DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

LIFE, ACCIDENT AND HEALTH , Series 4-2

3 CCR 702-4 Series 4-2

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

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

Section 1 Authority

This amended regulation is promulgated 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 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 and a health care coverage plan offered by a health maintenance organization (except Medicare supplement insurance, 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 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. 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. For the purposes of this regulation, accident and sickness insurance includes health coverage plans issued by health maintenance organizations as defined in § 10-16-102(22.5), C.R.S.

B “Direct response” means a solicitation through a sponsoring or endorsing entity or individually solely through mail, telephone, the Internet or other mass communication media.

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 accident and sickness insurance in force or whether accident and sickness insurance is intended to replace or be in addition to any other accident and sickness insurance 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 policy.

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

c. You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.

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

2. [Questions]

To the best of your knowledge:

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

(1) If so, with which company?

(2) If so, do you intend to replace your current accident and sickness insurance with this policy (contract)?

b. Do you have any other accident and sickness 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:

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

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

(3) For other Medicaid medical benefits?

B. Producers shall list any other accident and sickness insurance they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies 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 insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of accident and sickness insurance, other than a direct response issuer, or its producer, shall furnish the applicant, prior to issuance or delivery of the accident and sickness insurance policy or contract, 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 old without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant, at the time of issuance of the policy, The Notice to Applicant Regarding Replacement of Accident and Sickness Insurance, located in Appendix A of this regulation.

E. The Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (Appendix A) required by Subsection D above for an issuer, shall be provided in the format prescribed and adopted by the Commissioner of Insurance.

F. Paragraphs 1 and 2, contained in such Notice to the Applicant Regarding Replacement of Accident and Sickness Insurance, (applicable to preexisting conditions), in Appendix A, may be deleted by the issuer if the replacement does not involve the application of a new preexisting condition limitation.

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

Section 6 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 7 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders and/or suspension or revocation of certificates of authority. Among others, the penalties provided for in §10- 3-1108, C.R.S. may be applied.

Section 8 Effective Date

This regulation is effective May 1, 2010.

Section 9 History

Originally issued as Regulation 74-2, effective March 15, 1974.

Amended December 22, 1975, effective January 1, 1976.

Amended effective January 14, 1977.

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.

Appendix A NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

[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 [Insurance Carrier Name]. Your new policy will provide [Number days of free look period, if any] days within which you may decide without cost whether you desire 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 ISSUER OR PRODUCER:

I have reviewed your current accident and sickness insurance 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 (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.

2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or

probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. 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 has 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 present 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 Issuer or Producer]

_____

(Applicants Signature)

_____

(Date)

*Signature not required for direct response sales

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

Section 1 Authority

This regulation is issued based upon the authority granted the commissioner under § § 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 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 any hospital under governmental control whether federal, state, county or city. It includes Veterans Administration hospitals.

C. "Hospital indemnity policy" means 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 (s)he 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, 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 suspension or revocation 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 is effective July 1, 2010.

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.

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

Section 1 Authority

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

Section 2 Scope and Purpose

The purpose of this regulation is to establish minimum criteria to assure proper and accurate description and to protect prospective purchasers with respect to the advertisement of accident and sickness insurance in the same manner as the regulation governing advertisements of Medicare supplement 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 this State when such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, producer or solicitor, as those terms are defined in the Insurance Code of this state 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. "Accident and sickness insurance policy" means, 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 shall become totally and permanently disabled as defined by the contract or

supplemental contract.

B. “Advertisement” means 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 contains;

a. Descriptive literature and sales aids of all kinds issued by an insurer, producer, or solicitor 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; and

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

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, producers and solicitors.

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.

C. “Certificate” means 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.

D. “Exception” means 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.

E. “Institutional advertisement” means 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. Carriers are required to comply with Section 15A of the regulation, clearly identifying the name of the carrier.

F. “Invitation to contract” means an advertisement that is neither an “invitation to inquire” nor an “institutional advertisement.”

G. “Invitation to inquire” means 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” may 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].”

H. “Lead-generating device” means 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.

I. “Limitation” means a provision that restricts coverage under the policy other than an exception or a reduction.

J. “Limited benefit health coverage” means a health policy, contract, or certificate offered or marketed 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 hospital and medical expense policies, contracts or certificates, or catastrophic health policies, contracts, or certificates. Such non-supplemental plans are included under the term “health benefit plan” as defined in Section 10-16-102(21)(b), C.R.S.

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

K. “Prominently” or “conspicuously” means that the information to be disclosed “prominently” or “conspicuously” will be presented in a manner that is noticeably set apart from other information or images in the advertisement.

L. “Reduction” means 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.

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. Format means the arrangement of the text and the captions.

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 in 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, solicitor 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 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, solicitor 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.

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 or 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.

This paragraph 6 does not apply to individual major medical expense coverage, individual basic medical expense coverage, 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 payable 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.

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) working

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 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. The term “juxtaposition” means side by side or immediately above or below. 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 company 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 the preceding paragraph 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 company 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 company 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, cancelable or renewable at the option of the company. Examples of qualifying conditions are (1) age limits, (2) reservation of a right to increase premiums, and (3) 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 or solicitors, shall:

1. Establish marketing procedures to assure that any comparison of policies by its producers or solicitors 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 major medical expense coverage and disability income coverage; and

3. Establish auditable procedures for verifying compliance with this subsection.

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 insurance company.

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 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 the preceding paragraph, 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 the Colorado Insurance Laws:

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 company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.

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

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

Section 12 Identification of Plan or Number of Policies

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

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

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

Section 13 Disparaging Comparisons and Statements

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

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

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

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

Section 14 Jurisdictional Licensing and Status of Insurer

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

B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of this 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.

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;

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 or solicitors 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.

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.

1. An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than [insert number] months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than ten (10) days and not more than forty (40) days from the date that the enrollment period is advertised for the first time. This regulation applies to all advertising media, i.e., mail, newspapers, the Internet, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.

2. 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.

3. The phrase "a particular insurance product" in Paragraph (2) of this subsection means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

B. 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.

C. 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 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 20 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 an other 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 21 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of all applicable sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines and suspension or revocation of license.

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

Section 22 Effective Date

This regulation is effective May 1, 2010.

Section 23 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.

Regulation 4-2-5 HOSPITAL DEFINITION

Section 1 Authority

This amended regulation is promulgated under the authority of §10-1-109 C.R.S.

Section 2 Purpose

The purpose of this regulation is to standardize the definition of “hospital” used in sickness and accident insurance policy forms in this state to ensure the adequate provision of inpatient health care services.

Section 3 Scope

This regulation shall apply to all entities marketing or selling policies of sickness and accident insurance within the State of Colorado which provide coverage for inpatient health care services at a hospital; except this regulation does not include a Medicare supplement insurance policies and a waiver of premium or double indemnity benefit included in a life insurance policy or annuity contract.

Section 4 Definition

“Hospital” means a hospital currently licensed or certified by the department of public health and environment pursuant to the department's authority under section 25-1-107 (1) (l). This definition shall not be construed to create coverage for any health care service that is not otherwise covered under the terms of the sickness and accident insurance policy.

Section 5 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any applicable sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines and/or suspension or revocation of license.

Section 6 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 7 Effective Date

This regulation is repealed effective May 1, 2010.

Section 8 History

Originally issued as Regulation 76-6, effective January 14, 1977.

Renumbered as Colorado Regulation 4-2-5 on June 1, 1992.

Amended Regulation effective March 1, 1994.

Amended Regulation effective January 1, 2001.

Repealed Regulation effective May 1, 2010.

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

Section 1 Authority

This amended regulation is promulgated under the authority granted to the Commissioner of Insurance under § § 10-1-109, 10-16-109 and 10-3-1110, 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 entities marketing or selling policies of sickness and accident insurance within the State of Colorado; except that this regulation will not apply to Medicare supplement insurance policies and a waiver of premium or double indemnity benefit included in a life insurance policy or annuity contract.

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 insurers 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.

Section 6 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 7 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines issuance of cease and desist orders, and/or suspensions or revocation of certificates of authority. Among others, the penalties provided in § 10-3-1108, C.R.S. may be applied.

Section 8 Effective Date

This amended regulation shall become effective March 2, 2010.

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

Section 1 Authority

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.; and

3. Any insurance policy, contracts 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 Requirements for Home Health Services

A. Definitions.

1. “Home health agency” means 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.

2. "Home health services" means the following services provided by a certified home health agency under a plan of care to eligible persons in their place of residence:

   a. Skilled nursing services;

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

   c. Physical therapy, occupational therapy or speech and language therapy services, as such therapy and services are defined in C.R.S.

   d. 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).

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

3. "Home health visit" is 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 4 hours by a home health aide shall be considered as one visit.

B. 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.

C. Benefits for Home Health Care Services.

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

2. The policy or certificate may contain a limitation on the number of home health visits, but no policy offered may provide for fewer than 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 therapy;

    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;

    k. Rental or purchase of durable medical equipment; and

4. The services identified in subsections C3(i) through C3(l) of this section may be included elsewhere in the policy, rather than specifically in the home health benefit provisions.

D. 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 5 Requirements for Hospice Care

A. Definitions.

1. A "hospice" is 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.

2. "Hospice care" is 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.

3. A "patient" is an individual in the terminal stage of illness who has an anticipated life expectancy of six 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.

4. A "patient/family" is 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.

5. "Palliative services" are 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.

6. The "interdisciplinary team" is a group of qualified individuals, which shall include, but is not limited to, a physician, registered nurse, clergy/counselors, volunteer director, and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of hospice patient/families.

7. "Core services" are, nursing services, pastoral, trained volunteers, and psychosocial services routinely provided by hospice staff or volunteers.

8. "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.

9. "Homemaker services" means services provided the patient which include:

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

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

10. "Home care services" are 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.

11. "Inpatient services" are hospice services provided to patient/families who require 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.

12. "Hospice levels of care:"

    a. "Routine home care:" 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.

    b. "Continuous home care:" 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 (not need to be consecutive) in one calendar day. Home health aide and homemaker services, or both, may be provided to supplement nursing care.

    c. "Inpatient hospice respite care:" 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.

    d. "General inpatient hospice care:" 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.

13. "Bereavement" is 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.

14. An "inpatient hospice facility" is one, which shall directly provide inpatient services and may provide any or all of the continuum of hospice services as described in Section 5A (1). These services are provided 24 hours a day and, to the extent possible, in a homelike setting.

15. A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.

16. A "hospice per diem" rate is 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.

17. An "unrelated illness" is a diagnosed condition, which is not a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness.

18. "Evaluation" means an objective, formal and regular assessment of the functioning of the organization and of the provision of hospice care.

B. 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 months or less, except that benefits may exceed six 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.

C. 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 24 hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;

    b. Intermittent and 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-one (91) 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.

D. 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 6 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 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 and the application of such provision shall not be affected thereby.

Section 8 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 suspension or revocation of license. Amount others, the penalties provided for in § 10-3-1108, C.R.S. may be applied.

Section 9 Effective Date

The effective date of this regulation is March 2, 2011.

Section 10 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.

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

Section 1 Authority

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

Section 2 Scope and Purpose

The purpose of this regulation is to establish standards that will assure nondiscriminatory 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 health coverage in this state including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident company, a life or annuity company, and any other entity providing a plan of life, annuity, health coverage or health benefits subject to the insurance laws and regulations of Colorado.

Section 4 Definitions

A. "Insurance Coverage" shall mean life insurance policies and health coverage plans.

B. "Person" shall have the meaning in § 10-3-1104.5(2)(f), 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 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. Insurers 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). A copy of this USDPHHS publication is on file at the Colorado Division of Insurance. This regulation does not include later editions or amendments to this USDPHHS report.

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; or

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

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 Exhibit 1.

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 insurer 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 Exhibit 1.

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, will not be approved 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 provisions of this regulation or the application thereof to any person or circumstance are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 7 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines, issuance of cease and desist orders, and/or suspension or revocation of license. Amount others, the penalties provided for in § 10-3-1108, C.R.S. may be applied.

Section 8 Effective Date

This regulation as amended is effective May 1, 2010.

Section 9 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.

Appendix A

FDA Licensed/Approved HIV Tests for Colorado Regulation 4-2-9

Published as of 7/16/98

Licensed Tests Antibody to Human Immunodeficiency Virus (HIV-1 Antigen Assay)

Tradename(s)	Format	Sample	Use
.	.	.	.
Abbott HIVAG-1 Monoclonal	EIA	Serum / Plasma	Donor Screen & Neu Kit
Coulter HIV-1 p24 Ag Assay; HIV-1 p24 Antigen ELISA Test System	EIA	Serum / Plasma	Donor Screen & Neu Kit
Abbott HIVAG-1	EIA	Serum / Plasma	Prognosis & Neut. K
Abbott HIVAG-1	EIA	Serum / Plasma	Prognosis & Neut. K

Monoclonal			
Coulter HIV-1 p24 Ag Assay; HIV-1 p24 Antigen ELISA Test System	EIA	Serum / Plasma	Prognosis & Neut. K
Coulter HIV-1 p24 Ag Assay	EIA	Viral Culture Super-natant	Prognosis (Quantitat & Neut. Kit

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

Tradename(s)	Format	Sample	Use
.	.	.	.
HIVAB HIV-1 EIA	EIA	Serum / Plasma	Donor Screen
Recombigen (env & gag) HIV-1 EIA	EIA	Serum / Plasma	Donor Screen
Microtrak HIV-1 EIA (env & gag)	EIA	Serum / Plasma	Donor Screen
RLAV EIA	EIA	Serum / Plasma	Donor Screen

Tradename(s)	Format	Sample	Use
.	.	.	.
Murex SUDS HIV-1 Test	Rapid EIA	Serum / Plasma	Donor Screen
Vironostika HIV-1 Microelisa System	EIA	Serum / Plasma	Donor Screen
UBI-OLYMPUS HIV-1 EIA	EIA	Serum / Plasma	Donor Screen
Novapath HIV-1 Immunoblot	WB	Serum / Plasma	Donor Supplemental
HIV-1 Western Blot Kit	WB	Serum / Plasma	Donor Supplemental
EPIblot HIV-1	WB	Serum / Plasma	Donor Supplemental
Fluorognost HIV 1 IFA	IFA	Serum / Plasma	Donor Supplemental

HIVAB HIV-1 EIA	EIA	Dried Blood Spot	Non-Donor Screen
HIV-1 Urine EIA; Seradyn Sentinel HIV-1 Urine EIA	EIA	Urine Screen	Non-Donor Screen
RLAV EIA	EIA	Dried Blood Spot	Non-Donor Screen
Vironostika HIV-1 Microelisa System	EIA	Dried Blood Spot	Non-Donor Screen
Oral Fluid Vironostika HIV-1 Microelisa System	EIA	Oral Fluid	Non-Donor Screen
HIV-1 Western Blot Kit	WB	Dried Blood Spot	Non-Donor Supplem
HIV-1 Western Blot Kit	WB	Urine	Non-Donor Supplem
OraSure HIV-1 Western Blot Kit	WB	Oral Fluid	Non-Donor Supplem
Fluorognost HIV 1 IFA	IFA	Dried Blood Spot	Non-Donor Supplem

Tradename(s)	Format	Sample	Use
.	.	.	.
Abbott HIVAB HIV-1/HIV-2 (rDNA) EIA	EIA	Serum / Plasma	Donor Screen
Genetic Systems HIV-1/HIV-2 Peptide EIA	EIA	Serum / Plasma	Donor Screen
UBI HIV-1/2 EIA	EIA	Serum / Plasma	Donor Screen

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

Tradename(s)	Format	Sample	Use
.	.	.	.
Genetic Systems HIV-2 EIA	EIA	Serum / Plasma	Donor Screen

Premarket Approvals -Anti-HIV-1 Testing Service

Tradename(s)	Format	Sample	Use
.	.	.	.
Home Access HIV-1 Test System	Dried Blood Spot Collection Device	Dried Blood Spot	Non-Donor Screen

Anti-HIV-1 Oral Specimen Collection Device

Tradename(s)	Format	Sample	Use
.	.	.	.
Epitope OraSure HIV-1 Oral Specimen Collection Device	Oral Specimen Collection Device	Oral Fluid	For Use in Designate Non- Donor Screen a Non-Donor Supplem Assays

HIV-1 Viral Load Assay

Tradename(s)	Format	Sample	Use
.	.	.	.
Roche Amplicor HIV-1 Monitor Test	PCR	Serum / Plasma	Prognosis

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

Section 1. Authority

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

Section 2. Scope and Purpose

Many Multiple Employer Welfare Arrangements (MEWAs) have previously claimed ERISA preemption whereby health plans may operate without obtaining a license from the Division of Insurance. Section 10-3-903.5, C.R.S., regarding the Division's jurisdiction over providers of health care benefits was effective as of March 31, 1993. This statute, as well as recent advisory opinions from the US Department of Labor, has clarified the limited nature of the federal ERISA (Employee Retirement Income Security Act) preemption.

