

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

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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?

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- (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.
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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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Method of Disclosure of Required Information
Section 6	Format and Content of Advertisements
Section 7	Advertisement of Benefits Payable, Losses Covered or Premiums Payable
Section 8	Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination
Section 9	Standards for Marketing
Section 10	Testimonials or Endorsements by Third Parties
Section 11	Use of Statistics
Section 12	Identification of Plan or Number of Policies
Section 13	Disparaging Comparisons and Statements
Section 14	Jurisdictional Licensing and Status of Insurer
Section 15	Identity of Insurer
Section 16	Group or Quasi-Group Implications
Section 17	Introductory, Initial or Special Offers
Section 18	Statements about an Insurer
Section 19	Enforcement Procedures
Section 20	Severability
Section 21	Incorporated Materials
Section 22	Enforcement
Section 23	Effective Date
Section 24	History

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.

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- 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 through 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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Requirements for Home Health Services
Section 6	Requirements for Hospice Care
Section 7	Additional Requirements for Home Health Services
Section 8	Severability
Section 9	Enforcement
Section 10	Effective Date
Section 11	History

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.

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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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Incorporated Materials
Section 8	Enforcement
Section 9	Effective Date
Section 10	History
Appendix A	FDA Licensed/Approved HIV Tests

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)	Infectious 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)	Infectious 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 Immunodeficien cy 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 Immunodeficien cy 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/C OBAS TaqMan HIV-1 Test	HIV-1	PCR	Plasma	Patient Monitoring: Quantitation of Human Immunodeficien cy 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- luminesce nt Immunoas say (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	Micropartic le Chemi- luminometr ic Immunoas say	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 Immunoas say	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 Immunoas say	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 Immunoas say	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 Immunoas say	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 Immunoas say	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)	Infectious Agent	Format	Current Sample	Use	Manufacturer	Approval Date	STN
ARCHITECT HIV Ag/Ab Combo	HIV-1, HIV-2	Chemiluminescent 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)	Infectious 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	Chemiluminescent 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 REPORTING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAS)

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Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § 10-1-109, 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; and to clarify the responsibilities of licensed producers.

Section 3 Applicability

This regulation applies to all multiple employer welfare arrangements subject to § 10-3-903.5, C.R.S.

Section 4 Definitions

- A. "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.
- B. "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.
- C. "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.
- D. "Producer" means, for the purposes of this regulation, a licensed person as defined by Article 2 of Title 10.
- E. "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

- A. A filing under this regulation by a MEWA is solely for the purpose of providing the information required by the Commissioner in order to demonstrate if the MEWA's complies with the requirements of § 10-3-903.5(7)(c), C.R.S. Determination of compliance or noncompliance will be provided in writing to the MEWA.
- B. The following information is required to be filed 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., 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 the 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 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.

Section 7 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 8 Continuing Compliance

In the event that a MEWA ceases to qualify under Section 6 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.

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 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 11 Effective Date

This amended regulation shall be effective September 1, 2017.

Section 12 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

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

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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 nor 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 defined at § 10-16-102(32)(b), C.R.S., and including, but not limited to the following types of coverage: dental (except for plans covering pediatric dental as an essential health benefit), long-term care, long-term disability, Medicare supplement, prepaid dental, short-term disability, 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. "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 accident or specified kinds of accident.
- B. "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.
- C. "Annual renewable term" or "ART" 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.
- D. "Benefits ratio" shall have the same meaning as found at § 10-16-102(5), C.R.S.
- E. "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.G. of this regulation.
- F. "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.G. of this regulation.
- G. "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.G. of this regulation.
- H. "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.
- I. "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.G.
- J. "Covered lives" means, for the purposes of this regulation, the number of members, subscribers and dependents.

- K. "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.
- L. "Dividends" mean, for the purposes of this regulation, both policyholder and stockholder dividends.
- M. "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.
- N. "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.
- O. "Filing date" means, for the purposes of this regulation, the date the rate filing is received at the Division.
- P. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- 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. For purposes of this regulation, this definition shall not include health benefit plans.
- S. "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.
- T. "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.
- U. "Implementation 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.
- V. "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.

- W. "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.
- X. "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.
- Y. "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 rate of interest should be used in calculating 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.
- Z. "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.
- AA. "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.
- AB. "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, and a direct written policy form is different from a policy sold using producers, etc.
- AC. "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.
- AD. "Plan" means, for the purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.
- AE. "Premium" shall have the same meaning as found at § 10-16-102(51), C.R.S.
- AF. "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.

- AG. "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.
- AH. "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.
- AI. "Rate filing" means, for the 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.
- AJ. "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.
- AK. "Rating period" shall have the same meaning as found at § 10-16-102(58), C.R.S.
- AL. "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.
- AM. "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).
- AN. "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.
- AO. "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.
- AP. "SERFF" means, for the purposes of this regulation, System for Electronic Rate and Form Filing.
- AQ. "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.

- AR. "Trend" 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.
- AS. "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.
- AT. "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.
- AU. "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.
- AV. "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.

Section 5 General Rate Filing Requirements

A. Rate Filing Types

1. Any rate increase is subject to prior 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. Dental rate increases equal to or above five (5) percent, are also considered to be review and approval.

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. Any rate decrease is not subject to prior approval.

All new products and rate decreases are considered file and use. Carriers shall submit rate filing to the Commissioner prior to usage of the rates.

B. Timing and General Rate Filing Requirements

1. Carrier Requirements

- a. 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.
- 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 (1) day prior to the implementation date.

- c. Filings that are resubmissions of previously withdrawn, rejected or disapproved rate filings shall be considered new filings and subject to the requirements in Section 5 B.1.a. or b. of this regulation.

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) If the Commissioner does not approve or disapprove a rate filing within sixty (60) calendar 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.
- (3) Medicare supplement carriers shall not use the rates until the Division has closed the filing as approved. Medicare Supplement rates are subject to prior approval.

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 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) 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. Carriers shall submit compliant rate filings within sixty (60) days of the Division's approval.
 - (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 nor 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 filing date, to ensure that the rates are not excessive, inadequate nor unfairly discriminatory.
 - (8) Carriers shall not represent an existing product to be a new policy form, or product. The offering of additional cost-sharing options (i.e., deductibles and copayments) or benefit levels to what is offered as an existing product, does not create a new policy form or product.
 - (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.
- 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, nor 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) 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 points.
- (8) 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.
- (9) 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.
- (10) 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

Rates for file and use rate filings shall not be used prior to the implementation 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) 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 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, 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 provide notice to the carrier if the request for confidentiality is rejected.
- f. Premium rounding and truncation rules shall be provided in the rate manual for all rate filings.

- g. Rating factors shall be calculated and displayed to four (4) decimal points.

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 Schedule tab in SERFF.

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. 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

4. 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.

5. Overall Rate Action

Identify the total overall, minimum, and maximum rate percentage changes.

6. 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 A for the required format.

7. Marketing Type(s). Indicate the appropriate marketing type(s) (i.e. individual, small group, large group). Identify if the product will be sold to associations, trusts, etc. and provide the name(s) of the associations or trusts, etc.

8. 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. Age factors;
- b. Benefit factors;
- c. Family composition (individual or family);
- d. Gender (except for individual products);
- e. Geographic rating area;
- f. Group size;
- g. Modal factors;
- h. Participation factors;
- i. Tobacco use factors;
- j. Underwriting class (Preferred or Standard); and
- k. Other (describe in detail).

This information shall be included in an Excel spreadsheet. See Appendix B for the required format.

9. Product Descriptions

This section shall describe the benefits provided by the policy, rider or contract.

This information shall be included in the narrative.

10. Policy/Rider or Contract

All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

11. Age Basis

This section shall state that the premiums will be charged on an issue-age basis or an attained-age basis.

This information shall be included in an Excel spreadsheet. See Appendix B for the required format.

12. Renewability Provision

Indicate all renewability provisions for the forms as applicable:

- a. Guaranteed renewable;
- b. Option to renew;
- c. Cancellable;
- d. Non-cancellable;
- e. Non-renewable; and
- f. Other (describe in detail).

13. Rate Change Distribution

Complete the Rate Change Distribution table.

This table shall be provided in an Excel spreadsheet. See Appendix B for the required format.

- 14.** For individual 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.
- 15.** For group products, the proposed base rates, the underlying rating factors and 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.

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 member of the group participating in a "series of activities or events" or for a "season" as related to the group.

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 effective 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.a.(5) for merger, acquisition or assumption rate filing requirements.

This information shall be included in the narrative.

C. Rating Period

Identify the period for which the rates will be effective to include both the implementation and end dates. 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.

This information shall be included in the narrative.

D. Underwriting

The memorandum shall include a brief description to the extent to which the product will be underwritten. If the product is a new product, 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.K., "Other Factors".

This information shall be included 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 included in the narrative.

F. Rate History

The memorandum shall include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) rate approvals immediately prior to the filing date, including the implementation 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 implementation 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 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. Coordination of Benefits

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.

Note: Limited benefit policies, hospital indemnity policies, fixed indemnity policies, specified disease policies, accident only policies, accidental death and dismemberment policies, accidental 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 or as permitted in §10-16-203 (4), (5) or (6), that allows the policy to reduce its benefits with respect to any other coverage the covered insured may have.

H. Relation of Benefits to Premium

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 either 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 of this regulation and for Medicare supplement policies, see Section 8 of this regulation.
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 for year 1, years 2 through 5, and years 6 through 10. The commissions for lifetime priced 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 that is not below the benefits ratio guidelines identified in Section 6.H.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.H.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%
Excess Loss	60%
Group Medicare Supplement	75%
Hospital Indemnity	60%
Limited Benefit Plans	60%
Long-Term Disability Income	60%
Short-Term Disability Income	60%
Sickness-only	60%
Specified or Dread Disease	60%
Travel Accident/Sickness	60%
Vision	60%

Individual Policies:

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

This information shall be provided in an Excel spreadsheet. See Appendix D for the required format.

I. Lifetime Loss Ratio

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 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 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.

The rate filing shall 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 shall 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 shall 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.

J. 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 information shall be provided in both the narrative and an Excel spreadsheet. See Appendix F for the required format.

K. 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.

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 coverage.

L. 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, continued use of trend factors shall be supported annually. Continued use of trend without an annual filing will be deemed as using unfilled 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 may include 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, with pharmacy data shown separately from medical data, 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 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 "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 G1 (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 G1 (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 G1, including the impact on trend due to anticipated demographic changes. The components of the medical trend noted as (1A) through (1D) in Appendix G1 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 G1 (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 G1 (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 G1.

The assumptions shall be presented in the narrative, and the data shall be provided in an Excel spreadsheet. See Appendices G1 – Trend and G2 – Monthly Historical Trend for the required formats.

- 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 unfilled 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.

M. Credibility

The actuarial 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 information 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 H - Credibility for the required format.

N. 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 of this regulation and in Colorado Insurance Regulation 4-4-1.

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

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.

Note: 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 experience available, with as much weight as possible placed upon the Colorado experience. Data used to support the 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.

6. 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. The carrier shall also provide information on how the number of claims was calculated.
7. 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.

The information shall be provided in this Section N, shall be provided in an Excel spreadsheet. See Appendix I for the required format.

- O. Side-by-Side Comparison: Each actuarial 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 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 spreadsheet. See Appendix J for the required format.

- P. 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.

This information shall be provided in an Excel spreadsheet. See Appendix J for the required format.

- Q. Rating Manuals and Underwriting Guidelines

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.

R. 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. Medicare supplement rate filings shall include the certification required by Colorado Insurance Regulation 4-3-1 Section 14. Long-term care rate filings shall include the certification requirements required by Colorado Insurance Regulation 4-4-1, Section 10. 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

Long-term care policies are regulated pursuant to §§ 10-19-101 to 115, C.R.S., and Colorado Insurance Regulation 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.

- A. Long-term care filings require prior approval.
- B. Assessment of reasonable increases includes consideration of all relevant factors, including no less than the following:
 1. Statistical credibility of incurred claims experience and earned premiums;
 2. Period for which rates are computed to provide coverage;
 3. Experienced and projected trends;
 4. Concentration of experience within early policy durations;
 5. Expected claim fluctuation;
 6. Experience refunds, adjustments or dividends;
 7. Renewability features;
 8. All appropriate expense factors;
 9. Interest rates;
 10. Policy reserves;
 11. Mix of business by risk classification;
 12. Product features such as long elimination periods, high deductibles and high maximum limits; and
 13. 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 prior approval.

- C. Carriers are required to complete the Key Assumption Long-term Care Table found in Appendix K – Key Assumption Long-term Care Table. References to documents and their page numbers shall be included with the filing or documents.
- D. Lifetime loss ratio shall include the incurred claims, premium and membership. Future premium and membership calculations shall include how all premiums and membership were calculated. If claim formulas are too complex to include in the spreadsheet, detailed support shall be provided illustrating how all projected future claims were calculated.

All lifetime loss ratio projections shall contain a separate entry for estimated IBNR 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. A table with the annual investment rates applicable from date of initial sale to current date shall be provided. Interest earnings assumptions are expected to be based on reasonably achievable interest rates from inception through the end of any projections.

A version of the lifetime loss ratio calculations shall be provided on an “if-known” premium basis.

A lifetime loss ratio calculation shall be provided on an “on-rate level premium” basis.

- E. The benefit variations available at issue for the policy form(s) subject to the rate filing and whether the Colorado distribution differs materially from nationwide shall be identified, especially if the rate increase filing is substantially built from a nationwide rate increase effort. The carrier shall indicate whether distribution of current policies among benefit variations is different for Colorado than for nationwide. The carrier shall provide, at a minimum, age, gender (except for Individual coverage pursuant to § 10-16-107(2)(b), C.R.S., 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.
- F. 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).
- G. Where applicable, experience and justification of any rate increase shall be split by benefit period, such as when there are policies with lifetime benefits that are a large portion of the distribution.
- H. Separate justification, specifically the lifetime loss ratios, for any rate increase, whether it is a level rate increase across policy characteristics (benefit, issue age, etc.) or whether the rate increase varies across policy characteristics. The carrier shall be prepared to provide several lifetime loss ratio demonstrations, as applicable.
- I. If the carrier offers any special benefit reduction variations, only available because of and at the time of the rate increase being implemented, then the carrier shall provide a lifetime loss ratio demonstration for only those policies eligible for such offer, first assuming 100% of policyholders accept the offer and then assuming 0% of policyholders accept the offer.
- J. Regarding morbidity expectations, the carrier shall provide evidence to support their current morbidity assumptions, including justification of the assumptions for the relevant benefit period (e.g., data may justify a rate increase for lifetime benefits but not for limited period benefits). The carrier shall provide the most recent comprehensive claims study.

- K. A table with the annual investment rates applicable from date of initial sale to current date shall be provided. Interest earnings assumptions are expected to be based on reasonably achievable interest rates from inception through the end of any projections. The Division appreciates the use of the valuation rate for certain demonstrations of lifetime loss ratios, but expects reasonable interest earnings assumptions to be disclosed and finds them useful in assessing whether premiums are appropriate as compared to benefits. At a minimum, the Division expects that if a level accumulation/discount rate is used to demonstrate the lifetime loss ratio, the level rate shall reflect the original pricing investment earnings assumption from the time the first policy under consideration was issued to the time the last policy under consideration was issued.

All lifetime loss ratio demonstrations shall be included for:

1. All policies combined.
 2. Only those policies that are not currently paid-up in a permanent waiver of premium status, or under a limited-payment premium option, where paid-up includes anyone who has previously elected nonforfeiture benefits.
 3. Only those policies that are currently paid-up, in a permanent waiver of premium status, or under a limited-payment premium options, where paid-up includes anyone who has previously elected nonforfeiture benefits.
 4. Any portion of the distribution that has materially different experience or future assumptions than another, especially if the rate increase percentage varies across the filing.
 5. Including variations of each demonstration provided with a discount rate that represents actual historical and reasonable future investment earnings rates.
- L. The carrier shall provide a history of rate increases that were filed for the forms and include a description of assumption changes that were made in projections that justified each increase. In addition, for each rate increase, note whether the carrier requested the full rate increase intended to implement over time within each rate increase request. Include whether the carrier intends, based on current experience and assumptions, to request additional future increases. The carrier shall explain any instance in past rate filings where it requested a lower increase than what it knew would be required.
- M. 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 increases and status of rate filings. See Appendix M1 for the required format.
- N. The carrier shall include a history of the rate increases for this rate filing by policy and state since inception. This information shall include a listing by state of all prior increase requests, receipts, effective date, amounts and status. The history shall be specific to the policy or policies identified in the rate filing. See Appendix M2 for the required format.
- O. Notice Requirements

The carrier shall provide notice to the policyholder of the rate increase at least thirty (30) days prior to the increase.

The carrier shall submit a copy of the proposed policyholder notice of the rate increase associated with the most recent implemented rate for the form(s) included in this filing.

Section 8 Additional Rate Filing Requirements for Medicare Supplement Policies

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 prior 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.

A. Requirements for Medicare Supplement New Business Rate Filings

1. 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.
2. Carriers shall provide complete support for development of starting claim costs and base rates, including experience relevant to the carrier and any manual claims costs used from third party consultants.
3. When developing initial rates for Medicare supplement plans, carriers shall use the following supporting data:
 - a. Carrier's own fully credible Colorado Medicare supplement experience on similar plans.
 - b. Carrier's partially credible Colorado experience, and also similar national experience.
 - c. Carrier has its own similar national experience to utilize when there is no Colorado experience.
 - d. Carrier has a parent or affiliated company and Colorado and/or national experience on similar Medicare supplement plans that can be utilized.
 - e. 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.
 - f. Collateral data 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.
4. 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:
 - a. Age factors;
 - b. Area factors, including what zip code or county definition of area used;

- c. Modal factors;
 - d. Tobacco/smoking factors;
 - e. Gender factors;
 - f. Family status (married/single);
 - g. Underwriting class; and
 - h. Change in rating methodology.
- 5. 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.
 - 6. 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.
 - 7. 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. 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.
 - 8. 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.
 - 9. 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.
 - 10. Carriers shall demonstrate that the under age sixty-five (65) rates are 1.5 times the age sixty-five (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.
 - 11. The rate filing shall include the carrier's definition of 'residency'.
 - 12. 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'.

B. Requirements for Medicare Supplement Existing Business Rate Filings

1. 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.
2. Medicare supplement rate request filings shall include the following specific items:
 - a. 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 starting claim costs in the rate filing is as follows:
 - (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 has its own similar national experience to utilize 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) Collateral data 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.

b. 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.
- c. **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.
- d. **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.
- e. **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.
- f. **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 there is sufficient support 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.

a. **Experience**

The 2010 Standardized plans shall be filed separately from the closed Standardized 1990 plans. Experience for the Standardized 2010 plans and 1990 Standardized plans shall be included in each rate filing.

The experience shall be reported separately by plan for each type, 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. This information shall be provided in an Excel spreadsheet, including formulas for how the carrier arrives at projected earned premium and incurred claims for all future years.

h. **Under Age Sixty-Five (65) Rates**

- (1) Verification shall be provided that indicates the under age sixty-five (65) rates do not exceed 1.5 times the age sixty-five (65) rates for new business plans entering the market.

- (2) If the under age sixty-five (65) rates are more than 1.5 times the sixty-five (65) rates, the rate increase shall not be more than the percent increase in the age sixty-five (65) plus rates. The carrier shall maintain the relationship between the under age 65 rates and the age 65 rates.
- i. The rate filing shall include the carrier's definition of 'residency'.
- j. 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, which is 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. Policies issued to employers covering employees in a valid employer/employee relationship do 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. Additional requirements for associations also apply as follows: 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. 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 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(1.5)(b), C.R.S; and
- D. Pursuant to § 10-16-107.2, C.R.S., individual health coverage plans, other than Medicare supplement, shall not vary the rates due to the gender of the individual policyholder, enrollee, subscriber, or member.

Section 11 Wellness Benefit Requirements

- A. Wellness benefits shall be paid to the policyholder and shall be paid on an indemnity basis. If the policy includes wellness benefits, the benefits shall be fully disclosed and properly labeled on the front page of the policy and the certificate.
- B. Wellness benefits, such as preventive care, diagnostic laboratory services, diagnostic x-ray services and similar services may be included in the following types of coverage:
 - 1. Accident-only policies

If these policies include wellness benefits, the policies shall be labeled "Accident-only policy with wellness benefits". Accident-only policies and accident-only policy with wellness benefits shall not include medical expense benefits. These policies shall 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 insured may have.
 - 2. Disability income policies

If these policies include wellness benefits, the policies shall be labeled "Disability income policy with wellness benefits". Disability income policies and disability income policies with wellness benefits shall not include annual doctor visits or outpatient coverage. If additional benefits are provided, such benefits shall be periodic payment to replace income lost when the insured is unable to work as the result of a sickness or injury. Loan payments and mortgage expenses benefit shall be filed as credit disability insurance.

3. Hospital indemnity policies

If these policies include wellness benefits, the policies shall be labeled "Hospital indemnity policy with wellness benefits". Hospital indemnity policies and hospital indemnity policies with wellness benefits shall 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 insured 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 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 is amended effective February 1, 2020.

Section 15 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.

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 attestation form specified by the Division.

APPENDIX B: SUMMARY

Summary		
1. Block Opened Date:		
2. Block Closed Date (if applicable):		
3. Reason(s):		Experience
		Trend
		New Product
		New Benefits
		Benefit Change(s)
		Regulation or Law Changes
		Federal
		State
		Other (Please describe):
4. Requested Rate Action (Enter the percentage for each factor changing):		Base Rate Change
		Trend
		Benefit Factor Change
		Area Factor Change
		Other (Please describe):
5. Overall Rate Action:		Average Total Change
		Minimum
		Maximum
6. Marketing Method(s):		Agency / Producer
		Direct Response
		Internet
		Other (Please describe):
7. Marketing Type(s)		Individual
		Large Group
		Small Group
8. Premium Classification(s):		Age
		Benefit

		Family Composition	
		Gender	
		Geographic Area	
		Group Size	
		Modal	
		Participation	
		Tobacco	
		Underwriting Class	
		Preferred	
		Standard	
		Other (Please describe):	
		Other (Please describe):	
		Other (Please describe):	
9. Product Description(s):		Provide a narrative describing the benefits.	
10. Policy/Rider or Contract Impacted:		Complete the form schedule tab with all applicable policy, riders and/or contract forms affected.	
11. Age Basis:		Attained Age	
		Component / Community Age	
		Issue Age	
		Not Utilized	
		Other (Please describe):	
12 Renewability Provision:		Guaranteed	
		Option to Renew	
		Cancellable	
		Non-Cancellable	
		Non-Renewable	
		Other (Please describe):	
13 Rate Change Distribution			

Rate Increase	Distribution Percentage	Members
< 0%		
0 - 4%		
4 - 8%		
8 - 12%		
12 - 16%		
16 - 20%		
> 20%		

APPENDIX C: UNDERWRITING

UNDERWRITING		
Underwriting Method		Explanation
	Yes / No Questions	If explanation is needed, provide in the narrative.
	Accept / Reject	
	Limited (Provide explanation)	
	Partial (Provide explanation)	
	Full	
	Other (Provide explanation)	

APPENDIX D: RATE HISTORY

RATE HISTORY					
Provide rate changes made in at least the last three (3) approved filings (If available)					
For Medicare supplement and Long-term care rate filings, provide all rate increases over the lifetime of the product in an exhibit labeled as Rate History.					
<input type="checkbox"/> N/A New Filing					
COLORADO					
		% OF CHANGE			
SERFF Tracking Number	Effective Date	Minimum	Average	Maximum	Cumulative for past 12 Months
NATIONWIDE					
Effective Date	Average % of change	Cumulative for past 12 Months			
Additional Information:					

APPENDIX E: RELATION OF BENEFITS TO PREMIUM

RELATION OF BENEFITS TO PREMIUM	
Description	Percentage
Commissions	
General Expenses	
Premium Taxes	
Pre-Tax Profit/Contingencies	
Investment Income	
Guaranteed Fund	
Other – (Please specify)	
Total Retention	0.00%
Targeted Loss Ratio	100.00%

APPENDIX F: PROFIT AND CONTINGENCIES

PROVISION FOR PROFIT AND CONTINGENCIES	
(1) Pre-Tax Provision for Profit and Contingencies	
(2) Investment Income (expressed as a negative number)	
(3) Pre-tax Profit and Contingencies, including Investment Income (3) = (1) + (2)	0.00%
(4) Federal Income Tax	
(5) Post-Tax Provision for Profit and Contingencies:	

APPENDIX G1: TREND

TREND	
	Not Applicable
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)	0.00%
PHARMACEUTICAL TREND	
(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)	0.00%
TOTAL AVERAGE ANNUALIZED TREND (1F) and (2F) weighted proportionately by the mix of carrier's business	

APPENDIX G2: MONTHLY HISTORICAL TREND

In this Model, the carrier will only be asked to enter data shown in Blue (found on the fillable template in SERFF). The other cells are all calculated as part of the state's evaluation model.

Step 1: Enter your member and claim Information for the most recent 4 years. If your plan has less than 4 years of data, 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:

MM/YY

Row#	Month	Members	Medical		Pharmacy		Medical	Pharmacy	Total
			Total	Estimated	Total	Estimated	12-Month	12-Month	12-Month
			Incurred Claims	IBNR Claims	Incurred Claims	IBNR Claims	PMPM Trend	PMPM Trend	PMPM Trend
1	MM/YY								
2	MM/YY								
3	MM/YY								
4	MM/YY								
5	MM/YY								
6	MM/YY								
7	MM/YY								

8	MM/YY								
9	MM/YY								
10	MM/YY								
11	MM/YY								
12	MM/YY								
13	MM/YY								
14	MM/YY								
15	MM/YY								
16	MM/YY								
17	MM/YY								
18	MM/YY								
19	MM/YY								
20	MM/YY								
21	MM/YY								
22	MM/YY								
23	MM/YY								
24	MM/YY								
25	MM/YY								
26	MM/YY								

27	MM/YY								
28	MM/YY								
29	MM/YY								
30	MM/YY								
31	MM/YY								
32	MM/YY								
33	MM/YY								
34	MM/YY								
35	MM/YY								
36	MM/YY								
37	MM/YY								
38	MM/YY								
39	MM/YY								
40	MM/YY								
41	MM/YY								
42	MM/YY								
43	MM/YY								
44	MM/YY								
45	MM/YY								

46	MM/YY								
47	MM/YY								
48	MM/YY								

			Medical		Pharmacy		One Year Trends		
Start Month	End Month	Member Months	Total Incurred Claims	Estimated IBNR Claims	Total Incurred Claims	Estimated IBNR Claims	Medical Trend	Pharmacy Trend	Total Trend
MM/YY	MM/YY	0	0	0	0	0			
MM/YY	MM/YY	0	0	0	0	0			
MM/YY	MM/YY	0	0	0	0	0			
MM/YY	MM/YY	0	0	0	0	0			

APPENDIX H: CREDIBILITY

Credibility (Note: This appendix does not apply to Long-term care products.) (Note: If the carrier is using experience other than their own for this rate filing, explain what experience or data source was utilized.)			
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	0%		
Other Experience Credibility Weighting Assigned	0%		
2. Number of years of data used to calculate above credibility percentage:	<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Years	<input type="checkbox"/> 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 I: EXPERIENCE

EXPERIENCE							
<p>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.</p> <p>Note: Experience for Long-term care products require more detail as required in Colorado Insurance Regulation 4-4-1. For Medicare Supplement, the full lifetime of experience for the product shall be provided. The additional experience data for these two products shall be provided in an exhibit which is labeled Experience.</p>							
COLORADO EXPERIENCE							
Experience is for:	<input type="checkbox"/> Existing Product		<input type="checkbox"/> Comparable Product		<input type="checkbox"/> 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							
<p>*This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY</p>							

COLORADO EXPERIENCE PERIOD							
Date		Earned Premium	Incurred Claims	Estimated IBNR Claims	Total Estimated Incurred Claims	Loss Ratio	Paid Through Date
From	To						
Blocks of Business Included in Experience:							

OTHER EXPERIENCE						
Experience is for:	<input type="checkbox"/> Existing Product	<input type="checkbox"/> Comparable Product	<input type="checkbox"/> National	<input type="checkbox"/> Other	(Check all that apply)	
Year	Earned Premium	Incurred Claims	Total Estimated IBNR Claims	Total Estimated Incurred Claims	Average Covered Lives	Number of Claims
20xx						
20xx						
20xx						
20xx						
Experience Period:	From:		To:			
Additional Information:						

APPENDIX J: SIDE-BY-SIDE COMPARISON

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.			<input type="checkbox"/> N/A New Product
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 K: BENEFITS RATIO PROJECTIONS

PROJECTED EXPERIENCE FOR RATING PERIOD			
	Premiums	Incurred Claims	Benefits Ratio
Projected Experience Without Rate Change			
Projected Experience With Rate Change			
Additional Information			

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

APPENDIX L: KEY ASSUMPTION LONG-TERM CARE TABLE

Key Assumption	As of Original Pricing	As of Most Recent Rate Increase	Experience Used to Justify Current Assumptions	Current Assumptions for Projected Premiums and Claims	Portion of Cumulative Increase Attribution*	If-Known Attribution**
Mortality						
Voluntary Lapse						
Shock Lapse (from rate increase)						
Morbidity						
Shock Morbidity (from rate increase)						
Interest Earnings						
				Cumulative Rate Increase		
*Portion of Cumulative Increase Attribution = Portion of the cumulative rate increases, including the request in this filing, associated with the change in this assumption since original pricing.						

APPENDIX M1: LONG-TERM CARE PROPOSED RATE CHANGE BY STATE

LTC PROPOSED RATE CHANGE									
CURRENT INCREASE									
Provide a listing by state for the current increases requested on all inforce business under the policy. History shall be specific to the Policy or Policies identified in the filing.								NATIONWIDE	COLORADO
POLICY #						AVERAGE ISSUE AGE			
						AVERAGE ATTAINED AGE			
						POLICYHOLDERS ON CLAIM			
STATE A-Z	AVERAGE % INCREASE REQUESTED	AVERAGE % INCREASE RECEIVED / STATUS	RANGE MAX / MIN	AVERAGE PREMIUM BEFORE INCREASE	AVERAGE PREMIUM AFTER INCREASE	TOTAL ANNUAL PREMIUM	NUMBER OF POLICY-HOLDERS	% OF POLICY-HOLDERS WITH LIFETIME BENEFITS	NOTES
AK									
AL									
AR									
AZ									

CA									
CO									
CT									
DC									
DE									
FL									
GA									
HI									
IA									
ID									
IL									
IN									
KS									
KY									
LA									
MA									
MD									
ME									
MI									

MN									
MO									
MS									
MT									
NC									
ND									
NE									
NH									
NJ									
NM									
NV									
NY									
OH									
OK									
OR									
PA									
RI									
SC									
SD									

TN									
TX									
UT									
VA									
VT									
WA									
WI									
WV									
WY									
TOTAL									

APPENDIX M2: LONG-TERM CARE RATE INCREASE HISTORY BY POLICY AND STATE SINCE INCEPTION

Provide a listing by State of all Prior Increase Requests, Receipts, Effective Date, Amounts and Status. History shall be specific to the Policy or Policies identified in the filing.							
Policy #							
STATE A-Z	DATE OF INCEPTION	DATE 1 ST INCREASE REQUESTED	AVERAGE % REQUESTED	AVERAGE % RECEIVED	DATE 2ND INCREASE REQUESTED	AVERAGE % REQUESTED	AVERAGE % RECEIVED
AK							
AL							
AR							
AZ							
CA							
CO							
CT							
DC							
DE							
FL							
GA							
HI							
IA							

ID							
IL							
IN							
KS							
KY							
LA							
MA							
MD							
ME							
MI							
MN							
MO							
MS							
MT							
NC							
ND							
NE							
NH							
NJ							
NM							
NV							
NY							
OH							
OK							
OR							

PA							
RI							
SC							
SD							
TN							
TX							
UT							
VA							
VT							
WA							
WI							
WV							
WY							
TOTAL							

STATE A-Z	DATE OF INCEPTION	DATE 3RD INCREASE REQUESTED	AVERAGE % REQUESTED	AVERAGE % RECEIVED	DATE 4TH INCREASE REQUESTED	AVERAGE % REQUESTED	AVERAGE % RECEIVED
AK							
AL							
AR							
AZ							
CA							
CO							
CT							

DC							
DE							
FL							
GA							
HI							
IA							
ID							
IL							
IN							
KS							
KY							
LA							
MA							
MD							
ME							
MI							
MN							
MO							
MS							
MT							
NC							
ND							
NE							
NH							
NJ							

NM							
NV							
NY							
OH							
OK							
OR							
PA							
RI							
SC							
SD							
TN							
TX							
UT							
VA							
VT							
WA							
WI							
WV							
WY							
TOTAL							

STATE A-Z	DATE OF INCEPTION	DATE 5TH INCREASE REQUESTED	AVERAGE % REQUESTED	AVERAGE % RECEIVED	DATE 6TH INCREASE REQUESTED	AVERAGE % REQUESTED	AVERAGE % RECEIVED
AK							
AL							

AR							
AZ							
CA							
CO							
CT							
DC							
DE							
FL							
GA							
HI							
IA							
ID							
IL							
IN							
KS							
KY							
LA							
MA							
MD							
ME							
MI							
MN							
MO							
MS							
MT							

NC							
ND							
NE							
NH							
NJ							
NM							
NV							
NY							
OH							
OK							
OR							
PA							
RI							
SC							
SD							
TN							
TX							
UT							
VA							
VT							
WA							
WI							
WV							
WY							
TOTAL							

STATE A-Z	DATE OF INCEPTION	DATE 7TH INCREASE REQUESTED	AVERAGE % REQUESTED	AVERAGE % RECEIVED	CUMULATIVE % APPROVED
AK					
AL					
AR					
AZ					
CA					
CO					
CT					
DC					
DE					
FL					
GA					
HI					
IA					
ID					
IL					
IN					
KS					
KY					
LA					
MA					
MD					

ME					
MI					
MN					
MO					
MS					
MT					
NC					
ND					
NE					
NH					
NJ					
NM					
NV					
NY					
OH					
OK					
OR					
PA					
RI					
SC					
SD					
TN					
TX					
UT					
VA					

VT					
WA					
WI					
WV					
WY					
TOTAL					

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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 of 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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Compliance Requirements
Section 6	Form and Manner of Notices
Section 7	Standard Utilization Review
Section 8	Expedited Utilization Review
Section 9	Emergency Services
Section 10	Peer-to-Peer Conversation
Section 11	First Level Review
Section 12	General Requirements for First Level and Voluntary Second Level Review Meetings
Section 13	Expedited Review of an Adverse Determination
Section 14	Rescission and Initial Eligibility Determinations
Section 15	Severability
Section 16	Enforcement
Section 17	Effective Date
Section 18	History

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" means, 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.

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- AA. "Retrospective review" means, 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 physician 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 physician 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 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:

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- (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 deemed not 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 deem 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/or 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 deemed not 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 deem 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 or 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. The physician and 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 August 1, 2020.

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.

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Incorporated Materials
Section 8	Enforcement
Section 9	Effective Date
Section 10	History
Appendix A	Colorado Supplement to the Summary of Benefits and Coverage Form
Appendix B	Instructions for Completing 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 excludes certain limited benefit plans, credit, health policies, preneed funeral contracts, excess loss insurance forms, and sickness and accident insurance other than health benefit plans.

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. “Glossary” means, for the purposes of this regulation, the form required by the ACA as described in the final rule published on June 16, 2015 in Volume 80, No. 115 of the Federal Register (80 FR 34292), Summary of Benefits and Coverage and Uniform Glossary).
- D. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

- E. "Summary of Benefits and Coverage" or "SBC" means, for the purposes of this regulation, the form required by the ACA as described in the final rule published on June 16, 2015 in Volume 80, No. 115 of the Federal Register (80 FR 34292).

Section 5 Rules

- A. All carriers offering or providing health benefit plan coverage shall make available to a producer or consumer through electronic means or paper copy, a Summary of Benefits and Coverage form, and a completed copy of the COSSBC Form shown 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 April 2017 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 in Appendix A. 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 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), C.R.S., in completing the form, carriers shall not misrepresent the benefits, advantages, conditions, or terms of the policy.
- E. Carriers shall provide a SBC form and a COSSBC form that is specific with respect to the particular policy provisions of the policy or contract within seven (7) business days of a potential policyholder 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. Along with a SBC form and a COSSBC form, 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 individual, employee and/or dependent no later than the first day of coverage.

5. The notices, forms and information required in Section 5 D 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. Or if the policy has not been issued or renewed before such 30-day period, 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 required forms 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.
 3. The carrier shall maintain documentation that the requirements of Section 5.A. have been met.
- G. A carrier shall develop a separate SBC form and COSSBC form for each of its health benefit plans.
- 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.H.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 with service areas which include a county where ten percent (10%) or more of the population are only literate in the same non-English language 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 the non-English language, in a conspicuously-visible font size, an offer to provide, upon request, a fully-translated version of these notices in the non-English language and which clearly indicates how to access the alternate language services provided by the carrier; and
 2. Once a request has been made by an individual, provide all subsequent forms to the policyholder in the non-English language.

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

Volume 80, No. 115 of the Federal Register (80 FR 34292) published by the United States Government Printing Office shall mean Volume 80, No. 115 of the Federal Register (80 FR 34292) as published on the effective date of this regulation and does not include later amendments to or editions of Volume 80, No. 115 of the Federal Register (80 FR 34292). A copy of Volume 80, No. 115 of the Federal Register (80 FR 34292) 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.gpo.gov/fdsys/pkg/FR-2015-06-16/pdf/2015-14559.pdf>. A certified copy of Volume 80, No. 115 of the Federal Register (80 FR 34292) may be requested from the Colorado Division of Insurance for a fee.

