishes requirements for carrier investments in primary care, per the requirements of HB19-1233, and targets for carrier total medical expenditures in alternative payment models.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing non-grandfathered individual, small group, and/or large group health benefit plans with over 10,000 covered lives in Colorado on or after the effective date of this regulation. This regulation excludes individual short-term health insurance policies, as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. “Advanced primary care model” means, for the purposes of this regulation, primary care delivery models that build core competencies around whole person care and incorporate any of the elements identified in Colorado’s Primary Care Payment Reform Collaborative Recommendations First Annual Report.

B. “Alternative payment model” or “APM” means, for the purposes of this regulation, health care payment methods that use financial incentives to promote greater value – including higher quality care at lower costs – for patients, purchasers, and providers. Unlike traditional fee for service payments, APMs utilize cost and quality control strategies that benefit consumers by increasing the value of care delivered and, ultimately, the affordability of care.

C. "APM framework" means, for the purposes of this regulation, the AMP Framework published by the Health Care Payment Learning and Action Network.

D. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

E. "Fee For Service" or "FFS" payment means, for the purposes of this regulation, the payment of a set amount per health care service, and payment based solely on the number of services provided or procedures rendered.

F. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

G. "Health Care Payment Learning and Action Network" or "LAN" means, for the purposes of this regulation, the national group of public and private health care leaders organized by the Department of Health and Human Services and dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate the adoption of alternative payment models in United States health care.

H. "Plan" means, for the purposes of this regulation, the pairing of the health insurance coverage benefits under the product with a particular cost sharing structure, provider network, and service area.

I. "Primary care" means, for the purposes of this regulation, the provision of integrated, equitable, and accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

J. "Primary care provider" means, for the purposes of this regulation, the provider taxonomies identified in Appendix A, when the provider is practicing general primary care in an outpatient setting.

K. "Prospective payment" means, for the purposes of this regulation, payments that are made in advance of service delivery.

L. "Rate filing" means, for the purposes of this regulation, a carrier's electronic submission to the Division in accordance with Colorado Insurance Regulation 4-2-39.

M. "Total medical expenditures" means, for the purposes of this regulation, payments to reimburse the cost of physical and behavioral health care provided to enrollees, excluding prescription drugs, vision care and dental care, whether paid on a fee for service basis or as part of an alternative payment model.

Section 5 General Requirements

A. The standards to enhance affordability of health benefit plans are as follows:

1. Requirements for carrier investments in primary care.

a. Carriers shall increase the proportion of total medical expenditures in Colorado allocated to primary care by one (1) percentage point annually in calendar years 2022 and 2023, compared to each carrier's baseline primary care spending.

i. A carrier's baseline for primary care spending will be the proportion of total medical expenditures allocated to primary care for the calendar year 2021.

ii. The one percentage point annual increase will be calculated by comparing the percent of a carrier's total medical expenditures allocated to primary care in 2022 and 2023 to the carrier's 2021 baseline.

b. Of a carrier's total primary care expenditures, carriers should target twenty-five (25) percent of the expenditure to be made through prospective payments by the end of calendar year 2023.

2. Targets for carrier total medical expenditures made through APMs.

a. Carriers should target fifty (50) percent of a carrier's total medical expenditures in Colorado to be made through APMs by the end of calendar year 2022.

b. Of a carrier's total APM expenditures, carriers should target ten (10) percent of the expenditure to occur through prospective payments by the end of calendar year 2022.

Section 6 Primary Care Requirements

A. Primary care investment requirements.

1. The proportion of a carrier's total medical expenditures allocated to primary care for the 2022 calendar year shall be one (1) percentage point higher than the proportion of a carrier's total medical expenditures allocated to primary care for the baseline period.

2. The proportion of a carrier's total medical expenditures allocated to primary care shall increase by one (1) additional percentage point for the 2023 calendar year, compared to the baseline period (i.e. in 2023 primary care spending will increase by two (2) percentage points from the baseline).

3. Carriers shall not translate increased primary care spending into higher premiums, and should adopt strategies that improve value and quality of care without increasing total medical expenditures.

B. Primary care expenditure reporting requirements.

1. Carriers must submit a Primary Care Implementation Plan, which describes the carrier's strategies for increasing the percentage of total medical expenditures allocated to primary care in the 2021 plan year, to the Division no later than February 1, 2021.

2. Carriers must use the template in Appendix B to complete and submit the Primary Care Implementation Plan.

3. Starting with the 2022 plan year, carriers must submit the Primary Care Implementation Plan as part of the annual rate filing.

C. Primary care expenditure calculations.

1. Carriers shall submit data on an annual basis for primary care and total medical expenditures made through paid claim amounts and non-claims payments to the Colorado All-Payer Claims Database (APCD), in the manner and timeline prescribed by the Colorado Department of Health Care Policy and Financing (HCPF), pursuant to HCPF Regulation 1.200.

2. The Division will determine whether a carrier has met the required one percentage point increase in the proportion of total medical expenditures allocated to primary care in 2022 and 2023 by comparing the carrier's primary care expenditure percentage reported in the current calendar year with that reported in the baseline year (2021).

3. Targets established under this section do not apply in the case of a nonprofit, nongovernmental health maintenance organization with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group.

Section 7 Alternative Payment Model Targets

A. APM expenditure targets.

1. Carriers should target fifty (50) percent of a carrier's total medical expenditures in Colorado to be made through APMs by the end of calendar year 2022.

2. Fully integrated payment and delivery systems shall be considered to meet the APM minimum standards in this section, provided the integrated system of care is contractually obligated to use a value-based payment model.

3. Carriers should target ten (10) percent of the APM spend to be paid through prospective payments by the end of 2022 with a focus on primary care.

B. APM expenditure reporting requirements.

1. Carriers must submit an APM Implementation Plan, which describes the carrier's strategy for APM adoption in the 2021 plan year, to the Division no later than February 1, 2021.

2. Carriers must use the template in Appendix C to complete and submit the APM Implementation Plan.

3. Starting with the 2022 plan year, carriers must provide the APM Implementation Plan as part of the annual rate filing.

C. APM expenditure calculations.

1. Carriers shall submit data for primary care and total medical expenditures made through FFS and APM payment arrangements on an annual basis to the Colorado APCD, in the manner and timeline prescribed by HCPF, pursuant to HCPF Regulation 1.200.

2. The Division will determine whether a carrier has met the target for medical expenditures made through APMs by evaluating the carrier's percentage of total medical expenditures made through APMs at the end of calendar year 2022.

D. The Commissioner requests the Primary Care Payment Reform Collaborative continue to formulate recommendations to increase the use of APMs by both providers and insurers.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 9 Incorporated Materials

"Colorado's Primary Care Payment Reform Collaborative Recommendations First Annual Report" shall mean the "Colorado's Primary Care Payment Reform Collaborative Recommendations First Annual Report" published by the Primary Care Payment Reform Collaborative on December 15, 2019 and does not include later amendments or editions of the report. A copy of "Colorado's Primary Care Payment Reform Collaborative Recommendations First Annual Report" can be found at the following link: https://www.colorado.gov/pacific/dora/primary-care-payment-reform-collaborative and may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of "Colorado's Primary Care Payment Reform Collaborative Recommendations First Annual Report" may be requested from the Division of Insurance. A charge for certification or copies may apply.

HCPF Regulation 1.200 shall mean Regulation 1.200, found at 10 CCR 2505-5, as published on the effective date of this regulation and does not include later amendments to or editions of Regulation 1.200, found at 10 CCR 2505-5. A copy of Regulation 1.200, found at 10 CCR 2505-5, may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of Regulation 1.200, found at 10 CCR 2505-5, may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A charge for certification or copies may apply. A copy may also be obtained online at https://www.sos.state.co.us/CCR/Welcome.do.

"The APM Framework" shall mean "The APM Framework" as published by LAN on the effective date of this regulation and does not include later amendments to or editions of the "The APM Framework". A copy of the "The APM Framework" can be found at the following link: http://hcplan.org/workproducts/apmframeworkonepager.pdf and may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the "The APM Framework" may be requested from the Division of Insurance. A charge for certification or copies may apply.

Section 10 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 11 Effective Date

This regulation shall be effective January 15, 2021.

Section 12 History

New regulation effective January 15, 2021.

Appendix A: Primary Care Provider Taxonomies

1. Family medicine physicians in an outpatient setting when practicing general primary care;

2. General pediatric physicians and adolescent medicine physicians in an outpatient setting when practicing general primary care;

3. Geriatric medicine physicians in an outpatient setting when practicing general primary care;

4. Internal medicine physicians in an outpatient setting when practicing general primary care (excludes internists who specialize in areas such as cardiology, oncology, and other common internal medicine specialties beyond the scope of general primary care);

5. OB-GYN physicians in an outpatient setting when practicing general primary care;

6. Providers such as nurse practitioners and physicians' assistants in an outpatient setting when practicing general primary care; or and

7. Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting.

Appendix B: Primary Care Implementation Plan

Section 1: Primary care investment strategies

In a written narrative of no more than three (3) pages, please provide the following:

a. A description of how the carrier intends to increase primary care expenditures, and engage patients and providers in affordability initiatives;

b. A description of how increased primary care expenditures, including prospective payments, will support primary care providers' adoption of advanced primary care models or otherwise improve the state's primary care infrastructure; and

c. A description of how increased primary care expenditures will reduce health disparities and promote health equity.

Section 2: Primary care expenditure budget

Primary care expenditures, for the purposes of this regulation, include but are not limited to:

a. Claims-based payments to primary care providers for primary care services, made through FFS or APMs; and

b. Non-claims-based payments, made through FFS, APMs, or incentive payments to support activities and initiatives including:

i. Practice transformation efforts and other activities to support the adoption of advanced primary care models by primary care providers and/or primary care practices;

ii. Workforce development incentives, to increase the supply and retention of primary care providers;

iii. Quality improvement initiatives;

iv. Infrastructure and other structural investments supporting the development of advanced primary care delivery; and

v. Payments for care management services, including the care management protocols established pursuant to § 10-16-1105(5), C.R.S.

Colorado Primary Care Expenditures			
	(Proposed for following calendar year, as applicable)		
Category/Activity	**2021**	**2022**	**2023**
Number of primary care visits			
Fee-for-Service Payments:			
Increase in E&M codes			
Other (please specify all):			
TOTAL			

Other Expenditures:			
Practice transformation			
Workforce development initiatives			
Quality improvement initiatives			
Infrastructure, including health information technology			
Care management services, including care management protocols			
Other (please specify all):			
TOTAL			

Appendix C: Alternative Payment Model (APM) Implementation Plan

Section 1: APM expenditure strategies

In a written narrative of no more than three (3) pages, please describe the following:

a. Which APM approaches the carrier intends to implement during the following year, using the categories found in the APM Framework. Plans should include payment model names (if available), estimated number of covered lives included in each APM category, and a brief description of the APM.

b. Which market(s) and line(s) of business will implement each APM and in what timeframe.

c. Financial and quality measurement goals of each APM, in total across all plans and lines of business.

d. How the carrier's APM adoption strategy supports and aligns with statewide goals around health care spending and other payers' APM adoption strategies, including Medicare and Medicaid.

e. Impact of a carrier's APM(s) on patients, including: how the APM achieves health equity; impact of the APM on patient experience, patient outcomes, and patient spending.

f. A contingency plan in the event that provider organizations with whom they contract for APM implementation are unable to manage their responsibilities related to APM contracts or are unwilling to enter into APM contracts.

Section 2: APM expenditure worksheet

Complete the following chart by entering the dollar amount and percent of your annual total medical spending that is expected to occur in each category from the APM Framework during the following year.

LAN APM Category	**Total Spend ($, %)**
Category 1: Fee For Service (FFS) – No Link to Quality & Value	**Total Category 1:**
Category 2: Fee For Service (FFS) – Link to Quality & Value	**Total Category 2:**
Foundational payments to improve care (2A)	
FFS plus pay-for-reporting payments (2B)	
FFS plus pay-for-performance payments (2C)	
Category 3: APMs Built on Fee For Service (FFS) Architecture	**Total Cat 3:**
Traditional shared savings; utilization-based shared savings (3A)	
FFS-based shared risk; procedure-based bundled or episode payments (3B)	

Category 4: Population-Based Payment	**Total Cat 4:**
Condition-specific population-based payment; condition-specific bundled or episode payments (4A)	
Comprehensive population-based payments that are not condition-specific; full or percent of premium population-based payments (4B)	
Integrated finance and delivery system programs (4C)	
Categories 2, 3, and 4, combined	**Total Cats 2,3,4:**

Regulation 4-2-73 CONCERNING HUMAN IMMUNODEFICIENCY VIRUS PRE-EXPOSURE PROPHYLAXIS PRESCRIPTION DRUGS AND BASELINE AND MONITORING SERVICES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-104(18)(b)(X), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements for individual and group health benefit plans to provide coverage for human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) as well as baseline and monitoring services in accordance with Article 16 of Title 10 of the Colorado Revised Statutes, and the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the "Affordable Care Act" (ACA).

Section 3 Applicability

This regulation applies to all carriers marketing and issuing individual and group health benefit plans subject to the individual and group laws of Colorado on or after the effective date of this regulation. This regulation does not apply to grandfathered health benefit plans or short-term limited duration insurance policies.

Section 4 Definitions

A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

C. "Human immunodeficiency virus" and "HIV" mean, for the purposes of this regulation, the virus that attacks the immune system that can lead to acquired immunodeficiency syndrome or AIDS if not treated.

D. "Pre-exposure prophylaxis" and "PrEP" mean, for the purposes of this regulation, medication or medications intended to prevent HIV infection when an individual is exposed to HIV.

E. "Serodiscordant sex partner" means, for purposes of this regulation, having a sexual relationship with a partner who is living with HIV.

F. "United States Preventive Services Taskforce" and "USPSTF" shall have the same meaning as found at § 10-16-104(18)(c)(IV), C.R.S.

G. "Urgent prior authorization request" shall have the same meaning as found at § 10-16-124.5(8)(b), C.R.S.

Section 5 Carrier Coverage Requirements

A. Consistent with USPSTF Recommendations, carriers must provide coverage for the federal Food and Drug Administration (FDA)-approved medication prescribed for pre-exposure prophylaxis (PrEP) without copayment or cost-sharing for individuals who, according to their provider or pharmacist pursuant to § 12-280-125.7, C.R.S., are indicated for PrEP. Carriers shall provide such coverage without copayment or cost-sharing for the PrEP medication that is clinically indicated for the individual according to the prescribing provider or pharmacist. Based on Centers for Disease Control and Prevention Guidelines, individuals indicated for PrEP include:

1. Men who have sex with men, are sexually active, and have one of the following characteristics:

   a. Having a serodiscordant sex partner;

   b. Inconsistent use of condoms during receptive or insertive anal sex; or

   c. A sexually transmitted infection (STI) with syphilis, gonorrhea, or chlamydia within the past 6 months.

2. Heterosexually active women and men who have one of the following characteristics:

   a. Having a serodiscordant sex partner;

   b. Inconsistent use of condoms during sex with a partner whose HIV status is unknown and who is at high risk (e.g., a person who injects drugs or a man who has sex with men and women); or

   c. An STI with syphilis or gonorrhea within the past 6 months.

3. Persons who inject drugs and have one of the following characteristics:

   a. Shared use of drug injection equipment; or

   b. Engage in any of the behaviors or have any of the conditions identified in Sections 5.A.1. or 5.A.2.

4. Persons who engage in transactional sex, such as sex for money, drugs, or housing, including commercial sex workers or persons trafficked for sex work.

5. Men who have sex with men and women who engage in any of the behaviors or have any of the conditions identified in Sections 5.A.1. through 5.A.4.

6. Transgender women and men who are sexually active and who engage in any of the behaviors or have any of the conditions identified in Sections 5.A.1. through 5.A.4.

B. Carriers must provide coverage for PrEP baseline and monitoring services, consistent with USPSTF recommendations, articulated in the FAQs about Affordable Care Act Implementation Part 47, without copayment or cost sharing for services obtained from participating providers when HIV PrEP medication is prescribed.

1. Baseline and monitoring services include: HIV testing; Hepatitis B and C testing; creatinine testing and calculated estimated creatinine clearance (eCrCl) or glomerular filtration rate (eGFR); pregnancy testing; sexually transmitted infection screening and counseling; and adherence counseling.

2. Office visits associated with baseline and monitoring services must also be covered without cost sharing, when the service is not billed separately from an office visits, and the primary purpose of the office visit is the delivery of the recommended preventive service.

3. Carriers cannot limit or restrict the frequency of PrEP baseline and monitoring services in a manner inconsistent with the USPSTF PrEP recommendation. Carriers also cannot limit or restrict the number of times an individual may start PrEP if the individual meets the criteria specified in the USPSTF recommendation and PrEP is deemed to be medically appropriate by the individual's health care provider.

C. No more than 50% of drugs on a carrier's formulary used for the prevention of HIV may be placed on the plan's highest cost formulary tier. This section C only applies to individual and small group health benefit plans.

D. Carriers shall not require a covered person to undergo step therapy or receive prior authorization before a pharmacist may prescribe and dispense PrEP, pursuant to § 10-16-152, C.R.S.

E. Carriers shall consider any request for PrEP from a provider, as specified in § 10-16-124.5(8)(b), C.R.S., other than from a pharmacist, to be an urgent prior authorization request, and a carrier must comply with the requirements for an urgent prior authorization request found in Colorado Insurance Regulation 4-2-49, "Concerning the development and implementation of a uniform drug benefit prior authorization process, the required drug appeals process, and the coverage of certain opioid dependence and other substance use disorder treatment drugs."

F. Carriers shall not impose additional utilization management procedures or requirements that restrict or limit access to PrEP.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Incorporated Materials

The U.S. Preventive Services Task Force A and B Recommendations as published on the effective date of this regulation and does not include later amendments or editions of the Recommendations. A copy of the Recommendations may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of the Recommendations may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A charge for certification or copies may apply. A copy may also be obtained online at:
https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis

The Centers for Disease Prevention Control and Prevention Guidelines as published on the effective date of this regulation and does not include later amendments or editions of the Guidelines. A copy of the Guidelines may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of the Guidelines may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A charge for certification or copies may apply. A copy may also be obtained online at https://www.cdc.gov/hiv/effective-interventions/prevent/prep/index.html

The FAQs about Affordable Care Act Implementation Part 47 as published on the effective date of this regulation and does not include later amendments or editions of the FAQs. A copy of the FAQs may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A certified copy of the FAQs may be requested from the Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A charge for certification or copies may apply. A copy may also be obtained online at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-47.pdf.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall be effective March 2, 2022

Section 9 History

New regulation effective January 1, 2021.
Amended regulation effective March 2, 2022

Regulation 4-2-74 [Repealed eff. 07/30/2024]

Regulation 4-2-75 CONCERNING REQUIREMENTS FOR REPORTING MEDICATION-ASSISTED TREATMENT COVERAGE

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-109, and 10-16-710 C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the data reporting requirements for carriers concerning the coverage of medication-assisted treatment as required by § 10-16-710, C.R.S.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing or renewing health benefit plans in the individual, small group and large group markets in Colorado, including non-grandfathered plans, short-term limited duration health insurance policies, and student health insurance coverage, on or after the effective date of this regulation. This regulation does not apply to limited benefit plans, as defined in § 10-16-102(32)(b), C.R.S., and exclusions for coverage of specific mandated benefits as found at § 10-16-104(1.4), C.R.S.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

C. “Medication-assisted treatment” shall have the same meaning as found at § 23-21-803(4), C.R.S

D. “Medication to treat opioid use disorder” shall mean medications to treat opioid use disorder as defined in this regulation.

E. “Opioid use disorder” shall mean a substance use disorder relating to the use of an opioid.

F. “Opioid Treatment Program” shall mean a program with current, valid certification from the Substance Abuse and Mental Health Services Administration and qualified by the Secretary of Health and Human Services under section 303(g)(1) of the Controlled Substances Act (21 U.S.C. 823(g)(1)) to dispense opioid drugs in the treatment of opioid use disorder. It must be qualified under section 303(g)(1) of the Controlled Substances Act, and must be determined to be qualified by the Attorney General under section 303(g)(1), to be registered by the Attorney General to dispense opioid agonist treatment medications to individuals for treatment of opioid use disorder.

G. "Short-term limited duration health insurance policy" and "short-term policy" shall have the same meaning as found at § 10-16-102(60), C.R.S.

H. "Student health insurance coverage" and "student health policy" shall have the same meaning as found at § 10-16-102(65), C.R.S.

I. "Substance use disorder" means, for the purposes of this regulation, the recurring use of alcohol and/or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities.

J. "Substance use disorder benefits" means, for the purposes of this regulation, the benefits supplied for items or services for substance use disorders.

Section 5 Reporting Requirements

A. Carriers shall annually report the data in Sections 5.B through 5.F to the Commissioner of Insurance using the template in Attachment A and instructions provided by the Division.

1. No later than September 1, 2021, carriers shall report all required data for medication-assisted treatment (MAT) and medication to treat opioid use disorder (MOUD) coverage provided in the 2020 calendar year.

2. On February 1, 2022, and annually thereafter, carriers shall report all required data for MAT coverage in the previous calendar year

3. Annual reports shall include data pertaining to the carrier's coverage of MAT, as well as coverage administered by third-party administrators (TPAs).

B. Carriers shall provide the following information for each network regarding in network providers that are federally licensed to prescribe MAT for substance use disorders (SUD) and opioid use disorder (OUD), including buprenorphine.

1. The number of providers by type at the beginning of the calendar year;

2. The number of providers by type at the end of the calendar year;

3. The number of SUD and opioid treatment programs (OTPs);

4. The number of providers who are authorized to prescribe methadone for the treatment of OUD;

5. The number of providers in each county; and

6. The number of providers with a federal waiver to prescribe buprenorphine for the treatment of OUD.

C. Carriers shall provide the Division with the total number of plan enrollees at the beginning and end of the plan year.

D. Carriers shall provide to the Division the total number of prescriptions filled by unique enrollees and the average number of prescriptions filled per enrollee for MAT for SUD and OUD.

E. Carriers shall provide to the Division a detailed description of its efforts to ensure sufficient capacity for and access to MAT for SUD, including the following:

1. Policies and procedures to ensure enrollee access to OTPs, including any policies and procedures to assist with transportation, telehealth services, take-home dosing, and complementary behavioral health services;

2. The methodology or other formal processes used by the carrier and TPA, if applicable, to determine network sufficiency to ensure access to MAT for SUD and OUD, and process(es) undertaken if the carrier or TPA has found insufficiencies;

3. Policies and procedures regarding prior authorization requirements for MAT for SUD and OUD, including requirements for pregnant and parenting people as well as minors;

4. Coverage and utilization management for MAT prescriptions, including differences in coverage and utilization management provisions for different FDA-approved medications for the treatment of OUD;

5. Processes to recruit and retain providers to prescribe MAT for SUD and OUD, including care received in an OTP and office-based buprenorphine, to enrollees; and

6. The evidentiary or other standards and practices used to determine eligibility of providers who prescribe MAT for SUD and OUD to join the network.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in §10-3-1108, C.R.S., may be applied.

Section 8 Effective Date

This regulation shall be effective on June 15, 2021.

Section 9 History

New regulation effective June 15, 2021.

Attachment A: Medication-Assisted Treatment (MAT) Reporting Requirements

Carriers shall use this template to submit annual reporting requirements to the Division pursuant to Colorado Insurance Regulation 4-2-75 and § 10-16-710 CRS as it applies to the carrier and third-party administrator (TPA), if applicable. When providing information regarding medication-assisted treatment (MAT) for substance use disorder (SUD) and opioid use disorder (OUD), please differentiate data between the two treatment types. Do not include OUD-specific data in SUD-specific data.

Carrier	
TPA (if applicable)	
Network	
Contact Name	
Contact Email	
Date of Submission	

1. Indicate the number of in-network providers that are federally-licensed to provide MAT for SUD and OUD at the beginning of the calendar year and at the end of the calendar year, including the type of medications available to treat opioid use disorder (MOUD).

   Beginning of Calendar Year

Provider Type	**SUD**	**OUD**	**MOUD**
Physician, MD or DO			
Nurse Practitioner			
Physician Assistant			
Clinical Nurse Specialist			
Certified Registered Nurse Anesthetist			
Certified Nurse-Midwife			
Other			

   End of Calendar Year

Provider Type	**SUD**	**OUD**	**MOUD**
Physician, MD or DO			
Nurse Practitioner			
Physician Assistant			
Clinical Nurse Specialist			
Certified Registered Nurse Anesthetist			
Certified Nurse-Midwife			
Other			

2. Provide the number of SUD and opioid treatment programs in the network, as well as the type of MOUD.

Type of Program	Number	Type(s) of MOUD
SUD treatment program		
Opioid treatment program		

3. Provide the number of providers treating SUD & OUD in each county at the end of the calendar year.

County	SUD	OUD	County	SUD	OUD
Adams			Kit Carson		
Alamosa			La Plata		
Arapahoe			Lake		
Archuleta			Larimer		
Baca			Las Animas		
Bent			Lincoln		
Boulder			Logan		
Broomfield			Mesa		
Chaffee			Mineral		
Cheyenne			Moffat		
Clear Creek			Montezuma		
Conejos			Montrose		
Costilla			Morgan		
Crowley			Otero		
Custer			Ouray		
Delta			Park		
Denver			Phillips		
Dolores			Pitkin		
Douglas			Prowers		
Eagle			Pueblo		
El Paso			Rio Blanco		
Elbert			Rio Grande		
Fremont			Routt		
Garfield			Saguache		
Gilpin			San Juan		
Grand			San Miguel		
Gunnison			Sedgwick		
Hinsdale			Summit		
Huerfano			Teller		
Jackson			Washington		
Jefferson			Weld		
Kiowa			Yuma		

4. Provide the number of providers who are authorized to prescribe methadone for the treatment of OUD at the beginning and end of the calendar year in the network.

Time Period	Providers
Beginning of Calendar Year	
End of Calendar Year	

5. Describe the policies in place and strategies utilized to ensure enrollee access to OTPs, including any policies and procedures to assist with transportation, telehealth services, take-home dosing, and complementary behavioral health services.

6. Provide the number of unique enrollees at the beginning of the calendar year and end of the calendar year using SUD and OUD services.

Time Period	Enrollees
Beginning of Calendar Year	
End of Calendar Year	

7. Provide the number of unique patients being seen for MAT for SUD, OUD, and MOUD.

Provider Type	Number of Patients - SUD	Number of Patients - OUD	Number of Patients Receiving MOUD
Physician, MD or DO			
Nurse Practitioner			
Physician Assistant			
Clinical Nurse Specialist			
Certified Registered Nurse Anesthetist			
Certified Nurse-Midwife			
Other			

8. Provide the total number of prescriptions that were filled by unique enrollees for MAT for SUD and OUD in the calendar year.

Condition Type	Total Prescriptions filled by Unique Enrollees
SUD	
OUD	

9. Provide a 'yes' or 'no' response following questions regarding MAT for SUD

◯ Yes ◯ No	Is prior authorization, step therapy, or other utilization management policies required for any FDA-approved medications used as part of the treatment of SUD?
◯ Yes ◯ No	Is prior authorization, step therapy, or other utilization management policies required for any FDA-approved medications used as part of MAT for OUD?
◯ Yes ◯ No	Does the formulary use place any of the medications used for OUD, SUD, alcohol use disorder, or nicotine dependence on the lowest-cost tier of the formulary?
◯ Yes ◯ No	Does the formulary contain all FDA-approved medications for the treatment of OUD, SUD, alcohol use disorder, and nicotine dependence?
◯ Yes ◯ No	Is Naloxone covered? Please list all formulations that are covered below.
◯ Yes ◯ No	Is Buprenorphine covered? Please list all formulations that are covered below.
◯ Yes ◯ No	Is Methadone covered?
◯ Yes ◯ No	Is Naltrexone covered?
◯ Yes ◯ No	Is Disulfiram covered?
◯ Yes ◯ No	Is Acamprosate covered?
◯ Yes ◯ No	Is Clonidine covered?

Naloxone formulations:

Buprenorphine formulations:

10. If prior authorization is required for MAT for SUD or OUD, provide an overview of the carrier's or TPA's policies and procedures regarding requiring prior authorization, including the appeals process when a medication is denied. This should include, at a minimum, the education and professional qualifications of the reviewer who is responsible for making the determinations at each level of the appeals process.

11. Provide an overview of any other utilization management protocols in place for each covered medication, including differences in utilization management provisions for different FDA-approved medications for the treatment of OUD.

12. Provide a detailed description of the carrier's and TPA's, if applicable, processes to recruit and retain providers that prescribe MAT for SUD and OUD, including both care received in an OTP and office-based buprenorphine and methadone, to enrollees.

13. Provide a detailed description of the methodology or other formal processes used by the carrier and TPA, if applicable, to determine network sufficiency to ensure access to MAT for SUD and OUD and process(es) undertaken if the carrier or TPA has found insufficiencies;

14. Provide a detailed description of the evidentiary or other standards and practices used to determine eligibility of providers that are federally licensed to prescribe MAT for SUD and OUD to join the network.

Regulation 4-2-76 CONCERNING THE HEALTH INSURANCE AFFORDABILITY FEE ASSESSMENT AND COLLECTION PROCESS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109, 10-16-109, 10-16-1205(1)(a)(I), and 10-16-1207(5), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the process by which the Health Insurance Affordability Enterprise will assess and collect the Health Insurance Affordability Fee annually from carriers, pursuant to § 10-16-1205(1)(a)(I), C.R.S. This regulation replaces Emergency Regulation 21-E-01 in its entirety.

Section 3 Applicability

This regulation applies to all carriers that issue health benefit plans in the state, including all carriers offering individual, small group, and large group plans subject to the insurance laws of Colorado.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Enterprise” shall have the same meaning as found at § 10-16-1203(3), C.R.S.

C. “Fee” shall have the same meaning as found at § 10-16-1203(5), C.R.S.

D. “Health Benefit Plan” shall have the same meaning as found at § 10-16-102(32)(a), C.R.S.

Section 5 Health Insurance Affordability Fee Assessment and Collection Requirements

A. Starting in 2021, all carriers issuing health benefit plans in the state shall report to the Division of Insurance (Division) by March 1 of each year the amount they owe for the Health Insurance Affordability Fee. Carriers shall report the Fee amount through the same electronic filing method they use to report annual premium tax and fee filings required by §§ 10-3-209, 10-6-128, and 10 5 110, C.R.S. Carriers will use either the Colorado Division of Insurance Online Premium Tax System or Colorado Division of Insurance Surplus Lines Tax System to report Fee amounts owed. Starting in 2021, Health Maintenance Organizations will also report and pay all fees through the Colorado Division of Insurance Online Premium Tax System.

1. The Fee amount for nonprofit carriers is 1.15 percent of gross premiums collected in the immediately preceding calendar year on all health benefit plans issued in the state.

2. The Fee amount for for-profit carriers is 2.10 percent of gross premiums collected in the immediately preceding calendar year on all health benefit plans issued in the state.

B. Starting in 2021, all carriers issuing health benefit plans in the state shall submit payments to the Division by June 15 of each year for the total amount owed for the Health Insurance Affordability Fee based on the premiums collected for the previous calendar year. Carriers shall use the same payment transaction and processing method they use for submitting annual premium tax and fee payments. The Health Insurance Affordability Fee can be paid prior to March 1, at the same time premium taxes and fees are paid. All premium taxes and fees, including the Health Insurance Affordability Fee, must be paid through the premium tax system.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall be effective June 15, 2021.

Section 9 History

Emergency Regulation 21-E-01, effective February 5, 2021.
Regulation effective June 15, 2021.

Regulation 4-2-77 CONCERNING PAYMENTS TO CARRIERS FOR THE COLORADO REINSURANCE PROGRAM

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-16-1104(1)(i), 10-16-1105(1)(d); 10-16-1105(1)(e); 10-16-1105(3)(c); and 10-16-1105(4)(d), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the process and timeline by which the Division of Insurance will notify carriers and disburse reinsurance payments to carriers for the applicable benefit year.

Section 3 Applicability

This regulation applies to all eligible carriers that participate in the Colorado Reinsurance Program pursuant to Title 10, article 16, part 11.

Section 4 Definitions

A. “Actuarial Completion Factor” shall mean the percent of estimated ultimate claims for a given benefit year that have been paid.

B. “Benefit Year” shall have the same meaning as found at § 10-16-1103(2), C.R.S.

C. “Eligible Carrier” shall have the same meaning as found at § 10-16-1103(5), C.R.S.

D. “Payment Parameters” shall have the same meaning as found at § 10-16-1103(9), C.R.S.

E. “Reinsurance Program” shall have the same meaning as found at § 10-16-1103(12), C.R.S.

Section 5 Reinsurance Payment Process to Carriers

A. The Division of Insurance (Division) shall notify eligible carriers by email of reinsurance payment amounts that will be distributed for the applicable benefit year by June 30 of the year following the applicable benefit year.

1. The Division shall use the Centers for Medicare and Medicaid (CMS) External Data Gathering Environment (EDGE) Server to calculate reinsurance payments due to each eligible carrier. The Division will only use paid claims data that have been submitted and accepted to the CMS EDGE database for reinsurance payment calculations.

a. Payment amounts are based on the reinsurance payment parameters for the applicable benefit year.b. Eligible carriers must have submitted all claims for the applicable benefit

year to the EDGE server by April 30 of the year following the applicable benefit year in order for claims to be included in the reinsurance payment calculation.

B. Starting in December of 2021 and November of each year thereafter, each time CMS runs a preliminary State Reinsurance (SRI) report using EDGE data, all eligible carriers must submit to the Division or the Division's designated representative a single actuarial completion factor for claims submitted to EDGE that are within the reinsurance payment parameters as of the day CMS runs the report. For example, if a preliminary SRI report is dated January 25, and as of then the carrier has submitted claims to EDGE incurred and paid through November 30, the actuarial completion factor should be developed starting from November 30.

1. The factor should estimate, after applied to total submitted EDGE claims within the reinsurance payment parameters, the ultimate amount of claims within the reinsurance payment parameters for the benefit year. The estimate should be developed so that the carrier's best estimate of ultimate claims subject to reinsurance represents the claims that would apply to the Colorado Reinsurance Program.

2. For carriers with capitation arrangements or special care-delivery arrangements, these arrangements must be taken into account when developing the completion factor.

C. Consistent with section 10-16-1105(4)(d), C.R.S., carriers must notify the Division in writing within thirty (30) days of notification of the reinsurance payment amount if they wish for the Division to reconsider their reinsurance payment amount.

1. Requests for reconsideration must clearly state all of the grounds on which the carrier’s request is based, and should include evidence and other materials as necessary to support the request. No late filings, including any supplemental evidence or materials, will be accepted after the deadline.

2. The Division will respond in writing to a request for reconsideration within ten (10) days of the request deadline, and will notify carriers of any changes to their reinsurance payment amounts as soon as practicable thereafter.

3. Requests for reconsideration based on claims data outside of EDGE will not be considered by the Division.

D. The Colorado Department of Regulatory Agencies (DORA) shall disburse electronic funds transfer (EFT) payments to all carriers for the reinsurance payment amounts by August 15 of the year following the applicable benefit year.

1. Carriers must have submitted a W9 and have a current account set up in the Colorado Operations Resource Engine (CORE) to receive reinsurance payments.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall be effective December 1, 2021.

Section 9 History

New regulation effective June 15, 2021
Amended regulation effective December 1, 2021.

Regulation 4-2-78 CONCERNING COST SHARING REDUCTION ENHANCEMENTS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-1207(5), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide standards for including payments to carriers pursuant to C.R.S. § 10-16-1205(1)(b)(II) in health benefit plans regulated by the Colorado Division of Insurance.

Section 3 Applicability

This regulation applies to all carriers issuing non-grandfathered individual health benefit plans starting in benefit year 2025 and annually thereafter.

Section 4 Definitions

A. “87% Cost Sharing Reduction Enhancement” or “87% CSR Enhancement” means, for the purpose of this regulation, an increase in silver plans’ actuarial value from 87% to 94% for eligible enrollees.

B. “Actuarial value” and “AV” means, for the purpose of this regulation, the percentage of total average costs for covered benefits that a health benefit plan will cover, with calculations based on the provision of essential health benefits to a standard population.

C. “Benefit year” shall have the same meaning as found at § 10-16-1103(2), C.R.S.

D. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

E. “Cost Sharing Reduction Enhancement” or “CSR Enhancement” means, for the purpose of this regulation, an increase in silver plans’ actuarial value from 87% to 94% for eligible enrollees.

F. “CSR Load” means, for the purpose of this regulation, the load in the silver plan premiums necessary to cover the cost of providing cost-sharing reductions in the on-exchange silver health benefit plans.

G. “CSR variant” means, for purposes of this regulation, a cost-sharing reduction plan variation defined in 45 C.F.R. § 156.420(a).

H. "Eligible enrollee" means, for the purpose of this regulation, an individual enrolled in a CSR variant plan whose household income is from 150% to 200% of the Federal Poverty Level.

I. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

J. "Federal Actuarial Value Calculator" or "Federal AV Calculator" means, for the purpose of this regulation, the AV Calculator required pursuant to 45 C.F.R. § 156.135(a).

K. "Federal Poverty Level" or "Federal Poverty Line" shall have the same meaning as found at § 10-16-1203(4), C.R.S.

L. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

M. "Induced Demand Factor" shall mean the anticipated induced demand associated with the plan's cost sharing (metal) level.

N. "Metal AV Adjustment Factor" means, for the purpose of this regulation, the differences in Metal AV values as produced by the Federal AV Calculator, and the actuarial values used by carriers in pricing.

O. "Plans and Benefits Template" or "PBT" means, for the purpose of this regulation, the Plans & Benefits Template created by the Centers for Medicare & Medicaid Services.

P. "Rate" means, for the purpose of this regulation, the value in the carrier's Rates Table Template available in SERFF corresponding to the enrollee's age, geographic rating area, and tobacco status.

Q. "Rate filing" means, for the purpose of this regulation, a carrier's electronic submission to the Division in accordance with Colorado Insurance Regulation 4-2-39.

R. "Rates Table Template" means, for the purposes of this regulation, the Rates Tables Template created by the Centers for Medicare and Medicaid Services.

S. "Standard silver plan" shall have the same meaning as found at § 10-16-103.4(2)(b), C.R.S.

T. "URRT" means, for the purpose of this regulation, the Unified Rate Review Template created by the Centers for Medicare & Medicaid Services.

Section 5 Requirements for CSR Variant Plans

For the 2025 benefit year, and annually thereafter, carriers shall offer a CSR enhancement to all eligible enrollees in silver metal level health benefit plans.

A. On the PBT, carriers shall file silver plans with CSR variants, according to current, standard practice.

B. The on-exchange silver plans included in the URRT, and any other template in the carrier's rate filing, shall reflect expected changes in enrollment and induced demand based on the increased uptake of the 94% AV plan variant as a result of the CSR Enhancement.

Section 6 87% CSR Enhancement Payments to Carriers

A. Pursuant to C.R.S. § 10-16-1205(1)(b)(II), the Colorado Health Insurance Affordability Enterprise created in C.R.S. § 10-16-1204(1)(a), through the Division, will make payments to carriers by June 30, 2026 for the 2025 benefit year, and by June 30 of subsequent calendar years, to compensate for the difference between the 94% AV plan variant projected claims costs the carrier paid during the benefit year because of the CSR enhancement, and the 87% AV plan variant projected claims costs the carriers would have paid absent the CSR enhancement for the previous benefit year. Pursuant to Section 5.B., payments to carriers will not reflect expected changes in induced demand based on the 94% AV plan variant as compared with the 87% AV plan variant.

B. The Division will calculate carrier payment amounts by determining the difference between what the carrier expects to pay in standard silver claims costs for plans with a 94% AV and the standard claims costs for plans with an 87% AV, using the following methodology.

1. A Silver Plan Claims Cost for a standard silver plan will be calculated as follows:

Rate X Incurred Claims as a Percent of Premium / CSR Load

a. The Incurred Claims as a Percent of Premium will be calculated as the URRT Worksheet 2, Total, line 4.15 divided by URRT Worksheet 2, Total, Line 4.17.

b. The CSR Load will be determined from the information provided in the Supplemental Template filed in the annual rate filing as set forth in Colorado Insurance Regulation 4-2-39, Section 6.C.3 available in SERFF.

2. An 87% AV Silver Claims Cost will be calculated as follows:

$$\text{Silver Plan Claims Cost} \times \frac{\text{Adjusted AV of 87\% CSR Variant}}{\text{Adjusted AV of Standard Silver On-Exchange Plan}} \times \frac{\text{Induced Demand for 94\% CSR Variant}}{\text{Induced Demand for Standard Silver Plan}}$$

a. The Silver Plan Claims Cost will be determined by the calculation in subsection 6(B)(1).

b. The Adjusted AV of the 87% CSR Variant will be calculated by the formula:

Metal AV X Silver 87% CSR Metal AV Adjustment Factor

(1) The Metal AV will be determined as follows:

If the plan design is unique, the AV of the 87% CSR Variant will be determined by the value entered in the Issuer Actuarial Value in the carrier's PBT. Otherwise, the AV of the 87% CSR Variant will be determined by the value entered in the AV Calculator Output Number in the carrier's PBT.

(2) Section 7 provides the Silver 87% CSR Metal AV Adjustment Factor used in this calculation.

c. The Adjusted AV of the Standard Silver On-Exchange Plan will be calculated by the formula:

Metal AV X Silver Base (70%) Metal AV Adjustment Factor

(1) The Metal AV will be determined as follows:

If the plan design is unique, the AV of the Standard Silver On-Exchange Plan will be determined by the value entered in the Issuer Actuarial Value in the carrier's PBT. Otherwise, the AV of the Standard Silver On-Exchange Plan will be determined by the value entered in the AV Calculator Output Number in the carrier's PBT.

(2) Section 7 provides the Silver Base (70%) Metal AV Adjustment Factor used in this calculation.

d. The Induced Demand for the 94% CSR Variant will be determined using the adjusted actuarial value in subsection 6(B)(3)(b) in the induced demand factor formula from the risk adjustment methodology pursuant to 45 C.F.R. § 153.320(a)(1).

e. The Induced Demand for a Standard Silver Plan will be determined using the adjusted actuarial value in subsection 6(B)(2)(c) in the induced demand factor formula from the risk adjustment methodology pursuant to 45 C.F.R. § 153.320(a)(1).