In addition, it has come to the Division's attention that producers who are licensed by the Colorado Division of Insurance have been involved in the sale of health plans offered by unlicensed entities. This regulation is intended to: (1) clarify the information to be filed under the provisions of §10-3-903.5(7)(c), C.R.S. by MEWAs claiming exempt status from formal licensing requirements; (2) clarify the responsibilities of licensed producers, and; (3) to repeal and replace Insurance Regulation 4-2-10 (3 CCR 702-4, pg. 122).

Section 3. Applicability

This regulation applies to all multiple employer trusts subject to §10-3-903.5, C.R.S It does not apply to the Multiple Employer Welfare Arrangement Pilot Program regulated under Colorado Insurance Regulation 4-2-25.

Section 4. Definitions

A. "Fully insured" means 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 enrollee. 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 and administration and all other insurance related functions remain the ultimate responsibility of the licensed entity.

B. "Health plan" is an arrangement such as a fund, trust, plan, program or other funding mechanism that provides health care benefits.

C. "Licensed entity" means 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 a licensed person as defined by Article 2 of Title 10.

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

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 Division of Insurance to make a determination regarding the qualification of a Multiple Employer Welfare Arrangement (MEWA) seeking exemption from licensure requirements.

A. Evidence that the MEWA has existed continuously since January 1, 1983. This is accomplished by submitting copies of formation documents, bylaws, if applicable, and financial reports, audited preferred, for years 1983, 1987 and 1991.

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

C. 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 disclose and support the required five percent (5%) unallocated reserve level.

D. The method of marketing and enrolling eligible participants.

E. Actuarial information that must be prepared and signed by a qualified actuary as indicated by §10-7-114(1)(e), C.R.S. This information must include:

1. An opinion that:

   a. is prepared in a format consistent with that required, and from time to time amended, by the National Association of Insurance Commissioners for commercial health insurers, and

   b. opines on the adequacy of the health plan reserves and liabilities reflected in the financial report.

2. A copy of the underlying actuarial report supporting such opinion, 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.

F. 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 state's mandated benefit provisions.

G. Such other relevant information as the Commissioner may request in order to evaluate the financial, actuarial and benefits of the health plan.

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

Items A and B above are only required to be filed once, unless materially altered. Items C through G will be required to be filed annually within sixty (60) days following the fiscal year end of the MEWA. Item H shall be filed annually as indicated.

Section 6. Authorized Insurance Arrangements

Qualifying health plans that are not subject to licensure as an insurer under Colorado law are 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(b)(I), C.R.S.; or

E. Determined to be in compliance with §10-3-905.3(7)(c), C.R.S. and Section IV of this regulation.

Pursuant to Colorado law, health plans sold to residents of Colorado are subject to Colorado law even if the master policy is issued and delivered outside of Colorado.

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, 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, C.R.S. and this regulation are subject to discipline or action including fines, suspension or revocation of their 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. Any insurer that may have issued a contract to a health plan is not

exempt from the liability under its contract solely due to the unauthorized status of a health plan.

Section 9. Enforcement

Noncompliance with this regulation may result, after proper notice and opportunity for 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 suspension or revocation of licenses. Among others, the penalties provided for in § 10-3-1108, C.R.S. may be applied.

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. Effective Date

This regulation as amended shall be effective October 2, 2006.

Section 12. History

Regulation 4-2-10, effective July 1, 1994.

Amended regulation effective October 2, 2006.

Regulation 4-2-11 RATE FILING SUBMISSIONS FOR HEALTH INSURANCE

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, and 10-18-105(2), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to ensure that health insurance rates are not excessive, inadequate or unfairly discriminatory, by establishing the requirements for rate filings.

Section 3 Applicability

This regulation applies to all carriers, as defined in Section 4.C, operating in the State of Colorado. This regulation concerns all health insurance rate filings, including, but not limited to, comprehensive health insurance, long-term care, supplemental health, limited benefit health, prepaid dental, limited service licensed provider networks, disability, Medicare supplement, Health Maintenance Organization (HMO) coverages and stop loss carriers for employers with self insured health plans.

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" means, for purposes of this regulation, the ratio of policy benefits, not including policyholder dividends, to the value of the earned premiums, not reduced by policyholder dividends, over the entire period for which rates are computed to provide coverage. 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" means, for purposes of this regulation, a carrier as defined in § 10-16-102(8), C.R.S., and includes, but is not limited to, licensed property and casualty insurance companies; licensed life and health insurance companies; non-profit hospital, medical-surgical, and health service corporations; HMOs; prepaid dental companies; and limited service licensed provider networks.

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. "File and use" is 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.

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

I. "Health coverage plan" shall have the same meaning as defined in § 10-16-102(22.5), C.R.S.

J. "Implementation date" means, for purposes of this regulation, the date that the filed or approved rates can be charged to an individual or group.

K. "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.

L. "Indemnity benefits" means, for the purpose of the twenty percent (20%) limitation imposed on HMOs, the following benefits: out-of-area services, supplemental benefits (such as vision and dental provided on a non-contractual fee-for-service basis) and point-of-service benefits. It does not include any benefits provided by an HMO for which there exists a hold harmless agreement between the providers and the HMO.

M. "Lifetime loss ratio":

1. "Lifetime loss ratio," for purposes of this regulation, is 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.

N. "Non-developed rates" are rates that are established by agreement with a governmental entity through a bidding process or by some other means and include, but are not limited to: rates for Medicare, Title XVIII of the federal "Social Security Act;" Medicaid, Title XIX of the federal "Social Security Act;" and the State Children's Health Insurance Program (SCHIP), Title XXI of the federal "Social Security Act."

O. "On-rate-level premium" is the premium that would have been generated if the present rates had been

in effect during the entire period under consideration.

P. "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.

Q. "Prior approval" is a filing procedure that requires a rate change to be affirmatively approved by the Commissioner prior to distribution, release to agents, collections of premium, advertising, 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.

R. "Qualified actuary" is a person who meets the qualifications in Colorado Insurance Regulation 1-1-1.

S. "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.

T. "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.

U. "Rate increase" shall have the same meaning as defined in § 10-16-102(36.5), C.R.S., and includes an increase in any current rate or factor used to calculate premium rates for new or existing policyholders or certificateholders.

V. "Renewed." A health coverage plan shall be deemed renewed upon the occurrence of the earliest of: the annual anniversary date of issue; or 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 care coverage contract 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 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.

W. "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).

X. "Trend" or "trending" means any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing.

Y. "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 wearoff, deductible leveraging, and antiselection resulting from rate increases and discontinuance of new sales. Underwriting wearoff means the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wearoff does not apply to guaranteed issue products. Trend factors include inflation factors, durational factors and the Index Rate for small group business.

Z. "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; 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.

AA. "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 including advertising, distributing rates or premiums to agents, 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.

AB. "Wellness and prevention program" for the purposes of this regulation, shall have the same meaning as provided under § 10-16-136(7)(b), C.R.S.

Section 5 General Rate Filing Requirements

All rate filings shall be submitted electronically by licensed entities. Failure to supply the information required in Sections 5, 6 and 7 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. 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 other than dental insurance or a rate increase of 5% or more annually for dental insurance, which is effective on or after January 1, 2009, is subject to prior approval by the Commissioner and must be filed with the Division at least 60 calendar days prior to the proposed implementation or use of the rates. If the Commissioner approves the rate filing within 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. 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. 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. If the Commissioner does not approve or disapprove the rate filing within 60 calendar days after the filing date, the carrier may

implement and make use of the rates. 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. 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. Rates for Medicare supplement insurance are subject to prior approval as specified in Colorado Insurance Regulation 4-3-1, but are not subject to the 60 day filing requirement of this paragraph. 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 and 7 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.

2. File and Use: Any rate filing not specified in Paragraph 1 of this subsection is classified as file and use. If a rate change has been implemented or used without being filed with the Division, corrective actions may be ordered, including fines, 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.

3. Non-Developed Rates: Non-developed rates are not subject to the filing requirements of Sections 5, 6 and 7 of this regulation.

4. Required Submissions:

a. All carriers must submit rate filings whenever the rates charged new or renewal policyholders or certificateholders 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 the 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 would take appropriate action as defined by Colorado law.

b. All carriers must submit a rate filing on at least an annual basis 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 the carrier is proposing to use is not excessive, inadequate or unfairly discriminatory. Note: Trend factors which change on a predetermined basis can only be continued for a maximum period of twelve months. To continue use of trend factors that change on a predetermined basis, a filing with an implementation date on or before the one-year anniversary of the implementation date of the most recent rate filing must be made for that particular form.

c. All carriers must submit a rate filing when the rates are changed on an existing product even though the rate change only pertains to new business. For example: Non-renewable short term disability or any other type of non-renewable product. The rate filing must be compliant with this regulation including providing overall experience data for this existing product.

d. All carriers must submit a rate filing within 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.

e. A separate rate filing is required for each major line of business. Rate filings should not be combined with form filings. Each type requires a separate filing.

f. All carriers are expected to review their experience on a regular basis, at least annually, and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of filing large rate changes and to ensure that rates are not excessive.

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. Submission of rate filings: All health, sickness and accident insurance (Title 10, Article 16), health care coverage (Title 10, Article 16), Medicare supplement insurance (Title 10, Article 18), long-term care insurance (Title 10, Article 19), and health excess/stop loss insurance (Title 10, Article 16) 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.

7. 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.

8. Required Inclusions: 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 whenever possible. This information may include the carrier’s experience and judgment; the experience or

data of other carriers or organizations relied on by the carrier; the interpretation of any statistical data relied on by the carrier; descriptions of methods used in making the rates; and any other similar information. In addition, the Commissioner may request additional information necessary to adequately support the rate change request.

9. Confidentiality: All rate filings submitted shall be considered public and shall be open to inspection by the public, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. If the carrier desires confidential treatment of any information submitted as required in this regulation, a "Confidentiality Index" must be completed. 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 must also complete a Confidentiality Index.

B. Required Forms and Actuarial Certification

1. Required Forms: A Form HR-1 must be completed for each rate filing. Only one Form HR-1 is allowed to be submitted in a rate filing.

2. Actuarial Certification: 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. (The requirements for the actuarial certification for Medicare supplement rate filings can be found in Section 14.H of Colorado Insurance Regulation 4-3-1. The requirements for the actuarial certification for certain long-term care rate filings can be found in Sections 10.B and 18.B of Colorado Insurance Regulation 4-4-1).

Section 6 Actuarial Memorandum

The rate filing must contain an actuarial memorandum, either signed by, or prepared under the supervision of, a qualified actuary, containing, at a minimum, the following sections in the designated order shown below or an alternate template supplied by the Division:

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 whether this is a new filing, a rate revision, or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision should be stated.

2. Requested Rate Action: The overall rate increase or decrease amount should be listed.

3. Marketing method(s): A brief description of the marketing method used for the filed form should be listed.

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 form: A listing of all policy/rider forms impacted by the filing (for standardized Medicare supplement, the plans should be identified).

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 should be specified.

8. Renewability provision: A statement regarding the renewability provision and whether the

policy/rider is guaranteed renewable, cancellable, non-cancellable, or optionally renewable.

B. Assumption, Acquisition or Merger: The memorandum must state whether or not the products included in the rate filing were part of an assumption, acquisition or merger of policies from/with another carrier. If so, then the memorandum must include the full name of the carrier/carriers from which the policies were assumed, acquired or merged, and the closing date of assumption, acquisition or merger.

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 months, starting from the proposed implementation date.

D. Underwriting: The memorandum must include a brief description of the extent to which this product will be underwritten, if a new product, or the changes, if any, to the underwriting standards, if an existing product. The memorandum should include the expected impact on the claim costs by duration and in total. 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 – see paragraph Q, "Other Factors", in this section.

E. 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.

F. 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 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, average increase or decrease, minimum and maximum increase and cumulative rate change for the past 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.

G. Coordination of Benefits: Each rate filing must reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

H. 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. Medicare Supplement and Long-Term Care Policies: See Section 7.F and 7.G of this regulation.

2. Retention Percentage: The actuarial memorandum must list and adequately support each specific component of the retention percentage. 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. 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 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.

3. Benefits Ratio Guidelines: The Commissioner uses these percentages as guidelines for 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 must list the components of the retention percentage, as defined in Subsection H.2 of this section. The Commissioner will evaluate these components for reasonableness. 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 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)	65%
Comprehensive Major Medical (Small Group)	80%
Comprehensive Major Medical (Large Group)	85%
Specified or Dread Disease	60%
Limited Benefit Plans	60%
Disability Income	60%
Dental/Vision	60%
Stop Loss	60%
Short Term Limited Duration Health Insurance	60%

    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.

I. Lifetime Loss Ratio: 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 benefits 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 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 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: The memorandum must identify the percentage of the provision for profit and contingencies, and how this provision is included in the final rate. If 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 in excess of 7% after federal income tax.

K. 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.

L. Trend: This section must describe the trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also 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. The trend assumptions shall be, if practical, separately quantified into two categories, medical and insurance, as defined below:

1. Medical trend is the combined effect of medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology.

2. Insurance trend is the combined effect of underwriting wearoff, deductible leveraging, and antiselection resulting from rate increases and discontinuance of new sales. Note: medical trend must be determined or assumed before insurance trend can be determined. Underwriting wearoff means the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wearoff does not apply to guaranteed issue products.

M. 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 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 applicability of the use of such data must be discussed. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is SQRT [(# life years or claims)/full credibility standard]. The full credibility standard is defined above. 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.

N. Data Requirements: The memorandum must, at a minimum, include earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least 3 years. National or other relevant data shall also be provided in order to support the rates, if the Colorado data is not fully 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. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience for the new product is available, experience for a comparable product must be provided, if available. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. The experience period must include consecutive data no older than six months prior to the filing date. The loss data must be on an incurred basis, including both the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date. 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 about how the number of claims was calculated.

O. 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). If the proposed rating factor(s) are new, the memorandum must specifically so state, and provide detailed support for each of the factors.

P. Benefits Ratio Projections: The memorandum must contain a section projecting the benefits ratio, over the rating period, both with and without the requested rate change. For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.

Q. Other Factors: The memorandum must clearly display or clearly reference all other rating factors and definitions, including the area factors, age factors, gender factors, etc., and support for each of these factors in a new rate filing. The same level of support for changes to any of these factors must be included in renewal rate filings. In addition, the Commissioner expects each carrier to review each of these rating factors at least every five years and provide detailed support for the continued use of each of these factors in a rate filing. Gender factors shall not vary for individual health care coverage effective on or after January 1, 2011. See Section 8.C of this regulation. Note: this requirement does not apply to Medicare supplement coverage.

R. Rating manuals and underwriting guidelines: A rating manual and the underwriting guidelines that affect the calculation of the rates must be submitted to the Division for each new product. All changes to the rating manual and/or underwriting guidelines must be filed with the Division in an appropriate rate filing. Rating manuals and underwriting guidelines based on an accept or reject basis are not required to be filed.

Section 7 Additional Rate Filing Requirement by Line of Business

The following subsections set forth the requirements by separate lines of business, which must be complied 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. 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., 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.;

   b. The carrier shall document 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.

C. Small Employer Group Health Benefit Plans: The provisions of § § 10-16-105 and 10-16-107, C.R.S., and Colorado Insurance Regulations 4-6-5, 4-6-7, and 4-6-8, shall apply to the filing of rates for small employer health benefit plans.

1. The factors usually included in the determination of a trend percentage are not considered a small group rating variable and must be included in the calculation of the Index Rate. A carrier may, in a single rate submission, file up to a maximum of twelve different Index Rates in the subsequent twelve-month period; however, only one Index Rate can be effective at any given time. Only the factors defined in Colorado Insurance Regulation 4-6-7 may be used to adjust the filed Index Rate, and changes should be clearly set forth in the side-by-side comparison. Each rate filing should contain all tables necessary to recalculate the small group renewal rates, even if the factors in the table have not changed. It should be clearly indicated that the factors in these tables are unchanged.