The April 2017 edition of the Summary of Benefits and Coverage template published by the United States Department of Labor shall mean the April 2017 edition of the Summary of Benefits and Coverage template as published on the effective date of this regulation and does not include later amendments to or editions of the April 2017 edition of the Summary of Benefits and Coverage template. A copy of the April 2017 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.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits>. A certified copy of the April 2017 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 March 15, 2017.

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.

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	<p>[EMBEDDED DEDUCTIBLE</p> <p>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.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.</p> <p>AGGREGATE DEDUCTIBLE</p> <p>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.</p> <p>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.]</p>

<p>5. Out-of-Pocket Maximum</p>	<p>[(EMBEDDED OUT-OF-POCKET)</p> <p>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.</p> <p>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.]</p> <p>[(AGGREGATE OUT-OF-POCKET)</p> <p>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%.</p> <p>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.]</p>
<p>6. What is included in the In-Network Out-of-Pocket Maximum?</p>	<p>[Place the major categories that are subject to the network out-of-pocket here]</p>
<p>7. Is pediatric dental covered by this plan?</p>	<p>[Yes, pediatric dental is subject to the medical deductible and out-of-pocket]</p> <p>[Yes, pediatric dental is subject to a separate \$X deductible and \$X/ individual or \$X/ family out-of-pocket]</p> <p>[Yes, pediatric dental is covered at 100% of allowable charges.]</p> <p>[No, the plan does not include pediatric dental]</p>
<p>8. What cancer screenings are covered?</p>	

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
8. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?		
9. 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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Notice and Disclosure of Right to External Review
Section 6	Request for External Review
Section 7	Exhaustion of Internal Appeal Process
Section 8	Standard External Review
Section 9	Expedited External Review
Section 10	Binding Nature of External Review Decisions
Section 11	Approval of Independent External Review Entities
Section 12	Minimum Qualifications for Independent External Review Entities
Section 13	External Review Record Requirements
Section 14	Funding of External Review
Section 15	Severability
Section 16	Enforcement
Section 17	Effective Date
Section 18	History

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 health 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.

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- 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.

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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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History
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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Additional Information
Section 7	Severability
Section 8	Incorporated Materials
Section 9	Enforcement
Section 10	Effective Date
Section 11	History

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 AND PEDIATRIC STAND ALONE DENTAL
PLANS COMPLIANT WITH THE AFFORDABLE CARE ACT**

Section 1	Authority
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Appendix A	Cover Letter Template
Appendix B	HIOS Plan ID Listing
Appendix C	Side – by – Side Comparison
Appendix D	Individual Policyholder Letter Template
Appendix E	Small Group Policyholder Letter Template

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 10-16-105.1(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., and to pediatric stand alone dental plans.

Section 3 Applicability

This regulation applies to all carriers seeking to make reasonable modifications to any individual or small group health benefit plan and/or a pediatric stand alone dental plan compliant with the Affordable Care Act.

Section 4 Definitions

- A. “Carrier” means, for the purposes of this regulation, a carrier as defined in § 10-16-102(8), C.R.S.
- B. “Pediatric stand alone dental plans” means, for the purposes of this regulation, a plan that provides the required pediatric dental benefits as a part of the Essential Health Benefits (EHB) package, separate from the medical plan.
- 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. “PPACA” 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.

- E. "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.
- F. "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 do not necessitate the filing of a new plan.
- G. "SERFF" means, for the purposes of this regulation, System for Electronic Rate and Form Filings.

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.
 - 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 Regulation 4-2-51.
 - B. Pediatric Stand Alone Dental Plans
 - 1. Federal or State Requirement Changes
 - a. A carrier may reasonably modify the benefits of a plan in accordance with a change to 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 modification must be applied uniformly to all individuals and small groups covered by the plan and must meet all of the following criteria:
 - (1) The plan is offered by the same dental insurance 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; and
 - (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.
 - 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) Actuarial Value change from high to low;
 - (2) Actuarial Value change from low to high; or
 - (3) Removing a benefit.
 - d. If a carrier is changing a service area, or discontinuing plans in certain areas, a discontinuance filing must be submitted to the Division via SERFF.
- C. 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 at a date to be specified by the Division through instructions published annually;
 - 2. The proposed reasonable modification request for pediatric stand alone dental plans must be submitted at a date to be specified by the Division through instructions published annually.
 - 3. 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. Required Documentation
 - 1. 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:
 - a. The market type of the plan (i.e. individual or small group), and whether it is a medical plan or a dental plan;
 - b. The grandfathered or non-grandfathered status of the plan;

- c. The effective date;
 - d. The total number of Colorado groups and members affected; and
 - e. The reason the plan(s) is/are being modified.
- 2. 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:
 - a. The first column must contain the HIOS plan ID;
 - b. The second column must contain the plan marketing name;
 - c. The third column must contain the form number; and
 - d. The fourth column must contain the status of the HIOS plan ID, using only one of the following terms:
 - (1) "Modifying";
 - (2) "Continuing without Modification"; or
 - (3) "Discontinuing".
 - e. 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.
 - f. Plans identified as being continued without modifications or discontinued must not be modified.
- 3. 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:
 - a. HIOS Plan ID;
 - b. Plan Name;
 - c. Form Number;
 - d. Current Benefit;
 - e. Proposed Benefit;
 - f. Benefit Impact to AV
 - g. Total Actuarial Value before the Changes;
 - h. Total Actuarial Value after the Changes;
 - i. Total Rate Impact of all Modified Benefits; and
 - j. Comments (Optional).

4. Policyholder notifications must include the following:
 - a. The template for the letter that must be sent to individual policyholders is contained in Appendix D of this regulation. The template for the letter that must be sent to small group policyholders is contained in Appendix E of this regulation. Carriers must not alter the sections of the letter but may modify language with Division approval.
 - b. A side-by-side comparison concerning only the modified benefits which must contain:
 - (1) A first column identifying the "Benefit Name";
 - (2) A second column identifying the "Current Benefit"; and
 - (3) A third column identifying the "New Benefit".
 - c. The required notification must include the various options available to the policyholder, which include:
 - (1) Continuing the current plan;
 - (2) Purchasing another plan with the same carrier;
 - (3) Purchasing a new plan with another carrier; and
 - (4) Purchasing a new plan through Connect for Health Colorado.
 - d. The required notification must be sent 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.
5. 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. Carriers are not permitted to auto-enroll a policyholder in another plan offered either by the same carrier or an associated carrier.
6. 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 15, 2017.

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.

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] [ACA-Compliant Pediatric Dental] 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]	<u>[-.14]</u>	[81.39]	[80.98]	[-3.1%]	[Applicable comments]
[12345CO00100009]	[Sample Plan]	[CO16]	[In-Network Deductible]	[\$6500.00]	[\$6850.00]	<u>[+.24]</u>				[Applicable comments]
[12345CO00100009]	[Sample Plan]	[CO16]	[In-Network Out-of-Pocket]	[\$6850.00]	[\$7150.00]	<u>[-.51]</u>				[Applicable comments]

Appendix D: Individual Policyholder Letter Template

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. If you want to keep your plan, you don't have to do anything. Your plan will automatically be renewed on January 1st and you just have to pay the new monthly premium.

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 a Health Coverage Guide.

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]

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 Children's Health Insurance Program (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 en Español, llame al [Carrier Contact Information.]

Thank you,
[Carrier Logo]

Appendix E: Small Group Policyholder Letter Template

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 don't have to do anything. Your plan will automatically renewed on [Renewal Date] and you just have to pay the new monthly premium. You should review the changes being made to this group policy to determine if you want to renew it 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]

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 plan 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]

Regulation 4-2-28 CONCERNING THE PAYMENT OF EARLY INTERVENTION SERVICES FOR ELIGIBLE CHILDREN

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Incorporated Materials
Section 8	Enforcement
Section 9	Effective Date
Section 10	History
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**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

Section 1 Authority

This regulation is being promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-16-135, 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 a health benefit plan identification cards, pursuant to § 10-16-135, 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.

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. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- D. "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.
- E. "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.
- F. "Short-term limited duration health insurance policy" shall have the same meaning as found at § 10-16-102(60), C.R.S.

Section 5 Rules

- A. The requirements of this regulation shall apply to identification cards issued to persons covered under health benefit plans. These requirements do not apply to identification cards issued to persons covered by limited benefit health coverage.

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- 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. Cards issued in connection with coverage provided by short-term limited duration health insurance policies do not have to 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 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 non-specific amount notation of “Deductible and coinsurance” is sufficient; otherwise, the required copayments must be specified. If both a deductible and copayment apply, a non-specific amount notation of “Deductible” 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” for any and all health benefit plans regulated in whole or in part by the State of Colorado’s Division of Insurance. This designation must be placed on the card in a clear and conspicuous manner.
- E. 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) for member/customer service;
 - c. Website address;

- d. 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
 - e. 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. "Card issued" date, which must be displayed in a clear and conspicuous manner.
- F. The card may include other information at the carrier's discretion.
- G. 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.
- H. 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 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 September 1, 2017.

Section 9 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

**Regulation 4-2-30 CONCERNING THE RULES FOR COMPLYING WITH MANDATED
COVERAGE OF HEARING AIDS AND PROSTHETICS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Hospital Reimbursement Rate Record Retention and Report
Section 6	Annual Cost Report
Section 7	Annual Excess Loss Report
Section 8	Incorporated Materials
Section 9	Severability
Section 10	Enforcement
Section 11	Effective Date
Section 12	History

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-109, 10-16-111(4), 10-16-119(3) and 10-16-134, 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. This includes, but is not limited to carriers operating with the following types of business: comprehensive health insurance, Health Maintenance Organization (HMO) coverage (pursuant to §§ 10-16-119 and 10-16-119.5, C.R.S.).

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.

C. Annual Excess Loss Report

The following types of business are waived: Comprehensive health insurance, Health Maintenance Organization (HMO) coverage, supplemental health, limited service licensed provider network business, long-term care, disability income, accident-only, specified or dread disease, hospital indemnity, vision only, dental only, other limited-medical payment plans, and Medicare supplement insurance.

Section 4 Definitions

- A. "Average reimbursement rate" means, for the purposes of this regulation, is 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. "Diagnostic-Related Group" and "Diagnosis-Related Group" means, for purposes of this regulation, the classification assigned to an inpatient hospital service claim based on the patient's age and sex, the principal and secondary diagnoses, the procedures performed, and the discharge status.
- D. "Dividends" means, for purposes of this regulation, both policyholder and stockholder dividends.
- E. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.
- F. 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.
- G. "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.
- H. "Reimbursement rate" means, for the purposes of this regulation, the amount, by MS-DRG code, that a carrier paid for a procedure at a facility or hospital, plus any expected deductible, copayment, and/or coinsurance. It is important that only the entire hospital/facility reimbursement be included in this rate, not just the carrier's portion. Provider reimbursement charges should be excluded from this total. Private room, personal item and other charges that are generally the responsibility of the policyholder should also be excluded.
- I. "Trend," means, for the purposes of this regulation, the rate of increase in costs for the reporting period.
- J. "Excess loss" means, for the purposes of this regulation, individual or group policies providing coverage to a carrier, a self-insured employer plan, or a medical provider providing coverage to insure against the risk that any one claim or an entire plan's losses will exceed a specified dollar amount.

Section 5 Hospital Reimbursement Rate Record Retention and Report

- A. The Division will annually publish on its website or communicate directly to carriers the list of MS-DRG codes associated with the twenty-five (25) most common inpatient procedures performed in Colorado for the previous reporting year. This will include more than twenty-five (25) MS-DRG codes, as there are multiple codes for different levels of severity in many of the identified procedures.
- B. Pursuant to the Health Care Transparency Act, § 10-16-134, C.R.S., each carrier shall report to the Division the average reimbursement rates and number of procedures on a statewide basis for the twenty-five (25) most common inpatient procedures performed in Colorado at hospitals/facilities reporting to the Colorado Hospital Association. This information shall be filed electronically using the Division of Insurance website in a format made available by the Division.
- C. Timing and Submission: The required data shall be filed on or before March 1 of each year. Pursuant to § 10-3-109(2)(a), C.R.S., failure to file this report by March 1 may result in a late penalty not to exceed \$100 per day and any applicable surcharges. Reports not containing all of the information specified in this section may be subject to the assessment of a penalty for an incomplete report.
- D. Each entity subject to the Health Care Transparency Act shall:
 - 1. Maintain its books, records, and documents in a manner that ensures the necessary data can be readily ascertained and reported to the Division.
 - 2. Format records for each Diagnostic-Related Group to be recorded and classified using the MS-DRG coding format and procedures at the time of discharge.
 - 3. Ensure that reimbursement/claim records shall:
 - a. Be maintained to clearly identify the MS-DRG code assigned and reimbursement rate of each procedure;
 - b. Be sufficiently clear and specific so that the pertinent dates, locations, cases and charges of these events can be reconstructed; and
 - c. Include and, if necessary, calculate the complete reimbursement rate, hospital/facility, and MS-DRG Code for each inpatient procedure.

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 and must contain the information specified in subsection C. 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. Pursuant to § 10-3-109(2)(a), C.R.S., failure to file this report by June 1 will result in a late penalty not to exceed \$100 per day. Reports not containing complete and accurate information specified in subsection C. of this section may be subject to the assessment of a penalty for an incomplete report.
- C. Annual Cost Reports filed by carriers identified in Section 3 must contain, where applicable, all of the information in this subsection. For every carrier the report shall include the following information from the previous calendar year unless a specified date is included.

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/certificateholders/policyholders as of 12-31 in the previous reporting calendar year;
 - d. Number of Colorado individual Subscribers/certificateholders/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. 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. 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. Executive salaries as reported on the carriers Supplemental Compensation Exhibit of the annual financial statement are to be reported. 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.a. 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 Annual Excess Loss Report

- A. Pursuant to § 10-16-119(3), C.R.S., carriers subject to this regulation shall file an Annual Excess Loss Report as described in this section for each calendar year through 2018. This report must comply with the requirements of this section and must contain the information specified in subsection C. of this section and shall be filed electronically via a form provided on the Division of Insurance website, www.dora.colorado.gov/insurance.
- B. Timing and Submission: All Annual Excess Loss Reports shall be filed electronically in a format made available by the Division of Insurance via the Division's website on or before March 1 of each year. Pursuant to § 10-3-109(2)(a), C.R.S., failure to file this report by March 1 will result in a late penalty not to exceed \$100 per day. Reports not containing complete and accurate information specified in subsection C. of this section may be subject to the assessment of a penalty for an incomplete report.
- C. Annual Excess Loss Reports filed by carriers identified in Section 3 must contain, where applicable, all of the information required by this subsection. For every carrier the report shall include the following information from the previous calendar year.
 - 1. The information required in this report identified in paragraph 2 of this subsection must be categorized by the number of full-time equivalent employees: 10 or fewer, 11-25, 26-50, and 51-100.
 - 2. The following information referred to below is to be reported for the groups specified in paragraph 1 of this subsection:
 - a. The total number of groups;
 - b. The average group size;
 - c. The number of lives covered in Colorado;
 - d. The mean and median attachment points; and
 - e. The source of prior coverage for the groups including:
 - (1) Employers previously self-insured with excess loss coverage;
 - (2) Employers previously self-insured without excess loss coverage;

- (3) Employers previously not offering coverage;
 - (4) Groups previously fully insured outside the Exchange; and
 - (5) Groups previously fully insured inside the Exchange.
3. The smallest group size covered and the carrier's minimum group size requirements.

Section 8 Incorporated Materials

FY 2017 Final Rule Tables, Table 5 published by the Centers for Medicare & Medicaid Services organization shall mean FY 2017 Final Rule Tables, Table 5 as published on the effective date of this regulation and does not include later amendments to or editions of FY 2017 Final Rule Tables, Table 5. A copy of FY 2017 Final Rule Tables, Table 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 Centers for Medicare & Medicaid Services website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html>. A certified copy of FY 2017 Final Rule Tables, Table 5 may be requested from the Colorado Division of Insurance for a fee.

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 March 15, 2017.

Section 12 History

New Regulation 4-2-31, Effective January 1, 2010.
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.

**Regulation 4-2-32 STANDARDIZED ELECTRONIC IDENTIFICATION AND COMMUNICATION
SYSTEMS GUIDELINES FOR HEALTH BENEFIT PLANS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Incorporated Materials
Section 8	Enforcement
Section 9	Effective Date
Section 10	History

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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 policies, 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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Protected Health Information
Section 7	Severability
Section 8	Enforcement
Section 9	Effective Date
Section 10	History

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History
Appendix A	Required Questions
Appendix B	Form of Affidavit

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	General Rate Filing Requirements
Section 6	Actuarial Memorandum
Section 7	Premium Rate Setting for Individual and Small Group Health Benefit Plans
Section 8	Rate Filings and Actuarial Certification
Section 9	Additional Requirements for Large Group Health Benefit Plans
Section 10	Prohibited Rating Practices
Section 11	Use of Composite Rates in the Small Group Market
Section 12	Severability
Section 13	Incorporated Materials
Section 14	Enforcement
Section 15	Effective Date
Section 16	History
Appendix A	Rate Filing Requirements for Non-Grandfathered Individual and Small Group Health Benefit Plans
Appendix B	Sample Rate Table
Appendix C	Summary
Appendix D	Rate History
Appendix E	Relationship of Benefits to Premium
Appendix F	Federal Medical Loss Ratio (MLR)
Appendix G	Profit and Contingencies
Appendix H1	Trend
Appendix H2	Monthly Historical Trend
Appendix H3	Monthly Normalized Trend
Appendix I	Credibility
Appendix J	Experience
Appendix K	Side-by-Side Comparison
Appendix L	Projected Experience for Rating Period

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-104.9, 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. This regulation replaces Colorado Insurance Emergency Regulation 18-E-01 that became effective on June 13, 2018 in its entirety.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing non-grandfathered individual, small group, and/or large group health benefit plans on or after the effective date of this regulation; health benefit plans subject to the individual, small group, and large group 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.

Section 4 Definitions

- A. "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.
- B. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- C. "Catastrophic plan" shall have the same meaning as found at § 10-16-102(10), C.R.S.
- D. "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.
- E. "Covered lives" mean, for the purposes of this regulation, the number of members, subscribers and dependents.
- F. "Dividends" mean, for the purposes of this regulation, both policyholder and stockholder dividends.
- G. "Essential health benefit" and "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.
- H. "Essential health benefits package" and "EHB package" shall have the same meaning as found at § 10-16-102(23), C.R.S.
- I. "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 additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.
- J. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.
- K. "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%.
- L. "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 implementation or effective date specified in the rate filing. Carriers may bill members but not require the member to remit premium prior to the proposed implementation or effective date of the rate change.
- M. "Filing date" means, for the purposes of this regulation, the day after the rate filing is received at the Division.

- N. "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. (See Section 7.A.3. of this regulation.)
- O. "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.
- P. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.
- Q. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- R. "Implementation 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.
- S. "Index rate" shall have the same meaning as found at § 10-16-102(39), C.R.S.
- T. "Inadequate rates" mean, 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 additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.
- U. "Valid Multistate associations" shall have the same meaning as found at § 10-16-102(68), C.R.S.
- V. "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. 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.
- W. "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.
- X. "PPACA" 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.
- Y. "Premium" shall have the same meaning as found at § 10-16-102(51), C.R.S.
- Z. "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.
- AA. "Prior 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.

- AB. "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.
- AC. "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.
- AD. "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. Rates for all health benefit plans and pediatric dental plans must be filed with the Division.
- AE. "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 must be submitted. Support for all changes in existing rates, factors and assumptions must be provided, including the continued use of previously filed trend factors. Support for new product offerings must 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 must be provided, including the continued use of previously filed trend factors. Support for new product offerings must be provided. Groups must meet the definition contained in §§ 10-16-214(1) and 10-16-215, C.R.S.
- AF. "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.
- AG. "Rating period" shall have the same meaning as found at § 10-16-102(58), C.R.S.
- AH. "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.
- AI. "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.
- AJ. "SERFF" means, for the purposes of this regulation, System for Electronic Rates and Forms Filing.

- AK. "Silver plan variation" means, for the purposes of this regulation, the three (3) silver plan variations that must be submitted to the Division for review to ensure compliance with § 45 CFR 156.420(a).
- AL. "Student health insurance coverage" shall have the same meaning as found at § 10-16-102(65), C.R.S.
- AM. "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 costsharing 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.
- AN. "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.
- AO. "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 must be submitted on an annual basis to support the continued use of trend factors. Underwriting wear-off does not apply to guaranteed issue products.
- AP. "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.
- AQ. "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 must be filed with the Division and forms, as required by § 10-16-107.2, C.R.S., must 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

All rates associated with health benefit plans and other evidence of health coverage associated with health benefit plans and stand-alone pediatric dental plans must be filed with the Division prior to issuance or delivery of coverage. All rate filings must be submitted electronically by licensed entities. Failure to supply the information required in Sections 5, 6, 7, 8 and 9 of this regulation will render the filing incomplete. Incomplete filings are not reviewed for substantive content. 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 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, other than as allowed by § 10-16-216.5, C.R.S. 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 for health benefit plans or a rate increase of 5% or more annually for dental insurance 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, use of the rates by the carrier for new business and upon renewal for existing business may occur 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 using the rates before the proposed implementation date will be considered as using unfiled rates and the Division will take appropriate action as allowed by Colorado law.
 - c. After the rate filing has been approved by the Commissioner, carriers may bill policyholders, but not require the policyholder to remit premium prior to the proposed implementation date of the approved 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 use the rates as of the implementation date in the filing.
2. Existing law defines a rate increase as any increase in the current rate. This, for purposes of this regulation, includes an increase in any base rate, or any rating factor, or continued use of trend used to calculate premium rates which 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 and would be considered a prior approval filing. Rate increases as applied to “new business only” are also subject to prior approval.

To determine prior approval, calculations must reflect both the 12-month cumulative impact of trend and any changes to rating factors or base rates. Calculations must not reflect a particular policyholder’s movement within each rating table (i.e., change in family status, move to a new geographic area, etc.). Trend does not renew automatically and must be filed annually. Any continued use of any trend for more than twelve (12) months is subject to prior approval.

The Commissioner may require submission of any relevant information deemed 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, other than as allowed by § 10-16-216.5, C.R.S., 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 5, 6, 7, 8, 9 and 10 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;
 - d. The rate filing is incomplete; or
 - e. The data in the filing fails to adequately support the proposed rates.
3. File and Use: Any rate filing not specified in Section 5.A.1. 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. Rates for all health benefit plans must be filed with the Division prior to use. Dental insurance rate changes that are less than 5% are considered file and use filings.

To determine file and use, calculations must 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 new rates, rating factors, or a rate change have been implemented or used without being filed with the Division, corrective actions may be ordered, including, but not limited to, civil penalties, refunds to policyholders, and/or rate credits. Use of unfiled rates may also be deemed excessive. Under no circumstances shall the carrier provide insurance coverage using 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 will take appropriate action as defined by Colorado law. Carriers may bill policyholders but not require the policyholder to 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. New Policy Forms and Products: 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.V. If a policy form is not a new policy form or product, and the rate is increasing, the rate filing will be considered a prior approval filing and the required supporting documentation required by law and this regulation shall be submitted with the filing. In the case of reasonable modifications, pursuant to § 10-16-105.1, C.R.S., if an existing policy form is modified and it is truly not a new policy form or product, the policy form must be in compliance with the provisions of § 10-16-105.1, C.R.S.
5. Required Submissions:
 - a. Rates on all health insurance policies, riders, contracts, endorsements, certificates, and other evidence of health coverage, must be filed with the Division prior to issuance or deliverance of policies, certificates or evidence of coverage.
 - b. All carriers must submit a compliant rate filing whenever the rates charged to new or 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.
 - c. All carriers must submit a compliant rate filing on an annual basis, at minimum, to support the continued use of trend factors, which changes 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 must 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 date on or before the one-year anniversary of the implementation date of the most recent rate filing for that form.
 - d. All carriers must submit compliant rate filings when rates are changed on an existing product, even though the rate change pertains to new business only. Colorado experience data for this existing product must be submitted. If Colorado data is partially credible, nationwide data must also be submitted. Detailed support must be provided for the rate change. Support must also be provided to ensure rates are not discriminatory. Assessing different rates for the same product based on issue dates may violate Colorado law.
 - e. All carriers must submit compliant rate filings within sixty (60) calendar days after Commissioner approval of the assumption or acquisition of a block of business. This rate filing must provide detailed support for the rating factors the assuming or acquiring carrier is proposing to use, even if there is no change in rating factors. The new filing must demonstrate that the rating assumptions are still appropriate.
 - f. Each line of business requires a separate rate filing.
 - g. Rate filings shall not be combined with form filings. Rate filings must be submitted under SERFF Filing Type "RATE", whereas form filings must be submitted under SERFF Filing Type "FORM".

- h. 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 and unfairly discriminatory, and to avoid filing large rate changes
 - i. The Form Schedule tab in SERFF must be completed for all rate and form filings. This tab must list all the forms affected by the rate filing. Actual forms must not be attached to the rate filing.
 - j. The Implementation Date Requested field on the General Information tab in SERFF must be completed with a specific date. "Prior approval" filings must be submitted at least sixty (60) days prior to the requested implementation date. "File and use" filings must have an implementation date that is after the filing date; retroactive dates are not permitted. Incomplete filings shall be rejected prior to the 30th day after the filing date. Rates on rejected, withdrawn or disapproved filings shall not be used or distributed and use of the rates is a violation of Colorado law.
- 6. Withdrawn, Rejected, or Disapproved Filings: Filings that have been withdrawn by the filer, rejected by the Division as incomplete or disapproved as unjustified, which are subsequently resubmitted, shall be considered as new filings. If a filing is withdrawn, rejected, or disapproved, those rates shall not be used or distributed. Nothing in this regulation shall render a rate filing subject to prior approval by the Commissioner which is not otherwise subject to prior approval as provided by Colorado law.
- 7. Submission of Rate Filings: All health benefit plan and stand-alone pediatric dental 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. Electronically submitted rate filings must meet all relevant general requirements and shall include all necessary rate and policy forms. If a filing is rejected as incomplete, those rates shall not be used or distributed.
- 8. Carrier Specific: A separate filing must 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 the experience for a product is combined with a sister company for credibility purposes; specific experience for each carrier must be presented.
- 9. Required Inclusions: Rate filings require the submission of a compliant actuarial memorandum in the format specified in Section 6 of this regulation. A complete response must be provided for each element contained in Section 6. 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 must be accompanied by sufficient information to support the reasonableness of the rate. Valid carrier experience must be used whenever possible. This information may include the carrier's experience and judgment; the experience or data of other carriers or organizations relied upon by the carrier; the interpretation of any statistical data relied upon by the carrier; descriptions of methods used in making the rates; and any other similar information deemed necessary by the carriers. Actual Colorado experience must be submitted for changes to existing products. In addition, the Commissioner may request additional information used by the carrier to support the rate change request.

For medical filings, carriers must provide full rate tables, in both an Excel spreadsheet and a PDF format, for each plan offered (see Rate Table Format exhibit in Appendix B). For each plan, the corresponding rate table created must be provided with one of the following rate table statuses indicated in the table header: Initial Filing – Not Final Approved; Adjusted During Review - Not Final Approved; or Final Approved Table.

10. 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 must be a separate SERFF component for the confidential exhibits, which must be indicated as such by the confidential icon in SERFF. Non-confidential information, such as the actuarial memorandum, must be in a separate SERFF component.
11. 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.
12. Premium rounding and truncation rules must be provided in the rate manual for all rate filings.
13. Rating factors must be calculated and displayed to four (4) decimal points.

B. Actuarial Certification

Each rate filing must 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. Stand-alone dental plans that do not provide pediatric dental coverage as mandated by PPACA must include notification language similar to the following at the time of solicitation:

“This policy DOES NOT include coverage of pediatric dental services as required under the Affordable Care Act. 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.”

D. To be considered a complete filing, rate filings must comply with the submission and requirements for non-grandfathered individual and small group health benefit plans contained in Appendix A of this regulation.

Section 6 Actuarial Memorandum

The rate filing must contain a compliant actuarial memorandum. To ensure compliance with this regulation, the Division will supply an Excel template for the items required to be submitted in Excel. Carriers must supply all items that require a narrative as a separate document in PDF format. The narrative must contain complete support for any calculated item or provide adequate details. The actuarial memorandum and all supporting documents or exhibits 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. Only the rate manual must be attached to the Rate/Rule tab in SERFF.

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- A. Summary: The memorandum must contain a summary that includes, but is not limited to, the following:
1. Block Opened Date: Enter the date the product was first sold.
 2. Block Closed Date: Enter the date the product was closed (if applicable).
 3. Reason(s) for the rate filing: Select all appropriate reasons for the rate filing.
 4. Requested Rate Action: Identify the rate increase or decrease amount for all appropriate items (i.e. Base Rate Change, Trend, Benefit Factor Change, etc.).
 5. Overall Rate Action: Identify the overall, minimum, and maximum rate percentage changes.
 6. Marketing Method(s): Select all marketing methods used for the filed form.(i.e. Producer, Internet, Direct Response, Other).
 7. Marketing Type(s): Select the appropriate marketing type(s) (i.e. individual, small group, large group). Identify if the product will be sold to associations, trusts, etc.
 8. Premium Classification: Select all attributes upon which the premium rates vary. This section must comply with all rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas.
 9. Product Descriptions: Describe the benefits provided by the policy, or contract in the narrative. For non-grandfathered individual and small group health benefit plans and stand-alone pediatric dental, this section must include EHB(s) and list any substitution of benefits or any additional benefits provided above the required EHB(s).
 10. Policy or Contract: All policy or contract forms impacted must be listed on the Form Schedule tab in SERFF.
 11. Age Basis: Select the appropriate age basis used for the forms.
 12. Renewability Provision: Select all renewability provisions used for the forms. All health benefit plans are guaranteed renewable.
 13. Rate Change Distribution: Complete the Rate Change Distribution table. This must be provided in an Excel spreadsheet. See Appendix C for the required format.
- 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 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, acquisition or merger, and the SERFF Tracking Number of the merger, acquisition, or assumption rate filing. Commissioner approval of the merger, assumption or acquisition of a block of business is required. See Section 5.A.5.e. for merger, acquisition or assumption rate filing requirements. This information shall be included in the narrative.
- C. Rating Period: Identify the period for which the rates will be effective, including both the Implementation and End Date. The date must concur with the Implementation Date Requested field in SERFF. The maximum rating period for products using trend is one (1) year. This information must be included in the narrative.
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1. Individual Market: The rating period must be twelve (12) months and premiums cannot change through the year.
 2. Small Group Market: An annual rate filing must be made each year with an effective date of January 1. Rating periods may be no more than twelve (12) months. Rates in the annual filing may be trended quarterly. Quarterly filings may be made with effective dates of April 1, July 1, and October 1 only.
- D. 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 must 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. This information must be included in the narrative.
- E. Rate History: The memorandum must 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 implementation date of each rate change. Rate changes must include the impact of trend.
1. This chart must 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 increase, and the cumulative rate change for the past twelve (12) months.
 2. This chart must contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.
 3. The rate history must be provided on both a Colorado basis, as well as an average nationwide basis, if applicable.
- This information must be provided in an Excel spreadsheet. See Appendix D for the required format.
- F. Coordination of Benefits: The memorandum must reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation. This information must be included in the narrative.
- 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. Carriers must include all retention from expenses, fees and profits that will be loaded into rates. At a minimum, carriers must provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financials. The carrier must comply with the following adjusted minimum benefit ratio guidelines.

Comprehensive Major Medical - Individual	80%
Comprehensive Major Medical - Small Group	80%
Comprehensive Major Medical - Large Group	85%
Stand-Alone Dental (SADP)	65%

This information must be provided in an Excel spreadsheet. See Appendix E for the required format.

H. Federal Medical Loss Ratio

Medical carriers shall provide a calculation of the federal medical loss ratio (MLR) for the two (2) most recent completed calendar years and a projected MLR for the prospective calendar year and show all allowable adjustments in the numerator and denominator.

This information must be provided in an Excel spreadsheet. See Appendix F for the required format.

I. Provision for Profit and Contingencies.

Carriers must indicate pre-tax and post-tax levels, and must 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 must be considered in the ratemaking process. Detailed support must be provided for any proposed load. This information shall be provided in an Excel spreadsheet. See Appendix G for the required format.

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 support for each 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 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.

1. Index Rate Development

- a. Carriers must develop a market-wide index rate based on the total combined EHB claims experience of all enrollees in all non-grandfathered (NGF) plans in the respective individual and small group single risk pool.
- b. After setting the Index Rate, the carrier must make a market-wide adjustment based on the expected aggregated payments and charges under the risk adjustment and reinsurance programs in Colorado.
- c. The premium rate for any given plan must not vary from the resulting adjusted market-wide Index Rate, except for the following factors:
 - (1) The actuarial value and cost-sharing structure of the plan;
 - (2) The plan's provider network;
 - (3) Delivery system characteristics;
 - (4) Utilization management practices;
 - (5) Plan benefits in addition to EHB; and with respect to catastrophic plans
 - (6) The expected impact of specific eligibility categories for those plans.

- d. The Index Rate, the market-wide adjustment to the Index Rate, and the plan-specific adjustments must be actuarially justified and implemented transparently, consistent with federal and state rate review processes.

2. Geographic Factors

A complete explanation as to how the geographic factors were developed must be provided. Health claims may be used in the process of developing geographic factors. As stated in the ACA, rating factors may not reflect differences in member health status. Geographic rating factors shall only reflect differences in the costs of delivery and must not include differences for population morbidity by geographic area. Geographic factors must be actuarially justified and verified to have been set based upon the above criteria.

3. Benefit Factors

A complete explanation as to how the benefit factors were developed must be provided. Differences in the rates for different benefit plans, for persons with the same case characteristics of age, geographic location, family size, and tobacco use must only be attributable to plan design. Benefit factors must not reflect the health status of members assumed to be enrolled in any particular plan, and must not reflect claims experience of members on a particular plan. The benefit cost relativity between plans must 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 must be higher (lower).

4. Morbidity

Other projected population changes from the experience period to the rating period must include considerations of newly insureds entering the market, grandfathered members moving into NGF products.

5. Other Factors (Dental and Large Group Only)

The memorandum's narrative must clearly display or clearly reference all other rating factors and definitions used, including the area factors, age factors, gender 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 to provide detailed support for the continued use of each of these factors in a rate filing. Gender factors shall not vary for individual dental plans. This information must be included in the narrative.

- 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 shall not automatically renew. Continued use of trend factors must be supported annually.

- 1. The four (4) most recent years of monthly experience data used to evaluate historical trends must 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 must indicate the number of paid claim months of run out used beyond the end of the incurred claims period.
3. The provided claims experience must 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.
4. Data elements must be aggregated into 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 must be identified. The trend assumptions shall be quantified into two (2) categories, medical and insurance, as defined below:
 - a. Medical trend [(1A) – (1F) in Appendix H1 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.
 - b. Other insurance trend [(1E) in the Appendix H1 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) in Appendix H1, 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 (1A) through (1D) in Appendix H1 must be determined or assumed before determining the impacts of the other insurance trend items included in (1E), which must be fully justified in the rate filing.
 - c. Pharmaceutical trend [(2A) – (2F)] in Appendix H1 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, found at (2E) in Appendix H1, 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), including the effect of pharmaceutical deductible leveraging.

This information must be provided in an Excel spreadsheet. See Appendix H1 – H3 for the required format.

- 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. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period. Partial credibility must be used if the Colorado data is not fully credible. 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).
1. The memorandum must 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 companies), must be provided and the use of such data must be justified.
 2. 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 the square root of (number of life years or claims/full credibility standard). The full credibility standard is defined above, and Colorado data must be provided.
 3. The memorandum must also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data must include a discussion as to how the rating methodology was modified for the partially credible data.

This information must 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 must be provided in the narrative. See Appendix I for the required format.

- M. Experience: The memorandum must include, at a minimum, 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.
1. Pharmacy claims experience must be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.
 2. National or other relevant experience must 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.
 3. If the purpose of the filing is to introduce a new product in Colorado, the product must be substantially different from an existing product. Nationwide experience for this product must be provided. If no experience from the new product is available, experience from a comparable product must be provided, including experience data from other carriers that have been used to support the rates.
 4. Support for new policy forms must be provided. If the new policy form is based on an existing policy form, the existing policy form experience must 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 must be supported by the most recent experience available, with as much weight as possible placed upon the Colorado experience. Data used to support rates must be included in the filing. For both renewal filings and new business filings, the experience period must include consecutive data no older than six (6) months prior to the filing date.
6. The loss experience 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. Capitation payments must be considered as claim or loss payments. The carrier must also provide information on how the number of claims was calculated.

This information must be provided in an Excel spreadsheet. See Appendix J for the required format.

- N. Side-by-side Comparison: Each memorandum must include a “side-by-side comparison” identifying any proposed change(s) in rates. This comparison must include three (3) 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). If the proposed rating factor(s) are new, the memorandum must specifically state this and provide detailed support for each of the rating factors.

This information must be provided in an Excel spreadsheet. See Appendix K for the required format.

- 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 must 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 must be included.

If the filing is for a new product, the expected projected premiums and projected incurred claims must be provided. See Appendix L for the required format.