3. A 94% AV Silver Claims Cost will be calculated as follows:

$$\text{Silver Plan Claims Cost} \times \frac{\text{Adjusted AV of 94\% CSR Variant}}{\text{Adjusted AV of Standard Silver On-Exchange Plan}} \times \frac{\text{Induced Demand for 94\% CSR Variant}}{\text{Induced Demand for Standard Silver Plan}}$$

a. The Silver Plan Claims Cost will be determined by the calculation in subsection 6(B)(1).

b. The Adjusted AV of the 94% CSR Variant will be calculated by the formula:

Metal AV X Silver 94% CSR Metal AV Adjustment Factor

(1) The Metal AV will be determined as follows:

If the plan design is unique, the AV of the 94% CSR Variant will be determined by the value entered in the Issuer Actuarial Value in the carrier's PBT. Otherwise, the AV of the 94% CSR Variant will be determined by the value entered in the AV Calculator Output Number in the carrier's PBT.

(2) Section 7 provides the Silver 94% CSR Metal AV Adjustment Factor used in this calculation.

c. The Adjusted AV of the Standard Silver On-Exchange Plan will be calculated by the formula:

Metal AV X Silver Base (70%) Metal AV Adjustment Factor

(1) The Metal AV will be determined as follows:

If the plan design is unique, the AV of the Standard Silver On-Exchange Plan will be determined by the value entered in the Issuer Actuarial Value in the carrier's PBT. Otherwise, the AV of the Standard Silver On-Exchange Plan will be determined by the value entered in the AV Calculator Output Number in the carrier's PBT.

(2) Section 7 provides the Silver Base (70%) Metal AV Adjustment Factor used in this calculation.

d. The Induced Demand for the 94% CSR Variant will be determined using the adjusted actuarial value in subsection 6(B)(3)(b) in the induced demand factor formula from the risk adjustment methodology pursuant to 45 C.F.R. § 153.320(a)(1).

e. The Induced Demand for a Standard Silver Plan will be determined using the adjusted actuarial value in subsection 6(B)(2)(c) in the induced demand factor formula from the risk adjustment methodology pursuant to 45 C.F.R. § 153.320(a)(1).

4. The Payment to Carriers will be calculated as follows, for each eligible member during each month the member is enrolled (i.e., Per Member Per Month, or PMPM):

Payment to Carriers = 94% AV Silver Claims Cost - 87% AV Silver Claims Cost

a. The 94% AV Silver Claims Cost will be determined by the calculation in subsection 6(B)(3).

b. The 87% AV Silver Claims Cost will be determined by the calculation in subsection 6(B)(2).

c. In cases where an enrollee is not enrolled for the full month, payments will be calculated on a pro rata basis.

5. The Division will apply this method consistently across carriers using values supplied in rate filings, particularly URRTs, PBTs, and Rate Table Templates.

a. This method provides an actuarially sound estimate of the claims cost by carrier, plan, and age for a given person insured in the Colorado individual market.

b. This method will also allow for a determination of total cost after the completion of the previous benefit year given the actual population distribution and total member months during the benefit year.

Section 7 Metal AV Adjustment Factor

The Metal AV Adjustment Factor reflects the differences in Metal AV values produced by the Federal AV Calculator and the actuarial values used in pricing. Due to the confidentiality of carrier pricing models, an average adjustment will be applied and determined using the information provided to the Division in a data call. Based on the data submitted by carriers and an analysis completed by the Division, the Metal AV Adjustment Factor will vary by CSR variant and be revised annually. The Metal AV Adjustment Factors for the benefit year 2025 are listed in the table below:

Metal Level	Adjustment Applied to Metal AV
Silver Base (70%)	1.097
Silver 87% CSR	1.021
Silver 94% CSR	1.014

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 9 Incorporated Materials

45 C.F.R. § 156.135 published by the Government Printing Office shall mean 45 C.F.R. § 156.135 as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. 156.135(a). A copy of 45 C.F.R. § 156.135(a) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. 156.135(a) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 156.420 shall mean 45 CFR §156.420 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.420. A copy of 45 C.F.R. § 156.420 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.420 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 153.320 shall mean 45 CFR § 153.320 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 153.320. A copy of 45 CFR §153.320 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 CFR § 153.320 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 10 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process

Section 11 Effective Date

This amended regulation shall become effective on October 30, 2024.

Section 12 History

This regulation replaces Emergency Regulation 21-E-08, which became effective on May 9, 2021, in its entirety.
This regulation shall be effective on September 1, 2021.
Amended regulation effective November 14, 2022.
Amended regulation effective September 14, 2023.
Amended regulation effective October 30, 2024.

Regulation 4-2-79 CONCERNING THE REQUIREMENTS FOR PROVIDER DATA REQUESTS AND CARRIER RESPONSES CONFIRMING OUT-OF-NETWORK PAYMENT METHODOLOGY UTILIZATION

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, and 10-16-704(13), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements for provider and health care facility submitted requests for out-of-network payment methodology data from carriers pursuant to § 10-16-704(13), C.R.S., as well as the fields that must be supplied in any response provided by a carrier pursuant to that same statute.

Section 3 Applicability

This regulation applies to all provider and health care facility requests and carrier responses to data requests pursuant to § 10-16-704(13), C.R.S.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Commissioner” means, for the purposes of this regulation, the Commissioner of Insurance or his or her designee.

C. “Out-of-network provider” means, for the purposes of this regulation, a provider in this state that has not entered into a contract with a carrier or with its contractor or subcontractor to provide health care services to covered persons.

D. “Provider” shall have the same meaning as found at § 10-16-102(56), C.R.S.

Section 5 Requirements for Data Requests and Carrier Responses

A. An out-of-network provider or health care facility that has received payment pursuant to § 10-16-704(13), C.R.S., and is submitting a request to the Commissioner seeking data to evaluate the carrier’s compliance in paying the highest rate required in § 10-16-704(3)(d) or (5.5)(b), C.R.S. must utilize the “Out-of-Network Data Request and Response Form found in Appendix A” of this regulation.

B. A separate spreadsheet containing multiple claims must be submitted for each distinct facility or provider requesting confirmation that the appropriate payment methodology was used pursuant to § 10-16-704(3)(d) or (5.5)(b), C.R.S.

C. All provider fields in the "Out-of-Network Data Request and Response Form" must be populated by the requesting provider or health care facility prior to the form being sent to the Division. An incomplete form will not be sent to the applicable carrier until it has been completely populated by the requesting provider.

D. Upon receipt of an "Out-of-Network Data Request and Response Form" from the Division, a carrier shall populate the carrier fields and return the completed template to the Division no later than thirty (30) calendar days after receipt. Additional time to respond may be granted by the Division when the "Out-of-Network Data Request and Response Form" contains more than one hundred (100) claims. The fields populated by the carrier in response to a request from the Division must identify which out-of-network payment methodologies and amounts were considered in determining payment, clearly state which methodology and payment was selected, and include a description of how the carrier has determined its median in-network rate.

E. Upon request by the Division, the carrier shall provide a separate document containing the methodology for determining the carrier's median in-network rate or reimbursement for each service in the same geographic area, to accompany a specified completed "Out-of-Network Data Request and Response Form."

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective January 15, 2022.

Section 9 History

New regulation effective January 15, 2022.

APPENDIX A: Out-of-Network Data Request and Response Form

NAME OF REQUESTING PROVIDER/FACILITY AND CONTACT INFORMATION:																
REQUESTING PROVIDER OR FACILITY TIN:																
NAME OF CARRIER AND CONTACT INFORMATION:																
DATE OF REQUEST:																
REQUESTING PROVIDER DATA FIELDS (must be completely filled-out by requester)										**CARRIER DATA FIELDS (must be completed by carrier)***						
Carrier Member Number	Carrier Claim Number	Patient Account Number	Date of Service	CPT/ HCPCS Code	Units	Total Facility/ Provider Charges	Total Amount Paid	Date Claim Paid	CO DOI Regulated Plan? Y/N	DOI Geographic Rating Areas	Carrier Provider Methodology Calculation: 60th Percentile of Average In-network Rate – APCD Data	Carrier Provider Methodology Calculation 110% of carrier median in-network rate	Carrier Facility Methodology Calculation: Median In-network Rate – APCD Data	Carrier Facility Methodology Calculation 105% of carrier median in-network rate	Other Negotiated Amount (If applicable)	Amount Paid to Include Member Cost Sharing

* Carriers may be subject to the imposition of penalties, or any sanctions authorized by the insurance code for providing false or misleading information in completing this form.

Regulation 4-2-80 CONCERNING NETWORK ADEQUACY STANDARDS AND REPORTING REQUIREMENTS FOR COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-1304(2)(c), 10-16-1312, and 10-16-1306(3)(c), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide carriers offering the Colorado Option standardized bronze, silver, and gold health benefit plans with the requirements to offer a culturally responsive network of providers and the action plan elements if the network does not meet these standards as required by § 10-16-1304(1)(g) and (2), C.R.S.

Section 3 Applicability

In addition to Colorado Regulations 4-2-53, 4-2-54, 4-2-55, and 4-2-56, the following requirements apply to all carriers offering individual and small group Colorado Option Standardized plans required by § 10-16-1304, C.R.S. Colorado Option requirements do not apply to large group health benefit and/or student health insurance coverage plans.

Section 4 Definitions

A. “Acute inpatient hospital” means, for the purposes of this regulation, a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short term illness or condition).

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. “Colorado Option Standardized plan” or “Standardized plan” shall have the same meaning as found at § 10-16-1303(14), C.R.S.

D. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

E. “De-identified data” means, for the purposes of this regulation, data that cannot reasonably be used to infer information about, or otherwise be linked to, an identified or identifiable individual, or a device linked to such individual, if the carrier that possesses the data:

(a) Takes reasonable measures to ensure that the data cannot be associated with an individual;

(b) Publicly commits to maintain and use the data only in a de-identified fashion and not attempt to re-identify the data, and;

(c) Contractually obligates any recipients of the information to comply with these requirements.

F. "Essential community provider" or "ECP" means, for the purposes of this regulation, a provider that serves predominantly low-income, medically underserved individuals, including health care providers defined in § 25.5-5-403(2), C.R.S., § 25.5-8-103(6), C.R.S., and at 45 C.F.R. § 156.235(c).

G. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

H. "Individual provider" means, for the purposes of this regulation, any physician, dentist, optometrist, anesthesiologist, or other individual who is licensed or otherwise authorized in this state to furnish health-care services.

I. "Mental health, behavioral health, and substance use disorder care providers" shall have the same meaning as found at Section 4.N. of Colorado Insurance Regulation 4-2-53.

J. "Most restrictive network" means, for the purposes of this regulation, the carrier's nonstandardized plan network that has the smallest number of participating providers, measured by service category in Section 7.D of this regulation, within the plan's rating area of all the nonstandardized plans that the carrier offers in that rating area.

K. "No more narrow" means, for the purposes of this regulation, a carrier's network including as many or more participating providers, measured by service category in Section 7.D of this regulation, in the plan's rating area compared to another network offered by the carrier in the rating area.

L. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.

M. "Nonstandardized plan" means, for the purposes of this regulation, a health benefit plan that does not meet the definition of Standardized plan found at § 10-16-1303(14), C.R.S.

N. "NPI" or "national provider identifier" shall have the same meaning as found at § 25.5-4-420(1)(b), C.R.S.

O. "Obstetric and gynecological provider" means, for the purposes of this regulation, a participating health care professional designated by the carrier to supervise, coordinate, or provide initial care or continuing obstetric or gynecological care, including physicians, physician assistants, nurse practitioners supervised by, or collaborating with, a physician.

P. "Outpatient dialysis" shall have the same meaning as found at § 25-1.5-108(1)(a), C.R.S.

Q. "Participating provider" shall have the same meaning as found at § 10-16-102(46), C.R.S.

R. "Pediatric provider" means, for the purposes of this regulation, a participating health care professional designated by the carrier to supervise, coordinate, or provide initial care or continuing care to infants, children, and/or adolescents, including physicians, physician assistants, nurse practitioners supervised by, or collaborating with, a physician.

S. "Primary care provider" or "PCP" shall have the same meaning as found at Section 4.Q. of Colorado Insurance Regulation 4-2-53.

T. "Provider" shall have the same meaning as found at § 10-16-102(56), C.R.S.

U. "Rating area" means, for the purposes of this regulation, a geographic area comprised of Colorado counties established pursuant to the fair health insurance premium requirements under 45 C.F.R. § 147.102. A list of the Rating Areas can be found in Colorado Insurance Regulation 4-2-39 Section 6.A.15.g.

V. "SERFF" means, for the purposes of this regulation, the System for Electronic Rates and Forms Filing.

Section 5 Network Adequacy Requirements for the Colorado Option Standardized Plans

A. Demographic Data Collection

1. Network Provider Data:

a. Carriers shall develop written materials for network providers and their front office staff requesting the voluntary reporting of demographic data to the carrier explaining the intended uses of the data and how such data will be shared. In their written materials, carriers shall explain that the data will be used to improve racial health equity, reduce health disparities for covered persons who experience higher rates of health disparities and inequities, and to provide aggregate information about the diversity of the providers in the carrier's network.

Carriers shall include any voluntarily reported network provider demographic data in the network access plan in the aggregate only. Personally identifiable information shall be kept confidential and will not be disclosed without the written consent of the reporting provider or office staff member.

b. Carriers shall collect the following demographic data voluntarily submitted by network providers and their front office staff for the carriers' Colorado Option Standardized plans:

(1) Race and ethnicity data, collected using the racial/ethnic categories included in the U.S. Office of Budget and Management's Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting;

(2) Sexual orientation and gender identity data, collected using the following questions:

(a) How do you identify your sexual orientation? (Select all that apply):

- Straight
- Lesbian
- Gay
- Bisexual
- Pansexual
- Queer
- Asexual
- A sexual orientation not listed here (specify): _____

- Prefer not to answer

(b) How do you describe your current gender identity? (Select all that apply):

- Female
- Male
- Transgender Female/Transgender Woman
- Transgender Male/Transgender Man
- Non-Binary
- Two-spirit
- Intersex
- Gender Queer/Gender Fluid
- A gender identity not listed here (specify): _____
- Prefer not to answer

(c) What was your sex assigned at birth?

- Female
- Male
- Non-Binary
- Not Designated on Birth Certificate
- Prefer not to answer

(3) Ability status data, collected using the following question:

(a) Do you have a disability?

- Yes
- No
- Prefer not to answer

c. Carriers may request the data directly from network providers or use such other data sources as may be available. In collecting such data from network providers, carriers shall minimize the burden on network providers by including the request with its request for data for the provider directory.

2. Covered Person Data:

a. Carriers shall develop educational materials about the reasons for collecting covered persons' demographic data and shall post the educational materials on its website in a manner that is accessible to the public. The educational materials must clearly indicate that demographic data collected will be confidential, de-identified, and used to improve racial health equity, reduce health disparities for covered persons who experience higher rates of health disparities and inequities and provide aggregate information regarding the demographic diversity of the insurer's covered population.

Carriers shall include any voluntarily reported covered person demographic data in the network access plan in the aggregate only and de-identified as to any individual. Personally identifiable information shall be kept confidential and will not be disclosed without the written consent of the covered person

b. Carriers shall collect the following demographic data from covered persons who voluntarily choose to provide such data:

(1) Race and ethnicity data, collected using the racial/ethnic categories included in the U.S. Office of Budget and Management's Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting;

(2) Sexual orientation and gender identity data, collected using the following questions:

(a) How do you identify your sexual orientation? (Select all that apply):

- Straight
- Lesbian
- Gay
- Bisexual
- Pansexual
- Queer
- Asexual
- A sexual orientation not listed here (specify): _____
- Prefer not to answer

(b) How do you describe your current gender identity? (Select all that apply):

- Female
- Male
- Transgender Female/Transgender Woman
- Transgender Male/Transgender Man
- Non-Binary
- Two-spirit
- Intersex
- Gender Queer/Gender Fluid
- A gender identity not listed here (specify): _____
- Prefer not to answer

(c) What was your sex assigned at birth?

- Female
- Male
- Non-Binary
- Not Designated on Birth Certificate
- Prefer not to answer

(3) Ability status data, collected using the following question:

(a) Do you have a disability?

- Yes
- No
- Prefer not to answer

B. Inclusion of Certified Nurse Midwives in the Colorado Option Standardized Plan Networks

To address racial health disparities and improve perinatal health care coverage, carriers shall attest that at least one certified nurse midwife is available within the maximum road travel distance of any covered person in the Colorado Option Standardized plan network based on the categories of geographic areas listed below:

	Large Metro	Metro	Micro	Rural	CEACs
Provider Type	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)
Certified Nurse Midwives	5	10	20	30	60

C. Training requirements

1. Carrier Customer Service Representatives

a. Prior to the commencement of plan year 2023 open enrollment and on an annual basis thereafter, carriers' customer service representatives who assist applicants in the enrollment process and covered persons in utilizing their Colorado Option Standardized plan benefits must complete at least one anti-bias, cultural competency, or similar training designed to educate carrier customer service representatives about the health care needs of covered persons who experience higher rates of health disparities and inequities.

b. Carriers shall report on customer service representatives training using a standard reporting form created by the Division which will include, at a minimum, the duration of the training for carrier's customer service representatives, any certifications, and a description of the training.

2. Providers and Providers' Front Office Staff

a. Carriers shall create a process for their Colorado Option Standardized plan network providers and providers' front office staff to annually report on the anti-bias, cultural competency, or similar training that providers and their front office staff have taken in the last year designed to assist covered persons who experience higher rates of health disparities and inequities.

b. Carriers shall collect network providers and their front office staff training information using a standard reporting form created by the Division which will include, at a minimum, the duration of the training for network providers and their front office staff, any certifications, and a description of the training.

c. Carriers, at a minimum, shall ensure:

(1) At least 50% of providers and their front office staff have undertaken such training no later than January 1, 2023;

(2) At least 75% of providers and their front office staff have undertaken such training no later than January 1, 2024; and

(3) At least 90% of providers and their front office staff have undertaken such training no later than January 1, 2025.

D. Provider Directories

1. In addition to the provider directory requirements in Colorado Regulation 4-2-55, carriers must include in their Colorado Option Standardized plan provider directories information regarding:

a. The availability of translation and interpreter services in languages other than English for individuals with limited English proficiency;

b. Accessibility services for people with disabilities and the procedures for requesting such services from the carrier; and

c. Information on how to file a complaint with the Division or with a carrier related to the accuracy of the provider directory and/or the provider experience.

2. The provider directories, both printed and online, shall identify the following information about network providers and their front office staff:

a. Providers who are multilingual or employ multilingual front office staff including the languages spoken by providers and their front office staff;

b. If the provider offers extended and weekend hours; and

c. The accessibility of the provider office and examination rooms for persons with disabilities.

E. Language Access

1. Carriers shall ensure that language assistance services, including American Sign Language (ASL) and other communication services for people who are Deaf, Hard of Hearing, and DeafBlind, are available to covered persons enrolled in a Colorado Option Standardized plan and develop a process for notifying covered persons of the availability of these services and how they can be accessed.

a. Carriers must ensure language assistance services are available for covered persons when communicating directly with the carrier (i.e., customer service representatives).

b. Carriers must ensure language assistance services are available for covered persons when communicating with network providers.

c. Carriers may require covered persons to provide timely notice of the need for language assistance for communications with the carrier and/or a network provider. For the purposes of this section, “timely” means in a manner appropriate for the situation in which language assistance is needed. Language assistance services are not timely if delay results in the effective denial of the service, benefit, or right at issue.

d. Language assistance services shall be offered at no cost to covered persons during all points of contact when language assistance is needed and timely notice is given.

2. Carriers shall provide covered persons with written notice of the availability of interpretation and translation services for documents from the carrier in the covered person's indicated language and make those documents available at provider offices. Carriers are required to post taglines in at least the top fifteen (15) languages spoken by individuals with limited English proficiency indicating the availability of language assistance services, including ASL and other communication services for people who are Deaf, Hard of Hearing, and DeafBlind, free of charge.

Section 6 Essential Community Provider Standards for Colorado Option Standardized Plans

Carriers must ensure that networks used for Colorado Option Standardized plans include a sufficient number of ECPs to meet one of the following Colorado Option-specific ECP standards:

A. General ECP Standard: Carriers utilizing this standard shall have greater than 50% of the essential community providers in each service area for each of the Colorado Option Standardized plan provider networks. Carriers shall demonstrate in their "Essential Community Provider/Network Adequacy Template" that greater than 50 percent (50%) of available ECPs in each plan's service area participate in each Colorado Option Standardized plan network. This standard applies to all carriers except those who qualify for the alternate ECP standard.

B. Alternate ECP Standard. Carriers utilizing this standard shall demonstrate in their "Essential Community Provider/Network Adequacy Template" and justifications, that they have the same number of ECPs as defined in the general ECP standard (calculated as greater than 50 percent (50%) of the ECPs in the carrier's service area), but the ECPs should be located within Health Professional Shortage Areas (HPSAs) or five-digit ZIP codes in which 30 percent (30%) or more of the population falls below 200 percent (200%) of the federal poverty level (FPL). An alternate ECP standard carrier is one that provides a majority of covered professional services through physicians it employs or through a single contracted medical group.

Section 7 Network Access Plan Reporting Requirements

In addition to the access plan requirements set forth in Regulation 4-2-54, a carrier offering the Colorado Option Standardized plan shall include a description of the carrier's efforts to construct a diverse and culturally responsive network in its access plan, due with the annual network adequacy form filing. The following information shall be included:

A. Summary of Demographic Data Collected

1. Carriers shall report any demographic data voluntarily reported by network providers or covered persons in accordance with Subsections 5.A.1 and 5.A.2. in aggregate only. No identifiable or individual network provider or covered person data should be included in the access plan.

2. Network Provider Demographic Data:

a. A copy of the information provided to network providers on the relevance of collecting demographic data;

b. The methods used to collect demographic data;

c. The number of providers in the network and the number of network providers who submitted demographic data;

d. A description of any other data sources used to assess network provider demographic data and the completeness of those data sources; and

e. A breakdown of the demographic data, by race and ethnicity, disability, sexual orientation, and gender identity using the categories in Sections 5. A.1.b.

3. Covered Person Demographic Data:

a. A copy of the information provided to covered persons on the relevance of collecting demographic data; and

b. A summary of the number of covered persons who submitted demographic data and a breakdown by race and ethnicity, disability, and sexual orientation and gender identity using the categories in Section 5.A.2.b.

B. Summary of the Anti-Bias, Cultural Competency, or Similar Training Offered

1. Customer Service Training:

a. The subject matter and duration of the training(s) offered; and

b. The total number and the percentage of customer service representatives who completed the training in the past 12 months.

2. Provider and Provider Front Office Staff Training:

a. A description of the type of training reported by providers and their front office staff; and

b. The total number and the percentage of network providers and their front office staff who completed the training in the past 12 months.

C. A description of the network providers and services that are included in the Colorado Option Standardized plan networks, such as community health workers or promotoras, to assist covered persons who experience higher rates of health disparities and inequities.

D. For carriers offering plans in the individual market: Data to demonstrate that each Colorado Option Standardized plan network offered by the carrier in the individual market is no more narrow than the most restrictive network the carrier is offering for nonstandardized plans in the individual market for that rating area, by providing the following information for each of the following service categories: primary care providers, mental health, behavioral health, and substance use disorder care providers, acute inpatient hospitals, pediatric providers, obstetric and gynecological providers, and outpatient dialysis facilities.

1. For primary care providers, mental health, behavioral health, and substance use disorder care providers, pediatric providers, and obstetric and gynecological providers:

a. Names, addresses, and NPIs of providers in each Standardized plan network, by rating area;

b. Names, addresses, and NPIs of providers in the most restrictive network, by rating area;

c. Total number of unique individual providers in the service categories listed above in each Standardized plan network, by rating area; and

d. Total number of unique individual providers in the service categories listed above in the most restrictive network, by rating area

2. For acute inpatient hospitals and outpatient dialysis facilities ("hospitals or facilities"):

a. Names, addresses, and NPIs of hospitals or facilities in each Standardized plan network, by rating area;

b. Names, addresses, and NPIs of hospitals or facilities in the most restrictive network, by rating area;

c. Total number of hospitals or facilities in each Standardized plan network, by rating area; and

d. Total number of hospitals or facilities in the most restrictive network, by rating area.

E. Carriers' evaluation of the efforts to create a culturally responsive network, which includes a description of how the carrier has assessed the network is adequate for the anticipated volume of demand for outpatient visits for perinatal, primary care, and behavioral health care as required in the Standardized plan.

Section 8 Required Carrier Attestations and Reporting

A. For carriers offering plans in the individual market: In addition to the attestations required by Regulation 4-2-54, a carrier offering Colorado Option Standardized plans in the individual market shall attest that the Colorado Option Standardized plan network:

1. Is not more narrow than the most restrictive network that the carrier offers for nonstandardized plans in the individual market for the metal tier for that rating area based on the criteria in Section 7;

2. Meets the requirements of Sections 5, 6 and 7 of this regulation or, if not, that it has made good faith efforts to build such networks and has documented those efforts in its action plan as required by Sections 8 and 9 of this Regulation; and

3. Each attestation shall be made on the "Carrier Network Adequacy Summary and Attestation Form" submitted with the annual network adequacy form filings.

B. Reporting required by Section 5 Network Adequacy Requirements for the Colorado Option Standardized Plans of this regulation will be completed using the Colorado Option Network Access Plan-Reporting Template, which will be submitted in annual network adequacy form filings. The template and instructions for reporting will be provided by the Division.

C. If the carrier does not meet the Colorado Option Standardized Plans 50% ECP standards, described in Section 6 above, the carrier shall submit a copy of the "Colorado Supplementary Response: Inclusion of Essential Community Providers" form that will be generated by the Division, if necessary, during review of the "Essential Community Provider/Network Adequacy" (ECP/NA) Template in the Binder filing.

Section 9 Network Adequacy Action Plans

A. A carrier shall file an action plan in the annual network adequacy form filing in SERFF under the following circumstances:

1. If the carrier attests that it does not meet the Demographic Data Collection, Inclusion of Certified Nurse Midwives, Training, Provider Directories, and Language Access requirements in Section 5 or the Network Access Plan requirements specified in Section 7;

2. If a carrier is unable to build a culturally responsive network, and one that reflects the diversity of its enrollees to the greatest extent possible in the area that the network exists, for the Colorado Option Standardized plan;

3. For carriers offering plans in the individual market: If the carrier is unable to demonstrate that the Colorado Option Standardized Plan network is no more narrow than the most restrictive network the carrier is offering for nonstandardized plans in the individual market for that rating area, as required in Section 7.D; or

4. If the Division notifies the carrier, after a review of the carrier's network access plan and summary and attestation form, or the carrier determines, that the network does not meet the requirements of Sections 5, 6, 7, and 8 of this regulation.

B. The action plan shall contain the following information:

1. If applicable, the reasons the carrier was unable to obtain demographic data from providers and/or covered persons;

2. If applicable, the reasons the carrier was unable to build a culturally responsive network and one that reflects the diversity of its enrollees to the greatest extent possible in the area that the network exists, for the Colorado Option Standardized plan;

3. A description of the outreach efforts to out-of-network providers, or providers with whom the carrier is negotiating to achieve network adequacy, including:

a. The types of providers that were contacted;

b. The method(s) by which the outreach was conducted;

c. The specific dates of outreach, including a summary of the communication and the provider's response;

d. The reasons providers did not join the network;

e. Whether the carrier is continuing to negotiate with providers that did not join the network during previous attempts but that would contribute to a carrier meeting the network adequacy requirements of this regulation;

4. The number and a description of the complaints that the carrier has received from covered persons regarding any network adequacy requirements in this regulation and the approach used to address issues raised in complaints; and

5. For carriers offering plans in the individual market: If the carrier meets the circumstance in Section 9.A.3:

a. The providers that are included in the most restrictive nonstandardized plan network and excluded from the Colorado Option Standardized plan network;

b. The percentage by which the Colorado Option standardized plan network differs from the most restrictive nonstandardized plan network, by rating area, calculated using the following formula:

[[(Total Number of Individual Providers in the Colorado Option Standardized Plan Network) - (Total Number of Individual Providers in the most restrictive network)] ÷ (Total Number of Individual Providers in the most restrictive network)] X 100

c. The percentage by which the Colorado Option standardized plan network differs from the most restrictive nonstandardized plan network, by rating area, for each of the provider types in Section 7.D., calculated using the following formula:

[[(Number of Individual Providers in the Colorado Option Standardized Plan Network) - (Number of Individual Providers in the most restrictive network)] ÷ (Number of Individual Providers in the most restrictive network)] X 100

C. For each circumstance in section 9.A described in the action plan, the carrier shall identify in the action plan:

1. A set of measurable steps and goals for taking necessary corrective action(s);

2. The timelines for achieving each step or goal for each corrective action; and

3. For carriers offering plans in the individual market: If the circumstance is that the carrier is unable to demonstrate that the Colorado Option Standardized Plan network is no more narrow than the most restrictive network the carrier is offering for nonstandardized plans in the individual market for the metal tier for that rating area, the carrier shall specifically include in the action plan:

a. A plan to continue negotiations with providers, including specific milestones and reimbursement rates, that will ensure the Colorado Option standardized plan is no more narrow than the most restrictive network the carrier is offering for nonstandardized plans;

b. Pursuant to § 10-16-1306(11)(b), C.R.S., the names and contact information for the providers that the carrier must include in the carrier's Colorado Option Standardized plan network in order for the carrier to comply with § 10-16-1304(1)(g)(II), C.R.S.; and

c. The timelines for providing regular status updates to the Division on the carrier's Standardized plan's network compliance with § 10-16-1304(1)(g)(II), C.R.S., including updates prior to the approval of the carrier's final rate. The regular status updates must include whether continued negotiations with a hospital or health-care provider would be beneficial, whether the negotiations have met the specific milestones or rates in this subsection a, and an update on the information provided to the Division in subsection b.

D. If the Division determines the action plan's proposed corrective action(s) and/or timelines are insufficient, unreasonable, or do not comply with the requirements of this regulation, it will notify the carrier of deficiencies. The Division will work with the carrier to determine reasonable remediation steps, goals, milestones, and timelines and the carrier must resubmit a revised action plan with deficiencies corrected within 14 business days of notification from the Division unless the carrier requests additional time for good cause.

E. If the carrier fails to resubmit a revised action plan that corrects the deficiencies within 14 business days or within the additional time allowed upon request, the action plan filing shall be deemed incomplete and rejected.

F. An action plan shall be deemed incomplete and rejected if the carrier fails to comply with the action plan prior to the approval of the carrier's final rates, including, but not limited to, failing to comply with measurable steps, goals, milestones, and timelines.

G. If a carrier's action plan is deemed incomplete and rejected, the carrier may be subject to imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance subject to the requirements of due process.

H. All action plans shall be considered public and shall be open to inspection, unless the information may be considered confidential pursuant to the Colorado Open Records Act, §§ 24-72-201-05, C.R.S. A carrier may make a claim of confidentiality to the Division as to information submitted in the Network Adequacy Action Plan. Any carrier submitting information under a claim of confidentiality shall file, as part of the public record (i.e., not confidential), a confidentiality index specifying the basis(es) for the claim of confidentiality as to the information requested under a claim of confidentiality. A claim of confidentiality constitutes a representation to the Commissioner that the carrier has a reasonable and good faith belief that the subject document or information is, in fact, confidential under applicable state and federal law, including the Colorado Open Records Act. Nothing in this Section 9.H. modifies the confidentiality requirements set forth in Sections 5.A.1.a and 5.A.2.a of this regulation and carriers shall comply with the confidentiality requirements in those sections.

Section 10 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 11 Incorporated Materials

45 C.F.R. § 147.102 published by the Government Printing Office shall mean 45 C.F.R. § 147.102 as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 147.102. A copy of 45 C.F.R. § 147.102 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 147.102 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 156.235(c) published by the Government Printing Office shall mean 45 C.F.R. § 156.235(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.235(c). A copy of 45 C.F.R. § 156.235(c) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.235(c) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

U.S. Office of Budget and Management Statistical Policy Directive No.15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting as published on the effective date of this regulation and does not include later amendments or editions of the Standards. A copy of the Standards may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of the Standards may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A charge for certification or copies may apply. A copy may also be obtained online at https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf.

Section 12 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 13 Effective Date

This regulation shall become effective on March 1, 2024.

Section 14 History

Regulation effective March 2, 2022.
Amended regulation effective May 30, 2023.
Amended regulation effective March 1, 2024.

Regulation 4-2-81 CONCERNING COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-109, and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for the required bronze, silver, and gold Standardized plans to be offered by all carriers offering individual and small group health benefits plans issued or renewed on or after January 1, 2025.

Section 3 Applicability

This regulation applies to all carriers offering individual and small group health benefit plans subject to the individual and small group laws of Colorado and the requirements of federal law.

Section 4 Definitions

A. “Actuarial value” or “AV” means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a plan will cover, with calculations based on the provision of essential health benefits to a standard population.

B. “Behavioral, mental health, and substance use disorder” shall have the same meaning as found at § 10-16-104(5.5)(d), C.R.S.

C. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

D. “Colorado Option Standardized Plan” or “Standardized plan” shall have the same meaning as found at §10-16-1303(14), C.R.S.

E. “Colorado Plans and Benefits Template” or “Colorado PBT” means, for the purposes of this regulation, the Colorado-specific modified version of the Federal PBT for submission of plans offered through the Public Benefit Corporation.

F. “Colorado Supplement to the Summary of Benefits and Coverage Form” or “COSSBC” shall have the same meaning as found at Colorado Insurance Regulation 4-2-20.

G. "Consumer Facing Materials" means, for the purposes of this regulation, plan-specific policy forms including the Summary of Benefits and Coverage Form, Colorado Supplement to the Summary of Benefits and Coverage Form, Evidence of Coverage, Certificate of Coverage, and plan-specific marketing materials including brochures, direct mail, website landing page, broker website portal landing page, welcome kit, newsletters, advertisements, and shopping portals on-exchange and off-exchange through the Public Benefit Corporation.

H. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

I. "Embedded deductible" means, for the purposes of this regulation, a cost-sharing provision within family policies where a covered person may satisfy their own individual deductible before the overall family deductible is satisfied.

J. "Embedded out-of-pocket maximum" means, for the purposes of this regulation, a cost-sharing provision within family policies where a covered person may satisfy their own individual out-of-pocket maximum before the overall family out-of-pocket maximum is satisfied.

K. "Essential health benefits" or "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.

L. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.

M. "Federal Plans and Benefits Template" or "Federal PBT" means, for the purposes of this regulation, the Plans & Benefits Template created by the Centers for Medicare & Medicaid Services.

N. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

O. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.

P. "Preventive drug" shall have the same meaning as found at Colorado Insurance Regulation 4-2-58.

Q. "Provider" shall have the same meaning as found at § 10-16-102(56), C.R.S.

R. "Public Benefit Corporation" shall have the same meaning as found at § 10-16-1303(12), C.R.S.

S. "Silver Enhanced Plan" means, for the purposes of this regulation, the standardized silver plan offered by Connect for Health Colorado on the Colorado Public Benefit Corporation with an increase in the plan's actuarial value to 94% and a $0 premium containing the same plan design and cost sharing as the Colorado Option On-Exchange Silver (94% AV) Standardized Plan.

T. "Summary of Benefits and Coverage Form" or "SBC" means, for the purposes of this regulation, the Summary of Benefits and Coverage Form created by the Centers for Medicare & Medicaid Services.

Section 5 Standardized Health Benefit Plan

A. Carriers shall offer a Standardized plan at the bronze, silver, and gold metal level tiers, as required under §10-16-1304, C.R.S., and shall:

1. Offer the individual market Standardized plans on-Exchange, and off-Exchange through the Public Benefit Corporation.

2. Use the following naming conventions in the Federal PBT and Colorado PBT as well as on consumer facing materials.

    a. For all metal tier plans: "[Name of Carrier] Colorado Option [Metal Tier]." The name of the carrier may be shortened to an easily identifiable acronym that is commonly used by the carrier in consumer facing publications.

    b. For silver cost-sharing reduction variant plans: "[Name of Carrier] Colorado Option Silver [% AV value]." The name of the carrier may be shortened to an easily identifiable acronym that is commonly used by the carrier in consumer facing publications.

3. Use the following naming conventions on identification cards:

    a. For all metal tier plans: "CO Option [Metal Tier]."

    b. For silver cost-sharing reduction variant plans: "CO Option Silver [% AV value]."

4. Use a Division approved, co-branded logo in individual and small group Standardized plan consumer facing materials. A co-branded logo will use both the Colorado Option logo and the carrier's logo, to form a dual logo that is a single image.

5. Include a service area or network identifier in the plan name if the plan is not offered on a statewide basis with a statewide network.

B. Coverage must be provided in a manner consistent with the requirements of:

1. Federal law.

2. Article 16 of Title 10 of the Colorado Revised Statutes, as applicable to individual and small group health benefit plans, including but not limited to:

    a. §§ 10-16-1304, 10-16-1305, 10-16-1306, C.R.S.

    b. §§ 10-16-104(5.5) and 10-16-147, C.R.S. and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as defined at § 10-16-102(43.5), C.R.S.

        (1) Carriers shall submit the CO Financial Requirement and Quantitative Treatment Limitation Classification Template and the Financial Requirements Attestation Template for Standardized Plans, required by Colorado Insurance Regulation 4-2-64, no later than March 1 of each year.

        (2) If it is determined that a carrier's standardized plan does not comply with MHPAEA financial requirements and quantitative treatment limitations, the Division will make the minimum adjustments necessary to the cost sharing structure in the standardized plan to meet these requirements.

3. United States Preventive Services Task Force A and B recommendations, Advisory Committee on Immunization Practices age-appropriate immunization and vaccine schedules, and the Women's Preventive Services Guidelines published by the Health Resources and Services Administration (HRSA).

C. As part of the annual filings process, Standardized plans must be consistent with Colorado Insurance Regulations and guidance regarding rate and form filings, including but not limited to Colorado Insurance Regulations 4-2-39, 4-2-41, 4-2-58 and 4-2-64.

D. Individual market carriers must file all Standardized plans, except bronze plans, on Benefits Package 1 and bronze plans on Benefits Package 2 of the federal Plans and Benefits Template. Individual market carriers must file the Standardized bronze, off-exchange silver, silver enhanced, and gold plans on the Colorado Plans and Benefits Template. Small group market carriers must file all Standardized plans, except bronze plans, on Benefits Package 1 and bronze plans on Benefits Package 2 of the federal Plans and Benefits Template.

E. Coverage must provide essential health benefits as defined in Colorado Insurance Regulation 4-2-42. Carriers are not permitted to add benefits outside of those outlined in Colorado Insurance Regulation 4-2-42 except that carriers may include reproductive health services in addition to the benefits in Colorado Insurance Regulation 4-2-42, subject to approval by the Division of Insurance. Carriers must follow the defined cost-sharing requirements for the benefits listed in Appendix A. Carriers may vary cost-sharing amounts for essential health benefits not listed in Appendix A.

F. The bronze, silver, and gold Standardized plans must include the following coverage:

1. Mental health, behavioral health and substance use disorder visits and primary care visits in accordance with the cost-sharing requirements contained in Appendix A.

2. Prenatal and postnatal visits in accordance with the cost-sharing requirements contained in Appendix A.

    a. Carriers utilizing a global billing structure for pregnancy-related care shall account for the cost sharing outlined in the Standardized plan in the global billing fee structure.

    b. Home visits shall be considered a covered postnatal care visit, subject to the cost-sharing for “prenatal and postnatal visits” contained in Appendix A.

    c. Prenatal and postnatal visits shall be combined in instances where a number of visits is specified in Appendix A.

3. Diabetes supplies, including but not limited to Continuous Glucose Monitors, must be provided with no cost sharing.

4. Carrier formularies:

    a. Formularies shall have five drug tiers that allow copay only cost sharing:

        (1) Tier 1: The prescription drug tier which consists of drugs used for preventive purposes.

        (2) Tier 2: The prescription drug tier which consists of the lowest cost tier of prescription drugs, most are generic.

        (3) Tier 3: The prescription drug tier which consists of medium-cost prescription drugs, most are generic, and some brand-name prescription drugs.

(4) Tier 4: The prescription drug tier which consists of the higher-cost prescription drugs, most are brand-name prescription drugs, and some specialty drugs.

(5) Tier 5: The prescription drug tier which consists of the highest-cost prescription drugs, most are specialty drugs.

b. Carriers may assign prescription drugs to one of the five tiers based on drug usage, cost and clinical effectiveness so long as such classification remains in compliance with applicable Federal and Colorado state law requirements.

c. The cost-share amounts in Appendix A are for a 30-day supply of a prescription drug. A carrier may apply up to three times the cost-share amount for a 90-day supply.

4. Consistent with existing coverage requirements, carriers must provide the following:

a. Carriers must include the “Colorado QuitLine” as part of covered tobacco cessation programs;

b. When outpatient education for prediabetes is recommended by a provider, carriers must include a program recognized by the National Centers for Disease Control and Prevention (CDC) Diabetes Prevention Program as part of diabetes prevention coverage.

G. The Colorado Option bronze, silver, and gold Standardized plans may not have a tiered network with different copays for different network tiers.

H. Covered persons in the Standardized plans must receive care at the cost-sharing levels required for the different services in the Standardized plans for any “In-Network” provider. In-network services include services provided by an out-of-network provider, but are approved as in-network by the carrier.

I. The Standardized bronze, silver, and gold plans do not specify cost-sharing amounts for any out-of-network services except for those services required under state or federal law to have in-network cost-share amounts.

J. Any copay, coinsurance, and deductible payments for in-network covered services shall apply to the out-of-pocket maximum.

K. Carriers shall use an embedded deductible.

L. Carriers shall use an embedded out-of-pocket maximum.

M. Carriers are not required to submit reasonable modification requests for benefits and/or cost-sharing modifications found in Appendix A of this regulation. Carriers are required to submit any other benefits and/or cost-sharing reasonable modification requests to the Standardized plans, pursuant to Colorado Insurance Regulation 4-2-27.

Section 6 Incorporation by Reference

The age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices, as published by the Advisory Committee on Immunization Practices shall mean age-appropriate immunization and vaccine schedules as published on the effective date of this regulation and do not include later amendments to, or editions of, the age-appropriate immunization and vaccine schedules. The age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Advisory Committee on Immunization Practices website at http://www.cdc.gov/vaccines/schedules/hcp/index.html. Certified copies of the age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices are available from the Colorado Division of Insurance for a fee.

The United States Preventive Services Task Force A and B Recommendations, published by the United States Preventive Services Task Force shall mean the United States Preventive Services Task Force A and B Recommendations, as published on the effective date of this regulation and does not include later amendments to, or editions of, the United States Preventive Services Task Force A and B Recommendations. The United States Preventive Services Task Force A and B Recommendations may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the United States Preventive Services Task Force website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Certified copies of the United States Preventive Services Task Force A and B Recommendations are available from the Colorado Division of Insurance for a fee.