2. Pursuant to § 10-16-105(6), C.R.S., all small group insurers or other entities must file a complete and detailed description of rating practices and renewal underwriting practices. This paragraph shall not apply to non-developed rates.

3. The Commissioner has determined that the information required under Paragraph 2 of this Subsection B may be considered confidential pursuant to § 24-72-204, C.R.S., and/or § 10-16-105(6.6), C.R.S. If a carrier desires confidential treatment of the information specified in Paragraph 2 of this subsection, a "Confidentiality Index" must be completed. It should be noted that HMOs are not afforded automatic confidential treatment in the filing of this report and must also complete a "Confidentiality Index" if the carrier chooses to hold such report confidential.

D. 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 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.

E. Valid Multi-State Association Groups: Pursuant to § 10-16-107(6), C.R.S., any health benefit plan issued or renewing on or after May 1, 2010, for any valid multi-state association under § 10-16-214(2), C.R.S., 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.

F. Medicare Supplement: A Medicare supplement policy is defined in § 10-18-101(4), C.R.S., and regulated pursuant to Colorado Insurance Regulation 4 3-1 and § § 10-18-101 to 109, C.R.S. If the requirements of both Colorado Insurance Regulation 4-3-1 and this regulation are not met, the filing will be considered incomplete and returned to the carrier. Medicare supplement filings require prior approval. (The requirements for the actuarial certification for Medicare supplement rate filings can be found in Section 14.H of Colorado Insurance Regulation 4-3-1. Rating requirements can be found in Sections 10.E, 13 and 14.F – J).

G. Long-Term Care: Long-term care insurance is defined in § 10-19-103(5), C.R.S., and regulated pursuant to Colorado Insurance Regulation 4-4-1 and § § 10-19-101 to 115, C.R.S. If the requirements of both Colorado Insurance Regulation 4-4-1 and this regulation are not met, the filing will be considered incomplete and returned to the carrier. The filing must also:

1. Demonstrate that investment income has been considered in the development of the rate;

2. Provide the expected benefits ratios for both the experience period and the projection period on an annual basis;

3. Provide the ratio of the actual benefits ratio to the expected benefits ratio for each year of the life of the policy on both a durational and calendar year basis; and

4. Provide a discussion as to how the original pricing assumptions have changed historically, and how the assumptions for the future period compare to the original pricing assumptions and the current rating assumptions.

H. Disability Income: The filing must demonstrate that investment income has been considered in the development of the rate.

I. Health Maintenance Organization (HMO): The rates for all HMO point-of-service (POS) benefits must be separately determined and supported. The actuarial memorandum supporting any rate filing for a policy which includes POS or other indemnity benefits must include a statement that all indemnity benefits are not expected to exceed twenty percent (20%) of the net medical and hospital expenses incurred. HMOs that exceed the 20% limitation in the prior calendar year may be prohibited from offering a point-of-service plan for new issues until compliance can be demonstrated.

J. Limited Service Licensed Provider Network (LSLPN): Rates and premiums for products issued by an LSLPN are to be determined on a fixed prepayment basis. Therefore, no LSLPN product may be issued on a cost-plus or retrospective rating basis.

Section 8 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. 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. For individual health insurance plans, other than Medicare supplement, 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.

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, 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 certificates of authority. Among others, the penalties provided in § § 10-3-1108, 10-16-107, 10-16-107.1, and 10-16-216.5, C.R.S., may be applied.

Section 11 Effective date

This regulation is amended effective January 1, 2012.

Section 12 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 4-2-13 Repealed in Full [eff. 01/01/2010]

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

Section 1 Authority

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

Section 2 Scope and Purpose

The purpose of this regulation is to describe the entities subject to the provisions of Sections 10-16-121, and 10-16-705, C.R.S., which concerns 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(25.5), C.R.S.

C. "Managed care plan" is defined in § 10-16-102(26.5), C.R.S.

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

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

Section 5 Rules

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

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

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

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

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

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

2. "The carrier or an entity representing or working for such carrier shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of an individual or group of providers covered by any contract executed by [name of intermediary];"

3. " The carrier shall not terminate any contract executed by [name of intermediary] because any individual or group of providers covered by the contract :

   a. Expresses disagreement with a decision by the carrier or an entity representing or working for such carrier to deny or limit benefits to a covered person ,

   b. Assists the covered person to seek reconsideration for the carrier's decision , or

   c. Discusses with a current, former or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the needs of such patients."

C. Any contract entered into by a carrier with one or more intermediaries to conduct utilization management, utilization reviews, provider credentialing, administration of health insurance benefits, setting or negotiation of reimbursement rates, payment to providers, network development, or disease management programs , when issued, renewed, amended or extended shall contain provisions requiring the intermediary to:

1. Comply with the same standards, guidelines, medical policies, and benefit terms of the carrier

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, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in §10- 3-1108, C.R.S. may be applied.

Section 8 Effective Date

This regulation shall become effective on December 1, 2009

Section 9 History

New regulation effective October 30, 1996.

Amended regulation effective December 1, 2009.

Regulation 4-2-16 WOMEN'S ACCESS TO OBSTETRICIANS, GYNECOLOGISTS AND CERTIFIED NURSE MIDWIVES UNDER MANAGED CARE PLANS

Table of Contents

Section 1 Authority

This regulation is promulgated pursuant to Section 10-1-109 and 10-16-107(5)(b), C.R.S.

Section 2. Purpose

The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of Section 10-16-107(5), C.R.S., concerning women's access to obstetricians, gynecologists, and certified nurse midwives in managed care plans.

Section 3. Applicability And Scope

The provisions of this regulation shall apply to all managed care plans that provide coverage far reproductive health or gynecological care. “Managed care plan” is defined in Section 10-16-102(26.5), C.R.S. Examples of managed care plans include but are not limited to: preferred provider plans,

gatekeeper plans, health maintenance organization plans, plans offered by limited service licensed provider networks, and plans that provide better coverage (e.g., pay a greater percentage of covered expenses or have lower copayment requirements) if a covered person uses specified providers (sometimes called participating or in-network providers).

Section 4. Definitions

A. "Reproductive health and gynecological care" means care for both the normal and abnormal processes of the female reproductive system, including medical and surgical management of disorders, pregnancy and childbirth, and related preventive care.

Section 5. Rules

A. A managed care plan that provides coverage for reproductive health or gynecological care shall not be issued or renewed unless such plan either provides a woman covered under the plan direct access to an obstetrician, gynecologist, or certified nurse midwife, participating and available under the plan, for her reproductive or gynecological care or has referral procedures in place that comply with this regulation.

B. A managed care plan will be considered to have provided "direct access" to an obstetrician, gynecologist, or certified nurse midwife for reproductive and gynecological care only if a woman covered under the plan has the option of selecting a participating obstetrician, gynecologist or certified nurse midwife who is available under the plan as her primary care provider, or :

1. Can herself directly make an appointment with an obstetrician, gynecologist or certified nurse midwife who is participating and available under the plan;

2. Is not required as a condition of coverage to get prior approval or a referral from her primary care provider, the managed care plan, a representative of the managed care plan, or any other entity for an appointment/visit with an obstetrician, gynecologist or certified nurse midwife who is participating and available under the plan; and

3. Is not required to pay more out-of-pocket for directly accessing an obstetrician, gynecologist, or certified nurse midwife who is participating and available under the plan than if she received prior approval for, or a primary care provider referral to, such an obstetrician, gynecologist or certified nurse midwife.

C. A managed care plan that does not provide direct access pursuant to subsection B shall have procedures in place to ensure that a woman covered under the plan who requests a referral to, or preauthorization of care provided by, an obstetrician, gynecologist or certified nurse midwife participating and available under the plan for her reproductive and gynecological care shall not have such referral or preauthorization unreasonably withheld. Such procedures shall be in writing, shall be provided upon request and at no charge to the Division of Insurance, a covered person, or a participating provider, and shall make provision for the following:

1. A request for a referral or preauthorization may be made orally (e.g., by telephone) or in writing, at the discretion of the covered woman making the request The managed care plan's procedures shall specify whether the request should be submitted to the plan or to the primary care provider, or whether either may receive the request.

2. A managed care plan may require that a request by a woman for a referral to, or preauthorization of care provided by, a participating obstetrician, gynecologist or certified nurse midwife include the following information only:

    a. The reason for the request for referral or preauthorization of care and the type of care

being sought (e.g., ongoing gynecological care, prenatal care, etc.), including sufficient information to determine if referral services requested are a benefit under the plan;

b. The number of visits or period for which the referral or preauthorization is being requested (e.g., for one visit, for all obstetrical care throughout the term of a pregnancy, etc.); and

c. Identifying information (e.g., name of primary care provider, name of the obstetrician, gynecologist or certified nurse midwife to whom the woman wants a referral, plan number, enrollee name, etc.).

3. A request for a referral or preauthorization shall be approved or denied within three (3) working days of the date on which the request was made if it is an oral request, or within three (3) working days of the date on which it was received if it is a written request Where a plan allows a primary care provider to process referral requests, pursuant to Section V.C.1, of this regulation, the same timelines shall apply.

4. An approval of a request by a woman for a referral to, or preauthorization of care provided by, a participating obstetrician, gynecologist or certified nurse midwife shall include, at minimum, the following information:

a. The number of visits or period for which the referral or preauthorization is being approved (e.g., for one visit, for all obstetrical care throughout the term of a pregnancy, etc.); and

b. The plan's understanding of the reason for the referral (e.g., ongoing gynecological care, prenatal care, etc.).

5. Approvals and denials of requests may be made orally but all denials shall be followed up by the health coverage plan or its representative within three (3) working days of the receipt of the original oral or written request with a detailed written explanation of the reason (s) for the denial, The written denial shall also describe the process by which the covered person may appeal and/or file a grievance concerning the denial pursuant to Division of Insurance Regulation 4-2-17.

6. Managed care plans shall not financially penalize, sanction, terminate, or reward a participating provider responsible for making referrals based on the volume and/or consequent expenditures incurred as a result of that provider's referrals to participating obstetricians, gynecologists, or certified nurse midwives made pursuant to this regulation.

7. A managed care plan or its representative shall not deny a request for a referral to, or preauthorization of care by, a participating obstetrician, gynecologist, or certified nurse midwife solely because a covered woman's primary care provider is able/qualified to provide the same reproductive health or gynecological care, treatment or diagnostic tests as the obstetrician or gynecologist.

8. Managed care plans may require an obstetrician, gynecologist, or certified nurse midwife to whom a woman has been referred to send information concerning care for the woman to her primary care provider, in order to promote ongoing management of her care and continuity of care. However, failure of an obstetrician, gynecologist, or certified nurse midewife to provide such information shall not in any way result in financial or other penalties being imposed by the plan on either the patient or the primary care provider.

D. All managed care plans subject to subsection C shall keep a log on file of all denied requests for

referrals to, and denials of preauthorizations of care provided by, an obstetrician, gynecologist, or certified nurse midwife who is participating and available under the plan that have been appealed. The log shall indicate the date of each request, the reason for each denial, and the final outcome of each appeal. The log of denied requests mat have been appealed shall not include patient identifying information. The log shall be made available upon request to the Division of Insurance.

E. Nothing in this regulation shall be construed to require a managed care plan to make or approve a referral to an obstetrician, gynecologist, or certified nurse midwife who is not a participating provider under the plan. Also, nothing in this regulation shall be construed to require a managed care plan to include in its plan of coverage specific obstetrical or gynecological services except to the extent otherwise required by law or regulation.

Section 6. 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 penalties, issuance of cease and desist orders, and/or suspensions or revocations of license.

Section 7. Severability

If any provision of this regulation or the application thereof to any person or circumstance is held invalid or unenforceable by a court of competent jurisdiction, such invalidity or unenforceability shall not affect the other provisions, and this regulation is expressly declared to be severable.

Section 8. Effective Date

This amended regulation is effective on March 1, 2000.

Section 9. History

1. Originally effective December 30, 1996 for health coverage plans issued or renewed on or after January 31, 1997.

2. Amended March 1, 2000 to include access to certified nurse midwives.

Regulation 4-2-17 PROMPT INVESTIGATION OF HEALTH CLAIMS INVOLVING UTILIZATION REVIEW AND DENIAL OF BENEFITS

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, subsections (2) and (3)(b), 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 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, and certain denials of benefits for treatments excluded by health coverage plans.

Section 3 Applicability

The provisions of this regulation shall apply to all health coverage plans, but 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.

Section 4 Definitions

A. "Adverse determination" means a determination by a health carrier or its designee that a request for a benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirement for medical necessity, or is determined to be experimental or investigational, and is therefore denied, reduced, or terminated. An adverse determination also includes a denial for a benefit excluded by a health coverage plan for which the claimant 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.

B. “Ambulatory review” means utilization review of health care services performed or provided in an outpatient setting.

C. “Carrier” as defined in §10-16-102(8), C.R.S.

D. “Case management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

E. “Clinical peer” means 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.

F. “Complaint” means a written communication primarily expressing a grievance.

G. “Covered person” as defined in §10-16-102(13.5), C.R.S.

H. “Date of receipt of a notice” for purposes of this regulation means the date that shall be calculated to be no less than three calendar days after the date the notice is postmarked by the carrier.

I. “Designated representative” means:

1. A person, including the treating health care professional or a person authorized by paragraph 2. of this subsection H., to whom a covered person has given express written consent to represent the covered person; 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; or

3. In the case of an urgent care request, a health care professional with knowledge of the covered person’s medical condition.

J. “Discharge planning” means 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.

K. “Emergency medical condition” means 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 person’s health in serious jeopardy.

L. “Grievance” means a circumstance regarded as a cause for protest, including the protest of an adverse determination.

M. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

N. “Health coverage plan” as defined in §10-16-102(22.5), C.R.S.

O. “Life or limb threatening emergency” means any event that a prudent lay person 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.

P. “Medical professional” means an individual licensed pursuant to the “Colorado Medical Practice Act” , article 36 of title 12, C.R.S., or, for dental plans only, a dentist licensed pursuant to the “Dental Practice Law of Colorado” , article 35 of title 12, C.R.S., acting within his or her scope of practice.

Q. “Prospective review” means utilization review conducted prior to an admission or course of treatment.

R. “Provider” shall have the same meaning as defined in §10-16-102(36), C.R.S.

S. “Retrospective review” means any utilization review that is not prospective review, but does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

T. “Second opinion” means 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 clinical necessity and appropriateness of the initial proposed health service.

U. “Stabilized” means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred.

V. “Urgent care request” means:

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 persons with a physical or mental disability, create an imminent and substantial limitation on their 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 paragraph 3. of this subsection V., in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health 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 paragraph 1 shall be treated as an urgent care request.

W. “Utilization review” means 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 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 Compliance Requirements

A. A health carrier that does not use a procedure for investigating claims involving utilization review that

is consistent with this regulation shall be deemed not to be in compliance with 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. (§10-3-1104(1)(h)(IV), C.R.S.)

B. A health carrier that uses standards in the review of claims involving utilization review that are not in compliance with the rules contained in this regulation shall be deemed not to be in compliance with 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. (§10-3-1104(1)(h)(III), C.R.S.)

C. A health carrier that does not investigate claims involving utilization review within the time frames set out in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly investigate claims. (§10-3-1104(1)(h)(II), C.R.S.)

D. A health carrier that does not follow the procedures for explaining the basis of a utilization review decision set forth in this regulation shall be deemed not to be in compliance with 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. (§10-3-1104(1)(h)(XIV), C.R.S.)

E. A health 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 not to be in compliance with 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. (§10-3-1104(1)(h)(IV), C.R.S.)

Section 6 Standard Utilization Review

A. A health carrier shall maintain written procedures pursuant to this section for making utilization review decisions and for notifying covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.

B. Prospective review determinations.

1. Time period for determination and notification.

a. Subject to subparagraph b. of paragraph 1., a health carrier shall make the determination and notify the covered person and the covered person's provider 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) days after the date the health carrier receives the request. Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with subsection E.

b. The time period for making a determination and notifying the covered person of the determination pursuant to subparagraph a. of paragraph 1. may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:

(1) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(2) Notifies the covered person prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

c. If the extension under subparagraph b. of paragraph 1. 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) 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.