- P. Rating Manuals: A rating manual must be submitted to the Division for each new product. All changes to the rating manual must be filed with the Division in an appropriate rate filing. Rate pages and rate manual must be attached to the Rate tab in SERFF.
- Q. Actuarial Certification: An actuarial certification must 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 for Individual and Small Group Health Benefit Plans

- A. Calculating premium rates adjusted for case characteristics for non-grandfathered health benefit plans.
1. Index Rate: Each carrier offering a health benefit plan to individuals and small groups in Colorado shall develop a single index rate for all individual and small group non-grandfathered (NGF) plans it offers. The index rate for a market segment (individual or small group) must be based on:
 - a. The EHB claims experience of all enrollees in all NGF health benefit plans in a risk pool;

- b. Adjusted for risk adjustment/reinsurance payments and charges, and Exchange user fees;
 - c. Index rates may be developed separately for supplemental stand-alone benefits, as all such similar benefits are pooled for setting the respective index rate; and
 - d. The premium rate charged during a rating period shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this section.
- 2. Benefit Design Adjustment: The index rate may be adjusted to reflect differences attributable to different benefit designs. Differences in the rates for different benefit plans, for enrollees 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 richer benefits must be higher than the rates for a plan with lesser benefits.
- 3. Acceptable Case Characteristic Factor Categories
 - a. 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.
 - b. Rates may vary based on whether a plan covers an individual or a family. 42 U.S. Code § 300gg provides that, with respect to family coverage, the rating variation permitted for age and tobacco use must be applied based on the portion of the premium attributable to each family member covered under a plan.
 - c. The per-member rating methodology under 45 CFR § 147.102(c)(1) must 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.
 - d. Geographic area rating factors must not vary by product; there is only one set of area factors for each rate filing. Geographic area rating factors are separate from network factor rating adjustments, and must not vary by network.

For example, a particular carrier's geographic area rating factors might be:

<u>Geographic Area</u>	<u>Rating Factor</u>
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. As stated in the ACA, 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

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.

- e. **Age Factors.** Age factors and age bands must be determined based on an enrollee's age on the date of policy issuance or renewal and must 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

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 in the individual and small group market may remove the tobacco rating factor (as described in 42 U.S. Code § 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 18 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 must be defined by carriers in terms of the time since the individual's last use of a tobacco product.

g. Family Size Categories.

Mandatory Family Size Categories
All adults can be rated based on their age
Up to 3 children (oldest), under the age of 21 can be rated. This includes child only coverage

h. Health status and claims experience must not be used as case characteristics.

B. Rating Period

1. The rating period for all small group health plans shall be no more than twelve (12) months.
2. A carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

C. 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.

D. 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, 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:

$$\frac{(\text{Total Overall Health Costs} - \text{Total Enrollee Cost Sharing})}{\text{Total Overall Health Costs}}$$

AV must 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.

E. Calculating the Actuarial Value of Unique Plan Designs

1. To satisfy actuarial value (AV) requirements, carriers are required to use the Actuarial Value Calculator (AVC) developed and made available by the United States Department of Health and Human Services (HHS) unless the plan design is not compatible with the AVC (a unique plan design). 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. For standard plan designs, carriers will determine AV using the HHS-developed AVC. 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, HHS allows for alternative calculation methods supported by certification of an actuary.

F. Calculating the Actuarial Value of Health Benefit Plans that are not Compatible with the AVC

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 must 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 must:
 - 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 must 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 must submit an actuarial certification.

3. Family Plan Design

The AVC standard population and claims data were developed using claims data that did not include any family cost-sharing information. Carriers issuing plans with deductibles and/or out-of-pocket maximum costs that accumulate at the family rather than the individual level have several options depending on the specifics of the family plan.

In the case of a plan with a deductible and/or out-of-pocket maximum that accumulates first at the individual level and then at the family level, the carrier enters the individual deductible and out-of-pocket maximum into the AVC to determine AV. If deductible and out-of-pocket maximum accrues only at the family level and not at the individual level, the carrier may either include the family deductible and out-of-pocket maximum into that AVC or, if the carrier believes that the family plan cost-sharing features will make a material difference in the AV produced by the AVC, the carrier may use one of the 45 CFR § 156.135(b) exceptions described above to calculate AV, and include plan-specific data on how the family-specific cost sharing is adjusted.

- G. Unique Plan Design

1. If carriers are still unable to obtain an AV from the SERFF Plans and Benefits Template that matches what they obtain via the stand-alone AVC, then they must designate that particular plan as a unique plan design using the *Unique Plan Design?* field of the SERFF Benefits Package worksheet.
2. For this plan, the carrier must complete the *Issuer Actuarial Value* data field with the value from the stand-alone AVC. The carrier must also upload a screen shot of the stand-alone AVC with that value as a supporting document for each plan for which this situation occurs. They must indicate the *HIOS Plan ID (Standard Component)* in the Description field when uploading the screen shot as a supporting document in SERFF as well as indicating the *HIOS Plan ID (Standard Component)* in the file name of the screen shot.

3. Carriers must provide justification for unique AV plan designs by completing the appropriate Centers for Medicare and Medicaid Services (CMS) justification document located on the CMS website.

H. Determining Minimum Value (MV)

A group health benefit plan provides minimum value (MV) if the total allowed costs of benefits paid by the plan are no less than 60%. An individual eligible for coverage in an employer-sponsored plan that provides MV is not eligible for premium tax credits.

The following methods must be used to determine if a group health benefit plan provides MV:

1. The Minimum Value Calculator;
2. A safe harbor established by HHS and Internal Revenue Service (IRS); or
3. Certification by an actuary if neither is suitable.

I. Cost Sharing Limitations

Section 1302(c)(1) of the ACA sets an annual limitation on cost sharing (commonly referred to as a maximum out-of-pocket limit) as part of the EHB package that NGF policies sold in the individual and small group markets must offer. As provided in 45 CFR § 156.130(c), cost sharing for benefits provided outside of a health plan's network do not count towards the annual limitation on cost sharing when the health plan uses a provider network. For plan or policy years beginning after January 1, 2015, this limit will be the out-of-pocket limit for high deductible health plans (HDHP), adjusted by the Consumer Price Index (CPI-U), and set by the IRS pursuant to Section 223(c)(2)(A)(ii) of the Internal Revenue Code.

J. Market Wide Index Rate

1. The market's risk pool index rate must be used to set the rates for all products of the carrier in that particular market. A carrier must make a market-wide adjustment to the index rate based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in Colorado. A market-wide adjustment to the index rate must be made for Exchange user fees.
2. 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;
 - 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.
3. Rates on an individual policy issued on or after January 1, 2015, are only guaranteed through Dec 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, 2016 would have his or her rates in effect until December 31, 2016, and would then be subject to the new rates implemented on January 1, 2017.

K. Market Wide Index Rate Development

1. Average Projected Benefit Cost Per-Member-Per-Month
 - a. The index rate must 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 per-member-per-month (PMPM) cost, from their experience, including the following:
 - b. Credibility: Carriers must determine the credibility levels of the experience being used and adjust appropriately. Carriers must 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:
 - (1) Supplement the Colorado experience with similar national business; or
 - (2) Supplement small employer business with other Colorado experience with similar characteristics (membership, network, plan designs).
2. Carriers must always discuss the impact of large claims on their business; apply methods for adjusting data by pooling large claims above a threshold and apply pooling charges. This consideration is separate from the Transitional Federal Reinsurance program impacts for individual plans in years 2014 through 2016.
3. Carriers must support and provide estimates for the IBNR claims portion of total incurred claims.
4. In developing the health cost trend, costs must be projected to the applicable rating period, assuming an actuarially justifiable health cost trend. For individual business index rates must not be trended monthly or quarterly through any rating period, and index rates must be the same for each month during a rating period. For small employer business, index rates may increase quarterly to reflect trend.
5. Adjustments for Demographic Mix, Benefit Mix, and Area: Other projected population changes from the experience period to the rating period must include considerations of newly uninsureds entering the market and grandfathered members moving into NGF products.
6. Adjustments for underwriting wear-off must be made due to members who were previously underwritten.

L. The development of the plan cost and index rate must include market-wide adjustments for the federal risk mitigations programs.

1. Reinsurance Recoveries: For NGF individual business, carriers must include an adjustment reflecting expected reinsurance recoveries from the Transitional Federal Reinsurance program in years 2014 through 2016. This assumed reduction in claims cost must be actuarially supported by available studies or other analysis indicating expected recoveries for the carriers' assumed population risk.

2. Risk Adjustment Payments: For NGF individual and small employer business, carriers must consider estimates of risk adjustment payment transfers either to or from HHS. Carriers with risk profiles of members indicating higher than market risks must consider adjusting the index rate to reflect receiving payments from the risk adjustment program.

- M. The development of the plan cost and index rate must include market-wide adjustments for Exchange user fees.

Carriers must 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, creating a level playing field inside and outside the Exchange, and further protecting against adverse selection.

- N. Plan Level Rating Adjustment

Index rate plan level adjustments can be modified for specific plans using only the following factors:

1. The actuarial value and cost-sharing design of the plan;
2. The plan's provider network and delivery system characteristics, as well as utilization management practices. This factor is intended to pass savings onto consumers when carriers negotiate robust provider discounts, construct efficient networks, or manage care more intensely;
3. Benefits provided by the product in addition to EHBs. The additional benefits must be pooled with similar benefits provided in other products to determine the allowed rate variation for products that offer these benefits;
4. Administrative costs other than Exchange user fees; and
5. With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans must be reflected.

- O. Benefit Factor Adjustments to the Index Rate

1. The adjusted index rate as developed from the process in Section 7.A. may be modified for each plan design by reflecting benefit cost adjustments due to the different benefit plan designs. 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. Benefit factors must not reflect the health status of members assumed to be enrolled in any particular plan, and must not reflect claims experience of members in a particular plan. The benefit cost relativity between plans must 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 must be higher (lower).
2. With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans must be reflected.

P. Retention Factor Adjustments to the Index Rate

Carriers must adjust the index rate to include all retention from expenses, fees and profits that will be loaded into rates. Retention loads must be spread out across all rates in the NGF pool using the same rating factor. Retention rating factors must not vary between on-Exchange and off-Exchange plans. Differences in expenses due to Exchange fees must be spread out across all NGF pooled plans.

At a minimum, carriers must 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:

1. Administrative expenses;
2. Commissions and other acquisition expenses (may be separated);
3. Taxes;
4. PPACA Fees (Transitional Reinsurance, Health Insurer, Comparative Effectiveness Research Fee (CERF)): these are market-wide adjustments as stated above;
5. Other assessments; and
6. Profit and contingencies.

Q. Network Factor Adjustments

1. The adjusted index rate may be modified to reflect cost differences between different provider networks. Network factors must not be developed to reflect health status or claims experience of members included in the different networks. Factors must be set assuming each network has the same average member risk profile and levels of member health. Therefore, claims experience must not be directly used as the basis for setting a network factor. Network factors must reflect the following estimated cost differences between networks:
 - a. Differences in reimbursement levels and discounts between providers;
 - b. Differences in the utilization management of members, including tighter control of referrals, stricter managed care, disease management and wellness programs, etc.;
 - c. Other delivery system characteristics of a network; and
 - d. Plan level network factor adjustments for any plan design and network must not vary by geographic area.
2. Carriers must provide a table showing the network factor for each plan.
 - a. "Plan" is defined by HIOS Plan ID, which is the combination of "benefit design and cost sharing" (i.e. silver plan) with the network.
 - b. Plan level network factor adjustments must not vary by geographic area. As illustrated in the following table, all factors must be the same across areas (across rows in this table).

HIOS Plan ID Description	Denver MSA Network Factor	Boulder MSA Network Factor	East Non-MSA Network Factor
Silver 1750 Network A	0.83	0.83	0.83
Silver 1600 Network B	0.86	0.86	0.86
Bronze 2000 Network A	0.81	0.81	0.81
Bronze 1800 Network	0.84	0.84	0.84

As defined on the SERFF Plans and Benefits Template: HIOS Plan ID = Benefit Design, Network, Geographic Area. The combined effect of the geographic and network factors on the index rate for a particular plan is: (Index Rate) x (Geographic Area Factor) x (Network Factor)

- R. 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.
1. The carrier must provide the estimate of the MLR for the current calendar year and the following calendar year. The carrier must indicate all adjustments allowed in the minimum MLR calculation that will be used to reach the minimum required MLR. Federal minimum MLR requirements are as follows:
 - a. Large Group: 85%
 - b. Small Group: 80%
 - c. Individual: 80%, includes Student Health Plans
 2. Carriers must 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.
- S. Essential Health Benefits (EHBs)
1. Carriers must provide EHBs and essential health care benefit packages.
 2. Essential benefits include providing prescription drug coverage that covers at least the greater of:
 - a. One drug in every United States Pharmacopeial Convention (USP) Model category and class; or
 - b. The same number of prescription drugs in each category and class as the EHB benchmark plan. A drug is considered covered if the health benefit plan pays for all or part of the drug regardless of tiers and cost sharing. The specific drugs covered on each carrier's formulary may vary as long as the minimum number in each category and class is met.

T. Stand-alone Dental (SADP)

1. QHPs in an Exchange may omit the pediatric dental EHB if a SADP on the Exchange offers pediatric dental EHB coverage.
2. SADPs are allowed a separate out-of-pocket maximum.
 - a. SADPs must demonstrate that the out-of-pocket maximum is reasonable for pediatric dental EHB.
 - b. The Division will make the final determination as to what constitutes a reasonable out-of-pocket maximum for pediatric dental EHB.
 - c. The cost sharing annual limit for a pediatric dental plan will be at or below \$350 for a plan with a single child enrollee, or \$700 for a plan with two (2) or more child enrollees is considered reasonable and no higher limit will be approved.
3. SADPs must comply with the adjusted minimum benefits ratio guideline of 65%.
4. Pediatric dental plans must provide coverage up to age 19.
5. 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.
6. 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.
7. The pediatric dental EHB offered by a SADP must 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.
8. The AV calculation for all SADPs shall include a summary statement and certification signed and dated by a qualified actuary.

U. Student Health Insurance Coverage

1. 45 CFR § 147.145 exempts student health insurance coverage from the guaranteed availability and guaranteed renewability requirements of the Public Health Service Act (PHSA) to the limited extent provided for in PHSA sections 2702 and 2703, added by the ACA. However, coverage in a student health plan is guaranteed available and guaranteed renewable for students and their dependents.
2. Non-grandfathered student health insurance coverage is not subject to the single risk pool requirement of section 1312(c) of the ACA. The premium rate charged by a carrier offering student health insurance coverage must be based on a school-specific group community rate if, consistent with section 2701 of the PHSA, the carrier offers the coverage without rating for age or tobacco use.
3. Pursuant to federal law, these plans are defined as "individual health insurance coverage."

Section 8 Rate Filings and Actuarial Certification

- A. The provisions of § 10-16-107, C.R.S., and this regulation shall apply to the filing of rates for individual, small and large group health benefit plans. Expected rate increases for individual, small and large group health benefit plans shall be submitted for approval to the Division at least sixty (60) days prior to the proposed rate implementation and/or effective date.
- B. Small group health benefit plan rate filings must not be combined with either individual or large group health benefit rate filings. Additionally, they shall be filed separately by type of coverage (indemnity, preferred provider organization, or health maintenance organization).
- C. Individual health benefit plan rates shall be filed no more frequently than annually. Small group health benefit plan rates shall be filed annually, with an effective date of January 1.
 - 1. Small group health benefit plan filings may include quarterly trend increases. Small group health benefit plan rates may be filed no more frequently than quarterly.
 - 2. Annual filings for rates effective on January 1 must be submitted no later than May 15 of the previous year, or a date specified by the Commissioner. For example, for rates to be effective on January 1, 2017, rates must be filed no later than May 15, 2016.
- D. Stand-alone dental plans offering the pediatric dental coverage mandated by PPACA as EHBs, must be "Exchange certified stand-alone dental plans". The "Product Name" on the General Information tab in SERFF must identify the filings as "PPACA Dental." New filings must be submitted in accordance with the PPACA rate filing requirements for Colorado.

Section 9 Additional Requirements for Large Group Health Benefit Plans

- A. Large Group Health Benefit Plans: 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 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 must 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 must be identified in the detail material and lie within the range identified in the rate filing on file with the Division. The carrier must 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.

- B. Valid Multistate Association Groups: Valid multistate associations 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.
- C. 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; or
 - b. A safe harbor established by HHS and the IRS; or
 - c. Certification by an actuary if neither is suitable.
- D. Network Factor Adjustments
- The rate may be modified to reflect cost differences between different provider networks. Network factors must not be developed to reflect health status or claims experience of members included in the different networks. Factors must be set assuming each network has the same average member risk profile and levels of member health. Therefore, claims experience must not be directly used as the basis for setting a network factor. Network factors must 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.

Section 10 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, 10-16-109, 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. Pursuant to § 10-16-107(2)(b), C.R.S., individual health benefit plans rates shall not vary due to the gender of the individual policyholder, enrollee, subscriber, or member.
- D. For large group 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 must 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; 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, 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 its rating structure. The Commissioner expects carriers to review the appropriateness of area factors at least every five (5) years and provide detailed support for the continued use of the factors in rate filings and upon request.

Section 11 Use of Composite Rates in the Small Group Market

- A. 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 7 of this regulation. If a small group carrier offers composite rating, the carrier must offer the small group the choice of both individually-rated employees and composite rates, at initial application and each renewal.

- B. If a small group carrier offers both rating methodologies for a plan, the small group carrier must ensure that:
 - 1. Both methods are offered to every small group, with differences between methodologies clearly explained in writing: or
 - 2. Every small group must be given a written option to indicate in check-off form, or other similar form, in the application or renewal application, that:
 - a. Both rating methods need to be presented;
 - b. Only rates for individual employees need to be presented; or
 - c. Only the composite rate needs to be presented.
- C. Small group carriers may offer small groups four-tier composite rates as an alternative to rates calculated individually for each employee pursuant to Section 7. of this regulation. If the small group carrier offers composite rating, the carrier must make the same offer for all plans, except as allowed by Section 11.H.
- D. Calculating Composite Rates
 - 1. The total premium charged to the small group must be calculated using the per-member methodology in Section 7 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.
 - 2. Once the small group's total premium has been calculated, it must 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:
 - a. Employee Only = 1.00
 - b. Employee and Spouse = 2.00
 - c. Employee and Child(ren) = 1.85
 - d. Employee, Spouse, and Child(ren) = 2.85
 - 3. Any allowable tobacco use factor must be allocated separately to the corresponding individual employee or dependent, so the average Employee Only premium does not include any tobacco factor.
- E. A small group's total composite premium must 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 must not vary during the plan year, regardless of any census changes within the group.
- F. 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, except as allowed by Section 11.H.
- G. Small group carriers may decide which plans will offer composite premiums and which plans will not.

- H. 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.

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 Incorporated Materials

42 U.S. Code § 300gg, published by the Government Printing Office shall mean 42 U.S. Code § 300gg as published on the effective date of this regulation and does not include later amendments to or editions of 42 U.S. Code § 300gg. 42 U.S. Code § 300gg 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 U.S. Code § 300gg 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 § 147.102 published by the Government Printing Office shall mean 45 CFR § 147.102 as published 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 published by Government Printing Office shall mean 45 CFR §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 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 published by Government Printing Office shall mean 45 CFR §147.145 as published 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 CFR §156.420 published by Government Printing Office shall mean 45 CFR §156.420 as published 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 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 shall become effective on October 15, 2018.

Section 16 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.

APPENDIX A RATE FILING REQUIREMENTS FOR NON-GRANDFATHERED INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS

- A. Format: All required reports and documentation must be submitted through SERFF in a searchable PDF format. All tables identified in Section 6 of this regulation must also be submitted in an Excel format (in addition to the searchable PDF).
- B. Submission Requirements for New Rate Filings: Carriers must complete and submit the following information in SERFF in order for a rate filing submission to be considered complete:
1. Carriers must complete all SERFF required data fields.
 2. Carriers must list all forms associated with the rate filing under the Form Schedule Tab.
 - a. Carriers must complete all data fields (Form Name, Form Number, Form Type, Action, Readability Score) under this tab.
 - b. Carriers must attach copies of the actual form documents as part of a rate filing.
 3. Carriers must attach a copy of the Rate Tables/Manual under the Rate/Rule Schedule Tab.
 4. Carriers must 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 form filing on their behalf, a Letter of Authority, which must 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. The following documents required by CMS:
 - i. Part I – Unified Rate Review Template;
 - ii. Part II – Consumer Justification Narrative must be completed for all rate increases, but is optional for new plans;
 - iii. Part III – Actuarial Memorandum.
 - d. Any applicable justification or attestations forms specified by the Division.
 5. Carriers must complete and upload the following templates, under the Template Tab in the Plan Management (Binder) section of SERFF:
 - a. Business Rules Template;
 - b. Plans and Benefits Template;
 - c. Prescription Drug Template;
 - d. Network Template;

- e. Rate Data Template; and
 - f. Service Area Template.
- 6. Carriers must attach copies of the following documents required by CMS under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF
 - a. Part I - the Unified Rate Review Template; and
 - b. Part II - Consumer Justification Narrative, which must be completed for all rate increases, but optional for new plans.

APPENDIX B – Sample Rate Table

201X Individual Market Rate Table

Issuer Name: Example Health Insurance Table Creation Date: Month/Day/Year
 Plan HIOS Number: XXXXXXXXXX Table Status: Initial Filing – Not Final Approval
 Metal Tier: Gold Benefit Type: Medical
 Smoker Rate Type: Non-Tobacco Exchange Status: On-Exchange Only

Age	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
0-14	153.00	153.00	153.00	153.00	153.00	153.00	153.00	153.00	153.00
15	166.60	166.60	166.60	166.60	166.60	166.60	166.60	166.60	166.60
16	171.80	171.80	171.80	171.80	171.80	171.80	171.80	171.80	171.80
17	177.00	177.00	177.00	177.00	177.00	177.00	177.00	177.00	177.00
18	182.60	182.60	182.60	182.60	182.60	182.60	182.60	182.60	182.60
19	188.20	188.20	188.20	188.20	188.20	188.20	188.20	188.20	188.20
20	196.37	200.30	192.45	197.36	189.50	191.47	203.25	197.36	185.57
21	309.26	315.45	303.08	310.81	298.44	301.53	320.09	310.81	292.25
22	309.26	315.45	303.08	310.81	298.44	301.53	320.09	310.81	292.25
23	309.26	315.45	303.08	310.81	298.44	301.53	320.09	310.81	292.25
24	309.26	315.45	303.08	310.81	298.44	301.53	320.09	310.81	292.25
25	310.50	316.71	304.29	312.05	299.63	302.74	321.37	312.05	293.42
26	316.68	323.02	310.35	318.27	305.60	308.77	327.77	318.27	299.26
27	324.10	330.58	317.62	325.72	312.76	316.00	335.45	325.72	306.28
28	336.17	342.89	329.44	337.85	324.40	327.76	347.93	337.85	317.68
29	346.06	352.98	339.14	347.79	333.94	337.41	358.17	347.79	327.02
30	351.01	358.03	343.99	352.76	338.72	342.23	363.29	352.76	331.70
31	358.44	365.60	351.27	360.23	345.89	349.47	370.98	360.23	338.72
32	365.85	373.17	358.54	367.68	353.05	356.71	378.66	367.68	345.73
33	370.49	377.90	363.08	372.34	357.52	361.23	383.46	372.34	350.11
34	375.44	382.95	367.93	377.32	362.30	366.05	388.58	377.32	354.79
35	377.91	385.47	370.35	379.80	364.68	368.46	391.14	379.80	357.12
36	380.39	388.00	372.78	382.29	367.08	370.88	393.70	382.29	359.47
37	382.86	390.52	375.20	384.77	369.46	373.29	396.26	384.77	361.80
38	385.34	393.05	377.63	387.27	371.85	375.71	398.83	387.27	364.15
39	390.29	398.09	382.48	392.24	376.63	380.53	403.95	392.24	368.82
40	395.23	403.13	387.32	397.20	381.40	385.35	409.06	397.20	373.49
41	402.66	410.71	394.60	404.67	388.56	392.59	416.75	404.67	380.51
42	409.76	417.96	401.57	411.81	395.42	399.52	424.11	411.81	387.23
43	419.66	428.06	411.27	421.76	404.97	409.17	434.35	421.76	396.58
44	432.03	440.67	423.39	434.19	416.91	421.23	447.15	434.19	408.27
45	446.57	455.50	437.64	448.80	430.94	435.40	462.20	448.80	422.01
46	463.89	473.16	454.61	466.20	447.65	452.29	480.12	466.20	438.37
47	483.37	493.04	473.70	485.79	466.45	471.29	500.29	485.79	456.78
48	505.64	515.75	495.52	508.17	487.94	493.00	523.33	508.17	477.83
49	527.59	538.14	517.04	530.23	509.13	514.40	546.06	530.23	498.57
50	552.36	563.39	541.29	555.10	533.01	538.53	571.67	555.10	521.96
51	576.76	588.30	565.23	579.65	556.58	562.34	596.95	579.65	545.04
52	603.67	615.74	591.59	606.69	582.54	588.58	624.80	606.69	570.47
53	630.89	643.50	618.27	634.04	608.80	615.11	652.97	634.04	596.19

Age	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
54	660.27	673.47	647.06	663.57	637.16	643.76	683.38	663.57	623.95
55	689.64	703.44	675.85	693.09	665.51	672.40	713.78	693.09	651.71
56	721.50	735.93	707.07	725.10	696.24	703.46	746.75	725.10	681.81
57	753.66	768.74	738.59	757.43	727.29	734.82	780.04	757.43	712.21
58	787.99	803.75	772.23	791.93	760.41	768.29	815.57	791.93	744.65
59	805.00	821.10	788.90	809.03	776.83	784.88	833.18	809.03	760.73
60	839.33	856.11	822.54	843.52	809.95	818.34	868.70	843.52	793.16
61	869.01	886.39	851.63	873.36	838.60	847.29	899.43	873.36	821.22
62	888.50	906.27	870.73	892.94	857.40	866.28	919.59	892.94	839.63
63	912.93	931.19	894.67	917.50	880.98	890.11	944.88	917.50	862.72
64+	927.79	946.34	909.23	932.43	895.32	904.59	960.26	932.43	876.76

Per member rates for no more than 3 children (oldest) under the age of 21 can be taken into account in determining the family premium. This includes child only coverage.

APPENDIX C: SUMMARY

Summary	
1. Block Opened Date:	
2. Block Closed Date (if applicable):	
3. Reason(s):	Experience
	Trend
	New Product
	New Benefits
	Benefit Change(s)
	Regulation or Law Changes
	Other (Please describe):
4. Requested Rate Action (Enter the percentage for each factor changing):	Base Rate Change
	Trend
	Benefit Factor Change
	Area Factor Change
	Other (Please describe):
5. Overall Rate Action:	Average Total Change
	Minimum
	Maximum
6. Marketing Method(s):	Agency / Producer
	Internet
	Direct Response
	Other (Please describe):
7. Marketing Type(s)	Individual
	Large Group
	Small Group
	Association
	Blanket
	Discretionary Group
	Employer Group
	Trust
	Other Non-Employer Group
8. Premium Classification(s):	Age
	Family Composition
	Tobacco

	Geographic Area	
	Benefit	
	Other (Please describe):	
9. Product Description(s):	Provide a narrative describing the benefits.	
10. Policy/Contract Impacted:	Complete the form schedule tab with all applicable policy and/or contract forms affected.	
11. Age Basis:	Renewal Age	
	Attained Age	
	Issue Age	
	Community Rating	
	Not Utilized	
	Other (Please describe):	
12 Renewability Provision:	Guaranteed Renewable	
	Option to Renew (Dental Only)	
13: Rate Change Distribution		
Rate Increase	Distribution Percentage	Members
< 0%		
0 - 4%		
4 - 8%		
8 - 12%		
12 - 16%		
16 - 20%		
> 20%		

APPENDIX D: RATE HISTORY

Provide rate changes made in at least the last three approved filings (If available)					
<input type="checkbox"/> N/A New Filing					
COLORADO					
		% OF CHANGE			
SERFF Tracking Number	Effective Date	Minimum	Average	Maximum	Cumulative for past 12 Months
NATIONWIDE					
Effective Date	Average % of change	Cumulative for past 12 Months			
Additional Information:					

APPENDIX E: RELATION OF BENEFITS TO PREMIUM

Relation of Benefits to Premium	
Description	Percentage
Commissions	
General Expenses	
Premium Taxes	
Federal Income Tax*	
Profit/Contingencies	
Investment Income	
PPACA Fees	
Health Insurer Fee	
PCORI**	
Exchange Fees	
Guaranteed Fund	
Other	
Total Retention	0.00%
Targeted Loss Ratio	100.00%

*Not included in the total retention

**PCORI stands for Patient-Centered Outcomes Research
Institute

APPENDIX F: FEDERAL MEDICAL LOSS RATIO (MLR)

Federal Medical Loss Ratio (MLR)			
Calculation for Calendar Years:	20XX-2	20XX-1	20XX
Numerator			
(1) Incurred claims			
(2) Expenditures on quality improving activities			
(3) Transitional insurance receipts			
(4) Risk corridors and risk adjustment related payments			
(5) Risk corridors and risk adjustment related receipts			
(6) Numerator Total = (1) + (2) - (3) + (4) - (5)	\$0.00	\$0.00	\$0.00
Denominator			
(7) Earned premiums			
(8) Federal and State taxes and assessments			
(9) Licensing and regulatory fees, including transitional reinsurance contributions			
(10) Denominator Total = (7) - (8) - (9)	\$0.00	\$0.00	\$0.00
Credibility Adjustment			
(11) Credibility adjustment, if any			
MLR with credibility adjustment percentage			
(12) MLR with credibility adjustment = $\frac{(6)}{(10)} + (11)$	0.00%	0.00%	0.00%
(13) Rebates paid			

APPENDIX G: PROFIT AND CONTINGENCIES

PROVISION FOR PROFIT AND CONTINGENCIES	
(1) Pre-Tax Provision for Profit and Contingencies (1) = (4) + (5)	0.00%
(2) Investment Income (expressed as a negative number)	
(3) Pre-tax Profit and Contingencies, including Investment Income (3) = (1) + (2)	0.00%
(4) Federal Income Tax	
(5) Post-Tax Provision for Profit and Contingencies:	

APPENDIX H1: 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)	0.00%
PHARMACEUTICAL TREND	
(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)	0.00%
TOTAL AVERAGE ANNUALIZED TREND (1F) and (2F) weighted proportionately by the mix of carrier's business	

APPENDIX H2: MONTHLY HISTORICAL TREND

In this Model the health plan will only be asked to enter data shown in Red, the other cells are all calculated as part of the State's Evaluation Model

Step 1: 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:

Row #	Month	Members	Medical		Pharmacy		Medical	Pharmacy	Total
			Total	Estimated	Total	Estimated	12-Month	12-Month	12-Month
			Incurred Claims	IBNR Claims	Incurred Claims	IBNR Claims	pmpm Trend	pmpm Trend	pmpm Trend
1	MM/YY								
2	MM/YY								
3	MM/YY								
4	MM/YY								
5	MM/YY								
6	MM/YY								
7	MM/YY								
8	MM/YY								
9	MM/YY								
10	MM/YY								
11	MM/YY								
12	MM/YY								
13	MM/YY								
14	MM/YY								

Row #	Month	Members	Medical		Pharmacy		Medical	Pharmacy	Total
			Total	Estimated	Total	Estimated	12-Month	12-Month	12-Month
			Incurred Claims	IBNR Claims	Incurred Claims	IBNR Claims	pmpm Trend	pmpm Trend	pmpm Trend
15	MM/YY								
16	MM/YY								
17	MM/YY								
18	MM/YY								
19	MM/YY								
20	MM/YY								
21	MM/YY								
22	MM/YY								
23	MM/YY								
24	MM/YY								
25	MM/YY								
26	MM/YY								
27	MM/YY								
28	MM/YY								
29	MM/YY								
30	MM/YY								
31	MM/YY								
32	MM/YY								
33	MM/YY								
34	MM/YY								
35	MM/YY								
36	MM/YY								
37	MM/YY								
38	MM/YY								
39	MM/YY								
40	MM/YY								

			Medical		Pharmacy		Medical	Pharmacy	Total
			Total	Estimated	Total	Estimated	12-Month	12-Month	12-Month
Row #	Month	Members	Incurring Claims	IBNR Claims	Incurring Claims	IBNR Claims	pmpm Trend	pmpm Trend	pmpm Trend
41	MM/YY								
42	MM/YY								
43	MM/YY								
44	MM/YY								
45	MM/YY								
46	MM/YY								
47	MM/YY								
48	MM/YY								

			Medical		Pharmacy		One Year Trends		
Start Month	End Month	Members Months	Total Incurring Claims	Estimated IBNR Claims	Total Incurring Claims	Estimated IBNR Claims	Medical Trend	Pharmacy Trend	Total Trend
MM/YY	MM/YY	0	0	0	0	0			
MM/YY	MM/YY	0	0	0	0	0			
MM/YY	MM/YY	0	0	0	0	0			
MM/YY	MM/YY	0	0	0	0	0			

APPENDIX H3: MONTHLY NORMALIZED TREND

In this Model the health plan will only be asked to enter data shown in Red, the other cells are all calculated as part of the State's Evaluation Model

Enter Your Member and Normalized 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.

Claims should be normalized for demographic changes, benefit changes, uw wear-off if applicable, and any other rating factors that are appropriate to normalize for.

Dental carriers please only complete the medical portion of this template.

Month Through Which Claims
are Paid:

MM/YY

			Medical	Pharmacy	Medical	Pharmacy	Total
			Normalized	Normalized	12-Month	12-Month	12-Month
Row #	Month	Members	Incurred Claims	Incurred Claims	pmpm Trend	pmpm Trend	pmpm Trend
1	MM/YY						
2	MM/YY						
3	MM/YY						
4	MM/YY						
5	MM/YY						
6	MM/YY						
7	MM/YY						
8	MM/YY						
9	MM/YY						
10	MM/YY						
11	MM/YY						

Row #	Month	Members	Medical	Pharmacy	Medical	Pharmacy	Total
			Normalized	Normalized	12-Month	12-Month	12-Month
			Incurred Claims	Incurred Claims	pmpm Trend	pmpm Trend	pmpm Trend
12	MM/YY						
13	MM/YY						
14	MM/YY						
15	MM/YY						
16	MM/YY						
17	MM/YY						
18	MM/YY						
19	MM/YY						
20	MM/YY						
21	MM/YY						
22	MM/YY						
23	MM/YY						
24	MM/YY						
25	MM/YY						
26	MM/YY						
27	MM/YY						
28	MM/YY						
29	MM/YY						
30	MM/YY						
31	MM/YY						
32	MM/YY						
33	MM/YY						
34	MM/YY						
35	MM/YY						
36	MM/YY						
37	MM/YY						
38	MM/YY						

			Medical	Pharmacy	Medical	Pharmacy	Total
			Normalized	Normalized	12-Month	12-Month	12-Month
Row #	Month	Members	Incurred Claims	Incurred Claims	pmpm Trend	pmpm Trend	pmpm Trend
39	MM/YY						
40	MM/YY						
41	MM/YY						
42	MM/YY						
43	MM/YY						
44	MM/YY						
45	MM/YY						
46	MM/YY						
47	MM/YY						
48	MM/YY						

			Medical	Pharmacy	One Year Trends		
Start Month	End Month	Members Months	Total Incurred Claims	Total Incurred Claims	Medical Trend	Pharmacy Trend	Total Trend
MM/YY	MM/YY	0	0	0			
MM/YY	MM/YY	0	0	0			
MM/YY	MM/YY	0	0	0			
MM/YY	MM/YY	0	0	0			

APPENDIX I: 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		0%	
Other Experience Credibility Weighting Assigned		0%	
2. Number of years of data used to calculation above credibility percentage:			
<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> 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 J: 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 must include consecutive data no older than 6 months prior to the proposed effective date.							
COLORADO MEDICAL EXPERIENCE							
Experience is for:	<input type="checkbox"/> Existing Product		<input type="checkbox"/> Comparable Product		<input type="checkbox"/> 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 EXPERIENCE PERIOD							
Date		Earned Premium	Incurred Claims	Estimated IBNR Claims	Total Estimated Incurred Claims	Loss Ratio	Paid Through Date
From	To						
Blocks of Business Included in Experience:							

COLORADO PHARMACY EXPERIENCE							
Experience is for:	<input type="checkbox"/> Existing Product		<input type="checkbox"/> Comparable Product		<input type="checkbox"/> 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 EXPERIENCE PERIOD							
Date		Earned Premium**	Incurred Claims	Estimated IBNR Claims	Total Estimated Incurred Claims	Loss Ratio	Paid Through Date
From	To						
Blocks of Business Included in Experience:							

COLORADO TOTAL EXPERIENCE							
Experience is for:	<input type="checkbox"/> Existing Product		<input type="checkbox"/> Comparable Product		<input type="checkbox"/> 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 EXPERIENCE PERIOD							
Date		Earned Premium	Incurred Claims	Estimated IBNR Claims	Total Estimated Incurred Claims	Loss Ratio	Paid Through Date
From	To						
Blocks of Business Included in Experience:							

OTHER EXPERIENCE						
Experience is for:	<input type="checkbox"/> Existing Product	<input type="checkbox"/> Comparable Product	<input type="checkbox"/> National	<input type="checkbox"/> Other	(Check all that apply)	
Year	Earned Premium	Incurred Claims	Total Estimated Incurred Claims	Total Estimated IBNR Claims	Average Covered Lives	Number of Claims
20xx						
20xx						
20xx						
20xx						
Experience Period:	From:		To:			
Additional Information:						

APPENDIX K: SIDE-BY-SIDE COMPARISON

SIDE-BY-SIDE COMPARISON			
If the proposed rating factor(s) are new, the memorandum must specifically so state, and provide detailed support for each of the factors.	<input type="checkbox"/> N/A		
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 L: PROJECTED EXPERIENCE FOR RATING PERIOD

PROJECTED EXPERIENCE FOR RATING PERIOD			
	Premiums	Incurred Claims	Benefits Ratio
Projected Experience Without Rate Change			
Projected Experience With Rate Change			
Additional Information			

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules for Form Filings
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
Section 7	Rules for Form Filings and Annual Reports for Credit Life and Health Products
Section 8	Rules for Form and Annual Report Filings for Preneed Funeral Contracts
Section 9	Rules for Filing Excess/Stop Loss Insurance Forms
Section 10	Wellness Benefits
Section 11	Readability
Section 12	Severability
Section 13	Enforcement
Section 14	Effective Date
Section 15	History
Appendix A	Form Health – Colorado Health Coverage Certification Form for Listings of New and/or Revised Policy Forms
Appendix B	Form Health Annual – Colorado Health Coverage Certification Form for Annual Reports
Appendix C	Form CI – Colorado Credit Insurance Policy Certification Form for Annual Reports and Listings of New and/or Revised Policy Forms
Appendix D	Form PN – Colorado Preneed Certification Form for Annual Reports and Listings of New and/or Revised Contracts
Appendix E	Form Colorado Health Excess/Stop Loss - Colorado Health Excess/Stop Loss Insurance for Self-Insured Employer Benefit Plans Under ERISA Certification Form

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), 10-16-107.2(1),(2),(3), 10-16-107.3(1)(b), 10-16-109, and 10-16-119(1), 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 Filings (SERFF). This includes insurers and other entities who provide sickness and accident insurance, credit disability, credit - FMLA, credit - life, accident only, specified disease, intensive care, organ & 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, prescription drug, and 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 or short-term limited duration health insurance policies.