The Women's Preventive Services Guidelines, published by the Health Resources and Services Administration, shall mean the Women's Preventive Services Guidelines published by the Health Resources and Services Administration, as published on the effective date of this regulation and does not include later amendments to, or editions of the Women's Preventive Services Guidelines published by the Health Resources and Services Administration. The Women's Preventive Services Guidelines published by the Health Resources and Services Administration may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Health Resources and Services Administration website at https://www.hrsa.gov/womens-guidelines Certified copies of the Women's Preventive Services Guidelines, published by the Health Resources and Services Administration are available from the Colorado Division of Insurance for a fee.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective on June 15, 2024,

Section 10 History

This regulation shall become effective June 30, 2022.

Amended regulation effective June 15, 2024.

Appendix A: 2025 Gold, Silver, and Bronze Standardized Plans

This Appendix outlines the plan designs for the gold, silver, and bronze metal tier standardized plans.

- The column "**Member Cost Share (In Network)"** refers to the cost share amount paid by the covered person after their deductible is met.
- The "**x" in the** "**Deductible Applies"** column indicates that a covered person is expected to meet their deductible prior to paying the cost share amount listed in the "Member Cost Share (In Network)" column.
- If there is **no** "**x" in the** "**Deductible Applies"** column, this indicates that the cost-share is pre-deductible or first dollar coverage.

Standardized Silver Cost Sharing Reduction Plans at 73% AV and 87% AV are only required to be offered in the individual, On Exchange market. Standardized Silver Cost Sharing Reduction Plans at the 94% AV level are required to be offered in the individual, On Exchange market, and the individual, Off Exchange market through the Public Benefit Corporation.

Gold Standardized Plan

Actuarial Value			**78.0%**
Individual Deductible (Combined Medical & Drug)			$1,875
Individual Out-of-Pocket Maximum			$8,700
Family Deductible			$3,750
Family Out-of-Pocket Maximum			$17,400
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$50	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	30%	X

	Mental/Behavioral Health and Substance Use Disorder Inpatient services	30%	X
Tests	Laboratory tests	30%	X
	X-rays and diagnostic imaging	30%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	30%	X
Drugs to treat Illness or Condition	Tier 1	$0	
	Tier 2	$10	
	Tier 3	$50	
	Tier 4	$200	
	Tier 5	$600	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	30%	X
	Physician/Surgical Services	30%	X
Need Immediate Attention	Urgent care centers or facilities	$50	
	Emergency room services	30%	X
	Emergency medical transportation (ambulance)	30%	X
Hospital Stay	Inpatient Hospital services	30%	X
	Inpatient Physician and Surgical Services	30%	X
	Inpatient Rehabilitation Services	30%	X
	Inpatient Habilitation Services	30%	X
Help recovering or other health needs	Speech Therapy	30%	X
	Physical Therapy	30%	X

	Occupational Therapy	30%	X
	Durable medical equipment[1]	30%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing
[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver Standardized Plan

(On-Exchange Individual Market & Small Group Market)

Actuarial Value			**70.0%**
Individual Deductible (Combined Medical & Drug)			$4,000
Individual Out-of-Pocket Maximum			$9,000
Family Deductible			$8,000
Family Out-of-Pocket Maximum			$18,000
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$80	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	40%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	40%	X
Tests	Laboratory tests	40%	X
	X-rays and diagnostic imaging	40%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	40%	X
Drugs to treat Illness or	Tier 1	$0	

Condition	Tier 2	$20	
	Tier 3	$125	
	Tier 4	$300	
	Tier 5	$650	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	40%	X
	Physician/Surgical Services	40%	X
Need Immediate Attention	Urgent care centers or facilities	$80	
	Emergency room services	40%	X
	Emergency medical transportation (ambulance)	40%	X
Hospital Stay	Inpatient Hospital services	40%	X
	Inpatient Physician and Surgical Services	40%	X
	Inpatient Rehabilitation Services	40%	X
	Inpatient Habilitation Services	40%	X
Help recovering or other health needs	Speech Therapy	40%	X
	Physical Therapy	40%	X
	Occupational Therapy	40%	X
	Durable medical equipment[1]	40%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing
[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver (73% AV) Standardized Plan

(On-Exchange Individual Market)

Actuarial Value			**73.0%**
Individual Deductible (Combined Medical & Drug)			$2,600
Individual Out-of-Pocket Maximum			$7,350
Family Deductible			$5,200
Family Out-of-Pocket Maximum			$14,700
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$80	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	40%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	40%	X
Tests	Laboratory tests	40%	X
	X-rays and diagnostic imaging	40%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	40%	X
Drugs to treat Illness or	Tier 1	$0	

Condition	Tier 2	$20	
	Tier 3	$125	
	Tier 4	$300	
	Tier 5	$600	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	40%	X
	Physician/Surgical Services	40%	X
Need Immediate Attention	Urgent care centers or facilities	$80	
	Emergency room services	40%	X
	Emergency medical transportation (ambulance)	40%	X
Hospital Stay	Inpatient Hospital services	40%	X
	Inpatient Physician and Surgical Services	40%	X
	Inpatient Rehabilitation Services	40%	X
	Inpatient Habilitation Services	40%	X
Help recovering or other health needs	Speech Therapy	40%	X
	Physical Therapy	40%	X
	Occupational Therapy	40%	X
	Durable medical equipment[1]	40%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing
[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver (87% AV) Standardized Plan

(On-Exchange Individual Market)

Actuarial Value			**87.0%**
Individual Deductible (Combined Medical & Drug)			$900
Individual Out-of-Pocket Maximum			$3,050
Family Deductible			$1,800
Family Out-of-Pocket Maximum			$6,100
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$60	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	30%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	30%	X
Tests	Laboratory tests	30%	X
	X-rays and diagnostic imaging	30%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	30%	X
Drugs to treat Illness or Condition	Tier 1	$0	
	Tier 2	$0	

	Tier 3	$60	
	Tier 4	$120	
	Tier 5	$180	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	30%	X
	Physician/Surgical Services	30%	X
Need Immediate Attention	Urgent care centers or facilities	$60	
	Emergency room services	30%	X
	Emergency medical transportation (ambulance)	30%	X
Hospital Stay	Inpatient Hospital services	30%	X
	Inpatient Physician and Surgical Services	30%	X
	Inpatient Rehabilitation Services	30%	X
	Inpatient Habilitation Services	30%	X
Help recovering or other health needs	Speech Therapy	30%	X
	Physical Therapy	30%	X
	Occupational Therapy	30%	X
	Durable medical equipment[1]	30%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing
[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver (94% AV) Standardized Plan

(On-Exchange Individual Market and Off-Exchange Individual Market through the Public Benefit Corporation)

Actuarial Value			**94.5%**
Individual Deductible (Combined Medical & Drug)			$100
Individual Out-of-Pocket Maximum			$1,225
Family Deductible			$200
Family Out-of-Pocket Maximum			$2,450
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$40	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	20%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	20%	X
Tests	Laboratory tests	20%	X
	X-rays and diagnostic imaging	20%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	20%	X
Drugs to treat Illness or	Tier 1	$0	

Condition	Tier 2	$0	
	Tier 3	$20	
	Tier 4	$40	
	Tier 5	$60	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	20%	X
	Physician/Surgical Services	20%	X
Need Immediate Attention	Urgent care centers or facilities	$40	
	Emergency room services	20%	X
	Emergency medical transportation (ambulance)	20%	X
Hospital Stay	Inpatient Hospital services	20%	X
	Inpatient Physician and Surgical Services	20%	X
	Inpatient Rehabilitation Services	20%	X
	Inpatient Habilitation Services	20%	X
Help recovering or other health needs	Speech Therapy	20%	X
	Physical Therapy	20%	X
	Occupational Therapy	20%	X
	Durable medical equipment[1]	20%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing
[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver Off Exchange Standardized Plan

(Individual Market Off-Exchange)

Actuarial Value			**70.0%**
Individual Deductible (Combined Medical & Drug)			$4,000
Individual Out-of-Pocket Maximum			$9,000
Family Deductible			$8,000
Family Out-of-Pocket Maximum			$18,000
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$80	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	40%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	40%	X
Tests	Laboratory tests	40%	X
	X-rays and diagnostic imaging	40%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	40%	X
Drugs to treat Illness or	Tier 1	$0	

Condition	Tier 2	$20	
	Tier 3	$125	
	Tier 4	$300	
	Tier 5	$650	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	40%	X
	Physician/Surgical Services	40%	X
Need Immediate Attention	Urgent care centers or facilities	$80	
	Emergency room services	40%	X
	Emergency medical transportation (ambulance)	45%	X
Hospital Stay	Inpatient Hospital services	40%	X
	Inpatient Physician and Surgical Services	40%	X
	Inpatient Rehabilitation Services	40%	X
	Inpatient Habilitation Services	40%	X
Help recovering or other health needs	Speech Therapy	40%	X
	Physical Therapy	40%	X
	Occupational Therapy	40%	X
	Durable medical equipment[1]	40%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing
[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Bronze Standardized Plan

Actuarial Value			**63.5%**
Individual Deductible (Combined Medical & Drug)			$7,500
Individual Out-of-Pocket Maximum			$9,200
Family Deductible			$15,000
Family Out-of-Pocket Maximum			$18,400
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	First 3 visits $0, then deductible, then $50	X
	Specialist visit	50%	X
Pregnancy	Prenatal and postnatal visits	First 3 visits $0, then deductible, then $50	X
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	50%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	50%	X
Tests	Laboratory tests	50%	X
	X-rays and diagnostic imaging	50%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	50%	X
Drugs to treat Illness or Condition	Tier 1	$0	
	Tier 2	$30	

	Tier 3	$200	
	Tier 4	$350	
	Tier 5	$700	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	50%	X
	Physician/Surgical Services	50%	X
Need Immediate Attention	Urgent care centers or facilities	50%	X
	Emergency room services	50%	X
	Emergency medical transportation (ambulance)	50%	X
Hospital Stay	Inpatient Hospital services	50%	X
	Inpatient Physician and Surgical Services	50%	X
	Inpatient Rehabilitation Services	50%	X
	Inpatient Habilitation Services	50%	X
Help recovering or other health needs	Speech Therapy	50%	X
	Physical Therapy	50%	X
	Occupational Therapy	50%	X
	Durable medical equipment[1]	50%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing
[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Regulation 4-2-82 CONCERNING CARRIER NOTICES TO POLICYHOLDERS FOR REASONABLE MODIFICATIONS, DISCONTINUANCES, MARKET EXITS, DRUG FORMULARY MODIFICATIONS AND CARRIER RENEWAL FOR SMALL GROUP PLANS AND OFF-EXCHANGE PLANS

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109, 10-16-105.1(6)(a), 10-16-105.7(3)(c), 10-16-122.4(2), and 10-16-109 C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide carriers with the policyholder notice templates for plans that are being modified through the reasonable modifications process in accordance with Colorado Insurance Regulation 4-2-27, being discontinued in accordance with Colorado Insurance Regulation 4-2-51, or being continued without modification. The regulation provides notice templates for carrier's exit from the health insurance market, and modifications to current prescription drug formularies during the current plan year in accordance with Colorado Insurance Regulation 4-2-93.

Section 3 Applicability

This regulation applies to all carriers offering non-grandfathered and grandfathered individual health benefit plans, small group and large group health benefit plans, and student health insurance coverage. This regulation does not apply to short-term limited duration health benefit plans.

Section 4 Definitions

A. "ACA" or "PPACA" means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

B. "Carrier" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(8), C.R.S.

C. "Exchange" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(26), C.R.S.

D. "Health Benefit Plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(32), C.R.S.

E. "Market Exit" shall, for the purposes of this regulation, mean a discontinuance of all of a carrier's health benefit plans or student health insurance coverage policies.

F. "Plan" means, for the purposes of this regulation, the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, specific cost-sharing amounts, provider network, and service area.

G. "Prescription drug formulary" or "list of covered drugs" is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

H. "Reasonable modification" means, for the purposes of this regulation, a modification to the benefits of a plan that is fair and reasonable, as determined by the Division of Insurance (Division), and does not necessitate the filing of a new plan.

I. "Student Health Insurance Coverage" shall, for the purpose of this regulation, have the same meaning as found at § 10-16-102(65), C.R.S.

Section 5 Reasonable Modification Notices

A. Carriers shall use the policyholder notice language in Appendix A for Individual plans and Appendix B for Small Group plans for existing plans that are renewing with modifications. Carriers must not alter the sections of the notice but may modify the language with Division approval.

B. Carriers must also include the following:

1. A side-by-side comparison of the modified benefits which shall contain:

a. A first column identifying the "Benefit Name";

b. A second column identifying the "Current Benefit"; and

c. A third column identifying the "New Benefit".

2. The required notice must include the following options:

a. Continuing the current plan;

b. Purchasing another plan with the same carrier;

c. Purchasing a new plan with another carrier; and

d. Purchasing a new plan through the Exchange with the same carrier or another carrier.

C. Carriers must send the required notice to:

1. Individual policyholders no less than ninety (90) days prior to January 1.

2. Small group policyholders no less than ninety (90) days prior to renewal.

Section 6 Carrier Discontinued Plan Notices

A. Carriers must use the policyholder notice in Appendix C for individual plans or Appendix D for small group plans in order to provide sufficient notification to policyholders when a carrier is discontinuing a plan. Additional communication with the policyholders regarding their enrollment options is not prohibited.

B. Carriers must include the following options for discontinued on-exchange individual plans only:

1. Purchasing any other plan offered by the carrier;

2. Purchasing a plan from another carrier; and

3. Purchasing a new plan through the Exchange with the same carrier or another carrier.

C. Carriers must include the following options for discontinued off-exchange individual plans and discontinued small group plans:

1. Purchasing any other plan offered by the carrier;

2. Purchasing a plan from another carrier; and

3. Purchasing a new plan through the Exchange with the same carrier or another carrier.

D. Carriers must include the following options for discontinued large group plans and student health insurance coverage:

1. Purchasing any other plan options offered by the carrier; and

2. Purchasing a plan from another carrier.

E. Carriers must send the notice to the policyholder at least ninety (90) days prior to the discontinuance effective date.

Section 7 Carrier Market Exit Notices

A. Carriers must use the policyholder notice in Appendix E, when the carrier is exiting the market, in order to provide sufficient notification to policyholders. Additional communication with the policyholders regarding their enrollment options is not prohibited.

B. Carriers must include the following options for individual and small group plans:

1. Purchasing another plan from another carrier; and

2. Purchasing a plan through the Exchange.

C. Carriers must send the notice to the policyholder at least 180 days prior to the market exit effective date.

Section 8 Carrier Renewal Notice for Off-Exchange Plans

Carriers must use the notification found in Appendix F of this regulation for off-exchange plans only, when the carrier is renewing off-exchange plans.

Section 9 Carrier Renewal Notice for Small Group Plans

Carriers must use the notification found in Appendix G of this regulation only when renewing small group plans, regardless of whether the carrier has made any reasonable modifications to the plan.

Section 10 Carrier Prescription Drug Formulary Modification Notices for Individual Health Benefit Plans

A. Carrier must use the notification found in Appendix H to inform individual health benefit plan policyholders that the carrier is modifying or applying a modification to the current prescription drug formulary or list of covered drugs during the current plan year pursuant to section 10-16-122.4(2), C.R.S. and Colorado Insurance Regulation 4-2-93.

The notice must include:

1. the prescription drug(s) subject to the mid-year formulary modification;

2. the action taken, including moving the drug(s) to a higher cost sharing tier or removing the drug from the carrier's formulary;

3. the reason for the modification pursuant to section 10-16-122.4, C.R.S.;

4. the preferred alternative prescription drug(s).

B. Carriers must send the notice to individual policyholders at least sixty (60) days prior to the prescription drug formulary modification effective date.

Section 11 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 12 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 13 Effective Date

This regulation shall be effective May 30, 2023.

Section 14 History

New regulation effective May 30, 2022.
Amended regulation effective May 30, 2023.

Appendix A – Individual Policyholder Notice Template for Plans with Reasonable Modifications

[Carrier Logo and name]

[Current health plan name]

Dear [Policyholder Name or Covered Person Name],

Your health insurance coverage is coming up for renewal. Your current plan [Plan Name] will continue to be offered in the upcoming [Upcoming Year] plan year, **with changes**. Your plan will automatically renew on January 1, [Upcoming Year]. If you want to keep your plan, just pay your new monthly premium on time.

You should review the changes to your benefits, confirm that your health care providers are still in the plan's network and confirm any prescriptions you take are still covered.

You can change plans by enrolling in a new plan by visiting [Carrier Website Address], ConnectforHealthCO.com, or by speaking with your Broker or Assister.

Changes that are being made to your current health plan:

Plan Name		
Benefit Name	Current Benefit	New Benefit
[PCP Office Visit Copay]	[$20.00]	[$25.00]
[Benefit Name]	[Dollar Amount]	[Dollar Amount]
Add additional lines as needed		

What if I want to change plans?

- The [Upcoming Year] Open Enrollment period is from [Date] to [Date]. If you would like to switch to a different plan with coverage that starts on January 1, [Upcoming Year], the deadline to enroll is December 15, [Current Year].
- You can choose a new plan from us, another insurance carrier or through Connect for Health Colorado. You or your family may also qualify for Health First Colorado (Colorado's Medicaid Program) or the Child Health Plan Plus (CHP+) both of which are public programs that offer low-cost health coverage.
- If you qualify for financial assistance and/or lower costs, you can get those savings only if you enroll through Connect for Health Colorado.
- You can always contact us, a broker, a Health Coverage Guide, or a Connect for Health Colorado customer service representative for any help you may need.

What else should I look at before deciding to keep or change my plan?

Call us or visit [Website Address] to make sure your doctor and other health care providers are currently listed in the network for the [Upcoming Year] plan year, as this may have changed. Also check to make sure any prescription medications you take will be covered.

Questions?

- For plan or benefits questions, please call [Carrier Name, Contact Information and Hours of Operation] or visit [Website Address].

- For premium tax credit and eligibility questions or to learn more about qualifying for financial assistance, please call a Connect for Health Colorado customer service representative at 1-855-752-6749 (TTY: 1-855-346-3432) or visit ConnectforHealthCO.com.

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.]

Spanish (Español): Para obtener asistencia in Español, llame al [Carrier Contact Information.]

Thank you,

[Carrier Logo or Signature]

Appendix B Small Group Policyholder Notice Template for Plans with Reasonable Modifications

[Carrier Logo and name]

[Current health plan name]

Dear [Policyholder Name],

Your health insurance coverage is coming up for renewal. Your current plan [Plan Name] will continue to be offered in the upcoming [Upcoming Year] plan year **with changes**. If you want to keep your plan, you must pay the new monthly premium at the established payment due date and your plan will automatically renew on [Renewal Date]. You should review the changes being made to this group policy to determine if you want to renew this plan or change to a new plan. You can change plans by enrolling in a new plan by visiting [Carrier Website Address], ConnectforHealthCO.com, or by speaking with your broker.

Changes that are being made to your current health plan(s):

Plan Name		
Benefit Name	Current Benefit	New Benefit
[PCP Office Visit Copay]	[$20.00]	[$25.00]
Add additional lines as needed		

What if I want to change plans?

- You can choose a new plan from us, another insurance carrier or through Connect for Health Colorado.
- You can always contact us, a broker, a Health Coverage Guide, or a Connect for Health Colorado customer service representative for any help you may need.

Questions?

- For plans or benefits questions, please call [Carrier Name, Contact Information and Hours of Operation] or visit [Website Address].
- Please contact your broker or, if you purchased the plan through Connect for Health Colorado, contact Connect for Health CO at 1-855-752-6749 or visit www.connectforhealthCO.com.

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.]

Spanish (Español): Para obtener asistencia en Español, llame al [Carrier Contact Information.]

Thank you,

[Carrier Logo]

Appendix C – Carrier Discontinuance Notice for Individual Plans

[Carrier Logo and name]

[Current health plan name]

Dear [Policyholder Name],

We would like to notify you that your current policy will be discontinued or not renewed at least ninety (90) days from now, on [Effective Date] because [company name] will no longer offer your current health plan in the State of Colorado. You must enroll prior to [date] to avoid a gap in coverage.

This discontinuance triggers a special enrollment period which allows you to select a new health plan. You will have sixty (60) days before your plan ends and sixty (60) days after the date your plan ends to enroll in a new plan.

You may begin shopping for a new health benefit plan immediately to replace the plan that is ending, and you can enroll in a new health benefit plan up to sixty (60) days before your current plan ends, but you will need to be able to provide proof that your current plan is ending to the carrier of the plan you want to enroll in.

This notice can serve as the proof required for enrollment in a new plan. Knowing your plan is ending gives you the ability to enroll in a new plan with coverage beginning no earlier than the day this coverage ends so that you may avoid a gap in coverage.

Your options include:

- [Purchasing [Marketing Name] plan from us;] [Use for On-Exchange Individual Plans Only]
- Purchasing another [individual/small group/large group] health plan from us;
- Purchasing a plan from another carrier; or
- Purchasing a new plan through Connect for Health Colorado, where you may qualify for federal financial assistance (www.connectforhealthco.com).

[If student health insurance coverage is involved, use:

If you are in need of a new student health insurance coverage plan, please contact your [school/college/university] directly to determine what plans are available.]

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.

Spanish (Español): Para obtener asistencia en Español, llame al [Carrier Contact Information.]

Thank you,

[Carrier Logo]

Appendix D – Carrier Discontinuance Notice for Small/Large Group

[Carrier Logo and name]

[Current health plan name]

Dear [Policyholder Name],

We would like to notify you that your current policy will be discontinued or not renewed at least ninety (90) days from now, on [Effective Date] because [company name] will no longer offer your current health plan in the State of Colorado.

Your options include:

- Purchasing another [small group/large group] health plan from us;
- Purchasing a plan from another carrier; or
- [Purchasing a new plan through Connect for Health Colorado, where you may qualify for federal financial assistance (www.connectforhealthCO.com.] [Use for small group only]

Questions?

For plans or benefits questions, please call [Carrier Name, Contact Information and Hours of Operation] or visit [Website Address].

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state:

Spanish (Español): Para obtener asistencia en Español, llame al [Carrier Contact Information.]

Thank you.

[Carrier Logo]

Appendix E: Carrier Market Exit Required Notice

[Carrier Logo and name]

[Current health plan name]

Dear [Policyholder]:

We, [Carrier name], would like to notify you that we will no longer be offering plans in the [individual/ small group/ large group/ student health] market in the State of Colorado. The market exit is effective on [Effective Date].

[If the market exit pertains to an individual/ student health insurance market, use the following paragraph:

This market exit triggers a special enrollment period which allows you to select a new health benefit plan during the 180 days before your health benefit plan ends. You may select any plan from any other carrier available either through your broker, a health coverage guide or through Connect for Health Colorado (www.connectforhealthCO.com).]

[If the market exit pertains to the small group market use the following paragraph:

[For employer policyholder:

If you choose not to provide group health coverage as a result of this notice, your employees will have a special enrollment period to enroll in individual coverage during the sixty (60) days before their health benefit plan ends or during the annual open enrollment period which is November 1, [Current Year] through January 15, [Upcoming Year].

[Notice to small group/large group employee:

In the event your employer chooses not to provide group health coverage as a result of this notice, you will have a special enrollment period to enroll in individual coverage during the sixty (60) days before the end of the health benefit plan or during the open enrollment period from November 1, [Current Year] through January 15, [Upcoming Year]. For coverage to be effective prior to the end of the current coverage, you will want to enroll in new coverage by the 15th of the month preceding the effective date of the termination of coverage, [Effective Date].]

You may begin to shop for another plan at this time to replace the plan you are currently enrolled in.

This notice can serve as the proof required for enrollment in a new plan. Knowing you plan is ending gives you the ability to enroll in a new plan with coverage beginning no earlier than the day this coverage ends so that you may avoid a gap in coverage.

We are not going to be selling new [individual, small group, large group, student health insurance] plans so you will not be able to purchase a new plan from us.

Your options include:

- Purchasing a new plan from another carrier.
- Purchasing a new plan through Connect for Colorado, where you may qualify for federal financial assistance (www.connectforhealthCO.com).

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.

Spanish (Español): Para obtener asistencia en Español, llame al [Carrier Contact Information.]

Thank you.

[Carrier Logo]

Appendix F: Carrier Renewal Notice for Off-Exchange Plans

[Carrier Logo and name]

[Current health plan name]

Dear [Policyholder Name or Covered Person Name],

Your health insurance coverage is coming up for renewal. Your current plan [Plan Name] will continue to be offered in the upcoming [Upcoming Year] plan year. If you want to keep your plan, you must pay the new monthly premium at the established payment due date and your [Current Year] plan will be automatically renewed on January 1, [Upcoming Year] *You should review changes to your benefits, check to confirm that your health care providers are in the plan's network and confirm any prescriptions you take are still covered.* You can change plans by enrolling in a new plan by visiting [Carrier Website Address], ConnectforHealthCO.com, or by speaking with your Broker or Assister.

Changes that are being made to your current health plan:

Premium – Your new premium starts in January. Your new premium will be $[Dollar Amount] each month.

[Insert table – Current [Current Year] Benefits vs. [Upcoming Year] Benefits]

Premium tax credits and other cost savings may be available to people who purchase a health plan through Connect for Health Colorado. To find out if you qualify based on your income and household size, go to ConnectforHealthCO.com.

What if I want to change plans?

- The [Upcoming Year] Open Enrollment period is from November 1, [Current Year] to January 15, [Upcoming plan year]. If you would like to switch to a different plan with coverage that starts on January 1, [Upcoming Year], the deadline to enroll is December 15, [Current Year].
- You can choose a new plan from us, another insurance company or through Connect for Health Colorado. You or your family may also qualify for Health Fist Colorado (Colorado's Medicaid Program) or Child Health Plan Plus (CHP+), both of which are public programs that offer low-cost health coverage.
- If you qualify for financial assistance and/or lower costs, you can get those savings only if you enroll through Connect for Health Colorado.
- You can always contact us, a Broker, Assister, or a Connect for Health Colorado customer service representative for any help you may need.

What else should I look at before deciding to keep or change my plan?

Call [Carrier Name] or visit [Website Address] to make sure your doctor and other health care provider are currently listed in the network for the [Upcoming Year] plan year, as they are subject to change. Also check to make sure any prescription medications you take will be covered.

Questions?

- For plan or benefits questions, please call [Carrier Name, Contract Information and Hours of Operation], or visit [Website Address].

- For premium tax credit and eligibility questions or to learn more about qualifying for financial assistance, please call a Connect for Health Colorado customer service representative at 1-855-752-6749 (TTY: 1-855-346-3432) or visit ConnectforHealthCO.com.

Getting Help in Other Languages

[Include for the following counties where the population with limited English proficiency exceeds 10% of the county's total population. Carriers must attach the taglines for the tope 15 languages spoken by individuals with Limited English Proficiency as required by 45 CFR § 92.8(f)(1) and the non-discrimination statement required by 45 CFR § 92.8(a).]

Spanish (Español): Para obtener asistencia en Español, llame al [Carrier Contact Information.]

Thank you,

[Carrier Logo]

Appendix G: Carrier Renewal Notice for Renewing Small Group Plans

[Carrier Logo and name]

[Current health plan name]

Dear [Policyholder Name],

Your health insurance coverage is coming up for renewal. Your current plan [Plan Name] will continue to be offered in the upcoming [Upcoming Year] plan year. If you want to keep your plan, you must pay the new monthly premium at the established payment due date and your [Current Year] plan will be automatically renewed in your on [Date], [Upcoming Year]. You can change plans by enrolling in a new plan by visiting [Carrier Website Address], ConnectforHealthCO.com, or by speaking with your Broker.

Changes that are being made to your current health plan:

Premium – Your new premium starts in [Month]. Your new premium will be $[Dollar Amount] each month.

[Insert table – Current [Current Year] Benefits vs. [Upcoming Year] Benefits]

Premium tax credits may be available through Connect for Health Colorado. To find out if you qualify, go to ConnectforHealthCO.com.

What if I want to change plans?

- You can choose a new plan from us, another insurance company or through Connect for Health Colorado.
- You can always contact us, a Broker, or a Connect for Health Colorado customer service representative for any help you may need.

What else should I look at before deciding to keep or change my plan?

Call [Carrier Name] or visit [Website Address] to make sure your doctor and other health care provider are currently listed in the network for the [Upcoming Year] plan year, as they are subject to change. Also check to make sure any prescription medications you take will be covered.

Questions?

- For plan or benefits questions, please call [Carrier Name, Contract Information and Hours of Operation], or visit [Website Address].
- For premium tax credit and eligibility questions or to learn more about qualifying for financial assistance, please call a Connect for Health Colorado customer service representative at 1-855-752-6749 (TTY: 1-855-346-3432) or visit ConnectforHealthCO.com.

Getting Help in Other Languages

[Include for the following counties where the population with limited English proficiency exceeds 10% of the county's total population. Carriers must attach the taglines for the tope 15 languages spoken by individuals with Limited English Proficiency as required by 45 CFR § 92.8(f)(1) and the non-discrimination statement required by 45 CFR § 92.8(a).]

Spanish (Español): Para obtener asistencia en Español, llame al [Carrier Contact Information.]

Thank you,

[Carrier Logo]

Appendix H – Carrier Prescription Drug Formulary Modification Notice Template for Individual Health Benefit Plans

[Carrier Logo and name]

[Current individual health plan name]

Dear [Policyholder Name or Covered Person Name],

We are making changes to your prescription drug formulary list effective [insert effective date of change]

Please read this letter for important information about your pharmacy benefit. Colorado law requires we notify you in advance of changes to your current prescription drug benefit.

You should review the changes to your pharmacy benefits and discuss with your healthcare provider how these changes might impact you. If you have questions regarding your pharmacy benefit and the benefit updates below, please contact us.

What change is being made to my pharmacy benefit? [select one]

Your medication is moving to a higher cost-sharing tier.

On [insert effective date of change], the medication listed below will be moved to a higher cost-sharing prescription drug tier on your current plan's drug formulary. As a result, your medication may cost you more to fill at the pharmacy. We are making this change because:

[Select one]:

- a generic drug or biosimilar drug was added to the formulary that is approved by the U.S. Food and Drug Administration (FDA) for use as a therapeutic equivalent*;
- a generic drug or biosimilar drug was added to the formulary that is in a drug cost sharing tier with a lower copay or deductible than the brand-name drug*;
- the medication's underlying cost was greater than $500 at the start of the benefit year and increased by a net cost of at least fifteen percent during the benefit year and the medication will be replaced on the formulary with a therapeutically equivalent generic or multi-source brand name drug, an interchangeable biologic, or biosimilar drug that is available at a lower cost.

Your plan still covers medications that are used to treat the same condition, and those alternatives are listed below.

Your medication (moving to a higher tier)	Generic and/or biosimilar alternative(s)
[Drug name]	[Alternative drug name] [Alternative drug name] [Alternative drug name]

*Please check your plan materials to learn more about how your plan covers brand name medications that have a generic equivalent available. Depending on your plan, you may have to pay an additional charge (on top of your plan's cost-share) for filling the brand name medication.

Your medication is being removed from your prescription drug formulary.

On [insert effective date of change], the medication listed below will no longer be covered on your current plan's prescription drug formulary. If you continue to fill this prescription on or after [insert effective date of change], you will pay the full cost of the medication out-of-pocket. We are making this change because:

[Select one]:

- the U.S. Food and Drug Administration (FDA) has issued a notice regarding the clinical safety of this medication; or
- the medication is approved by the U.S. Food and Drug Administration (FDA) for use without a prescription; or
- the medication's underlying cost was greater than $500 at the start of the benefit year and increased by a net cost of at least fifteen percent during the benefit year and the medication will be replaced on the formulary with a therapeutically equivalent generic or multi-source brand name drug, an interchangeable biologic, or biosimilar drug that is available at a lower cost.

Your plan still covers medications that are used to treat the same condition, and those alternatives are listed below.

You medication (Will not be covered without prior approval)*	Generic and/or biosimilar alternative(s)
[Drug name]	[Alternative drug name] [Alternative drug name] [Alternative drug name]

*This medication needs approval from [insert carrier name] before your plan will cover it. If your doctor feels an alternative medication is not right for you, he or she can ask [insert carrier name] to consider approving coverage of your medication. If you do not get approval and you continue to fill this prescription on or after [insert effective date of change], you will pay the full cost of the medication out-of-pocket directly to the pharmacy.

What are my next steps?

- Discuss your options with a healthcare professional.
- Ask if the suggested therapeutically equivalent generic or biosimilar alternative may be right for you. If your doctor agrees, ask for a new prescription. Or, ask your pharmacist to contact your doctor for a new prescription. You do not have to wait until [effective date of change] to do this – you can change your prescription at any time. You should do this now, before your medication coverage changes.

- If your doctor wants you to continue taking your current medication, please ask your doctor's office to contact [carrier's name] before [effective date of change] and we can start the coverage review process.

- If your medication will be excluded from coverage, ask if there's another treatment option that will work for you.

Questions?

- For plan or benefits questions, please call [Carrier Name, Contact Information and Hours of Operation] or visit [Website Address].

Getting Help in Other Languages

[Include the tagline below for the top languages spoken by 10% or more of the population in the state.]

Spanish (Español): Para obtener asistencia in Español, llame al [Carrier Contact Information.]

Thank you,

[Carrier Logo]

Regulation 4-2-83 CONCERNING HEALTH INSURANCE AFFORDABILITY ENTERPRISE SUBSIDIES FOR QUALIFIED INDIVIDUALS THROUGH PREMIUM WRAP AND COST SHARING REDUCTION ENHANCEMENTS ON THE COLORADO OPTION SILVER PLAN

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-1207(5), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide standards for including payments to carriers pursuant to C.R.S. § 10-16-1205(1)(b)(III) in rate filings for health benefit plans regulated by the Colorado Division of Insurance and guidelines for the Colorado Option Silver Enhanced Benefit Plan.

Section 3 Applicability

This regulation applies to all carriers issuing non-grandfathered individual health benefit plans starting in benefit year 2024 and annually thereafter.

Section 4 Definitions

A. “Actuarial value” and “AV” means, for the purpose of this regulation, the percentage of total average costs for covered benefits that a health benefit plan will cover, with calculations based on the provision of essential health benefits to a standard population.

B. “Benefit year” shall have the same meaning as found at § 10-16-1103(2), C.R.S.

C. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

D. “Colorado Option Silver Enhanced Plan” or “Silver Enhanced Plan” means, for the purpose of this regulation, the Colorado Option Silver Plan offered by Connect for Health on the Colorado Public Benefit Corporation with an increase in the plan’s actuarial value to 94% and a $0 premium containing the same plan design and cost-sharing as the Colorado Option On-Exchange Silver (94% AV) Standardized Plan.

E. “Colorado Option Silver Plan” or “Silver Plan” means, for the purpose of this regulation, the Colorado Option Silver Off Exchange Standardized Plan, the standardized health benefit plan offered by Connect for Health Colorado off exchange on the Public Benefit Corporation.

F. "Colorado Plans and Benefits Template" or "Colorado PBT" means, for the purpose of this regulation, the Colorado PBT created and supplied by the Division to use when submitting any Standardized Plan on the PBC.

G. "Cost Sharing Reduction Enhancement" or "CSR Enhancement" means, for the purpose of this regulation, an increase in the Colorado Option Silver Plan's actuarial value to 94% for eligible enrollees.

H. "Eligible enrollee" means, for the purpose of this regulation, a Qualified Individual enrolled in a Colorado Option Silver Plan on the PBC whose household income is from 0-150% of the Federal Poverty Level.

I. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

J. "Federal Actuarial Value Calculator" or "Federal AV Calculator" means, for the purpose of this regulation, the AV Calculator required pursuant to 45 C.F.R. § 156.135(a).

K. "Federal Poverty Level" or "Federal Poverty Line" shall have the same meaning as found at § 10-16-1203(4), C.R.S.

L. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

M. "Health Insurance Affordability Board" shall have the same meaning as found at § 10-16-1207, C.R.S.

N. "Health Insurance Affordability Enterprise" or "Enterprise" shall have the same meaning as found at § 10-16-1203(3), C.R.S.

O. "Induced Demand Factor" shall mean the anticipated induced demand associated with the plan's cost sharing (metal) level.

P. "Metal AV Adjustment Factor" means, for the purpose of this regulation, the differences in Metal AV values as produced by the Federal AV Calculator and the actuarial values used by carriers in pricing.

Q. "Premium wrap" means, for the purpose of this regulation, financial subsidies to reduce eligible enrollees' monthly premium.

R. "Public Benefit Corporation" or "PBC" shall have the same meaning as found at § 10-16-1203(11), C.R.S.

S. "Qualified Individuals" shall have the same meaning as found in § 10-16-1203(12), C.R.S.

T. "Rate" means, for the purpose of this regulation, the value in the carrier's Rates Table Template available in SERFF corresponding to the enrollee's age, geographic rating area, and tobacco status.

U. "Rate filing" means, for the purpose of this regulation, a carrier's electronic submission to the Division in accordance with Colorado Insurance Regulation 4-2-39.

V. "Rates Table Template" means, for the purpose of this regulation, the Rates Table Template created by the Centers for Medicare and Medicaid Services.

W. "Standardized plans" shall have the same meaning as found at § 10-16-1303(14), C.R.S.

X. "URRT" means, for the purpose of this regulation, the Unified Rate Review Template created by the Centers for Medicare & Medicaid Services.

Section 5 HIAE Subsidy for Eligible Enrollees

For the 2024 benefit year, and annually thereafter, carriers shall offer the Colorado Option Silver Enhanced Plan to all eligible enrollees on the Public Benefit Corporation as recommended by the Health Insurance Affordability Board.

Section 6 Naming Conventions and Filing Requirements

A. Carriers shall use the following naming convention for Silver Enhanced Plans: "[Name of Carrier] Colorado Option Silver Enhanced 94%." The name of the carrier may be shortened to an easily identifiable acronym that is commonly used by the carrier in consumer facing publications.

B. Carriers shall use the same HIOS ID as the off-exchange Colorado Option Silver Plan using a newly established state plan identifier with an "07" suffix.

C. Carriers must file the Colorado Option Silver Enhanced Plan on the Colorado PBT. The Colorado PBT will be in the SERFF binder filing under the supporting documentation tab.

D. The URRT submitted with the carrier's rate filing shall reflect expected changes in enrollment and induced demand factor based on the increased uptake of the Silver Enhanced Plan.

Section 7 Requirements for CSR Enhancements and Premium Wrap

For the 2024 benefit year, and annually thereafter, carriers shall offer a CSR enhancement and a premium wrap to all eligible enrollees in a Silver Enhanced Plan.

A. The CSR enhancement shall increase the Silver Plan's actuarial value to 94% for eligible enrollees.

B. The premium wrap shall provide eligible enrollees a $0 premium for the Silver Plan.

Section 8 Payments to Carriers

A. Pursuant to C.R.S. § 10-16-1205(1)(b)(III), the Colorado Health Insurance Affordability Enterprise created in C.R.S. § 10-16-1204(1)(a), through the Division, will make payments to carriers by June 30, 2025 for the 2024 benefit year, and by June 30 of subsequent calendar years, to compensate for the cost of the premium wrap, plus the difference between the Colorado Option Silver Enhanced Plan Projected Claims Cost and the Colorado Option Silver Plan Projected Claims Cost.

B. The Division will calculate carrier payment amounts by adding the costs of the premium wrap and the cost sharing reduction enhancement into one payment to applicable carriers.

1. The cost of the annual premium wrap is the full monthly premium of the Silver Enhanced Plan for eligible enrollees times the number of months the enrollee is enrolled in the plan.

a. The monthly premium wrap is the eligible enrollee's rate.

b. The annual premium wrap is calculated as follows:

Monthly Premium Wrap X Enrollee's Month of Enrollment

The Enrollee's Months of Enrollment will be determined by data provided by the Exchange.

2. The cost of the CSR enhancement is calculated by determining the difference between what the carrier expects to pay in Silver Enhanced Plan claims costs and the Silver Plan claims costs using the following methodology.

a. A Silver Plan Claims Cost will be calculated as follows:

Rate X Incurred Claims as a Percent of Premium

The Incurred Claims as a Percent of Premium will be calculated as the URRT Worksheet 2, Total, line 4.15 divided by URRT Worksheet 2, Total, Line 4.17.

b. A Silver Enhanced Plan Claims Cost will be calculated as follows:

Silver Plan Claims Cost X (Silver Enhanced Plan Adjusted AV/Silver Plan Adjusted AV)

(1) The Silver Plan Claims Cost will be determined by the calculation in subsection 8(B)(2)(a).

(2) The Silver Enhanced Plan Adjusted AV will be calculated by the formula:

Metal AV X Silver 94% CSR Metal AV Adjustment Factor

(a) The Metal AV will be determined using the Actuarial Value of the Silver (94% AV) Standardized Plan, in accordance with Colorado Insurance Regulation 4-2-81.

(b) Section 9 provides the Silver 94% CSR Metal AV Adjustment Factor used in this calculation.

(3) The Silver Plan Adjusted AV will be calculated by the formula:

Metal AV X Silver Base (70%) Metal AV Adjustment Factor

(a) The Metal AV will be determined using the Actuarial Value of the Silver Off-Exchange Standardized Plan, in accordance with Colorado Insurance Regulation 4-2-81.

(b) Section 9 provides the Silver Base (70%) Metal AV Adjustment Factor used in this calculation.

c. The Payment to Carriers will be calculated as follows, for each eligible member during each month the member is enrolled (i.e., Per Member Per Month, or PMPM):

Payments to Carriers = Silver Enhanced Plan premium wrap +

(Silver Enhanced Plan Claims cost – Silver Plan Claims Cost)

(1) The Silver Enhanced Plan premium wrap will be determined by the calculation in subsection 8(B)(1)(b).

(2) The Silver Enhanced Plan Claims Cost will be determined by the calculation in subsection 8(B)(2)(b).

(3) The Silver Plan Claims Cost will be determined by the calculation in subsection 8(B)(2)(a).

(4) In cases where an enrollee is not enrolled for the full month, payments will be calculated on a pro rata basis.

d. The Division will apply this method consistently across carriers using values supplied in rate filings, particularly URRTs, PBTs, Colorado PBTs, and Rate Table Templates.

(1) This method provides an actuarially sound estimate of the claims cost by carrier, plan, and age for a given person insured in the Colorado individual market.

(2) This method will also allow for a determination of total cost after the completion of the previous benefit year given the actual population distribution and total member months during the benefit year.