2. Failure to meet the health carrier's filing procedures.

a. Whenever the health carrier receives a prospective review request from a covered person that fails to meet the health carrier's filing procedures, the health 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 subparagraph a. of paragraph 2. shall be provided, as soon as possible, but in no event later than five (5) days following the date of the failure.

(2) The health carrier shall provide the notice in writing.

c. The provisions of paragraph 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 health 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 provider for which certification 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, the health care service or treatment that is the subject of an adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the carrier.

4. The requirements of subsection B. apply to all written requests involving utilization review received by the health carrier which are submitted by a covered person, the covered person's designated representative, or provider requesting a determination of coverage for a specific health care service or treatment for a specific member.

C. Retrospective review determinations.

1. For retrospective review determinations, a health carrier shall make the determination and

notify the covered person and the covered person's provider of the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request. If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person in accordance with subsection 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 paragraph 1. may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:

        (1) Determines that an extension is necessary due to matters beyond the health carrier's control; and

        (2) Notifies the covered person prior to the expiration of the initial thirty-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

    b. If the extension under subparagraph a. of paragraph 2. 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 thirty (30) 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 subsections B. and C., the time period within which the determination is required to be made shall begin on the date the request is received by the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

2. Extensions.

    a. If the time period for making the determination under subsection B. or 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 health carrier sends the notification of the extension to the covered person until the earlier of:

        (1) The date on which the covered person responds to the request for additional information; or

        (2) The date on which the specified information was to have been submitted.

    b. If the covered person fails to submit the information before the end of the period of the extension, as specified in subsection B. or C., the health carrier may deny the

certification of the requested benefit.

E. Requirements for adverse determination notifications.

1. Except for the adverse determinations described in paragraph 2. of this subsection E., 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 health 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 or experimental or investigational treatment or similar exclusion or limit, 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. 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 subparagraph e. of this paragraph; or

(2) The written statement of the scientific or clinical rationale for the adverse determination, as provided in subparagraph f. of this paragraph; and

h. A description of the health coverage plan's review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision.

2. For denials based on a contractual exclusion, the adverse determination notice 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 health carrier shall provide the notice required under this section in writing, either on paper or electronically.

Section 7 Expedited Utilization Review

A. Procedures.

1. A health carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons and for making and notifying covered persons of expedited utilization review with respect to urgent care requests. For purposes of this section, "covered person" includes the designated representative of a covered person.

2. Notification requirements.

a. As part of the procedures required under paragraph 1., a health carrier shall provide that, in the case of a failure by a covered person to follow the health carrier's procedures for filing an urgent care request, the covered person shall be notified of the failure and the proper procedures to be following for filing the request.

b. The notice required under subparagraph a. of this paragraph:

(1) Shall be provided to the covered person as soon as possible but not later than twenty-four (24) hours after receipt of the request; and

(2) Shall be in writing.

c. The provisions of this paragraph 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 health 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 provider 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 health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health coverage plan, the health carrier shall notify the covered person and the covered person's provider of the health 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 receipt of the request by the health carrier.

b. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection E.

2. Notification requirements for insufficient information.

a. If the covered person has failed to provide sufficient information for the health carrier to make a determination, the health 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 receipt of the request.

b. The health 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 subparagraph a. of this paragraph.

c. The health carrier shall notify the covered person and the covered person's provider 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 health 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 subparagraph b. of this paragraph, the health carrier may deny the certification of the requested benefit.

e. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection E.

C. Concurrent urgent care review requests.

1. For concurrent review urgent care 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 health carrier shall make a determination with respect to the request and notify the covered person and the covered person's provider 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 health carrier's receipt of the request.

2. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection E.

D. For purposes of calculating the time periods within which a determination is required to be made under subsection B. or C., the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

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 to perfect the request;

e. If the health 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 or experimental or investigational treatment or similar exclusion or limit, 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. 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 subparagraph e. of this paragraph; or

(2) The written statement of the scientific or clinical rationale for the adverse determination, as provided in subparagraph f. of this paragraph; and

h. A description of the health coverage plan's expedited review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision.

2. Notification requirements.

a. A health 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 health carrier shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

F. The requirements of section 7 apply to all written requests involving utilization review received by the health carrier which are submitted by a covered person, the covered person's designated representative, or provider requesting a determination of coverage for a specific health care service or treatment for a specific member.

Section 8 Emergency Services

A. A health 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 lay person having average knowledge of health 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 provider to secure prior authorization. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a health 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 contracting provider 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 provider.

B. 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 9 Peer-to-Peer Conversation

A. In a case involving a prospective review determination, a health carrier shall give the provider 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) days of the receipt of the request and shall be conducted between the provider rendering the 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) 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., and Colorado Insurance Regulation 6-2-1 concerning complaints and complaint records, a request for a peer-to-peer conversation shall not be considered a complaint.

Section 10 First Level Review

A. A health carrier shall establish written procedures for the review of an adverse determination that does not involve an urgent care request. 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 providers to whom the health carrier shall send a copy of the review decision.

B. 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.

C. Pursuant to §10-3-1104(1)(i), C.R.S., all written requests for a first level review must be entered into the carrier’s complaint record.

D. Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to section 6 or 7 or after the receipt of notification of a benefit denied due to a contractual exclusion, a covered person may file a grievance with the health 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.

E. Conduct of first level reviews.

1. First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, 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 or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services 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.

F. Covered person's rights.

1. A covered person does not have the right to attend or to have a representative in attendance at the first level review, but the covered person is entitled to:

   a. Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers 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

   b. Receive from the health 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.

2. For purposes of subparagraph 1.b. of this subsection, 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 health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; 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.

G. Notification requirements.

1. A health carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in paragraph 2. or 3.

2. With respect to a request for a first level review of an adverse determination involving a prospective review request, the health 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) days after the date of the health carrier's receipt of the grievance requesting 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 health carrier shall notify and issue a decision within a reasonable period of time, but no later than thirty (30) days after the date of the health carrier's receipt of a request for the first level review.

H. For purposes of calculating the time periods within which a determination is required to be made and notice provided under subsection G., the time period shall begin on the date the grievance requesting the review is filed with the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

I. The decision issued pursuant to subsection G. 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 consults. (For the purposes of this section, 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.

J. A first level review decision involving an adverse determination issued pursuant to subsection G. shall include, in addition to the requirements of subsection I.:

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 subsection F.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 or experimental or investigational treatment or similar exclusion or limit, 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; and

5. 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 paragraph 3. of this subsection; and

    b. The written statement of the scientific or clinical rationale for the determination, as provided in paragraph 4. of this subsection.

6. A description of the process to obtain a voluntary second level review, including:

    a. The written procedures governing the voluntary second level review, including any 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 health 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) 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 should be provided to the health carrier at least five (5) 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 of the covered person's choice, including counsel, advocates, and health care professionals;

    c. A statement that the carrier will provide 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 Colorado Insurance Regulation 4-2-21 if the covered person chooses not to file for a voluntary second level review of the first level review decision involving an adverse determination.

Section 11 Voluntary Second Level Review

A. A carrier shall establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at 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 health carrier, a review panel of health care professionals, selected by the carrier. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the second level review decision. The purpose of the voluntary review process is to give the covered person the opportunity to explain their grievance and to provide any relevant evidence in support of their 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 voluntary second level reviews, pursuant to §10-3-1104(1)(i), C.R.S., and Colorado Insurance Regulation 6-2-1.

D. Within thirty (30) days after the date of receipt of a notice of an adverse determination, a 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.

F. Procedures.

1. 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 health 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 review panel, shall meet the following criteria:

    a. Were not previously involved in the appeal, and

    b. Who do not have a direct financial interest in the appeal or outcome of the review.

3. The reviewer or the review panel shall have the legal authority to bind the health carrier to the reviewer’s or review panel’s decision.

G. A health carrier's procedures for conducting a voluntary second level review shall include the following:

1. The reviewer or review panel shall schedule and hold a review meeting within sixty (60) days of receiving a request from a covered person for a voluntary second level review. The covered person shall be notified in writing at least twenty (20) days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.

2. Notice requirements. The notice to the covered person of the review 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 at least five (5) 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 to the health carrier at least five (5) 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) days in advance of the review, 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 will be provided to the carrier when practicable.

    e. The health carrier shall use this notification to advise the covered person if it intends to have an attorney present to represent the interests of the health carrier.

    f. The health carrier shall use this notification to advise the covered person that the plan shall make an audio or video recording of the review unless neither the covered person nor the health carrier wants the recording made. The notice shall advise that this recording shall be made available to the covered person and that if there is an external review, the audio or video recording shall, at the request of either party, be included in the material provided by the carrier to the reviewing entity.

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 health carrier shall offer the covered person the opportunity to communicate, at the health carrier's expense, by telephone conference call. A carrier may also offer video conferencing or other appropriate technology.

4. In conducting the review, 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 pursuant to section 10.J.6.b., 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. The reviewer or review panel shall issue a written decision, as provided in subsection H., to the covered person within seven (7) days of completing the review meeting.

6. For purposes of calculating the time periods within which a decision is required to be made

and notice provided, the time period shall begin on the date the request for a voluntary second level review is filed with the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

H. A decision issued pursuant to subsection G. shall include:

1. The name(s), title(s) and qualifying credentials of the reviewer or 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 voluntary second level 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 10.F.2., to the covered person's benefit request;

   c. If the reviewer or review panel has 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 or experimental or investigational treatment or similar exclusion or limit, 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; and

   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 subparagraph c. of this paragraph; and

      (2) The written statement of the scientific or clinical rationale for the determination, as provided in subparagraph d. of this paragraph;

   f. A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to Colorado Insurance Regulation 4-2-21.

Section 12 Expedited Review of an Adverse Determination

A. A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination. A health carrier shall also provide an expedited review to a request for a benefit for a covered person who has received emergency services but has not been discharged from a 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 providers to whom the health carrier shall send a copy of the review decision.

B. An expedited review shall be available to, and may be initiated by, the covered person or the provider 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 must be entered into the carrier's complaint record.

D. Expedited appeal evaluations.

1. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case under review. (For the purposes of this section, the clinical peers shall be called "the reviewers" .) The clinical peer or peers shall not have been involved in the initial adverse determination.

2. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination.

E. Covered person's rights.

1. 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:

a. Submit written comments, documents, records and other materials relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

b. Receive from the health 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 10.F.1.b.

F. In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the provider acting on behalf of the covered person by telephone, facsimile or similar expeditious method available.

G. In an expedited review, a health carrier shall make a decision and notify the covered person or the provider 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 review is commenced. If the expedited review is a concurrent review determination, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

H. A health carrier shall provide written confirmation of its decision concerning an expedited review within three (3) 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 contain the provisions specified in

sections 10.I. and 10.J. of this regulation.

J. For purposes of calculating the time periods within which a decision is required to be made under subsection G., the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

K. In any case where the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may request a voluntary second level appeal or request an independent external review.

L. A health carrier shall not provide an expedited review for retrospective adverse determinations.

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 the regulation shall not be affected.

Section 14 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspension or revocation of licenses or certificates of authority. Among others, the penalties provided for in §10-3-1108, C.R.S., may be applied.

Section 15 Effective Date

This amended regulation is effective on November 1, 2010.

Section 16 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.

Regulation 4-2-18 CONCERNING THE METHOD OF CREDITING AND CERTIFYING CREDITABLE COVERAGE FOR PRE-EXISTING CONDITIONS

Section 1 Authority

Section 2 Purpose and Background

Section 1. Authority

This regulation is promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S.

Section 2. Purpose and Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10- 16-118(1)(b), C.R.S. he purpose of the 2004 amendments to this regulation is to make clarifications and allowances to ensure Colorado consumers receive correct certificates of creditable coverage in a timely manner.

Section 3. Applicability and Scope

This amended regulation shall apply to all certificates of creditable coverage issued on or after October 1, 2004.

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

B. "Student health plan" means a health benefit plan that covers the students of an educational institution.

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in the federal regulations incorporated below.

2. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

3. The following sections of the federal regulations, adopted by the U.S. Department of Health and Human Services, are hereby incorporated by reference and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S.:

   45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). These sections concern the method for counting creditable coverage; requirements for providing certificates of creditable coverage to those who were insured under group plans, including the form and content of the certificates; and requirements for providing certificates of creditable coverage to those who were insured under individual plans, including the form and content of the certificates.

4. Later amendments to, or editions of, the above-referenced federal regulations are not included in this regulation. Interested parties are encouraged to refer to the summary and supplementary information concerning the incorporated federal regulations which begins in Volume 62, number 67, page 16894 of the Federal Register, April 8, 1997, for assistance in interpreting the federal regulations.

5. Copies of the incorporated federal regulations may be obtained or examined from the Commissioner's office by contacting the Assistant to the Commissioner at 1560 Broadway, Suite 850, Denver, Colorado, 80202. The above-referenced federal regulations may also be examined at any state publications depository library.

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.

3. Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state. The laws applicable to the health coverage plan that has the pre-existing condition exclusion will determine which break rule applies.

4. Certifying creditable coverage

   Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. owever, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.

C. Maximum six (6) month pre-existing condition exclusion period for group health plans.

Colorado law prohibits group health plans from imposing a pre-existing condition limitation period that exceeds six (6) months, except with respect to late enrollees as provided for in Section 10-16-118(1)(c), C.R.S. ll references in the federal regulations to twelve (12) month pre-existing condition limitations for group health benefit plans are not applicable in Colorado.

D. Student health plans are considered group health plans.

Colorado law considers student health benefit plans to be group plans. As such, student health plans shall comply with the group health benefit plan provisions of Colorado law including those related to pre-existing condition limitations.

E. Children's Basic Health Plan is considered a group health plan.

Colorado law considers the Children's Basic Health Plan (also known as CHP+) to be a group plan. As such, carriers offering coverage through the Children's Basic Health Plan shall comply with the group health benefit plan provisions of Colorado law.

F. Treatment of late enrollees.

Colorado law requires late enrollees (i.e., those individuals who did not enroll when initially offered coverage and who are not special enrollees pursuant to section 10-16-102(26), C.R.S.) to be enrolled upon request. However, late enrollees are subject to longer pre-existing condition periods, affiliation periods, and waiting periods for coverage, as provided for in Section 10-16-118(1)(c), C.R.S.

Section 6. Enforcement

Noncompliance with this rule may result, after notice and opportunity for hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws including the imposition of fines, issuance of cease and desist orders, and/or suspension or revocation of certificates of authority.

Section 7. Severability

In the event any part of this rule or application of it to any person or circumstance is determined to be invalid for any reason, the remainder of the rule shall not be affected.

Section 8. Effective Date

This amended rule is effective October 1, 2004.

Section 9. History

1. Originally issued as Emergency Regulation 97-E-6, effective July 31, 1997.

2. Issued as Regulation 4-2-18, effective October 30, 1997.

3. Amended, effective November 1, 1999.

4. Amended, effective October 1, 2004.

Regulation 4-2-19 CONCERNING INDIVIDUAL HEALTH BENEFIT PLANS ISSUED TO SELF-EMPLOYED BUSINESS GROUPS OF ONE

Section 1 Authority

This regulation is promulgated pursuant to § § 10-1-109(1), 10-16-105.2(1)(c)(I) and (3), 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 and implement rules concerning health benefit plans marketed and/or newly issued to self-employed business groups of one. In some cases such plans are exempt from Colorado's small group guarantee issue laws, pursuant to § 10-16-105.2(1)(c), (d) and (3), C.R.S.

Section 3 Applicability

This amended regulation shall apply to individual health benefit plans marketed and/or newly issued to self-employed business groups of one.

Section 4 Definitions

A. "Self-employed business group of one" means, pursuant to § 10-16-105(1)(c)(I), C.R.S., that type of business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees.

B. "Health benefit plan" shall have the same meaning as defined in § 10-16-102(21)(a), which includes high deductible health savings account (HSA) plans.

Section 5 Rules

A. An individual health benefit plan marketed and/or newly issued, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage meet all the following conditions:

1. Pursuant to § 10-16-105.2(1)(c)(I)(A), C.R.S., the carrier issuing the policy determines whether or not the applicant is a self-employed business group of one. A carrier shall meet this requirement by having all applicants fill out the "Determination of Self-Employed Business Group of One Form" available from the Division. A copy of the completed form shall be kept on file with each application. In addition, pursuant to § 10-16-102(6)(c), C.R.S., a carrier may require all business group of one applicants to supply certain tax and withholding documents in order to determine if an applicant meets the definition of a business group of one. Applicants who answer "yes" to all the questions in the form and, if required by the carrier, who can document their answers shall be considered to have met the test of a self-employed business group of one. An applicant who does not meet

this test falls into one of two categories. Either:

a. The applicant is a small employer that is not a self-employed business group of one and thus any plan sold to such person is subject to the small group laws of Colorado, pursuant to § 10-16-105.2(1)(a), C.R.S.; or

b. The applicant is neither a small employer, nor a self-employed business group of one, nor any other person covered by the small group laws of Colorado (see § 10-16-105.2(1), C.R.S.) and thus any plan sold to such person is not subject to this regulation but is subject to the other laws of Colorado relating to individual health benefit plans.