Section 4 Definitions

- A. "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.
- B. "Accident only with wellness benefits" means, for the purposes of this regulation, the same as "Accident only" as defined above along with wellness benefits such as preventive care, diagnostic laboratory services, diagnostic x-ray services and similar services.
- 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 7.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 8.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 8.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 insurer.
- G. "Certification of compliance for excess/stop loss insurance" means, for the purposes of this regulation, a certification form, which contains the elements of certification as determined by the Commissioner, signed by a designated officer of the insurer, and used in conjunction with self-insured employer benefit plans under ERISA.
- H. "Contract seller" shall have the same meaning as found at § 10-15-102(6), C.R.S.
- I. "Credit Insurance" shall have the same meaning as found at § 10-10-103(2), C.R.S.
- J. "Disability income" means, for the purposes of this regulation, coverage that provides periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury.

- K. "Disability income with wellness benefits" means, for the purposes of this regulation, the same as "Disability income" as defined above. Additional requirements are included in Section 10.B.2. of this regulation.
- 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, and that comply with the requirements set forth in § 10-16-119, C.R.S.
- N. "Health benefit plan" shall 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" shall 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" means, for the purposes of this regulation, a 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.
- R. "Hospital indemnity with wellness benefits" means, for the purposes of this regulation, the same as "Hospital indemnity" as defined above along with wellness benefits. Additional requirements are included in Section 10.B.3. of this regulation.
- S. "Implementation date" means, for the purposes of this regulation, the specific date that the filed or approved forms can be offered to an individual.
- T. "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.
- U. "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, and a direct written policy form is different from a policy sold using producers, etc.
- V. "Officer of an entity" 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.
- W. "Plan" means, for the purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.

- X. "Policy of sickness and accident" shall have the same meaning as found at § 10-16-102(50), C.R.S.
- Y. "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.
- Z. "Program" means, for the purposes of this regulation, the title of an entity's insurance program, product or preneed funeral contract.
- AA. "Revised policy form" means, for the purpose of this regulation, an existing form previously submitted to the Division, which has been revised or modified. Carriers may be required to submit redline copies.
- AB. "SERFF" means, for the purpose of this regulation, the NAIC System for Electronic Rate and Form Filings.
- AC. "Signature" includes an electronic signature as found at § 24-71.3-102(8), C.R.S.
- AD. "Specified disease coverage" means, for the purposes of this regulation, payment of benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or principal sum.
- AE. "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 form.

Section 5 Rules for Form Filings

Any new and/or revised policies, riders, contracts, application forms, certificates or other evidence of coverage associated with all limited benefit plans, credit life and health, preneed funeral contracts, excess/stop loss insurance forms, sickness and accident insurance, and other limited benefit health plans shall 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 shall be submitted electronically by licensed entities. Failure to supply the information required in this Section 5 of this regulation will render the filing incomplete.

New plan designs under an existing product or policy form shall be filed and shall identify the difference in benefits and state if the benefits have been previously offered under the policy form and then later removed. 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.

This section summarizes the general SERFF requirements for all form filings and the standardized format for the certification of all forms. This section shall apply to each new product form introduced, to an existing form that is being modified or amended, and to the submission of forms certifications.

A. SERFF General Information Tab

- 1. SERFF Implementation Date Requested: This date shall be at least thirty-one (31) days after the submission date of the filing and shall be reflected in "MM/DD/YYYY" format. Do not use "On Approval" (**except** health excess/stop loss insurance and preneed forms which are filed concurrently to the date of use).

2. SERFF Requested Filing Mode: "File and Use" ("Informational" filings are not allowed in Colorado and may be rejected).
3. SERFF FILING TYPE: "Form".
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 shall be approved as being a "valid group" 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, shall be submitted with the filing prior to issuance of coverage. These documents, for the potential groups, shall 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; complete all fields including the "Readability Score" (for additional details, see § 10-16-107.3, C.R.S.: "Health Insurance Policies – Plain Language Required - Rules"). Do not attach the actual forms (**except** health excess/stop loss insurance). A separate "Forms List" under the "Supporting Documentation" tab is no longer required.

C. SERFF Supporting Documentation Tab

1. Letter of authority (if a carrier uses a third party to submit a form filing on its behalf).
2. All insurers authorized to conduct business in Colorado which provides any of the types of insurance specified in this regulation shall file the fully executed Colorado certification form specific to the insurance product and filing type as specified in the following sections. Applicable Colorado certification forms are attached in the appendices of this regulation.

The elements of certification as determined by the Commissioner, which shall be included in the "Colorado - Certification Form" and "Colorado - Certification Form for Annual Reports" applicable to the type of insurance 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 the policy forms, subscription certificates, membership certificates, or other evidences of sickness and accident insurance or health care benefits (other than health benefit plans), preneed funeral contracts, excess/stop loss insurance, or credit insurance, whichever is being certified and identified on the Form Schedule Tab in SERFF;
- c. A statement that the officer signing the certification form has carefully reviewed the policy forms, subscription certificates, membership certificates, preneed funeral contracts or other evidences of health care coverage identified on the Form Schedule Tab in SERFF, or in the case of excess/stop loss insurance, the actual forms are attached;
- d. A statement that the officer signing the certification form has read and understands each applicable law, regulation, and bulletin;

- e. A statement that the officer signing the certification form is aware of applicable penalties for certification of a noncomplying form or contract;
- f. 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;
- g. 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 shall be in compliance with § 24-71.3-101 et seq., C.R.S., and applicable regulations; and
- h. 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 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 shall be filed with the Division. All form filings shall be submitted electronically by licensed entities as specified in Section 5. above, with the following specific requirements:
 - 1. Use the appropriate SERFF TOI codes for the product that is being submitted, and the appropriate “State Specific Code” of either “700 - Large Group”, “701 - Small Group” or “850 - Individual”.
 - 2. The SERFF “Implementation Date Requested” field is required to be completed and shall be at least thirty-one (31) days after the submission date of the filing
 - 3. Carriers 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 of this regulation.

The officer signing the form shall certify, “to the best of my good faith knowledge and belief, that the new policy forms, revised 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.”

- B. Annual Form Certifications - 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 Section 5 above, with the following additional specific requirements:

1. Insurance companies shall use SERFF TOI code "H21 – Health – Other" and Health Maintenance Organizations shall use "HOrg03 Health – Other." All health lines of business should be submitted in ONE Annual Form Certification filing.
2. The SERFF Filing Type shall be "Annual Certification."
3. The SERFF "Implementation Date Requested" field is not required to be completed.
4. On the Form Schedule tab, the carrier shall 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.
5. Listing of the readability score and attaching the actual forms is not required.
6. Carriers shall file a fully-executed "Colorado Health Coverage Certification Form for Annual Reports (Form Health Annual)", available in Appendix B of this regulation.

The officer signing the form shall "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 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, 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."

Section 7 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 shall be filed at least thirty-one (31) days prior to use as prescribed in Section 5. with the following additional specific requirements:
 1. Use SERFF TOI code "CR07 - Credit Other."
 2. The SERFF "Implementation Date Requested" field is required to be completed.
 3. Carriers shall 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.

The officer signing the form shall "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 user, 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."

- B. Annual Reports - No later than July 1 of each year, each credit insurer shall file an annual report of policy forms as specified in Section 5 above, with the following specific requirements:
1. Use SERFF TOI code "CR07 - Credit Other."
 2. The SERFF Filing Type shall be "Annual Certification."
 3. The SERFF "Implementation Date Requested" field is not required to be completed.

Section 8 Rules for Form and Annual Report Filings for Preneed Funeral Contracts

- A. Form Filings - Preneed funeral contract sellers shall file compliant form filings, prior to, or concurrently with, the use of the form by a contract seller, as prescribed in Section 5. with the following specific requirements:
1. Use SERFF TOI codes "ML02 Multi-Line - Other", and the appropriate "State Specific Code" of either "710 – Preneed Trust Manuscript" or "711 – Preneed Insurance Manuscript".
 2. The SERFF "Implementation Date Requested" field is required to be completed. Do not use "On Approval" **except** on preneed forms which are filed concurrently to the date of use.
 3. The actual forms, including a red lined version of the forms, to be used shall be attached to the "Form Schedule" tab in SERFF.
 4. Contract sellers shall file a fully-executed "Colorado Preneed Certification Form for Annual Reports and Listings of New and/or Revised Contracts (FORM "PN")", available in Appendix D of this regulation.

The officer signing the form shall "certify that, to 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."

- B. Annual Reports - No later than July 1 of each year, each preneed contract insurer shall file an annual report of policy forms as specified in Section 5 above, with the following additional specific requirements:
1. Use SERFF TOI code "ML02 Multi-Line - Other",
 2. The SERFF Filing Type shall be "Annual Certification,"
 3. The SERFF "Implementation Date Requested" field is not required to be completed.

Section 9 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 shall be filed prior to use as prescribed in Section 5., with the following additional specific requirements:

- A. Use SERFF TOI code "H12 Health – Excess/Stop Loss", the appropriate Sub-TOI code, and the appropriate "State Specific Code" of either "700 - Large Group" or "701 - Small Group". SERFF "TOI Code":
- B. The SERFF "Implementation Date Requested" field is required to be completed. Do not use "On Approval" **except** on forms which are filed concurrently to the date of use.
- C. The actual forms to be used, and red lined versions of any revised forms, shall be attached to the "Form Schedule" tab in SERFF.
- D. Carriers shall 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)," available in Appendix E of this regulation, for each form filing.

The officer signing the form shall "certify, to the best of the officer's good faith, knowledge and belief, that 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."

Section 10 Wellness Benefits

- A. Wellness benefits shall be paid to the insured and shall be paid on an indemnity basis. If the policy includes wellness benefits, they shall be fully disclosed and properly labeled on the front page of the policy and the certificate.
- B. Wellness benefits, such as preventive care, diagnostic laboratory services, diagnostic x-ray services and similar services may be included in the following types of coverage:
 - 1. Accident only coverage: If these coverages include wellness benefits, the coverage shall be labeled "Accident only policy with wellness benefits". Accident only coverage and accident only coverage with wellness benefits shall not include medical expense benefits. This coverage shall 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 insured may have.
 - 2. Disability income coverage: If these coverages include wellness benefits, the coverage shall be labeled "Disability income coverage with wellness benefits". Disability income coverage and disability income coverage with wellness benefits shall not include annual doctor visits or outpatient coverage. If additional benefits are provided, such benefits shall be periodic payment to replace income lost when the insured is unable to work as the result of a sickness or injury. Loan payments and mortgage expenses benefit shall be filed as credit disability insurance.
 - 3. Hospital indemnity coverage: If these coverages include wellness benefits, the coverage shall be labeled "Hospital indemnity coverage with wellness benefits". Hospital indemnity coverage and hospital indemnity coverage with wellness benefits shall 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 insured may have.

Section 11 Readability

- A. Pursuant to § 10-16-107.3, C.R.S., carriers writing health coverage plans, limited benefit health insurance, dental plans, or long-term care 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.
- C. All policies, riders, amendments, endorsements, application forms, and other forms that are made a part of the policy by a carrier shall either be scored as a separate form, or as part of the policy with which they may be used.
- D. For the purposes of the readability score, amendments, riders, application forms, and endorsements 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 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 this regulation shall not be affected.

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 become effective on September 1, 2018.

Section 15 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.

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 9-1-2018

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 9-1-2018

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 9-1-2018

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 9-1-2018

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 9-1-2018

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules for Form Filings
Section 6	Rules for Annual Form Certification
Section 7	Certification Requirements
Section 8	Readability Score
Section 9	Severability
Section 10	Incorporated Materials
Section 11	Enforcement
Section 12	Effective Date
Section 13	History
Appendix A	"Form Health - Colorado Health Coverage Certification Form for Listing of New and/or Revised Policy Forms"
Appendix B	"Form Health Annual - Colorado Health Coverage Certification Form for Annual Reports"

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, 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" 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. "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. "Annual Report for Health Coverage Plans" means, for the purpose of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 6. of this regulation.
- D. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- E. "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.
- F. "Connect for Health Colorado" shall have the same meaning as "exchange" as found at § 10-16-102(26), C.R.S.
- G. "Covered person" means, for the purposes of this regulation, a person entitled to receive benefits or services under a health benefit plan.
- H. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.
- I. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.
- J. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- K. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.
- L. "Listing of New and/or Revised Policy Forms for Health Coverage" means, for the purpose of this regulation, completing the Form Schedule Tab in SERFF, including the documents and information listed in Section 5.A.1.a. of this regulation.
- M. "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.
- N. "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.
- 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 twelve (12) months preceding the coverage effective date under a short-term policy.
- Q. "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.
- R. "Program" means, for the purpose of this regulation, the title of a carrier's health coverage program or product.

- S. "Revised policy form" means, for the purpose of this regulation, an existing form previously submitted to the Division that has been revised or modified. Carriers may be required to submit redline copies.
- T. "SERFF" means, for the purpose of this regulation, the NAIC System for Electronic Rate and Form Filings.
- U. "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.
- V. "Signature" includes an electronic signature as found at § 24-71.3-102(8), C.R.S.
- W. "Student health insurance coverage" shall have the same meaning as found at § 10-16-102(65), C.R.S.
- X. "Substantially different new benefit" means, for the purpose of this regulation, a new benefit that, in the minimum, 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, coinsurance, copayments, and maximum out-of-pocket amounts) to what is offered as an existing product does not create a new form.

Section 5 Rules for Form Filings

All policies, riders, contracts, application forms, certificates, or other evidence of health coverage associated with health benefit plans, ACA-compliant stand-alone dental plans (SADPs), student health insurance coverage, and short-term limited duration health insurance policies shall be filed with the Division of Insurance (Division). All form filings shall be submitted electronically by licensed entities. Failure to supply the information required in Section 5 of this regulation will render the filing incomplete.

A. General 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, in a format prescribed by the Commissioner, 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.
 - a. In order to file a "Listing of New and/or Revised Policy Forms for Health Coverage" the carrier shall complete the Form Schedule Tab in SERFF. The listing shall include any new or revised policy forms and/or application forms for any health benefit plan, ACA-compliant SADP, student health insurance coverage, or short-term policy, 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 by law.
 - b. Carriers shall file, in a format prescribed in Section 7.C., a fully-executed "Colorado Health Coverage Certification Form for Listing of New and/or Revised Policy Forms (Form Health)", available in Appendix A, for each form filing.
 - c. Carriers shall complete all SERFF required data fields.
 - d. Carriers shall attach copies of the following documents under the Supporting Documentation Tab in SERFF:

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- (1) Letter of Authority (if a carrier uses a third party to submit a form filing on its behalf); and
 - (2) Colorado Health Coverage Certification Form for Listing of New and/or Revised Policy Forms (Form Health).
 2. 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. UETA guidance is provided by the Colorado Office of Information Technology and the Division.
 3. Each type of insurance shall have a separate form filing. Form filings must not be combined with rate filings.
 4. 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.
 5. 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.
 6. For evidences of coverage, policies, certificates and other applicable forms, carriers shall use the section names as specified in Colorado Insurance Regulation 4-2-34.
- 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, copies of the actual form documents shall be attached and 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 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 4-2-42);
 - b. Bracketed language shall be complete and options 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 Evidence of Coverage (EOC) and Summary of Benefit and Coverage (SBC) forms, if applicable:

- (1) For health benefit plans:
 - (a) The EOC and SBC 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, the EOC and SBC documents, following review, will be attached under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF, as described below. For plans offered through Connect for Health Colorado, all SBCs must be submitted in English and in Spanish. The Spanish EOCs must be available upon request, but are not required to be submitted to the Division.
- (2) For ACA-compliant SADPs
 - (a) The EOC 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, the EOC documents, following review, shall be attached under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF, as described below. The Spanish EOCs must be available upon request, but are not required to be submitted to the Division. Connect for Health Colorado provides the requirements for preparation and submittal of SBCs. SBCs for dental plans, in English and in Spanish, shall be submitted in the Plan Management (Binder) section of SERFF.

5. Submission Requirements for ACA-Compliant New and/or Revised Form Filings

Carriers shall complete and submit the following information in SERFF 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, 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, and attach copies of the following documents:
 - (1) Evidence of Coverage (EOC);
 - (2) Any additional policy forms.
 - (3) No riders or endorsements are permitted.
 - c. Following form filing review, and at the time requested by the Division, carriers offering plans through Connect for Health Colorado shall complete and upload the following documents 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 CFR 156.420, and as directed by the Division. These documents will be posted on the Connect for Health Colorado website.
 - (1) Evidence of Coverage (EOC),
 - (2) Summary of Benefits and Coverage (SBC), in English and Spanish; and,
 - (3) Colorado Supplement to the SBC, in English and Spanish (not applicable to SADP carriers).
- 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 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 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 applicable mandated benefits pursuant to § 10-16-104, C.R.S.

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2. Carriers shall complete the Form Name, Form Number, Form Type, Action, Readability Score data fields on the Form Schedule Tab. Copies of the actual form documents must not be attached unless requested by the Division:
 - a. Evidence of Coverage (EOC);
 - b. Summary of Benefits and Coverage (SBC);
 - b. Application; and
 - c. Policy forms, riders and endorsements.
 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.
 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 Form Schedule Tab, and attach copies of the following documents, with page numbers:
 - a. Evidence of Coverage (EOC);
 - b. Application; and
 - c. Any other policy forms, riders, and endorsements.
 - d. 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. Carriers shall incorporate the following disclaimers in BOLD type in 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 INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY.

THIS SHORT-TERM POLICY IS NOT REQUIRED TO PROVIDE COVERAGE FOR THE TEN (10) ESSENTIAL HEALTH BENEFITS FOUND AT § 10-16-103.4, C.R.S.”
 - 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

- A. 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 including a fully executed “Colorado Health Coverage Certification Form for Annual Reports (Form Health Annual)”, available in Appendix B, and complete the Form Schedule Tab in SERFF.
- B. In order to file an “Annual Report for Health Coverage Plans”, the carrier shall complete the Form Schedule Tab in SERFF. The report 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.
- C. Listing the readability score and attaching the actual forms is not required.

- D. Failure to supply the information required in this section of this regulation will render the Annual Form Certification filing incomplete.

Section 7 Certification Requirements

A. Timing Requirements for Certification

1. Form filings shall be filed at least thirty-one (31) days prior to using any new form, as specified in Section 5.A.1. of this regulation.
2. Annual form certifications shall be filed no later than December 31 of each year, as specified in Section 6.A. of this regulation.

B. Elements of certification: The elements of certification as determined by the Commissioner, which shall be included in the "Colorado Health Coverage Certification Form for Listing of New and/or Revised Policy Forms (Form Health)", and "Colorado Health Coverage Certification Form for Annual Reports (Form Health Annual)", are as follows:

1. The name of the carrier;
2. A statement that the officer signing the certification form is knowledgeable of the health coverage insurance being certified;
3. 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;
4. A statement that the officer signing the certification form has read and understands each applicable law, regulation and/or bulletin; and
5. A statement that the officer signing the certification form is aware of applicable penalties for certification of a noncomplying form or contract.
6. A statement that the officer signing the certification form certifies:
 - a. 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:
 - (1) New and/or revised policy forms;
 - (2) Application forms (to include any health questionnaires used as part of the application process used by large group plans only);
 - (3) 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

- (4) Contracts, certificates, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado.
- b. 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.
- 7. 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;
- 8. 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
- 9. 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 CFR 156.420 published by the Government Printing Office shall mean 45 CFR § 156.420 as published 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 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 September 1, 2018.

Section 13 History

Regulation effective October 1, 2013.

Revised regulation effective April 15, 2014.

Repealed and Re-promulgated regulation effective September 1, 2018.

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 9-1-2018

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 9-1-2018

Regulation 4-2-42 CONCERNING ESSENTIAL HEALTH BENEFITS

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Essential Health Benefits
Section 6	Preventive Services Requirements
Section 7	Incorporation by Reference
Section 8	Severability
Section 9	Enforcement
Section 10	Effective Date
Section 11	History

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. “Actuarial value” and “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. “AV calculator” means, for the purposes of this regulation, the publicly available actuarial value (AV) calculator developed by the U.S. Department of Health and Human Services (HHS) and available electronically on the Center for Consumer Information & Insurance Oversight (CCIIO) website.
- C. “Behavioral, mental health, and substance use disorder” shall have the same meaning as found at § 10-16-104(5.5)(d), C.R.S.
- 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. “Essential health benefits” and “EHB” shall have the same meaning as found at § 10-16-102(22), C.R.S.

- G. "Essential health benefits package" shall have the same meaning as found at § 10-16-102(23), C.R.S.
- H. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.
- I. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.
- J. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.
- K. "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.
- L. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- M. "Premium adjustment percentage" means, for purposes of this regulation, the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance, as published in the HHS "Notice of benefits and payment parameters."

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).
- 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.
- 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 fillings;
 - (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. Carriers must limit cost-sharing for EHB coverage in accordance with state and federal law.
 - a. Cost-sharing (or maximum out-of-pocket limits) for individual and small group plans must not exceed the out-of-pocket limit set by federal law. For managed care plans, out-of-network deductibles and out-of-pocket maximums do not count toward these cost sharing limits.
 - b. Cost sharing limits for individual and small group plans may not be increased beyond the annual premium adjustment percentage for individuals, and no more than twice the individual amount for family plans. Increases in annual deductibles must be in multiples of fifty (50) dollars, and if not, must be rounded to the next lowest multiple of fifty (50) dollars.
 - c. Cost-sharing (or maximum out-of-pocket limits) for stand-alone pediatric dental plans must not exceed the annual out-of-pocket limit set by federal law. For managed care plans, out-of-network deductibles and out-of-pocket maximums do not count toward these cost sharing limits.
 - d. The Division will annually publish the federally established annual premium adjustment percentages and annual out-of-pocket limits for medical and dental plans, as determined by HHS.
- 4. Carriers must offer health benefit plans that meet state and federally defined levels of coverage.

- a. In order to be a qualified health plan for purposes of sale on the Exchange, a carrier must meet the federal standards found in 45 CFR § 156.200(c)(1), which require a carrier to offer at least one (1) silver plan and at least one (1) gold plan for purchase in each region in which it offers health benefit plans.
 - b. Carriers must offer plans that meet at least one (1) of the following metal tiers of coverage:
 - (1) Bronze level: benefits actuarially equivalent to sixty percent (60%) of the full actuarial value of the benefits provided under the plan;
 - (2) Silver level: benefits actuarially equivalent to seventy percent (70%) of the full actuarial value of the benefits provided under the plan;
 - (3) Gold level: benefits actuarially equivalent to eighty percent (80%) of the full actuarial value of the benefits provided under the plan; or
 - (4) Platinum level: benefits actuarially equivalent to ninety (90%) of the full actuarial value of the benefits provided under the plan.
 - c. Carriers are allowed a de minimis range of +/- two percentage (2%) points for each metal tier.
 - d. Carriers offering health benefit plans at any of the levels of coverage listed in Section 5.A.4.b. of this regulation must offer child-only plans at that same level.
 - e. Carriers may offer a catastrophic plan that does not provide a bronze, silver, gold, or platinum level of coverage to certain qualified individuals.
 - 5. 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.
 - 6. 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.
 - 7. 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.
 - 8. 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.
- B. Carriers must use actuarial value (AV) to determine the level of coverage of a health benefit plan. The AV is the percentage of total average costs for covered benefits that a plan will cover, and must be calculated based on the provision of EHB to a standard population.

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1. For standard plan designs, carriers must use the AV calculator developed by HHS to determine AV.
 2. Carriers offering plans with benefit designs that cannot be accommodated by the AV calculator may alternatively:
 - a. Decide how to adjust the plan's benefit design (for calculation purposes only) to fit the parameters of the calculator, and have a member of the American Academy of Actuaries certify that the methodology to fit the parameters of the AV calculator was in accordance with generally accepted actuarial principles and methodologies; or
 - b. Use the AV calculator for the plan design provisions that correspond to the parameters of the calculator, and have a member of the American Academy of Actuaries calculate appropriate adjustments to the AV as determined by the AV calculator for the plan design features that deviate substantially, in accordance with generally accepted actuarial principles and methodologies.
- C. Substitution of Benefits
1. Carriers are permitted to substitute EHB if the following conditions are met:
 - a. The substituted benefit must be actuarially equivalent to the benefit that is being replaced. Carriers must submit evidence of actuarial equivalence that is:
 - (1) Certified by a member of the American Academy of Actuaries;
 - (2) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
 - (3) Based on a standardized population; and
 - (4) Determined regardless of cost-sharing.
 - b. A benefit substitution may be made only within the same EHB category (substitutions across categories are not permitted); and
 - c. Prescription drug benefits cannot be substituted.
- D. Prohibition on Discrimination
1. Carriers may not offer benefit plans that, either through their design or implementation, discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other medical conditions.
 2. Carriers may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
 3. Carriers may not offer plans with benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.

E. 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.

F. A carrier offering individual or small group health benefit plans that provide EHBs shall not impose annual and lifetime dollar limits on those benefits.

Section 6 Preventive Services Requirements

A. Carriers must provide coverage for any new preventive service receiving a USPSTF A or B recommendation, changes adopted by the ACIP, and/or changes published by the Health Resources and Services Administration (HRSA) no later than the plan year that begins on or after one (1) year after the date the recommendation or change is issued, adopted or published.

B. The Division shall publish, by bulletin, the list of covered preventive services in accordance with:

1. The "USPSTF A and B Recommendations," published by the United States Preventive Services Task Force (USPSTF);
2. The preventive services mandated by Colorado statute; and
3. The women's preventive service guidelines published by the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services.

C. The Division shall review this bulletin no less frequently than annually to determine if amendments are required. If it is determined that amendments are required, any changes made to the list of covered preventive services will be incorporated to include:

1. New preventive services added to Colorado statute;
2. New A or B recommendations or changes to existing preventive service recommendations adopted by the USPSTF; and/or
3. New guidelines or changes to existing guidelines published by HRSA.

Section 7 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 actuarial value calculator developed by the U.S. Department of Health and Human Services, and published by the Center for Consumer Information & Insurance Oversight shall mean the actuarial value calculator developed by the U.S. Department of Health and Human Services as published on the effective date of this regulation and does not include later amendments to, or editions of, the actuarial value calculator developed by the U.S. Department of Health and Human Services. The actuarial value calculator developed by the U.S. Department of Health and Human Services may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Center for Consumer Information & Insurance Oversight website at <https://www.cms.gov/ccio/>. Certified copies of the actuarial value calculator developed by the U.S. Department of Health and Human Services 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.

The HHS Notice of benefits and payment parameters published by The Centers for Medicare & Medicaid Services shall mean the HHS Notice of benefits and payment parameters, as published on the effective date of this regulation and does not include later amendments to, or editions of, the HHS Notice of benefits and payment parameters. The HHS Notice of benefits and payment parameters 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 & Medicaid Services website at <https://www.cms.gov/newsroom/press-releases/cms-issues-final-rule-2020-annual-notice-benefit-and-payment-parameters>. Certified copies of the HHS Notice of benefits and payment parameters are available from the Colorado Division of Insurance for a fee.

The federally established premium adjustment percentages and out-of-pocket limits for medical and dental plans published by the Centers for Medicare & Medicaid Services shall mean the federally established premium adjustment percentages and out-of-pocket limits for medical and dental plans, as published on the effective date of this regulation and does not include later amendments to, or editions of, the federally established premium adjustment percentages and out-of-pocket limits for medical and dental plans. The federally established premium adjustment percentages and out-of-pocket limits for medical and dental plans 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 & Medicaid Services website at <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/>. Certified copies of the federally established premium adjustment percentages and out-of-pocket limits for medical and dental plans are available from the Colorado Division of Insurance for a fee.

45 CFR § 156.200(c)(1), published by the Government Printing Office shall mean 45 CFR § 156.200(c)(1), as published on the effective date of this regulation and does not include later amendments to, or editions of, 45 CFR § 156.200(c)(1). 45 CFR § 156.200(c)(1) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Government Printing Office website at <https://www.ecfr.gov/>. Certified copies of 45 CFR § 156.200(c)(1) are available from the Colorado Division of Insurance for a fee.

The USPSTF A and B Recommendations, published by the United States Preventive Services Task Force shall mean the USPSTF A and B Recommendations, as published on the effective date of this regulation and does not include later amendments to, or editions of, the USPSTF A and B Recommendations. The USPSTF 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/Page/Name/uspstf-a-and-b-recommendations/>. Certified copies of the USPSTF A and B Recommendations are available from the Colorado Division of Insurance for a fee.

The women's preventive service guidelines, published by the Health Resources and Services Administration shall mean the women's preventive service 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 service guidelines published by the Health Resources and Services Administration. The women's preventive service 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/index.html>. Certified copies of the women's preventive service 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 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 1, 2020.

Section 11 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.

**Regulation 4-2-43 ENROLLMENT PERIODS RELATING TO INDIVIDUAL AND GROUP HEALTH
BENEFIT PLANS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Individual Enrollment Periods
Section 6	Group Enrollment Periods
Section 7	Annual Market Stabilization Special Enrollment Period
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Section 10	Enforcement
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Section 12	History

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)(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).

The Commissioner finds that the volatility and uncertainty within the individual insurance market, and the potential for consumer harm, constitute a triggering event requiring a special enrollment period, as specified in Section 7, to reduce the potential for consumer harm and ensure the continued health and stability of the Colorado health insurance market.

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. "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.
- I. "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.
- J. "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. The open enrollment period for plans effective on or after January 1 shall begin on November 1 of the prior year and extend through December 15 of that same 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. The open enrollment period will be extended through the annual market stabilization special enrollment period each year, as found in Section 7 of this regulation.
 - 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. Except as provided in Section 7, following a triggering event, a carrier must provide a special enrollment period of sixty (60) days.
2. Except as provided in Section 7, when an individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the thirty (30) 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 must be able 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. Except as provided in Section 7, when a qualified individual is notified or becomes aware of a triggering event that will occur in the future, he or she 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 must be able 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 his or her 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 the effective date of the loss of coverage;
 - b. An individual or his or her 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 his or her dependent, dies;
 - d. An individual or his or her 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 his or her 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 his or her 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 his or her 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 his or her 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 he or she 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; or
 - (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 his or her employer discontinuing or changing coverage within the next sixty (60) days, provided the enrollee is able to terminate his or her 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.
- i. An individual or his or her 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 his or her 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 his or her 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;
- o. An individual or his or her dependent enrolling in a health benefit plan may apply for enrollment in a new health benefit plan during the annual market stabilization special enrollment period, as specified in Section 7 of this regulation;
- p. An individual who is a victim of domestic abuse or spousal abandonment, as defined by 26 C.F.R. § 1.36B-2T, 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;
- q. 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;
- r. An individual or his or her 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;
- s. An individual, or his or her 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;
- t. An individual, or his or her 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;
- u. An individual, or his or her 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; or
- v. 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 his or her 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.

5. Special Enrollment Period Eligibility Verification and Prior Coverage Requirements
 - a. Carriers shall 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 his or her 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 he or she 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 he or she may appeal that decision with the carrier and that he or she 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 an involuntary loss of creditable coverage shall be considered sufficient if the individual produces:
 - (a) Written confirmation of the loss of creditable coverage;
 - (b) An official letter or other notice from an employer or sent on behalf of an employer that provides notice of eligibility for COBRA or for state continuation benefits;
 - (c) Official documentation for loss due to exhaustion of COBRA or state continuation benefits; or
 - (d) A letter confirming such loss from the Division.
 - (2) Evidence of gaining or becoming a dependent shall be considered sufficient if the individual produces:
 - (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.
 - (c) A court order or designated beneficiary documents, if the gaining or becoming a dependent occurs due to a court order.
 - (3) 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 is no longer eligible to be covered under a parent's health benefit plan.

- (4) Evidence of a permanent change in residence shall be considered sufficient if the individual produces:
 - (a) Proof of change of address provided to, and acknowledged by, the U.S. Postal Service;
 - (b) A copy of a lease or purchase agreement listing the new address;
 - (c) A copy of utility bills listing the new address; or
 - (d) A copy of a driver's license listing the new address.
- (5) Evidence of a material violation of a carrier's contract shall be considered sufficient if the individual produces a letter confirming eligibility for a special enrollment from the Division.
- (6) Evidence of a change in citizenship or immigration status shall be considered sufficient if the individual produces official documentation of the change.
- (7) Evidence of status as an American Indian/Native American shall be considered sufficient if the individual produces official documentation of his or her status.
- (8) Evidence of a new determination of eligibility or ineligibility for federal advance premium tax credits or cost-sharing reductions available through the Exchange shall be considered sufficient if the individual produces the determination from the Exchange.
- (9) Documentation providing 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 ceased all short-term policy sales in the state, or that the carrier has exited the market, which includes, but is not limited to, written communication from the carrier or from a broker.
- (10) Any other documentation reasonably sufficient to verify eligibility for the special enrollment period requested.

d. 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 he or she 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 he or she 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 he or she possessed minimum essential coverage, carriers may require the requesting individual to demonstrate:

- (a) He or she 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) That he or she is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act; or
 - (c) He or she 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.
- e. The special enrollment period eligibility verification and prior coverage requirements found in Section 5.D.5. of this regulation do not apply to the annual market stabilization special enrollment period found in Section 7 of this regulation.
- 6. Except as provided in Section 7, coverage effective dates will be:
 - a. In the case of marriage, civil union, or in the case where an individual loses creditable coverage, coverage must be effective no later than the first day of the month following plan selection.
 - b. 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.
 - c. 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.f. and 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.
 - d. 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.f. and g. of this regulation at the election of the primary individual policyholder.

- e. 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.
- f. In the case of all other triggering events where individual coverage is purchased between the first and fifteenth day of the month, coverage shall become effective no later than the first day of the following month.
- g. In the case of all other triggering events where individual coverage is purchased between the sixteenth and last day of the month, coverage shall become effective no later than the first day of the second 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 for a group it has declined to an 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 between the first and the fifteenth day of the month, the first effective day of the health benefit plan will be no later than the first day of the following month.
 - c. If a fully completed application that includes plan selection is received between the sixteenth and last day of the month, the first effective day of the health benefit plan will be no later than the first day of the second 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, he or she 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.

Section 7 Annual Market Stabilization Special Enrollment Period

- A. Carriers shall establish an annual market stabilization special enrollment period in order to ensure that consumers have sufficient opportunity to enroll in a health benefit plan after the end of the annual open enrollment period, and to ensure the continued health and stability of the Colorado health insurance market.
- B. The annual market stabilization special enrollment period shall begin each year on December 16 and extend through January 15.
- C. Individual health benefit plans purchased on or off of the Exchange during the annual market stabilization special enrollment period shall be effective no later than February 1 of the plan year.
- D. The special enrollment period eligibility verification and prior coverage requirements found in Section 5.D.5. of this regulation do not apply to the annual market stabilization special enrollment period.

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

26 C.F.R. § 1.36B-2T, published by Government Printing Office shall mean shall mean 26 C.F.R. § 1.36B-2T 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-2T. A copy of 26 C.F.R. § 1.36B-2T 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-2T 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 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 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 September 1, 2019.

Section 12 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.

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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 Colorado insurance laws. 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 uniform application forms:
 - 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.
- 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.

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 October 15, 2013.

Section 9 History

New regulation effective October 15, 2013.



Division of Insurance

COLORADO UNIFORM INDIVIDUAL APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's initial 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:	<input type="checkbox"/> New Coverage	<input type="checkbox"/> Change/Modification to Existing Coverage	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Special Enrollment*
Requested Effective Date:	____/____/____ (MM/DD/YYYY)			

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

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:			
Social Security #:			Date of Birth:	____/____/____		Current Age:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Physical Address:							City:	
County:			State:			Zip:		
Mailing Address (if different):							City:	
County:			State:			Zip:		
Home Phone:			Alternate Phone:			Email:		
Are you (check one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law* <input type="checkbox"/> Civil Union* <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Under 21								
Are you or is anyone in your family American Indian or Alaskan Native? <input type="checkbox"/> Yes <input type="checkbox"/> No								
* A common law, civil union, or designated beneficiary certification may be required by the carrier								
Employer Name and Address:						Work Phone:		

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.

* Social Security Numbers (or document numbers for any legal immigrants) are needed for anyone applying for health insurance, missing numbers will be requested after enrollment

Name (First, MI, Last)	Sex	Social Security #	Relationship	Disabled	Birth Date (MM/DD/YY)	Employer Name and Position
	<input type="checkbox"/> M <input type="checkbox"/> F		SPOUSE/PARTNER			
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

Primary Applicant Name: _____				
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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 if 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: _____		

TOBACCO USE				
<p><i>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."</i></p> <p>Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.</p>				
Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		

MEDICARE/MEDICAID INFORMATION	
Is any applicant enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 this individual's Medicaid status.	