Section 9 Metal AV Adjustment Factor

The Metal AV Adjustment Factor reflects the differences in Metal AV values produced by the Federal AV Calculator and the actuarial values used in pricing. Due to the confidentiality of carrier pricing models, an average adjustment will be applied and determined using the information provided to the Division in a data call. Based on the data submitted by carriers and an analysis completed by the Division, the Metal AV Adjustment Factor will vary by CSR variant and be revised annually. The Metal AV Adjustment Factors for the benefit year 2025 are listed in the table below:

Metal Level	Adjustment Applied to Metal AV
Silver Base (70%)	1.097
Silver 94% CSR	1.014

Section 10 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 11 Incorporation by Reference

45 C.F.R. § 156.135 published by the Government Printing Office shall mean 45 C.F.R. § 156.135 as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. 156.135(a). A copy of 45 C.F.R. § 156.135(a) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. 156.135(a) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 12 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 13 Effective Date

This amended regulation shall be effective October 30, 2024.

Section 14 History

New regulation effective June 14, 2022
Amended regulation effective November 14, 2022.
Amended regulation effective September 14, 2023.
Amended regulation effective October 30, 2024.

Regulation 4-2-84 CONCERNING THE SPECIAL ASSESSMENT ON HOSPITALS FOR THE COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-1205(5)(a) and 10-16-1207(5), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the process by which the Colorado Health Insurance Affordability Enterprise (Enterprise) will assess and collect the special assessment on hospitals, pursuant to § 10-16-1205(1)(a)(II) and (5)(a), C.R.S.

Section 3 Applicability

This regulation applies to all hospitals subject to the requirements found in title 10, article 16, part 12.

Section 4 Definitions

A. "Enterprise" shall have the same meaning as found at § 10-16-1203(3), C.R.S.

B. "Hospital," for the purposes of this regulation, means hospital as used in 10 CCR 2505-10, Section 8.3003.

Section 5 Special Assessment on Hospitals

A. The Division of Insurance (Division) will collect the special assessment on hospitals for calendar year 2022, in the amount of twenty (20) million dollars, by December 1, 2022.

B. The Division will collect the special assessment on hospitals for calendar year 2023, in the amount of twenty (20) million dollars, by December 1, 2023.

C. The Colorado Department of Health Care Policy and Financing will calculate the special assessment amounts for each hospital and notify hospitals of their special assessment amounts by November 1 of each year in which the assessment is collected.

D. The special assessment on hospitals shall be paid no later than December 1 of the year in which it is due.

E. The collection of the special assessment on hospitals must comply with the requirements found at 42 CFR § 433.68. As such, the percentage of the twenty million dollar annual assessment for which each hospital shall be responsible equals the percentage of the total inpatient and outpatient services fee for which each hospital is responsible pursuant to 10 CCR 2505-10, Section 8.3003

F. The Automated Clearing House debit process as provided in 10 CCR 2505-10, Section 8.3002.B.1. will be used to collect the special assessment on hospitals.

G. All special assessments on hospitals shall be deposited in the health insurance affordability cash fund established pursuant to § 10-16-1206(1)(b), C.R.S.

1. All monies generated from the special assessment on hospitals shall be expended for the Enterprise, and shall not transfer to any other fund or be used for any purpose other than the purposes specified in part 12 pursuant to § 10-16-1206(2), C.R.S.

2. None of the monies generated from the special assessment on hospitals are available for the general expenses of the state, nor are those monies credited to the state's general fund.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Incorporated Materials

10 CCR 2505-10:8.3002.B.1 shall mean 10 CCR 2505-10: 8.3002.B.1, as published by the Colorado Secretary of State on the effective date of this regulation and does not include later amendments to or editions of 10 CCR 2505-10: 8.3002.B.1. A copy of 10 CCR 2505-10:8.3002.B.1, may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 10 CCR 2505-10:8.3002.B.1, may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at https://www.sos.state.co.us.

10 CCR 2505-10:8.3003shall mean 10 CCR 2505-10:8.3003, as published by the Colorado Secretary of State on the effective date of this regulation and does not include later amendments to or editions of 10 CCR 2505-10:8.3003. A copy of 10 CCR 2505-10:8.3003, may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 10 CCR 2505-10:8.3003.A.3, may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at https://www.sos.state.co.us.

42 CFR § 433.68 shall mean 42 CFR § 433.68 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 42 CFR § 433.68. A copy of 42 CFR 433.68 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 42 CFR § 433.68 may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at https://www.ecfr.gov.

Section 8 Enforcement

If a hospital fails to pay the special assessment owed by that hospital, the Commissioner of Insurance may use all powers conferred by the laws of this state to enforce payment of the special assessment on hospitals.

Section 9 Effective Date

This regulation shall become effective June 14, 2022.

Section 10 History

New regulation effective June 14, 2022.

Regulation 4-2-85 CONCERNING THE METHODOLOGY FOR CALCULATING PREMIUM RATE REDUCTIONS FOR COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-109, 10-16-1304, 10-16-1305, 10-16-1306, and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for the required premium reduction methodology for the Colorado Option standardized bronze, silver and gold health benefit plans to be offered by all carriers offering individual and small group health benefits plans issued or renewed on or after January 1, 2025.

Section 3 Applicability

This regulation applies to all carriers offering individual and small group health benefit plans subject to the individual and small group laws of Colorado and the requirements of federal law.

If Colorado's Section 1332 Innovation Waiver Request for the Colorado Option is not approved by the U.S. Department of Health and Human Services and the Department of Treasury, then these premium reductions will not go into effect.

Section 4 Definitions

A. "Actuarial value" or "AV" means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a health benefit plan will cover, with calculations based on the provision of essential health benefits to a standard population.

B. "Baseline Plan" or "2021 Baseline Plan" means, for the purposes of this regulation, the health benefit plan with the carrier's lowest 21-year-old non-tobacco use premium rate, by metal level, in the applicable county from the 2021 Benefit Year, regardless of whether the health benefit plan is sold in the entire county or a partial county. The Baseline Plan shall only consider on-exchange health benefit plans for the Individual market and be determined prior to the impact of the Colorado reinsurance program. The Baseline Plan shall only consider off-exchange health benefit plans for the Small Group market.

C. "Benefit Year" means, for the purposes of this regulation, the calendar year for individual health benefit plans, or the twelve month period beginning with the health benefit plan contract date for small group health benefit plans.

D. “Calibrated Plan Adjusted Index Rate” means, for the purpose of this regulation, line 3.14 on Worksheet 2 of the URRT.

E. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

F. “Colorado Option Standardized Plan” or “Standardized Plan” or shall have the same meaning as found at § 10-16-1303(14), C.R.S.

G. “CSR” means, for the purposes of this regulation, a cost-sharing reduction health benefit plan variation defined in 45 C.F.R. § 156.420(a).

H. “CSR Load” means, for the purposes of this regulation, the load in the silver plan premiums necessary to cover the cost of providing the CSR benefit to qualified consumers in the on-exchange silver health benefit plans.

I. “CPI-U” means, for the purposes of this regulation, the Consumer Price Index for all urban consumers, U.S. city average, and all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.

J. “Essential health benefits” or “EHB” shall have the same meaning as found at § 10-16-102(22), C.R.S.

K. “Exchange” shall have the same meaning as found at § 10-16-102(26), C.R.S.

L. “Expanded bronze” means, for the purposes of this regulation, a bronze health benefit plan that provides coverage for at least one (1) major service, other than preventive services, prior to meeting the deductible, or meets the requirements to qualify as a high deductible health plan under 26 U.S.C 223(c)(2), as established at 45 C.F.R. § 156.140(c), with a bronze actuarial value of 60%.

M. “Federal Actuarial Value Calculator” or “Federal AV Calculator” means, for the purposes of this regulation, the AV Calculator required pursuant to 45 C.F.R. 156.135.

N. “Federal law” shall have the same meaning as found at § 10-16-102(29), C.R.S.

O. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

P. “Healthcare coverage cooperative” shall have the same meaning as found at § 10-16-1002(2), C.R.S.

Q. “Induced demand factor” means, for the purposes of this regulation, the anticipated induced demand associated with the health benefit plan’s cost sharing (metal) level.

R. “Medical Inflation” shall have the same meaning as found at § 10-16-1303(10), C.R.S.

S. “Metal Level" means, for the purposes of this regulation, the bronze, silver, and gold health benefit plans available in the individual and small group market as found at § 10-16-103.4, C.R.S.

T. “Non-EHB” means, for the purposes of this regulation, any benefit in a health benefit plan that is not an EHB as found at § 10-16-102(22), C.R.S.

U. “Plans and Benefits Template” or “PBT” means, for the purpose of this regulation, the Plans & Benefits Template created by the Centers for Medicare & Medicaid Services (CMS).

V. “Premium” shall have the same meaning as found at § 10-16-102(51), C.R.S.

W. "Reinsurance" shall have the same meaning as found at § 10-16-1103(12), C.R.S.

X. "SERFF" means, for the purposes of this regulation, System for Electronic Rate and Form Filing.

Y. "Supplemental Template" shall have the same meaning as found at Colorado Insurance Regulation 4-2-39 Section (6)(C)(3).

Z. "Substantially Similar Plan" means, for the purposes of this regulation, the silver level health benefit plan that is substantially similar to the on-exchange CSR-loaded silver health benefit plan, but without the CSR load, for those off-exchange consumers who do not qualify for advanced premium tax credits or CSRs.

AA. "URRT" means, for the purpose of this regulation, the Unified Rate Review Template created by the Centers for Medicare & Medicaid Services.

Section 5 Premium Rate Reduction Methodology for Colorado Option Standardized Health Benefit Plans

A. Pursuant to § 10-16-1305(2)(a)-(c), C.R.S., carriers offering a Standardized Plan at the bronze, silver, and gold metal levels must offer standardized plans with a premium that is reduced by a specified percent relative to their 2021 premiums, after adjustments for medical inflation. The Division will define the allowable adjustments for the calculation of the premium rate reduction methodology required for the Colorado Option. The required premium reductions are:

1. Five percent premium reduction for the Benefit Year beginning in 2023;

2. Ten percent premium reduction for the Benefit Year beginning in 2024; and

3. Fifteen percent premium reduction for the Benefit Year beginning in 2025.

B. Pursuant to § 10-16-1305(2)(d), C.R.S., for the Benefit Year beginning on or after January 1, 2026, and each year thereafter, each carrier and healthcare coverage cooperative shall limit any annual premium rate increase to a rate that is no more than medical inflation, relative to the previous year.

C. The Division will calculate whether a carrier meets the premium reductions specified in Sections 5.A. and 5.B. using the following methodology.

1. Bronze and Expanded Bronze health benefit plans will be combined to determine the lowest cost premium rate for the Bronze Colorado Option Standardized Plan.

2. The 2021 Baseline Plan Unadjusted Premium will be calculated on a county, metal level, and market basis for each carrier. The 2021 Baseline Plan Unadjusted Premium will be calculated as follows:

a. For the Individual Market:

(1) 2021 Baseline Plan Unadjusted Premium =

(minimum 2021 Calibrated Plan Adjusted Index Rate offered in the county for the metal level) x (1.0 age factor) x (2021 Geographic Rating Factor for the applicable county)

(2) The Minimum 2021 Calibrated Plan Adjusted Index Rate will be determined using the carrier's 2021 "No Reinsurance" URRT.

b. For the Small Group Market:

(1) 2021 Baseline Plan Unadjusted Premium =

(minimum annual filing 2021 Calibrated Plan Adjusted Index Rate offered in the county for the metal level) x ((fourth quarter rate of 2021 Baseline Plan) / (first quarter rate of 2021 Baseline Plan)) x (1.0 age factor) x (2021 Geographic Rating Factor for the applicable county)

(2) If a carrier submitted quarterly rate filing(s) subsequent to the annual filing, the last filing submitted will be used to determine the fourth quarter rate for the Baseline plan.

3. An adjustment factor will be applied to reflect changes in the member cost sharing from the 2021 Baseline Plan to the applicable Colorado Option Standardized Plan design and underlying data changes in the 2023, 2024, and 2025 federal AV calculators, including meaningfully different changes across the various metal levels beyond the impact of claim cost and utilization trends and trend leveraging. The Changes in Member Cost Sharing Adjustment will be calculated as follows:

(Colorado Option Standardized Plan AV) x (CY2023 AV Calculator Adjustment) x (CY2024 AV Calculator Adjustment) x (CY2025 AV Calculator Adjustment) x (Pricing AV Adjustment)

÷

(2021 Baseline Plan AV)

a. Colorado Option Standardized Plan AV for the applicable metal level.

b. The CY2023 AV Calculator Adjustment will be:

(1) 0.992 for Gold Metal Level Plans

(2) 0.971 for Silver Metal Level Plans

(3) 1.002 for Bronze Metal Level Plans

c. The CY2024 AV Calculator Adjustment will be:

(1) 1.017 for Gold Metal Level Plans

(2) 1.019 for Silver Metal Level Plans

(3) 1.020 for Bronze Metal Level Plans

d. The CY2025 AV Calculator Adjustment will be:

(1) 1.027 for Gold Metal Level Plans

(2) 1.040 for Silver Metal Level Plans

(3) 1.039 for Bronze Metal Level Plans

e. The Pricing AV Adjustment will be consistent across carriers and determined using information provided to the Division in a data call.

f. The 2021 Baseline Plan AV will be determined by the value entered in the carrier's PBT for the 2021 Baseline Plan.

4. An adjustment factor will be applied to reflect changes in the loading applied to Individual market Silver health benefit plans for CSR payments. The CSR load will be calculated for both the Colorado Option Standardized Plan and the 2021 Baseline Plan using the ratio of the on-Exchange silver health benefit plan and the off-Exchange Substantially Similar Plan. The CSR Load Adjustment will be calculated as follows:

(Colorado Option Standardized Plan CSR Load) ÷

(2021 Baseline Plan CSR Load)

a. The Colorado Option Standardized Plan CSR Load will be calculated using the Calibrated Plan Adjusted Index Rate for the on-exchange Colorado Option Standardized Silver Plan divided by the Calibrated Plan Adjusted Index Rate of the Substantially Similar off-Exchange Colorado Option Standardized Silver Plan.

b. The 2021 Baseline Plan CSR Load will be calculated using the Calibrated Plan Adjusted Index Rate for the 2021 Baseline Plan divided by the Calibrated Plan Adjusted Index Rate of the Substantially Similar off-Exchange plan of the 2021 Baseline Plan.

5. An adjustment factor will be applied to reflect changes in the induced demand factor applied in 2021 and the applicable Colorado Option Standardized Plan design. The Induced Demand Factor Adjustment will be calculated as follows:

(Colorado Option Standardized Plan Induced Demand Factor) ÷

(2021 Baseline Plan Induced Demand Factor)

a. The Colorado Option Standardized Plan Induced Demand Factor will be determined by the following formula:

Colorado Option Standardized Plan Induced Demand Factor =

$1.24 - (AV) + (AV)2$

b. The 2021 Baseline Plan Induced Demand Factor will be determined by the value supplied to the Division in a data call regarding 2021 plans. The 2021 Baseline Plan Induced Demand Factors are normalized based on the projected membership carriers assumed for the 2021 Benefit Year. To ensure the induced demand adjustment is consistent, a normalization factor will be developed and applied to the Induced Demand Factor using the formula in (a). This normalization factor will be developed separately for each carrier and ensure that the shift from carrier-specific induced demand factor to the federal induced demand formula is revenue-neutral across each carrier's 2021 rate filing.

6. The Adjustment for EHB Changes of 1.0016 will be applied to reflect the changes in the EHB-benchmark plan, which will be in effect starting with the 2023 Benefit Year. This adjustment will be based on the cost impact of the benefit changes in the actuarial analysis submitted to CMS for approval of these changes.

7. If the Baseline Plan has non-EHBs not reflected in the Colorado Option Standardized Plan, an adjustment will be made based on the EHB Percent of Total Premium in the Plan & Benefits Template for 2021. Additionally, if the 2021 Baseline Plan did not include any non-EHB benefits but the carrier chooses to offer allowable non-EHB benefits in the Colorado Option Standardized Plan, an adjustment would also be made based on the EHB Percent of Total Premium in the Plan & Benefits Template for the Benefit Year. The Adjustment for non-EHB Changes will be calculated as follows:

   ("EHB Percent of Total Premium" for 2021 Baseline Plan) ÷

   ("EHB Percent of Total Premium" for the Colorado Option Standardized Plan)

   a. The "EHB Percent of Total Premium" for the Colorado Option Standardized Plan will be determined by the value entered in the carrier's PBT for the Colorado Option Standardized Plan.

   b. The "EHB Percent of Total Premium" for the Baseline Plan will be determined by the value entered in the carrier's 2021 PBT.

8. The Medical Inflation Trend will be calculated as follows:

   (1 + "Medical Inflation) ^ (Months of Trend/12)

   a. "Medical Inflation" will be based on the latest CPI-U for Medical Care for the Denver-Aurora-Lakewood, CO Core Based Statistical Area published 30 days prior to the issuance of a Division bulletin by June 30, 2023 for the 2024 Benefit Year, and January 1 of each year thereafter.

   b. Months of Trend will be calculated as the difference between the midpoint of the Colorado Option Standardized Plan Benefit Year and the midpoint of the effective period of the 2021 Baseline Plan.

9. The Required Rate Reduction Factor will be calculated as follows:

   (1 – Benefit Year Required Rate Reduction Percentage)

   The Benefit Year Required Rate Reduction will equal 5% for Benefit Year 2023, 10% for Benefit Year 2024 and 15% for Benefit Years 2025 and all subsequent Benefit Years.

10. The Colorado Option Standardized Plan premium rate for a 21-year-old non-tobacco user, calculated on a county, metal level, and market basis for each carrier must be less than or equal to the Maximum Colorado Option Standardized Premium. The Maximum Colorado Option Standardized Plan Premium will be calculated as follows:

    a. For Colorado Option Standardized Gold and Bronze Plans in the Individual and Small Group markets, and Colorado Option Standardized Silver Plans in the Small Group Market:

       (1) Maximum Colorado Option Standardized Plan Premium =

       (2021 Baseline Plan Unadjusted Premium) x (Changes in Member Cost Sharing Adjustment) x (Induced Demand Factor Adjustment) x (Adjustment for EHB Changes) x (Adjustment for non-EHB Changes) x (Medical Inflation Trend) x (Required Rate Reduction Factor)

(2) The Maximum Colorado Option Standardized Plan Premium for the Small Group Market is the maximum allowable premium for all plans commencing during the applicable benefit year, irrespective of whether the rates are based on an annual or quarterly rate filing.

b. For On-Exchange Colorado Option Standardized Silver Plans in the Individual Market:

(1) Maximum Colorado Option Standardized Plan Premium =

(2021 Baseline Plan Unadjusted Premium) x (Changes in Member Cost Sharing Adjustment) x (CSR Load Adjustment) x (Induced Demand Factor Adjustment) x (Adjustment for EHB Changes) x (Adjustment for non-EHB Changes) x (Medical Inflation Trend) x (Required Rate Reduction Factor)

(2) A separate calculation will not be required for the Off-Exchange Colorado Option Standardized Silver Plan.

c. If a carrier is offering the Standardized Plan in a county where the carrier did not sell plans in 2021, the Maximum Colorado Option Standardized Plan Premium will be the weighted average, using enrollment as of April 1, 2021, of the Maximum Colorado Option Standardized Plan Premiums, across all carriers, that offered plans in the applicable county in 2021, regardless of whether plans are sold in the entire county or a partial part of the county. If a county did not have enrollment in any plans in the applicable metal level as of April 1, 2021, the Maximum Colorado Option Standardized Plan Premium will be the average of all plans in the applicable county in 2021, regardless of whether plans are sold in the entire county or a partial part of the county. A carrier's 2021 premiums will be excluded from the calculation described in this paragraph if the carrier has exited the market nationwide since 2021.

D. Carrier-filed Colorado Option Standardized Plan premiums submitted as part of rate filings pursuant to § 10-16-1306(1), C.R.S., must be at or below the rates set forth in Section 5.C.10. in order to be compliant with the required premium rate reductions pursuant to § 10-16-1305(2), C.R.S.

Section 6 Filing Requirements

A. Carriers shall notify the commissioner whether the carrier's Colorado Option Standardized Plan will comply with the required premium rate reductions set forth in § 10-16-1305(2), C.R.S., and calculated pursuant to Section 5.

1. For premium rates applicable in 2023, the carrier shall notify the commissioner. If a carrier's Colorado Option Standardized Plan fails to comply with the required premium rate reductions set forth in § 10-16-1305(2), C.R.S., and calculated pursuant to this Section 5, the carrier shall notify the commissioner of the reasons why the carrier is unable to meet the requirements in compliance with § 10-16-1306(2), C.R.S.

2. For premium rates applicable in 2024 or any subsequent year, the carrier shall notify the commissioner by March 1 of the preceding year.

B. Format of Filings

1. Carriers shall submit the notification of whether Colorado Option Standardized Plans will meet the required premium rate reductions through the "Colorado Option Standardized Plan Premium Rate Reduction" template supplied by the Division.

2. Carriers shall submit the "Colorado Option Standardized Plan Premium Rate Reduction" template in SERFF through an "Colorado Option Rate Reduction Notice" filing. This filing shall be submitted separately from any rate, form, annual certification, binder or network adequacy filing.

3. For the Individual market, Carriers shall use January 1 of the Benefit Year for which the filing applies for the "Effective Date" in SERFF.

4. For the small group market, Carriers shall use January 1 of the Benefit Year for the annual filing period as the "Effective Date" in SERFF. For other periods, the carrier shall use April 1, July 1 or October 1 of the Benefit Year for which the filing applies for the "Effective Date" in SERFF.

5. Carriers shall use "Informational" for the "Requested Filing Mode" in SERFF.

6. Carriers shall complete the SERFF Form Schedule tab to specify the forms to which this filing applies.

7. Carriers shall provide a filing description, including the Benefit Year the filing will support.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Incorporation by Reference

45 C.F.R. § 156.420(a) published by the Government Printing Office shall mean 45 C.F.R. § 156.420(a) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.420(a). A copy of 45 C.F.R. § 156.420(a) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.420(a) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 156.140(c) published by the Government Printing Office shall mean 45 C.F.R. § 156.140(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 156.140(c). A copy of 45 C.F.R. § 156.140(c) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.140(c) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 156.135 published by the Government Printing Office shall mean 45 C.F.R. § 156.135 as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 156.135. A copy of 45 C.F.R. § 156.135 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.135 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

This regulation shall be effective June 15, 2024.

Section 11 History

New regulation effective June 15, 2023.
Amended regulation effective June 15, 2024.

Regulation 4-2-86 CONCERNING THE METHODOLOGY FOR CALCULATING THE HEALTHCARE COVERAGE COOPERATIVE EXEMPTION FOR THE COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLANS AND PREMIUM RATE REDUCTION REQUIREMENT

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-109, 10-16-1304, 10-16-1305, 10-16-1306, 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for the required premium reduction methodology to determine whether a healthcare coverage cooperative, and a carrier offering health benefit plans under agreement with the healthcare coverage cooperative, have met the requirements of § 10-16-1306(9)(a), C.R.S.

Section 3 Applicability

This regulation applies to all healthcare coverage cooperatives and carriers offering health benefit plans under agreement with healthcare coverage cooperatives to purchasers in the individual and small group markets and is subject to the individual and group laws of Colorado and the requirements of federal law.

If Colorado's Section 1332 Innovation Waiver Request for the Colorado Option is not approved by the US Department of Health and Human Services and Department of Treasury, then these premium reductions will not go into effect.

Section 4 Definitions

A. "Actuarial value" and "AV" means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a health benefit plan will cover, with calculations based on the provision of essential health benefits to a standard population.

B. "Baseline Plan" or "2021 Baseline Plan" means, for the purposes of this regulation, the health benefit plan with the carrier's lowest 21-year-old non-tobacco use premium rate, by metal level, in the applicable county from the 2021 Benefit Year, regardless of whether the health benefit plan is sold in the entire county or a partial county. The Baseline Plan shall only consider on-exchange health benefit plans for the Individual market and be determined prior to the impact of the Colorado reinsurance program. The Baseline Plan shall only consider off-exchange health benefit plans for the Small Group market.

C. "Benefit Year" means, for the purposes of this regulation, the calendar year for individual health benefit plans, or the twelve month period beginning with the health benefit plan contract date for small group health benefit plans.

D. "Calibrated Plan Adjusted Index Rate" means, for the purpose of this regulation, line 3.14 on Worksheet 2 of the URRT.

E. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

F. "Colorado Option Standardized Plan" or "Standardized Plan" or shall have the same meaning as found at § 10-16-1303(14), C.R.S.

G. "CPI-U" means, for the purposes of this regulation, the consumer price index for all urban customers, U.S. city average, and all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.

H. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.

I. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

J. "Healthcare coverage cooperative" shall have the same meaning as found at § 10-16-1002(2), C.R.S.

K. "Medical Inflation" shall have the same meaning as found at § 10-16-1303(10), C.R.S.

L. "Metal Level" means, for the purposes of this regulation, the bronze, silver, and gold health benefit plans available in the individual and small group market as found at § 10-16-103.4, C.R.S.

M. "Premium" shall have the same meaning as found at § 10-16-102(51), C.R.S.

N. "Reinsurance" shall have the same meaning as found at § 10-16-1103(12), C.R.S.

O. "SERFF" means, for the purposes of this regulation, System for Electronic Rate and Form Filing.

P. "URRT" means, for the purpose of this regulation, the Unified Rate Review Template created by the Centers for Medicare & Medicaid Services

Section 5 Healthcare Coverage Cooperatives Exemption

A. Pursuant to § 10-16-1306(9)(a), C.R.S., a healthcare coverage cooperative, and a carrier offering health benefit plans under agreement with the healthcare coverage cooperative, will be deemed by the Commissioner as having met the requirements of §§10-16-1304 and 10-16-1305, C.R.S., if they have:

1. Relative to premiums offered by health benefit plans that were in existence prior to the entrance of the healthcare coverage cooperative into the market, offered premium rates at least 15% lower prior to June 16, 2021, after adjusting for medical inflation and other actuarially justifiable factors as detailed in this Section, for all benefit years.

2. Maintained at least a 15% premium rate reduction since June 16, 2021, after accounting for medical inflation and adjustments as detailed in this Section.

B. If a carrier offers health benefit plans under agreement with a healthcare coverage cooperative that meets the requirements of Section 6.A., and the carrier offers health benefit plans outside of a healthcare coverage cooperative, the carrier's health benefit plans offered outside of the healthcare coverage cooperative will not be deemed pursuant to § 10-16-1306(9)(a), C.R.S. as having met the requirements of §10-16-1304 and §10-16-1305, C.R.S.

C. The Division will calculate whether a healthcare coverage cooperative meets the requirements of Section 5.A.1 using the following methodology.

1. The healthcare coverage cooperative will be evaluated separately by county, metal level, and market basis for each healthcare coverage cooperative.

2. The Healthcare Coverage Cooperative Comparison Plan premium rate for a 21-year-old non-tobacco user will be the lowest cost plan premium, without reinsurance, if applicable, offered by the healthcare coverage cooperative in the first year the healthcare coverage cooperative operates in the applicable county. The Healthcare Coverage Cooperative Comparison Plan will be determined separately for each metal level, county, and market. The Healthcare Coverage Cooperative Comparison Plan Premium will be calculated as follows:

   a. Healthcare Coverage Cooperative Comparison Plan Premium =

      (minimum Calibrated Plan Adjusted Index Rate offered by the healthcare coverage cooperative in the county for the metal level) x (1.0 age factor) x (Geographic Rating Factor for the applicable county)

   b. The Minimum Calibrated Plan Adjusted Index Rate will be determined using the URRT from the first year the healthcare coverage cooperative operates in the applicable county. The “No Reinsurance” URRT will be used, if applicable.

3. The Healthcare Coverage Cooperative Baseline Plan Unadjusted Premium will be equal to the lowest cost plan premium, without reinsurance, if applicable, by county and metal level in the year prior to the introduction of the healthcare coverage cooperative plan. The Baseline Plan Unadjusted Premium will be calculated as follows:

   a. Healthcare Coverage Cooperative Baseline Plan Unadjusted Premium =

      (minimum Calibrated Plan Adjusted Index Rate offered in the county for the metal level) x (1.0 age factor) x (Geographic Rating Factor for the applicable county)

   b. The Minimum Calibrated Plan Adjusted Index Rate will be determined using all carriers’ plans in the year prior to the introduction of the healthcare coverage cooperative. All carriers’ URRTs from the year prior to the introduction of the healthcare coverage cooperative will be used to determine the Minimum Calibrated Plan Adjusted Index Rate.

      i. The “No Reinsurance” URRT will be used, if applicable.

      ii. The Geographic Rating Factor will be the Geographic Rating Factor from the carrier that has the lowest cost plan premium.

4. An adjustment factor will be applied to reflect changes in member cost sharing from the Baseline Plan to the applicable healthcare coverage cooperative plan. The Changes in Member Cost Sharing Adjustment will be calculated as follows:

   (Healthcare Coverage Cooperative Plan AV) ÷ (Baseline Plan AV)

5. The Medical Inflation Trend will be calculated as follows:

   (1 + “10 Year Average CPI-U for Medical Services, Annualized”) ^ (Months of Trend/12)

a. The "10 Year Average CPI-U for Medical Services, Annualized" will be based on medical inflation.

b. Months of Trend will be calculated as the difference between the midpoint of the Healthcare Coverage Cooperative Comparison Plan Benefit Year and the midpoint of the effective period of the Baseline Plan.

6. The required rate reduction will be 15.0% for all benefit years. Healthcare coverage cooperatives at or above the 15.0% rate reduction for a particular market, metal level, and county will be considered to have met the requirements of Section 5.A.1. Healthcare coverage cooperatives with a rate reduction less than 15.0% would not meet the requirements of Section 5.A.1. The Required Rate Reduction Factor will be calculated as follows:

(1 – 15.0%) = 0.85

7. To meet the requirements of Section 5.A.1, the Healthcare Coverage Cooperative Comparison Plan Premium must be less than or equal to the Healthcare Coverage Cooperative Baseline Plan Adjusted Premium, calculated as follows:

Healthcare Coverage Cooperative Baseline Plan Adjusted Premium =

(Healthcare Coverage Cooperative Baseline Plan Unadjusted Premium) x (Changes in Member Cost Sharing Adjustment) x (Medical Inflation Trend) x (Required Rate Reduction Factor)

D. If the healthcare cooperative meets the initial healthcare cooperative exemption outlined in Section 5.C, the healthcare cooperative must also maintain a 15% rate reduction in subsequent years after the initial year that the healthcare cooperative offered plans in a particular county. The Division will calculate whether a healthcare coverage cooperative is maintaining a 15% rate reduction, and therefore, meets the requirements of Section 5.A.2. using the following methodology:

1. The Healthcare Cooperative Comparison Plan and the Healthcare Cooperative Comparison Plan Premium will be the same as described in Section 5.C.2.

2. The Healthcare Cooperative Reduction Maintenance Test Plan premium will be the premium rate for a 21-year-old non-tobacco user will be the lowest cost plan premium, without reinsurance, if applicable, offered by the healthcare coverage cooperative in the year prior to the applicable plan year for which the healthcare coverage cooperative is being evaluated in the applicable county. The Healthcare Coverage Cooperative Reduction Maintenance Test Plan will be determined separately for each metal level, county, and market. The Healthcare Coverage Cooperative Comparison Plan Premium will be calculated as follows:

a. Healthcare Coverage Cooperative Reduction Maintenance Test Plan Premium =

(minimum Calibrated Plan Adjusted Index Rate offered by the healthcare coverage cooperative in the county for the metal level) x (1.0 age factor) x (Geographic Rating Factor for the applicable county)

b. The Minimum Calibrated Plan Adjusted Index Rate will be determined using the URRT from the year prior to the applicable plan year in the applicable county. The "No Reinsurance" URRT will be used, if applicable.

3. The Medical Inflation Trend will be calculated as follows:

(1 + "10 Year Average CPI-U for Medical Services, Annualized") ^ (Months of Trend/12)

a. The "10 Year Average CPI-U for Medical Services, Annualized" will be based on medical inflation. This will be calculated based on the latest CPI-U published 30 days prior to the publication of a bulletin by April 1, 2022 for the 2023 Benefit Year, and January 1 of each year thereafter.

b. Months of Trend will be calculated as the difference between the midpoint of the Healthcare Cooperative Comparison Plan Benefit Year and the midpoint of the effective period of the Healthcare Coverage Cooperative Reduction Maintenance Test Plan.

4. To meet the 15% rate reduction maintenance test, and therefore the healthcare cooperative continues to meet the requirements of Section 5.A.2, the Healthcare Coverage Reduction Maintenance Test Plan premium must be less than or equal to the Healthcare Coverage Cooperative Comparison Plan Adjusted Premium, calculated as follows:

Healthcare Coverage Cooperative Comparison Plan Adjusted Premium =

(Healthcare Coverage Cooperative Comparison Plan Premium) x (Medical Inflation Trend)

E. Plans that do not meet the requirements in Section 5.C will be required to offer the Colorado Option Standardized Health Benefit plans starting in 2023, in compliance with§§ 10-16-1304, 10-16-1305, C.R.S.

F. Plans that do not meet the maintenance requirements in Section 5.D will be required to offer the Colorado Option Standardized Health Benefit plans for the benefit year in which they failed to meet the maintenance requirements, in compliance with §§ 10-16-1304, 10-16-1305, C.R.S.

Section 6 Filing Requirements

A. To file as a healthcare coverage cooperative meeting the requirements in Section 5, a healthcare coverage cooperative must notify the Division via email and attach the "Healthcare Coverage Cooperative Exemption" template, supplied by the Division.

1. For the initial exemption applicable in 2023, the carrier shall file by April 1, 2022.

2. For any subsequent year, the carrier shall file for the exemption by February 1.

3. If a healthcare coverage cooperative fails to meet the requirements of Section 5, the carrier must comply with the filing requirements for Colorado Option Standardized Health Benefit plans.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall be effective June 14, 2022.

Section 10 History

New regulation effective June 14, 2022.

Regulation 4-2-87 CONCERNING OCCUPATIONAL ACCIDENT INSURANCE COVERAGE

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 40-11.5-102(5), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the minimum coverage requirements for carriers offering occupational accident insurance coverage pursuant to § 40-11.5-102(5), C.R.S.

Section 3 Applicability

This regulation applies to all insurers offering occupational accident insurance coverage in Colorado pursuant to § 40-11.5-102(5), C.R.S.

Section 4 Definitions

A. “Insurer” shall have the same meaning as found at § 10-1-102(13), C.R.S.

B. “Certification” means, for the purposes of this regulation, the form that contains the necessary elements of certification, as determined by the Commissioner, which has been signed by the designated officer of the entity.

C. “Commercial vehicle” shall have the same meaning as found at § 42-4-235(1)(a)(I)(B), C.R.S.

D. “Limited benefit health coverage” means, for the purposes of this regulation, any type of health coverage that is not a health benefit plan.

E. “Motor carrier” shall have the same meaning as found at § 42-4-235(1)(c), C.R.S.

F. “Occupational accident insurance coverage” means, for the purposes of this regulation, insurance purchased by an independent contractor or sole proprietor pursuant to § 40-11.5- 102(5), C.R.S. that provides coverage at a minimum aggregate policy limit of $1,500,000 for all benefits paid for the benefit of the operator, including medical, temporary and permanent disability, death and dismemberment, and survivor benefits.

G. “Operator” shall have the same meaning as found at § 40-11.4-102 (6)(a)(II), C.R.S.

H. “SERFF” means, for the purpose of this regulation, the NAIC System for Electronic Rate and Form Filing.

I. "Signature" includes an electronic signature as found at § 24-71.3-102(8), C.R.S.

Section 5 Coverage and Filing Requirements

A. An insurer may issue occupational accident insurance coverage, with benefits payable up to a policy limit of at least $1,500,000, if the following conditions are met:

1. The occupational accident insurance coverage shall provide, at a minimum, for injuries sustained in the course of working as an independent contractor or sole proprietor under a written agreement with a motor carrier company:

a. Temporary and permanent disability benefits;

b. Death, including survivor benefits, and dismemberment benefits; and

c. Medical expense benefits, to cover the following services:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization services;

(4) Laboratory and radiology services;

(5) Behavioral health, mental health, and substance use disorder and services;

(6) Prescription drug coverage; and,

(7) Dental coverage

B. All occupational accident insurance coverage rates shall be filed with the Division prior to such policies being marketed or issued in Colorado.

1. The rate SERFF filing requirements are as follows:

a. Type of Insurance (TOI) Code: H21 - Other;

b. Filing Type: Rate;

c. Effective Date Requested: This date must be a prospective date after the submission of the rate filing. Carriers shall submit rate filings for rate increases to the Commissioner at least sixty (60) days prior to the proposed implementation date of the rates.

d. Requested Filing Mode: 'File & Use' or 'Review & Approval';

e. Market Type: Individual or Group. All associations must be reviewed by the Division prior to issuance of coverage. The Association By-laws and Articles of Incorporation shall be submitted in a separate filing under the H21 – Other TOI code.

f. Filing Description shall include reference to Occupational Accident Coverage;

g. Form Schedule Tab: this tab shall be completed with all forms to which this filing applies, including policies, certificates, applications, etc. and

h. Rate/Rule Schedule tab shall be completed and shall include the rating manual and underwriting guidelines.

2. The rate filing shall also include a compliant actuarial memorandum and rate template according to Colorado Insurance Regulation 4-2-11. Additional guidance is also included in Regulation 4-2-11.

C. All occupational accident insurance coverage form filings shall be submitted to the Division for review and shall comply with the requirements found in Colorado Insurance Regulation 4-2-40.

1. The form SERFF filing requirements are as follows:

a. Type of Insurance (TOI) Code: H21 - Other;

b. Filing Type: Form;

c. Effective Date Requested: This date shall be a prospective date that is at least thirty-one (31) days after the filing submission date.

d. Requested Filing Mode: 'File & Use';

e. Market Type: Individual or Group. All associations must be reviewed by the Division prior to issuance of coverage. The Association By-laws and Articles of Incorporation shall be submitted in a separate filing under the H21 – Other TOI code.

f. Filing Description shall include reference to Occupational Accident Coverage; and

g. Form Schedule Tab: this tab shall be completed with all forms to which this filing applies, including policies, certificates, applications, etc. The forms shall be attached to this tab.

2. The form filing shall also include a completed form certification according to Colorado Insurance Regulation 4-2-40 Appendix A Form Health – Colorado Health Coverage Certification Form for Listings of New and/or Revised Policy Forms. Additional guidance is also included in Regulation 4-2-40. This certification shall include a 'live' or 'wet' signature of a qualified officer or comply with § 24-71.3-102(8), C.R.S.

3. The policies and certificates shall follow the requirements found in Colorado Insurance Regulation 4-2-34. The section names in the policies and certificates shall be as stated in the regulation and in the order demonstrated in the regulation.

D. Insurers that wish to offer occupational accident coverage shall have an accident and health line of authority.

Section 6 Required Disclosure

A. All occupational accident insurance coverage policies issued to comply with § 40-11.5-102(5), C.R.S. shall include the following statement in bold type on the policy's face page, and on the front page of the application:

"THIS IS AN OCCUPATIONAL ACCIDENT INSURANCE POLICY THAT PROVIDES LIMITED BENEFIT COVERAGE FOR ONLY THOSE ACCIDENT RELATED INJURIES SUSTAINED AS AN OPERATOR OF A COMMERCIAL VEHICLE AS AN INDEPENDENT CONTRACTOR OR SOLE PROPRIETOR AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE."

B. Not including the required disclosure statement shall be considered a deceptive trade practice and a violation of § 10-3-1104, C.R.S.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective on November 30, 2022.

Section 10 History

New regulation effective November 30, 2022.

Regulation 4-2-88 CONCERNING GAG CLAUSES IN INDIVIDUAL AND GROUP HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-109, 10-16-704(18), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to align Colorado law with the federal "No Surprises Act", Pub. L. 116-260, as amended, pursuant to the Commissioner's rulemaking authority, and to increase price and quality transparency by removing gag clauses on information for plan sponsors and group and individual consumers.

Section 3 Applicability

This regulation applies to carriers offering individual, small group, large group and student health benefit plans on or after January 1, 2022.

Section 4 Definitions

A. "Business associate" shall have the same meaning as found in 45 CFR § 160.103.

B. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

D. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.

E. "Provider" shall have the same meaning as found at § 10-16-102(56), C.R.S.

F. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

Section 5 Prohibition on Gag Clauses on Price and Quality Information for Group Health Plans

A carrier offering group health benefit coverage may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a health insurance carrier offering such coverage from:

A. Providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, covered persons, or individuals eligible to become covered persons of the plan or coverage;

B. Electronically accessing de-identified claims and encounter information or data for each covered person in the plan or coverage, upon request, and including, on a per claim basis:

1. financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

2. provider information, including name and clinical designation;

3. service codes; or

4. any other data element included in claim or encounter transactions.

C. Sharing information or data described in Sections 5.A or 5.B or directing that such data be shared with a business associate.

Section 6 Prohibition on Gag Clauses on Price and Quality Information for Individual Health Plans

A carrier offering individual health benefit coverage may not enter into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the health insurance carrier offering such coverage from:

A. Providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, covered persons, or individuals eligible to become covered persons of the plan or coverage; or

B. Sharing information or data described in Section 6.A, for plan design, plan administration, and plan, financial, legal, and quality improvement activities with a business associate.

Section 7 Public Disclosure and Confidentiality

A. Nothing in Sections 5.A or 6.A prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information in Sections 5 or 6.

B. Nothing in this regulation shall be construed to modify or eliminate existing privacy protections and standards under Colorado or Federal law, including but not limited to, the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 9 Incorporation by Reference

45 CFR § 160.103 published by the Government Printing Office shall mean 45 CFR § 160.103 as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 160.103. A copy of 45 CFR § 160.103 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 CFR § 160.103 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

"No Surprises Act", Pub. L. 116-260, shall mean Pub. L. 116-260 as published on the effective date of this regulation and does not include later amendments to or editions of Pub. L. 116-260. A copy of Pub. L. 116-260 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of Pub. L. 116-260 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.congress.gov.

Section 10 Enforcement

Noncompliance with this Regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 11 Effective Date

This new regulation shall be effective on November 30, 2022.

Section 12 History

New regulation effective November 30, 2022.

Regulation 4-2-89 COMPENSATION DISCLOSURES FOR HEALTH INSURANCE CARRIERS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-109, and 10-16-133(6)(b), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to align disclosure requirements related to insurance producer compensation for health insurance carriers offering individual health benefit plans or short-term limited duration health insurance policies under the federal "No Surprises Act", Pub. L. 116-260, as amended, with Colorado law.