2. Pursuant to § 10-16-105.2(1)(c)(I)(B), C.R.S., the carrier issuing the individual health benefit plan accepts or rejects a self-employed business group of one who applies for coverage and, if such person is applying for family coverage, his/her entire family (all dependents), unless the applicant waives coverage for a family member who has other coverage in effect. A carrier shall meet this family coverage requirement by:

   a. Asking each self-employed business group of one applicant requesting coverage for himself/herself and one or more dependents for the names of all his/her dependents;

   b. Where the applicant waives coverage for a family member, keeping on file with the application a signed statement from the applicant that he/she is waiving coverage for a dependent because that person already has other coverage in effect and shall state what that coverage is and when it became effective; and

   c. Where a self-employed business group of one is rejected for individual coverage because one or more family members fail to meet normal and actuarially-based underwriting criteria, the carrier shall clearly state this as part of the reason for the denial and shall notify the applicant in writing of the availability of coverage for his/her whole family under a small group policy.

3. If, pursuant to Section 5A (2) of this regulation, a carrier rejects an application by a self-employed business group of one for coverage under an individual health benefit plan, and if that same carrier sells coverage in both the individual and small group markets, then pursuant to § 10-16-105.2(1)(c)(I)(C), C.R.S., the carrier notifies the applicant of the availability of small group coverage both through the small group market and through the carrier. The notice shall inform the applicant of his/her guarantee issue rights as detailed in § 10-16-105(7.3)(a) and (c), C.R.S. This notice shall be in writing and shall be included as part of the denial of individual coverage letter. A copy of the denial letter and the notice concerning the availability of small group coverage shall be maintained by the carrier in the file with the original application.

4. A carrier issuing an individual health benefit plan to a self-employed business group of one shall abide by the disclosure requirements as described in § 10-16-105.2(1)(c)(I)(D), C.R.S. Accordingly:

   a. The carrier, as part of its application form, shall require each self-employed business group of one purchasing an individual health benefit plan pursuant to § 10-16-105.2(1)(c)(I), C.R.S., to read and sign a disclosure form, as required by the Division, attesting that they understand that they are forfeiting their rights to purchase a business group of one basic, standard, or other health benefit plan from a small employer carrier for a period of three (3) years after the date of purchase, unless a small employer carrier voluntarily permits the purchase of a

business group of one policy within that three-year period.

b. The carrier must provide the applicant with a Colorado Health Benefit Plan Description Form for the state's Standard Health Benefit Plans, available from the Division. Carriers may reproduce and distribute this form in order to comply with the provisions of § 10-16-105.2(1)(c)(I)(D), C.R.S.

B. Material failure by a carrier or its representative to comply with the requirements of subsection A of Section 5 of this regulation will result in individual health benefit plans sold to self-employed business groups of one becoming subject to Colorado's small group laws.

1. A small employer carrier may reject for coverage under a small group plan a self-employed business group of one otherwise eligible for small group coverage if, at the time of application for small group coverage, the small employer carrier determines that the self-employed person has in place, or within the immediately preceding thirty (30) days has had in place, an individual health benefit plan, other than a short-term policy, that meets the requirements of subsection A of Section 5 of this regulation (and any applicable statutory provisions) and such individual health benefit plan has been in place for less than three (3) years.

2. The small employer carrier shall make this determination by requesting, in writing, from the individual carrier from whom the self-employed business group of one has had coverage, verification that the coverage was or was not issued pursuant to § 10-16-105.2(1)(c)(I), C.R.S., and this regulation. The small employer carrier shall also request information as to how long the coverage was or has been in place if such coverage was issued pursuant to § 10-16-105.2(1)(c)(I), C.R.S., and this regulation.

3. Requests for such verification shall be answered in writing, be signed by a representative of the individual carrier, and shall be responded to within five (5) business days of the date the request was received.

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 orders, and/or suspensions or revocation of certificates of authority. Among others, the penalties provided in § 10-3-1108, C.R.S., may be applied.

Section 8 Effective Date

This amended regulation is effective on May 1, 2010.

Section 9 History

Original regulation effective November 1, 1997.

Amended regulation hearing September 8, 1999; effective November 1, 1999.

Amended regulation effective January 1, 2002.

Amended regulation effective October 1, 2004

Amended regulation 4-2-19, effective May 1, 2010.

Regulation 4-2-20 CONCERNING THE COLORADO HEALTH BENEFIT PLAN DESCRIPTION FORM

Section 1. Authority

This regulation is promulgated pursuant to Sections 10-1-109, 10-3-1110(1), 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 establish and implement rules concerning the format for, elements of, and issuance of a Colorado Health Benefit Plan Description Form, pursuant to Section 10-16-108.5(11)(b), C.R.S. As required by law, the form is designed to facilitate comparison of different health plans by persons interested in purchasing or obtaining coverage under a health benefit plan. As also required by law, this regulation sets out procedures for carriers to make available a Colorado Health Benefit Plan Description 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. This regulation is being changed in response to concerns from interested parties.

Section 3. Applicability

This amended regulation shall apply to all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage on and after July 1, 2007.

Section 4. Rules

A. Effective July 1, 2007, all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage shall make available to a producer or consumer through electronic means or hard copy, a completed copy of the Colorado Health Benefit Plan Description Form shown in Appendix A for each policy, contract, and plan of health benefits that either covers a Colorado resident or is selected by a Colorado resident or such resident's employer as one of the final choices from which the ultimate selection will be made, except as provided in Part B of Section 4 of this regulation.

B Carriers marketing or providing a Medicare supplemental plan will be deemed to have met the requirement of Part A of Section 4 of this regulation if, in lieu of the Colorado Health Benefit Plan Description Form, they make available for each such plan a Medicare supplement outline of coverage as prescribed in Colorado insurance regulation 4-3-1, 3 C.C.R. 702-4. Carriers shall make available the Medicare supplement Outline of Coverage pursuant to Part E of Section 4 below.

C. Carriers shall use the exact format found in Appendix A for the Colorado Health Benefit Plan Description Form, including all headings, notes, row numbers, and footnotes. All boxes must be filled in. Carriers may modify box dimensions, reduce margins, or use a landscape rather than a portrait page layout format, but carriers shall follow the exact requirements and use only the choices set forth in the directions found in Appendix B of this regulation. A carrier may also add its logo to the form and print the form in color or black and white. Pursuant to Section 10-3-1104(1), C.R.S., in completing the form, carriers shall not misrepresent the benefits, advantages, conditions, or terms of the policy.

D. Carriers shall follow the directions for completing the Colorado Health Benefit Plan Description Form found in Appendix B of this regulation.

E. Carriers shall provide a Colorado Health Benefit Plan Description Form that is specific with respect to the particular policy provisions of the policy (e.g., individual deductible = $500 per year) as follows:

1. Automatically, as part of the health benefit plan description materials 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. Automatically within three (3) 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 (e.g., “I am interested in the Gold Plan, the $500 deductible PPO plan, your HMO plan with vision care coverage, etc,” or “I want to purchase your Plan 200, $5 copay HMO plan,” etc.);

3. Upon request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier; and

4. Upon request within three (3) business days to a producer on behalf of any person, group, association, or health care cooperative that is interested in coverage or is covered by a health benefit plan of the carrier.

F.

1. Carriers shall prominently include with all marketing materials the following notice:

   "Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier."

2. The carrier shall ensure that the form is given to the person making the request within three (3) business days of receipt of such request. The request may be made orally or in writing and may be made to either a carrier or a producer.

G. Concerning the carrier’s obligation contained in Part E(1) of Section 4 to make the health benefit plan description form available to employees, or members of a group, association, or health care cooperative, a carrier is in compliance if:

1. The carrier provides the health benefit description form to the group, association, or health care cooperative, or to a producer on behalf of the group, association, or health care cooperative, or to an individual; or

2. The carrier determines that the employer has developed and will distribute or has distributed a conforming grid.

   a. A grid is conforming if an employer offers an employee a choice of health plans and compares the benefits for the plans on a grid that meets all the following requirements:

      (1) The grid must follow the exact format contained in Appendix A for the

Colorado Health Benefit Plan Description Form, including the labeling and numerical identification of rows and columns, the headings, the footnotes, and the notes, except as set forth in subparagraph (b), below.

(2) At the employer's sole discretion, the grid also may include additional rows, as long as the numbering of those rows does not interfere with the ordering and numbering of rows established in Appendix A. For example, the "PRESCRIPTION DRUGS" row is always row 11 on the grid; the "HOSPICE CARE" row is always row 26 on the grid. In addition, the employer grid could include more rows (e.g., "10A INFERTILITY TREATMENT," "11A. CONTRACEPTIVES," "31A NATUROPATHY").

(3) The benefit descriptions in the grid must follow exactly the directions contained in Appendix B of this regulation for completing the grid, except as set forth in subparagraph (b), below.

(4) At the employer's sole discretion, the benefit descriptions may include additional relevant information.

(5) The grid must be given to all new enrollees, to all employees eligible for coverage during any open enrollment periods, and, upon request, to any covered employee and any person interested in obtaining coverage.

(6) The grid may contain several columns comparing the benefits of the different plans available to the employer's employees, which shall also conform to this regulation.

b. Where employees of an employer or members of a health care purchasing cooperative are given a choice of two or more plans, the form may be further modified as follows. Where a specific benefit for all plans is the same, the comparison grid may simply describe that same benefit once, across all columns, for all plans, or state "see rider" across all columns, for all plans. For example:

EXAMPLE

.	HMO A	HMO B	PPO Z
.	.	In-Network	Out-of- Network
28. DENTAL CARE	See rider.	See rider.	See rider.
29. VISION CARE	All plans cover up to $50 per year toward eyeglasses.	All plans cover up to $50 per year toward eyeglasses.	All plans cover up to per year toward eyeglasses.

c. Nothing in this regulation shall be construed to require an employer to develop or use a grid for comparing employee benefit plan choices.

H. With respect to the specific Colorado Health Benefit Plan Description Form required to be made available by carriers pursuant to Part E(1) of Section 4, a carrier shall develop a separate Colorado Health Benefit Plan Description Form for each of its policies, contracts, and plans of benefits. If a carrier offers a policy with a choice of copayments, coinsurance levels, deductibles, lifetime maximums, annual maximums, and/or other benefit maximums, minimums or restrictions, the carrier shall provide a separate Colorado Health Benefit Plan Description Form specific to the particular benefits of the policy being sold, marketed, or that is in place.

I. The Colorado Health Benefit Plan Description Form is designed to be a stand-alone piece describing a

health benefit plan. The forms should not include attachments, except that a carrier may:

1. Attach a list of exclusions developed pursuant to Part K of Section 4 of this regulation;

2. Attach information on premiums;

3. Attach information on riders;

4. Include as an attachment information specifying the plan's cancer screening coverages and their respective parameters, as required by Section 10-16-108.5(11)(c), C.R.S.;

5. Include at the end of the form or as an attachment 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 Section 10-16-704(1), (2) and (9), C.R.S.); or

6. Include the Optional Attachment, "Selected Benefit Descriptions," that appears at the end of the Colorado Health Benefit Plan Description Form.

J. A carrier shall make a list of policy exclusions available immediately upon request (but in no event more than three (3) business days after the request) for each of its health benefit plans.

K. The Colorado Health Benefit Plan Description Forms developed for each policy, contract, and plan of benefits shall be in standard, easy-to-read type sizes and fonts, of no less than 10 points.

Section 5. Enforcement

Noncompliance with this regulation is a violation of Section 10-3-1104, C.R.S., and subject to the sanctions specified in Section 10-3-1108, C.R.S., including the imposition of fines and the suspension or revocation of insurance licenses and/or certificates of authority.

Section 6. Severability

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

Section 7. Effective Date

This amended regulation is effective on July 1, 2007.

Section 8. History

- Hearing date: September 10, 1997; Effective: November 15, 1997

- Hearing date: August 4, 1998: Effective date: September 30, 1998.

- Amended Sections 1,2,3,4,7, Appendix A, and Appendix B.

- Hearing date: March 2003, Effective: January 1, 2004.

- Hearing date: August 4, 2004; Effective: January 1, 2005

- Amended effective July 1, 2007.

NOTE: An unofficial copy of this amended regulation, including the description form, is available on the

Colorado Division of Insurance web site on the Internet at: http://www.dora.state.co.us/insurance/regs

Appendix A Colorado Health Benefit Plan Description Form

Appendix A

Colorado Health Benefit Plan Description Form

_____
Name of Carrier

_____
Name of Plan

Part A: TYPE OF COVERAGE

1. TYPE OF PLAN	
2. OUT-OF-NETWORK CARE COVERED?[1]	
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. Deductible Type[2]		
4a. ANNUAL DEDUCTIBLE[3][4] a) [Individual] [Single][4a] b) [Family] [Non-single][4b]		
5. OUT-OF-POCKET ANNUAL MAXIMUM[5] a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?		
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE		
7A. COVERED PROVIDERS		
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?		Not applicable.
8. MEDICAL OFFICE VISITS[6] a) Primary Care Providers b) Specialists		
9. PREVENTIVE CARE a) Children's services b) Adults' services		
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care[7]		
11. PRESCRIPTION DRUGS[8] Level of coverage and restrictions on prescriptions.		
12. INPATIENT HOSPITAL		
13. OUTPATIENT/AMBULATORY SURGERY		
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services		
15. EMERGENCY CARE[9][10]		
16. AMBULANCE		
17. URGENT, NON-ROUTINE, AFTER HOURS CARE		
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]		
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care		
20. ALCOHOL & SUBSTANCE ABUSE		
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY		
22. DURABLE MEDICAL EQUIPMENT		
23. OXYGEN		
24. ORGAN TRANSPLANTS		
25. HOME HEALTH CARE		
26. HOSPICE CARE		
27. SKILLED NURSING FACILITY CARE		
28. DENTAL CARE		
29. VISION CARE		
30. CHIROPRACTIC CARE		
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)		

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[11]	
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?		
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?		
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?		
39. What is the main customer service number?		
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]		
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?		
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.		
43. Does the plan have a binding arbitration clause?		

Endnotes

1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2 "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement".

2a "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

2b "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

2c "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

3 "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

4 Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.

5 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

6 Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

7 "Emergency care" means all services delivered in an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

8 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

9 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

10 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

11 Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Optional Attachment

Selected Benefit Descriptions
Colorado Health Benefit Plan Description Form Addendum

Name of Carrier

Name of Plan

Individual/Group Name and/or Number (optional)

Benefit	Benefit Level
4. Deductible Type	
4a. ANNUAL DEDUCTIBLE a) [Individual] [Single] b) [Family] [Non-single]	
5. OUT-OF-POCKET ANNUAL MAXIMUM a) Individual b) Family	
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions.	
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	
20. ALCOHOL & SUBSTANCE ABUSE	
22. DURABLE MEDICAL EQUIPMENT	
28. DENTAL CARE	
29. VISION CARE	
30. CHIROPRACTIC CARE	

Appendix B Directions for Filling Out the Colorado Health Benefit Plan Description Form

TOP OF FORM

Carrier and plan names. Fill in complete carrier name on the first line and the name of the plan on the second line. Plans 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.

PART A: TYPE OF COVERAGE

Question 1, Type of Plan . Enter type of plan. Select one of the following choices only: (1)"Medical expense policy," (2) "Hospital expense policy," (3) "Preferred provider plan," (4) "Health maintenance organization (HMO)," (5) "Point of service (i.e., an HMO plan with some out-of-network benefits)," or (6) "Limited service licensed provider network (LSLPN) plan." Note: Plans that have in-network and out-of-network benefits that are not offered by an HMO but which use gatekeepers should enter "Preferred Provider Plan."