CURRENT MEDICAL COVERAGE				
Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 applicant is accepted? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____				

Primary Applicant Name: _____

CERTIFICATION OF DENTAL INSURANCE COVERAGE	
(Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No Note: you may be required 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:

Primary Applicant Name:	
-------------------------	--

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 # (NPR):	Agent ID # (NPR):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? <input type="checkbox"/> Yes <input type="checkbox"/> 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://www.dora.colorado.gov/insurance>. 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.

[illegible]

Signature of Primary Applicant: _____ Date Signed: _____



Division of Insurance

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:		<input type="checkbox"/> New Coverage <input type="checkbox"/> Change/Modification to Existing Policy <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Special Enrollment*							
<small>* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp</small>									
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:				
Social Security #:			Date of Birth:		Current Age:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Address:			City:						
County:			State:		Zip:				
Mailing Address (if different):			City:						
County:			State:		Zip:				
Home Phone:			Email:		<input type="checkbox"/> Home <input type="checkbox"/> Work				
What is your job title at your current employer?					Work Phone:				
What was your first day of employment?					How many hours, on average, do you work each week?				
Are you (check one):		<input type="checkbox"/> Single		<input type="checkbox"/> Married		<input type="checkbox"/> Common Law*		<input type="checkbox"/> Civil Union*	
		<input type="checkbox"/> Designated Beneficiary*		<input type="checkbox"/> Legally Separated		<input type="checkbox"/> Divorced		<input type="checkbox"/> Widow or Widower	
<small>* A common law, civil union, or designated beneficiary certification may be required by the carrier</small>									
Are you on COBRA or State Continuation?			<input type="checkbox"/> Yes <input type="checkbox"/> No		Start Date:		Stop Date:		
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: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Family									
DEPENDENT INFORMATION (list all dependents to be covered)									
Name (First, MI, Last)	Sex	Social Security Number	Relationship	Disabled	Birth Date (MM/DD/YY)				
	<input type="checkbox"/> M <input type="checkbox"/> F		SPOUSE/PARTNER						
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No					

Employee Name:	Employer Name:
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TOBACCO USE				
<p><i>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."</i></p> <p>Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.</p>				
Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		

EMPLOYEE/DEPENDENT WAIVER OF COVERAGE		
<p>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:</p>		
	Name (Last, First, MI)	Birth Date (Mo/Day/Year)
Employee		
Spouse/Partner		
Dependent 1		
Dependent 2		
Dependent 3		
<p>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):</p> <p> <input type="checkbox"/> I am covered under my spouse/partner's group policy. <input type="checkbox"/> My spouse/partner is covered under another plan (including this plan, if spouse/partner is also an employee). <input type="checkbox"/> My dependents are covered under another plan. <input type="checkbox"/> I wish to continue other coverage obtained through an Individual Plan or Medicare <input type="checkbox"/> Other (Please explain): _____ </p>		
<p>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.</p> <p>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.</p>		
Signature of Employee:		Date Signed:

Employee Name: _____	Employer Name: _____
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MEDICARE INFORMATION	
<p>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.</p> <p>Are you, your spouse/partner or your child(ren) covered by:</p> <p>Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," reason for Medicare: <input type="checkbox"/> 65+ Eff. Date _____ <input type="checkbox"/> Disability Eff. Date _____</p> <p><input type="checkbox"/> End-Stage Renal Disease (ESRD) Eff. Date _____ <input type="checkbox"/> Disability and ESRD Eff. Date _____</p> <p>Name of person covered by Medicare: _____</p>	

CURRENT MEDICAL COVERAGE					
<p>Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the plan information listed below the same for your spouse/partner and all dependents? If yes, skip to next section. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Your information will help the small employer carrier(s) to coordinate benefits with any other group health coverage you may have.</p>					
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)
<p>Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; M5 = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain: _____</p>					

HEALTH PROVIDER OR PRODUCT SELECTION, IF APPLICABLE				
<p>Please select the type of coverage for which you are applying from the plans offered by your employer and issued by the carrier. 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 and for each carrier from which insurance coverage is being sought. The provider information may be listed in the provider materials that are supplied by each carrier to your employer. Use additional sheets if necessary.</p>				
Covered Person's Name	Medical Plan	Primary Care Physician Name:	Primary Care Physician Address: (optional)	Is this your current provider?

Employee Name: _____	Employer Name: _____
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TERMS AND CONDITIONS

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.

Signature of Employee:  _____ Date Signed: _____

DISCLOSURES

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 <http://dora.colorado.gov/insurance>. For questions regarding coverage or enrollment please see your employer.

**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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Requirements to Maintain Grandfathered Status and Recordkeeping
Section 6	General Rate Filing Requirements
Section 7	Actuarial Memorandum
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Section 9	Use of Composite Rates for Small Group Health Benefit Plans
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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 $\text{SQRT} \{(\# \text{ life years or claims})/\text{full credibility standard}\}$. 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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Form
Section 7	Severability
Section 8	Incorporated Materials
Section 9	Enforcement
Section 10	Effective Date
Section 11	History
Appendix A	Colorado Universal Prior Authorization Drug Benefit Request Form

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";

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- 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.

<input type="checkbox"/> Urgent ¹ <input type="checkbox"/> Non-Urgent			
Requested Drug Name:			
Is this drug intended to treat opioid dependence?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
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* <input type="checkbox"/>	No <input type="checkbox"/>
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:		<input type="checkbox"/> New Request <input type="checkbox"/> 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:		<input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician Office <input type="checkbox"/> Other:	
Prescriber or Authorized Signature:			Date:
Dispensing Pharmacy Name and Phone Number:			
<input type="checkbox"/> Approved <input type="checkbox"/> Denied			

	If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:
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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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Notices
Section 7	Severability
Section 8	Enforcement
Section 9	Effective Date
Section 10	History

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 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 April 15, 2015, 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 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 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;
 - 2. Obtaining proof of purchase from the consumer who is a childless adult that they possess low-cost/no-cost child-only pediatric dental EHB coverage; or
 - 3. 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 standalone 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 in any way.

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 April 15, 2015.

Section 10 History

Regulation effective July 15, 2014.
Amended regulation effective April 15, 2015.

Regulation 4-2-51 CARRIER DISCONTINUANCE OF A HEALTH BENEFIT PLAN AND A STUDENT HEALTH PLAN

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Discontinuance of Individual and Small Group Health Benefit Plans
Section 6	Discontinuance of Large Group Health Benefit Plans and Student Health Insurance Coverage
Section 7	Required SERFF Submissions
Section 8	Severability
Section 9	Enforcement
Section 10	Effective Date
Section 11	History
Appendix A	Example Notice
Appendix B	Health Benefit Plan Discontinuances Summary Data Template
Appendix C	Health Benefit Plan Discontinuances by County Data Template

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), 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 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 plans 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. "Exchange" shall, for the purposes of this regulation, have the same meaning as set forth in § 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. "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.
- F. "SERFF" shall, for the purposes of this regulation, mean System for Electronic Rate and Form Filings.

- G. "Small group plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(63), C.R.S.
- H. "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.
- I. "Transition plan" shall, for the purposes of this regulation, mean non-compliant non-grandfathered health benefit plans that a carrier elected to continue into 2015, but that cannot continue beyond December 31, 2015.

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 Insurance (Division) of such discontinuance by submitting a filing to the Division. All filings shall 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. Until an individual or small group health benefit plan becomes subject to the provisions of HB13-1266, carriers electing to discontinue individual or small group plans must do so in accordance with the requirements found at § 10-16-201.5, C.R.S. (2012).
- C. For plans issued after January 1, 2014, carriers that elect 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 shall offer policyholders the option of purchasing any other health benefit plan currently being offered by the carrier for which they qualify.
- D. The carrier shall provide notice of the decision not to renew or continue coverage to each policyholder at least ninety (90) days prior to the date of nonrenewal or discontinuance.
- E. Carriers shall include notice to the policyholder of eligibility for special enrollment periods, as established pursuant to § 10-16-105.7, C.R.S., with the nonrenewal or discontinuance notice.
- F. Carriers must use the notification language provided in Attachment A in order to provide sufficient notification to policyholders.
- G. Carrier discontinuance of a health benefit plan qualifies the policyholder for a special enrollment period pursuant to § 10-16-105.7(3), C.R.S. as an involuntary loss of creditable coverage.

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 Appendix A must be used. Additional communication with the policyholders regarding their enrollment options is not prohibited.
- B. The large group and student health 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.
- C. The large group or student health 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.
- D. With respect to the discontinuance of a particular large group plan(s), the carrier must notify the Insurance Commissioner before providing the notification required in subsection A. above.
- E. A carrier discontinuing all of its large group health benefit plans or student health insurance coverage plans as part of an exit from that particular market segment shall comply with the requirements found at § 10-16-105.1(2)(h), C.R.S.

Section 7 Required SERFF Submissions

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 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 actions must be attached as a supporting document and must contain the following information:
 - 1. Effective date of the discontinuance and/or exit from the market;
 - 2. The reason for the carrier's action;
 - 3. The market segment being exited or discontinued;
 - 4. Number of people affected (by county);
 - 5. Grandfathered/Non-Grandfathered status; and
 - 6. A statement as to whether or not the plan is a transition plan.
- D. The form found in Appendix B of this regulation shall be completed and included with this filing.
- E. The form found in Appendix C of this regulation shall be completed and included with this filing.

Section 8 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 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 August 1, 2015.

Section 11 History

New regulation effective August 15, 2014.
Amended regulation effective August 1, 2015.

APPENDIX A – Carrier Discontinuance Notice

Notice to Consumers for Carrier Discontinuance (Pursuant to § 10-16-201.5, C.R.S. (2012) and § 10-16-105.1, C.R.S.)

We would like to notify you that your current policy will be discontinued or not renewed at least ninety (90) days from now, on [Month, Day, Year] because [company name] will no longer offer your current health plan in the State of Colorado.

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.

[If carrier is offering new plans, use:

Your options include:

- 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 carrier does not offer new plans, use:

We are not going to be selling new [individual/small group/large group] plans so you won't be able to buy a new plan from us. Your options include:

- Purchasing a new plan from another carrier.
- Purchasing a new plan through Connect for Health Colorado, where you may qualify for federal financial assistance (www.connectforhealthco.com).

You should schedule the start date of your new plan to match the end date of this plan to avoid a gap in coverage.

You can contact us, your insurance advisor, or Connect for Health Colorado for assistance and additional information. [Insert Connect for Health Colorado's contact information and company contact information.]

[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.]

Health Benefit Plan Discontinuances Summary

[illegible]

**APPENDIX C – HEALTH BENEFIT PLAN DISCONTINUANCES BY COUNTY DATA TEMPLATE
(WITH EXAMPLES):**

DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:				
SERFF FILING #:	111111	222222	333333	COUNTY TOTAL:
NAIC #:	44444	55555	66666	
PLAN/PRODUCT NAME:	Plan X	Plan Y	Plan Z	
ADAMS COUNTY		2	3	5
ALAMOSA COUNTY				
APAPAHOE COUNTY		3	6	9
ARCHULETA COUNTY				
BACA COUNTY				
BENT COUNTY				
BOULDER COUNTY		6	100	106
BROOMFIELD COUNTY		2	43	45
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		8	200	208
DOLORES COUNTY			1	1
DOUGLAS COUNTY			50	50
EAGLE COUNTY			1	1
EL PASO COUNTY			3	3
ELBERT COUNTY				
FREMONT COUNTY		2	9	11
GARFIELD COUNTY				
GILPIN COUNTY				
GRAND COUNTY		3	150	153
GUNNISON COUNTY				
HINSDALE COUNTY				
HUERFANO COUNTY		6	40	46
JACKSON COUNTY		2	30	32
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		8	125	133
MESA COUNTY			1	1
MINERAL COUNTY			60	60
MOFFAT COUNTY			1	1
MONTEZUMA COUNTY			3	3
MONTROSE COUNTY				
MORGAN COUNTY				
OTERO COUNTY		2	12	14
OURAY COUNTY				
PARK COUNTY		3	45	48
PHILLIPS COUNTY				
PITKIN COUNTY				
PROWERS COUNTY		6	150	156
PUEBLO COUNTY		2	11	13
RIO BLANCO COUNTY	1			1
RIO GRAND COUNTY				
ROUTT COUNTY			1	1

DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:					
SERFF FILING #:		111111	222222	333333	COUNTY TOTAL:
NAIC #:		44444	55555	66666	
PLAN/PRODUCT NAME:		Plan X	Plan Y	Plan Z	
SAGUACHE COUNTY					
SAN JUAN COUNTY					
SAN MIGUEL COUNTY				1	1
SEDGWICK COUNTY					
SUMMIT COUNTY					
TELLER COUNTY			8	120	128
WASHINGTON COUNTY				1	1
WELD COUNTY				75	75
YUMA COUNTY				1	1
OUT OF STATE				3	3
TOTAL:		3	63		1616

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Reporting Requirements
Section 6	Network Adequacy Standards
Section 7	Availability Standards
Section 8	Geographic Access Standards
Section 9	Essential Community Provider Standards
Section 10	Network Adequacy Requirements for Plans with Embedded Dental Benefits
Section 11	Requirements for Annual Network Adequacy Reporting
Section 12	Required Attestations
Section 13	Severability
Section 14	Incorporated Materials
Section 15	Enforcement
Section 16	Effective Date
Section 17	History
Appendix A	Designating County Types
Appendix B	Designating Provider/Facility Types

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 Affordable Care Act (ACA)-compliant health benefit plans with standards and guidance on Colorado filing requirements for health benefit plan network adequacy filings, including the requirements found in HB 19-1269. These standards shall serve as the measurable requirements used by the Division to evaluate the adequacy of carrier networks. This regulation replaces Colorado Emergency Insurance Regulation 19-E-03 in its entirety.

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 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. "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. "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.

- C. "Community emergency center" means, for the purposes of this regulation, a community clinic that delivers emergency services. The care shall be provided 24 hours per day, 7 days per week every day of the year, unless otherwise authorized herein. A community emergency center may provide primary care services and operate inpatient beds.
- 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(5.5)(e)(II), 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 that serves predominantly low-income, medically underserved individuals, including health care providers defined in § 25.5-5-403(2), C.R.S. and at 45 C.F.R. § 156.235(c).
- 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., which are provided by a home health agency certified by the Colorado Department of Public Health and Environment.
- 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 range of common mental or behavioral health conditions, or substance use disorders provided by a physician or non-physician professionals.
- 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, includes psychiatrists, psychologists, psychotherapists, licensed clinical social workers, psychiatric practice nurses, licensed addiction counselors, 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) and physician assistants and nurse practitioners supervised by, or collaborating with, a primary care physician.
- 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, 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.
- S. "Student health insurance coverage" shall have the same meaning as found in § 10-16-102(65), C.R.S.
- T. "Telehealth" shall have the same meaning as found in § 10-16-123(4)(e), C.R.S.
- U. "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 for an ACA-compliant health benefit plan shall be filed with the Division through the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing ("SERFF") prior to use and annually thereafter.
- B. The following four (4) measurement standards shall be used to evaluate a carrier's network adequacy:
1. Compliance with network adequacy 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, shall be provided on the "Carrier Network Adequacy Summary and Attestation Form" submitted as part of the network adequacy filing.

Section 6 Network Adequacy Standards

The following access to service and waiting time standards shall be met by all carriers filing ACA-compliant health benefit plans in order to comply with network adequacy requirements:

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
Behavioral Health, Mental Health and Substance Use Disorder Care, initial and follow-up appointments – Routine, non-urgent, non-emergency	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 60 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”. The groupings/categories for the specific providers are listed in Appendix B.
- 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 availability standards shall be met by all carriers filing ACA-compliant health benefit plans 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, behavioral health and 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. Access standards may require that a policyholder cross county or state lines to reach a provider.
- C. Network Adequacy Geographic Access Standards by Provider Type:

Specialty	Geographic Type				
	Large Metro	Metro	Micro	Rural	CEAC
	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
Chiropracty	15	30	60	75	110
Dermatology	10	30	45	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 Clinical Social Worker	10	30	45	60	100
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurological Surgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100

Specialty	Geographic Type				
	Large Metro	Metro	Micro	Rural	CEAC
	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)
Oncology - Radiation/ Radiation Oncology	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
Physiatry, 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 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 Psychiatric Facility	15	45	75	75	140
Orthotics and Prosthetics	15	30	120	120	140
Outpatient Infusion/Chemotherapy	10	30	60	60	100
OTHER FACILITIES	15	40	120	120	140

Section 9 Essential Community Provider Standards

- A. ACA-compliant health benefit plans and dual (both medical and dental) carriers 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 two (2) ECP standards for carrier ECP submissions:
 - 1. General ECP Standard. Carriers utilizing this standard shall demonstrate in their "Essential Community Provider/Network Adequacy Template" that at least 30 percent (30%), as specified by Colorado, 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" and justifications, that they have the same number of ECPs as defined in the general ECP standard (calculated as 30 percent (30%) 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 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 filing carrier's network, the carrier shall include network adequacy reporting for the "outside" dental network(s) within the medical network adequacy filing.

- A. The carrier shall attest that at least one (1) dental provider listed below is available within the maximum road travel distance for at least 90% of its enrollees in each specific Colorado service area as defined in Appendix A of this regulation:

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

- B. Access standards may require that a policyholder cross county or state lines to reach a provider.

Section 11 Requirements for Annual Network Adequacy Reporting

- A. Annual network adequacy filings shall consist of the documents specified in this Section 11 and shall be filed annually by carrier network, rather than by plan type or group size.
- B. Carriers shall report each network in the carrier's service area that provides managed care services for a carrier's individual, small group, large group, and student health insurance coverage plans.
- C. Networks for ACA-compliant individual and small group health benefit plans, including those that are used by members of large group health benefit plans, shall be filed during the annual health benefit plan certification process.
- D. 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 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 shall be included in the carrier's ECP/NA template filing and in the carrier's network adequacy form filing. Templates and instructions specified by the Commissioner shall be used, and will be made available to carriers annually.

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. All essential community providers (ECPs) in each network must be included in this template. The templates must be completed and filed as described in the Division instructions. Templates require validation before submittal to the Division.
- 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 Colorado thirty percent (30%) ECP standard, the carrier shall submit a copy of the federal "Supplementary Response: Inclusion of Essential Community Providers" as part of its Binder filing. Specific requirements for submitting the "Supplementary Response: Inclusion of Essential Community Providers" form are available from the Centers for Medicare and Medicaid Services (CMS).

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, pursuant to § 10-16-704(9), C.R.S.

- b. Carriers shall submit an “Enrollment Document” containing separate spreadsheets for each network. “Enrollment Document” instructions will be provided to carriers by the Division. Enrollment documents shall be submitted in an Excel format using the “DOI Enrollment Document Template”. 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.
- E. Large Group Health Benefit Plans and Student Health Insurance Coverage Not Utilizing Networks Filed with Annual ACA Filings
 - 1. Network adequacy reporting for large group health benefit and/or student health insurance coverage plans that do not utilize the same network as an individual or small group health benefit plan shall be contained in a separate network adequacy filing submitted annually to the Division.
 - 2. 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 the network adequacy form filings.
 - 3. Templates and instructions specified by the Commissioner shall be used and will be made available to carriers annually. The ECP/NA template referenced in Section 11.D. is not applicable to the large group health benefit plan or student health insurance coverage plan network adequacy filings, and will be replaced by the “Network Provider Listing” and “Network Facility Listing” referenced in Section 11.E.4.d.
 - 4. The form filing will include the following items, all attached on the “Supporting Documentation” tab:
 - a. Carriers shall submit network adequacy access plans for each network, pursuant to § 10-16-704(9), C.R.S.;

- b. Carriers shall submit an “Enrollment Document” containing separate spreadsheets for each network. The Division will provide “Enrollment Document” instructions to carriers. Enrollment documents shall be submitted in an Excel format using the “DOI Enrollment Document Template”. 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.
- c. The carrier shall provide screen shots from the provider directory(ies) showing:
 - (1) The master (entry) page of the carrier’s website, directing users to the provider directory(ies);
 - (2) The 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 revisions, and directory disclosures;
 - (4) The simple search screen;
 - (5) A page of a provider directory produced from the search; and
 - (6) A detail screen for at least one (1) provider and one (1) facility.
- d. All carriers must submit the “Network Provider Listing” and the “Network Facility Listing” for each network included in the network adequacy filing. Copies of the templates and instructions for providing provider and network facility 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 another 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 on the “Carrier Network Adequacy Summary and Attestation Form”.

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 does not apply to networks only serving large group health benefit plans or student health insurance coverage plans.
- C. Each attestation shall be made on the “Carrier Network Adequacy Summary and Attestation Form” submitted with the network adequacy form filing.

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) can be found at the following link: <http://www.gpo.gov/> 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 45 C.F.R. § 156.235(c) may be requested from the Division of Insurance. A charge for certification or copies may apply.

The “Supplementary Response: Inclusion of Essential Community Providers” published by the Centers for Medicare and Medicaid Services shall mean “Supplementary Response: Inclusion of Essential Community Providers” as published on the effective date of this regulation and does not include later amendments to or editions of the “Supplementary Response: Inclusion of Essential Community Providers”. A copy of the “Supplementary Response: Inclusion of Essential Community Providers” can be found at the following link: <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy> 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 “Supplementary Response: Inclusion of Essential Community Providers” may be requested from the Division of Insurance. A charge for certification or copies may apply.

“Essential Community Providers/Network Adequacy Template” published by the Centers for Medicare and Medicaid Services shall mean “Essential Community Providers/Network Adequacy Template” as published on the effective date of this regulation and does not include later amendments to or editions of the “Essential Community Providers/Network Adequacy Template”. A copy of the “Essential Community Providers/Network Adequacy Template” can be found at the following link: <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy> 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 “Essential Community Providers/Network Adequacy Template” may be requested from the Division of Insurance. A charge for certification or copies may apply.

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 January 1, 2020.

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.

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
<i>Large Metro</i>	≥ 1,000,000	≥ 1,000/sq. mile
---	500,000 – 999,999	≥ 1,500/ sq. mile
---	Any	≥ 5,000/ sq. mile
<i>Metro</i>	≥ 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
<i>Micro</i>	50,000 – 199,999	10 – 99.9 /sq. mile
---	10,000 – 49,999	50 – 999.9/sq. mile
<i>Rural</i>	10,000 – 49,999	10 – 49.9/sq. mile
---	<10,000	10 – 4,999.9/sq. mile
<i>CEAC</i>	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	CEAC	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	CEAC
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	Rural
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 – DESIGNATING PROVIDER/FACILITY TYPES

Provider Types – For ECP/Network Adequacy Template and Enrollment Document
Primary Care (including General Practice, Family Medicine, Internal Medicine, and Geriatric physicians, and Primary Care Physician Assistants and Nurse Practitioners)
Gynecology, OB/GYN
Pediatrics - Routine/Primary Care
Allergy and Immunology
Cardiovascular Disease
Chiropracty
Dermatology
Endocrinology
ENT/Otolaryngology
Gastroenterology
General Surgery
Infectious Diseases
Nephrology
Neurology
Neurological Surgery
Medical Oncology & Surgical Oncology
Radiation Oncology
Ophthalmology
Orthopedic Surgery
Physiatry, Rehabilitative Medicine (including physiatrist, physical medicine and rehabilitation specialist)
Plastic Surgery
Podiatry
Psychiatry
Pulmonology
Rheumatology
Urology
Vascular Surgery
Cardiothoracic Surgery
Licensed Clinical Social Worker
Psychology
OTHER MEDICAL PROVIDER
Dental

Facility Types – For ECP/Network Adequacy Template and Enrollment Document
<p>Pharmacy</p> <p>General Acute Care Hospital</p> <p>Cardiac Surgery Program</p> <p>Cardiac Catheterization Services</p> <p>Critical Care Services - Intensive Care Units (ICU)</p> <p>Outpatient Dialysis</p> <p>Surgical Services (Ambulatory Surgical Centers and Outpatient Hospital)</p> <p>Skilled Nursing Facilities</p> <p>Diagnostic Radiology (free-standing; hospital outpatient; ambulatory health facilities with Dx Radiology)</p> <p>Mammography</p> <p>Physical Therapy (individual physical therapists providing care in Free-standing; hospital outpatient and ambulatory health care facilities)</p> <p>Occupational Therapist</p> <p>Speech Therapy</p> <p>Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)</p> <p>Orthotics and Prosthetics</p> <p>Home Health Services</p> <p>Durable Medical Equipment</p> <p>Ambulatory Health Care Facilities – Infusion Therapy/Oncology/ Radiology</p> <p>Heart Transplant Program</p> <p>Heart/Lung Transplant Program</p> <p>Kidney Transplant Program</p> <p>Liver Transplant Program</p> <p>Lung Transplant Program</p> <p>Pancreas Transplant Program</p> <p>OTHER FACILITIES</p>

**Regulation 4-2-54 NETWORK ACCESS PLAN STANDARDS AND REPORTING
REQUIREMENTS FOR ACA-COMPLIANT HEALTH BENEFIT PLANS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
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Section 7	Network Access Plan Procedures for Referrals
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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 health benefit plans with standards and guidance on Colorado filing requirements for health benefit plan network access plan filings. 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 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" 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(5.5)(b)(I), C.R.S.
- E. "Emergency services" shall have the same meaning as found at § 10-16-704(5.5)(b)(II), 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 that serves predominantly low-income, medically underserved individuals, including health care providers defined in part 4 of article 5 of title 25.5, C.R.S. and at 45 C.F.R. § 156.235(c).
- H. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- I. "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.
- J. "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 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.
- K. "Mental health, behavioral health, and substance abuse disorder care" means, for the purposes of this regulation, health care services for a range of common mental or behavioral health conditions, or substance abuse disorders provided by a physician or non-physician professionals.
- L. "Mental health, behavioral health, and substance abuse disorder care providers" for the purposes of this regulation, and for the purposes of network adequacy measurements, include psychiatrists, psychologists, psychotherapists, licensed clinical social workers, psychiatric practice nurses, licensed addiction counselors, licensed marriage and family counselors, and licensed professional counselors.
- M. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.
- N. "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.
- O. "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.
- P. "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.

- Q. “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.
- B. Carriers shall file, maintain, and make available on their website, an access plan for each managed care 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 Commissioner 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 plans 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 under the health benefit plan shall be included in the contract provisions of the health benefit plan, regardless of whether or not such provisions are also specified in the access plan.
- G. Carriers shall submit current network access plans to the Division through the National Association of Insurance Commissioners System for Electronic Rates and Forms Filing (“SERFF”) with the annual network adequacy form filing specified in Colorado Insurance Regulation 4-2-53.
- H. Carriers shall prepare and file an access plan prior to offering a new managed care network, and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network.
- I. An access plan submitted by a carrier offering a managed care plan shall demonstrate that the carrier has:
 1. An adequate network that it is actively maintaining;
 2. Procedures to address referrals within its network and to providers outside of its network;
 3. The required disclosures and notices to inform consumers of the plan’s services and features; and
 4. A documented process and plan for coordination and continuity of care.

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;
- B. The specific provider and facility types that will be measured and reported in the network access plan filed via SERFF. 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. The factors a carrier uses to build 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 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;
- 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.

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), 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 an ACA-compliant health benefit plan 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 allowing members 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, 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 policyholders in the network access plan, pursuant to § 10-16-704(9)(h), 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 persons in the event of the carrier's insolvency or other inability to continue operations 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. The data provided in the network access plans shall be specific to each network in a carrier's service area.
- B. The following attestations shall be made on the "Carrier Network Adequacy Summary and Attestation Form" submitted with the form filing.
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 abuse 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 July 1, 2018.

Section 15 History

New regulation effective January 1, 2017.
Amended regulation effective on July 1, 2018.

**Regulation 4-2-55 STANDARDS AND REPORTING REQUIREMENTS FOR ACA-COMPLIANT
HEALTH BENEFIT PLAN PROVIDER DIRECTORIES**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Provider Directories
Section 6	Requirements for Provider Directory Updates and Audits
Section 7	Materially Inaccurate Information in Provider Directories
Section 8	Severability
Section 9	Incorporated Materials
Section 10	Enforcement
Section 11	Effective Date
Section 12	History
Appendix A	Provider Directory Contents

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 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. This regulation excludes individual short-term policies as defined in § 10-16-102(60), C.R.S.

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 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 that serves predominantly low-income, medically underserved individuals, including health care providers defined in part 4 of article 5 of title 25.5, C.R.S. and at 45 C.F.R. § 156.235(c).
- 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 directory" means, for the purposes of this regulation, a comprehensive listing, produced and maintained by the carrier, or its 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.
- K. "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.

Section 5 Provider Directories

- A. Provider directories shall be maintained by the carrier. Screen shots of the provider directory must be filed in the National Association of Insurance Commissioner's System for Electronic Rates and Forms Filing ("SERFF") with 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 network plans with the information and search functions as described in Appendix A no less than monthly;
 - 2. When making the 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;
 - 3. The carrier shall 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 shall 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 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 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;
 - c. 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.
- 6. 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;
 - 7. 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;
 - 8. 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 directory, the source of the information and any limitations; and
 - 9. 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.

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.
- 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 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. 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 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.
- 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 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 1, 2018.

Section 12 History

New regulation effective January 1, 2017
Amended regulation effective July 1, 2018.

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) 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;
 - (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
 - (3) Languages spoken other than English, if applicable.
 - 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 NETWORK ADEQUACY AND CONTINUITY OF CARE
REQUIREMENTS FOR ACA-COMPLIANT HEALTH BENEFIT PLANS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Network Adequacy Continuity of Care Requirements
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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 health benefit plans with the continuity of care requirements for health benefit plans as they relate to network adequacy. These standards shall serve as the measurable requirements used by the Division to evaluate carrier compliance with network adequacy continuity of care requirements.

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 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 abuse 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. "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.

Section 5 Network Adequacy 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.

- 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, 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. 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.
- 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.
- E. 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.

- F. 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.
- 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 the covered person's authorized representative;
 2. Requests for continuity of care shall 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 Section 5 of 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 shall be subject to the health benefit 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 who are in their second or third trimester of pregnancy shall extend through the postpartum period; and
 5. The continuity of care period for covered persons 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 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. In addition to the provisions of Section 5.G. 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.

- 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.

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 July 1, 2018.

Section 9 History

New regulation effective January 1, 2017.
Amended regulation effective July 1, 2018.

**Regulation 4-2-57 NETWORK ADEQUACY STANDARDS AND REPORTING REQUIREMENTS
FOR ACA-COMPLIANT STAND-ALONE DENTAL MANAGED CARE PLANS**

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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, “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 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 for calendar year 2013 (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 that serves predominantly low-income, medically underserved individuals, including health care providers defined under part 4 of article 5 of title 25.5, C.R.S and at 45 C.F.R. § 156.235(c).
- 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. "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.
- O. "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 NAIC's System for Electronic Rate and Form Filing ("SERFF") prior to use and annually thereafter.

- B. Network adequacy filings for ACA-compliant SADPs shall consist of the documents listed below. Instructions for preparation of these documents will be published 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.

Section 6 Dental Network Adequacy Standards

- A. The carrier shall attest that at least one (1) providers listed below is available within the maximum road travel distance of any enrollee in each specific Colorado service area, as defined in Appendix A of this regulation:

Geographic Type					
	Large Metro	Metro	Micro	Rural	CEAC
Provider Type – the plan provides access to at least one dental provider for at least 90% of the enrollees	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

- B. Access standards may require that a policyholder cross county or state lines to reach a 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” that at least thirty percent (30%) 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. Annual individual and small group ACA-compliant SADP network adequacy filings shall consist of two (2) sections, the Essential Community Providers(ECP)/Network Adequacy Template filing in the Plan Management (Binder) section in SERFF, and a network adequacy form filing in SERFF. All network adequacy documents will be filed by carrier network, rather than by plan type or group size. 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 and instructions specified by the Insurance Commissioner shall be used, and will be made available to carriers annually.
 1. The binder/template section of the filing shall consist of the submittal of the "ECP/Network Adequacy Template" in each applicable binder. The "ECP Write-in Worksheet", if applicable, will be filed on the "Supporting Documentation" tab.
 2. The network adequacy form filing section shall consist of filing the following documents on the "Supporting Documentation" tab in the network adequacy form filing filed with TOI code NA001.0004:
 - a. "Network Access Plans";
 - b. Dental enrollment documents;
 - c. Screen prints of provider directories for each network;
 - d. Maps;
 - e. "Essential Community Provider supplemental response form"; and
 - f. "ACA-Compliant Dental Carrier Network Adequacy Summary and Attestation Form".
- 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. All ECPs in each network shall be included in this template. The templates shall be completed and filed as described in the Division instructions, published on an annual basis. Templates require validation before submittal to the Division. Carriers shall submit a justification for any requirements that are not met in the network adequacy form filing.
 2. The "ECP Write-in Worksheet", if applicable, shall be filed on the "Supporting Documentation" tab of the binder filing

C. Elements of the Network Adequacy Form Filing.

1. All carriers shall submit a "Network Access Plan" for each network, 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 of Insurance's (Division's) website, and on the carrier's website.
2. All carriers shall submit a "Dental Enrollment Document," containing separate spreadsheets for each network. Enrollment document instructions will be provided to each carrier by the Division. Enrollment documents shall be submitted in an Excel format using the "DOI Dental Enrollment Document Template". 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 Colorado statute and regulation. 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. Instructions for preparation of the screen shots will be published by the Division on an annual basis.
4. All carriers shall submit maps showing geographic access standards for selected providers for each network. Instructions for preparation of these documents and the providers to be included will be published by the Division on an annual basis.
5. If a carrier does not meet the Colorado thirty percent (30%), as specified by Colorado, ECP standard, the carrier shall submit a copy of the completed "ECP Supplementary Response Form", providing a justification for all requirements that are not met, as part of its annual network adequacy filing,. This form is found in Appendix C of this regulation. The justification shall include the reason that the requirement was not met and the corrective action(s) that shall be taken by the carrier. The Division will review the justification and provide feedback on a case-by-case basis.

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. The instructions for its completion are found in Appendix D.

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

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, published by the Government Printing Office shall mean 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, as published on the effective date of this regulation and does not include later amendments to or editions 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. A copy 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 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 Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 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.

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.

The Model QHP Addendum for Indian Health Care Providers published by the Department of Health and Human Services shall mean the Model QHP Addendum for Indian Health Care Providers as published on the effective date of this regulation and does not include later amendments to or editions of The Model QHP Addendum for Indian Health Care Providers. A copy of The Model QHP Addendum for Indian Health Care Providers 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 Model QHP Addendum for Indian Health Care Providers 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.cms.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 June 1, 2018.

Section 14 History

New regulation effective January 1, 2017.
Amended regulation effective June 1, 2018.

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	CEAC	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	CEAC
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	Rural
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 measureable 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.

APPENDIX C – ECP SUPPLEMENTARY RESPONSE FORM

Instructions for Submitting a Supplementary Response

Please answer the questions below regarding access to essential community providers in the carrier's proposed service area(s). Please be as complete and specific as possible in each of your responses. In order to be considered complete, the supplementary response shall contain an appropriate explanation for each applicable question. Please note that if the carrier is applying in multiple service areas, the response shall address each service area.

Carriers that do not qualify for the alternate ECP standard shall complete Section 1. Carriers that qualify for the alternate ECP standard shall complete Section 2.

Section 1: Instructions for Carriers Subject to the General ECP Standard

For carriers that qualify for the general ECP standard: Please indicate which portion of the general ECP standard that the carrier does not meet (check all that apply), and respond to each applicable question:

Instructions for Carriers Subject to the General ECP Standard		Instructions	Check all that apply
A.	Does not offer a contract to all Indian health providers in the service area.	Complete Question #1	
B.	Does not offer a contract to at least one ECP in each available ECP category in each county in the service area	Complete Question #2	
C.	Carrier's plan network does not include at least thirty percent (30%) of available ECPs in the service area.	Complete Question #3	

- The carrier does not offer a contract to all Indian health providers in the service area using the recommended "Model QHP Addendum for Indian Health Care Providers" developed by the Department of Health and Human Services. How will the carrier's provider network(s), as currently structured, provide adequate access to care for American Indians/Alaska Natives?
- The carrier does not offer a contract to at least one (1) ECP in each available ECP category¹ in each county in the service area. How will the carrier's provider networks, as currently structured, provide access to a broad range of ECP types?
 - ECP categories include: federally qualified health centers; Indian health providers; hospitals; and other providers. If the carrier's plans do not include at least thirty percent (30%) of available ECPs in the service area, please respond to questions 3-5.*
- Describe why the carrier is unable to achieve the thirty percent (30%) standard for ECPs. The response must address the carrier's efforts to contract with additional ECPs (including provider information and contract offer dates, as applicable) and why those efforts have been unsuccessful. Please be as specific as possible in your response. Please be sure to indicate:

- a. Number of contracts offered to ECPs for the plan benefit year;
 - b. Names of the ECPs to which the carrier has offered contracts, but an agreement with the providers has not yet been reached. For example, the carrier may want to indicate whether contract negotiations are still in progress or the extent to which the carrier was not able to agree on contract terms with available ECPs (and if so, which terms).
4. Describe how the carrier plans to increase ECP participation in its provider networks in the future. Identify the number of additional contracts carrier expects to offer for the plan benefit year and the timeframe of those planned negotiations.
5. Describe how the carrier's provider networks, as currently structured; provide an adequate level of service for low-income and medically underserved individuals. Please be specific in your response.
 - a. Describe how the carrier's current networks provide adequate access to care for individuals with HIV/AIDS and those with co-morbid behavioral health conditions.
 - b. Describe how the carrier's current networks provide adequate access to care for American Indians and Alaska Natives.

Section 2: Instructions for Carriers that Qualify for the Alternate ECP Standard

For carriers that qualify for the alternate ECP standard: If the number of the carrier's providers that are located in, or contiguous to, Health Professional Shortage Areas (HPSA) or zip codes in which thirty percent (30%) or more of the population falls below 200 percent of the federal poverty level is fewer than the equivalent of thirty percent (30%) of available ECPs in the service area, please respond to each question below.