Section 3 Applicability

The requirements of this regulation apply to all health insurance carriers offering individual health insurance coverage or short-term limited duration insurance coverage in the state of Colorado.

Section 4 Definitions

A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. "Commission schedule" means an itemized list or table that provides the commission levels that are paid by a carrier to an insurance producer for the sale, placement, or renewal of individual health insurance coverage or short-term limited-duration insurance.

C. "Direct compensation" means monetary amounts, including sale and base commissions, paid by a carrier that are attributable directly to the policy, certificate, or contract of insurance and that are paid to an insurance producer for the enrollment, selection, sale, placement, or renewal of individual health insurance coverage or short-term limited-duration insurance.

D. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

E. "Indirect compensation" means payments by a carrier attributable indirectly to a policy, certificate or contract of insurance to insurance producers, and other persons for items other than sales and base commission. Examples of indirect compensation include service fees, consulting fees, finders' fees, profitability and persistency bonuses, awards, prizes, volume-based incentives, and non-monetary forms of compensation.

F. "Insurance producer" or "producer", shall have the same meaning as found at §10-2-103(6), C.R.S., with the exception that for the purposes of this regulation, it does not include public adjusters as defined at § 10-2-103(6)(b), C.R.S.

G. "Policyholder" means, for the purposes of this regulation, the person who is choosing the coverage and agreeing to be financially responsible for premiums and other payments due under the insurance contract, and does not include all plan enrollees.

H. "Sale" means, for the purposes of this regulation, the exchange of a contract of insurance for money or its equivalent.

I. "Short-term limited duration health insurance" shall have the same meaning as found at § 10-16-102(60), C.R.S.

Section 5 Carriers Disclosing Compensation

A. All health insurance carriers must make the following disclosures to policyholders purchasing individual health benefit plans or short-term limited duration health insurance policies:

1. Disclose any direct or indirect compensation provided by the carrier to an insurance producer or other person enrolling individuals in coverage for services provided by the insurance producer associated with plan selection and enrollment.

2. Disclosures shall be:

a. For new, initial enrollments, made prior to the individual finalizing plan selection and included on any documentation confirming the initial enrollment, including enrollment documentation required by applicable state or federal law or an initial enrollment package;

b. For renewals of enrollment, included on any documents confirming enrollment and any renewal notice of coverage required by applicable state or federal law; and

c. In the absence of any documentation required by applicable state or federal law to confirm initial enrollment or the requirement for a notice of renewal of coverage, provided with the invoice for the first premium payment for the initial coverage term and for each renewal period.

3. The disclosure is required to include the commission schedule used to determine the compensation owed to a producer as part of the appointment contract between the producer and the carrier offering individual health insurance coverage or short-term limited duration insurance, as well as the structure for compensation not captured on the commission schedule.

4. All disclosures must be made available in all of the 15 most common languages in the state and ensure accessibility for individuals with disabilities and limited English proficiency consistent with 45 C.F.R. § 155.205(c), including provision of appropriate auxiliary aids and services at no cost to the individual.

B. Delegation

Carriers may satisfy their obligations under this regulation by requiring insurance producers to make the insurance producer compensation disclosures outlined in this regulation on the carriers' behalf.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Incorporated Materials

45 C.F.R. § 155.205(c) shall mean 45 C.F.R. § 155.205(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 155.205(c). A copy of 45 C.F.R. § 155.205(c) may be examined during regular business house at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 155.205(c) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov

"No Surprises Act", Pub. L. 116-260, shall mean Pub. L. 116-260 as published on the effective date of this regulation and does not include later amendments to or editions of Pub. L. 116-260. A copy of Pub. L. 116-260 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of Pub. L. 116-260 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.congress.gov.

Section 8 Enforcement

Noncompliance with this Regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This new regulation shall be effective on November 30, 2022.

Section 10 History

New regulation effective November 30, 2022.

Regulation 4-2-90 [Repealed eff. 08/30/2023]

Regulation 4-2-91 CONCERNING THE METHODOLOGY FOR CALCULATING REIMBURSEMENT RATES TO SUPPORT PREMIUM RATE REDUCTIONS FOR COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-109, 10-16-1306, and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish a hospital and health-care provider reimbursement rate setting methodology for the Colorado Option premium rate reduction requirements on standardized health benefits plans.

Section 3 Applicability

This regulation applies to contracted reimbursement rates for standardized plans between carriers and hospitals or health-care providers in Colorado.

Section 4 Definitions

A. “Adjusted Discharges” shall mean, for the purposes of this regulation, a measure of the overall volume of services provided by a hospital inpatient and outpatient departments. Adjusted discharges are calculated as

(Total Revenue/Total Inpatient Revenue) * Inpatient Discharges

Where Total Revenue is found in Worksheet G-2, Column 3, Line 28 of 2552-10 Medicare Cost Reports; Total Inpatient Revenue is found in Worksheet G-2, Column 1, Line 28 of 2552-10 Medicare Cost Reports; Inpatient Discharges are found in Worksheet S-3 Part 1, Column 15, Lines 14 and 16 through 18 in 2552-10 Medicare Cost Reports.

B. “All-Payer Health Claims Database” or “APCD” shall have the same meaning as found at § 25.5-1-204.7(1)(b), C.R.S.

C. “Aggregate Medicare Reimbursement Rate” shall mean, for the purposes of this regulation, the average of Medicare Reimbursement Rates, outlined in Section 4.X, for all services, as a percentage of Medicare, weighted by utilization in the plan.

D. "Aggregate Negotiated Rate" shall mean, for the purposes of this regulation, the average of negotiated reimbursement rates for all services, weighted by the utilization in the plan as a percentage of the Aggregate Medicare Reimbursement Rate.

E. "Applicable plan year" shall mean, for the purposes of this regulation, the plan year for which the carrier is filing a notification on March 1 regarding compliance with Premium Rate Reduction Requirements or network adequacy requirements.

F. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

G. "Colorado Option Standardized Plan" or "Standardized Plan" shall have the same meaning as found at § 10-16-1303(14), C.R.S.

H. "Critical Access Hospital" shall have the same meaning as found at § 10-16-1303(2), C.R.S.

I. "Equivalent Rate" shall have the same meaning as found at § 10-16-1303(3), C.R.S.

J. "Essential Access Hospital" shall have the same meaning as found at § 10-16-1303(4), C.R.S.

K. "Hospital" shall have the same meaning as found at § 10-16-1303(6), C.R.S.

L. "Health-Care Provider" shall have the same meaning as found at § 10-16-1303(8), C.R.S.

M. "Health-Care Provider Reimbursement Floor" shall mean, for the purposes of this regulation, the lowest reimbursement rate, as an aggregate percent of the Medicare Reimbursement Rate, the Commissioner may set for a specific health-care provider.

N. "Health System" shall have the same meaning as found at § 10-16-1303(9), C.R.S.

O. "Hospital Medicare/Medicaid Payer Mix" shall mean, for the purposes of this regulation, the proportion of total charges represented in the Medicare Cost Report in the previous three years that were for Medicaid or Medicare patients. An average of the hospital's three most recent Medicare Cost Reports will be used as of each October prior to the year in which a public hearing may be held. If an included hospital does not have this information reported, inpatient bed days or a payer mix from the APCD will be used.

P. "Hospital Net Income" shall mean, for the purposes of this regulation, the excess or net patient revenue and other income over total operating and other expenses. Net Income is found in Worksheet G-3, Column 1, Line 29 in 2552-20 Medicare Cost Reports. The hospital's three most recent Medicare Cost Reports will be used as of each October prior to the year in which a public hearing may be held.

Q. "Hospital Net Patient Revenue" shall mean, for the purposes of this regulation, the revenue from providing services to patients and is found in Worksheet G-3, Column 1, Line 3 from Medicare Cost Reports 2552-10. An average of the hospital's three most recent Medicare Cost Reports will be used as of each October prior to the year in which a public hearing may be held.

R. "Hospital Operating Expenses" shall mean, for the purposes of this regulation, the total cost associated with hospital-related services and patient care, which is Operating Expenses for Reimbursable Departments plus Reasonable Compensation Equivalent disallowance. Operating Expenses for Reimbursable Departments are found in Worksheet B Part I, Column 26, Line 118 of 2552-10 Medicare Cost Reports. An average of the hospital's three most recent Medicare Cost Reports will be used as of each October prior to the year in which a public hearing may be held.

S. "Hospital Reimbursement Floor" shall mean for the purposes of this regulation, the lowest reimbursement rate, as an aggregate percent of the Medicare Reimbursement Rate, the Commissioner may set for a specific hospital. This floor will be calculated as outlined in § 10-16-1306, C.R.S., and detailed in Section 5 of this regulation below.

T. "Independent Hospital" shall mean, for the purposes of this regulation, any hospital that is not a part of a larger health system with more than two hospitals as of January 1 of the applicable plan year.

U. "Low Volume Medicare Services" shall mean, for the purposes of this regulation, any service that is low volume statewide relative to other Medicare services.

V. "Medicare fee schedule" shall mean, for the purposes of this regulation, a complete listing of fees used by the Centers for Medicare & Medicaid Services to pay doctors or other providers and suppliers under the Medicare program.

W. "Medicare Inpatient and Outpatient Prospective Payment Systems" shall mean, for the purposes of this regulation, a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount for a particular inpatient or outpatient service based on a classification system of that service.

X. "Medicare Reimbursement Rate" shall have the same meaning as found at § 10-16-1303(11) and § 10-16-1303(3), C.R.S. Specifically:

1. For hospitals that Medicare reimburses under its Hospital Inpatient Prospective Payment System (IPPS) and the Hospital Outpatient Prospective Payment System (OPPS), the Medicare Reimbursement Rate will be based on the applicable Prospective Payment System fee schedule effective as of each October prior to the year in which a public hearing may be held.

2. Long-term Care, Psychiatric, and Rehabilitation Hospitals' Medicare Reimbursement Rates will be determined using the appropriate Medicare Prospective Payment System rates for each hospital effective as of each October prior to the year in which a public hearing may be held.

3. For Critical Access Hospitals, the Medicare Reimbursement Rate will be 101 percent of allowable costs, as determined using the cost-to-charge ratio, for hospital based services as reported in an average of the hospital's three most recent Medicare Cost Reports as of each October prior to the year in which a public hearing may be held. The Division may also consider additional information provided by a Critical Access Hospital to determine if further adjustments are required, such as, but not limited to, unreimbursed cost items.

4. For Pediatric Hospitals, as detailed in § 10-16-1303(3), C.R.S., the Medicare Reimbursement Rate shall be calculated using the Medicaid fee schedule effective as of each October prior to the year in which a public hearing may be held multiplied by 1.52, adjusted annually for cumulative inflation by a factor equal to the average percentage increase of the Medicare Inpatient and Outpatient Prospective Payment Systems over the previous three years.

5. For Health-care providers, the Medicare Reimbursement Rate shall equal the payment rates for the appropriate Medicare fee schedule for the provider type or service effective as of October prior to the year in which a public hearing will be held.

6. For any health-care service without an existing Medicare Reimbursement Rate and for any Low Volume Medicare Services an equivalent rate will be determined utilizing the ratio of Medicaid Payment Rates to existing Medicare Payment Rates, whenever possible.

7. For Sole Community Hospitals, the Medicare Reimbursement Rate will be the higher of the Prospective Payment Rate outlined in U.1 above or the Sole Community Hospital Rate outlined in 42 C.F.R. §§ 412.92(d)(1) and (2).

Y. "Negotiated Rate" shall mean, for the purposes of this regulation, the reimbursement rate, as a percent of Medicare, agreed upon between the carrier and hospital or health-care provider for a given plan year.

Z. "Pediatric Hospital" shall mean, for the purposes of this regulation, a hospital that is part of a pediatric specialty hospital system where over ninety (90) percent of the hospital's population is under eighteen (18) years of age and that has a Level One Pediatric Trauma Center.

AA. "Premium" shall have the same meaning as found at § 10-16-102(51), C.R.S.

AB. "Premium Rate Reduction Requirements" shall mean the rates set forth in § 10-16-1305, C.R.S., and calculated pursuant to Colorado Insurance Regulation 4-2-85.

AC. "Sole Community Hospital" shall have the same meaning as found at 42 C.F.R. § 412.92(a).

AD. "Statewide Average Medicare/Medicaid Payer Mix" shall mean, for the purposes of this regulation, the proportion of total charges across all hospitals in the state that filed a Medicare Cost Report in the previous three years, as of each October prior to the year in which a public hearing may be held, that were for Medicaid or Medicare patients, excluding psychiatric, long-term care, and rehabilitation hospitals, weighted by total charges.

AE. "State Average Net Income" shall mean, for the purposes of this regulation, the average Net Income per Adjusted Discharge across all hospitals in the state that filed a Medicare Cost Report in the previous three years, as of each October prior to the year in which a public hearing may be held, excluding psychiatric, long-term care, and rehabilitation hospitals, weighted by adjusted discharges.

AF. "State Average Net Patient Revenue" shall mean, for the purposes of this regulation, the average Net Patient Revenue per Adjusted Discharge across all hospitals in the state that filed a Medicare Cost Report in the previous three years, as of each October prior to the year in which a public hearing may be held, excluding psychiatric, long-term care, and rehabilitation hospitals, weighted by adjusted discharges.

AG. "State Average Operating Expenses" shall mean, for the purposes of this regulation, the average Operating Expenses per Adjusted Discharge across all hospitals in the state that filed a Medicare Cost Report in the previous three years, as of each October prior to the year in which a public hearing may be held, excluding psychiatric, long-term care, and rehabilitation hospitals, weighted by adjusted discharges.

Section 5 Hospital Reimbursement Floor Methodology

A. The Division will calculate a hospital reimbursement floor using the following methodology.

1. The Hospital Reimbursement Floor will be equal to 155% of the Aggregate Medicare Reimbursement Rate for that specific hospital with additional percentage points added as detailed below.

2. Percentage-points will be added to the Hospital Reimbursement Floor based on the following hospital-specific characteristics:

   a. Independent Hospitals will receive a twenty-percentage-point increase.

   b. Essential Access Hospitals will receive a twenty-percentage-point increase.

   c. Hospitals with a combined percentage of patients who receive services through programs established through the "Colorado Medical Assistance Act," Articles 4 to 6 of Title 25.5, or Medicare, Title XVIII of the Federal "Social Security Act," as amended, that exceeds the statewide average will receive up to a thirty-percentage-point increase. The actual percentage point increase, not to be less than zero, is determined based on the hospital's percentage share of such patients using the following formula:

$$Hospital\ Payer\ Mix\ = \frac{(Hospital\ \ Payer\ Mix) - (Statewide\ Average\ Payer\ Mix)}{0.99 - (Statewide\ Average\ Payer\ Mix)}\ X\ 30$$

   d. Hospitals efficient in managing the underlying cost of care as determined by the hospital's net patient revenue, operating expenses, and total margins will receive up to a forty-percentage point increase. The actual percentage point increase, not to be less than zero, is determined based on the following:

      (1) A ten-percentage-point increase may be received to account for a hospital's net patient revenue (NPR) using this formula:

$$NPR\ = \frac{(State\ Average\ NPR\ Per\ Adj.Discharge) - (Hospital\ \ NPR\ per\ Adj.Discharge)}{(State\ Average\ NPR\ Per\ Adj.Discharge)}\ X\ 10$$

      (2) A ten-percentage-point increase may be received to account for a hospital's operating expenses (OE) using this formula:

$$OE = \frac{(State\ Average\ OE\ Per\ Adj.Discharge) - (Hospital\ \ OE\ per\ Adj.Discharge)}{(State\ Average\ OE\ Per\ Adj.Discharge)}\ X\ 10$$

      (3) A twenty-percentage-point increase may be received to account for a hospital's net income using this formula:

$$Net\ Income = \frac{(State\ Average\ Net\ Income\ Per\ Adj.Discharge) - (Hospital\ \ Net\ Income\ per\ Adj.Discharge)}{(State\ AverageNet\ Income\ Per\ Adj.Discharge)}\ X\ 20$$

B. If using the formula detailed in Subsection A above would yield a Hospital Reimbursement Floor less than 165% of the Aggregate Medicare Reimbursement Rate for a specific hospital, the hospital reimbursement floor shall be equal to 165% of the Aggregate Medicare Reimbursement Rate.

C. For a Pediatric Hospital, the Hospital Reimbursement Floor shall be calculated using the Equivalent Rate as outlined in Section 4.I of this regulation and § 10-16-1303(3)(a) and (b), C.R.S. and § 10-16-1306(4)(a)(V), C.R.S.

Section 6 Health-Care Provider Reimbursement Floor

The Health-Care Provider Reimbursement Floor may not be less than 135% of the Aggregate Medicare Reimbursement Rate.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Incorporation by Reference

42 C.F.R. § 412.92 published by the Government Printing Office shall mean 42 C.F.R. § 412.92 as published on the effective date of this regulation and does not include later amendments to or editions of 42 C.F.R. § 412.92. A copy of 42 C.F.R. § 412.92 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 42 C.F.R. § 412.92 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes.

Section 10 Effective Date

This regulation shall be effective February 1, 2025.

Section 11 History

New regulation effective January 14, 2023.
Amended regulation effective February 1, 2024.
Amended regulation effective February 1, 2025.

Regulation 4-2-92 CONCERNING COLORADO OPTION PUBLIC HEARINGS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-107, 10-16-109, 10-16-1304, 10-16-1305, 10-16-1306, and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the procedures for noticing and conducting public hearings on proposed Colorado Option Standardized Plans that fail to meet the Premium Rate Reduction Requirements or network adequacy requirements, as required by § 10-16-1306, C.R.S.

Section 3 Applicability

This regulation applies to public hearings that will occur on or after January, 1, 2025 and to carriers offering individual and small group Colorado Option Standardized Plans on or after January 1, 2026. This regulation further applies to hospitals and health-care providers subject to the requirements in § 10-16-1306, C.R.S.

Section 4 Definitions

A. "Aggregate Medicare Reimbursement Rate" shall have the same meaning as found in Section 4.C. of Colorado Insurance Regulation 4-2-91.

B. "Aggregate Negotiated Rate" shall have the same meaning as found at Section 4.D. of Colorado Insurance Regulation 4-2-91.

C. "Aggrieved" shall have the same meaning as found at § 24-4-102(3.5), C.R.S.

D. "All-Payer Health Claims Database" shall have the same meaning as described in § 25.5-1-204, C.R.S.

E. "Applicable plan year" shall mean, for the purposes of this regulation, the plan year for which the carrier is filing a notification on March 1 regarding compliance with Premium Rate Reduction Requirements or network adequacy requirements.

F. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

G. "Cause" shall mean, for the purposes of this regulation, that establishing a reimbursement rate pursuant to § 10-16-1306(4)(a), (b), (5), or (7), C.R.S., would reduce a carrier's Colorado Option Standardized Plan premiums, or in the case of network adequacy, assist the carrier in achieving network adequacy requirements.

H. "Colorado Option Standardized Plan" or "Standardized Plan" shall have the same meaning as found at § 10-16-1303(14), C.R.S.

I. "Colorado Open Records Act" means the Colorado Open Records Act, §§ 24-72-201, et seq., C.R.S.

J. "Commissioner" shall have the same meaning as found at § 10-16-102(13), C.R.S.

K. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

L. "CMS Certification Number (CCN)" shall mean, for the purposes of this regulation, the six-digit alpha-numeric code assigned to hospitals by the Centers for Medicare & Medicaid Services (CMS), outlined in the CMS Manual System, where all Colorado facilities start with a 06.

M. "Day" shall mean calendar day.

N. "Division" shall have the same meaning as found at § 10-1-102(7), C.R.S.

O. "Hospital" shall have the same meaning as found at § 10-16-1303(6), C.R.S.

P. "Health-care provider" shall have the same meaning as found at § 10-16-1303(8), C.R.S.

Q. "Health-care Provider Reimbursement Floor" shall have the same meaning as found at Section 4.M. in Colorado Insurance Regulation 4-2-91.

R. "Hospital Reimbursement Floor" shall have the same meaning as found at Section 4.T. in Colorado Insurance Regulation 4-2-91.

S. "Insurance Ombudsperson" means the Office of the Insurance Ombudsman established in § 25.5-1-131, C.R.S.

T. "Material Provider" shall mean, for the purposes of this regulation, an in-network hospital or health-care provider identified by the carrier, the Division, another provider, or another party that has a greater than or equal to 0.15% contribution to a carrier's premium rate in a particular Rating Area. Any hospital or health-care provider that has less than 0.15% contribution to a carrier's premium rate in a particular Rating Area shall not be considered a Material Provider and shall not be required to participate in the public hearing regarding a carrier's failure to achieve the Premium Rate Reduction Requirements.

The contribution to a carrier's premium shall be calculated, for the purposes of this regulation, as total medical claim paid amounts divided by total premiums for each Colorado Option plan by network and by Rating Area.

U. "Medicare Reimbursement Rate" shall have the same meaning as found at Section 4.X. of Colorado Insurance Regulation 4-2-91.

V. "National Provider Identifier" or "NPI" shall have the same meaning as found at § 25.5-4-420(1)(b), C.R.S.

W. "Negotiated Rate" shall mean, for the purposes of this regulation, the reimbursement rate, as a percent of Medicare, agreed upon between the carrier and hospital or health-care provider for a given plan year.

X. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.

Y. "Non-Standardized plan" means, for purposes of this regulation, a health benefit plan that does not meet the definition of Standardized Plan found at § 10-16-1303(14), C.R.S.

Z. "Party" or "Parties" shall have the same meaning as found at § 24-4-102(11), C.R.S., and specifically includes the entities admitted by the Commissioner under Section 7.A.1-6.

AA. "Person" shall have the same meaning as found at § 10-16-102(48), C.R.S.

AB. "Premium Rate Reduction Requirements" shall mean the rates set forth in § 10-16-1305, C.R.S., and calculated pursuant to Colorado Insurance Regulation 4-2-85.

AC. "Rating Area" means, for the purposes of this regulation, a geographic area comprised of Colorado counties established pursuant to the fair health insurance premium requirements under 45 C.F.R. § 147.102. A list of the Rating Areas can be found in Colorado Insurance Regulation 4-2-39 Section 6.A.15.g.

AD. "Service" as used in Sections 9 and 12 of this regulation, shall have the same meaning as found at 42 C.F.R. § 400.202.

AE. "SERFF" means the System for Electronic Rates and Forms Filing.

AF. "SFTP" shall mean, for the purposes of this regulation, a Secure File Transfer Protocol that enables the transfer of secure files.

AG. "Statewide Hospital Median Reimbursement Rate" shall mean, for the purposes of this regulation, the median reimbursement rate of Colorado hospitals, measured as a percentage of the Medicare Reimbursement Rate for the 2021 plan year using data from the All-Payer Health Claims Database.

Section 5 Setting of Public Hearings and Notification of Parties

A. The Commissioner shall provide notice no later than January 31 of the year in which the hearings will be held of the proposed dates for public hearings pursuant to § 10-16-1306, C.R.S. The notice shall be posted on the Division's website and emailed to all individuals on the Division's email list.

B. After the filing of a Complaint, the Commissioner shall give final notice of the date, time, location, and estimated duration for the public hearing to the Parties at least fifteen (15) days prior to the date of the hearing.

C. In the absence of a Complaint, or after a Complaint has been resolved, the Commissioner may set a hearing for public comment, which shall include allowing the Parties and any person or entity the opportunity to comment on a Colorado Option Standardized Plan offered by a carrier, pursuant to § 10-16-1306(3)(c)(II)(B), C.R.S. The Commissioner shall give final notice of the date, time, location, and scope of the hearing for public comment at least fifteen (15) days prior to the date of the hearing.

Section 6 Applicable Federal and State Laws

For purposes of the March 1st notification and the public hearing only, federal and state laws in effect on March 1st of the year preceding the applicable plan year will be considered to determine whether a carrier has met the Premium Rate Reduction Requirements and network adequacy requirements required by §§ 10-16-1304 and 10-16-1305, C.R.S. The Commissioner, in their discretion, will determine what weight to give any changes in federal or state law between March 1 and the issuance of a final agency order pursuant to Section 23.

Section 7 Public Hearing Parties

A. The Parties to the public hearing before the Commissioner shall include the following entities:

1. A carrier that fails to meet the Premium Rate Reduction Requirements or network adequacy requirements or is alleged to have failed to meet the Premium Rate Reduction Requirements or network adequacy requirements.

2. Any Material Provider named in any complaint.

3. Any hospital or health-care provider that is named in a network adequacy complaint or cross-complaint.

4. The Insurance Ombudsperson to represent the interests of consumers.

5. The Division of Insurance.

6. A person who demonstrates to the Commissioner that they will be aggrieved by agency action and who demonstrates that their interests are not adequately represented by the Parties listed above.

    a. Such a person must request admission as a Party to the public hearing that they seek to participate in within seven (7) days from the date the Commissioner posts the complaint on the Division's website.

b. An application for Party status must identify the person making the request, including an address, email address, and telephone number. The application must also contain a statement of the reasons for seeking Party status, the manner in which the person is aggrieved, an explanation as to why the existing Parties do not adequately represent the person's interests, a description of the legal and/or factual issues which the prospective party intends to raise, any responsive pleadings the person intends to file, and any potential witnesses the prospective Party intends to call at the hearing. In addition, the application must describe the evidence the applicant intends to present at the hearing.

B. Consistent with Section 21.B., interested persons, who are not Parties, including consumer advocacy organizations, shall be given the opportunity to comment during the public hearing.

Section 8 Service of Documents

A. A Party filing any pleading or other document shall serve a copy, including all supporting attachments or exhibits, on every other Party in the proceeding. Such service shall include service upon the Commissioner and their assigned staff and attorneys.

B. Service may be by hand, first class mail, or by email. Service by email may be accomplished on a Party if the Party has consented to service by email. After the initial filing of the Complaint and Answer, all Parties shall consent to service by email and shall provide an email address for each subsequent service.

C. Proof of service of a filing shall be demonstrated through a certificate of service identifying the document served, the method of service, and the date of service. For each public hearing proceeding, the Commissioner shall maintain an updated certificate of service template to be used for service by the Parties and shall update it with any changes.

Section 9 Carrier Notification Requirements

A. Pursuant to § 10-16-1306(2), C.R.S., a carrier shall notify the Commissioner of the reasons why the carrier is unable to meet the Premium Rate Reduction Requirements, as provided in §§ 10-16-1304 and 10-16-1305, C.R.S., and submit the notification, and related documents identified in Section 9.B, via SERFF or SFTP to the Commissioner no later than March 1 of the year preceding the applicable plan year The Notification shall be completed by the carrier using Division provided templates and shall include the following information:

1. A completed Premium Rate Reduction Notification template as required in Colorado Insurance Regulation 4-2-85.

2. A table showing the list of Material Providers with their relative contribution to the plan’s premium in a Rating Area. The carrier must include the following information for each Material Provider:

a. The name, National Provider Identifier (NPI), CMS Certification Number (CCN), if applicable, and contact information of each Material Provider. Contact information shall include email address, physical and mailing address, and current contact information for the compliance or legal department for Colorado.

b. Whether the Material Provider is in-network for the applicable plan year and, if the Material Provider is in-network for only a subset of services, for which services they are in-network

3. A completed Negotiated Rate Template, confidentially submitted via SFTP, for the two years preceding the applicable plan year and for the applicable plan year for each Material Provider containing:

    a. The Aggregated Negotiated Rate for each Material Provider expressed as both a dollar and as a percentage of Medicare;

    b. The Negotiated Rate by service expressed as both a dollar amount and as a percentage of Medicare;

    c. The payment methodology (i.e. Diagnosis Related Group (DRG), Ambulatory Payment Classifications (APC), Per Diem, etc.) as outlined in rate sheets submitted in Section 9.A.2.d of this regulation;

    d. The analytic methodologies and tools used to aggregate the Negotiated Rates by service at the Material Provider level and to determine Negotiated Rates as a percentage of Medicare, including a service mix estimate; and

    e. If a carrier contracts and negotiates at the hospital system level, the Negotiated Rates, analyses, and agreements at the system level must also be submitted.

    f. For each Material Provider, the carrier must also identify in the Negotiated Rate Template whether the Aggregated Negotiated Rate for the applicable plan year is:

        (1) Above, consistent with, or below the reimbursement rates set forth in § 10-16-1306(5)(a) and (b) or § 10-16-1306(4)(b), C.R.S.

        (2) Above, consistent with, or below the reimbursement rate set forth in § 10-16-1306(4)(a), C.R.S., if the Material Provider is a hospital that qualifies for a reimbursement rate as set forth in § 10-16-1306(4)(a), C.R.S.

4. To demonstrate Negotiated Rates with Material Providers, the carrier shall submit confidentially via SFTP an unredacted copy of all of the carrier's Colorado Option Standardized Plan rate sheets, including addendums, for the year preceding the applicable plan year and for the applicable plan year. The rate sheets shall include the agreed upon rates by code or payment methodology and any additional payment agreements (add-on, outlier, stop-loss, etc.) and shall clearly outline whether the agreements are hospital or health-care provider- specific or if they apply to a health-care provider organization or hospital system. If non-Standardized Plan information is included in the same rate sheet as a Colorado Option Standardized Plan rate sheet, the carrier may redact the sections specific to non-Standardized Plans. The carrier must also disclose whether any contracts with Material Providers are set to expire, lapse, terminate, or otherwise end before or during the applicable plan year.

5. If a carrier has negotiated a reimbursement rate with a Material Provider that is a Hospital for the applicable plan year that is consistent with or below the reimbursement rate set forth in § 10-16-1306(4)(a), (5)(a) or (b), whichever is applicable to the Hospital, then the carrier must submit a joint attestation of those negotiated rates with the applicable Hospital to the Division as part of the March 1 filing.

6. A statement clarifying whether the carrier and the hospital or health-care provider engaged in nonbinding arbitration as allowed under § 10-16-1306(1)(b), C.R.S., or consent to participate in the opportunity for settlement afforded by Section 12.

7. An actuarial analysis, including trends and assumptions that includes the following information:

   a. For Material Providers with reimbursement rates that are above the reimbursement rates set forth in § 10-16-1306(4)(a) and (b), C.R.S., or § 10-16-1306(5)(a) and (b), C.R.S., the reimbursement rates for the year preceding the applicable plan year and the reimbursement rates for the applicable plan year.

   b. The impact on further reducing premiums on Colorado Option Standardized Plans, by plan, network, and Rating Area, if the carrier set the reimbursement rates for all of the Material Provider's referenced in subsection (a) reimbursement rates were set at to the reimbursement rates in § 10-16-1306(4)(a) or (b), C.R.S. or § 10-16-1306(5)(a) or (b), C.R.S.

B. Notwithstanding the carriers' notice in Section 9.A., every carrier shall submit the following documents to the Commissioner no later than March 1 of the year preceding the applicable plan year:

1. A completed Premium Rate Reduction Notification template as required in Colorado Insurance Regulation 4-2-85.

2. A statement outlining the good faith efforts the carrier made with in-network hospitals and/or health-care providers to negotiate reimbursement rates that would support the carrier in lowering premiums on Colorado Option Standardized Plans.

3. Pursuant to § 10-16-1306(3), C.R.S., if a carrier is unable to meet the network adequacy requirements, a carrier shall notify the Commissioner of the reasons why the carrier is unable to meet the network adequacy requirements. If the carrier is able to meet the network adequacy requirements, the carrier shall provide an attestation regarding the carrier's ability to meet network adequacy requirements for the applicable plan year and that the network for the Colorado Option Standardized Plan is no more narrow than the most restrictive network the carrier is offering for non-Standardized plans in the individual or small group market for the metal tier for that Rating Area. Nothing in this subsection shall preclude the Division from requesting additional information regarding a carrier's compliance with network adequacy requirements.

C. Upon request from the Division, the carrier shall submit a completed Cost of Care Data Template, confidentially submitted via SFTP, that summarizes the claims experience and cost of providing care by hospital or healthcare provider. If a hospital or healthcare provider constitutes a Material Provider, the carrier must also provide the summarized claims experience and cost of providing care by service.

D. The carrier shall respond to any follow up inquiries by the Division requesting additional information regarding the notifications required by Sections 9.A. and 9.B.

E. Documents provided pursuant to Sections 9.A., 9.B. and 9.C. must be bates numbered and clearly identify the Party submitting the documentary evidence.

F. The Commissioner shall post on the Division's website the information provided by the carrier pursuant to Section 9, including the Negotiated Rates except as provided in Section 14 relating to Confidential Information. If the carrier's submission is incomplete, the Division shall notify the carrier and allow the carrier up to seven (7) days to submit complete information. The Commissioner shall post the information within three (3) days of the Division determining the information to be complete.

G. Upon the filing and service of a complaint, the carrier shall produce the notifications required by Sections 9.A., 9.B., and any additional information produced under 9.C. to all Parties. However, the Division shall produce the notifications submitted by the carriers pursuant to Sections 9.A., 9.B., and any additional information produced under 9.C. to the Insurance Ombudsperson.

H. The carrier has an affirmative duty to notify the Division of any changes, discrepancies, errors, or omissions regarding the notifications required under this Section 9.

Section 10 Complaint

A. Simultaneous with the filing of the carrier's notification detailed in Section 9, the carrier may file a Complaint identifying the Material Provider(s) that were a cause of the carrier's failure to meet the Premium Rate Reduction Requirements alleging:

1. The inability of the carrier to meet the Premium Rate Reduction Requirements;

2. The reasons the carrier failed to meet the Premium Rate Reduction Requirements including any reasons not tied to Material Providers;

3. The Material Provider(s) that were a cause of the carrier's failure to meet the Premium Rate Reduction Requirements.

4. Sections of the template(s) summarizing each Material Provider's contributions to premiums provided pursuant to Section 9 to support the carrier's identification of Material Providers as a reason the carrier claims it failed to meet the Premium Rate Reduction Requirements;

5. A reimbursement rate pursuant to §§ 10-16-1306(4), (5) and (7), C.R.S., applicable to such Material Provider(s) that would allow the carrier to further reduce premiums on its Colorado Option Standardized Plans; and

6. Any legal authority supporting the complaint.

B. If a carrier has notified the Division that it failed, or the Division alleges that the carrier has failed, to meet the Premium Rate Reduction Requirements, the Division may also initiate a Complaint or Cross-Complaint against any Material Provider and carrier after reviewing the carrier's March 1 Notice and filings. The Division's complaint may include the information set forth in Section 10.A.

C. A carrier may file a network adequacy Complaint, or Cross Complaint, which may name or include hospitals or health-care providers. The Division may also file a network adequacy Complaint, or Cross Complaint, which may name or include a carrier and hospitals or health-care providers. A network adequacy Complaint may be filed in conjunction with a Complaint specified in subsections A and B; however, a carrier or the Division is not required to bring both Complaints at the same time or in the same proceeding.

The Division's network adequacy complaint may contain allegations that a carrier failed to comply with § 10-16-1304(1)(f), C.R.S., and network adequacy requirements, including, but not limited to, Colorado Insurance Regulations 4-2-53, 4-2-54, 4-2-55, and 4-2-56 and may identify the hospital(s) or health-care provider(s) that were a cause of the Carrier failing to meet network adequacy requirements.

A carrier's network adequacy complaint may include the reasons why the carrier is unable to comply with § 10-16-1304(1)(f), C.R.S., and network adequacy requirements, including, but not limited to, Colorado Insurance Regulations 4-2-53, 4-2-54, 4-2-55, and 4-2-56, and shall identify the hospital(s) or health-care provider(s) that were a cause of the Carrier failing to meet network adequacy requirements.

If a Carrier is unable to comply with the network adequacy requirements under § 10-16-1304(1)(g), C.R.S., the carrier shall follow the action plan procedures set forth in Colorado Insurance Regulation 4-2-80. The Commissioner may issue a procedural order modifying any of the deadlines or requirements in this regulation as needed upon the filing of a network adequacy Complaint to ensure adequate notice and an opportunity to be heard to the Parties.

D. The Complaint shall be served on all Parties consistent with the requirements set forth in Section 8.

E. The Division will submit a status update to the Commissioner within four (4) weeks of the March 1 Notice and filings, which will provide a procedural update on the timeline for filing any complaints. The Division shall serve the status update on the carrier and the Insurance Ombudsperson. The Commissioner shall post the status update on the Division's website. Upon request of the Commissioner, the Division shall file other status updates.

F. Nothing in this regulation shall be interpreted to prohibit the Division from investigating and initiating an enforcement action at any time during the year if the Division has determined that the carrier is no longer in compliance with its network adequacy requirements.

Section 11 Answer to Complaint of Failure to Meet the Premium Rate Reduction or Network Adequacy Requirements

A. A carrier alleged by the Division to have failed to meet the Premium Rate Reduction Requirements or network adequacy requirements pursuant to Sections 10.B and 10.C shall file an Answer within twenty-one (21) days from the date of service of the Complaint. Simultaneously with the Answer, the carrier may also file a Cross-Complaint alternately or hypothetically that identifies the hospital(s) or health-care provider(s) that the carrier alleges were a cause of the carrier's failure to meet the requirements. The Cross-Complaint shall contain all of the information required of a Complaint in Sections 10.A and 10.B.

B. Any hospital or health-care provider named in a Complaint or Cross-Complaint shall file an Answer within twenty-one (21) days from the date of service of the Complaint or Cross-Complaint, as applicable. The Answer shall:

1. Respond to all allegations in the Complaint or Cross-Complaint;

2 Identify whether the carrier could have met the Premium Rate Reduction Requirements or network adequacy requirements, and if so, attach any analysis supporting this allegation;

3. Provide a substantive response as to why the hospital or health-care provider contends the reimbursement rates offered by the carrier are insufficient, if applicable, including any potential effects of the requested reimbursement rates on the hospital's or health-care provider's operations; and

4. To the extent known, provide a statement as to whether the carrier and the hospital or health-care provider engaged in nonbinding arbitration as allowed under § 10-16-1306(1)(b), C.R.S., or consent to participate in the opportunity for settlement afforded by Section 12.

C. Documents provided as exhibits to the Answer must be bates numbered and clearly identify the Party submitting the documentary evidence.

D. The Insurance Ombudsperson and the Division may, but are not required to, file a response to a Complaint or Cross-Complaint within twenty-one (21) days of receipt of the Complaint or Cross-Complaint. The Division may file a Cross-Complaint naming additional hospitals or health-care providers.

Section 12 Settlement

A. The carrier, hospital(s) and/or health-care provider(s), and the Division may negotiate a settlement. The Commissioner shall enter a final agency order approving or disapproving the settlement or recommend a modification as a condition for approval.

If the Commissioner does not approve the negotiated settlement or a settlement is not reached, the Parties shall proceed with the public hearing. All negotiations during the settlement period are considered confidential and shall not be introduced into the hearing.

B. If a settlement is achieved that concludes the adjudicatory session of the public hearing and is approved by the Commissioner, the Commissioner may still hold a hearing for public comment prior to the approval of the carrier's final rates. The Commissioner shall issue notice of the date, time, location, and scope of any public hearing held pursuant to this subsection B.

C. The Division may conduct settlement negotiations with the carrier and hospitals or health-care providers to determine whether a settlement may be reached prior to the Division filing a complaint.

D. Prior to a settlement being reached or upon request of the Division, the carrier shall provide the following documentation to the Division to verify the reimbursement rates and premium impact of the proposed reduction in those reimbursement rates:

1. The two years preceding the applicable plan year's and the applicable plan year's:

a. Negotiated Rates for most common services, which account for 85% of spend between the carrier and named hospital or health-care provider.

b. Payment methodology and tools outlining how the carrier reimburses the hospital or health-care provider for different services (i.e., Diagnosis Related Groups, Per Diem, etc.).

c. The Aggregate Negotiated Rate, as a percent of Medicare, and documentation of the methodology and tools used to calculate the Aggregate Negotiated Rate as a dollar value and the rate as a percent of Medicare. The Medicare rates effective when March 1 filings are submitted must be used to determine the percent of Medicare.

d. Premium impact statement demonstrating the overall impact of the hospital or health-care provider reimbursement Rate reduction by plan, metal tier, network, and Rating Area, including negotiated reimbursement rate reduction agreements entered into before and after the March 1 filing.

2. If a carrier and a hospital or health-care provider agree on a twenty percent (20%) reduction to the applicable plan year's Negotiated Rate compared to the current year's Negotiate Rate for the year preceding the applicable plan year, then the carrier must submit, for the year preceding the applicable plan year and the applicable plan year:

a. Negotiated Rates for most common services, which account for 85% of spend between the carrier and named hospital or health-care provider.

b. Payment methodology outlining how the carrier reimburses the hospital or health-care provider for different services (i.e., Diagnosis Related Groups, Per Diem, etc.).

c. The Aggregate Negotiated Rate, as a percent of Medicare and documentation of the methodology used to calculate the Aggregate Negotiated Rate and the rate as a percent of Medicare

d. The methodology, adjustments, and assumptions used to assess the twenty percent (20%) reduction on a service level, in aggregate, and as a percent of Medicare.

e. Premium impact statement demonstrating the overall impact of the hospital or health-care provider's reimbursement rate reduction by plan, metal tier, and Rating Area, including reimbursement rate reduction agreements entered into before and after the March 1 filing.

3. An attestation, and supporting documentation the Division requests, to verify that the hospital or health-care provider will be in-network for the entire applicable plan year.

E. At all times, the carrier has an affirmative duty to notify the Division of any changes, discrepancies, errors, or omissions regarding the information provided pursuant to this Section 12, including, but not limited to, in-network status, reimbursement rates, Negotiated Rates, and premium impact.

Section 13 Public Availability of Documents

A. In accordance with the Colorado Open Records Act and § 10-16-1306(3)(b), C.R.S., information submitted to the Commissioner as part of the public hearing process is presumed to be a public record and open for inspection, subject to restrictions specifically provided by law.

B. The Commissioner shall post all pleadings, documents submitted by the Parties, and orders of the Commissioner on the Division's website except as provided in Section 14 relating to Confidential Information.

Section 14 Confidential Information

A. Documents Submitted Pursuant to Section 9

1. In accordance with § 10-16-1306(3)(b), C.R.S., and subject to the requirements of the Colorado Open Records Act, the following information submitted for purposes of Section 9 and the public hearing may be filed under a claim of confidentiality as set forth in the procedures of this Section 14:

    a. The premium data, Cost Sharing Reduction loads, and carrier assumptions and projections by service area included in the Premium Rate Reduction Notification template, as specified in Section 9.A.1 of this regulation

    b. The Material Providers' relative contribution to the plan's premium in a Rating Area as included in the table specified in Section 9.A.2 of this regulation

    c. The Negotiated Rate Template as specified in Section 9.A.3 of this regulation

    d. The actuarial analysis as specified in Section 9.A.5 of this regulation

    e. The Cost of Care Template as specified in Section 9.B.2 of this regulation

2. Information submitted pursuant to this Section 14.A.1.a, b, and d may be subject to the requirements set forth in § 10-16-107(1)(g)(I), C.R.S., and, subject to the provisions of the "Colorado Open Records Act," part 2 of article 72 of title 24, may be made public after carriers file premium rates with the Division in June.