Question 2, Coverage for Out-of-Network Care . Indicate if out-of-network care is covered. Select one of the following choices only: (1) "Only for emergency care" ; (2) "Only for emergency and urgent care" ; (3) "Only for specified services; patient pays more for such out-of-network care" [e.g., POS plans]; (4) "Yes, but patient pays more for out-of-network care." [e.g., PPO's]; (5) "Yes; policy makes no distinction between in-network and out-of-network care." [e.g., traditional indemnity plans]. (6) 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, 12 pt. caps:

“INTERESTED POLICY HOLDERS, 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, 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 over state or county lines.

PART B: SUMMARY OF BENEFITS

Questions 4-31: General Directions.

- If the plan has separate in-network and out-of-network benefits (e.g., preferred provider plan), use two columns and label them “In-network” and “Out-of-network.”

- If the plan does not make such a distinction (e.g., traditional indemnity plan) replace two columns with a single column labeled “Benefit Levels.”

- HMOs may use one rather than two columns to describe their benefits. HMOs that decide to use one column only should label that column as follows: "In-Network Only (out-of network care is not covered except as noted)." Wherever the plan does provide out-of-network care (e.g., emergency care), this should be noted in the appropriate boxes describing benefits. Point of service plans and preferred provider plans should continue to use two columns—one for in-network and one for out-of-network coverage—to describe their plans.

- For questions 4-6, 11, 19-20, 22 and 28-30, carriers may write in “See benefit schedule attached” and show actual benefit levels on a separate schedule attached to the form. Carriers that choose to use a separate schedule for the designated questions shall use the form labeled “Selected Benefit Descriptions,” which is found at the end of the description form and labeled Optional Attachment. The same rules apply for filling out the boxes on this optional form as on the main description form.

  Question 4, Deductible Type* . Enter “Calendar Year” or “Benefit Year” . If the deductible is anything other than per calendar or benefit year, the specific requirements must be disclosed here.

  Question 4a, Annual Deductible* . Specify “Individual” and “Family” for non-HSA qualified plans or “Single” or “Non-single” for HSA-qualified plans. Enter applicable “individual” or “single” and “family” or “non-single” annual deductibles for the plan as a whole. Indicate whether they are aggregate or separate deductibles. Carriers shall identify what services are subject to the deductible by making a text notation next to those services in items 8 through 31 of the Colorado Health Benefit Plan Description Form. If the plan does not require deductibles, enter “No deductibles.”

  Question 5, Out-of-Pocket Annual Maximum* . Enter applicable out-of-pocket individual and family annual maximums. If the out-of-pocket maximum excludes deductibles and/or copayments, so indicate. If the plan has combined in-network and out-of-network annual out-of-pocket maximums, so indicate. Carriers may identify what deductibles and copayments are included in calculating the out-of-pocket maximums by making a text notation next to any applicable deductibles or copayments in items 8 through 31 of the Colorado Health Benefit Plan Description Form. If the plan has no out-of-pocket maximum, enter “No out-of-pocket maximum.”

Question 6, Lifetime/benefit Maximum* . Enter lifetime maximum (e.g., "$2 million") and other benefit maximums that apply to the whole policy (e.g., "$50,000 per year" or "$20,000 per episode of care"). If lifetime/benefit maximums apply to both in-network and out-of-network expenses, so indicate. If the plan has no lifetime maximum, enter "No lifetime maximum."

Question 7A, Covered Providers . Indicate covered providers. Select one of the following choices only: (1) "[Insert name of provider network]. See provider directory for complete list of current providers" ; (2) "[Insert total number] physicians and [Insert total number] hospitals in Colorado as of [insert date]. See provider directory for complete list of current providers" ; or (3) "All providers licensed or certified to provide covered benefits."

Question 7B, Accessibility of Providers . One purpose of this question is to get at the so-called "pod" issue. In some plans, once an enrollee selects a PCP, that PCP only refers to a selected subset of otherwise covered network providers, sometimes called a pod. The subset is usually a physician-hospital network that has made special arrangements with the carrier concerning provider payment. An enrollee who wants to be referred to a specialist who is covered by his plan as a network provider but who is not part of his PCP's pod would have to select a new PCP who practices in the same pod as the specialist in order to get a referral. Select one of the following choices only: Network plans using this kind of pod system should answer "No" ; all other network plans should answer "Yes" . If the answer depends on the service area or some other factor, so indicate (e.g., "Yes, except in Denver and Adams County.")

A note should be added if the Plan includes network providers located over state or county lines.

Plans that do not use networks should enter: "Not applicable. This is not a network plan."

Questions 8-30: General Directions.

Show benefit levels, including copayments, coinsurance, and other applicable payment. If deductibles or copayments can vary by provider, disclose how this will apply. Indicate significant benefit limits. If per diem, annual, or per visit maximums apply, show them. If separate deductibles apply, so indicate. Examples: "80% for up to 6 visits per year," or "80% for generic drugs only," or "$10 per visit copayment," or "$50 per day up to $500 per year," or "50% after separate $100 per year physical therapy deductible," or "50% for 2 acute care detoxifications per year." If no coverage is provided for a category of benefit write in "Not covered." If full coverage is provided, write in "No copayment (100% covered)" . Coinsurance options should reflect the carrier's reimbursement level.

HMOs that use one rather than two columns to describe their benefits should note in the appropriate boxes where the plan does cover out-of-network care (e.g., emergency care).

Question 8, Medical Office Visits . Indicate coverage for primary care provider and specialist services separately.

Question 9, Preventive Services . Carriers are reminded that Colorado law has benefit mandates regarding the coverage of children's preventive services (all individual and group health benefit plans). Indicate coverage for children's and adult preventive services separately. A complete, detailed list of services does not need to be provided.

Question 10, Maternity. Carriers are reminded that Colorado law has benefit mandates regarding maternity care coverage (employer group plans only). Indicate coverage for prenatal care and for delivery and inpatient well baby care separately.

Question 11, Prescription Drugs* . Indicate the amount of coverage for prescription drugs. Also indicate whether the level of coverage is based on generic versus brand name drugs, use of a

prescription drug card, and/or other requirements. Note if separate copayments and deductibles apply. Examples: “Separate $100 deductible. $8 copayment per prescription” ; or “80% generic; 50% brand name drugs” ; or “90% with prescription drug card. Maximum benefit of $200/month” ; or “$5 per prescription for drugs on our approved list only.” If a formulary is used, add this statement: “For drugs on our approved list, contact [position title], at [telephone number].”

Questions 12 and 13, Inpatient Hospital and Outpatient/Ambulatory Surgery. See General Directions for Questions 8-30, above.

Question 14, Laboratory & X-ray . If coverage, copayments, or deductibles for diagnostic benefits vary depending on whether they are associated with a medical office visit, so indicate.

Questions 15, 16 and 17, Emergency Care, Ambulance, and Urgent Care . If copayments or deductibles differ by service among emergency care, ambulance, or urgent care, so indicate.

Question 18, Biologically Based Mental Illness Care . For group plans issued or renewed on or after January 1, 1998, carriers must enter: “Coverage is no less extensive than the coverage provided for any other physical illness.”

Question 19, Other Mental Health Care* . Carriers are reminded that Colorado law has benefit mandates for group plans regarding the coverage of other, non-biologically based mental health conditions. If coverage varies depending on whether inpatient or outpatient, so indicate.

Question 20, Alcohol & Substance Abuse* . See General Directions for Questions 8-30, above. If coverage varies depending on whether the care is inpatient or outpatient, so indicate. Also indicate if coverage varies depending on whether care is for alcohol versus other substance abuse.

Question 21, Physical, Occupational and Speech Therapy. If benefit levels vary, so indicate. Example: “Physical therapy: 50% maximum for up to six visits per event; Occupational: 80%; Speech: not covered.” If coverage varies depending on whether inpatient or outpatient, so indicate.

Question 22, Durable Medical Equipment* . Carriers must indicate benefit level. Carriers may also add the following statement: “See policy for types and circumstances of coverage.” If coverage varies depending on whether inpatient or outpatient, so indicate.

Questions 23, 24, 25, 26 and 27 . See General Directions for Questions 8-30, above. If coverage varies depending on whether inpatient or outpatient, so indicate.

Questions 28-30, Dental Care, Vision Care and Chiropractic Care* . Briefly describe coverage, if any, and note if coverage may be obtained either under a separate dental/vision/chiropractic care plan or as an optional benefit. If no coverage is provided, write in “No coverage” .

Question 31, Significant Additional Covered Services . You may list up to five additional covered benefits not already asked about in questions 10-30. Examples: acupuncture; other alternative medical treatments; transportation. Information specifying the plan’s cancer screening coverages, as required by Section 10-16-108.5(11)(c), C.R.S., must be included in box 31 if it is not included at the end of the form or attached as allowed by Section 4.I.4. of this regulation. Information regarding cancer screening coverages counts as only one (1) of the five (5) additional services that can be listed in this box.

PART C: LIMITATIONS AND EXCLUSIONS

Question 32, Pre-existing Condition Exclusion Period. Select one of the following choices only: (1) “____

months [insert the length of the limitation period] for all pre-existing conditions" ; (and for business groups of one the limitation period may not exceed 12 months.) (2) "____ months [insert the length of the limitation period] for selected pre-existing conditions only; no pre-existing condition limitation for all other conditions. See policy for details." ; (3) "Not applicable; plan does not impose limitation periods for pre-existing conditions." (4) "This individual short-term health benefit plan does not cover pre-existing conditions." Note: For group plans (except business groups of one) the limitation period may not exceed six (6) months; for business groups of one the limitation period may not exceed 12 months. Individual carriers that use pre-existing exclusion periods shall also add the following to their answer: "unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions." This additional language is not applicable to individual short-term health benefit plans. Carriers are reminded that Colorado law governs allowable pre-existing periods for all health benefit plans.

Question 33, Exclusionary Riders . All group carriers must enter "No" . Depending on the policy, individual carriers should enter "Yes" or "No."

Question 34, Definition of a Pre-existing Condition . Enter the definition of a pre-existing condition under this policy. Select one of the following choices only: (1) "Not applicable. Plan does not exclude coverage for pre-existing conditions." ; (2) for group plans: "A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last ___ [insert a number not to exceed 12 for business groups of one and not to exceed 6 for all other group plans] months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy" ; (3) for individual plans: "A pre-existing condition is an injury, sickness or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within ___ [insert a number not to exceed 12] months immediately preceding the effective date of coverage." ; or (4) for individual short-term health benefit plans: "Pre-existing conditions are not covered."

Question 35, Policy Exclusions . All carriers must enter the following language: "Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy." On demand, carriers must give applicants and insureds a complete list of exclusions. Carriers are encouraged, but not required, to list the exclusions in alphabetical order (e.g., custodial care; enteral feedings; growth hormone therapy; health services which are not medically necessary; travel or transportation expenses except for ambulance).

PART D: USING THE PLAN

Questions 36-38: General Directions . If the plan has separate in-network and out-of-network benefits, use two columns and label them "In-network" and "Out-of-network." If the plan does not make such a distinction (e.g., a traditional indemnity plan), replace two columns with a single column labeled "Using the Plan."

Questions 36, 37, and 38, Specialty Care, Surgical Procedures, and 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 (e.g., "Yes, except for obstetrical or gynecological care.")

Question 39, Customer Service Number . Enter your main customer service number for members/insureds.

Question 40, Filing Complaints . Enter name, address and phone number for complaints and grievances.

Question 41, Dissatisfaction With Resolution of Consumer Complaint . Except as noted, all plans enter:

“Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, CO 80202.”

Question 42, Form Number, Group Size, and Short-Term . Enter the policy form number by writing “Policy form # ___ [fill in]” . Indicate whether this is an individual, small, or large group policy. Select one of the following choices only: (1) “Individual” , (2) “Small group only” , (3) “Large group only” , or (4) “Group--all sizes.” Indicate if policy is short-term by writing “short term policy.” Examples: “Policy form # CO-1247, large group.” or “Policy form # 12-30-7, individual, short-term.” Note: If a carrier offers the identical policy in several markets (e.g., large group market, small group market, etc.) then multiple responses may be included here (e.g., "Policy form #CO-1247 large group, and #CO-807 small group."

Question 43, Binding Arbitration . Indicate, with a “Yes” or “No” , if the plan has binding arbitration.

OPTIONAL ATTACHMENT: SELECTED BENEFIT DESCRIPTIONS

Carriers are not required to use this form. At the carrier's option, with respect to questions 4-6,11, 19-20, 22, and 28-30 only, a carrier may describe its benefits with respect to these items on the optional attachment instead of on the main form. A carrier that chooses to do this must write in "See benefit schedule attached" for the designated questions and shall use the form labeled “Selected Benefit Descriptions,” which is found at the end of the description form and labeled Optional Attachment. The same rules apply for filling out the boxes on this optional form as on the main description form. Carriers using the optional attachment must attach it to all health plan description forms.

Endnote:

* For questions 4-6, 11, 19-20, 22 and 28-30, carriers may write in “See benefit schedule attached” and show actual benefit levels on a separate schedule attached to the form. Carriers shall use the form labeled “Specific Benefits Selected” which is shown as the Optional Attachment at the end of the form in Appendix A.

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 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-16-109, 10-16-113(3)(b) 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 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

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. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

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

C. "Carrier's adverse determination" means an adverse determination, as defined in Colorado Insurance Regulation 4-2-17, involving a covered benefit that has been upheld by a carrier at the completion or exhaustion of at least one of the carrier's internal appeal processes as set forth in Colorado Insurance Regulation 4-2-17. It also includes 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.

D. “Case management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

E. “Certification,” as used in the definition of "utilization review," means 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.

F. “Clinical review criteria” means 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.

G. “Concurrent review” means utilization review conducted during a patient’s hospital stay or course of treatment.

H. “Covered benefits” or “benefits,” means those health care services to which a covered person is entitled under the terms of a health coverage plan.

I. “Covered person” as defined in § 10-16-102(13.5), C.R.S.

J. “Designated representative” means:

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; or

3. In the case of an urgent care request, a health care professional with knowledge of the covered person’s medical condition.

K. “Discharge planning” means 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.

L. “Disability” shall mean, 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. “Facility” means 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.

N. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

O. “Health care services” means services for the diagnosis, prevention, maintenance, treatment, cure or relief of a health condition, illness, injury or disease.

P. “Health coverage plan” as defined in § 10-16-102(22.5), C.R.S.

Q. “Prospective review” means utilization review conducted prior to an admission or a course of

treatment.

R. “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.

S. “Retrospective review” means 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.

T. “Second opinion” means 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 clinical necessity and appropriateness of the initial proposed health service.

U. “Utilization review” means 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 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. 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 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. 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 or the covered person’s designated representative the opportunity to submit new information and including any forms used to process an external review, as specified by the Division of Insurance.

2. 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 will 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 first level review or within sixty (60) calendar days after the date of receipt of a notice of a carrier's adverse determination following the completion of a voluntary second level review, a covered person or the covered person's designated representative may file a 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 of Insurance.

C. A covered person or a covered person's designated representative requesting an expedited external review must include a request for an expedited review in the written request described in subsection A. of this section 6.

D. 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.

E. A request for external review submitted by the covered person or the covered person's designated representative may include new information, if significantly different from information provided or considered during the internal review process, for consideration by the carrier and the independent external review entity.

F. 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 of Insurance. A copy of the denial shall be sent to the Division of Insurance at the same time it is sent to the covered person or, if applicable, the covered person's designated representative.

G. 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 shall include the specific reasons for the denial and shall provide information about appealing the denial of the request with the Division of Insurance. A copy of the denial shall be sent to the Division of Insurance at the same time it is sent to the covered person or, if applicable, the covered person's designated representative.

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) working days.

2. If the carrier, before the expiration of the deadline for sending notification to the Commissioner, reverses its adverse determination based on new information submitted by the covered person or the covered person's designated representative pursuant to section 6, subsection E., the carrier must notify the covered person or the covered person's designated representative within one (1) working day of its reversal, electronically, by facsimile, or by telephone, followed by a written confirmation.

B. Division of Insurance requirements.

1. Within two (2) working 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, by facsimile, or by telephone, followed by a written confirmation, 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 within one (1) working day the covered person or the covered person's

designated representative, 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 or the covered person's designated representative 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) working days of receipt of notice from the carrier, the covered person or the covered person's designated representative 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) working day, another 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, by facsimile, or by telephone, followed by a written confirmation, 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 or the covered person's designated representative 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) working days of receipt of the notice from the carrier, the covered person or the covered person's designated representative 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) working days. The independent external review organization shall forward this information to the carrier within one (1) working day of receipt.