1. Describe why the carrier's plan does not meet the equivalent of the thirty percent (30%) threshold, and any plans to provide additional access to low-income and medically underserved consumers in the future.
2. Describe how the carrier's provider networks, as currently structured, provide an adequate level of service for low-income medically underserved individuals. Please be specific in your response.
3. Describe how the carrier's current networks provide adequate access to care for individuals with HIV/AIDS and those with co-morbid behavioral health conditions.
4. Describe how the carrier's current networks provide adequate access to care for American Indians/Alaska Natives.

APPENDIX D – ACA-COMPLIANT DENTAL CARRIER NETWORK ADEQUACY SUMMARY AND ATTESTATION FORM AND INSTRUCTIONS

The ACA-Compliant Dental Carrier Network Adequacy Summary and Attestation Form is a Colorado-specific consumer-facing three-page summary and attestations document. The form is available on SERFF and on the Division's website.

Network adequacy filings are filed by CARRIER NETWORK, not by plan type or group size. Multiple networks can be filed in one (1) filing. Please list all networks to which the form applies, by network name, on the first page of the form.

The summary document has been split into sections based on Colorado Insurance Regulation 4-2-57, followed by attachments.

Network Adequacy

The first questions specifically address the adequacy of each network, as specified in Colorado Insurance Regulation 4-2-57. If a "no" answer is provided for S-1. and/or S-2., further narrative explanation shall be provided in Attachment A, using the question number (S-x) to identify the appropriate response.

The next questions on page one apply to the network adequacy filing and "Applicable Geographic Access Standards." If "no" answers are provided regarding geographic access standards, Attachment B shall be completed with the listing of specific standards that are not being met. The instructions for each attachment follow these instructions.

Network Access Plans and Continuity of Care

This section consists of three (3) questions with "Yes/No" answers. If "no" answers are provided for any of the questions, further explanation shall be provided in Attachment A. The URL location of the carriers' network access plan(s) shall be listed on this page. The URL cannot be the general carrier website, but shall direct the reader within two (2) clicks of the network access plan. Access plans shall be clearly labeled with the network(s) that they cover.

Two (2) additional questions shall be completed in this section. The questions are as follows:

1. How does a consumer gain access to an out-of-network provider at in-network rates if an in-network provider is not available?
2. How does a consumer gain access to continuity of care if a provider is no longer in-network?

The carrier shall provide brief descriptions of processes a covered person should use to deal with either of these network access issues. This description shall be as simple as possible, and include customer service websites and/or phone numbers. The location (page number, section, etc.) of a more complete explanation of the process, in the non-confidential network access plan and/or evidence of coverage, or other document available to the covered person shall be listed as well. If additional space is required for the explanation, please reference an additional page and use the additional page so the entire explanation can be read by the consumer.

Provider Directories

The first question specifically addresses the provider directory for each network, as specified in Section 8.C.3. of Colorado Insurance Regulation 4-2-57. If a "no" answer is provided for this question, further narrative explanation shall be provided in Attachment A, using the question number (S-6.) to identify the appropriate response.

One additional question regarding consumer access to a print or hard copy of a provider directory shall be answered in this section. This access answer shall be as simple as possible and include customer service websites and/or phone numbers. The URL location of the carrier's provider directories shall be listed on this page. The Division will use the addresses listed here to access and review provider directories as specified in Section 8.C.3. of Colorado Insurance Regulation 4-2-57.

Attestation

The ACA-Compliant Dental Carrier Network Adequacy Summary and Attestation Form shall be signed and dated by an authorized officer of the filing entity. The carrier name shall also be entered. 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 shall 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.

ATTACHMENTS

Attachment A – Statutory/Regulatory Requirements Not Met

If a “no” answer is made on any of the statutory questions, numbered S-1 through S-6, an explanation shall be included in Attachment A. While there is no limit on the size of the explanation, please remember these explanations need to be written for consumer review. References can/should be made to other attachments and to specific sections of network access plans as appropriate; however, explanation sufficient for consumers and the Division shall be included.

Attachment B – Network Geographic Access Standards Not Met and What Corrective Actions will be Taken

Attachment B shall be completed with the specific geographic access standards that are not being met. Individual networks shall be listed on separate rows. “Reasons standards are not met” shall also be listed on separate rows. Possible reasons for not meeting geographic access standards may include, but are not limited to, “not enough, or no providers within ___ miles”, or “not enough contracted providers within ___ miles.” Please remember that geographic access standards may require that a covered person cross county or state lines to reach a provider. Provider types and counties may be combined in single entries to reduce repetition; however, the Division reserves the right to request more detail if the entries are found to be confusing. Separating county types (large metro, metro, micro, rural, and CEAC) is suggested for clarity. If additional space is required for the explanation, please reference an additional page and use the additional page so the entire explanation can be read by the consumer.

Attachment B shall also provide a summary of the corrective actions that will be taken to remedy inadequate networks. The carrier shall explain/describe actions to be taken, as required by item 3. of Appendix B of Colorado Insurance Regulation 4-2-57. Attachment B may reference the non-confidential network access plan for additional details, but the attachment shall summarize the actions to be taken. If additional space is required for the explanation, please reference an additional page and use the additional page so the entire explanation can be read by the consumer.

NOTE: The submittal of Attachment B does not serve as notification or communication with the Division, providers and/or policyholders.

**Regulation 4-2-58 NON-DISCRIMINATORY COST-SHARING AND TIERING REQUIREMENTS
FOR PRESCRIPTION DRUGS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Drug Tiering and Non-Discriminatory Plan Design
Section 6	Required Drug Copayment-only Payment Structures
Section 7	Required Methodology
Section 8	Severability
Section 9	Enforcement
Section 10	Effective Date
Section 11	History

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-3-1110, 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, 2019. This regulation does not apply to catastrophic plans, grandfathered plans, large group 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. "Service area" means, for the purposes of this regulation, the area a carrier offers a plan or plans. Service areas may include specific zip codes, counties or may be statewide.
- H. "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.

- I. “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 the drugs on a carrier's formulary that are used to treat a specific condition are placed on the health benefit plan's highest cost tier of the carrier;
 2. The most recent clinical studies are used in developing plans to ensure consumers have access to screening and treatment in a timely manner;
 3. The primary category and class for each drug will be utilized when calculating the fifty percent (50%) requirement, but secondary uses and off-label usage shall not be included in the calculation; and
 4. Drugs not included on a carrier's formulary shall not be considered as part of this calculation, including any drugs approved as part of the exception process.
- B. Carriers may use appropriate disease management or utilization reviews as part of a plan design.
- C. Carriers shall clearly and appropriately name all plans that have the copayment structure to aid in the consumer plan selection process.

Section 6 Required Drug Copayment-only Payment Structures

For each of a carrier's service areas, no fewer than twenty-five (25%) percent 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. For all other 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.
- C. 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.
- D. Carriers must meet these requirements separately for plans offered on the Exchange and plans that are offered outside of 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 of the Exchange.
- D. Plans that are marketed both on and off of 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 June 1, 2018.

Section 11 History

New regulation effective June 1, 2018.

**Regulation 4-2-59 CONCERNING PREMIUM RATE SETTING FOR SHORT-TERM LIMITED
DURATION HEALTH INSURANCE POLICIES**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	General Rate Filing Requirements
Section 6	Actuarial Memorandum
Section 7	Premium Rate Setting
Section 8	Rate Filings
Section 9	Prohibited Rating Practices
Section 10	Severability
Section 11	Enforcement
Section 12	Effective Date
Section 13	History
Appendix A	Rate Filing Requirements
Appendix B	Summary
Appendix C	Rate History
Appendix D	Relation of Benefits to Premium
Appendix E	Provision for Profit and Contingencies
Appendix F1	Trend
Appendix F2	Monthly Historical Trend
Appendix F3	Monthly Normalized Trend
Appendix G	Credibility
Appendix H	Experience
Appendix I	Side-by-Side Comparison
Appendix J	Projected Benefits Ratio

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):	<input type="checkbox"/>	Agency / Broker
	<input type="checkbox"/>	Internet
	<input type="checkbox"/>	Direct Sale
	<input type="checkbox"/>	Other (Please Specify):
5. Premium (Select all that apply):	<input type="checkbox"/>	Age
	<input type="checkbox"/>	Family Composition
	<input type="checkbox"/>	Tobacco
	<input type="checkbox"/>	Geographic Area
	<input type="checkbox"/>	Benefit
	<input type="checkbox"/>	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):	<input type="checkbox"/>	Issue Age	
	<input type="checkbox"/>	Not Utilized	
	<input type="checkbox"/>	Other (Please Specify):	
9. Renewability Provision:	<input type="checkbox"/>	Non-Renewable	

APPENDIX C: RATE HISTORY

RATE HISTORY					
Provide rate changes made in at least the last three (3) approved filings (If available)					
<input type="checkbox"/> 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													
14													
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38													
39													
40													
41													
42													
43													
44													
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													
3													
4													
5													
6													
7													
8													
9													
10													

11													
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43													
44													
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 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:	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> 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:	<input type="checkbox"/> Existing Product		<input type="checkbox"/> Comparable Product		<input type="checkbox"/> 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:	<input type="checkbox"/> Existing Product		<input type="checkbox"/> Comparable Product		<input type="checkbox"/> 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:	<input type="checkbox"/> Existing Product		<input type="checkbox"/> Comparable Product		<input type="checkbox"/> 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:	<input type="checkbox"/> Existing Product	<input type="checkbox"/> Comparable Product	<input type="checkbox"/> National	<input type="checkbox"/> 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.		<input type="checkbox"/> 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 DENTAL PLANS,
VISION PLANS, PHARMACY PLANS, SHORT-TERM LIMITED DURATION HEALTH
INSURANCE POLICIES AND OTHER NON-AFFORDABLE CARE ACT MANAGED CARE
PLANS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Network Adequacy Reporting Requirements
Section 6	Network Adequacy Access to Service and Waiting Time Standards
Section 7	Geographic Access Standards
Section 8	Requirements for Annual Network Adequacy Reporting
Section 9	Severability
Section 10	Enforcement
Section 11	Effective Date
Section 12	History
Appendix A	Designating County Types and Geographic Access Standards
Appendix B	Network Access Plan Instructions
Appendix C	Provider and Facility Listing Instructions
Appendix D	Provider Directory Contents
Appendix E	Carrier Network Adequacy Summary and Attestation Form Instructions

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 dental plans, vision plans, pharmacy plans, short-term limited duration health insurance policies, and other health coverage plans utilizing networks.

Section 3 Applicability

This regulation applies to all carriers that issue dental plans, vision plans, pharmacy plans, short-term limited duration health insurance policies, and any other 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" 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. "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 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 abuse 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. "Community emergency center" means, for the purposes of this regulation, a community clinic that delivers emergency services. The care provided at this type of community clinic shall be provided 24 hours per day, 7 days per week every day of the year, unless otherwise authorized herein. A community emergency center may provide primary care services and operate inpatient beds.
- F. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.
- G. "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.
- H. "Emergency medical condition" shall have the same meaning as found at § 10-16-704(5.5)(b)(I), C.R.S.
- I. "Emergency services" shall have the same meaning as found at § 10-16-704(5.5)(b)(II), C.R.S.
- J. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.
- K. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- L. "Health care services" shall have the same meaning as found at § 10-16-102(33), C.R.S.
- M. "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.
- N. "Health coverage plan" shall have the same meaning as found at § 10-16-102(34), C.R.S.
- O. "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.
- P. "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.
- Q. "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.
- R. "Mental health, behavioral health, and substance abuse disorder care," for the purposes of this regulation, health care services for a range of common mental or behavioral health conditions, or substance abuse disorders provided by a physician or non-physician professionals.
- S. "Mental health, behavioral health, and substance abuse disorder care providers", for the purposes of this regulation, and for the purposes of network adequacy measurements, includes psychiatrists, psychologists, psychotherapists, licensed clinical social workers, psychiatric practice nurses, licensed addiction counselors, licensed marriage and family counselors, and licensed professional counselors.
- T. "Network" shall have the same meaning as found at § 10-16-102(45), C.R.S.
- U. "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.
- V. "Plan" means, for the purpose of this regulation, the specific benefits and cost-sharing provisions available to a covered person.
- W. "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.
- X. "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.
- Y. "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.
- Z. "SERFF" means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filings.
- AA. "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.

- AB. “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.
- AC. “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.
- AD. “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.
- AE. “Telehealth” shall have the same meaning as found at § 10-16-123(4)(e), C.R.S.
- AF. “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 dental plans, vision plans, pharmacy plans, short-term limited duration health insurance policies, and other 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 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 on the “Colorado Network Adequacy Carrier Summary and Attestation Form” submitted as part of the Network Adequacy filing.

Section 6 Network Adequacy Access to Service and Waiting Time Standards

The following access to service and waiting time standards must be met by all carriers, filing 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 Abuse	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care – Medical, Behavioral, Mental Health and Substance Abuse	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 7 calendar days	Met ≥ 90% of the time
Behavioral Health, Mental Health and Substance Abuse Care – Routine, non-urgent, non-emergency	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

The access to service and waiting time standards to not apply to Non-ACA compliant dental plans.

Section 7 Geographic Access Standards

Colorado uses the “County Types” designations defined by the Centers for Medicare & Medicaid Services (CMS) in “CMS CY2016 MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance”. The methodology used to define county types and the designations for Colorado counties are in Appendix A of this regulation.

- A. The carrier must attest that at least one (1) of each of the providers and facilities, 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. 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

2. Vision plans:

Geographic Type					
Provider Type – the plan provides access to at least one vision 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)
Ophthalmology	10	20	35	60	85
Optometry	10	20	35	60	85
Other Vision Providers	10	20	35	60	85

3. 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	15	30	60	75	110

4. Short-term policies: provider types and maximum road travel distances are listed in Appendix A.
5. Other managed care plans: provider types and maximum road travel distances are listed in Appendix A.

B. 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 dental plans, vision plans, pharmacy plans, short-term policies, and other managed care 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 network must follow the Network Access Plan Instructions listed in Appendix B. The network access plan must demonstrate that the carrier has:
 - a. An adequate network that it is actively maintaining;
 - b. Procedures to address referrals within its network and to providers outside of its network;
 - c. The required disclosures and notices to inform consumers of the plan's services and features; and
 - d. A documented process and plan for coordination and continuity of care.
4. All rights and responsibilities of the covered person under the dental plan, vision plan, pharmacy plan, short-term policy, or other 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 for each network being reported in the network adequacy filing. Copies of the templates and instructions for provider and network facility listing documents are provided in SERFF and on the Division's website. Instructions are included in Appendix C. 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 on the Carrier Network Adequacy Summary and Attestation Form.

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 D 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;
 - 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.
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 a sample of at least twenty-five percent (25%) 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 must 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 the 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.
- D. Carrier Network Adequacy Summary and Attestation Form
 1. The Carrier Network Adequacy Summary and Attestation Form is a Colorado-specific, consumer-facing three-page summary and attestation document. This form can be found on SERFF and on the Division's website. Appendix E of this regulation provides the instructions for completing this summary and attestation form.

- a. On the first page of the form, the carrier must:
 - (1) Specify the number of networks that are being reported/ presented in the filing;
 - (2) If using a network that has been reported within the last twelve (12) months, list the network name(s), file number(s) and date(s) of filing(s);
 - (3) If not using an existing reviewed network, acknowledge that the provider and network facility listings are submitted with the filing;
 - (4) Attest that each of its health coverage plans using a network will maintain a provider network(s) that meets the standards of this regulation, and is sufficient in number and types of providers, including providers that specialize in mental health, behavioral health, and substance abuse care services, when appropriate, to assure that the services will be accessible without unreasonable delay; and
 - (5) Document that the carrier meets network adequacy access and waiting time standards and geographic access standards. If a network is found to be inadequate, the carrier must explain/describe specific actions to be taken, including remedies, timeframes, schedule for implementation, and proposed notification and communications with the Division, providers, policyholders, and enrollees. A summary of these corrective actions must be reported on Attachment D of this form.
- b. On the second page of the form, regarding the network access plan(s) and continuity of care, the carrier must attest to the following:
 - (1) 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.
 - (2) That all policies and marketing materials clearly disclose the existence and availability of network access plans;
 - (3) Provide the URL where the network access plan is available;
 - (4) That each of its health plan networks includes the continuity of care requirements, specified in item 8. of Appendix B of this regulation, to ensure sufficient continuity of care for its policyholders and/or enrollees; and
 - (5) Provide narratives answering questions regarding out-of-network providers and continuity of care.
- c. On the third page of the form, the carrier must:
 - (1) 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;
 - (2) Provide the URL where the current provider directory(ies) can be accessed and a narrative on how to gain access to a print or hard copy of a provider directory; and

- (3) 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 September 1, 2018.

Section 13 History

New regulation effective September 1, 2018.

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	CEAC	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	CEAC
Garfield	Micro	Saguache	CEAC
Gilpin	Rural	San Juan	CEAC
Grand	CEAC	San Miguel	CEAC
Gunnison	CEAC	Sedgwick	CEAC
Hinsdale	CEAC	Summit	Rural
Huerfano	CEAC	Teller	Rural
Jackson	CEAC	Washington	CEAC
Jefferson	Metro	Weld	Metro
Kiowa	CEAC	Yuma	CEAC

Network Adequacy Geographic Access Standards by Provider 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
Chiropracty	15	30	60	75	110
Dermatology	10	30	45	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 Clinical Social Worker	10	30	45	60	100
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurological Surgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100
Oncology - Radiation/Radiation Oncology	15	40	75	90	130
Ophthalmology	10	20	35	60	85

	Large Metro	Metro	Micro	Rural	CEAC
Specialty	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)
Optometry	10	20	35	60	85
Other Vision Provider	10	20	35	60	85
Orthopedic Surgery	10	20	35	60	85
Physiatry, 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
Dentist	15	30	60	75	110
Pharmacy	15	30	60	75	110
Acute Inpatient Hospital	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
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

	Large Metro	Metro	Micro	Rural	CEAC
Specialty	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)
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 Psychiatric Facility	15	45	75	75	140
Orthotics and Prosthetics	15	30	120	120	140
Outpatient Infusion/Chemotherapy	10	30	60	60	100
Other Facility	15	40	120	120	140

APPENDIX B - NETWORK ACCESS PLAN INSTRUCTIONS

The carrier must address the following in the network access plan for each network offered by the carrier:

1. Network Composition, Identification of Provider Criteria
 - a. The factors a carrier uses to build its provider network, including a description of the network; and
 - b. The carrier's quality assurance standards, 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. 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, policyholders, and enrollees, if a network is found to be inadequate.
3. Network Monitoring and Corrective Action Processes
 - a. The carrier's documented quantifiable and measureable process for monitoring and assuring the sufficiency of the network in order to meet the managed care needs of populations enrolled in managed care plans on an ongoing basis;
 - b. The carrier's description of how telehealth is used (or not used) to meet healthcare needs and network adequacy standards; and
 - c. 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 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.

5. Communications

The carrier, in the network access plan for each network offered, must describe its method for informing policyholders and/or enrollees of the plan's services and features through disclosures and notices provided to policyholders and/or enrollees.

6. Patients with Special Needs

The carrier must describe its 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.

7. Grievance and Appeal Procedures

The carrier must describe its 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 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 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 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 provision 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.
- 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 8. 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 - 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 and Medicaid (CMS).

Dental and Vision carriers are not required to submit network facility listing as part of their network adequacy filings.

APPENDIX D - 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;
 - (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 Section 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
 - (3) Languages spoken other than English, if applicable.
 - 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.

APPENDIX E - CARRIER NETWORK ADEQUACY SUMMARY AND ATTESTATION FORM INSTRUCTIONS

The Carrier Network Adequacy Summary and Attestation Form is a Colorado-specific consumer-facing three-page summary and attestation document. The form is available on SERFF and on the Division's website.

Network adequacy filings are filed by CARRIER NETWORKS, not by plan type or group size. Multiple networks can be filed in one filing; however, a separate form must be completed for each type of insurance. Please list all networks to which the form applies, by network name, on the first page of the form.

The summary document has been split into sections based on this Regulation 4-2-60, followed by attachments.

Network Adequacy

The first question will specifically address the adequacy of each network, as specified in Colorado Insurance Regulation 4-2-60. If a "No" answer is provided for this question, further narrative explanation must be provided in the Attachment A, using the question number (S-1) to identify the appropriate response.

The next two (2) questions on page one apply to the network adequacy "Access to Services and Waiting Time Standards" and "Applicable Geographic Access Standards." If "No" answers are provided for either of these questions Attachments B and/or C must be completed with the specific standards that are not being met. Instructions for these attachments follow.

If any standard is not met, the carrier must describe the standard not met and what corrective action will be taken on Attachment D of the Carrier Network Adequacy Summary and Attestation Form.

Network Access Plans and Continuity of Care

This section consists of three (3) questions with Yes/No answers. If "No" answers are provided for any of the questions, further explanation must be provided in Attachment A. The URL location of the carriers' network access plan(s) must be listed on this page. The URL cannot be the general carrier website, but must direct the reader within two (2) clicks of the network access plan. Access plans must be clearly labeled with the network(s) that they cover.

Two (2) additional questions must be completed in this section. The questions are as follows:

1. How does a consumer gain access to an out-of-network provider at in-network rates if an in-network provider is not available?
2. How does a consumer gain access to Continuity of Care if a provider is no longer in-network?

The carrier must provide brief descriptions the processes a covered person should use to deal with either of these network access issues. The description should be as simple as possible, and include customer service websites and/or phone numbers. The location (page number, section, etc.) of a more complete explanation of the process, in the non-confidential network access plan and/or evidence of coverage, or other document available to the covered person must be listed as well. If additional space is required for the explanation, please reference an additional page and use the additional page so the entire explanation can be read by the consumer.

Provider Directories

The first question will specifically address the provider directory of each network, as specified in Section 8.C. of Colorado Insurance Regulation 4-2-60. If a “No” answer is provided for this question, further narrative explanation must be provided in the Attachment A, using the question number (S-5) to identify the appropriate response.

One additional question regarding consumer access to a print or hard copy of a provider directory must be answered in this section. The access answer should be as simple as possible and include customer service websites and/or phone numbers. The URL location of the carrier’s provider directories must be listed on this page. The Division will use the addresses listed here to access and review provider directories as specified in Section 8.C. of Colorado Insurance Regulation 4-2-60.

Attestation

The Carrier Network Adequacy Attestation Form must be signed and dated by an authorized officer of the filing entity. The carrier name must also be entered. 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.

ATTACHMENTS

Attachment A – Statutory/Regulatory Requirements Not Met

If a “No” answer is made on any of the statutory questions, numbered S-1 through S-5, an explanation must be included in Attachment A. While there is no limit on the size of the explanation, please remember these explanations need to be written for consumer review. References can/should be made to other attachments and to specific sections of network access plans as appropriate; however, explanation sufficient for consumers and the Division must be included.

Attachment B – Network Access to Service and Waiting Time Standards Not Met

Attachment B must be completed with the specific network access to services and waiting time standards that are not being met. Individual networks must be listed on separate rows. Individual service types must also be on separate rows. Possible reasons for not meeting availability standards may include, but are not limited to, “not enough providers to meet time frame goal”. The Division reserves the right to request more detail if the entries are found to be confusing. If additional space is required for the explanation, please reference an additional page and use the additional page so the entire explanation can be read by the consumer.

Please note that if “standards not met” are listed on Attachment B, corrective actions for each entry must be described on Attachment D.

Attachment C – Network Geographic Access Standards Not Met

Attachment C must be completed with the specific geographic access standards that are not being met. Individual networks must be listed on separate rows. “Reasons standards are not met” must also be on separate rows. Possible reasons for not meeting geographic access standards may include, but are not limited to, “not enough, or no providers/facilities within ___ miles”, or “not enough contracted providers/facilities within ___ miles.” Please remember that geographic access standards may require that a covered person cross county or state lines to reach a provider. Provider/facility types and counties may be combined in single entries to reduce repetition; however, the Division reserves the right to request more detail if the entries are found to be confusing. Separating county types (large metro, metro, micro, rural, and CEAC) is suggested for clarity. If additional space is required for the explanation, please reference an additional page and use the additional page so the entire explanation can be read by the consumer.

Please note that if “standards not met” are listed on Attachment C, corrective actions for each entry must be described on Attachment D.

Attachment D – Corrective Actions to be Taken

Attachment D must provide a summary of the corrective actions that will be taken to remedy inadequate networks. The carrier will explain/describe actions to be taken, as mentioned in item 3.c. of Appendix B of this regulation. Attachment D may reference the non-confidential network access plan for additional details, but the attachment must summarize the actions to be taken. If additional space is required for the explanation, please reference an additional page and use the additional page so the entire explanation can be read by the consumer.

NOTE: The submittal of Attachment D does not serve as notification or communications with the Division, providers and policyholders.

**Regulation 4-2-61 CONCERNING THE PAYMENT PARAMETERS FOR THE COLORADO
REINSURANCE PROGRAM**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Payment Parameters for the 2020 Plan Year Reinsurance Program
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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
- Geographic areas five and nine shall have an attachment point of \$30,000.
 - Geographic areas four, six, seven, and eight shall have an attachment point of \$30,000.
 - Geographic areas one, two, and three shall have an attachment point of \$30,000.
- D. Coinsurance Rates
- Geographic areas five and nine shall have a coinsurance rate of eighty-five percent (85%).
 - Geographic areas four, six, seven, and eight shall have a coinsurance rate of fifty percent (50%).
 - Geographic areas one, two, and three shall have a coinsurance rate of forty-five percent (45%).
- E. Reinsurance Caps
- Geographic area five and nine shall have a reinsurance cap of \$400,000.
 - Geographic areas four, six, seven, and eight shall a reinsurance cap of \$400,000.
 - 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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History
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 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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Meaningful Difference Standards
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History

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, 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;
 - c. Having multiple in-network tiers rather than only one;
 - d. Having at least a five-percent (5%) difference in the maximum-out-of-pocket limit; or
 - e. 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 regulation shall be effective June 1, 2019.

Section 9 History

New regulation effective June 1, 2019.

Regulation 4-2-64 CONCERNING MENTAL HEALTH PARITY IN HEALTH BENEFIT PLANS

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Required Coverage
Section 6	Allowed Classifications
Section 7	Calculation of Substantially All and Predominant Benefits
Section 8	Financial Requirements and Quantitative Treatment Limitations
Section 9	Non-Quantitative Treatment Limitations
Section 10	Denial of Benefits for Behavioral, Mental Health or Substance Use Disorders
Section 11	Annual Reporting to the Commissioner
Section 12	Comparative Analysis Reporting
Section 13	Confidentiality
Section 14	Severability
Section 15	Enforcement
Section 16	Effective Date
Section 17	History
Appendix A	Financial Requirements Attestations
Appendix B	Medical Management Evaluation
Appendix C	Non-Quantitative Treatment Limitation Verifications
Appendix D	Quantitative Treatment Limitation Classifications
Appendix E	Non-Quantitative Treatment Limitations - Medical/Surgical Services Questionnaire
Appendix F	Non-Quantitative Treatment Limitations - Pharmacy Services Questionnaire
Appendix G	Non-Quantitative Treatment Limitations - Behavioral Health/Mental Health Questionnaire
Appendix H	Non-Quantitative Treatment Limitations - Substance Use Disorder Questionnaire
Appendix I	Non-Quantitative Treatment Limitations - Network Adequacy/Provider Credentialing and Network Admission Questionnaire
Appendix J	Non-Quantitative Treatment Limitations - Confidential Network Development Questionnaire
Appendix K	Non-Quantitative Treatment Limitation - Comparative Analysis Submission Template

Section 1 Authority

This emergency regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-104(5.5)(b) and 10-16-109, 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 to ensure compliance with § 10-16-104(5.5), C.R.S., and the Mental Health Parity and Addiction Equity Act of 2008. It replaces Emergency Regulation 19-E-04 in its entirety.

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 on or after the effective date of this regulation. This includes all 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, 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. "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. "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.
- C. "Autism spectrum disorder" shall have the same meaning as defined at § 10-16-104(1.4)(a)(III), C.R.S.
- D. "Behavioral health benefits" means, for the purposes of this regulation, the benefits supplied for items or services for behavioral health conditions.
- E. "Behavioral, mental health, and substance use disorder" shall have the same meaning as defined at § 10-16-104(5.5)(d), C.R.S.
- F. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- G. "FDA" means, for the purposes of this regulation, the Food and Drug Administration in the United States Department of Health and Human Services.
- H. "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.
- I. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- J. "Medical/surgical benefits" means, for the purposes of this regulation, the benefits supplied for items or services for medical conditions or surgical procedures, not including behavioral, mental health, and substance use disorder benefits.
- K. "Mental health benefits" means, for the purposes of this regulation, the benefits supplied for items or services for mental health conditions.
- L. "MHPAEA" shall have the same meaning as found at § 10-16-102(43.5) C.R.S.
- M. "Prior authorization" shall have the same meaning as found at § 10-16-112.5(7)(d), C.R.S.
- N. "SERFF" means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filing.
- O. "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.
- P. "Student health insurance coverage" and "student health policy" shall have the same meaning as found at § 10-16-102(65), C.R.S.
- Q. "Substance use disorder benefits" means, for the purposes of this regulation, the benefits supplied for items or services for substance use disorders.

- R. "Treatment limitations" means, for the purposes of this regulation, the limits applied based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as fifty (50) outpatient visits per year), and non-quantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. This term does not include any permanent exclusion of all benefits for a particular condition or disorder.

Section 5 Required Coverage

A. Preventive Care and Access to Coverage

1. Carriers that offer behavioral, mental health, and substance use disorder treatment must cover the following:
 - a. An unhealthy alcohol use screening for adults, which must be provided without deductibles, copayments or coinsurance;
 - b. A preventive screening for depression in adolescents and adults, which must be provided without deductibles, copayments or coinsurance; and
 - c. Perinatal maternal counseling for persons at risk, which must be provided without deductibles, copayments or coinsurance.
 - d. 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.
2. Effective January 1, 2020, carriers that provide coverage for an annual physical examination as a preventive health care service shall include coverage for behavioral health screenings using a validated screening tool for behavioral health, which coverage and reimbursement is no less extensive than the coverage and reimbursement for the annual physical examination.

B. Court-Ordered Treatment

1. Carriers shall provide coverage for court-ordered medically necessary services for behavioral, mental health, and substance use disorder, as specified in § 10-16-104.7, C.R.S., for substance use disorders and § 10-16-104.8, C.R.S., for behavioral and mental health treatment.
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. For policies issued or renewed on or after January 1, 2020, carriers shall not impose the following for medication-assisted treatment of substance use disorders:

1. Any prior authorization requirements on any FDA-approved medication on the carrier's formulary;
2. Any step therapy or fail-first requirements as a prerequisite for coverage of a prescription medication approved by the FDA on the carrier's formulary;

3. Place fewer than one (1) covered prescription medication approved by the FDA on the lowest tier of the drug formulary developed and maintained by the carrier, including any coverage administered by a pharmacy benefit manager on behalf of a carrier; or
 4. Exclude coverage for any FDA-approved prescription medication on the carrier's formulary and any associated counseling or wraparound services solely on the basis the medications and services were court-ordered.
- D. A carrier offering a managed care plan that does not cover services provided by an out-of-network provider may provide that the benefits required by this Section 5 are covered benefits if the services are rendered by a provider who is designated by or affiliated with the managed care plan only if the same requirement applies for services for a physical illness. A carrier is not required to cover out-of-network care at one hundred percent (100%) or without any cost share to the covered person.
- E. If a health benefit 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 9, relating to requirements for nonquantitative treatment limitations, and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to behavioral, mental health, or substance use disorder benefits, the health benefit plan satisfies the parity requirements with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

Section 6 Allowed Classifications

- A. Carriers shall use the following six (6) classifications of benefits in determining the appropriate behavioral, mental health, and substance use disorder benefits:
1. Inpatient In-Network;
 2. Inpatient Out-of-Network;
 3. Outpatient In-Network, except that carriers may use the following sub-classifications:
 - a. Office visits (such as physician visits); and
 - b. All other outpatient services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items);
 4. Outpatient Out-of-Network, except that carriers may use the following sub-classifications:
 - a. Office visits (such as physician visits); and
 - b. All other outpatient services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items);
 5. Emergency room; and
 6. Pharmacy.

B. Multiple In-Network Tiers

1. 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 9 of this regulation and without regard to whether a provider provides services with respect to medical/surgical benefits or behavioral, mental health, and substance use disorder benefits.
2. After the sub-classifications are established, the carrier shall not impose any financial requirement or treatment limitation on behavioral, mental health, and 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 as required by Section 7 of this regulation.

C. Carriers shall not use any other type of sub-classification, including but not limited to intermediate services, intensive care or any other sub-classification.

D. Carriers shall not sub-classify between primary care providers and specialists in the outpatient classifications.

Section 7 Calculation of Substantially All and Predominant Benefits

A. Carriers shall not impose any financial requirement or quantitative treatment limitation to behavioral, mental health, or substance use disorders in any classification that is more restrictive than the predominant financial requirement or treatment limitation than what is applied to substantially all medical/surgical benefits in the same classification.

B. Calculation of Substantially All and Predominant Level Tests

1. Carriers shall use a reasonable and credible method to determine the claims costs associated with the medical/surgical benefits that are subject to a financial requirement or quantitative treatment limitation. The method utilized by the carrier shall conform with Actuarial Standards of Practice.
2. Carriers shall not consider claims costs associated with behavioral, mental health, or substance use disorder benefits in the calculation.
3. Carriers shall consider all claims applying to the deductible and out-of-pocket maximum when calculating the deductible and out-of-pocket applicability in determining if the deductible and out-of-pocket apply to substantially all of the claims.

C. Carriers shall not use any financial requirement unless the carrier can provide verification that the following conditions have been met:

1. "Substantially All" Test

Carriers shall not apply any type of financial requirement or quantitative treatment limitation to behavioral, mental health, or substance use disorder benefits unless the financial requirement applies to substantially all medical/surgical benefits in a permitted classification, which consists of no less than two-thirds (2/3) of the expected medical/surgical claims for any given classification of benefits.

2. "Predominant Level" Test

Once the carrier has determined that the financial requirement or quantitative treatment limitation applies to at least two-thirds (2/3) of the benefits, it shall not apply any specific level of financial requirement or quantitative treatment limitation to any behavioral, mental health, or substance use disorder benefit unless the financial requirement applies to more than one-half (1/2) of the expected claims for any given classification of benefits.

Section 8 Financial Requirements and Quantitative Treatment Limitations

- A. Carriers shall not impose any financial requirement or quantitative treatment limitation on behavioral, mental health, or substance use disorder benefits that it does not impose on medical/surgical benefits.
- B. Carriers shall not impose annual maximums on the number of visits or dollar amounts for behavioral, mental health, or substance use disorder benefits.
- C. Carriers shall not impose any financial requirement or quantitative treatment limitation on behavioral, mental health, or substance use disorder benefits, unless the financial requirement or quantitative treatment limitation applies to substantially all of the medical/surgical benefits in a permitted benefit classification, as shown in Section 6 of this regulation.
- D. Carriers shall not impose a level of financial requirement or quantitative treatment limitation on behavioral, mental health, or substance use disorder benefits, unless the level of financial requirement or treatment limitation predominantly applies to medical/surgical benefits, as shown in Section 7 of this regulation.
- E. If a carrier determines that no one specific level of financial requirement or quantitative treatment level applies to more than one-half (1/2) of the expected claims for the classification, the carrier must use the least restrictive (lowest) amount that makes up one-half (1/2) of the expected claims.

For example, if a carrier applies five (5) copayments in a particular classification of benefits, the carrier may use any combination of copayments to comprise this requirement. If the carrier utilizes the top three (3) copayments, the carrier shall use the lowest copayment of the three (3) as the behavioral, mental health, and substance use disorder copayment for that benefit classification.

- F. Carriers shall use a combined deductible for behavioral, mental health, and substance use disorder and medical/surgical benefits.
- G. Carriers shall use a combined out-of-pocket for behavioral, mental health, and substance use disorder and medical/surgical benefits.
- H. Nothing in this section shall prohibit a carrier from:
 - 1. Providing some benefits that are subject to the deductible and other benefits that are not subject to the deductible within the same classification; or
 - 2. 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 applies to behavioral, mental health, or substance use disorder benefits that applies to medical/surgical benefits.

Section 9 Non-Quantitative Treatment Limitations

- A. Carriers shall not impose a non-quantitative treatment limitation with respect to behavioral, mental health, and substance use disorder services in any classification unless, under the terms of the coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to behavioral, mental health, or substance use disorder services are comparable to, and are applied no more stringently than, the processes strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.
- B. Examples of non-quantitative treatment limitations include, but are not limited to:
1. Medical management standards limiting or excluding benefits based on:
 - a. Medical necessity or medical appropriateness; or
 - b. Whether the treatment is experimental or investigational.
 2. Step therapy or fail-first protocols;
 3. Exclusions based on failure to complete a course of treatment;
 4. Restrictions based on:
 - a. Geographic location;
 - b. Facility type;
 - c. Provider specialty; and
 - d. Other criteria that limit the scope or duration of benefits.
 5. Formulary design for prescription drugs;
 6. Network tier design (when the plan has multiple network tiers); and
 7. Standards for provider admission to a network, including reimbursement rates.
- C. Allowable Non-Quantitative Treatment Limitations
- Carriers may utilize the following non-exhaustive standards when applying non-quantitative treatment limitations:
1. Medical management standards may be used, as long as the criteria are comparable, and applied no more stringently than for behavioral, mental health, and substance use disorder benefits than for medical/surgical benefits;
 2. Formulary design may be used, as long as the criteria used for behavioral, mental health, and substance use disorder benefits are comparable, and applied no more stringently than for medical/surgical benefits; and
 3. Network design may be used, as long as the criteria used for behavioral, mental health, and substance use disorder benefits are comparable, and applied no more stringently than for medical/surgical benefits that comply with state network adequacy requirements.