3. Nothing in this Section 14.A. shall be interpreted to limit a Party's ability to submit other documentation or information under a claim of confidentiality.

B. Procedures for requesting confidentiality.

1. Any Party may make a claim of confidentiality as to information or documents submitted to the Parties and the Commissioner.

2. A claim of confidentiality constitutes a representation to the Commissioner that the Party has a reasonable and good faith belief that the subject document or information is, in fact, confidential under applicable state and federal law, including the Colorado Open Records Act. If a claim of confidentiality is made in violation of this subparagraph, the Commissioner may impose an appropriate sanction upon the claiming Party, including an order to pay the amount of reasonable expenses incurred because of the claim of confidentiality, and reasonable attorney's fees.

3. Any Party submitting documents or information under a claim of confidentiality shall file, as part of the public record (i.e., not confidential), a notice of confidentiality specifying each document, the nature of the document on which confidential information is found, and the basis(es) for the claim of confidentiality as to the information and the bates numbers of the confidential documents. The notice of confidentiality shall be served upon the Parties. Failure to file a notice of confidentiality will result in administrative rejection of the filing of the confidential information.

4. Each page of each document on which confidential information is contained shall clearly be marked as "CONFIDENTIAL." Confidential documents will be maintained in the record by the Commissioner separately from other public documents.

5. The Commissioner's acceptance of information or documents under a claim of confidentiality is not, and shall not be construed to be, an agreement or determination by the Commissioner that the subject information or document is, in fact, confidential.

6. The Commissioner may, at any time, sua sponte or after considering a motion from any Party, issue a decision as to whether the subject information or documents submitted under a claim of confidentiality is confidential.

7. In the event the Commissioner rules that information submitted under a claim of confidentiality is not confidential, any person with access to the information shall not disclose the information or use it in the public record for seven (7) days. During this time period, the Party making a claim of confidentiality may seek a stay or other relief permitted by law.

B. Protection of Confidential Information

1. Information or documents ruled by the Commissioner as confidential, or information or documents submitted under a claim of confidentiality for which no ruling has been made by the Commissioner, shall be treated as confidential ("Confidential Information").

2. Confidential Information will only be made available to the Commissioner, the Commissioner's staff, and Parties. Confidential Information will not be made available to the public.

3. The Office of the Insurance Ombudsperson as a Party to the public hearing will be provided access to Confidential Information, but shall not provide Confidential Information to consumers, advocacy organizations, or the public.

   The Office of the Insurance Ombudsperson shall immediately notify the Commissioner and the Parties of any requests under the Colorado Open Records Act for Confidential Information.

4. Confidential Information may only be used for purposes of public hearings, and may not be shared with other persons or entities.

5. Confidential Information may be disclosed to experts or advisors for the Parties only for the purposes of public hearings.

6. Confidential Information shall not be used or disclosed for purposes of business or competition.

7. The Parties shall take all reasonable precautions to keep Confidential Information secure.

8. When reference is made to Confidential Information in exhibits, testimony, or pleadings, it shall be by citation to the title or nature of the document, or by some other description that will not disclose the Confidential Information.

9. Failure by any person to comply with the requirements of this Section regarding Confidential Information, or disclosure of Confidential Information to any person or entity who is not a Party to the public hearing, may result in sanctions as set forth in the Colorado Rules of Civil Procedure (C.R.C.P.) 37(b)(2) and may result in monetary penalties up to $750,000 pursuant to §§ 10-3-1107 and 10-3-1108(1)(a), C.R.S., for violating a rule or order of the Commissioner.

10. Within thirty (30) days of the conclusion of the proceedings, including any appeal of the final agency order, the Confidential information retained by the Parties shall be destroyed.

C. Public Hearing

1. Upon a showing that it is necessary for a Party to refer to Confidential Information during testimony at the public hearing, the Commissioner may convene the public hearing with only the Parties present to hear such testimony. A recording of this portion of the public hearing will be maintained by the Commissioner and will be treated as Confidential Information. Other Parties may cross-examine the witness as to the Confidential Information during this confidential portion of the public hearing.

2. Time devoted to the closed portion of the public hearing shall count against the time allotted to the Party requesting the closed hearing. Where multiple Parties request a closed hearing, the time allotted to the closed portion of the hearing shall be equally divided amongst the Parties that made such request.

D. Division and Commissioner Maintaining Confidential Information

Notwithstanding the provisions of this Section 14, and subject to the requirements of the Colorado Open Records Act, the Division and the Commissioner shall retain all Confidential Information. The Division and Commissioner may use Confidential Information for any lawful regulatory purpose, including, but not limited to, rate review, investigations, and enforcement actions.

E. Appeal

In the event the Commissioner's final agency order from the public hearing is appealed or otherwise subject to judicial review, the Commissioner will file all Confidential Information under seal with the Colorado Court of Appeals in accordance with applicable rules and regulations.

Section 15 Conflicts of Interest Screen

A. Where the carrier and hospitals and/or health-care providers elect to participate in the Opportunity for Settlement afforded under Section 12, any Division representatives that participate in the negotiations shall be screened from the Commissioner for the entirety of the applicable public hearing process. Additionally, the Division representatives that participate in the negotiations shall not disclose any information from the negotiations to the Commissioner.

The Division's representatives and staff supporting those representatives shall be screened from the Commissioner, and their representatives and staff, for the entirety of the applicable public hearing.

B. "Screened" as used in this Section includes, specific to the matter that is the subject of the screen, remaining as separate entities for the public hearing and being restricted from ex parte communications. Except for filings submitted in SERFF or SFTP and documents submitted to the Parties and the Commissioner for a determination of confidentiality pursuant to Section 14, "screened" shall include prohibiting the Commissioner and their representatives' access to non-public filings and documents in the possession of Division staff and representatives on the opposite side of the screen from the Commissioner. It does not include restrictions on communications when all Parties and the Commissioner are included in the communication or communications. "Screened" does not include any procedural status updates filed by the Division prior to the filing of a complaint if the status update is publicly posted on the Division's website.

Section 16 Party Disclosures

A. Unless otherwise set in a procedural order issued by the Commissioner, no later than fourteen (14) days after the Parties submit Answers, each Party shall serve upon the Commissioner and all Parties the following information:

1. A witness list including the name, address, and telephone number of any witness whom the Party may call to provide testimony at the public hearing, together with a detailed statement of the content of that person's testimony. The Party shall indicate for each witness whether the witness's testimony will be written or oral.

2. Any of the following additional documentary evidence a Party may wish to include in the record at the public hearing related to a carrier's failure to meet the Premium Rate Reduction Requirements or network adequacy requirements in the Rating Area at issue may be submitted for the Commissioner's review including but not limited to:

   a. An actuarial analysis demonstrating why the Premium Rate Reduction Requirements were not met.

   b. Negotiated rates with other hospitals or health-care providers in the same Rating Area.

   c. Enrollee and utilization data for the Rating Area.

   d. Hospital or health-care provider financial data, including but not limited to, profit and loss statements and balance sheets. Hospitals or health-care providers may also submit other data to demonstrate unique circumstances that may not be represented in the public hearing.

   e. Hospital or health-care provider rates with other carriers.

   f. Carrier initiatives and assumptions to reduce health care costs for the Rating Area.

   g. Demographics and acuity of covered persons within the Rating Area.

3. All documents submitted to the Commissioner and the Parties pursuant to this Section will be included in the record for the public hearing, subject to Sections 14 and 21.

Section 17 Additional Discovery

A. The Colorado Rules of Civil Procedure (C.R.C.P.) 26 through 37 do not apply to the public hearing proceedings.

B. The Parties shall confer on any additional discovery beyond the disclosures identified in Section 16 and the written testimony in Section 21. The Parties are encouraged to keep discovery requests limited, targeted, and narrowly tailored to information that is related to the reason the carrier failed to meet network adequacy requirements or the Premium Rate Reduction Requirements. If the Parties cannot reach an agreement, the Party seeking discovery shall file a motion with the Commissioner before serving discovery on another Party. Additional discovery shall be at the discretion of the Commissioner. The Party seeking discovery shall set forth in the motion the following:

   1. The specific data or information that the Party is requesting;

   2. The rationale for the requested data or information;

   3. The relevance to the carrier's failure to meet the Premium Rate Reduction Requirements or network adequacy requirements;

   4. Whether the data or information is available from another source.

C. If the Commissioner grants the additional discovery, the Commissioner will issue an order setting the deadline for the Party to produce the discovery.

Section 18 Motions

Parties shall have five (5) days to respond to any motion submitted by an opposing Party, unless otherwise ordered by the Commissioner. No reply briefs are permitted. Time shall be calculated as provided in Section 25.

Section 19 Consolidation of Proceedings

The Commissioner has the discretion to consolidate proceedings involving the same carrier.

Section 20 Burden of Proof

A. The burden of proof shall be on the Party that is the proponent of a decision.

B. Nothing in this Section 20 shall preclude a hospital or health-care provider from presenting evidence that the carrier's proposed reimbursement rate is insufficient.

Section 21 Public Hearing Proceedings

A. No later than fifteen (15) days before the hearing, the Commissioner shall issue an order setting forth the allotted time for the Parties to present evidence and testimony at the hearing.

B. Public Comment by Interested Persons

In addition to the Parties identified in Section 7, consumer advocacy organizations, trade organizations, and other entities or individuals shall be given the opportunity to present evidence regarding the carrier's failure to meet the Premium Rate Reduction Requirements or network adequacy requirements during the public hearing. Members of the public, consumer advocacy organizations, small businesses, trade organizations, and other entities or interested persons who seek to comment at the hearing shall sign up at least two (2) days in advance of the hearing on the Division's website. The Commissioner may set time limits on public comment.

Members of the public may submit written comments up to two (2) days after the hearing, in lieu of public comments at the hearing, which will be posted on the Division's website.

C. Presentation of Evidence

1. The Commissioner shall limit evidence presented at the hearing to information that is related to the reason the carrier failed to meet the network adequacy requirements or the Premium Rate Reduction Requirements for the Standardized Plans at issue in the hearing. Evidence shall be limited to information that is relevant to the Commissioner's determination pursuant to §§ 10-16-1306(3) to (11), C.R.S.

2. The Colorado Rules of Evidence and requirements of proof shall conform, to the extent practicable, with those in civil nonjury cases in the district courts. However, when necessary to ascertain facts affecting substantial rights of the Parties to the proceeding, the Commissioner may receive and consider evidence not admissible under the Colorado Rules of Evidence, if the evidence possesses probative value commonly accepted by reasonable and prudent persons in the conduct of their affairs. Informality in any proceeding or in the manner of taking testimony shall not invalidate any order, decision, rule, or regulation. The Commissioner may exclude incompetent and unduly repetitious evidence.

3. Exhibits

   a. Documentary evidence shall be admitted into the record, except as follows:

      (1) Any Party may object under the Colorado Rules of Evidence to inclusion of documentary evidence in the record at the public hearing, provided the objection is made in writing to the Commissioner at least five (5) days prior to the public hearing. The Commissioner may rule on these objections in writing or on the record during the public hearing.

      (2) At the Commissioner's discretion, the Commissioner may require the Party presenting a document in the record to present testimony or evidence as to the authenticity of that document.

   b. The Commissioner encourages Parties to offer written stipulations resolving any evidentiary dispute, fact, or matter of substance or procedure at issue. Oral stipulations may be made on the record at the public hearing, but the Commissioner may require that the stipulation be reduced to writing, signed by the Parties or their counsel, and filed with the Commissioner. Any stipulation must be approved by the Commissioner, and the Commissioner may modify a stipulation as a condition of approval.

4. Witness Testimony

   a. A Party may present the testimony of its witnesses through written testimony provided the Party has identified that the witness's testimony will be presented in writing in their witness list submitted pursuant to Section 16. Written testimony must be submitted to the Commissioner and the Parties no later than seven (7) days before the hearing.

   b. All Parties may make objections to witness testimony, and all witnesses are subject to cross-examination by or on behalf of Parties to the hearing. Any witness who's oral and/or written testimony a Party wishes to have as part of the record shall be available for cross-examination at the hearing.

5. Where lengthy cross-examination would use undue time, the Commissioner may require each Party to estimate the amount of time necessary for cross-examination. To promote an efficient hearing, the Commissioner may limit each Party's time for cross-examination. Time devoted to cross-examination shall count against the time allotted to the Party conducting the cross-examination.

Section 22 Recording of Hearing

The public hearing shall be recorded and posted on the Division's website.

Section 23 Establishment of Reimbursement Rates, if Necessary, and Issuance of Final Agency Order

A. Based on the evidence presented at the hearing, the Commissioner may establish and require hospitals and/or health-care providers to accept carrier reimbursement rates for hospitals and/or health-care providers, if necessary, to meet the network adequacy requirements or the Premium Rate Reduction Requirements. "If necessary" means essential to the achievement of network adequacy or reduced premiums, but not in all instances sufficient for a carrier to meet network adequacy requirements or the Premium Rate Reduction Requirements.

B. In determining the hospital's reimbursement rate, the Commissioner may:

1. Consult with employee membership organizations representing health-care providers' employees in Colorado and with hospital-based health-care providers in Colorado.

2. Take into account the cost of adequate wages, benefits, staffing, and training for health-care employees to provide continuous quality care.

3. Take into account the most current Medicare prospective or cost-based payment rates available, or any rate modifications published by the Centers for Medicare and Medicaid Services that may be relevant to the applicable plan year, including how the most current Medicare prospective or cost-based payment rates available may impact the applicable Premium Rate Reduction Requirements.

4. Utilize any publicly available hospital and provider data and cost tools.

C. The Commissioner may not set a reimbursement rate for a hospital or health-care provider that is lower than the Hospital Reimbursement Floor or Health-Care Provider Reimbursement Floor specific to that hospital or health-care provider.

D. The Commissioner cannot set the reimbursement rate for any hospital for any plan year at an amount that is more than twenty percent lower than the Negotiated Rate between the carrier and the hospital for the plan year preceding the applicable plan year. To determine the Aggregate Negotiated Rate between the carrier and hospital for the applicable plan year and the year preceding the applicable plan year, the carrier must submit the information required in Section 9.

E. For a hospital with an Aggregate Negotiated Rate that is at least ten percent less than the Statewide Hospital Median Reimbursement Rate measured as a percentage of the Medicare Reimbursement Rate for the 2021 plan year using data from the All-Payer Health Claims Database:

1. The Commissioner will set the hospital reimbursement rate for that hospital at no less than the greater of:

   a. The hospital's Aggregate Negotiated Rate minus one-third of the difference between the hospital's Aggregate Medicare Reimbursement Rate and the Hospital Reimbursement Floor established by Section 5 of Colorado Insurance Regulation 4-2-91.

   b. One hundred sixty-five percent of the hospital's Medicare Reimbursement Rate.

   c. The Hospital Reimbursement Floor established by Section 5 of Colorado Insurance Regulation 4-2-91.

2. If a hospital believes that their Aggregate Negotiated Rate is at least ten percent less than the Statewide Hospital Median Reimbursement Rate, then a hospital may work with the carrier to submit to the Division a joint attestation by March 1 of the year preceding the applicable plan year. The joint attestation must contain the applicable plan year's Aggregate Negotiated Rate, and documentation of the methodology to derive this estimate.

   If a joint attestation is not submitted for a hospital and carrier by March 1 of the year preceding the applicable plan year and the hospital does not provide the Division with any information regarding their Aggregate Negotiated Rate, the Division will calculate the Hospital Reimbursement Floor as the greater of:

a. One hundred sixty-five percent of the hospital's Aggregate Medicare Reimbursement Rate.

b. The reimbursement rate established by Section 5 of Colorado Insurance Regulation 4-2-91.

F. The Commissioner shall issue a final agency order which shall include the Commissioner's determination of the reimbursement rate, by hospital and/or health-care provider, that must be used by the carrier in its rate filings.

G. The decision of the Commissioner is a final agency order subject to judicial review pursuant to § 24-4-106(11) C.R.S.

Section 24 Modifications to Public Hearing Process

The Commissioner may issue appropriate orders to control the scope, course, and outcome of the public hearing including, but not limited to, dismissal.

Section 25 Computation and Modification of Time

A. In computing any time period pursuant to this regulation, the day of the event from which the time period begins shall not be included. If the due date falls on a weekend or state holiday, the due date will be the next business day.

B. At the Commissioner's discretion, a due date may be extended.

Section 26 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 27 Incorporation by Reference

42 C.F.R. § 400.202 published by the Government Printing Office shall mean 42 C.F.R. § 400.202 as published on the effective date of this regulation and does not include later amendments to or editions of 42 C.F.R. § 400.202. A copy of 42 C.F.R. § 400.202 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 42 C.F.R. § 400.202 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 147.102 published by the Government Printing Office shall mean 45 C.F.R. § 147.102 as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 147.102. A copy of 45 C.F.R. § 147.102 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 147.102 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 28 Enforcement

Noncompliance with this Regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 29 Effective Date

This regulation shall be effective on February 1, 2025

Section 30 History

New regulation effective February 14, 2023.
Amended regulation effective February 1, 2024.
Amended regulation effective February 1, 2025.

Regulation 4-2-93 CONCERNING PRESCRIPTION DRUG BENEFIT FORMULARY MODIFICATIONS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-16-122.4, 10-16-109, and 10-1-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements for a health insurer, offering a health benefit plan on the individual market that includes a prescription drug benefit, to make a modification to the prescription drug formulary during the current plan year pursuant to Section 10-16-122.4(2), C.R.S.

Section 3 Applicability

This regulation applies to all individual health benefit plans issued or renewed on or after January 1, 2024, in the state of Colorado that include a prescription drug benefit and utilize a prescription drug formulary or list of covered drugs.

Health insurers, regardless of whether the insurer utilizes a Pharmacy benefit management firm for claims processing services or other prescription drug or device services, are subject to the requirements of this regulation.

Section 4 Definitions

A. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

B. “Drug benefit” means, for the purposes of this regulation, the provision of a prescription drug used to treat a covered medical condition of a covered person.

C. “FDA” means, for the purposes of this regulation, the Food and Drug Administration in the United States Department of Health and Human Services.

D. Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

E. “Health insurer” shall have the same meaning as found at § 10-16-156(1)(b), C.R.S.

F. “Modify” or “modification” shall have the same meaning as found at § 10-16-122.4(1)(b), C.R.S.

G. “Network” shall have the same meaning as found at § 10-16-102(45), C.R.S.

H. "Other prescription drug or device services" shall have the same meaning as found at § 10-16-122.1(5)(b), C.R.S.

I. "Prescribing provider" shall have the same meaning as found at § 10-16-124.5(8)(a), C.R.S.

J. "Prescription drug formulary" or "list of covered drugs" means, for the purposes of this regulation a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

K. "Pharmacy benefit management firm" shall have the same meaning as found at § 10-16-102(49), C.R.S.

L. "SERFF" means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filings.

Section 5 Annual Prescription Drug Formulary Attestation

Pursuant to Section 10-16-122.4(3), C.R.S., health insurers shall file annually an attestation regarding the prescription drug formulary for the upcoming plan year for Colorado enrollees. The attestation must be submitted as part of the health insurer's annual binder filing in SERFF.

Health insurers shall make the following attestations on the "Prescription Drug Formulary Attestation Form" described in the instructions provided by the Division:

A. The health insurer will not modify or apply a modification to the current prescription drug formulary during the current plan year unless the modification is pursuant to Section 10-16-122.4(2), C.R.S.;

B. The health insurer will provide notice to the Division in accordance with Section 6 of this regulation and provide notice to covered persons pursuant to Colorado Regulation 4-2-82 prior to a modification to the prescription drug formulary pursuant to Section 10-16-122.4(2), C.R.S.

C. The health insurer will provide notice in accordance with Section 6.C. to a prescribing provider prior to a modification to the prescription drug formulary pursuant to Section 10-16-122.4(2), C.R.S.

Section 6 Prescription Drug Formulary Notice and Disclosure

A. A health insurer that is modifying or applying a modification to the current prescription drug formulary during the current plan year pursuant to Section 10-16-122.4(2), C.R.S., must provide notice to the Division, in accordance with the "Prescription Drug Formulary Notice Template" in Appendix A. Notice must be provided one hundred and twenty days (120) prior to the change being effective. The notice must include:

1. The prescription drug subject to the mid-year formulary modification;

2. The health insurer's action taken on the prescription drug, including moving the drug to a higher cost sharing tier or removing the prescription drug from the health insurer's prescription drug formulary;

3. The reason for the modification pursuant to Section 10-16-122.4(2), C.R.S.

4. The suggested preferred alternative prescription drug;

5. The number of people enrolled in plans that have this drug in the formulary and will be impacted by the formulary modification;

6. An explanation of the proposed drug formulary modification;

7. Any supporting documentation to support the modification; and

8. A copy of the notice to be sent to policyholders impacted by the modification in accordance with Colorado Insurance Regulation 4-2-82.

B. A health insurer shall submit the notice in Appendix A through a SERFF filing using the following information:

1. Filing Type: Form

2. Requested Filing Mode: Informational

2. Filing Description: Formulary Changes

3. Effective Date: Health insurers shall use the date that the prescription drug formulary modification will be effective.

4. Health insurers shall complete the SERFF Form Schedule tab to specify the forms to which this filing applies.

5. Health insurers shall provide a filing description, including the benefit year to which the prescription drug formulary modification applies.

C. The health insurer must provide notice, at least sixty (60) days prior to the effective date of the modification, to:

1. Covered persons enrolled in plans that have the drug in their formulary and will be impacted by the formulary modification in accordance with Colorado Insurance Regulation 4-2-82; and

2. Prescribing providers in the health insurer's network.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective on May 30, 2023.

Section 10 History

New regulation effective May 30, 2023.

Appendix A: Prescription Drug Formulary Notice Template

[Date]

Commissioner [Name]
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

RE: Proposed Mid-Year Prescription Drug Formulary Modifications to [Non-grandfathered][Grandfathered] Plans in the Individual Market

Dear Commissioner [Name]:

Please accept this letter and its attachments as [Health insurers name]'s notice of a mid-year prescription drug formulary modification pursuant to subsection [citation to reason for modification] in Section 10-16-122.4(2), C.R.S. This modification will be effective [Date].

We are proposing to make the following changes to the current prescription drug formulary for the current plan year:

Prescription Drug	Action Taken (Tier move or formulary removal)	Reason for Modification	Preferred Alternative Drug	Number of Enrollees Impacted	Explanation of Change

[Please attach any necessary supporting documentation]

Attached please find:

- Policyholder letter.

Thank you for your consideration of this request.

Sincerely,

Regulation 4-2-94 CONCERNING HEALTH INSURER REPORTING OF PRESCRIPTION DRUG REBATES AND DISCOUNTS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-16-156(10), 10-16-109, and 10-1-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the reporting requirements for health insurers to demonstrate that all prescription drug rebates and discounts received are used to reduce costs for policyholders in compliance with Section 10-16-156, C.R.S.

Section 3 Applicability

This regulation applies to all health benefit plans and optional participating plans issued or renewed on or after January 1, 2024 in the state of Colorado which provide prescription drug benefits.

Health insurers, regardless of whether the insurer utilizes a Pharmacy benefit management firm, are subject to the reporting requirements of this Regulation.

Section 4 Definitions

A. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

B. “Discount” shall have the same meaning as found at § 10-16-156(1)(a), C.R.S.

C. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

D. “Health insurer” shall have the same meaning as found at § 10-16-156(1)(b), C.R.S.

E. “Manufacturer” shall have the same meaning as set forth in § 10-16-1401(16), C.R.S.

F. “Optional participating plan” means, for the purposes of this regulation, a self-funded health benefit plan offered in Colorado that elects to subject its prescription drug benefits, purchases, and payer reimbursements to the requirements of § 10-16-156, C.R.S.

G. "Out-of-pocket costs" means, for the purposes of this regulation, the amount a covered person is required to pay in the form of deductibles, copayments, or coinsurance. Out-of-pocket costs do not include premium.

H. "Pharmacy benefit management firm" or PBM shall have the same meaning as found at § 10-16-102(49), C.R.S.

I. "PMPM" means, for the purposes of this regulation, per member per month.

J. "Point of sale" means, for the purposes of this regulation, a covered person's financial transaction for a prescription drug that is dispensed or administered to a covered person in person, by mail, or other means.

K. "Premium" shall have the same meaning as found at § 10-16-102(51), C.R.S.

L. "Prescription drug" has the same meaning as set forth in § 12-280-103(42) C.R.S; except that the term includes only prescription drugs that are intended for human use.

M. "Rebate" shall have the same meaning as found at § 10-16-156(1)(e), C.R.S.

N. "SERFF" means, for the purposes of this regulation, the System for Electronic Rate and Form Filing.

Section 5 Annual Prescription Drug Estimated Rebate and Discount Attestation and Calculating Estimated Rebates and Discounts

Pursuant to sections 10-16-156(2)-(3), C.R.S., health insurers shall file annually an attestation regarding the use of estimated prescription drug rebates and discounts. As part of the attestation, health insurers must submit an template with an estimate of the amount of rebates and discounts the health insurer expects to receive in connection with dispensing or administering prescription drugs included in the health insurer's formulary for that plan year for Colorado enrollees. The attestation and template must be submitted as part of the health insurer's annual rate filing in SERFF.

A. Health insurers shall make the following attestations on the "Prescription Drug Estimated Rebate Attestation Form" provided by the Division. The attestation form will contain the following information:

1. An actuarial certification that attests the health insurer is in compliance with subsections 10-16-156(2) and (3), C.R.S.;

2. A description, and all relevant written procedures, of how the health insurer intends to comply with the requirements in subsections 10-16-156(2) and (3), C.R.S.;

3. A statement and description of how the estimated rebates to be received in connection with dispensing or administering prescription drugs included in the health insurer's formulary for that plan year will be used to reduce costs, including premium and out-of-pocket costs, to policyholders;

4. A statement and description of how the health insurer will maximize the use of estimated rebates to reduce consumer out-of-pocket costs at the point of sale for individual health benefit plan members;

5. A statement and description of how the discounts received or to be received from a manufacturer in connection with dispensing or administering prescription drugs included in the health insurer's formulary for that plan year will be used to reduce costs, including premium and out-of-pocket costs, for the upcoming plan year.

B. Health insurers shall complete and submit the "Prescription Drug Estimated Rebate Calculations" template that details the calculation of estimated rebates to be received in connection with dispensing or administering prescription drugs included in the health insurer's formulary for that plan year and not reflected in the discounts received or to be received. The template shall include how the estimated rebates are factored into premiums or dispensed at point of sale or otherwise used to reduce out of pocket costs. This calculation shall be based on be based on guaranteed rebates for the upcoming plan year, with a multiplicative adjustment to the guaranteed rebates based on the enrollment weighted average of actual to guaranteed rebates over the previous one or more consecutive plan years immediately preceding the rate filing. A full explanation of the health insurer's calculation of estimated rebates for the upcoming plan year, including how many plan years considered, shall be provided.

C. Health insurers shall complete and submit the "Prescription Drug Estimated Discount Calculations" template that details the calculation of any and all discounts received or to be received from a manufacturer in connection with dispensing or administering prescription drugs included in the health insurer's formulary for that plan year and not reflected in the estimated rebates. The template shall include a description of what specific arrangement between the manufacturer or its affiliate and the health insurer qualifies as a discount and how the estimated discounts are factored into premiums or otherwise used to reduce out of pocket costs. The estimated discount calculation should be based on a weighted average of the amount of estimated discounts received over the previous one or more consecutive plan years immediately preceding the filing.

Section 6 Annual Reporting Requirements for Actual Rebates and Actual Discounts

A. On or before June 1, 2025 and each year thereafter, each health insurer shall submit a completed "Actual Rebate and Actual Discount Reporting Template" to the Division describing the actual prescription drug rebates received during the preceding plan year and discounts received from a manufacturer in connection with dispensing or administering prescription drugs included in the health insurer's formulary received during the preceding plans year. The template shall be submitted in SERFF as an "Annual Actual Rebate and Discount Reporting" filing.

B. The report shall include an actuarial certification that the data reported is accurate.

C. Pursuant to section 10-16-156(5) C.R.S., for the plan year beginning on or after January 1, 2024, and each year thereafter, each health insurer shall provide to the Division the following information:

1. The aggregate amount of actual rebates received by the health insurer;

2. The following information on actual rebates received by the health insurer:

a. the aggregate amount, over the entire plan year, and the average PMPM amount of allowed claims, prior to the reduction in claims due to rebates;

b. the aggregate amount, over the entire plan year, and the average PMPM amount of incurred claims, prior to the reduction in claims due to rebates;

c. the aggregate amount, over the entire plan year, and average PMPM amount of actual rebates received that were used at the point-of-sale to reduce a covered person's defined out-of-pocket costs for individual health benefit plans;

d. the aggregate amount, over the entire plan year, and average PMPM amount of savings per prescription for actual rebates received that were used at the point-of-sale to reduce a covered person's defined out-of-pocket costs for individual health benefit plans;

e. the aggregate amount, over the entire plan year, and average PMPM amount of actual rebates received that were used to reduce a covered person's premium;

f. the aggregate amount, over the entire plan year, and the average PMPM amount of allowed claims, after the reduction in claims due to rebates;

g. the aggregate amount, over the entire plan year, and the average PMPM amount of incurred claims, after the reduction in claims due to rebates;

h. the average PMPM premium savings, expressed as a percentage of premium, for actual rebates received that were used to reduce a covered person's premium.

3. A separate template including the following information on actual rebates received by the health insurer:

a. total rebates received for each prescription drug dispensed during the preceding plan year;

b. total rebates received per prescription drug formulary tier during the preceding plan year;

c. total rebates retained by the health insurer and/or PBM.

D. Pursuant to section 10-16-156(5) C.R.S., for the plan year beginning on or after January 1, 2024, and each year thereafter, each health insurer shall provide to the Division the aggregate amount of actual discounts received by the health insurer.

E. If applicable, for any health benefit plan not in compliance with section 10-16-156(3), C.R.S., an explanation of why the health insurer was not able to use one hundred percent of the actual rebates received to reduce policyholder costs.

F. For individual health benefit plans that have not passed through one hundred percent of the actual rebates received to reduce policyholder costs, health insurers must demonstrate that the actual rebates would have increased premiums, changed the actuarial value of the plan inconsistent with federal and state requirements, or resulted in other impacts to consumers;

G. If applicable, for any health benefit plan not in compliance with subsection 10-16-156(2), C.R.S., an explanation of why the health insurer was not able to use one hundred percent of the actual discounts received to reduce policyholder costs.

Section 7 Self-Funded Opt-in

An optional participating plan may opt-in to the requirements of subsections 10-16-156(2)-(3), (5), C.R.S. Optional participating plans must notify the Division of the intent to opt-in to the requirements of this regulation in writing, within thirty (30) days after such election.

Section 8 Confidentiality

Information submitted by the health insurers and PBMs to the Division in accordance with this regulation is subject to public inspection only to the extent allowed under the "Colorado Open Records Act", and in no case shall trade-secret, confidential, or proprietary information be disclosed to any person who is not otherwise authorized to access such information.

A health insurer shall submit a "Confidentiality Index" if the health insurer desires confidential treatment of a document submitted under this regulation, identifying which documents are confidential and the justification for confidentiality. Any information not marked as confidential or otherwise confidential under state law may be disclosed pursuant to the Colorado Open Records Act.

Section 9 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 10 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, orders to pay restitution, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 11 Effective Date

This regulation shall become effective on May 30, 2023.

Section 12 History

New regulation effective May 30, 2023.

Regulation 4-2-95 CONTRACEPTIVE BENEFIT REQUIREMENTS FOR HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-16-109 and 10-16-104.2, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to implement SB23-284 and ensure carriers offering health benefit plans or pharmacy benefit managers acting on behalf of carriers are providing coverage for contraception in accordance with the Public Health Service Act, as amended by the Affordable Care Act, and clarified in federal guidance from the U.S. Departments of Health and Human Services, Labor, and the Treasury.

Section 3 Applicability

The requirements and provisions of this regulation apply to carriers and pharmacy benefit management firms acting on behalf of carriers offering non-grandfathered individual, small group, and/or large group health benefit plans and student health insurance coverage. This regulation does not apply to grandfathered health benefit plans.

Section 4 Definitions

A. “Affordable Care Act” means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L.111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L 111-152.

B. “Carrier” means a carrier, as defined in § 10-16-102(8), C.R.S., offering a health benefit plan and shall include a pharmacy benefit manager acting on behalf of the carrier.

C. “Contraceptive” or “contraception” shall have the same meaning as defined in § 2-4-401(1.5), C.R.S.

D. “Dispensing entity” shall have the same meaning as defined in § 10-16-104.2(1)(c), C.R.S.

E. “Emergency contraception” means a drug approved by the FDA that prevents pregnancy after sexual intercourse, including, but not limited to, oral contraceptive pills; except that “emergency contraception” shall not include RU-486, mifepristone, or any other drug or device that induces a medical abortion, in accordance with § 25-3-110, C.R.S.

F. "Expedited exception request" means, for the purposes of this regulation, a coverage determination no later than twenty-four (24) hours following the carrier's receipt of the request.

G. "Food and Drug Administration" or "FDA" means, for the purposes of this regulation, the Food and Drug Administration in the United States Department of Health and Human Services.

H. "Grandfathered health benefit plan" shall have the same meaning as defined in § 10-16-102(31), C.R.S.

I. "Health benefit plan" shall have the same meaning as defined in § 10-16-102(32), C.R.S.

J. "Health Resources and Services Administration" or "HRSA" means, for the purposes of this regulation, the Health Resources and Services Administration in the United States Department of Health and Human Services.

K. "Health care provider," or "provider" shall have the same meaning as defined in § 10-16-102(56), C.R.S.

L. "Out-of-pocket costs" means, for the purposes of this regulation, the amount a covered person is required to pay in the form of deductibles, copayments, or coinsurance. Out-of-pocket costs do not include premium.

M. "Pharmacy benefit management firm," "pharmacy benefit manager," or "PBM" shall have the same meaning as defined in § 10-16-102(49), C.R.S.

N. "Prescription drug" shall have the same meaning as defined in § 12-280-103(42), C.R.S.; except that the term includes only prescription drugs that are intended for human use.

O. "Prior authorization" shall have the same meaning as defined in § 10-16-112.5(7)(d), C.R.S.

P. "SERFF" means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filing.

Q. "Step therapy" or "fail first" shall have the same meaning as defined in § 10-16-145(1)(g), C.R.S.

R. "Therapeutic equivalent" shall have the same meaning as defined in § 12-280-103(52), C.R.S.

Section 5 Rules

A. Carriers shall cover all FDA-approved, cleared, or granted contraception, whether or not the item or service is identified in the current FDA Birth Control Guide, and contraceptive care outlined in the HRSA Women's Preventive Services Guidelines as a preventive care service without consumer cost sharing in accordance with the requirements found in Section 2713 of the Public Health Service Act, as added by the Affordable Care Act.

B. Carriers shall cover, without cost sharing, items and services that are integral to the furnishing of an FDA-approved, cleared or granted contraceptive or contraceptive care, regardless of whether the item or service was billed separately. This coverage must include the clinical services and patient education and counseling needed for provision of the contraceptive product or service and any follow-up care, including laboratory tests integral to the furnishing of an FDA-approved, cleared, or granted contraceptive.

C. If the attending health care provider, in their reasonable professional judgment, determines that the use of an alternative contraceptive, whether that contraceptive is on the carrier's formulary or not, is medically necessary with respect to a covered person, the health care provider's determination shall be final, and a carrier must cover the contraceptive without prior authorization, step therapy, or cost-sharing. If a carrier requires a written request for contraceptives not currently on the plan's prescription drug formulary, the carrier shall use the standard exception form included in Appendix A and make such form available in paper and electronic format to providers and enrollees with other information regarding the exception process and with other plan materials.

D. A carrier that receives an exception request for an alternative contraceptive on the formulary or a non-formulary contraceptive shall consider that request as an expedited exception request and shall respond in no more than twenty-four (24) hours following the carrier's receipt.

E. Carriers are prohibited from requiring prior authorization, step therapy, or other utilization management practices as a prerequisite to covering a contraception, whether that contraceptive is on the carrier's formulary or not, that the covered person's health care provider has determined is medically necessary with respect to the covered person. Carriers are specifically prohibited from:

1. Requiring prior authorization or denying coverage for a single-source brand name contraceptive with no therapeutic or pharmaceutical equivalent if the covered person's health care provider determines the product is medically necessary with respect to that person.

2. Requiring a covered person to undergo step therapy using numerous other FDA-approved, cleared, or granted contraceptive products within the same contraceptive category prior to coverage if the person's health care provider determines the product is medically necessary with respect to that person.

3. Requiring a covered person to undergo step therapy using numerous other FDA-approved, cleared, or granted contraception in other contraceptive categories prior to coverage if the person's health care provider determines the product is medically necessary with respect to that person.

4. Imposing age limits on contraceptive coverage.

5. Imposing quantity or fill limits on contraceptives that are not based on the clinical evidence base or that result in a covered person receiving less than a twelve-months' supply of a contraceptive.

F. Carriers shall reimburse a provider or in-network dispensing entity for the single dispensing or furnishing of a contraceptive intended to last for a duration of twelve months, dispensed or furnished at one time.

G. Carriers shall cover without cost sharing over-the-counter (OTC) oral and emergency contraception with or without a prescription. Carriers are required to cover these products without cost sharing including when they are prescribed for advanced provision.

H. Carriers shall cover without cost-sharing elective sterilization procedures for people who menstruate.

Section 6 Carrier Reporting

Carriers shall report annually to the Commissioner data relating to contraception coverage in the previous calendar year. Such data shall be due to the Division on April 1, 2024, and on April 1 each year thereafter, and shall include, in a template provided in SERFF:

A. The total number of requests for contraceptives covered for each method of birth control identified in the current FDA Birth Control Guide, and the name and total number of any additional methods, items, or services not identified in the current FDA Birth Control Guide that are covered as a preventive service without consumer cost sharing, and:

1. The name of the item(s) or service(s) covered in each method;

2. Whether prior authorization or step therapy were required for each item or service; and

3. The total number of claims that were approved or denied for each item or service, and the top three reasons that the carrier or pharmacy benefit manager denied claims for the item or service.

B. The number of requests for a twelve-month supply of contraceptives, including the number of claims approved and denied for a twelve-month supply and:

1. The name, strength, quantity, and days supply of the FDA-approved contraceptive prescribed;

2. Whether prior authorization or step therapy were required; and

3. Whether the claim was approved or denied and the reason that the carrier or pharmacy benefit manager denied each claim.

C. The number of requests for over-the-counter contraceptives, including:

1. The number of claims approved and denied;

2. The reason that the carrier denied the claims; and

3. The number of claims that required the member to pay out-of-pocket.

D. The number of requests for an alternative contraceptive that is not otherwise included in the formulary or available without cost sharing, including the number of claims approved and denied and the reason that the carrier or pharmacy benefit management firm denied the claims.

Section 7 Incorporation by Reference

The Women's Preventive Services Guidelines, published by the Health Resources and Services Administration, shall mean the Women's Preventive Services Guidelines published by the Health Resources and Services Administration, as published on the effective date of this regulation and does not include later amendments to, or editions of the Women's Preventive Services Guidelines published by the Health Resources and Services Administration. The Women's Preventive Services Guidelines published by the Health Resources and Services Administration may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Health Resources and Services Administration website at https://www.hrsa.gov/womens-guidelines Certified copies of the Women's Preventive Services Guidelines, published by the Health Resources and Services Administration are available from the Colorado Division of Insurance for a fee.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocations of license, subject to the requirements of due process.

Section 10 Effective Date

This regulation shall become effective on December 30, 2023.

Section 11 History

New regulation effective December 30, 2023.

Appendix A: Standard Exemption Form for Contraceptive Products

REQUEST FOR AN ALTERNATIVE CONTRACEPTION DRUG, DEVICE, OR PRODUCT FOR PATIENTS COVERED UNDER A COLORADO HEALTH BENEFIT PLAN (other than self-funded ERISA coverage, Medicaid, Medicare, and TRICARE)

Carriers must cover a non-formulary contraceptive drug, device, or product without cost-sharing upon the recommendation of the patient's health care provider.

If the carrier, or pharmacy benefit management firm acting on behalf of a health benefit plan, requires a written request for a non-formulary contraceptive drug, device, or product, the provider must complete this form and send it to the patient's health benefit plan to obtain coverage of a contraceptive drug, device, or product that is not on the plan's prescription drug formulary, but is determined to be medically necessary for the patient by the provider.

Patient Information		
Name		**Date of Birth**
Address		
City	**State**	**Zip Code**
Health Insurer Name	**Patient's Member ID #**	

Attending Health Care Provider Information		
Name		
Address		
City	**State**	**Zip Code**
Office Phone	**Fax**	
Tax ID # / NPI # (if available)	**Facility Name (if applicable)**	
Office Point of Contact	**Preferred Contact Method**	

Alternative Contraceptive Drug, Device, or Product Request (to be completed by the attending health care provider)

The covered therapeutic and pharmaceutical equivalent versions of a contraceptive drug, device, or product are: (check one)

Not available; OR

☐

Deemed medically inappropriate

☐

Requested Alternative Contraceptive Drug, Device or Product: (complete applicable items)

I, the patient's attending health care provider, in my reasonable professional judgment, have determined that the use of the non-covered therapeutic or pharmaceutical equivalent of a contraceptive drug, device, or product listed below is warranted.

Contraceptive Drug/Device/Product Name	**Strength**	**Quantity per Month**
J-code	**Units Requested[1]**	**Proposed Date of Service**
□ **Check if a generic equivalent may be substituted for the requested contraceptive drug, device, or product.**		

Exception Request

NOTE: Per Colorado law, a carrier that receives this exception request for a non-formulary contraceptive shall consider that request as an expedited exception request and must respond within 24 hours following receipt of this request. Carriers are prohibited from requiring a covered person, a person's authorized representative, or an individual's provider to appeal an adverse benefit determination for a contraceptive using the carrier's internal claims and appeals process.

[1]Pursuant to section § 10-16-104.2, Colorado Revised Statute, carriers must reimburse a participating provider for prescription contraceptives intended to last for a 12-month period.

Signature

I certify that the information provided in this form is accurate to the best of my knowledge.