5. In reaching a decision, the independent external review entity is not bound by any decisions or conclusions reached during the carrier's utilization review process or the carrier's internal appeal process as set forth in Colorado Insurance Regulation 4-2-17.

C. Carrier requirements to provide documents and information.

1. Within five (5) working 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 or covered person's designated representative 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) working 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 or the covered person's designated representative the index of all materials that the carrier has submitted to the independent external review entity. The carrier shall provide to the covered person or covered person's designated representative, 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 or the covered person's designated representative, 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) working days of such a request, the covered person or the covered person's designated representative 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 covered person's designated representative or the health care professional of the covered person fails to provide the additional information or the explanation of why additional information is not being submitted within the timeframe specified in subparagraph a. of this paragraph 3., the independent external review entity shall make a decision based on the information submitted by the carrier as required by paragraph 1. of this subsection C.

4. Failure of the carrier to provide documents and information.

a. If the carrier fails to provide the required documents and information within the time specified in paragraph 1. of this subsection C., the independent external review entity may terminate the external review and make a decision to reverse the carrier's adverse determination.

b. Immediately upon the reversal under subparagraph a. of this paragraph 4., the independent external review entity shall notify the covered person, if applicable, the covered person's designated representative, 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) working day of making the decision to reverse its adverse determination, as provided in paragraph 3., the carrier shall notify the covered person or the covered person's designated representative, 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, the covered person's designated representative, 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. Notwithstanding the requirements of § 10-16-113.5(10), C.R.S., within forty-five (45) days after the date of receipt of the request for external review by the independent external review entity, it shall:

a. Make a decision to uphold or reverse the carrier's adverse determination; and

b. Provide a written notification of its decision to the following:

(1) The covered person;

(2) If applicable, the covered person's designated representative;

(3) The carrier;

(4) The physician or other health care professional of the covered person; and

(5) The Commissioner.

2. In addition to the requirements of § 10-16-113.5(10), 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) working day.

b. For retrospective reviews, the carrier shall approve the coverage within five (5) working 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) working 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 or the covered person's designated representative 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 pursuant to paragraph 1. of this subsection A., the carrier shall notify and send a copy of the request to the Commissioner within one (1) working day electronically or by telephone or facsimile or any other available expeditious method.

B. Division of Insurance requirements.

1. Within one (1) working 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) working day of notice from the Commissioner pursuant to paragraph 1. of this subsection B., the carrier shall notify the covered person or the covered person's designated representative, 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, the covered person's designated representative, 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(10), 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; and

   b. Provide a notification of the decision to the following:

      (1) The covered person;

      (2) The covered person's designated representative, if applicable;

      (3) The carrier;

      (4) The covered person's physician; and

      (5) 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, if applicable, the covered person's designated representative, 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 provided 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)(c), 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 of Insurance 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, 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 suspension or revocation of licenses or certificates of authority. Among others, the penalties provided for in § 10-3-1108, C.R.S., may be applied.

Section 17 Effective Date

This amended regulation shall be effective on September 1, 2011.

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.

Regulation 4-2-22 INSURER ASSESSMENTS FOR COVERCOLORADO

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109, 10-8-520, and 10-8-530(1.5), C.R.S.

Section 2 Scope and Purpose

CoverColorado was created by legislation in 1990 to provide access to health insurance for those Colorado residents who are termed “high risk” because they are unable to obtain health insurance or unable to obtain health insurance except at prohibitive rates or with restrictive exclusions. In order to keep up with the rising medical care costs for eligible individuals, § 10-8-530(1.5), C.R.S. was enacted to permit CoverColorado to assess special fees against certain insurers in Colorado, as necessary, to pay projected administrative expenses and losses of the program. Such special fees will be used to supplement premiums and other sources of funding, as set forth in § 10-8-530(1), C.R.S., received by the program.

The purpose of this regulation is to establish the procedures for the assessment of special fees for the CoverColorado program.

Section 3 Applicability

This regulation shall apply to insurers that are assessed special fees by CoverColorado.

Section 4 Definitions

For the purposes of this regulation, the following terms shall have the meanings set forth below:

A. "Benefit design weighted average" means the average actuarial value of the benefits provided under all plans issued in Colorado by the insurer during the previous year, weighted by enrollment in each plan.

B. "CoverColorado" is the Colorado program which provides health insurance for those individuals who are termed "high risk" because they are unable to obtain health insurance or are unable to obtain health insurance except at prohibitive rates or with restrictive exclusions. The program is described in §10-8-501 et seq., C.R.S.

C. "Eligible Individual" is either:

1. A resident of this state who meets the eligibility requirements set forth in §10-8-513, C.R.S.; or

2. An individual who meets the eligibility requirements for a federally eligible individual, as set forth in §10-8-513.5, C.R.S.

This term does not include the dependents of eligible individuals.

D. "Group health plan" has the same meaning as set forth in §10-16-105.5(1)(a), C.R.S.

E. "Higher level health benefit plan design" means a health plan benefit design for which the actuarial value of the benefits is at least one hundred percent (100%) but not greater than one hundred twenty percent (120%) of the benefit design weighted average.

F. "Insurer" is any entity that provides group or individual health benefit plans, as that phrase is defined in §10-16-102(21), C.R.S., and is subject to state insurance regulation in this state, as well as any entity, including a property and casualty insurance company, that, directly or indirectly, provides stop-loss or excess loss insurance to a self-insured group health plan.

G. "Lower level health benefit plan design" means a health benefit plan design for which the actuarial value of the benefits is at least eighty-five percent (85%) but not greater than ninety-nine percent (99%) of the benefit design weighted average.

H. "Total funding for the program" means the amount needed in a given calendar year to fund projected claims, administrative expenses, reserves for claims incurred but not reported, and amounts need to ensure that CoverColorado maintains a surplus equal to five percent (5%) of the projected annual claims of the program.

I. "Unexpected growth" means an increase in program enrollment or claims expenses in a calendar year of more than one hundred fifteen percent (115%) of the amount of the projected growth in program enrollment or claims expenses of that calendar year.

Section 5 Annual Report of Lives

A. On March 1 of each year, each insurer shall report to CoverColorado, on the prescribed form:

1. The total number of employees ex-employees covered under a COBRA or Colorado continuation policy, retired employees or individual policyholders or subscribers enrolled in all, of its health benefit plans offered in this state; and

2. The number of employees/retired employees for whom a premium is paid and coverage is provided under an excess loss, stop-loss or reinsurance policy issued by such insurer to an employer or group health plan in this state as of January 31 of that year

B. The Annual Report of Lives shall not include any employees, retired employees or individual policyholders or subscribers who receive health benefits through Medicare, Medicaid, the Children's Basic Health Plan (pursuant to article 8 of title 25.5, C.R.S.), or the Federal Employees Health Benefit Plan.

C. Insurers providing stop-loss, excess loss or reinsurance are permitted to exclude from their Annual Report of Lives those employees/retired employees or individual policyholders/subscribers who have been counted by the primary carrier or primary reinsurer.

Section 6 Determination of Amount of Special Fee Assessment to Each Insurer

A. For calendar year 2009 and thereafter, CoverColorado shall, on an annual basis and by August 1 of the preceding calendar year, determine the amount of special fees needed to pay twenty-five (25%) of the total funding for the program. The total funding for the program for any calendar year shall be determined by the board based on the incurred claims and administrative expenses of the program in the immediately preceding calendar year, the expected annual program growth, existing cash balances and interest earned thereon, and other actuarial considerations of the program. The projections shall not include any costs related to any dependent coverage offered by CoverColorado.

B. The amount of special fees needed by CoverColorado pursuant to subsection 6.A. shall be assessed in an equitable manner upon insurers, as follows:

1. The amount of special fees shall be divided by the total number of employees, retired employees and individual policyholders or subscribers reported by all insurers, to arrive at a per capita amount.

2. The special fee assessed to each insurer shall be equal to the number of employees and retired employees or individual policyholders or subscribers reported in the month of March immediately preceding multiplied by the per capita amount

C. In no event shall CoverColorado increase the amount of special fees to be collected from insurers in any calendar year because of unexpected growth during that calendar year. If CoverColorado's incurred administrative expenses or losses exceed the amounts collected through special fees and other sources in any calendar year, the amount needed to pay for such excess expenses and losses shall be requested from the Colorado Unclaimed Property Trust Fund in accordance with § 10-8-530(1)(d), C.R.S.

Section 7 Notice and Collection of the Assessed Special Fees

A. Each insurer shall receive written notice of the special fee to be paid by such insurer in a calendar year no later than August 15 of the preceding calendar year. Each notice of a special fee shall include:

1. The per capita amount, determined as in subsection 6.B.1 above;

2. A calculation of the special fee due and owing (based on the per capita amount multiplied by the number of employees and retired employees of individual policyholders or subscribers reported in the month of March immediately preceding issuance of the notice); and

3. A summary of the projections and underlying assumptions which support the need for the special fee in general and the per capita amount in particular.

B. Each insurer shall pay the special fees to CoverColorado in four installments, with the first installment due on March 31, the second installment due on June 30, the third installment due on September 30, and the fourth installment due on December 31 of each calendar year.

C. CoverColorado, or its designated agent, shall collect all assessed special fees and deposit the fees into the accounts specifically maintained by the CoverColorado board for this purpose. Any amounts not immediately needed to pay the expenses and losses for eligible individuals shall be invested by the board in accordance with the investment guidelines adopted by the board and filed with the Division of Insurance as part of CoverColorado's plan of operations.

D. If the special fees collected in any calendar year exceed the amount actually needed, the excess shall be invested by the board in accordance with the investment guidelines adopted by the board and filed with the Division of Insurance as a part of CoverColorado's plan of operations and shall, in accordance with subsection 6.A. above, be included as funds held by CoverColorado when the next projections are made.

E. In the event that any insurer fails to pay its special fee as assessed by CoverColorado, CoverColorado shall send one notice of nonpayment thirty (30) days after March 31, June 30, September 30, or December 31. If CoverColorado has not received payment of all amounts due from an insurer within thirty (30) days after the date of the notice of nonpayment, CoverColorado shall report same to the commissioner.

F. An insurer receiving a certificate of authority to do business in the State of Colorado market on or after the date of issuance by CoverColorado of a special fee assessment notice shall receive notice of the special fee at the time of licensure and shall be liable for a prorated amount of the special fee due and owing in the calendar year of licensure. Thereafter, a new insurer shall be liable for the special fee in the normal course of the assessment process.

G. Any insurer withdrawing from the Colorado market after a special fee assessment notice has been issued shall be liable for a prorated amount of the assessment owing in that calendar year and shall not be liable for any assessment owing thereafter. The date of withdrawal shall be the date on which the last contract or policy of the insurer in Colorado expires, is terminated by the insurer in accordance with Colorado insurance laws or is voluntarily terminated by the policyholder/subscriber, whichever is sooner. Any insurer discontinuing a type of health coverage (e.g. small group coverage) in the Colorado market shall be liable in the calendar year of discontinuation for a prorated amount of the assessment due an owing in that calendar year, and the amount of assessment due and owing shall be calculated pursuant to subsection 6.B., regardless of any reduction in the number of employees and retired employees or individual policyholders or subscribers in that calendar year by reason of the discontinuation.

Section 8 Deferral of or Credit Against Special Fees

A. Any insurer that believes that the payment of special fees would endanger its financial ability to fulfill its contractual obligations to its insureds may submit, no later than October 1 of the year preceding the calendar year for which payment is due, a written request for deferral of the payment of its assessed special fees to the commissioner, with a copy sent to CoverColorado. The written request for deferral shall be accompanied by certified copies of statutory annual and quarterly statements and any other documents necessary to demonstrate the claimed adverse financial position. Based on the Division of Insurance's risk-based capital guidelines, the commissioner may defer, in whole or in part, payment of the special fees owing for the coming the calendar year. The commissioner's determination regarding deferral shall be made no later than November 1 (e.g.within thirty (30) days of receipt of a written request for deferral), with written notice of the determination sent to CoverColorado. The insurer receiving the deferment shall

remain liable to CoverColorado for the deferred amount, and the deferred amount shall be incrementally reassessed to the insurer over such period as is deemed reasonable by CoverColorado, in consultation with the commissioner and the insurer, but in no event longer than three (3) years.

B. In the event a special fee assessed against an insurer is deferred, in whole or in part, the amount by which the special fee is deferred may be assessed against the other insurers in a manner consistent with the basis for assessments set forth in section 6 above (the resulting additional special fees shall be called “excess special fees”). Written notice of excess special fees shall be sent to all insurers no later than January 1 of the calendar year of payment. Such excess special fees amount shall be included by the insurer in its March 31 payment of previously assessed special fees to CoverColorado. As the deferred assessment is repaid in subsequent assessments by the deferring insurer, as provided in subsection 8.A. above, each insurer that paid such excess special fees shall receive a pro rata credit for its share of previously paid excess special fees.

C. An insurer shall be entitled to a credit, in the amount set forth in subsection 8.D. below, against special fees assessed (exclusive of excess special fees) if it meets any of the following criteria and has enrolled the required number of individuals in the health benefit plans described during the previous twelve-month period:

1. Any insurer that voluntarily and actively markets and offers, continuously over the twelve-month period preceding the calendar year in which a special fee assessment is due and owing, two different individual health benefit plans to an applicant who has a medical condition on the presumptive conditions list maintained by the CoverColorado board, with the premium for such plans no higher than 125% of the rate charged for a similarly situated (considering age and geographic location) but medically acceptable applicant. The two different plans shall be either:

    a. The two plans that are generally available and actively marketed to the public and are the plans with the largest and next to largest premium volume of all individual health benefit plans offered by the insurer in this state; or

    b. A lower level health benefit plan design and a higher level benefit plan design, both of which include benefits similar to other individual health benefit plans offered in the state.

2. Any insurer that voluntarily and actively offers, continuously over the twelve-month period preceding the calendar year in which a special fee assessment is due and owing, two different small group health benefit plans to an applicant who is a business group of one under all of the following conditions:

    a. Outside of the open enrollment periods established by §10-16-105(7.3)(i), C.R.S.; and

    b. Without regard to the health status of the applicant or any dependents.

    The two different plans shall meet either of the criteria set forth in subsections 8.C.1(a) and (b) above, except that the two plans are those offered by the insurer to small groups, including business groups of one, in Colorado.

3. Any insurer that voluntarily and actively offers, continuously over the twelve-month period preceding the calendar year in which a special fee assessment is due and owing, two different individual conversion health benefit plans to an applicant,

    a. Without regard to the health status of the applicant; and

b. At a premium rate that is 10% or more below the CoverColorado rate for a similarly situated individual (considering age, sex, smoking status and geographic location).

The two different plans shall meet one of the criteria set forth in subsections 8.C.1(a) and (b) above.

D. Under any of the criteria in subsections 8.C.1., 8.C.2. or 8.C.3. above, the insurer shall be entitled to a credit against any special fee assessment due and owing in a calendar year equal to three percent (3%) for enrolling the following number of individuals in the above-described plans during the preceding twelve-month period:

1. If the number of employees/retired employees or individual policyholders/subscribers reported by an insurer on its annual report to CoverColorado (pursuant to subsubsection 5.A. above) is 25,000 or less, 25 individuals;

2. If the number of employees/retired employees or individual policyholders/subscribers reported by an insurer on its annual report to CoverColorado is more than 25, 000, but less than 75,000, 50 individuals; or

3. If the number of employees/retired employees or individual policyholders/subscribers reported by an insurer on its annual report to CoverColorado is 75,000 or more, 100 individuals.

E. Any insurer that believes that it is entitled to a credit shall submit a written request for credit, along with supporting documentation satisfactory to the commissioner, of compliance with subsections 8.C.1., 8 C.2. or 8.C.3. above no later than March 1 of the calendar year in which any assessment is due and owing.

F. The commissioner shall make a determination regarding a credit within sixty (60) days of submission of a written request. All credits will be reported by the commissioner to CoverColorado.

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, after proper notice and hearing, in the suspension or revocation of the certificate of authority to transact insurance business in this state of any insurer which fails to pay a special fee assessment.

Section 11 Effective Date

This amended regulation shall become effective on January 1, 2010.

Section 12 History

New regulation effective on January 1, 2002.

Amended, effective July 1, 2002

Amended, effective September 1, 2008.

Amended, effective January 1, 2010.