D. Examples of Non-Quantitative Treatment Limitation Violations

1. Carriers shall not use the following medical management standards 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 services, but approves, on a routine basis, a lesser number of days without a treatment plan for behavioral, mental health, and substance use disorders.
 - b. The carrier applies concurrent review to inpatient stays with various lengths of stay due to the medical condition, but reviews all behavioral, mental health, and substance use disorder inpatient 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 a non-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 all outpatient behavioral, mental health, and substance use disorder benefits when no prior authorization has been obtained.
 - e. Employee Assistance Programs (Group Plans Only)

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.
2. Carriers shall not use the following pharmacy benefits 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.

3. Carriers shall not use the following network designs when applying limitations to behavioral, mental health, and substance use disorder benefits:
 - a. The carrier regularly allows licensed non-M.D. providers into the network while not permitting a licensed non-M.D. provider into the network who primarily treats behavioral, mental health, or substance use disorders.
 - b. The carrier regularly negotiates with a medical/surgical provider based on the rates for behavioral, mental health, and substance use disorder providers.

Section 10 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 on the notification 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 CDHS_Ombudsman_BH@state.co.us, 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 11 Annual Reporting to the Commissioner

- A. As part of their annual health benefit plan filings, carriers shall provide the annual compliance documents as shown in Appendices A through J of this regulation.
- B. Timing and Format of Filings
 1. Carriers offering plans in the non-grandfathered individual and small group markets shall submit fully completed documents as shown in Appendices A through J of this regulation by the date designated by the Division for annual filings.
 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 documents as shown in Appendices A through J of this regulation 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 offering plans in the non-grandfathered large group markets shall submit fully completed documents as shown in Appendices A through J of this regulation no later than March 1 of each year and prior to the submission of any rates for the upcoming plan year.

4. Carriers shall submit the completed documents as shown in Appendices A through J of this regulation 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.
5. Carriers shall use "On Approval" for the "Implementation Date" in SERFF.
6. Carriers shall use "File and Use" for the "Requested Filing Mode" in SERFF.
7. Carriers shall provide a filing description, including the plan year the filing will support.

C. Carrier Attestation of Other Benefit Categories

Carriers shall attest to the following using the attestation form in Appendix A:

1. The plan applies the same deductible for medical/surgical and behavioral, mental health, and substance use disorders;
2. The plan applies the same out-of-pocket for medical/surgical and behavioral, mental health, and substance use disorders;
3. The plan uses the same benefits for emergency room benefits, including all ancillary services provided as part of the emergency room benefits, for medical/surgical and behavioral, mental health, and substance use disorders;
4. The plan utilizes the same copayment, coinsurance or deductible structure for prescription drug benefits for medical/surgical and behavioral, mental health, and substance use disorders;
5. The plan utilizes the same copayment, coinsurance or deductible structure for autism spectrum disorders as it does for medical/surgical diagnoses 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, as required by Section 6.A.6. of this regulation;
 - e. Psychiatric care; and
 - f. Psychological care, including family counseling.
6. The carrier utilizes the same penalties for failure to obtain prior authorization for behavioral, mental health, and substance use disorders as it does for medical/surgical procedures.
7. The form shall be signed by 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. Financial Requirements/Non-Quantitative Treatment Limitations Reporting

1. Carriers shall provide the "Medical Management Evaluation" found in Appendix B of this regulation.
2. Carriers shall provide the "Non-Quantitative Treatment Limitation Verifications" found in Appendix C of this regulation.
 - a. Carriers shall provide data for the twelve (12) month period immediately preceding the filing date (i.e. if filing in June, carriers should use June through May to compile the data).
 - b. Carriers shall only list fully adjudicated claims. Carriers shall include any denied claims at the time of filing, with the appropriate denial reason.
 - c. Carriers shall use claim lines to calculate the number of claims.
 - d. Carriers shall use the primary diagnosis, if the entire claim is processed based on the primary diagnosis. Otherwise, carriers shall use the diagnosis code assigned to the individual claim line.
 - e. Carriers shall display the top nine (9) denial reasons for each category.
 - f. Carriers shall utilize the place of service of the claim. If the claim indicates inpatient as the place of service, but contains emergency room services, the claim shall be classified as inpatient.
 - g. For prior authorizations and concurrent review, carriers shall use the decision date.
3. Carriers shall provide the "Quantitative Treatment Limitation Classifications" calculations, contained in Appendix D of this regulation. Carriers shall provide the required calculations as follows:
 - a. For plan years beginning on or after January 1, 2020, for individual and small group plans, carriers shall provide the required calculations for plans identified by the Division.
 - 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.
 - c. Carriers shall provide the estimated claims payments made by the carrier for each of the benefits specified and provide the classification of each of the benefits as either inpatient or outpatient. If the carrier subclassifies 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 services" category.
 - d. If the carrier utilizes multiple in-network tiers, the carrier shall supply two (2) versions of the "Quantitative Treatment Limitation Classifications" worksheet, identifying the tier the template applies to.

- f. Carriers shall not include any behavioral, mental health, or substance use disorder benefits in the financial requirements calculations, including applied behavioral analysis therapy for autism spectrum disorders.
- 4. Carriers shall supply data for the immediately preceding calendar year no later than June 1st of the following year that demonstrates parity compliance for adverse determinations regarding claims for behavioral, mental health, or substance use disorders and includes the total number of adverse determinations for the following:
 - a. Processed claim counts for covered medical/surgical, behavioral, mental health, and substance use disorder claims shall be provided as follows:
 - (1) Claims by medical/surgical, behavioral health, mental health or substance use disorder, utilizing the primary diagnosis and service codes for each claim; and
 - (2) By classification, as shown in Section 6 of this regulation.
 - b. Non-duplicate claim service line denial counts for medical/surgical, behavioral, mental health, and substance use disorder claims for other than eligibility denials shall be provided as follows:
 - (1) Reasons for the claim denials, as well as the percent of total claims denied for other than eligibility reasons;
 - (2) Claims by medical/surgical, behavioral health, mental health or substance use disorder, utilizing the primary diagnosis and service codes for each claim; and
 - (3) By classification, as shown in Section 6 of this regulation.
 - c. Approved prior authorization counts for medical/surgical, behavioral health, mental health and substance use disorders shall be provided as follows:
 - (1) By medical/surgical, behavioral health, mental health, or substance use disorders; and
 - (2) By classification, as shown in Section 6 of this regulation.
 - d. Denied prior authorization counts for medical/surgical, behavioral health, mental health and substance use disorders shall be provided as follows:
 - (1) By medical/surgical, behavioral health, mental health or substance use disorders;
 - (2) By classification, as shown in Section 6 of this regulation; and
 - (3) By reason for denial for the medical/surgical, behavioral health, mental health or substance use disorders.
 - e. Approved concurrent review counts for medical/surgical, behavioral health, mental health and substance use disorders shall be provided as follows:
 - (1) By medical/surgical, behavioral health, mental health or substance use disorders;

- (2) By classification, as shown in Section 6 of this regulation; and
 - (3) By reason for denial for the medical/surgical, behavioral health, mental health or substance use disorder.
- f. Denied concurrent review counts for medical/surgical, behavioral health, mental health and substance use disorders shall be provided as follows:
 - (1) By medical/surgical, behavioral health, mental health or substance use disorder;
 - (2) By classification, as shown in Section 6 of this regulation; and
 - (3) By reason for denial for the medical/surgical, behavioral health, mental health or substance use disorder.
- g. Paid pharmacy claim counts for medical/surgical, behavioral, mental health, and substance use disorder claims shall be provided as follows:
 - (1) Claims by medical/surgical, behavioral health, mental health or substance use disorder, utilizing the primary diagnosis and service codes for each claim; and
 - (2) By classification, as shown in Section 6 of this regulation.
- h. Claim denial pharmacy claim counts for medical/surgical, behavioral, mental health, and substance use disorder claims for other than eligibility denials shall be provided as follows:
 - (1) Reasons for the claim denials, as well as the percent of total claims denied for other than eligibility reasons;
 - (2) By classification, as shown in Section 6 of this regulation; and
 - (3) Claims by medical/surgical, behavioral health, mental health or substance use disorder, utilizing the primary diagnosis and service codes for each claim.
- i. Approved prior authorization counts for medical/surgical, behavioral health, mental health and substance use disorder pharmacy services shall be provided as follows:
 - (1) By medical/surgical, behavioral health, mental health, or substance use disorder; and
 - (2) By classification, as shown in Section 6 of this regulation.
- j. Denied prior authorization counts for medical/surgical, behavioral health, mental health and substance use disorder pharmacy services shall be provided as follows:
 - (1) By medical/surgical, behavioral health, mental health or substance use disorder;
 - (2) By classification, as shown in Section 6 of this regulation; and

- (3) By reason for denial for the medical/surgical, behavioral health, mental health or substance use disorder.

- 5. A qualified actuary must certify that the calculations shown in the “substantially all” and “predominant” tests of the financial requirements and quantitative treatment limitations of Section 8 of this regulation are accurate and true to the best of the actuary’s knowledge and have been appropriately calculated in accordance with Actuarial Standards of Practice.

E. Non-Quantitative Treatment Limitations

- 1. Carriers shall provide responses for the following classifications for each question found in Appendices E through J of this regulation:
 - a. Inpatient In-Network;
 - b. Inpatient Out-of-Network, if the plan has out-of-network benefits available;
 - c. Outpatient In-Network;
 - d. Outpatient Out-of-Network, if the plan has out-of-network benefits available;
 - e. Emergency Room Services; and
 - f. Pharmacy Services shall be provided separately, as shown in Appendix F of this regulation.
- 2. Carriers shall provide the narratives for the following questionnaires in the format found in Appendices E through J of this regulation:
 - a. Non-Quantitative Treatment Limitations - Medical/Surgical Services Questionnaire (Appendix E):
 - (1) Carriers shall provide the processes for the development of medical necessity standards, providing the processes, strategies, evidentiary standards, and other factors used;
 - (2) Carriers shall provide any factors that were considered but discarded and explain why the factor was discarded;
 - (3) Carriers shall provide the eligibility criteria for case management services;
 - (4) Carriers shall provide the circumstances and method by which treatment plans must be submitted to obtain or continue coverage;
 - (5) Carriers shall provide how fail-first and step-therapy protocols are determined;
 - (6) Carriers shall provide how the concurrent review standards are determined, including how review intervals have been determined;
 - (7) Carriers shall provide any benefits that are contingent upon improvement within a set number of days;

- (8) Carriers shall provide any penalties that may be imposed for failure to obtain prior authorization;
 - (9) Carriers shall list any restrictions that apply to obtaining services from a facility or provider based on geographic location;
 - (10) Carriers shall list any restrictions that apply to obtaining services from specific facilities or provider specialties;
 - (11) Carriers shall list any other limitations imposed on obtaining covered services; and
 - (12) Carriers shall have the chief medical officer and director of medical/surgical services certify that the information contained in the questionnaire is accurate and in compliance with this regulation.
- b. Non-Quantitative Treatment Limitations - Pharmacy Services Questionnaire (Appendix F):
 - (1) Carriers shall supply specific information for medical/surgical, behavior and mental health and substance use disorders for each of the following:
 - (a) Carriers shall list any factors considered when establishing prior authorization for pharmacy services, including any factors considered and discarded;
 - (b) Carriers shall list any factors used in determining if fail-first or step-therapy is required for pharmacy services; and
 - (c) Carriers shall list any factors considered when tiering pharmacy drugs.
 - (2) Carriers shall have the chief medical officer and the director of pharmacy services certify that the information contained in the questionnaire is accurate and in compliance with this regulation.
- c. Non-Quantitative Treatment Limitations - Behavioral Health/Mental Health Questionnaire (Appendix G):
 - (1) Carriers shall provide the processes for the development of medical necessity standards, providing the processes, strategies, evidentiary standards, and other factors used;
 - (2) Carriers shall provide any factors that were considered but discarded and explain why the factor was discarded;
 - (3) Carriers shall provide the eligibility criteria for case management services;
 - (4) Carriers shall provide the circumstances and method by which treatment plans must be submitted to obtain or continue coverage;
 - (5) Carriers shall provide how fail-first and step-therapy protocols are determined;

- (6) Carriers shall provide how the concurrent review standards are determined, including how review intervals have been determined;
 - (7) Carriers shall provide any benefits that are contingent upon improvement within a set number of days;
 - (8) Carriers shall provide any penalties that may be imposed for failure to obtain prior authorization;
 - (9) Carriers shall list any restrictions that apply to obtaining services from a facility or provider based on geographic location;
 - (10) Carriers shall list any restrictions that apply to obtaining services from specific facilities or provider specialties;
 - (11) Carriers shall list any other limitations imposed on obtaining covered services; and
 - (12) Carriers shall have the chief medical officer and director of the behavioral health services certify that the information contained in the questionnaire is accurate and in compliance with this regulation.
- d. Non-Quantitative Treatment Limitations - Substance Use Disorder Questionnaire (Appendix H):
- (1) Carriers shall provide the processes for the development of medical necessity standards, providing the processes, strategies, evidentiary standards, and other factors used;
 - (2) Carriers shall provide any factors that were considered but discarded and explain why the factor was discarded;
 - (3) Carriers shall provide the eligibility criteria for case management services;
 - (4) Carriers shall provide the circumstances and method by which treatment plans must be submitted to obtain or continue coverage;
 - (5) Carriers shall provide how fail-first and step-therapy protocols are determined;
 - (6) Carriers shall provide how the concurrent review standards are determined, including how review intervals have been determined;
 - (7) Carriers shall provide any benefits that are contingent upon improvement within a set number of days;
 - (8) Carriers shall provide any penalties that may be imposed for failure to obtain prior authorization;
 - (9) Carriers shall list any restrictions that apply to obtaining services from a facility or provider based on geographic location;
 - (10) Carriers shall list any restrictions that apply to obtaining covered services from specific facilities or provider specialties;

- (11) Carriers shall list any other limitations imposed on obtaining services covered; and
 - (12) Carriers shall have the chief medical officer and director of the behavioral health services certify that the information contained in the questionnaire is accurate and in compliance with this regulation.
- e. Non-Quantitative Treatment Limitations - Network Adequacy/Provider Credentialing and Network Admission Questionnaire (Appendix I)
 - (1) Carriers shall provide the information requested for medical/surgical, behavioral and mental health and substance use disorder services;
 - (2) Carriers shall provide the factors and strategies used to determine how physicians, non-physicians, and facilities are credentialed and admitted to the network; and
 - (3) Carriers shall have the director of network operations certify that the information contained in the questionnaire is accurate and in compliance with this regulation.
- f. Non-Quantitative Treatment Limitations – Confidential Network Development Questionnaire (Appendix J)
 - (1) Carriers shall provide the factors utilized in determining the make-up of the network, including any factors that were considered but discarded;
 - (2) Carriers shall provide the calculations utilized in determining the required number of providers to supply the covered services without unreasonable delay; and
 - (3) Carriers shall provide the Division with reimbursement rates for medical/surgical, behavioral, mental health, and substance use disorder providers and facilities, as well as a description of how provider reimbursement rates are negotiated for medical/surgical, behavioral, mental health, and substance use disorder providers and facilities as specified in Appendix J of this regulation. Supplemental information required by Appendix J shall be submitted in Excel format.
- g. Non-Quantitative Treatment Limitation – Comparative Analysis Reporting (Appendix K)
 - (1) Carriers shall provide the comparative analysis information required by Section 12 of this regulation for the following Non-Quantitative Treatment Limitations:
 - (a) Medical/Surgical Services;
 - (b) Pharmacy Services;
 - (c) Behavioral Health/Mental Health;
 - (d) Substance Use Disorder;

- (e) Network Adequacy/Provider Credentialing and Network Admission; and
 - (f) Confidential Network Development.
 - (2) 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 in the appendices and by this Section 11 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 12 Comparative Analysis Reporting

- A. Carriers shall provide the Commissioner with a comparative analysis demonstrating that, for any non-quantitative treatment limitation, including medical necessity criteria, as written and in operation, 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, mental health, and substance use disorders 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 and surgical benefits within the corresponding classification of benefits.
- B. Carriers, shall provide these comparative analyses results to the Commissioner, showing the following, at a minimum:
 - 1. Identification of any factors used to determine whether a non-quantitative treatment limitation will apply to a benefit, including any factors considered and discarded;
 - 2. 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;
 - 3. Provide the 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;
 - 4. Provide the 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

5. 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.

Section 13 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 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 Appendix J 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 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, 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 16 Effective Date

This regulation shall become effective on February 1, 2020.

Section 17 History

Emergency regulation 19-E-02 effective June 13, 2019.
Emergency regulation 19-E-04 effective October 10, 2019.
Regulation effective February 1, 2020.

Appendix A: Financial Requirements Attestations

We, the undersigned authorized representatives of [Company Name], certify, to the best of our good faith and knowledge, that all plans offered by [Company Name] meet the requirements of § 10-16-104(5.5), C.R.S., and Colorado Insurance Emergency Regulation 19-E-04, in that all benefits associated with behavioral, mental health and substance use disorder meet all of the requirements of Colorado and federal law.

<input type="radio"/> Yes <input type="radio"/> No	The same deductible is used for medical/ surgical and behavioral, mental health, and substance use disorders, when applicable, and the application of deductible meets the requirements of the "Substantially All" test.	
<input type="radio"/> Yes <input type="radio"/> No	The same out-of-pocket is applied to behavioral, mental health, and substance use disorders and medical/ surgical services.	
<input type="radio"/> Yes <input type="radio"/> No	The same benefits apply for emergency room services, including all ancillary services, for behavioral, mental health, and substance use disorders and medical/ surgical services.	
<input type="radio"/> Yes <input type="radio"/> No	The same copayment, coinsurance or deductible structure is utilized for prescription drug benefits for behavioral, mental health, and substance use disorders and medical/ surgical services.	
<input type="radio"/> Yes <input type="radio"/> No	The same copayment, coinsurance or deductible structure applies to autism services as for medical/ surgical services, as defined in § 10-16-104(1.4), C.R.S.:	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Evaluation and Assessment Services
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Habilitative benefits, including occupational therapy, physical therapy and speech therapy
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Rehabilitative benefits, including occupational therapy, physical therapy and speech therapy
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Pharmacy care and medication
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric care
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Psychological care, including family counseling
<input type="radio"/> Yes <input type="radio"/> No	The same penalties for failure to obtain prior authorization apply for behavioral, mental health, and substance use disorders and medical/ surgical procedures.	

 (**Original** Signature of Officer)

 (Title of Officer)

 (Printed Name of Officer)

 (Date)

Appendix B: Medical Management Evaluation

Benefit Name	Medical Management			
	Prior authorization/ Precertification Required	Fail-First Requirements Apply	Step Therapy Requirements Apply	Concurrent Authorization Requirements Apply
Allergy Testing				
Autism Spectrum Disorders				
Applied Behavior Analysis (ABA) Based Therapies				
Evaluation and Assessment Services				
Habilitative Care				
Rehabilitative Care				
Pharmacy Care and Medication				
Psychiatric Care				
Psychological Care, Including Family Counseling				
Drugs - Generic				
Drugs - Preferred Brand				
Drugs - Non-Preferred Brand				
Drugs - Specialty				
Durable Medical Equipment				
Emergency Room Services				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Emergency Transportation/Ambulance				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Habilitative Occupational Therapy - Adult				
Habilitative Occupational Therapy - Child				
Habilitative Physical Therapy - Adult				
Habilitative Physical Therapy - Child				
Habilitative Speech Therapy - Adult				
Habilitative Speech Therapy - Child				
Home Health Care Services				
Hospice Services				
Imaging (CT/PET Scans, MRIs)				
Inpatient Hospital Services (e.g., Hospital Stay)				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Inpatient Physician and Surgical Services				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Intensive Outpatient Therapy for Mental Health				
Intensive Outpatient Therapy for Substance Use Disorder				
Laboratory Outpatient and Professional Services				
Long-Term/Custodial Nursing Home Care				

Appendix B: Medical Management Evaluation

Benefit Name	Medical Management			
	Prior authorization/ Precertification Required	Fail-First Requirements Apply	Step Therapy Requirements Apply	Concurrent Authorization Requirements Apply
Other Practitioner Office Visit (Nurse, Physician Assistant)				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				
Outpatient Surgery Physician/Surgical Services				
Partial Hospitalization for Behavioral Health/Mental Health				
Partial Hospitalization for Substance Use Disorder				
Postpartum Mental Health/Substance Use				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Preventive Care/Screening/Immunization - Adult				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Preventive Care/Screening/Immunization - Child				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Primary Care Visit to Treat an Injury or Illness				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Rehabilitative Occupational Therapy - Adult				
Rehabilitative Occupational Therapy - Child				
Rehabilitative Physical Therapy - Adult				
Rehabilitative Physical Therapy - Child				
Rehabilitative Speech Therapy - Adult				
Rehabilitative Speech Therapy - Child				
Residential Day Treatment for Mental Health				
Residential Day Treatment for Substance Use				
Skilled Nursing Facility				
Specialist Visit				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Telehealth PCP				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				

Appendix B: Medical Management Evaluation

Benefit Name	Medical Management			
	Prior authorization/ Precertification Required	Fail-First Requirements Apply	Step Therapy Requirements Apply	Concurrent Authorization Requirements Apply
Telehealth Specialist				
Medical/Surgical				
Behavioral Health/Mental Health				
Substance Use Disorder				
Transplant				
Urgent Care Centers or Facilities				
X-rays and Diagnostic Imaging				

Appendix C: Non-Quantitative Treatment Limitation Verifications

		Inpatient In-Network			Inpatient Out-of-Network		
		Medical/Surgical	Behavioral Health/Mental Health	Substance Use Disorder	Medical/Surgical	Behavioral Health/Mental Health	Substance Use Disorders
Claims Paid							
Claims Denied							
Denial Reasons							
Totals							
Prior Authorizations Approved							
Prior Authorizations Denied							
Denial Reasons							
Totals							
Concurrent Reviews Approved							
Concurrent Reviews Denied							
Denial Reasons							
Totals							
Pharmacy Claims Paid							
Pharmacy Claims Denied							
Denial Reasons							
Totals							
Pharmacy Prior Authorizations Approved							
Pharmacy Prior Authorizations Denied							
Denial Reasons							
Totals							

Appendix C: Non-Quantitative Treatment Limitation Verifications

		Outpatient In-Network					
		Medical/Surgical	Behavioral Health/Mental Health	Substance Use Disorder	Medical/Surgical	Behavioral Health/Mental Health	Substance Use Disorders
Claims Paid							
Claims Denied							
Denial Reasons							
Totals							
Prior Authorizations Approved							
Prior Authorizations Denied							
Denial Reasons							
Totals							
Concurrent Reviews Approved							
Concurrent Reviews Denied							
Denial Reasons							
Totals							
Pharmacy Claims Paid							
Pharmacy Claims Denied							
Denial Reasons							
Totals							
Pharmacy Prior Authorizations Approved							
Pharmacy Prior Authorizations Denied							
Denial Reasons							
Totals							

Appendix C: Non-Quantitative Treatment Limitation Verifications

		Outpatient Out-of-Network					
		Medical/Surgical	Behavioral Health/Mental Health	Substance Use Disorder	Medical/Surgical	Behavioral Health/Mental Health	Substance Use Disorders
Claims Paid							
Claims Denied							
Denial Reasons							
Totals							
Prior Authorizations Approved							
Prior Authorizations Denied							
Denial Reasons							
Totals							
Concurrent Reviews Approved							
Concurrent Reviews Denied							
Denial Reasons							
Totals							
Pharmacy Claims Paid							
Pharmacy Claims Denied							
Denial Reasons							
Totals							
Pharmacy Prior Authorizations Approved							
Pharmacy Prior Authorizations Denied							
Denial Reasons							
Totals							

Appendix C: Non-Quantitative Treatment Limitation Verifications

		Emergency Room			Pharmacy Services		
		Medical/Surgical	Behavioral Health/Mental Health	Substance Use Disorder	Medical/Surgical	Behavioral Health/Mental Health	Substance Use Disorders
Claims Paid							
Claims Denied							
Denial Reasons							
Totals							
Prior Authorizations Approved							
Prior Authorizations Denied							
Denial Reasons							
Totals							
Concurrent Reviews Approved							
Concurrent Reviews Denied							
Denial Reasons							
Totals							
Pharmacy Claims Paid							
Pharmacy Claims Denied							
Denial Reasons							
Totals							
Pharmacy Prior Authorizations Approved							
Pharmacy Prior Authorizations Denied							
Denial Reasons							
Totals							

Appendix D: Quantitative Treatment Limitation Classifications

Plan HIOS ID:

Does the plan subclassify "Outpatient Services"? ☐ Yes ☐ No

If "No," use "All other outpatient items & services" below.

Does the plan offer out-of-network benefits? ☐ Yes ☐ No

PLEASE NOTE: Carriers shall not subclassify outpatient benefits using any other classes other than "Office Visits" and "All Other Outpatient Services"

Benefit Name	In-Network					Out-of-Network				
	Classification	Projected Claim Payments	Copay	Coinsurance (*Enter Plan Coinsurance)	Deductible Applies?	Classification	Projected Claim Payments	Copay	Coinsurance (*Enter Plan Coinsurance)	Deductible Applies?
Allergy Testing										
Autism Spectrum Disorders										
Applied Behavior Analysis (ABA) Based Therapies										
Evaluation and Assessment Services										
Habilitative Care										
Rehabilitative Care										
Pharmacy Care and Medication										
Psychiatric Care										
Psychological Care, Including Family Counseling										
Durable Medical Equipment										
Habilitative Occupational Therapy - Adult										
Habilitative Occupational Therapy - Child										
Habilitative Physical Therapy - Adult										
Habilitative Physical Therapy - Child										
Habilitative Speech Therapy - Adult										
Habilitative Speech Therapy - Child										
Home Health Care Services										
Hospice Services										
Imaging (CT/PET Scans, MRIs)										
Inpatient Hospital Services (e.g., Hospital Stay)										
Medical/Surgical										
Behavioral Health/Mental Health										
Substance Use Disorders										
Inpatient Physician and Surgical Services										

Appendix D: Quantitative Treatment Limitations Classifications

Benefit Name	In-Network					Out-of-Network				
	Classification	Projected Claim Payments	Copay	Coinsurance (*Enter Plan Coinsurance)	Deductible Applies?	Classification	Projected Claim Payments	Copay	Coinsurance (*Enter Plan Coinsurance)	Deductible Applies?
*Carriers shall classify each of the following benefits as inpatient or outpatient, providing the project claim amounts, as required by § 10-16-147, C.R.S., as amended by HB19-1269										
Medical/Surgical										
Behavioral Health/Mental Health										
Substance Use Disorders										
Intensive Outpatient Therapy for Mental Health										
Intensive Outpatient Therapy for Substance Use Disorder										
Laboratory Outpatient and Professional Services										
Long-Term/Custodial Nursing Home Care										
Other Practitioner Office Visit (Nurse, Physician Assistant)										
Medical/Surgical										
Behavioral Health/Mental Health										
Substance Use Disorders										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services										
Partial Hospitalization for Behavioral Health/Mental Health										
Partial Hospitalization for Substance Use Disorder										
Postpartum Mental Health/Substance Use										
Medical/Surgical										
Behavioral Health/Mental Health										
Substance Use Disorders										
Preventive Care/Screening/Immunization - Adult										
Medical/Surgical										
Behavioral Health/Mental Health										
Substance Use Disorders										
Preventive Care/Screening/Immunization - Child										
Medical/Surgical										
Behavioral Health/Mental Health										
Substance Use Disorders										
Primary Care Visit to Treat an Injury or Illness										
Medical/Surgical										
Behavioral Health/Mental Health										
Substance Use Disorders										
Rehabilitative Occupational Therapy - Adult										
Rehabilitative Occupational Therapy - Child										
Rehabilitative Physical Therapy - Adult										
Rehabilitative Physical Therapy - Child										
Rehabilitative Speech Therapy - Adult										

Appendix D: Quantitative Treatment Limitations Classifications

Benefit Name	In-Network					Out-of-Network				
	Classification	Projected Claim Payments	Copay	Coinsurance (*Enter Plan Coinsurance)	Deductible Applies?	Classification	Projected Claim Payments	Copay	Coinsurance (*Enter Plan Coinsurance)	Deductible Applies?
*Carriers shall classify each of the following benefits as inpatient or outpatient, providing the project claim amounts, as required by § 10-16-147, C.R.S., as amended by HB19-1269										
Rehabilitative Speech Therapy - Child										
Residential Day Treatment for Mental Health										
Residential Day Treatment for Substance Use										
Skilled Nursing Facility										
Specialist Visit										
Medical/Surgical										
Behavioral Health/Mental Health										
Substance Use Disorders										
Telehealth PCP										
Medical/Surgical										
Behavioral Health/Mental Health										
Substance Use Disorders										
Telehealth Specialist										
Medical/Surgical										
Behavioral Health/Mental Health										
Substance Use Disorders										
Transplant										
Urgent Care Centers or Facilities										
X-rays and Diagnostic Imaging										

Appendix E: Non-Quantitative Treatment Limitations - Medical/Surgical Services Questionnaire

Carriers shall provide the following information for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network and emergency services, as applicable.

*Cells may be resized to accommodate the length of response

1. Describe the following in a clear and concise manner:

1a. What processes are utilized for developing medical necessity criteria?

1b. What strategies are utilized for developing medical necessity criteria?

1c. What evidentiary standards are utilized for developing medical necessity criteria?

1d. What other factors are utilized for developing medical necessity criteria?

1e. What strategies were considered but were discarded, and why?

1f. What methodology is used to determine if a given treatment is investigational or experimental?

2. Describe any retrospective review standards for medical necessity standards.

3. Describe any eligibility criteria utilized for case management services

4. Describe the circumstances and method by which treatment plans must be submitted to obtain or continue coverage.

5. Describe how fail-first and step-therapy protocols are determined.

6. Describe how factors for concurrent review requirements are determined. Must include how review intervals have been determined.

7. List all benefits that make approval contingent upon improvement within a specific number of days, including the number of days specified.

8. List the penalties that may be imposed for failure to obtain prior authorization.

9. List any restrictions that apply to obtaining services from a facility or provider based on geographic location.

10. List any restrictions that apply to obtaining services from specific facilities or provider specialties.

11. List any other limitations imposed on obtaining services covered by the health benefit plan.

We hereby certify that the responses given above are accurate and that [Company Name] is in compliance with the requirements contained in Colorado Insurance Emergency Regulation 19-E-04 relating to Non-Quantitative Treatment Limitation for Medical/Surgical Services

Required Signatures:

Chief Medical Officer Name

Director, Medical/Surgical Services Name

Chief Medical Officer Signature and Date

Director, Medical Surgical Services Signature and Date

Appendix F: Non-Quantitative Treatment Limitations - Pharmacy Services Questionnaire

Carriers shall provide the following information concerning the policies and procedures for determining coverage for pharmacy services:

*Cells may be resized to accommodate the length of response

1. List the factors considered when establishing prior authorization for pharmacy services including any factors considered and discarded for medical/surgical conditions:

2. List the factors considered when establishing prior authorization for pharmacy services including any factors considered and discarded for behavioral health/mental health conditions:

3. List the factors considered when establishing prior authorization for pharmacy services including any factors considered and discarded for substance use disorders:

4. Provide the decision-making process for determining if fail-first or step-therapy is required for pharmacy services for medical/surgical conditions:

5. Provide the decision-making process for determining if fail-first or step-therapy is required for pharmacy services for behavioral health/mental health conditions:

6. Provide the decision-making process for determining if fail-first or step-therapy is required for pharmacy services for substance use disorders:

7. List the factors considered when tiering pharmacy drugs for medical/surgical conditions:

8. List the factors considered when tiering pharmacy drugs for behavioral health/mental health conditions:

9. List the factors considered when tiering pharmacy drugs for substance use disorders:

10. List any additional factors or limitations imposed on obtaining pharmacy services covered by the health benefit plan.

We hereby certify that the responses given above are accurate and that [Company Name] is in compliance with the requirements contained in Colorado Insurance Emergency Regulation 19-E-04 relating to Non-Quantitative Treatment Limitations for Pharmacy Services as they relate to medical/surgical services, behavioral health/mental health services, and substance use disorder services.

Required Signatures:

Chief Medical Officer Name

Director, Pharmacy Services

Chief Medical Officer Sign and Date

Director, Pharmacy Services Sign and Date

**Appendix G: Non-Quantitative Treatment Limitations - Behavioral Health/Mental Health
Questionnaire**

Carriers shall provide the following information for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network and emergency services, as applicable.

*Cells may be resized to accommodate the length of response

1. Describe the following in a clear and concise manner:

1a. What processes are utilized for developing medical necessity criteria?

1b. What strategies are utilized for developing medical necessity criteria?

1c. What evidentiary standards are utilized for developing medical necessity criteria?

1d. What other factors are utilized for developing medical necessity criteria?

1e. What strategies were considered but were discarded, and why?

1f. What methodology is used to determine if a given treatment is investigational or experimental?

2. Describe any retrospective review standards for medical necessity standards.

3. Describe any eligibility criteria utilized for case management services

4. Describe the circumstances and method by which treatment plans must be submitted to obtain or continue coverage.

5. Describe how fail-first and step-therapy protocols are determined.

6. Describe how factors for concurrent review requirements are determined. The response must include how review intervals have been determined.

7. List all benefits that make approval contingent upon improvement within a specific number of days, including the number of days specified

8. List the penalties that may be imposed for failure to obtain prior authorization.

9. List any restrictions that apply to obtaining services from a facility or provider based on geographic location.

10. List any restrictions that apply to obtaining services from specific facilities or provider specialties.

11. List any other limitations imposed on obtaining services covered by the health benefit plan.

We hereby certify that the responses given above are accurate and that [Company Name] is in compliance with the requirements contained in Colorado Insurance Emergency Regulation 19-E-04 relating to Non-Quantitative Treatment Limitations for Behavioral Health and Mental Health.

Required Signatures:

Chief Medical Officer Name

Director of Behavioral Health Department Name

Chief Medical Officer Sign and Date

Director, Behavioral Health Department Sign and Date

Appendix H: Non-Quantitative Treatment Limitations - Substance Use Disorder Questionnaire

Carriers shall provide the following information for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network and emergency services, as applicable.

1. Describe the following in a clear and concise manner:

1a. What processes are utilized for developing medical necessity criteria?

1b. What strategies are utilized for developing medical necessity criteria?

1c. What evidentiary standards are utilized for developing medical necessity criteria?

1d. What other factors are utilized for developing medical necessity criteria?

1e. What strategies were considered but were discarded, and why?

1f. What methodology is used to determine if a given treatment is investigational or experimental?

2. Describe any retrospective review standards for medical necessity standards.

3. Describe any eligibility criteria utilized for case management services.

4. Describe the circumstances and method by which treatment plans must be submitted to obtain or continue coverage.

5. Describe how fail-first and step-therapy protocols are determined.

6. Describe how factors for concurrent review requirements are determined. The response must include how review intervals have been determined.

7. List all benefits that make approval contingent upon improvement within a specific number of days, including the number of days specified.

8. List the penalties that may be imposed for failure to obtain prior authorization.

9. List any restrictions that apply to obtaining services from a facility or provider based on geographic location.

10. List any restrictions that apply to obtaining services from specific facilities or provider specialties.

11. List any other limitations imposed on obtaining services covered by the health benefit plan.

We hereby certify that the responses given above are accurate and that [Company Name] is in compliance with the requirements contained in Colorado Insurance Emergency Regulation 19-E-04 relating to Non-Quantitative Treatment Limitations for Substance Use Disorders.

Required Signatures:

Chief Medical Officer Name

Director of Behavioral Health Department Name

Chief Medical Officer Sign and Date

Director, Behavioral Health Department Sign and Date

Appendix I: Non-Quantitative Treatment Limitations: Network Adequacy/Provider Credentialing and Network Admission Questionnaire

*Cells may be resized to accommodate the length of the response

1. List the factors and strategies used to determine how the following providers are credentialed and admitted to the network for medical/surgical services:

1a. Physician

--

1b. Non-physician

--

1c. Facility

--

2. List the factors and strategies used to determine how the following providers are credentialed and admitted to the network for behavioral health/mental health services:

2a. Physician

--

2b. Non-physician

--

2c. Facility

--

3. List the factors and strategies used to determine how the following providers are credentialed and admitted to the network for substance use disorder services:

3a. Physician

--

Page 1 of 2

3b. Non-physician

--

3c. Facility

--

We hereby certify that the responses given above are accurate and that [Company Name] is in compliance with the requirements contained in Colorado Insurance Emergency Regulation 19-E-04 relating to Non-Quantitative Treatment Limitations Network Adequacy/Provider Credentialing and Network Admission.

Required Signatures:

Network Director Name

Network Director Sign and Date

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**Appendix J: Non-Quantitative Treatment Limitations: Confidential Network Development
Questionnaire**

*Cells may be resized to accommodate the length of the response

1. Provide the negotiating process used for providers of **medical/surgical services**, including the following items:

1a. Provide the specific terms for the following medical/surgical services provider reimbursement rates:

Physician:

Non-Physician

Facility

1b. Provide the specific quality measures used in determining eligibility to join the network for the following medical/surgical services providers:

Physician:

Non-Physician

Facility

1c. Provide the specific differences in the negotiating process based upon the geographic region of the following medical/surgical services providers:

Physician:

Non-Physician

Facility

--

1d. Provide any other factors considered in the negotiating process with medical/surgical services providers.

Physician:

--

Non-Physician

--

Facility

--

2. Provide the negotiating process used for providers **of behavioral health/mental health services**, including the following items:

2a. Provide the specific terms for the following behavioral health/mental health services provider reimbursement rates:

Physician:

--

Non-Physician

--

Facility

--

2b. Provide the specific quality measures used in determining eligibility to join the network for the following behavioral health/mental health services providers:

Physician:

--

Non-Physician

--

Facility

--

2c. Provide the specific differences in the negotiating process based upon the geographic region of the following behavioral health/mental health services providers.