Health Care Provider's Signature	**Date**

Send the completed form to:

Fax Number:

[Insert carrier fax number(s)]

Email:

[Insert carrier email add

Regulation 4-2-96 CONCERNING PRIMARY CARE ALTERNATIVE PAYMENT MODEL PARAMETERS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-107(3.5), 10-16-109, and 10-16-157, C.R.S.

Section 2 Scope and Purpose

The purpose of the regulation is to establish primary care alternative payment model parameters for primary care services offered through health benefit plans.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing non-grandfathered individual, small group, and/or large group health benefit plans in Colorado on or after January 1, 2025. This regulation excludes individual short-term health insurance policies, as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. “Aligned quality measures set” means, for the purposes of this regulation, the Adult and Pediatric measure sets included in Appendix C of this regulation.

B. “Alternative payment model” or “APM” shall have the same meaning as found at § 10-16-157(2)(b), C.R.S.

C. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

D. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

E. “Measure steward” means, for the purposes of this regulation, an individual or organization that owns a measure and is responsible for maintaining the measure.

F. "Patient attribution" means, for the purposes of this regulation, the method used to determine which primary care practice is responsible for a patient's care and costs.

G. "Practice panel" means, for the purposes of this regulation, the unique patients who have seen any provider within a primary care practice within the last 18 months.

H. "Primary care" shall have the same meaning as found at § 10-16-157(2)(c), C.R.S.

I. "Primary care provider" or "provider" means, for the purposes of this regulation, the provider taxonomies identified in Appendix A, when the provider is practicing general primary care in an outpatient setting.

J. "Prospective payment" shall have the same meaning as found at § 10-16-157(2)(f), C.R.S.

K. "Risk adjustment" shall have the same meaning as found at § 10-16-157(2)(g).

Section 5 General Requirements

A. Carriers must incorporate the requirements set forth in Sections 6 - 9 of this regulation in APMs for primary care services offered through health benefit plans issued or renewed on or after January 1, 2025.

B. Carriers offering managed care plans that are issued or renewed on or after January 1, 2025, and in which services are primarily offered through one medical group contracted with a nonprofit health maintenance organization, must incorporate the requirements of Section 9 only in contracts with providers participating in the carrier's primary care APM.

Section 6 Risk Adjustment

A. Carriers must provide a detailed description of the risk adjustment methodology(ies) utilized in an APM for primary care services to all providers participating in the APM. This description must include, at a minimum:

1. Definitions of key terms used to describe the methodology, including "concurrent" and "prospective";

2. A description of the data that is used in the methodology, including but not limited to:

   a. The general morbidity assumptions associated with the population used to calibrate the model; and

   b. The services included in the calculation of risk scores, based on the payment arrangement used in the APM in which the provider is participating; and

3. A description of adjustments made to the data in risk adjustment calculations, including:

   a. Historical adjustments;

   b. Trends or future adjustments; and

   c. Patient mix adjustments (across providers).

B Carriers must also provide a description of how the risk adjustment methodology interacts with provider payments, including but not limited to:

1. A clear explanation of any retrospective uses of provider data; and

2. For risk adjustment methodologies that are applied at the end of a contract period, a clear explanation of any reconciliation processes and how and when they are applied.

Section 7 Patient Attribution

A. Carriers must provide a detailed description of the patient attribution methodology(ies) utilized in an APM for primary care services to all providers participating in the APM. This description must include, at a minimum:

1. Definitions of key terms used in the model, including but not limited to “prospective”, “retrospective”, or “hybrid”; and

2. The process(es) used to attribute adult and pediatric members, including newborns and infants, to a provider. This description must include, at a minimum:

a. How patient choice is prioritized;

b. If and how claims are used to determine a provider-patient relationship, including but not limited to:

(1) the look-back period for claims data that is included in the methodology;

(2) the type (e.g., wellness visit) or number of claims that are prioritized; and

(3) tie-breaker methodologies if different providers have an equal number or type of claims;

c. If and how geographic attribution is used;

d. Any other processes or methods, such as visit-based, that are utilized; and

e. Any members that are excluded from attribution.

B. Carriers must make available updated attribution lists, in a format that is easy to interpret and analyze, to providers no less frequently than on a quarterly basis.

C. Carriers must establish and maintain a process for providers to submit requests for misattributed patients to be added or removed from their attribution list (i.e., reattributed).

1. The process for submitting reattribution requests must be clearly communicated to the provider and must identify, at a minimum:

a. The appropriate mechanism(s) for submitting a request (e.g., phone, mail, or electronic);

b. A specific point of contact for attribution-related questions and issues; and

c. The information or documentation required to submit a request.

2. Carriers must establish a process that is clearly communicated to the provider about the regular review, no less than quarterly, of patient attribution lists and provider attribution requests.

Section 8 Aligned Core Competencies

A. Carriers must incorporate the aligned core competencies contained in Appendix B into the care delivery expectations used in APMs for primary care services.

1. Carriers must provide a simple attestation form for practices to identify the appropriate Track (Track 1, 2 or 3) as set forth in Appendix B that aligns with current or anticipated practice competence with the financial support of the APM.

2. Carriers must accept a practice's current association with the Centers for Medicare and Medicaid Services' Making Care Primary or Primary Care First models, Primary Care Medical Home designation, and National Committee for Quality Assurance's Behavioral Health Integration certification as recognition that the practice is, at minimum, ready to participate in an APM in Track 1.

B. Payments to support, incentivize, or reward provider performance of the competencies in the aligned core competencies must be meaningful. Carriers may determine the level and type of financial incentive(s), including but not limited to upfront payments, incentive structures, target performance levels, and reporting requirements, in mutual agreement with the provider to align with patient panel needs and practice priorities.

C. Carriers may include other care delivery expectations, in addition to the aligned core competencies, at the mutual agreement of the carrier and the provider. Additional specified care delivery expectations may not be redundant with the aligned core competencies in Appendix B and should be based on a provider's patient panel needs and practice priorities.

D. The aligned core competencies will be reviewed annually by the Commissioner.

1. The Division will seek input on proposed modifications to the aligned core competencies through a stakeholder process that includes the Primary Care Payment Reform Collaborative, carriers and providers participating in APMs that are not participating in the Primary Care Payment Reform Collaborative, relevant state agencies and programs including the Department of Health Care Policy and Financing, and consumers.

2. The Division will provide notice of stakeholder meetings on the Division website, at least two weeks in advance, and all meetings will be open to the public.

Section 9 Aligned Quality Measure Sets

A. Carriers must include the aligned quality measures for Adult and Pediatric populations set forth in Appendix C in a quality measure set utilized in an APM for primary care services.

1. Provider performance on measures in the aligned measure set must impact payment in a meaningful way, while still allowing for prospective, upfront payments. Carriers may not incorporate any measure that is part of the aligned measure set into a payment arrangement such that performance on the measure lacks meaningful financial implications to the provider.

a. Nothing in this Section 9(A) requires a carrier to include one or more of the measures in the aligned measure set into the terms of a contract with a specific provider or practice or intermediary. The measures in the aligned quality measure set must be included in the set of quality measures that are utilized in an APM, and available for selection by payers and providers, but carriers and providers should mutually determine the appropriate measures that will be included in the terms of a specific contract.

b. Carriers and providers must determine appropriate thresholds for provider or practice's performance, based on practice capacity and experience reporting quality measures.

2. Carriers must follow the measure steward specifications for all measures included in the aligned measure set. Any deviations or exceptions must be mutually agreed upon with the provider.

3. Carriers must include the Adult measure set, the Pediatric measure set, or both in the overarching quality measure set utilized in an APM for primary care services based on the age composition of the practice's full practice panel.

a. For practices with a majority (greater than 80%) of adults in their practice panel, carriers must include the aligned Adult measure set.

b For practices with a majority of pediatric patients (greater than 80%) in their practice panel, carriers must include the aligned Pediatric measure set.

c. For practices with a pediatric population of 20%-80% of their practice panel, carriers must include both the Adult and Pediatric measure sets.

B. Carriers may include measures in addition to the aligned quality measure set at the mutual agreement of the carrier and the provider. Additional measures should consider a provider's patient panel needs, practice priorities, other state and federal requirements, and feasibility of reporting.

C. A carrier may petition the Commissioner to modify or waive one or more of the requirements of Section 9(A). Any request to waive or modify one or more of the requirements must include a clear rationale supporting the request and must demonstrate how the waiver will advance the quality, accessibility, and/or affordability of healthcare services.

D. The aligned measure set will be reviewed annually by the Commissioner.

1. The Division will seek input on proposed modifications to the aligned quality measure set through a stakeholder process that includes the Primary Care Payment Reform Collaborative, carriers and providers participating in APMs that are not participating in the Primary Care Payment Reform Collaborative, relevant state agencies and programs including the Department of Health Care Policy and Financing, and consumers.

2. The Division will provide notice of stakeholder meetings on the Division website, at least two weeks in advance, and all meetings will be open to the public.

Section 10 Reporting Requirements

A. Carriers must annually report on their use of the aligned APM parameters for primary care services as part of the APM Implementation Plan required by Colorado Insurance Regulation 4-2-72. Annual reporting must include:

1. An attestation that the carrier and/or their vendor is in compliance with the requirements of Sections 6-9 of this regulation;

2. The carrier's and/or vendor's current or planned approach (if applicable) to incorporate social risk into their risk adjustment methodology(ies), including but not limited to social factors such as housing instability, behavioral health issues, disability, and neighborhood-level stressors. This description should include a statement regarding how health equity and patients with health-related social needs, and/or severe or complex health needs are or will be considered in the design of the risk adjustment methodology and the APM;

3. The carrier's efforts to educate members about patient attribution and/or the importance of selecting a primary care provider;

4. A complete list of any additional care delivery expectations, outside of the core competencies in Appendix B, included in the carrier's APMs for primary care services; and

5. A complete list of the additional measures outside of the quality measures in Appendix C included in the carrier's APMs for primary care services, and a brief description of any deviations or exceptions to the aligned measure set in accordance with Section 9.A.2 of this regulation.

B. Carriers may submit a "Confidentiality Index" for any information submitted per the requirements of this subsection that they consider to be confidential pursuant to § 24-72-204, C.R.S., along with the APM Implementation Plan. The Division will evaluate the reasonableness of any request for confidentiality and provide notice to the carrier if the request for confidentiality is rejected.

Section 11 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 12 Incorporated Materials

Measure steward specifications shall mean the measure specifications located in the Partnership for Quality Measurement's Submission Tool and Repository Measure Database as published on the effective date of this regulation and does not include later amendments to or revisions to the database. A copy of the measure specifications for the quality measures included in the Aligned Quality Measure Set, as of the effective date of this regulation, may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the measure specifications may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at https://p4qm.org/measures.

Section 13 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 14 Effective Date

This regulation shall be effective January 30, 2024.

Section 15 History

New regulation effective January 30, 2024.

Appendix A: Primary Care Provider Taxonomies

1. Family medicine physicians in an outpatient setting when practicing general primary care;

2. General pediatric physicians and adolescent medicine physicians in an outpatient setting when practicing general primary care;

3. Geriatric medicine physicians in an outpatient setting when practicing general primary care;

4. Internal medicine physicians in an outpatient setting when practicing general primary care (excludes internists who specialize in areas such as cardiology, oncology, and other common internal medicine specialties beyond the scope of general primary care);

5. OB-GYN physicians in an outpatient setting when practicing general primary care;

6. Providers such as nurse practitioners and physicians' assistants in an outpatient setting when practicing general primary care; and

7. Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting.

Appendix B: Aligned Core Competencies for Primary Care

The core competencies listed in the following table outline key capacities or skills that are needed for primary care providers to provide high quality, person-centered, whole-person care. Each row represents a "domain" or category of care delivery Each domain is further delineated into three (3) levels or tracks, with Track 1 reflecting competencies for practices that are starting the care transformation process and Track 3 reflecting competencies of a more advanced practice.

The aligned core competencies establish a common set of expectations around the type of care that primary care providers participating in APMs should have in order to deliver high-quality, person-centered, whole-person care. Carriers must support providers' achievement of the competencies through financial incentives. Carriers may determine the level and type of financial incentive(s), including but not limited to upfront payments, incentive structures, target performance levels, and reporting requirements, in mutual agreement with the provider to align with patient panel needs and practice priorities. Carriers and providers may determine additional competencies and activities that are appropriate within each domain, and at each level, and the process for evaluating performance and progress.

Care Delivery Domain	Track 1	Track 2	Track 3
Leadership	● Practice leadership sets practice-wide expectations for evaluating and improving clinical and operational processes and outcomes, and for incorporating health equity principles into operational processes and quality improvement initiatives. ● Practice leadership allocates appropriate resources (including time for appropriate quality improvement team membership) to ensure continuous quality improvement.	● Practice leadership develops and implements a process to review and evaluate clinic level quality improvement initiatives, including the creation of an improvement plan for each area of opportunity.	● Practice leadership incorporates health equity principles into quality improvement initiatives.
Data Driven Quality Improvement	● Practice sets quality metric goals using benchmarks and reviews performance on internally validated clinical quality measures at least quarterly.	● Practice uses an organized quality improvement approach to meet quality measure goals/benchmarks for at least one clinical quality measure.	● Practice collects and reports on measures specific to behavioral health efforts and tracks performance relative to targets. This includes tracking reach and outcomes with validated measures (e.g., PHQ-9, GAD-7,

	● Practice develops a quality improvement team that meets monthly.	● Practice discusses and develops a process to routinely gather and update patient demographics information, including race, ethnicity, language and communication needs, sexual orientation, and gender identity.	Edinburgh maternal depression scale). In practices caring for children, this includes developmental screening. ● Practice uses an organized quality improvement measure goal/benchmark for at least three clinical quality measures. ● Practice implements a process to routinely gather and update patient demographics information, including race, ethnicity, language and communication needs, sexual orientation, and gender identity.
Empanelment	● Practice designs and implements a process for validating primary care provider and/or care team assignments with patients.	● Practice has assessed patient panels and assigned primary care providers and/or care teams to 60% of the patient population.	● Practice has assessed patient panel and assigned primary care providers and/or care teams to 85% of the patient population.
Team Based Care	● Practice develops and reviews written roles and responsibilities for team-based care to ensure accountability for assigned tasks. ● Practice identifies and implements a team-based care strategy to improve communication (team huddle, debriefs, collaborative care planning).	● Practice incorporates behavioral health training into onboarding and ongoing professional development efforts, for primary care providers and all clinic staff.	● Practice team includes a family navigator, health coach, care coordinator, community health worker, or other team member with the responsibility of providing culturally relevant support, coordination, and service to the person and family. If these roles cannot be filled within the practice, the practice works with community-based organizations to make referrals for appropriate care.
Patient and Family Engagement	● Practice utilizes methods to obtain patient feedback on experience of care, such as through a patient experience survey or patient and family advisory council and uses data	● Practice reviews data from methods to obtain patient feedback on experience of care at least quarterly to identify areas for focus as part of their quality improvement	● Practice assesses the inclusivity of the practice through methods established to obtain patient feedback on experience of care.

	to assess their delivery of primary care services as well as patient satisfaction with care. ● Practice educates patients and family members/caregivers on availability of behavioral health services, including mental health and substance use disorder services within the practice or through referral.	process. ● Practice adopts at least one evidence-based decision aid or self-management support tool for a condition appropriate for their patient population.	● Practice acts on patient feedback to carry out identified quality improvement processes.
Population Management	● Practice implements a risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs: Step 1. Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed. ● Practice identifies strategies to identify care gaps (e.g., EHR prompts, patient registry, data aggregation tool). ● Practice identifies staff and develops workflows to provide care management for patients with chronic conditions and/or patients determined to be higher risk and for timely post-ED and hospitalization follow-up.	● Practice implements workflow for improving proactive care gap management and tracks specific outcomes. ● Practice identifies patients who need or would benefit from behavioral health services, including through universal screening for at least one priority mental health condition, one priority substance use condition, and one lifestyle behavior.	● Practice ensures positive behavioral health screens are offered treatment within the practice or referred to appropriate services outside of the practice. ● Practice assesses the impact of care gap management on outcomes and need for improvement in the process. ● Practice reassesses behavioral health symptoms, side effects, complications, and treatment adherence at regular intervals and utilizes evidence-based stepped care guidelines in adjusting treatment plans if patients are not improving as expected. Practice considers individual patient barriers to treatment.
Continuity of Care	● Practice measures and reviews	● Practice implements one	● Practice re-assesses continuity

	continuity of care for empaneled patients by primary care providers and/or care teams.	strategy that improves continuity for practitioners and care team(s).	of care and determines if further intervention is needed to improve continuity while balancing the need for prompt access to care. If further interventions are needed, the practice implements at least one intervention.
Access	● Practice assesses access to primary care services for its patients through availability of appointments and through patient experience surveys.	● Practice adopts extended hours, same day appointments, patient portal, or other methods to improve access and then reassesses for any problem areas. ● Practice ensures physical spaces and services are accessible and responsive to patients' and families' disability status, sexual orientation, and gender identity, racial and ethnic backgrounds, cultural health beliefs and practices, preferred languages, and health literacy.	● Practice has both same day (or next day) access and extended hours in place.
Comprehensiveness and Care Coordination	● Practice assesses the services it provides to patients and identifies key services that could be added to improve comprehensiveness of care, including behavioral health. ● Practice provides crisis resources and referrals as indicated. ● Practice develops a vision for behavioral health integration and chooses a strategy (e.g., full integration, virtual integration, collaborative care model) to improve comprehensiveness of behavioral health services.	● The primary care provider diagnoses and offers medication management for mild to moderate behavioral health conditions and links patients to therapy and/or specialty mental health settings as indicated. ● Practice has referral pathways for patients with behavioral health conditions including potential referral sources for populations with specific needs (e.g., LGBTQIA+ friendly). ● Practice develops workflows for referrals to social service providers.	● Practice has implemented a behavioral health integration strategy to improve comprehensiveness of behavioral health services. ● Practice ensures that primary behavioral health referral sources have appointment availability and tracks completion of first appointment.

Value Based Contracting	● Practice considers mechanisms to maximize benefit of participation in alternative and performance payment arrangements.	● Practice evaluates impact of value-based payment agreements on financial stability of practice, quality of care provided, and/or clinician and staff satisfaction.	● Practice demonstrates improvement on at least one cost or utilization metric.

Appendix C: Aligned Quality Measure Sets

Adult Measure Set

Domain	Measure	Consensus-Based Entity (CBE) ID/Steward
Preventive Care	Breast Cancer Screening	2372 / NCQA
Preventive Care	Cervical Cancer Screening	0032 / NCQA
Preventive Care	Colorectal Cancer Screening	0034 / NCQA
Preventive Care	Screening for Depression and Follow-Up	0418 / CMS
Chronic Conditions	Comprehensive Diabetes Care: HbA1c Poor Control (>9%)	0059 / NCQA
Chronic Conditions	Controlling High Blood Pressure	0018 / NCQA
Patient Experience	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Adult Survey -OR- Person-Centered Primary Care Measure (PRO-PM)	0006 / AHRQ 3568 / American Board of Family Medicine

Pediatric Measure Set

Domain	Measure	Consensus-Based Entity (CBE) ID/Steward
Preventive Care	Child and Adolescent Well-Care Visits	1516 / NCQA
Preventive Care	Developmental Screening in the First Three Years of Life	1448 / OHSU
Preventive Care	Well-Child Visits in the First 30 Months of Life	1392 / NCQA
Preventive Care	Screening for Depression and Follow-Up	0418 / CMS
Preventive Care	Childhood Immunization Status - Combo 10	0038 / NCQA

Preventive Care	Immunizations for Adolescents - Combo 2	1407 / NCQA
Patient Experience	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Child Survey -OR- Person-Centered Primary Care Measure PRO-PM	0006 / AHRQ 3568 / American Board of Family Medicine

Regulation 4-2-97 CONCERNING THE REQUIREMENTS FOR PHARMACY BENEFIT MANAGERS TO REGISTER IN COLORADO

Section 1 Authority

This regulation is being promulgated and adopted by the Commissioner of Insurance under the authority of § 10-16-122.1(2.5)(b)(I) and (4.7), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide the form and manner for a pharmacy benefit manager (PBM) to annually register with the Division pursuant to § 10-16-122.1(2.5)(b)(I), C.R.S.

Section 3 Applicability

This regulation applies to all PBMs operating or doing business in the state of Colorado.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “PBM-affiliated pharmacy” shall have the same meaning as found at § 10-16-122.1(5)(c), C.R.S.

C. “PBM network” shall have the same meaning as found at § 10-16-122.1(5)(d), C.R.S.

D. “PBM services” means, for the purpose of this regulation, claims processing services and other prescription drug or device services, as defined in § 10-16-122.1(5)(a), (b), C.R.S.

E. “Pharmacy benefit management firm”, “pharmacy benefit manager”, or “PBM” shall have the same meaning as found at § 10-16-102(49), C.R.S. and includes all PBMs doing business in the state, including a PBM that is not directly connected with a carrier.

F. “Prescription drug” has the same meaning as set forth in § 12-280-103(42) C.R.S; except that the term includes only prescription drugs that are intended for human use.

Section 5 Initial Registration

A. On or before July 1, 2024, and each year thereafter, each PBM operating in Colorado shall complete a pharmacy benefit manager registration application and submit to the Division.

B. The PBM shall provide as part of the registration application the following:

1. PBM Officer and Business Contact Information

a. The name and address of the PBM;

b. The names, business addresses, and job titles of the principal officers of the PBM;

c. The name, business address, business telephone number, business email address, and job title of the officer or employee who should be contacted regarding any PBM regulatory compliance concerns; and

d. The business telephone number and business e-mail address where the PBMs personnel directly responsible for the processing of appeals from patients, providers and pharmacies may be contacted.

2. PBM Organization Documents

a. A copy of the PBMs organizational documents, including Articles of Incorporation, Articles of Association, and partnership agreements of the PBM;

b. A copy of all by-laws or similar document(s), if any, regulating the conduct or the internal affairs of the PBM; and

c. The relevant documentation, such as policies and procedures, and a detailed explanation, that demonstrates the PBM has adopted processes to ensure compliance with the requirements in sections 10-16-122.1, 10-16-122.3, 10-16-122.4, 10-16-122.5, 10-16-122.6, 10-16-122.7, and 10-16-122.9, C.R.S, including any written policies or procedures describing the appeals or dispute resolution processes between the PBM and a PBM-affiliated pharmacy, as applicable.

3. Financial and Other Documents

a. The most recent year-end financial statement for the PBM;

b. A listing of all carriers the PBM contracts with to provide pharmacy benefit services for, in Colorado, including any non-ERISA self-funded or governmental plans;

c. The number of projected enrollees or beneficiaries in Colorado to be serviced by the applicant during the upcoming year for all contracted insurers; and

d. A listing of any delegated or contracted companies that perform part of the PBMs services.

4. Required Responses

A certified statement indicating whether the PBM:

a. Has been refused or denied a registration, license, or certification to act as or provide the services of a PBM in any state or federal entity, providing specific details separately for each such refusal or denial, if any, including the date, nature and disposition of the action;

b. Has had any registration, license or certification to act as or provide the services of a PBM suspended, revoked or nonrenewed for any reason by any state or federal entity, providing specific details separately for each such suspension, revocation or nonrenewal, if any, including the date, nature and disposition of the action; and

c. Has had a business relationship with a carrier terminated for any finding by a court of law of fraudulent or illegal activities in connection with the administration of a pharmacy benefits plan, providing specific details regarding the termination.

C. Application Fee

The PBM shall provide as part of the registration application a nonrefundable filing fee of $2,500, pursuant to section 10-16-122.1(2.5)(b)(I) C.R.S.

D. Attestation Form

1. On or before July 1, 2024, and each year thereafter, each PBM operating in Colorado shall complete the "Pharmacy Benefit Manager Attestation" in Appendix A and submit to the Division.

2. A PBM shall make the following attestations:

a. All the information submitted in the application including attachments are true and complete;

b. The PBM understands that submitting any false information may result in sanctions by the Commissioner pursuant to section 10-16.122.1(2.5)(b)(II), (4.5), C.R.S.;

c. The PBM will provide any additional information required by this regulation requested by the Division to complete the registration; and

d. The PBM is in compliance with sections 10-16-122.1, 10-16-122.3, 10-16-122.4, 10-16-122.5, 10-16-122.6, 10-16-122.7, and 10-16-122.9, C.R.S., as applicable.

E. A PBM providing services to less than 100 covered individuals in Colorado and unable to provide a required document in section 5 may submit to the Division an exception request. The request must list the required document and provide a brief explanation.

Section 6 Renewal Application

A. Beginning on July 1, 2025, and each year thereafter, each PBM operating in Colorado shall complete a renewal application and attestation form.

B. The PBM shall provide as part of the renewal application the information in section 5.B. and the attestation in section 5.D.

C. The PBM shall submit a non-refundable renewal application fee of $2,500.

Section 7 Application Review

Upon receipt of a completed application for registration or renewal as required by section 5 and 6, the Division shall review the application and may take the following actions:

A. Approve the application;

B. Notify the applicant, in writing, that the application is incomplete and request additional information to complete the review and, if the missing or requested information is not received, the Division may deny the application; or

C. Deny a registration pursuant to section 10-16-122.1(2.5)(b)(II), C.R.S.

If a PBM registration is denied, the Division shall:

1. Provide written notice to the applicant PBM that the application has been denied and the grounds therefor; and

2. Advise the applicant PBM that it may request a hearing in accordance with sections 24-4-104 and 24-4-105, C.R.S.

Section 8 Discipline

A. The Division may impose sanctions on a PBM for any violation of applicable laws in Title 10 during its registration, consistent with sections 24-4-104 and 24-4-105, C.R.S., including, but not limited to, suspension of registration, revocation of registration, and imposition of civil penalties.

B. The Division may enforce applicable laws in Title 10 against an unregistered PBM, including, but not limited to, issuing a cease and desist order.

Section 9 Confidentiality

Information submitted by the PBM to the Division in accordance with this regulation is subject to public inspection only to the extent allowed under the Colorado Open Records Act, and in no case shall trade-secret, confidential, or proprietary information be disclosed to any person who is not otherwise authorized to access such information.

A PBM shall submit a “Confidentiality Index” if the PBM desires confidential treatment of a document submitted under this regulation, identifying which documents are confidential and the justification for confidentiality. Any information not marked as confidential or otherwise confidential under state law may be disclosed pursuant to the Colorado Open Records Act.

Section 10 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 11 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 12 Effective Date

This regulation shall become effective on January 30, 2024.

Section 13 History

New regulation effective January 30, 2024.

Appendix A Pharmacy Benefit Manager Attestation

I hereby certify, under penalty of perjury, that all the information submitted in this application including attachments are true and complete. I am aware that submitting false information may result in sanctions by the Commissioner. I hereby certify that I will furnish any additional information required by this regulation upon request to complete the registration.

If applicable, I hereby certify, under penalty of perjury, that the entity applying for registration as a PBM is in compliance with 10-16-122.1, 10-16-122.3, 10-16-122.4, 10-16-122.5, 10-16-122.6, 10-16-122.7, and 10-16-122.9, C.R.S.

Print Name of Officer or Authorized Representative:

Date:

Signature:

Title:

Regulation 4-2-98 CONCERNING COVERAGE OF THE RESPIRATORY SYNCYTIAL VIRUS IMMUNIZATIONS AS A PREVENTIVE SERVICE

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7); 10-1-109(1); 10-16-104(18)(b)(X), (f); and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to require carriers to cover, without cost sharing, the cost of respiratory syncytial virus (RSV) immunizations and administration.

Section 3 Applicability

This regulation shall apply to all carriers offering individual, small group, large group plans, student health plans, and managed care plans subject to the insurance laws of Colorado. Carriers who are third-party administrators for self-funded plans are strongly encouraged to follow the requirements of this regulation in order to create uniform access and billing structures.

Section 4 Definitions

A. “ACIP” shall have the same meaning as found at § 10-16-104(18)(c)(I), C.R.S.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

D. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

E. “Network” shall have the same meaning as found at § 10-16-102(45), C.R.S.

F. “Out-of-network provider” means, for the purposes of this regulation, a provider in this state that has not entered into a contract with a carrier or with its contractor or subcontractor to provide health care services to covered persons.

G. “Provider” shall have the same meaning as found at § 10-16-102(56), C.R.S.

Section 5 Coverage for RSV Immunizations

A. Carriers providing health benefit plans shall cover all ACIP-recommended immunizations for RSV, including all associated costs of administration, at no cost-sharing to covered persons in accordance with the CDC Immunization Schedule.

B. If the carrier does not have an in-network provider that can perform this health care service, carriers providing health benefit plans shall cover all ACIP-recommended immunizations for RSV, including all associated costs of administration, when performed by an out-of-network provider and may not impose cost sharing.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Incorporation by Reference

The CDC Immunization Schedule shall mean the CDC Immunization Schedule as published on the effective date of this regulation and does not include later amendments to or editions of the CDC Immunization Schedule. A copy of the CDC Immunization Schedule may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the CDC Immunization Schedule may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at https://www.cdc.gov/vaccines/schedules/index.html.

Section 9 Effective Date

This regulation shall be effective on March 30, 2024.

Section 10 History

Regulation effective March 30, 2024

Regulation 4-2-99 DENTAL LOSS RATIO REPORTING REQUIREMENTS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-16-109, 10-1-109(1) and 10-16-165, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish reporting requirements for carriers offering dental coverage plans to report dental loss ratios.

Section 3 Applicability

This regulation applies to all carriers, which includes prepaid dental care plan organizations, offering dental coverage plans.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Community benefit expenditure” shall have the same meaning as found at § 10-16-165(1)(a), C.R.S.

C. “Dental coverage plan” shall have the same meaning as found at § 10-16-165(1)(b), C.R.S.

D. “Dental plan” means, for the purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.

E. “Dental loss ratio” or “DLR” shall have the same meaning as found at § 10-16-165(1)(c), C.R.S.

F. “Market segment” means, for the purposes of this regulation, the individual, small group, or large group market.

G. “Prepaid dental care plan organization” shall have the same meaning as found at § 10-16-102 (53), C.R.S.

H. "Product(s)" means, for the purposes of this regulation, a discrete package of dental coverage benefits that are offered using a particular product network type (such as dental health maintenance organization, preferred provider organization, exclusive provider organization, etc.) within a service area.

Section 5 Expenditures for Clinical Dental Services

A. Clinical dental care services shall mean, for the purposes of this regulation, diagnostic, preventive, or corrective procedures provided by any oral health care provider, including but not limited to dentists, dental therapists, hygienists, and assistants in the practice of their profession, including treatment of the teeth and associated structures of the oral cavity and treatment for disease, injury, or impairment that may affect the oral or general health of the enrollee.

B. Expenditures for clinical dental care services shall mean claims incurred, including claims incurred but have not yet been reported, by a carrier offering dental coverage plans for clinical dental care services provided to enrollees, and payments under capitation contracts with dental providers whose services are covered by the contract. Expenditures for clinical dental care services shall not include the following:

1. Activities that improve dental care quality as defined in Section 6(A).

2. Overhead and administrative cost expenditures as defined in Section 7.

3. Activities that are nonprofit community benefit expenditures as defined in Section 8.

Section 6 Activities that Improve Dental Care Quality

A. Activities that improve dental care quality include activities conducted by a carrier offering dental coverage plans to improve quality that meet the following requirements:

1. Improve oral and overall health and advance oral health quality, including increasing the likelihood of desired outcomes compared to a baseline; reducing dental disparities among specified populations; and improving patient safety, reducing medical errors, or lowering infection in ways that are capable of being objectively measured and of producing verifiable results and achievements;

2. Directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide oral health improvements to the population beyond those enrolled in coverage as long as no credit is taken for additional costs incurred due to the non-enrollees; and

3. Grounded in the implementation, development, or improvement of evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional dental associations, accreditation bodies, government agencies or other nationally recognized dental care quality organizations.

B. Activities that improve dental care quality shall not include:

1. Activities relating to lines of business or products other than dental, including the pro rata share of expenditures relating to both dental and non-dental business;

2. Activities paid for with grant money or other funding separate from premium revenue;

3. Activities that can be billed or allocated by a provider for care delivery and are reimbursed as clinical dental services;

4. Taxes and assessments;

5. Fines and penalties of regulatory authorities, and fees for examinations by any State or Federal Departments; or

6. Any marketing component that displays the name of the carrier, or that is paid for by the carrier to any affiliate of the carrier in any way, either directly or indirectly.

Section 7 Overhead and Administrative Cost Expenditures

A. Overhead expenditures shall include the following:

1. Rent;

2. Legal fees and expenses;

3. Professional consulting fees;

4. Travel expenditures; and

5. Utility expenditures.

B. Administrative cost expenditures shall include the following:

1. Activities designed primarily to control or contain costs;

2. Establishing or maintaining a claims adjudication system, including upgrades in information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims;

3. Retrospective and concurrent utilization review, and any prospective utilization review that cannot be specifically justified as meeting the definition of “activities that improve dental care quality”;

4. Fraud prevention activities;

5. Developing and executing provider contracts, including establishing or managing a provider network;

6. Provider credentialing;

7. Payroll, except for positions dedicated to activities that improve oral and overall health and the pro rata share of payroll for positions substantially involved in such activities;

8. Marketing expenses;

9. Calculating and administering individual enrollee or employee incentives unless used in the promotion of activities that improve oral and overall health;

10. Direct sales salaries, workforce salaries, and benefits;

11. Agents and brokers fees and commissions; and

12. General and administrative expenses.

Section 8 Nonprofit Community Benefit Expenditures

A. Nonprofit community benefit expenditures shall mean expenditures for activities or programs, or to organizations who administer activities or programs, that seek to achieve the objectives of improving access to dental care services, enhancing oral health and relief of government burden. This includes any of the following activities that:

1. Are available broadly to the public and serve low-income consumers;

2. Reduce geographic, financial, or cultural barriers to accessing dental services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);

3. Address Federal, State or local public health priorities, such as advancing oral health care knowledge through education or research that benefits the public;

4. Leverage or enhance public health department activities; or

5. Otherwise would become the responsibility of government or another tax-exempt organization to the degree the activity serves to improve dental health consistent with this subsection A.

B. Nonprofit community benefit expenditures shall not include overhead or administrative cost expenditures.

C. Nonprofit community benefit expenditures used in dental loss ratio calculations must be reported by type of expense, unless portions of the expense fit under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses. Payroll expenses included as nonprofit community benefit expenditures, as allowed under Section 7.B.7 of this regulation, should be reported separately by type of expense.

Section 9 Dental Loss Ratio Calculation and Reporting

A. The dental loss ratio shall be calculated for each market segment by dividing the numerator by the denominator, where:

1. The numerator is the sum of:

a. The amount incurred for clinical dental services provided to enrollees;

b. The amount incurred on activities that improve dental care quality; and

c. The amount of claims payments identified through fraud reduction efforts. The amount of claims payments identified through fraud reduction efforts is limited to the lesser of the total fraud reduction expenses or actual fraud recoveries collected on paid claims during the reporting year; and

2. The denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community benefit expenditures, and any other payments required by federal law. Nonprofit community benefit expenditures are community benefit expenditures made by entities that are exempt from federal income tax. These nonprofit community benefit expenditures included in the denominator must be limited to the highest of either:

a. Three percent of earned premium; or

b. The highest premium tax rate in Colorado, multiplied by the carrier's earned premium in the applicable Colorado market.

B. A carrier that offers a dental coverage plan shall report the number of covered lives and the data used in the dental loss ratio calculation separately for Colorado and Nationwide market segment experience in the Dental Loss Ratio Reporting template provided in SERFF by the Division.

C. On or before July 31, 2024, and on or before July 31 each year thereafter, a carrier that offers a dental coverage plan shall file a Dental Loss Ratio Reporting template electronically via SERFF with the Division for the preceding calendar year in which dental coverage was provided by the dental coverage plan. Both the calculated dental loss ratio and each data element described in Section 9A of this rule shall be reported for each market segment offered by the carrier.

D. For the initial dental loss ratio report due on or before July 31, 2024, a carrier that offers a dental coverage plan shall report the data elements required in Subsections 9A and B for complete plan years 2021 through 2023, by year.

E. Carriers that offer dental coverage plans that purchase a line or block of business from another carrier during a DLR reporting year are responsible for submitting the required information and reports for the assumed business, including for that part of the DLR reporting year that preceded the purchase.

F. If the Commissioner deems that data verification of a carrier's dental loss ratio for a dental coverage plan is necessary, the Commissioner shall give the carrier 30 days' notification prior to beginning the verification process with the carrier.

Section 10 Additional Data Reporting

A. On or before July 31, 2024, and on or before July 31 each year thereafter, a carrier that offers a dental coverage plan shall separately report the following data elements in the Dental Loss Ratio Reporting template provided in SERFF by the Division for the carrier's top ten dental plans for each market segment, based on enrollment in that market:

1. The number of enrollees enrolled in the carrier's dental coverage plan;

2. The plan cost-sharing and deductible amounts;

3. The annual maximum coverage limit; and

4. The number of enrollees who meet or exceed the annual coverage limit.

B. Carriers that offer dental coverage plans should also report the range of plan benefits in which enrollees met or exceeded the annual coverage limit in each market segment.

C. For the initial report due on or before July 31, 2024, a carrier that offers a dental coverage plan shall report the data elements required in subsections 10A and B for complete plan years 2021 through 2023, by year.

Section 11 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held invalid, the remainder of the regulation shall not be affected.

Section 12 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 13 Effective Date

This regulation shall become effective on June 30, 2024.

Section 14 History

New regulation effective June 30, 2024.

Regulation 4-2-100 CONCERNING REQUIREMENTS FOR PRESCRIPTION DRUG COVERAGE FOR SERIOUS MENTAL ILLNESSES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-16-145(6), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to implement sections 10-16-145(1)(f.5) and 10-16-145(4.5), C.R.S enacted in HB23-1130 and to establish the requirements, process, and form to be utilized by health benefit plans for step therapy utilization and exceptions for enrollees with serious mental illnesses.

Section 3 Applicability

This regulation applies to all carriers, private utilization review organizations, and pharmacy benefit managers (“PBM”) marketing and issuing or renewing health benefit plans in the individual, small group and large group markets in Colorado, including non-grandfathered plans, short-term limited duration health insurance policies, and student health insurance coverage.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

C. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

D. “Provider” shall have the same meaning as found at § 10-16-102(56), C.R.S.

E. “Private Utilization Review Organization” shall have the same meaning as found at § 10-16-112(1)(a), C.R.S.

F. “Pharmacy benefit management firm,” “pharmacy benefit manager,” or “PBM” shall have the same meaning as found at § 10-16-102(49), C.R.S.

G. “Serious mental illness” shall have the same meaning as found at § 10-16-145(1)(f.5), C.R.S.

H. “Step therapy” shall have the same meaning as found at § 10-16-145(1)(g), C.R.S.

Section 5 Rules

A. If, under a health benefit plan, a carrier, private utilization review organization, or PBM requires step therapy for a prescription medication to treat a serious mental illness, it may only require a covered person to try one (1) prescription drug other than the drug prescribed by the provider prior to covering the drug prescribed by the covered person's provider.

B. A carrier, private utilization review organization, or PBM shall use the Serious Mental Illness Step Therapy Exception Form included in Appendix A and make such form available in paper and electronic format, including on the company website, to providers for use in exceptions to step therapy for a covered person with a serious mental illness if at least one of the following conditions is met:

   a. the provider attests that the required prescription drug is contraindicated or will likely cause an adverse reaction or harm to the covered person;

   b. the required prescription drug is ineffective based on the known clinical characteristics of the covered person and the know characteristics of the prescription drug regimen;

   c. the covered person has tried, while under the covered person's current or previous health benefit plan, the required prescription drug or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the use of the prescription drug by the covered person was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or

   d. the covered person, while on the covered person's current or previous health benefit plan, is stable on a prescription drug selected by the prescribing provider for the medical condition under consideration after undergoing step therapy or after having sought and received a step-therapy exception.

C. A carrier, private utilization review organization, or PBM shall authorize coverage for a prescription drug prescribed by the covered person's provider when the Serious Mental Illness Step Therapy Exception Form in Appendix A is submitted and meets all necessary criteria for that drug. The provider's attestation shall be final, and a carrier must cover the prescription drug without additional step therapy requirements.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in §10-3-1108, C.R.S., may be applied.

Section 8 Effective Date

This regulation shall be effective on January 1, 2025.

Section 9 History

New regulation effective January 1, 2025.

Appendix A: Serious Mental Illness Step Therapy Exception Form

Serious Mental Illness Step Therapy Exception Form

Plan/Medical Group Name:_____ **Plan/Medical Group Fax#: (_____)**_____

Plan/Medical Group Phone #: (_____)_____

Instructions: Please fill out all applicable sections completely and legibly. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information			
First Name:	MI:	Last Name:	Date of Birth:
City:	State:	Zip Code:	Phone Number:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number (if applicable):	

Insurance Information	
Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information			
First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
NPI Number (individual):		Phone Number:	
DEA Number (if applicable):		Office Contact Person:	
Email Address:			

Medication:
Diagnosis:
Medication:

Attestation

☐ I attest the information provided is true and accurate to the best of my knowledge.

☐ I attest that any of the following criteria specified in subsections (4)(a)(I) –(IV) of § 10-16-145, C.R.S. have been met to exempt a step-therapy requirement for the prescription drug:

- (I) The provider attests that the required prescription drug is contraindicated or will likely cause an adverse reaction or harm to the covered person;
- (II) The required prescription drug is ineffective based on the known clinical characteristics of the covered person and the known characteristics of the prescription drug regimen;
- (III) The covered person has tried, while under the covered person's current or previous health benefit plan, the required prescription drug or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the use of the prescription drug by the covered person was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- (IV) The covered person, while on the covered person's current or previous health benefit plan, is stable on a prescription drug selected by the prescribing provider for the medical condition under consideration after undergoing step therapy or after having sought and received a step-therapy exception.

Prescriber Signature or Electronic I.D. Verification:_____ Date: _____

Emergency Regulation 25-E-01 CONCERNING COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-109, and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for the required bronze, silver, and gold Standardized plans to be offered by all carriers offering individual and small group health benefits plans issued or renewed on or after January 1, 2026.

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this emergency regulation is imperatively necessary to comply with state and federal law, including federal regulation, and for the preservation of public health, safety, or welfare and compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interests. The Department of Health and Human Services (“HHS”) released the 2026 Actuarial Value Calculator Methodology, pursuant to 45 C.F.R. § 156.135(g), on October 16, 2024. Carriers are required to use the 2026 Actuarial Value Calculator Methodology for benefit year 2026, pursuant to 45 C.F.R.§ 156.135(a). Carriers must also notify the Division of Insurance by March 1, 2025, whether they have achieved the premium rate reduction requirements for their 2026 standardized plans, pursuant to § 10-16-1306(2), C.R.S. This emergency regulation ensures that carriers have the guidance and instructions to develop and adjust their standardized plans to ensure compliance with state law, including the March 1, 2025, notification deadline under § 10-16-1306(2), C.R.S., and federal law.