Physician:

--

Non-Physician

--

Facility

--

2d. Provide any other factors considered in the negotiating process with behavioral health/mental health service providers.

Physician

--

Non-Physician

--

Facility

--

3. Provide the negotiating process used for providers of substance use disorder services, including the following items:

3a. Provide the specific terms for the following substance use disorder services provider reimbursement rates:

Physician

--

Non-Physician

--

Facility

--

3b. Provide the specific quality measures used in determining eligibility to join the network for the following substance use disorder services providers:

Physician:

--

Non-Physician

--

Facility

--

3c. Provide the specific differences in the negotiating process based upon the geographic region of the following substance use disorder services providers:

Physician:

--

Non-Physician

--

Facility

--

3d. Provide any other factors considered in the negotiating process with substance use disorder services providers:

Physician:

--

Non-Physician

--

Facility

--

4. Provide the specific projections of providers needed to furnish the benefits covered under the plan. Carriers shall use the provider listing found in Colorado Insurance Regulation 4-2-53.

Provider Type	Number of Providers
e.g Primary Care	e.g. 25

5. Carriers shall supply the following information for each provider type, by minimum, median, maximum and as a percent of Medicare.

Provider Type	Service Type	Service Code	Minimum	Median	Maximum	Percent of Medicare

I hereby certify that the responses given above are accurate and that [Company Name] is in compliance with the requirements contained in Colorado Insurance Regulation 4-2-64 relating to Non-Quantitative Treatment Limitations Network Adequacy/Provider Credentialing and Network Admission.

Required Signatures:

 Network Director Name

 Network Director Sign and Date

Appendix K: Non-Qualitative Treatment Limitation Comparative Analysis Submission Template

Carriers shall provide comparative analyses results to the Commissioner for the following six (6) Non-Qualitative

Treatment Limitation (NQTL) categories:

- Medical/Surgical Services
- Pharmacy Services
- Behavioral Health/Mental Health
- Substance Use Disorder
- Network Adequacy/Provider Credentialing and Network Admission
- Confidential Network Development

The submission for each NQTL category listed above must include a comparative analysis demonstrating that, for any non-quantitative treatment limitation, including medical necessity criteria, as written and in operation, 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, mental health, and substance use disorders 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 and surgical benefits within the corresponding classification of benefits.

Carriers shall complete the following attestation and submit related substantiating documents via SERFF.

<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis that includes the following, at minimum, been conducted for NQTL Medical/Surgical Services and provided to the Division.	
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified all factors used to determine whether a NQTL will apply as outlined in Section 12.B.1. of Colorado Insurance Regulation 4-2-64.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified and defined the specific evidentiary standards used to define the factors and any other evidence relied on in designing each non-quantitative treatment limitation as outlined in Section 12.B.2. of Colorado Insurance Regulation 4-2-64.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including any results of the analyses, has been performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, <i>as written</i> , 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, <i>as written</i> , and the written processes and strategies used to apply to each non-quantitative treatment limitation for medical and surgical benefits as required by Section 12.B.3. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.

	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including the results of the analyses, has been 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, <i>in operation</i> , for medical and surgical benefits as required by Section 12.B.4. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis discloses the specific findings and conclusions reached 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 as required by Section 12.B.5. of Colorado Insurance Regulation 4-2-64.

<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis that includes the following, at minimum, been conducted for NQTL Pharmacy Services and provided to the Division?	
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified all factors used to determine whether a NQTL will apply as outlined in Section 12.B.1. of Colorado Insurance Regulation 4-2-64.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified and defined the specific evidentiary standards used to define the factors and any other evidence relied on in designing each non-quantitative treatment limitation as outlined in Section 12.B.2. of Colorado Insurance Regulation 4-2-64.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including any results of the analyses, has been performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, <i>as written</i> , 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, <i>as written</i> , and the written processes and strategies used to apply to each non-quantitative treatment limitation for medical and surgical benefits as required by Section 12.B.3. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including the results of the analyses, has been 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, <i>in operation</i> , for medical and surgical benefits as required by Section 12.B.4. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.

<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis discloses the specific findings and conclusions reached 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 as required by Section 12.B.5. of Colorado Insurance Regulation 4-2-64.
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<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis that includes the following, at minimum, been conducted for NQTL Behavioral Health/Mental Health and provided to the Division?	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified all factors used to determine whether a NQTL will apply as outlined in Section 12.B.1. of Colorado Insurance Regulation 4-2-64.
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified and defined the specific evidentiary standards used to define the factors and any other evidence relied on in designing each non-quantitative treatment limitation as outlined in Section 12.B.2. of Colorado Insurance Regulation 4-2-64.
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including any results of the analyses, has been performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, <i>as written</i> , 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, <i>as written</i> , and the written processes and strategies used to apply to each non-quantitative treatment limitation for medical and surgical benefits as required by Section 12.B.3. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.
<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="radio"/> Yes <input checked="" type="radio"/> No	The comparative analysis, including the results of the analyses, has been 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, <i>in operation</i> , for medical and surgical benefits as required by Section 12.B.4. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis discloses the specific findings and conclusions reached 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 as required by Section 12.B.5. of Colorado Insurance Regulation 4-2-64.

<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis that includes the following, at minimum, been conducted for NQTL Substance Use Disorder and provided to the Division?	
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified all factors used to determine whether a NQTL will apply as outlined in Section 12.B.1. of Colorado Insurance Regulation 4-2-64.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified and defined the specific evidentiary standards used to define the factors and any other evidence relied on in designing each non-quantitative treatment limitation as outlined in Section 12.B.2. of Colorado Insurance Regulation 4-2-64.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including any results of the analyses, has been performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, <i>as written</i> , 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, <i>as written</i> , and the written processes and strategies used to apply to each non-quantitative treatment limitation for medical and surgical benefits as required by Section 12.B.3. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including the results of the analyses, has been 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, <i>in operation</i> , for medical and surgical benefits as required by Section 12.B.4. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis discloses the specific findings and conclusions reached 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 as required by Section 12.B.5. of Colorado Insurance Regulation 4-2-64.

<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis that includes the following, at minimum, been conducted for NQTL Network Adequacy/Provider Credentialing and Network Admission and provided to the Division?	
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified all factors used to determine whether a NQTL will apply as outlined in Section 12.B.1. of Colorado Insurance Regulation 4-2-64.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified and defined the specific evidentiary standards used to define the factors and any other evidence relied on in designing each non-quantitative treatment limitation as outlined in Section 12.B.2. of Colorado Insurance Regulation 4-2-64.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including any results of the analyses, has been performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, <i>as written</i> , 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, <i>as written</i> , and the written processes and strategies used to apply to each non-quantitative treatment limitation for medical and surgical benefits as required by Section 12.B.3. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including the results of the analyses, has been 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, <i>in operation</i> , for medical and surgical benefits as required by Section 12.B.4. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis discloses the specific findings and conclusions reached 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 as required by Section 12.B.5. of Colorado Insurance Regulation 4-2-64.

<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis that includes the following, at minimum, been conducted for NQTL Confidential Network Development and provided to the Division?	
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified all factors used to determine whether a NQTL will apply as outlined in Section 12.B.1. of Colorado Insurance Regulation 4-2-64.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis identified and defined the specific evidentiary standards used to define the factors and any other evidence relied on in designing each non-quantitative treatment limitation as outlined in Section 12.B.2. of Colorado Insurance Regulation 4-2-64.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including any results of the analyses, has been performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, <i>as written</i> , 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, <i>as written</i> , and the written processes and strategies used to apply to each non-quantitative treatment limitation for medical and surgical benefits as required by Section 12.B.3. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis, including the results of the analyses, has been 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, <i>in operation</i> , for medical and surgical benefits as required by Section 12.B.4. of Colorado Insurance Regulation 4-2-64 has been completed and provided to the Division.
	<input type="radio"/> Yes <input type="radio"/> No	The comparative analysis discloses the specific findings and conclusions reached 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 as required by Section 12.B.5. of Colorado Insurance Regulation 4-2-64.

I hereby certify that the responses given above are accurate and that [Company Name] is in compliance with the requirements contained in Colorado Insurance Regulation 4-2-64 relating to the submission of Non-Qualitative Treatment Limitation comparative analyses.

Required Signatures:

 (Original Signature of Officer)

 (Title of Officer)

 (Date)

 (Printed Name of Officer)

**Regulation 4-2-65 CONCERNING THE ESTABLISHMENT OF A CARRIER PAYMENT
ARBITRATION PROGRAM FOR OUT-OF-NETWORK PROVIDERS S**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Arbitration Process and Timeline
Section 6	Arbitrator Qualifications and Selection
Section 7	Severability
Section 8	Enforcement
Section 9	Effective Date
Section 10	History
Appendix A	Out-of-Network Provider Arbitration Request Form
Appendix B	Arbitration Decision and Reporting Form

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



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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/>	License Type:	
	Out-of-Network Health Care Provider <input type="checkbox"/>	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 <input type="checkbox"/> No <input type="checkbox"/>	

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



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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Decision Found for: <input type="checkbox"/> Out-of-Network Health Care Facility <input type="checkbox"/> Out-of-Network Health Care Provider <input type="checkbox"/> Carrier	
The decision was reached through: <input type="checkbox"/> Arbitrator's decision <input type="checkbox"/> 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 <input type="checkbox"/>	Provider/Facility <input type="checkbox"/>

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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Payment Methodology Rules
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History
Appendix A	Zip Code to DOI Geographic Area Crosswalk

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
80841	2	Colorado Springs	80215	3	Denver	80620	6	Greeley	81138	8	East	81650	9	West

CODE OF COLORADO REGULATIONS
Division of Insurance

3 CCR 702-4 Series 4-2

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
80860	2	Colorado Springs	80216	3	Denver	80621	6	Greeley	81140	8	East	81652	9	West
80863	2	Colorado Springs	80217	3	Denver	80622	6	Greeley	81141	8	East	81653	9	West
80864	2	Colorado Springs	80218	3	Denver	80623	6	Greeley	81143	8	East	81654	9	West
80866	2	Colorado Springs	80219	3	Denver	80624	6	Greeley	81144	8	East	81655	9	West
80901	2	Colorado Springs	80220	3	Denver	80631	6	Greeley	81146	8	East	81656	9	West
80902	2	Colorado Springs	80221	3	Denver	80632	6	Greeley	81148	8	East	81657	9	West
80903	2	Colorado Springs	80222	3	Denver	80633	6	Greeley	81149	8	East	81658	9	West
80904	2	Colorado Springs	80223	3	Denver	80634	6	Greeley	81151	8	East			
80905	2	Colorado Springs	80224	3	Denver	80638	6	Greeley	81152	8	East			
80906	2	Colorado Springs	80225	3	Denver	80639	6	Greeley	81154	8	East			
80907	2	Colorado Springs	80226	3	Denver	80642	6	Greeley	81155	8	East			
80908	2	Colorado Springs	80227	3	Denver	80643	6	Greeley	81201	8	East			
80909	2	Colorado Springs	80228	3	Denver	80644	6	Greeley	81211	8	East			
80910	2	Colorado Springs	80229	3	Denver	80645	6	Greeley	81212	8	East			
80911	2	Colorado Springs	80230	3	Denver	80646	6	Greeley	81215	8	East			
80912	2	Colorado Springs	80231	3	Denver	80648	6	Greeley	81221	8	East			
80913	2	Colorado Springs	80232	3	Denver	80650	6	Greeley	81222	8	East			
80914	2	Colorado Springs	80233	3	Denver	80651	6	Greeley	81223	8	East			
80915	2	Colorado Springs	80234	3	Denver	80652	6	Greeley	81226	8	East			
80916	2	Colorado Springs	80235	3	Denver	80729	6	Greeley	81227	8	East			
80917	2	Colorado Springs	80236	3	Denver	80732	6	Greeley	81228	8	East			
80918	2	Colorado Springs	80237	3	Denver	80742	6	Greeley	81232	8	East			
80919	2	Colorado Springs	80238	3	Denver	80754	6	Greeley	81233	8	East			
80920	2	Colorado Springs	80239	3	Denver	81001	7	Pueblo	81236	8	East			
80921	2	Colorado Springs	80241	3	Denver	81002	7	Pueblo	81240	8	East			
80922	2	Colorado Springs	80243	3	Denver	81003	7	Pueblo	81242	8	East			
80923	2	Colorado Springs	80244	3	Denver	81004	7	Pueblo	81244	8	East			
80924	2	Colorado Springs	80246	3	Denver	81005	7	Pueblo	81248	8	East			
80925	2	Colorado Springs	80247	3	Denver	81006	7	Pueblo	81252	8	East			
80926	2	Colorado Springs	80248	3	Denver	81007	7	Pueblo	81253	8	East			
80927	2	Colorado Springs	80249	3	Denver	81008	7	Pueblo	81290	8	East			
80928	2	Colorado Springs	80250	3	Denver	81009	7	Pueblo	80423	9	West			
80929	2	Colorado Springs	80251	3	Denver	81010	7	Pueblo	80424	9	West			
80930	2	Colorado Springs	80252	3	Denver	81011	7	Pueblo	80426	9	West			
80931	2	Colorado Springs	80256	3	Denver	81012	7	Pueblo	80428	9	West			
80932	2	Colorado Springs	80257	3	Denver	81019	7	Pueblo	80429	9	West			
80933	2	Colorado Springs	80259	3	Denver	81022	7	Pueblo	80430	9	West			
80934	2	Colorado Springs	80260	3	Denver	81023	7	Pueblo	80434	9	West			
80935	2	Colorado Springs	80261	3	Denver	81025	7	Pueblo	80435	9	West			
80936	2	Colorado Springs	80262	3	Denver	81069	7	Pueblo	80442	9	West			
80937	2	Colorado Springs	80263	3	Denver	80649	8	East	80443	9	West			
80938	2	Colorado Springs	80264	3	Denver	80653	8	East	80446	9	West			
80939	2	Colorado Springs	80265	3	Denver	80654	8	East	80447	9	West			
80941	2	Colorado Springs	80266	3	Denver	80701	8	East	80451	9	West			
80942	2	Colorado Springs	80271	3	Denver	80705	8	East	80459	9	West			

CODE OF COLORADO REGULATIONS
Division of Insurance

3 CCR 702-4 Series 4-2

Zip Code	DOI Region	Location	Zip Code	DOI Region	Location	Zip Code	DOI Region	Location	Zip Code	DOI Region	DOI
80944	2	Colorado Springs	80273	3	Denver	80720	8	East	80461	9	West
80946	2	Colorado Springs	80274	3	Denver	80721	8	East	80463	9	West
80947	2	Colorado Springs	80281	3	Denver	80722	8	East	80467	9	West
80949	2	Colorado Springs	80290	3	Denver	80723	8	East	80468	9	West
80950	2	Colorado Springs	80291	3	Denver	80726	8	East	80469	9	West
80951	2	Colorado Springs	80293	3	Denver	80727	8	East	80473	9	West
80960	2	Colorado Springs	80294	3	Denver	80728	8	East	80477	9	West
80962	2	Colorado Springs	80299	3	Denver	80731	8	East	80478	9	West
80970	2	Colorado Springs	80401	3	Denver	80733	8	East	80479	9	West
80977	2	Colorado Springs	80402	3	Denver	80734	8	East	80480	9	West
80995	2	Colorado Springs	80403	3	Denver	80735	8	East	80482	9	West
80997	2	Colorado Springs	80419	3	Denver	80736	8	East	80483	9	West
80001	3	Denver	80420	3	Denver	80737	8	East	80487	9	West
80002	3	Denver	80421	3	Denver	80740	8	East	80488	9	West
80003	3	Denver	80422	3	Denver	80741	8	East	80497	9	West
80004	3	Denver	80425	3	Denver	80743	8	East	80498	9	West
80005	3	Denver	80427	3	Denver	80744	8	East	81121	9	West
80006	3	Denver	80432	3	Denver	80745	8	East	81122	9	West
80007	3	Denver	80433	3	Denver	80746	8	East	81128	9	West
80010	3	Denver	80436	3	Denver	80747	8	East	81137	9	West
80011	3	Denver	80437	3	Denver	80749	8	East	81147	9	West
80012	3	Denver	80438	3	Denver	80750	8	East	81157	9	West
80013	3	Denver	80439	3	Denver	80751	8	East	81210	9	West
80014	3	Denver	80440	3	Denver	80755	8	East	81220	9	West
80015	3	Denver	80444	3	Denver	80757	8	East	81224	9	West
80016	3	Denver	80448	3	Denver	80758	8	East	81225	9	West
80017	3	Denver	80449	3	Denver	80759	8	East	81230	9	West
80018	3	Denver	80452	3	Denver	80801	8	East	81231	9	West
80019	3	Denver	80453	3	Denver	80802	8	East	81235	9	West
80020	3	Denver	80454	3	Denver	80804	8	East	81237	9	West
80021	3	Denver	80456	3	Denver	80805	8	East	81239	9	West
80022	3	Denver	80457	3	Denver	80807	8	East	81241	9	West
80023	3	Denver	80465	3	Denver	80810	8	East	81243	9	West
80024	3	Denver	80470	3	Denver	80812	8	East	81251	9	West
80030	3	Denver	80474	3	Denver	80815	8	East	81301	9	West
80031	3	Denver	80475	3	Denver	80818	8	East	81302	9	West
80033	3	Denver	80476	3	Denver	80821	8	East	81303	9	West
80034	3	Denver	80601	3	Denver	80822	8	East	81320	9	West
80035	3	Denver	80602	3	Denver	80823	8	East	81321	9	West
80036	3	Denver	80614	3	Denver	80824	8	East	81323	9	West
80037	3	Denver	80640	3	Denver	80825	8	East	81324	9	West
80038	3	Denver	80820	3	Denver	80826	8	East	81325	9	West
80040	3	Denver	80827	3	Denver	80828	8	East	81326	9	West
80041	3	Denver	80830	3	Denver	80834	8	East	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
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Disclosure Requirements
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History
Appendix A	Emergency and Non-emergency Services Disclosure

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 pursuant to HB 19-1174.

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, 2020, which are subject to the requirements of §§ 10-16-704(3) and 10-16-704(5.5), C.R.S. This regulation replaces Colorado Emergency Regulation 19-E-07 in its entirety.

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(5.5)(e)(II), 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.

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 which is subject to the requirements of §§ 10-16-704(3) and 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. A description of the covered person's protections required by §§ 10-16-704(3) and 10-16-704(5.5), C.R.S., shall be provided:
1. In the covered person's health plan documents;
 2. In communications approving, in whole or in part, requests for preauthorization of covered services; and
 3. In communications approving, in whole or in part, covered services where a prior authorization is required by the carrier.
- C. The disclosure contained in Appendix A of this regulation shall be made available on a carrier's public website in a clear and conspicuous manner.
- D. Carriers shall make the disclosure contained in Appendix A of this regulation 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 April 15, 2020.

Section 9 History

Emergency regulation effective December 20, 2019.
Regulation effective April 15, 2020.

Appendix A: Emergency and Non-emergency Services Disclosure

[CARRIER LOGO] Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from “surprise billing”. This is sometimes called “balance billing” and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a “CO-DOI” on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan’s network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as “out-of-network”.

Out-of-network hospitals, facilities or providers often bill you the difference between what [Carrier] decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called ‘surprise’ or ‘balance’ billing.

When you **CANNOT** be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan’s in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- [Carrier] will pay out-of-network providers and facilities directly. Again, you are only responsible for paying your in-network cost-sharing for covered services.
- [Carrier] will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of you reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance billed.

If you do receive a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at 303-894-7490 or 1-800-930-3745.

Ambulance Information: You may be balance billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by [Carrier], you may receive a balance bill.

Regulation 4-2-68 CONCERNING PRESCRIPTION INSULIN DRUG COST SHARING AND LIMITATIONS

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Cost-Sharing Requirements and Limitations
Section 6	Severability
Section 7	Incorporated Materials
Section 8	Enforcement
Section 9	Effective Date
Section 10	History

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 cost-sharing charged to the covered person per prescription to \$100 per thirty (30) day supply regardless of the type of insulin drug prescribed and filled in that thirty (30) day period. Carriers shall not charge any additional copayments, deductibles or coinsurance for an additional fill of that same prescription in that thirty (30) day period if that fill is to ensure the covered person has sufficient insulin available until the next thirty (30) day period begins.

- B. Carriers may reduce prescription insulin drug cost-sharing to an amount less than \$100 per thirty (30) day supply per prescription.
- C. Carriers may charge up to \$300 for a ninety (90) day supply of prescription insulin per prescription. Carriers shall not charge any additional copayments, deductibles or coinsurance for an additional fill of that same prescription in that ninety (90) day period if that 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 April 15, 2020.

Section 10 History

Emergency regulation effective December 23, 2019.
Regulation effective April 15, 2020.

**Regulation 4-2-69 CONCERNING HOSPITAL SPECIAL FEE COLLECTION FOR THE
COLORADO REINSURANCE PROGRAM**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Hospital Special Fee Collection Methodology
Section 6	Severability
Section 7	Incorporated Materials
Section 8	Enforcement
Section 9	Effective Date
Section 10	History

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, 10-16-1104(1)(i), and 10-16-1108(2), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the process and procedures for the assessment and collection of special fees against hospitals pursuant to § 10-16-1108, C.R.S.

Section 3 Applicability

This regulation applies to all hospitals subject to the requirements found in Title 10, Article 16, Part 11.

Section 4 Definitions

- A. "Hospital" shall have the same meaning as found at § 10-16-1103(6), C.R.S.
- B. "Reinsurance program" shall have the same meaning as found at § 10-16-1103(12), C.R.S.
- C. "Reinsurance payment" shall have the same meaning as found at § 10-16-1104(11), C.R.S.

Section 5 Hospital Special Fee

- A. The Division of Insurance (Division) shall collect the hospital special fee assessment for benefit year 2020, in the amount of forty (40) million dollars, between July 1, 2021 and July 31, 2021. Each hospital shall pay its portion of the hospital special fee assessment in one single payment.
- B. The collection of the assessed hospital special fee must comply with the requirements found at 42 CFR § 433.68. As such, the percentage of the reinsurance fee for which each hospital shall be responsible equals the percentage of the outpatient services fee for which each hospital is responsible pursuant to 10 CCR 2505-10:8.3003.A.3. The special fee amounts specific to each hospital will be calculated by the Colorado Department of Health Care Policy and Financing.
- C. The Automated Clearing House debit process as provided in 10 CCR 2505-10:8.3002.B.1. will be used to collect the special fees from hospitals and the Electronic Funds Transfer payment process as provided in 10 CCR 2505-10:8.3002.B.1. will be used to deposit reinsurance payments.

- D. The hospital special fee will reduce the need of hospitals to shift the cost of providing uncompensated care for uninsured individuals to other payers.
 - 1. All monies generated from the hospital special fee shall be credited to the cash fund, and the use of such monies is restricted to the reinsurance program's statutorily-defined purposes, including increasing the number of insureds on the individual market by decreasing premiums for health insurance, making private health insurance coverage more accessible and affordable, and stabilizing the health insurance market.
 - 2. The reinsurance program will encourage increased carrier participation in rural parts of the state. These goals benefit hospitals by increasing the likelihood that patients have consistent access to affordable health coverage and health care.
- E. All carriers that participate in the reinsurance program are required to file care management protocols with the Commissioner. These protocols will promote cost-effective health care coverage and assist carriers in working with hospitals and other providers to manage claims within the reinsurance payment parameters.
 - 1. The hospital special fee shall aid hospitals in improving cost efficiency, patient safety, and clinical and administrative processes by supporting carriers' implementation of care management protocols for their members.
 - 2. Carriers' implementation and support of care management protocols will aid hospitals in transitioning to value-based reimbursement models, which are becoming more prevalent in Medicare, Medicaid, and commercial lines of business. Enhanced care management and care coordination are typically necessary in order for hospitals to successfully participate in value-based payment programs.
- F. All hospital special fees for the reinsurance program shall be deposited in the reinsurance program cash fund established pursuant to § 10-16-1107(1), C.R.S.
 - 1. All monies generated from the hospital special fee shall be expended for the reinsurance payments under the reinsurance program and for the administrative and operating expenses of the reinsurance program pursuant to § 10-16-1107(3), C.R.S.
 - 2. None of the monies generated from the fee 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, published by the Colorado Secretary of State shall mean 10 CCR 2505-10:8.3002.B.1, as published 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 2505-10:8.3003.A.3, published by the Colorado Secretary of State shall mean 10 CCR 2505-10:8.3003.A.3, as published on the effective date of this regulation and does not include later amendments to or editions of 10 CCR 2505-10:8.3003.A.3. A copy of 10 CCR 2505-10:8.3003.A.3, 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, published by the Government Printing Office shall mean 42 CFR § 433.68 as published 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 or carrier, if applicable, fails to pay a special fee to the commissioner in accordance with the time periods established by rule, the commissioner may use all powers conferred by the insurance laws of this state to enforce payment of the special fees.

Section 9 Effective Date

This regulation shall become effective April 15, 2020.

Section 10 History

New regulation effective April 15, 2020.

**Emergency Regulation 20-E-07 CONCERNING COVERAGE AND REIMBURSEMENT FOR
COVID-19 TREATMENT DURING THE COVID-19 DISASTER EMERGENCY**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Coverage and Reimbursement for COVID-19 Treatment during the COVID-19 Disaster Emergency
Section 6	Out-of-network Provider Arbitration for COVID-19 Treatment during the COVID-19 Disaster Emergency
Section 7	Severability
Section 8	Enforcement
Section 9	Effective Date
Section 10	History

Section 1 Authority

This emergency regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109, 10-16-109, 10-16-708, C.R.S., and the Governor's Executive Order D 2020-003 declaring the presence of COVID-19 in Colorado a disaster emergency and Executive Order D 2020-032 extending the disaster emergency.

Section 2 Scope and Purpose

In light of the COVID-19 public health emergency crisis, the purpose of this emergency regulation is to require carriers to provide covered persons with treatment related to COVID-19. Pursuant to Executive Orders D 2020-009 and 2020-027, this emergency regulation also ensures that out-of-network providers rendering emergency services for emergency medical conditions, including but not limited to COVID-19, are appropriately compensated pursuant to § 10-16-704(5.5), C.R.S., without delay.

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare as allowing individuals safe access to healthcare services and ensuring facilities have adequate resources and availability to treat COVID-19 patients is imperative to preserve the health of the citizens of Colorado. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest.

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 billing structures during the duration of the COVID-19 emergency.

Section 4 Definitions

- A. "CARES Act" means, for the purposes of this regulation, the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. 116-136.
- 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. "Out-of-network provider" shall mean a provider, as defined at § 10-16-102(56), C.R.S., that is not a participating provider, as defined at § 10-16-102(46), C.R.S., in a covered person's network.

Section 5 Coverage and Reimbursement for COVID-19 Treatment during the COVID-19 Disaster Emergency

A. Coverage for the Treatment of COVID-19

1. COVID-19 shall be considered an emergency medical condition during the pendency of the emergency as declared by the Governor in Executive Order D 2020 003 and extended in Executive Order D 2020 032 if any of the following three things occur:
 - a. A provider documents the patient as having COVID-19;
 - b. Documentation of a COVID-19 positive test; or
 - c. Presumptive positive COVID-19 test result.
2. For the purposes of treating the COVID-19 virus during the emergency declared by the Governor, all treatment provided at an out-of-network facility for COVID-19 shall be considered:
 - a. Emergency services that are ancillary to the emergency department of a hospital; and
 - b. Necessary to treat the COVID-19 emergency medical condition in order to stabilize the patient and to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or if necessitated by circumstances, in accordance with waivers or flexibilities issued by the federal government.
3. Treatment of COVID-19 is subject to the provider reimbursement requirements, in-network benefits, direct payment rules and consumer protections against balance billing contained in §10-16-704(5.5), C.R.S., and related Colorado Insurance regulations.
4. Carriers shall reimburse out-of-network providers for emergency services rendered to covered persons for treatment of COVID-19 pursuant to § 10-16-704(5.5), C.R.S., but such covered persons shall only be responsible for cost-sharing for emergency services rendered during the COVID-19 emergency pursuant to § 10-16-704(5.5)(a)(V), C.R.S.
5. Carriers shall suspend prior authorization requirements as set forth in § 10-16-704(5.5)(a)(I), C.R.S., for emergency services rendered to covered persons with emergency medical conditions during the COVID-19 disaster emergency.

B. If a covered person is determined to not have COVID-19:

1. Emergency medical conditions shall continue to be covered to the extent required by § 10-16-704(5.5), C.R.S.; and
2. If there is no participating provider available that can accept the covered person for on-going, medically necessary treatment, the requirements of § 10-16-704(2), C.R.S., shall apply.

- C. The requirements of Section 5 apply to all COVID-19 services occurring during the course of a disaster emergency, including claims submitted after the end of the disaster emergency for services that occurred during an emergency.

Section 6 Out-of-network Provider Arbitration for COVID-19 Treatment During the COVID-19 Disaster Emergency

For the duration of the COVID-19 disaster emergency and the run-out of COVID-19-related claims, out-of-network providers are allowed to bundle COVID-19-related claims for the purposes of the arbitration program found at § 10-16-704(15), C.R.S.

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 emergency regulation shall be effective April 18, 2020.

Section 10 History

Emergency regulation effective April 18, 2020.

**Emergency Regulation 20-E-08 CONCERNING CARRIER CARE MANAGEMENT
PROTOCOLS FOR THE COLORADO REINSURANCE PROGRAM**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definition
Section 5	Hospital Special Fee Collection Methodology
Section 6	Severability
Section 7	Enforcement
Section 8	Effective Date
Section 9	History
Appendix A	Reinsurance Care Management Protocol Assessment

Section 1 Authority

This emergency 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 emergency regulation is to establish 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.

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare to ensure that the Colorado Reinsurance Program is administered in such a way as to ensure Colorado consumers have access to affordable health insurance coverage and to ensure Colorado carriers comply with the requirements of §§ 10-16-1105(5), C.R.S., which is imperative to preserve the health of the citizens of Colorado. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest.

Section 3 Applicability

This emergency 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.

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 Attachment Point is \$30,000 in total annual claims costs for an individual enrollee for program year 2020. The Attachment Point for program year 2021 was announced by the Division of Insurance (Division) on March 16, 2020.

- B. Beginning in 2020, Eligible Carriers shall file the Reinsurance Care Management Protocol Assessment (Appendix A) for the applicable benefit year with its annual rate filing, 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 (Appendix A) 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.
 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 to perform for the impacted enrollee population.
 - b. Carriers must describe how they track care management services and activities performed by contracted providers.
 4. Eligible Carriers must describe any payments made to contracted providers 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.
 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 emergency regulation shall be effective May 16, 2020.

Section 9 History

Emergency regulation effective May 16, 2020.

Appendix A: Reinsurance Care Management Protocol Assessment

Eligible Carriers must submit written responses to the following questions:

(Limit: 1500 words*)

- 1) Provide an overview of the carrier's care management strategy for members whose annual claims costs are expected to exceed the Reinsurance Program Attachment Point.
 - Describe how the carrier supports the provision of care management through its provider contracts and how it uses care management to promote cost-effective health care.
 - State the carrier's financial and care delivery goals related to care management.
 - Describe how the carrier identifies members whose claims are expected to be eligible for reinsurance.
- 2) State the carrier's requirements for contracted providers regarding patient care management for members whose claims may be eligible for reinsurance.
 - Which members receive care management? How, when, and by whom are these members identified? How are members notified regarding care management?
 - State the care management activities or services that providers are required to offer. What is the typical frequency and duration of these services?
 - Which provider groups are required to perform care management activities, and which practitioners within these groups perform the activities (e.g. physicians, non-physician practitioners, care coordinators, patient navigators, etc.)?
 - Approximately how many FTEs does the carrier expect providers to allocate per patient for care management?
- 3) Describe how the carrier tracks care management services and activities performed by contracted health care providers.
 - Does the carrier require contracted providers to report on the care management services and activities they perform? If yes, describe the reporting requirements.
 - To what extent does the carrier use claims data to track care management?
 - Does the carrier require providers to report particular quality measures (MIPS, NQF, etc.) related to care management or care coordination? If yes, list the measures.
 - Describe any data validation or auditing processes the carrier uses to verify care management data from providers.
 - Describe any penalties the carrier imposes in cases where providers do not meet care management requirements.
- 4) Describe any claims-based or non-claims-based payments the carrier provides for care management activities and services.

- Does the carrier provide per-member-per-month or other regularly scheduled payments for member care management? If yes, describe the amount and frequency of the payment, and state the activities and services it covers.
- 5) Estimate the savings to the Colorado Reinsurance Program the carrier expects its Care Management Protocols to generate.
- Savings should be represented by average annual claims reductions per enrollee for enrollees whose claims are eligible for reinsurance, along with aggregate savings across all eligible enrollees.
- 6) Attach any contracts (e.g. participation agreements, provider agreements, etc.), actuarial analysis or data, and other documentation supporting the responses above.

*Word limit does not apply to attached contracts or supporting materials.

**Emergency Regulation 20-E-9 CONCERNING COVERAGE AND COST SHARING REQUIREMENTS
FOR COMMERCIAL INSURANCE MARKET COVERAGE OF COVID-19 CLAIMS**

Section 1	Authority
Section 2	Scope and Purpose
Section 3	Applicability
Section 4	Definitions
Section 5	Coverage and Cost Sharing Requirements for COVID-19 Claims
Section 6	Access to Prescription Drugs during the COVID-19 Emergency
Section 7	Severability
Section 8	Enforcement
Section 9	Effective Date
Section 10	History

Section 1 Authority

This emergency regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-103.4, and 10-16-109, 10-16-141(1), C.R.S.

Section 2 Scope and Purpose

On March 11, 2020, Governor Polis issued Executive Order D 2020 003 declaring a disaster emergency due to the presence of COVID-19 in Colorado. That Executive Order has been extended, most recently on July 6, 2020 by Executive Order D 2020 125. In order to protect the general public and to direct health insurers toward a policy that advances the welfare of the public through overall efficiency, affordability, improved health care quality, and appropriate access, pursuant to § 10-1-108(7), C.R.S., the purpose of this regulation is to establish coverage and cost-sharing requirements for commercial insurance carriers related to claims arising from the testing and treatment of COVID-19 and to ensure covered persons have access to prescription drugs during the COVID-19 emergency.

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare as establishing coverage and cost sharing requirements for the testing and treatment of COVID-19 is imperative to preserve the health of the citizens of Colorado. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest.

Section 3 Applicability

This regulation applies to all carriers offering individual, small group and large group health benefit plans, student health plans, and managed care plans, including health-savings-account (HSA)-qualified health benefit plans, and grandfathered health benefit plans that are 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 billing structures during the COVID 19 emergency.

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. "Cost share" shall, for the purposes of this regulation, include co-payments, deductibles, and co insurance.

- D. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.
- E. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.
- F. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- G. "Managed care plan" shall have the same meaning as found at § 10-16-102(43), C.R.S.
- H. Based on the U.S. Centers for Disease Control and Prevention's identified symptoms, as provided on the adopted date of this regulation and available at <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>, a "person with symptoms of COVID-19" means, for the purposes of this regulation, anyone exhibiting any of the following symptoms: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.

Section 5 Coverage and Cost Sharing Requirements for COVID-19 Claims

- A. During any period when a disaster state of emergency has been declared, in the state of Colorado or nationally, due to the presence of COVID-19, carriers shall provide coverage for in network telehealth services for COVID-19-related testing and treatment with no cost share for the covered person.
- B. For a covered person with symptoms of COVID-19 or a covered person for whom testing is deemed medically appropriate by a health care provider:
 - 1. Carriers shall ensure that coverage is provided for COVID-19 diagnostic testing, including in home tests, with no cost share for the covered person and are prohibited from requiring providers to collect cost shares.
 - 2. Carriers shall not limit the number of covered diagnostic tests as long as the diagnostic tests are deemed medically appropriate for the covered person by a health care provider.
 - 3. When the purpose of a visit is for COVID-19 symptoms or testing, carriers shall cover any test that meets the criteria for use in detecting or diagnosis of COVID-19, as provided in the Families First Coronavirus Response Act, Pub. L. 116-127, and as amended in the Coronavirus Aid, Relief, and Economic Security Act, or CARES Act, Pub. L. 116-136, which includes serological testing, and any non-COVID-19 tests a provider determines medically appropriate to determine the need for COVID-19 diagnostic testing of the covered person, even if the visit does not result in an order for or administration of a COVID-19 test.
 - 4. Carriers shall cover cost sharing for an in-network provider office visit, an in-network urgent care center visit, an emergency room visit, and non-traditional care settings where licensed health care providers are administering the testing.
 - 5. Carriers shall ensure testing, diagnosis, and screening for COVID-19 is available without unreasonable delay.
 - a. Carriers must cover testing for COVID-19 if performed by an out-of-network provider, pursuant to § 10-16-704(2)(a), C.R.S., if an in-network provider is unable to conduct the testing.

- b. Carriers shall utilize both in-network and in-state out-of-network laboratories to process COVID-19 tests with no cost share to the covered person.
- 6. Any COVID-19 diagnostic test is considered to be an emergency medical service to treat COVID-19 as an emergency medical condition during any period when a disaster state of emergency has been declared, either in the state of Colorado or nationally, due to the presence of COVID-19.

Section 6 Access to Prescription Drugs During the COVID-19 Emergency

- A. During any period when a disaster state of emergency has been declared, either in the state of Colorado or nationally, due to the presence of COVID-19, carriers shall allow covered persons to obtain refills of up to 90 days of prescription drugs before the scheduled refill date so that covered persons are ensured an adequate supply of medications.
- B. Carriers shall not apply a different cost-sharing amount for an early refill of a prescription.

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 emergency regulation shall be effective July 18, 2020.

Section 10 History

Replaces Emergency Regulation 20-E-01 effective March 17, 2020.

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]