Section 3 Applicability

This regulation applies to all carriers offering individual and small group health benefit plans subject to the individual and small group laws of Colorado and the requirements of federal law.

Section 4 Definitions

A. “Actuarial value” or “AV” means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a plan will cover, with calculations based on the provision of essential health benefits to a standard population.

B. “Behavioral, mental health, and substance use disorder” shall have the same meaning as found at § 10-16-104(5.5)(d), C.R.S.

C. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

D. "Colorado Option Standardized Plan" or "Standardized plan" shall have the same meaning as found at § 10-16-1303(14), C.R.S.

E. "Colorado Plans and Benefits Template" or "Colorado PBT" means, for the purposes of this regulation, the Colorado-specific modified version of the Federal PBT for submission of plans offered through the Public Benefit Corporation.

F. "Colorado Supplement to the Summary of Benefits and Coverage Form" or "COSSBC" shall have the same meaning as found at Colorado Insurance Regulation 4-2-20.

G. "Consumer Facing Materials" means, for the purposes of this regulation, plan-specific policy forms including the Summary of Benefits and Coverage Form, Colorado Supplement to the Summary of Benefits and Coverage Form, Evidence of Coverage, Certificate of Coverage, and plan-specific marketing materials including brochures, direct mail, website landing page, broker website portal landing page, welcome kit, newsletters, advertisements, and shopping portals on-Exchange and off-Exchange through the Public Benefit Corporation.

H. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

I. "Embedded deductible" means, for the purposes of this regulation, a cost-sharing provision within family policies where a covered person may satisfy their own individual deductible before the overall family deductible is satisfied.

J. "Embedded out-of-pocket maximum" means, for the purposes of this regulation, a cost-sharing provision within family policies where a covered person may satisfy their own individual out-of-pocket maximum before the overall family out-of-pocket maximum is satisfied.

K. "Essential health benefits" or "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.

L. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

M. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.

N. "Federal Plans and Benefits Template" or "Federal PBT" means, for the purposes of this regulation, the Plans & Benefits Template created by the Centers for Medicare & Medicaid Services.

O. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

P. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.

Q. "Preventive drug" shall have the same meaning as found at Colorado Insurance Regulation 4-2-58.

R. "Provider" shall have the same meaning as found at § 10-16-102(56), C.R.S.

S. "Public Benefit Corporation" shall have the same meaning as found at § 10-16-1303(12), C.R.S.

T. "Silver Enhanced Plan" means, for the purposes of this regulation, the standardized silver plan offered by Connect for Health Colorado on the Colorado Public Benefit Corporation with an increase in the plan's actuarial value to 94% and a $0 premium containing the same plan design and cost sharing as the Colorado Option On-Exchange Silver (94% AV) Standardized Plan.

U. "Summary of Benefits and Coverage Form" or "SBC" means, for the purposes of this regulation, the Summary of Benefits and Coverage Form created by the Centers for Medicare & Medicaid Services.

Section 5 Standardized Health Benefit Plan

A. Carriers shall offer a Standardized plan at the bronze, silver, and gold metal level tiers, as required under § 10-16-1304, C.R.S., and shall:

1. Offer the individual market Standardized plans on-Exchange and off-Exchange through the Public Benefit Corporation.

2. Use the following naming conventions in the Federal PBT and Colorado PBT as well as on consumer facing materials.

a. For all metal tier plans: "[Name of Carrier] Colorado Option [Metal Tier]." The name of the carrier may be shortened to an easily identifiable acronym that is commonly used by the carrier in consumer facing publications.

b. For silver cost-sharing reduction variant plans: "[Name of Carrier] Colorado Option Silver [% AV value]." The name of the carrier may be shortened to an easily identifiable acronym that is commonly used by the carrier in consumer facing publications.

3. Use the following naming conventions on identification cards:

a. For all metal tier plans: "CO Option [Metal Tier]."

b. For silver cost-sharing reduction variant plans: "CO Option Silver [% AV value]."

4. Use a Division approved, co-branded logo in individual and small group Standardized plan consumer facing materials. A co-branded logo will use both the Colorado Option logo and the carrier's logo, to form a dual logo that is a single image.

5. Include a service area or network identifier in the plan name if the plan is not offered on a statewide basis with a statewide network.

B. Coverage must be provided in a manner consistent with the requirements of:

1. Federal law.

2. Article 16 of Title 10 of the Colorado Revised Statutes, as applicable to individual and small group health benefit plans, including but not limited to:

a. §§ 10-16-1304, 10-16-1305, 10-16-1306, C.R.S.

b. §§ 10-16-104(5.5) and 10-16-147, C.R.S. and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as defined at § 10-16-102(43.5), C.R.S.

(1) Carriers shall submit the CO Financial Requirement and Quantitative Treatment Limitation Classification Template and the Financial Requirements Attestation Template for Standardized Plans, required by Colorado Insurance Regulation 4-2-64, no later than March 1 of each year.

(2) If it is determined that a carrier's Standardized plan does not comply with MHPAEA financial requirements and quantitative treatment limitations, the Division will make the minimum adjustments necessary to the cost sharing structure in the Standardized plan to meet these requirements.

3. United States Preventive Services Task Force A and B recommendations, Advisory Committee on Immunization Practices age-appropriate immunization and vaccine schedules, and the Women's Preventive Services Guidelines published by the Health Resources and Services Administration (HRSA).

C. As part of the annual filings process, Standardized plans must be consistent with Colorado Insurance Regulations and guidance regarding rate and form filings, including but not limited to Colorado Insurance Regulations 4-2-39, 4-2-41, 4-2-58 and 4-2-64.

D. Individual market carriers must file all Standardized plans, except bronze plans, on Benefits Package 1 and bronze plans on Benefits Package 2 of the federal Plans and Benefits Template. Individual market carriers must file the Standardized bronze, off-Exchange silver, silver enhanced, and gold plans on the Colorado Plans and Benefits Template. Small group market carriers must file all Standardized plans, except bronze plans, on Benefits Package 1 and bronze plans on Benefits Package 2 of the federal Plans and Benefits Template.

E. Coverage must provide essential health benefits as defined in Colorado Insurance Regulation 4-2-42. Carriers are not permitted to add benefits outside of those outlined in Colorado Insurance Regulation 4-2-42 except that carriers may include reproductive health services in addition to the benefits in Colorado Insurance Regulation 4-2-42, subject to approval by the Division of Insurance. Carriers must follow the defined cost-sharing requirements for the benefits listed in Appendix A. Carriers may vary cost-sharing amounts for essential health benefits not listed in Appendix A.

F. The bronze, silver, and gold Standardized plans must include the following coverage:

1. Mental health, behavioral health and substance use disorder visits and primary care visits in accordance with the cost-sharing requirements contained in Appendix A.

2. Prenatal and postnatal visits in accordance with the cost-sharing requirements contained in Appendix A.

a. Carriers utilizing a global billing structure for pregnancy-related care shall account for the cost sharing outlined in the Standardized plan in the global billing fee structure.

b. Home visits shall be considered a covered postnatal care visit, subject to the cost-sharing for "prenatal and postnatal visits" contained in Appendix A.

c. Prenatal and postnatal visits shall be combined in instances where a number of visits is specified in Appendix A.

3. Diabetes supplies, including but not limited to Continuous Glucose Monitors and all associated components with automated insulin delivery systems, must be provided with no cost sharing.

a. Carriers must maintain an easy-to-understand, transparent, and searchable page on the carrier's website titled "Covered Diabetic Supplies for Colorado Option Plans" that includes the following information, updated for each plan year:

(1) A clear statement that Colorado Option plans provide coverage of diabetic supplies at $0 cost-sharing and not subject to a deductible, copayments, or coinsurance.

(2) A complete list of all diabetic supplies organized by category of items or supplies.

(a) For each category, the name of all items or supplies that are covered at $0 cost-sharing and not subject to a deductible, copayment, or coinsurance under the Colorado Option Standardized Health Benefit Plan must be listed.

(b) At a minimum, the list must include the following categories: “Continuous Glucose Monitors and Components”, “Insulin Pumps”, “Blood Glucose Monitors and Test Strips”, and “Other Covered Diabetic Supplies”.

(3) At all times, the list shall include all of the diabetic supplies that are covered for the current plan year. If a carrier has a change in the covered items and supplies, the carrier shall update the public-facing list within 10 business days of the change becoming effective.

(4) During the annual Open Enrollment Period, the website shall also display the diabetic supplies covered for the upcoming plan year.

b. If the carrier offers multiple Colorado Option plans that cover different diabetic supplies, a different list should be included for each plan, and clearly marked with the marketing name(s) of the Colorado Option plan(s) that cover the specific supplies listed.

c. Next to each item or supply, the carrier must clearly indicate whether it is covered under the medical benefit, including durable medical equipment (DME), or prescription drug benefit.

(1) If an item or supply is covered as DME, the carrier must include clear instructions for how a consumer may obtain the diabetic supply through the covered DME supplier, including where to find the contact information for the carrier’s covered DME supplier.

(2) If an item or supply is covered under the prescription drug benefit, the carrier must include clear instructions on how a consumer can access the carrier’s most recent prescription drug formulary and the carrier’s provider directory.

4. Carrier formularies:

a. Formularies shall have five drug tiers that allow copay only cost sharing:

(1) Tier 1: The prescription drug tier which consists of drugs used for preventive purposes.

(2) Tier 2: The prescription drug tier which consists of the lowest cost tier of prescription drugs, most are generic.

(3) Tier 3: The prescription drug tier which consists of medium-cost prescription drugs, most are generic, and some brand-name prescription drugs.

(4) Tier 4: The prescription drug tier which consists of the higher-cost prescription drugs, most are brand-name prescription drugs, and some specialty drugs.

(5) Tier 5: The prescription drug tier which consists of the highest-cost prescription drugs, most are specialty drugs.

b. Carriers may assign prescription drugs to one of the five tiers based on drug usage, cost and clinical effectiveness so long as such classification remains in compliance with applicable Federal and Colorado state law requirements.

c. The cost-share amounts in Appendix A are for a 30-day supply of a prescription drug. A carrier may apply up to three times the cost-share amount for a 90-day supply.

4. Consistent with existing coverage requirements, carriers must provide the following:

a. Carriers must include the “Colorado QuitLine” as part of covered tobacco cessation programs;

b. When outpatient education for prediabetes is recommended by a provider, carriers must include a program recognized by the National Centers for Disease Control and Prevention (CDC) Diabetes Prevention Program as part of diabetes prevention coverage.

G. The Colorado Option bronze, silver, and gold Standardized plans may not have a tiered network with different copays for different network tiers.

H. Covered persons in the Standardized plans must receive care at the cost-sharing levels required for the different services in the Standardized plans for any “In-Network” provider. In-network services include services provided by an out-of-network provider, but are approved as in-network by the carrier.

I. The Standardized bronze, silver, and gold plans do not specify cost-sharing amounts for any out-of-network services except for those services required under state or federal law to have in-network cost-share amounts.

J. Any copay, coinsurance, and deductible payments for in-network covered services shall apply to the out-of-pocket maximum.

K. Carriers shall use an embedded deductible.

L. Carriers shall use an embedded out-of-pocket maximum.

M. Carriers are not required to submit reasonable modification requests for benefits and/or cost-sharing modifications found in Appendix A of this regulation. Carriers are required to submit any other benefits and/or cost-sharing reasonable modification requests to the Standardized plans, pursuant to Colorado Insurance Regulation 4-2-27.

Section 6 Incorporation by Reference

The age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices, as published by the Advisory Committee on Immunization Practices shall mean age-appropriate immunization and vaccine schedules as published on the effective date of this regulation and do not include later amendments to, or editions of, the age-appropriate immunization and vaccine schedules. The age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Advisory Committee on Immunization Practices website at http://www.cdc.gov/vaccines/schedules/hcp/index.html. Certified copies of the age-appropriate immunization and vaccine schedules as recommended by the Advisory Committee on Immunization Practices are available from the Colorado Division of Insurance for a fee.

The United States Preventive Services Task Force A and B Recommendations, published by the United States Preventive Services Task Force, shall mean the United States Preventive Services Task Force A and B Recommendations, as published on the effective date of this regulation and does not include later amendments to, or editions of, the United States Preventive Services Task Force A and B Recommendations. The United States Preventive Services Task Force A and B Recommendations may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the United States Preventive Services Task Force website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Certified copies of the United States Preventive Services Task Force A and B Recommendations are available from the Colorado Division of Insurance for a fee.

The Women's Preventive Services Guidelines, published by the Health Resources and Services Administration, shall mean the Women's Preventive Services Guidelines published by the Health Resources and Services Administration, as published on the effective date of this regulation and does not include later amendments to, or editions of the Women's Preventive Services Guidelines published by the Health Resources and Services Administration. The Women's Preventive Services Guidelines published by the Health Resources and Services Administration may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Health Resources and Services Administration website at https://www.hrsa.gov/womens-guidelines. Certified copies of the Women's Preventive Services Guidelines, published by the Health Resources and Services Administration, are available from the Colorado Division of Insurance for a fee.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This emergency regulation shall become effective on February 14, 2025.

Section 10 History

This emergency regulation shall become effective February 14, 2025.

Appendix A: 2026 Gold, Silver, and Bronze Standardized Plans

This Appendix outlines the plan designs for the gold, silver, and bronze metal tier standardized plans.

- The column "**Member Cost Share (In Network)**" refers to the cost share amount paid by the covered person after their deductible is met.
- The "**x**" in the "**Deductible Applies**" column indicates that a covered person is expected to meet their deductible prior to paying the cost share amount listed in the "Member Cost Share (In Network)" column.
- If there is no "**x**" in the "**Deductible Applies**" column, this indicates that the cost-share is pre-deductible or first dollar coverage.

Standardized Silver Cost Sharing Reduction Plans at 73% AV and 87% AV are only required to be offered in the individual, on-Exchange market. Standardized Silver Cost Sharing Reduction Plans at the 94% AV level are required to be offered in the individual, on-Exchange market, and the individual, off-Exchange market through the Public Benefit Corporation.

Gold Standardized Plan

Actuarial Value			**78.0%**
Individual Deductible (Combined Medical & Drug)			$2,050
Individual Out-of-Pocket Maximum			$9,600
Family Deductible			$4,100
Family Out-of-Pocket Maximum			$19,200
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$55	

Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	30%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	30%	X
Tests	Laboratory tests	30%	X
	X-rays and diagnostic imaging	30%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	30%	X
Drugs to treat Illness or Condition	Tier 1	$0	
	Tier 2	$10	
	Tier 3	$50	
	Tier 4	$200	
	Tier 5	$600	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	30%	X
	Physician/Surgical Services	30%	X
Need Immediate Attention	Urgent care centers or facilities	$50	
	Emergency room services	30%	X
	Emergency medical transportation (ambulance)	30%	X

Hospital Stay	Inpatient Hospital services	30%	X
	Inpatient Physician and Surgical Services	30%	X
	Inpatient Rehabilitation Services	30%	X
	Inpatient Habilitation Services	30%	X
Help recovering or other health needs	Speech Therapy	30%	X
	Physical Therapy	30%	X
	Occupational Therapy	30%	X
	Durable medical equipment[1]	30%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver Standardized Plan

(On-Exchange Individual Market & Small Group Market)

Actuarial Value			**70.0%**
Individual Deductible (Combined Medical & Drug)			$4,400
Individual Out-of-Pocket Maximum			$9,800
Family Deductible			$8,800
Family Out-of-Pocket Maximum			$19,600
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$90	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	40%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	40%	X
Tests	Laboratory tests	40%	X

	X-rays and diagnostic imaging	40%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	40%	X
Drugs to treat Illness or Condition	Tier 1	$0	
	Tier 2	$20	
	Tier 3	$125	
	Tier 4	$300	
	Tier 5	$650	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	40%	X
	Physician/Surgical Services	40%	X
Need Immediate Attention	Urgent care centers or facilities	$80	
	Emergency room services	40%	X
	Emergency medical transportation (ambulance)	40%	X
Hospital Stay	Inpatient Hospital services	40%	X
	Inpatient Physician and Surgical Services	40%	X
	Inpatient Rehabilitation Services	40%	X
	Inpatient Habilitation Services	40%	X
Help recovering or other health needs	Speech Therapy	40%	X
	Physical Therapy	40%	X

	Occupational Therapy	40%	X
	Durable medical equipment[1]	40%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver (73% AV) Standardized Plan

(On-Exchange Individual Market)

Actuarial Value			**73.0%**
Individual Deductible (Combined Medical & Drug)			$2,850
Individual Out-of-Pocket Maximum			$8,000
Family Deductible			$5,700
Family Out-of-Pocket Maximum			$16,000
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$90	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	40%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	40%	X
Tests	Laboratory tests	40%	X

	X-rays and diagnostic imaging	40%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	40%	X
Drugs to treat Illness or Condition	Tier 1	$0	
	Tier 2	$20	
	Tier 3	$125	
	Tier 4	$300	
	Tier 5	$600	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	40%	X
	Physician/Surgical Services	40%	X
Need Immediate Attention	Urgent care centers or facilities	$80	
	Emergency room services	40%	X
	Emergency medical transportation (ambulance)	40%	X
Hospital Stay	Inpatient Hospital services	40%	X
	Inpatient Physician and Surgical Services	40%	X
	Inpatient Rehabilitation Services	40%	X
	Inpatient Habilitation Services	40%	X
Help recovering or other health needs	Speech Therapy	40%	X
	Physical Therapy	40%	X

	Occupational Therapy	40%	X
	Durable medical equipment[1]	40%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver (87% AV) Standardized Plan

(On-Exchange Individual Market)

Actuarial Value			**87.0%**
Individual Deductible (Combined Medical & Drug)			$950
Individual Out-of-Pocket Maximum			$3,350
Family Deductible			$1,900
Family Out-of-Pocket Maximum			$6,700
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$65	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	30%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	30%	X
Tests	Laboratory tests	30%	X

	X-rays and diagnostic imaging	30%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	30%	X
Drugs to treat Illness or Condition	Tier 1	$0	
	Tier 2	$0	
	Tier 3	$60	
	Tier 4	$120	
	Tier 5	$180	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	30%	X
	Physician/Surgical Services	30%	X
Need Immediate Attention	Urgent care centers or facilities	$60	
	Emergency room services	30%	X
	Emergency medical transportation (ambulance)	30%	X
Hospital Stay	Inpatient Hospital services	30%	X
	Inpatient Physician and Surgical Services	30%	X
	Inpatient Rehabilitation Services	30%	X
	Inpatient Habilitation Services	30%	X
Help recovering or other health needs	Speech Therapy	30%	X
	Physical Therapy	30%	X

	Occupational Therapy	30%	X
	Durable medical equipment[1]	30%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver (94% AV) Standardized Plan

(On-Exchange Individual Market and Off-Exchange Individual Market through the Public Benefit Corporation)

Actuarial Value			**94.5%**
Individual Deductible (Combined Medical & Drug)			$100
Individual Out-of-Pocket Maximum			$1,375
Family Deductible			$200
Family Out-of-Pocket Maximum			$2,750
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$40	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	20%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	20%	X
Tests	Laboratory tests	20%	X

	X-rays and diagnostic imaging	20%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	20%	X
Drugs to treat Illness or Condition	Tier 1	$0	
	Tier 2	$0	
	Tier 3	$20	
	Tier 4	$40	
	Tier 5	$60	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	20%	X
	Physician/Surgical Services	20%	X
Need Immediate Attention	Urgent care centers or facilities	$40	
	Emergency room services	20%	X
	Emergency medical transportation (ambulance)	20%	X
Hospital Stay	Inpatient Hospital services	20%	X
	Inpatient Physician and Surgical Services	20%	X
	Inpatient Rehabilitation Services	20%	X
	Inpatient Habilitation Services	20%	X
Help recovering or other health needs	Speech Therapy	20%	X
	Physical Therapy	20%	X

	Occupational Therapy	20%	X
	Durable medical equipment[1]	20%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Silver Off Exchange Standardized Plan

(Individual Market Off-Exchange)

Actuarial Value			**70.0%**
Individual Deductible (Combined Medical & Drug)			$4,400
Individual Out-of-Pocket Maximum			$9,800
Family Deductible			$8,800
Family Out-of-Pocket Maximum			$19,600
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$0, unlimited	
	Specialist visit	$90	
Pregnancy	Prenatal and postnatal visits	$0, unlimited	
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	40%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	40%	X
Tests	Laboratory tests	40%	X

	X-rays and diagnostic imaging	40%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	40%	X
Drugs to treat Illness or Condition	Tier 1	$0	
	Tier 2	$20	
	Tier 3	$125	
	Tier 4	$300	
	Tier 5	$650	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	40%	X
	Physician/Surgical Services	40%	X
Need Immediate Attention	Urgent care centers or facilities	$80	
	Emergency room services	40%	X
	Emergency medical transportation (ambulance)	45%	X
Hospital Stay	Inpatient Hospital services	40%	X
	Inpatient Physician and Surgical Services	40%	X
	Inpatient Rehabilitation Services	40%	X
	Inpatient Habilitation Services	40%	X
Help recovering or other health needs	Speech Therapy	40%	X
	Physical Therapy	40%	X

	Occupational Therapy	40%	X
	Durable medical equipment[1]	40%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Bronze Standardized Plan

Actuarial Value			**63.5%**
Individual Deductible (Combined Medical & Drug)			$7,500
Individual Out-of-Pocket Maximum			$10,000
Family Deductible			$15,000
Family Out-of-Pocket Maximum			$20,000
Common Medical Event	Service Type	Member Cost Share (In Network)	Deductible Applies
Health Care Provider's Office or Clinic Visit	Preventive care/screening/immunization	$0	
	Primary care visit or non-specialist practitioner visit to treat an injury or illness	First 3 visits $0, then deductible, then $50	X
	Specialist visit	50%	X
Pregnancy	Prenatal and postnatal visits	First 3 visits $0, then deductible, then $50	X
Mental/ Behavioral Health and Substance Use Needs	Mental/Behavioral Health and Substance Use Disorder Office Visit	$0, unlimited	
	Mental/Behavioral Health and Substance Use Disorder Outpatient services	50%	X
	Mental/Behavioral Health and Substance Use Disorder Inpatient services	50%	X
Tests	Laboratory tests	50%	X

	X-rays and diagnostic imaging	50%	X
	Advanced Imaging/Radiology (CT/PET scans, MRI)	50%	X
Drugs to treat Illness or Condition	Tier 1	$0	
	Tier 2	$30	
	Tier 3	$200	
	Tier 4	$350	
	Tier 5	$700	
Outpatient Surgery	Facility Fee (e.g. Ambulatory Surgery Center)	50%	X
	Physician/Surgical Services	50%	X
Need Immediate Attention	Urgent care centers or facilities	50%	X
	Emergency room services	50%	X
	Emergency medical transportation (ambulance)	50%	X
Hospital Stay	Inpatient Hospital services	50%	X
	Inpatient Physician and Surgical Services	50%	X
	Inpatient Rehabilitation Services	50%	X
	Inpatient Habilitation Services	50%	X
Help recovering or	Speech Therapy	50%	X

other health needs	Physical Therapy	50%	X
	Occupational Therapy	50%	X
	Durable medical equipment[1]	50%	X
	Diabetes Self-Management Education[2]	$5	

[1] Diabetes supplies, including Continuous Glucose Monitors, are provided with no-cost sharing

[2] At a minimum 10 hours of individual or group sessions in the first year of diagnosis, and 6 hours of individual or group sessions every year after diagnosis

Emergency Regulation 25-E-02 CONCERNING THE METHODOLOGY FOR CALCULATING PREMIUM RATE REDUCTIONS FOR COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-109, 10-16-1304, 10-16-1305, 10-16-1306, and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for the required premium reduction methodology for the Colorado Option standardized bronze, silver and gold health benefit plans to be offered by all carriers offering individual and small group health benefits plans issued or renewed on or after January 1, 2026.

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this emergency regulation is imperatively necessary to comply with state and federal law, including federal regulation, and for the preservation of public health, safety, or welfare and compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interests. The Department of Health and Human Services (“HHS”) released the 2026 Actuarial Value Calculator Methodology, pursuant to 45 C.F.R. § 156.135(g), on October 16, 2024. Carriers are required to use the 2026 Actuarial Value Calculator Methodology for benefit year 2026, pursuant to 45 C.F.R.§ 156.135(a). Carriers must also notify the Division of Insurance by March 1, 2025, whether they have achieved the premium rate reduction requirements for their 2026 standardized plans, pursuant to § 10-16-1306(2), C.R.S. This emergency regulation ensures that carriers have the guidance and instructions to develop and adjust their standardized plans to ensure compliance with state law, including the March 1, 2025, notification deadline under § 10-16-1306(2), C.R.S., and federal law.

Section 3 Applicability

This regulation applies to all carriers offering individual and small group health benefit plans subject to the individual and small group laws of Colorado and the requirements of federal law.

This regulation is applicable subject to § 10-16-1308(2)(b), C.R.S.

Section 4 Definitions

A. “Actuarial value” or “AV” means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a health benefit plan will cover, with calculations based on the provision of essential health benefits to a standard population.

B. "Baseline Plan" or "2021 Baseline Plan" means, for the purposes of this regulation, the health benefit plan with the carrier's lowest 21-year-old non-tobacco use premium rate, by metal level, in the applicable county from the 2021 Benefit Year, regardless of whether the health benefit plan is sold in the entire county or a partial county. The Baseline Plan shall only consider on-Exchange health benefit plans for the Individual market and be determined prior to the impact of the Colorado reinsurance program. The Baseline Plan shall only consider off-Exchange health benefit plans for the Small Group market.

C. "Benefit Year" means, for the purposes of this regulation, the calendar year for individual health benefit plans, or the twelve month period beginning with the health benefit plan contract date for small group health benefit plans.

D. "Calibrated Plan Adjusted Index Rate" means, for the purpose of this regulation, line 3.14 on Worksheet 2 of the URRT.

E. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

F. "Colorado Option Standardized Plan" or "Standardized Plan" or shall have the same meaning as found at § 10-16-1303(14), C.R.S.

G. "Commissioner" shall have the same meaning as found at § 10-16-102(13), C.R.S.

H. "CSR" means, for the purposes of this regulation, a cost-sharing reduction health benefit plan variation defined in 45 C.F.R. § 156.420(a).

I. "CSR Load" means, for the purposes of this regulation, the load in the silver plan premiums necessary to cover the cost of providing the CSR benefit to qualified consumers in the on-Exchange silver health benefit plans.

J. "CPI-U" means, for the purposes of this regulation, the Consumer Price Index for all urban consumers, U.S. city average, and all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.

K. "Essential health benefits" or "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.

L. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

M. "Expanded bronze" means, for the purposes of this regulation, a bronze health benefit plan that provides coverage for at least one (1) major service, other than preventive services, prior to meeting the deductible, or meets the requirements to qualify as a high deductible health plan under 26 U.S.C 223(c)(2), as established at 45 C.F.R. § 156.140(c), with a bronze actuarial value of 60%.

N. "Federal Actuarial Value Calculator" or "Federal AV Calculator" means, for the purposes of this regulation, the AV Calculator required pursuant to 45 C.F.R. § 156.135.

O. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.

P. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

Q. "Healthcare coverage cooperative" shall have the same meaning as found at § 10-16-1002(2), C.R.S.

R. "Induced demand factor" means, for the purposes of this regulation, the anticipated induced demand associated with the health benefit plan's cost sharing (metal) level.

S. "Medical Inflation" shall have the same meaning as found at § 10-16-1303(10), C.R.S.

T. "Metal Level" means, for the purposes of this regulation, the bronze, silver, and gold health benefit plans available in the individual and small group market as found at § 10-16-103.4, C.R.S.

U. "Non-EHB" means, for the purposes of this regulation, any benefit in a health benefit plan that is not an EHB as found at § 10-16-102(22), C.R.S.

V. "Plans and Benefits Template" or "PBT" means, for the purpose of this regulation, the Plans & Benefits Template created by the Centers for Medicare & Medicaid Services (CMS).

W. "Premium" shall have the same meaning as found at § 10-16-102(51), C.R.S.

X. "Reinsurance" shall have the same meaning as found at § 10-16-1103(12), C.R.S.

Y. "SERFF" means, for the purposes of this regulation, the System for Electronic Rate and Form Filing.

Z. "Supplemental Template" shall have the same meaning as found at Colorado Insurance Regulation 4-2-39 Section (6)(C)(3).

AA. "Substantially Similar Plan" means, for the purposes of this regulation, the silver level health benefit plan that is substantially similar to the on-Exchange CSR-loaded silver health benefit plan, but without the CSR load, for those off-Exchange consumers who do not qualify for advanced premium tax credits or CSRs.

AB. "URRT" means, for the purpose of this regulation, the Unified Rate Review Template created by the Centers for Medicare & Medicaid Services.

Section 5 Premium Rate Reduction Methodology for Colorado Option Standardized Health Benefit Plans

A. Pursuant to § 10-16-1305(2)(a)-(c), C.R.S., carriers offering a Standardized Plan at the bronze, silver, and gold metal levels must offer standardized plans with a premium that is reduced by a specified percent relative to their 2021 premiums, after adjustments for medical inflation. The Division will define the allowable adjustments for the calculation of the premium rate reduction methodology required for the Colorado Option. The required premium reductions are:

1. Five percent premium reduction for the Benefit Year beginning in 2023;

2. Ten percent premium reduction for the Benefit Year beginning in 2024; and

3. Fifteen percent premium reduction for the Benefit Year beginning in 2025.

B. Pursuant to § 10-16-1305(2)(d), C.R.S., for the Benefit Year beginning on or after January 1, 2026, and each year thereafter, each carrier and healthcare coverage cooperative shall limit any annual premium rate increase to a rate that is no greater than medical inflation, relative to the Maximum Colorado Option Standardized Plan Premium of the previous Benefit Year, as defined in Section 5.C.10 of this regulation.

C. The Division will calculate whether a carrier meets the premium reductions specified in Sections 5.A. and 5.B. using the following methodology.

1. Bronze and Expanded Bronze health benefit plans will be combined to determine the lowest cost premium rate for the Bronze Colorado Option Standardized Plan.

2. The 2021 Baseline Plan Unadjusted Premium will be calculated on a county, metal level, and market basis for each carrier. The 2021 Baseline Plan Unadjusted Premium will be calculated as follows:

    a. For the Individual Market:

        (1) 2021 Baseline Plan Unadjusted Premium =

            (minimum 2021 Calibrated Plan Adjusted Index Rate offered in the county for the metal level) x (1.0 age factor) x (2021 Geographic Rating Factor for the applicable county)

        (2) The Minimum 2021 Calibrated Plan Adjusted Index Rate will be determined using the carrier's 2021 "No Reinsurance" URRT.

    b. For the Small Group Market:

        (1) 2021 Baseline Plan Unadjusted Premium =

            (minimum annual filing 2021 Calibrated Plan Adjusted Index Rate offered in the county for the metal level) x ((fourth quarter rate of 2021 Baseline Plan) / (first quarter rate of 2021 Baseline Plan)) x (1.0 age factor) x (2021 Geographic Rating Factor for the applicable county)

        (2) If a carrier submitted quarterly rate filing(s) subsequent to the annual filing, the last filing submitted will be used to determine the fourth quarter rate for the Baseline plan.

3. An adjustment factor will be applied to reflect changes in the member cost sharing from the 2021 Baseline Plan to the applicable Colorado Option Standardized Plan design and underlying data changes in the 2023, 2024, 2025, and 2026 federal AV calculators, including meaningfully different changes across the various metal levels beyond the impact of claim cost and utilization trends and trend leveraging. The Changes in Member Cost Sharing Adjustment will be calculated as follows:

    (Colorado Option Standardized Plan AV) x (CY2023 AV Calculator Adjustment) x (CY2024 AV Calculator Adjustment) x (CY2025 AV Calculator Adjustment) x (CY2026 AV Calculator Adjustment) x (Pricing AV Adjustment)

    ÷

    (2021 Baseline Plan AV)

    a. Colorado Option Standardized Plan AV for the applicable metal level.

    b. The CY2023 AV Calculator Adjustment will be:

        (1) 0.992 for Gold Metal Level Plans

        (2) 0.971 for Silver Metal Level Plans

        (3) 1.002 for Bronze Metal Level Plans

c. The CY2024 AV Calculator Adjustment will be:

(1) 1.017 for Gold Metal Level Plans

(2) 1.019 for Silver Metal Level Plans

(3) 1.020 for Bronze Metal Level Plans

d. The CY2025 AV Calculator Adjustment will be:

(1) 1.027 for Gold Metal Level Plans

(2) 1.040 for Silver Metal Level Plans

(3) 1.039 for Bronze Metal Level Plans

e. The CY2026 AV Calculator Adjustment will be:

(1) 1.00 for Gold Metal Level Plans

(2) 1.00 for Silver Metal Level Plans

(3) 1.00 for Bronze Metal Level Plans

f. The Pricing AV Adjustment will be consistent across carriers and determined using information provided to the Division in a data call.

g. The 2021 Baseline Plan AV will be determined by the value entered in the carrier's PBT for the 2021 Baseline Plan.

4. An adjustment factor will be applied to reflect changes in the loading applied to Individual market Silver health benefit plans for CSR payments. The CSR load will be calculated for both the Colorado Option Standardized Plan and the 2021 Baseline Plan using the ratio of the on-Exchange silver health benefit plan and the off-Exchange Substantially Similar Plan. The CSR Load Adjustment will be calculated as follows:

(Colorado Option Standardized Plan CSR Load) ÷

(2021 Baseline Plan CSR Load)

a. The Colorado Option Standardized Plan CSR Load will be calculated as follows:

(The Calibrated Plan Adjusted Index Rate for the on-Exchange Colorado Option Standardized Silver Plan ÷ (the Calibrated Plan Adjusted Index Rate of the Substantially Similar off-Exchange Colorado Option Standardized Silver Plan) x (Substantially Similar off-Exchange Colorado Option Standardized Silver Plan Induced Demand Factor) ÷ (on-Exchange Colorado Option Standardized Silver Plan Induced Demand Factor).

b. The 2021 Baseline Plan CSR Load will be calculated using the Calibrated Plan Adjusted Index Rate for the 2021 Baseline Plan divided by the Calibrated Plan Adjusted Index Rate of the Substantially Similar off-Exchange plan of the 2021 Baseline Plan.

5. An adjustment factor will be applied to reflect changes in the Induced Demand Factor applied in 2021 and the applicable Colorado Option Standardized Plan design. The Induced Demand Factor Adjustment will be calculated as follows:

   (Colorado Option Standardized Plan Induced Demand Factor) ÷

   (2021 Baseline Plan Induced Demand Factor)

   a. The Colorado Option Standardized Plan Induced Demand Factor will be determined by the following formula:

      Colorado Option Standardized Plan Induced Demand Factor =

      $1.24 - (AV) + (AV)^2$

   b. The 2021 Baseline Plan Induced Demand Factor will be determined by the value supplied to the Division in a data call regarding 2021 plans. The 2021 Baseline Plan Induced Demand Factors are normalized based on the projected membership carriers assumed for the 2021 Benefit Year. To ensure the induced demand adjustment is consistent, a normalization factor will be developed and applied to the Induced Demand Factor using the formula in (a). This normalization factor will be developed separately for each carrier and ensure that the shift from carrier-specific Induced Demand Factor to the federal induced demand formula is revenue-neutral across each carrier's 2021 rate filing.

6. The Adjustment for EHB Changes of 1.0016 will be applied to reflect the changes in the EHB-benchmark plan, which will be in effect starting with the 2023 Benefit Year. This adjustment will be based on the cost impact of the benefit changes in the actuarial analysis submitted to CMS for approval of these changes.

7. If the Baseline Plan has non-EHBs not reflected in the Colorado Option Standardized Plan, an adjustment will be made based on the EHB Percent of Total Premium in the Plan & Benefits Template for 2021. Additionally, if the 2021 Baseline Plan did not include any non-EHB benefits but the carrier chooses to offer allowable non-EHB benefits in the Colorado Option Standardized Plan, an adjustment would also be made based on the EHB Percent of Total Premium in the Plan & Benefits Template for the Benefit Year. The Adjustment for non-EHB Changes will be calculated as follows:

   ("EHB Percent of Total Premium" for 2021 Baseline Plan) ÷

   ("EHB Percent of Total Premium" for the Colorado Option Standardized Plan)

   a. The "EHB Percent of Total Premium" for the Colorado Option Standardized Plan will be determined by the value entered in the carrier's PBT for the Colorado Option Standardized Plan.

   b. The "EHB Percent of Total Premium" for the Baseline Plan will be determined by the value entered in the carrier's 2021 PBT.

8. The Medical Inflation Trend will be calculated as follows:

   (1 + "Medical Inflation) ^ (Months of Trend/12)

   a. "Medical Inflation" will be defined as the latest CPI-U for Medical Care for the Denver-Aurora-Lakewood, CO Core Based Statistical Area published 30 days

prior to the issuance of a Division bulletin by June 30, 2023 for the 2024 Benefit Year, and January 1 of each year thereafter.

b. Months of Trend will be calculated as the difference between the midpoint of the Colorado Option Standardized Plan Benefit Year and the midpoint of the effective period of the 2021 Baseline Plan.

9. The Required Rate Reduction Factor will be calculated as follows:

(1 – Benefit Year Required Rate Reduction Percentage)

The Benefit Year Required Rate Reduction will equal 5% for Benefit Year 2023, 10% for Benefit Year 2024 and 15% for Benefit Years 2025 and all subsequent Benefit Years.

10. The Colorado Option Standardized Plan premium rate for a 21-year-old non-tobacco user, calculated on a county, metal level, and market basis for each carrier must be less than or equal to the Maximum Colorado Option Standardized Premium. The Maximum Colorado Option Standardized Plan Premium will be calculated as follows:

a. For Colorado Option Standardized Gold and Bronze Plans in the Individual and Small Group markets, and Colorado Option Standardized Silver Plans in the Small Group Market:

(1) Maximum Colorado Option Standardized Plan Premium =

(2021 Baseline Plan Unadjusted Premium) x (Changes in Member Cost Sharing Adjustment) x (Induced Demand Factor Adjustment) x (Adjustment for EHB Changes) x (Adjustment for non-EHB Changes) x (Medical Inflation Trend) x (Required Rate Reduction Factor)

(2) The Maximum Colorado Option Standardized Plan Premium for the Small Group Market is the maximum allowable premium for all plans commencing during the applicable benefit year, irrespective of whether the rates are based on an annual or quarterly rate filing.

b. For On-Exchange Colorado Option Standardized Silver Plans in the Individual Market:

(1) Maximum Colorado Option Standardized Plan Premium =

(2021 Baseline Plan Unadjusted Premium) x (Changes in Member Cost Sharing Adjustment) x (CSR Load Adjustment) x (Induced Demand Factor Adjustment) x (Adjustment for EHB Changes) x (Adjustment for non-EHB Changes) x (Medical Inflation Trend) x (Required Rate Reduction Factor)

(2) A separate calculation will not be required for the Off-Exchange Colorado Option Standardized Silver Plan.

c. If a carrier is offering the Standardized Plan in a county where the carrier did not sell plans in 2021, the Maximum Colorado Option Standardized Plan Premium will be the weighted average, using enrollment as of April 1, 2021, of the Maximum Colorado Option Standardized Plan Premiums, across all carriers, that offered plans in the applicable county in 2021, regardless of whether plans are sold in the entire county or a partial part of the county. If a county did not have enrollment in any plans in the applicable metal level as of April 1, 2021, the Maximum Colorado Option Standardized Plan Premium will be the average of all plans in the applicable county in 2021, regardless of whether plans are sold in the entire county or a partial part of the county. A carrier's 2021 premiums will be excluded from the calculation described in this paragraph if the carrier has exited the market nationwide since 2021.

D. Carrier-filed Colorado Option Standardized Plan premiums submitted as part of rate filings pursuant to § 10-16-1306(1), C.R.S., must be at or below the rates set forth in Section 5.C.10. in order to be compliant with the required premium rate reductions pursuant to § 10-16-1305(2), C.R.S.

Section 6 Filing Requirements

A. For premium rates applicable in 2026 or any subsequent year, carriers shall notify the Commissioner by March 1 of the preceding year whether the carrier's Colorado Option Standardized Plan will comply with the required premium rate reductions set forth in § 10-16-1305(2), C.R.S., and calculated pursuant to Section 5 of this regulation.

B. Format of Filings

1. Carriers shall submit the notification of whether Colorado Option Standardized Plans will meet the required premium rate reductions through the "Colorado Option Standardized Plan Premium Rate Reduction" template supplied by the Division.

2. Carriers shall submit the "Colorado Option Standardized Plan Premium Rate Reduction" template in SERFF through an "Colorado Option Rate Reduction Notice" filing. This filing shall be submitted separately from any rate, form, annual certification, binder or network adequacy filing.

3. For the Individual market, Carriers shall use January 1 of the Benefit Year for which the filing applies for the "Effective Date" in SERFF.

4. For the small group market, Carriers shall use January 1 of the Benefit Year for the annual filing period as the "Effective Date" in SERFF. For other periods, the carrier shall use April 1, July 1 or October 1 of the Benefit Year for which the filing applies for the "Effective Date" in SERFF.

5. Carriers shall use "Informational" for the "Requested Filing Mode" in SERFF.

6. Carriers shall complete the SERFF Form Schedule tab to specify the forms to which this filing applies.

7. Carriers shall provide a filing description, including the Benefit Year the filing will support.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Incorporation by Reference

45 C.F.R. § 156.420(a) published by the Government Printing Office shall mean 45 C.F.R. § 156.420(a) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.420(a). A copy of 45 C.F.R. § 156.420(a) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.420(a) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 156.140(c) published by the Government Printing Office shall mean 45 C.F.R. § 156.140(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 156.140(c). A copy of 45 C.F.R. § 156.140(c) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.140(c) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 156.135 published by the Government Printing Office shall mean 45 C.F.R. § 156.135 as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR § 156.135. A copy of 45 C.F.R. § 156.135 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.135 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

This emergency regulation shall be effective February 14, 2025.

Section 11 History

Emergency regulation effective February 14, 2025.

Editor's Notes

3 CCR 702-4 has been divided into smaller sections for ease of use. Versions prior to 09/01/2011 and rule history are located in the first section, 3 CCR 702-4. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective after 09/01/2011, select the desired part of the rule, for example 3 CCR 702-4 Series 4-1, or 3 CCR 702-4 Series 4-6.

History

[For history of this section, see Editor's Notes in the first section, 3 CCR 702-4]