Regulation 4-2-23 Procedure for Provider-Carrier Dispute Resolution

Section 1 Authority

This regulation is promulgated pursuant to § § 10-1-109, 10-3-1110, 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. "Necessary information" 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.

B. "Participating provider" shall have the same definition as in § 10-16-102(28.5), C.R.S. and includes any provider that enters into an agreement with a carrier for the provision of a particular health care service or services to a particular insured or insureds.

C. "Provider-carrier dispute" means 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.

D. "Provider-carrier dispute log" means 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 and patient name;

d. The member number;

e. The date of service;

f. The disputed amount, if applicable;

g. The nature of the dispute;

h. The date the request was closed;

i. Whether the request was pended for additional information; and

j. 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.

E. "Provider representative" means 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.

F. "Utilization review" means 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. 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 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. Where the carrier does not receive all necessary information to make a decision, the carrier shall request in writing within thirty (30) calendar days of receipt of the request the additional information needed. The carrier shall allow thirty (30) calendar days from the date of the request to receive 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) 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 rationale for the dispute resolution request; and

   c. The date by which the carrier must resolve the dispute resolution request.

   In the instance where the provider dispute resolution request is resolved in accordance with the requirements of this regulation within thirty (30) days, the notice required by Section 5.E. shall constitute the notice required by this Section 5.C.

2. In cases where the carrier does not receive all necessary information to make a decision, the carrier shall send, within thirty (30) days of receipt of the provider dispute resolution request, a written notice to the provider that must contain:

   a. A description of the additional necessary information required to process the request;

   b. The date 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.

3. 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 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 representatives 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) 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 and shall remain in full force and effect.

Section 7 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any sanctions made available in 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 suspension or revocation certificate of authority. Among others, the penalties provided for in § § 10-3-1108 and 10-3-1110(2), C.R.S., may be applied. Failure of a carrier to employ the procedures outlined in this regulation constitutes an unfair or deceptive act in the business of insurance under § 10-3-1104(1)(h)(IV), C.R.S.

Section 8 Effective Date

This regulation is effective on January 1, 2012.

Section 9 History

New regulation, effective August 1, 2002.

Amended regulation effective September 1, 2011.

Amended regulation effective January 1, 2012.

Regulation 4-2-24 CONCERNING CLEAN CLAIM REQUIREMENTS FOR HEALTH CARRIERS

Section 1 Authority

This regulation is promulgated under the authority of § §10-16-106.3(2), 10-16-109, and 10-1-109, C.R.S.

Section 2 Scope and Purpose

This regulation was originally promulgated to meet the requirement of Senate Bill 13, enacted during the 2002 General Assembly, that the Commissioner adopt a uniform list of required elements to be included on specified uniform claim forms in order to be considered a "clean claim" . It is being amended to update the list of required elements on the specified claim forms to incorporate the changes made by the federal government and the American Dental Association.

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.

Section 4 Rules

A. Clean claims, as defined in §10-16-106.5(2), C.R.S., shall be submitted on the appropriate uniform claim form (the American Dental Association Dental Claim Form, the CMS 1500, or the CMS 1450) and include all the required elements as specified in Section 5 of this regulation.

[Note: Formats for standardized forms CMS 1500 and CMS 1450 (UB-04) can be accessed at http://cms.hhs.gov/medicare/edi/edi5.asp. The dental form can be accessed though the American Dental Association.]

B. A carrier shall process clean claims within the time frames specified in statute.

C. A carrier shall pay interest pursuant to §10-16-106.5(5), C.R.S., when clean claims are not processed within the specified timeframes.

Section 5 Required Elements

A. The following fields of the American Dental Association Dental Claim Form (2006 version) must be completed before a claim can be considered a "clean claim" (See Attachment I):

1. Field 1: Type of Transaction;
2. Field 3: Insurance Company/Dental Benefit Plan Information;
3. Field 4: Other dental or medical coverage;
4. Fields 5-11: Other coverage information (if Field 4 answered "yes");
5. Field 12: Policyholder/Subscriber information;
6. Field 15: Policyholder/Subscriber ID;
7. Field 16: Plan/Group number (if group coverage);
8. Field 18: Relationship of patient to policyholder/subscriber;
9. Field 20: Patient name;
10. Field 21: Patient's date of birth;
11. Field 22: Patient's gender;
12. Field 24-33: Services provided;
13. Field 36: Information release;
14. Field 37: Assignment of benefits (required if payment is to be made to provider);
15. Field 38: Place of treatment;
16. Field 39: Number of enclosures (if radiographs or models enclosed);
17. Field 40: Treatment for orthodontics indicator;
18. Field 45: Cause of illness/injury;
19. Field 48: Name and address of billing dentist/entity;
20. Field 49: National Provider Identifier (NPI);
21. Field 50: Dentist's license number;
22. Field 51: Dentist/entity identification number;
23. Field 52: Dentist/entity phone number; and
24. Field 53: Treating dentist's signature.

B. The following fields of the CMS 1500 Claim Form must be completed before a claim can be considered a “clean claim” (See Attachment II):

1. Field 1: Type of insurance coverage;
2. Field 1a: Insured identification number;
3. Field 2: Patient’s name;
4. Field 3: Patient’s birth date and sex;
5. Field 4: Insured’s name;
6. Field 5: Patient’s address;
7. Field 6: Patient’s relationship to insured;
8. Field 7: Insured’s address (If same as patient address, can indicate “same” .);
9. Field 8: Patient’s status (required only if patient is a dependent);
10. Field 9 (a-d): Other insurance information (only if 11d is answered “yes”);
11. Field 10 (a-c): Relation of condition to: employment, auto accident or other accident;
12. Field 11: Insured’s policy, group or FECA number;
13. Field 11c: Insurance plan or program name;
14. Field 11d: Other insurance indicator;
15. Field 12: Information release (“signature on file” is acceptable);
16. Field 13: Assignment of benefits (“signature on file” is acceptable);
17. Field 14: Date of onset of illness or condition;
18. Field 17: Name of referring physician (if applicable);
19. Field 21: Diagnosis code(s);
20. Field 23: Prior authorization number (if any);
21. Field 24: Details about services provided; A, B, D, E, F, G (C, H Medicaid only)

21a. Field 24: I, J: Non-NPI provider information;

22. Field 25: Federal tax ID number;
23. Field 28: Total charge;
24. Field 31: Signature of provider including degrees or credentials (provider name sufficient);
25. Field 32: Address of facility where services were rendered;

26. Field 32a: National Provider Identifier (NPI);

27. Field 32b: Non-NPI (QUAL ID), as applicable;

28. Field 33: Provider's billing information and phone number;

29. Field 33a: National Provider Identifier (NPI); and

30. Field 33b: Non-NPI (QUAL ID), as applicable.

C. The following fields of the CMS 1450 (UB-04) Claim Form must be completed before a claim can be considered a "clean claim" (see Attachment III):

1. Field 1: Servicing provider's name, address, and telephone number;

2. Field 3: Patient's control or medical record number;

3. Field 4: Type of bill code;

4. Field 5: Provider's federal tax ID number;

5. Field 6: Statement Covers Period – From/Through;

6. Field 8: Patient's name;

7. Field 9: Patient's address;

8. Field 10: Patient's birth date;

9. Field 11: Patient's sex;

10. Field 12: Date of admission;

11. Field 13: Hour of admission;

12. Field 14: Type of admission/visit;

13. Field 15: Admission source code;

14. Field 16: Discharge hour (for maternity only);

15. Field 17: Patient discharge status;

16. Fields 31-36: Occurrence information (accidents only);

17. Field 38: Responsible party's name and address (If same as patient can indicate "same" .);

18. Fields 39, 40, and 41: Value codes and amounts;

19. Field 42: Revenue codes;

20. Field 43: Revenue descriptions;

21. Field 44: HCPCS/Rates/HIPPS Rate Codes;

22. Field 45: Service/creation date (for outpatient services only);

23. Field 46: Service units;

24. Field 47: Total charges;

25. Field 50: Payer(s) information;

26. Field 52: Information release;

27. Field 53: Assignment of benefits;

28 Field 56: National Provider ID (NPI);

29. Field 58: Insured's name;

30. Field 59: Relationship of patient to insured;

31. Field 60: Insured's unique ID number;

32. Field 62: Insurance group number(s) (only if group coverage);

33. Field 63: Prior authorization or treatment authorization number (if any);

34. Field 65: Employer information (for Workers' Comp. claims only);

35 Field 66: ICD Version Indicator;

36. Field 67: Principal diagnosis code;

37. Field 69: Admission diagnosis code (inpatient only);

38. Field 74: Principal procedure code and date (when applicable); and

39. Field 76: Attending physician's name and ID (NPI or QUAL ID).

Section 6 Additional Information

A. A claim with all required fields completed is not considered "clean" if additional information is needed in order to adjudicate 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. When additional information is required, the carrier shall make the specific request in writing within thirty calendar days after receipt of the claim form. 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 requested shall be requested within 30 calendar days after receipt of the claim form and identified for the provider upon request.

B. Additional information requested must be related to information in the required fields of the claim forms, although the genesis of the request may be from other sources, e.g., if the carrier has other information that indicates the information in a required field is incorrect, such as previous claims that indicate the treatment was for work-related injuries when the claim form indicates otherwise. Requests for additional information to determine if the treatment is medically necessary or if a pre-existing condition limitation applies would be related to the fields specifying the services provided.

C. A carrier is not permitted to request additional information for the purpose of determining medical necessity when the claim form has all required fields correctly completed and the services were preauthorized pursuant to §10-16-704(4), C.R.S.

D. When all additional information or documentation necessary to resolve the claim is provided with the appropriate claim form that includes all required elements as specified in Section 5 of this regulation, the claim shall be considered a clean claim and processed within the timeframes specified in statute. The following circumstances are those for which additional information is generally required by most health carriers:

1. When the coverage is not primary, an EOB 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.

E. 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.

F. 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 appropriate request for claim adjudication.

Medical information requested from institutional providers shall be additionally 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 Enforcement

Noncompliance with this regulation may result, after notice and opportunity for hearing, in the imposition of any of the sanctions pertaining to the business of insurance, including the imposition of fines and suspension or revocation of certificate of authority.

Section 8 Severability

If any provision of this regulation is for any reason held to be invalid, the remainder of the regulation shall not be affected thereby.

Section 9 Effective Date

This regulation is effective February 1, 2008.

Section 10 History

1. Emergency Regulation 02-E-7, effective July 2, 2002.

2. Temporary Regulation 02-T-7, effective October 1, 2002.

3. Regulation 4-2-24 effective February 1, 2003.

4. Amended Regulation 4-2-24 effective February 1, 2008.

Attachments

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an "X" on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature — Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number ( ) –
52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X_____
Signed (Treating Dentist) — Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
56A. Provider Specialty Code
57. Phone Number ( ) –
58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

ADA.

American Dental Association
www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
E. All dates must include the four-digit year.
F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 NPI (National Provider Indentifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: **www.ada.org/goto/npi**

ADDITIONAL PROVIDER IDENTIFIER

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

PROVIDER SPECIALTY CODES

56A Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at:
www.ada.org/goto/dentalcode

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other

Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO if yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, BSA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c / d / e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a							a
b							b

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
	a		
	b		
	c		
	d		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								1
2								2
3								3
4								4
5								5
6								6
7								7
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22								22
23		PAGE ____ OF ____	CREATION DATE		TOTALS			23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER PRV ID	B
C								C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	66 DX
		I	J	K	L	M	N	O	P	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC	
	a	
	b	
	c	
	d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC™ National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

Regulation 4-2-25 Repealed in Full [Eff. 04/01/2009]

Regulation 4-2-26 Repealed in Full [Eff. 11/01/2010]

Regulation 4-2-27 PROCEDURES FOR REASONABLE MODIFICATIONS TO INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS

Section 1 Authority

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109, 10-16-109, and 10 16 201.5(8)(b), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish procedures for the submission of reasonable modifications to individual and small group health benefit plans, as outlined in § 10-16-201.5(8), C.R.S.

Section 3 Applicability

This regulation applies to any carrier intending on making reasonable modifications to an individual or small group health benefit plan.

Section 4 Definitions

“Reasonable modification” : An alteration to the benefits of a health benefit plan that is fair and reasonable under the circumstances. The Division of Insurance (Division) determines if a modification is fair and reasonable.

Section 5 Rules

A. General Requirements

1. Timing and Submission: The benefit changes must be provided to the Commissioner and policyholders at least ninety (90) days prior to the effective date of the modification. Please note: as the modifications must be determined to be reasonable, entities are encouraged to submit the benefit modification filing to the Division thirty to sixty (30-60) days prior to the date that the first policyholder notifications will be mailed. This will provide an opportunity for the Division and the carrier to resolve any issues that may arise.

2. The Division is committed to enhancing the process of such filings and to assist in expediting such a review for reasonableness. This will only be realized through the use of electronic filings. The best way to achieve this is through SERFF (System for Electronic Rate and Form Filings).

The Rates and Forms Section of the Division will no longer accept reasonable modifications submitted by paper, as outlined in Colorado Regulation 1-1-9.

3. 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.

4. Required Information: A cover letter, side-by-side comparison of the benefit change(s), an identification of the rating impact of each benefit change and a copy of the policyholder notification.

    a. Side-by-Side Comparison: Each filing must include a "side-by-side comparison" identifying the proposed change(s). The "side-by-side comparison" should include three columns:

        (1) the first containing a description of the current benefit;

        (2) the second column containing the proposed benefit change(s);

        (3) and the third column containing the amount of the rating impact for each of the proposed change(s).

        All changes to the rates must be filed separately in accordance with all rating laws and regulations once the Division and the carrier have resolved all issues.

    b. All carriers shall submit a cover letter which contains a complete explanation of what the carrier is proposing to do.

    c. Rating Impact: The filing shall discuss or provide the following:

        (1) The impact on rates for each of the requested modifications as well as and the overall impact on rates for the entire product.

        (2) A narrative stating how each of the rating changes was determined.

        (3) A certification that the methodology used to determine the rates for these benefit modifications is consistent with the methodology used by the carrier to price similar products.

    d. Policy form filings require a forms certification and a listing of new forms in accordance with § 10-16-107.2, C.R.S., and Colorado Insurance Regulation 1-1-6. Also, the policy form certifications shall follow all requirements provided by a published bulletin.

B. Specific Requirements

Removal of an existing benefit is generally not considered to be a reasonable modification. However, the Division may determine, on a case-by-case basis, if the removal of an existing benefit is reasonable after reviewing the supporting documentation.

Section 6 Notice and Disclosure of Reasonable Modifications

The policyholder notification shall be provided no later than ninety (90) days prior to renewal of each policyholder's benefit plan. It shall provide the policyholder an opportunity to purchase any other health

benefit plan offered by the carrier in that specific market. A copy of this notification must be provided to the Division as part of the benefit modification filing.

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 and the application of such provision shall not be affected thereby.

Section 8 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 revocation of license. Among others, the penalties provided for in § 10-3-1108, C.R.S may be applied.

Section 9 Effective Date

This regulation shall become effective on May 1, 2010.

Section 10 History

Regulation 4-2-27 effective January 1, 2005.

Amended regulation 4-2-27, effective May 1, 2010.

Regulation 4-2-28 CONCERNING THE PAYMENT OF EARLY INTERVENTION SERVICES FOR CHILDREN ELIGIBLE FOR BENEFITS UNDER PART C OF THE FEDERAL "INDIVIDUALS WITH DISABILITIES EDUCATION ACT"

Section 1 Authority

This regulation is being promulgated and adopted by the Commissioner of Insurance under the authority of § §10-1-109 and 27-10.5-704(2), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide health carriers the guidance necessary to implement House Bill 1237 enacted in 2009 by the Colorado General Assembly to facilitate the payment of early intervention services by private insurance sources. It replaces Emergency Regulation 09-E-01 in its entirety.

Section 3 Applicability

This amended regulation applies to all individual and group sickness and accident insurance policies and all service or indemnity contracts issued or renewed on or after October 1, 2009 by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes, which provide coverage for health care services.

Section 4 Definitions

A. "Carrier" shall have the same meaning as set forth in §10-16-102(8), C.R.S.

B. "Case management services" are the service coordination activities as defined in 34 CFR 303.23.

C. "Certified early intervention service broker" or "broker" means 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 for Developmental Disabilities acting as the broker for any service area until another broker has been designated.

D. "Division for Developmental Disabilities" is a division of the Colorado Department of Human Services.

E. "Early intervention services" shall have the same meaning as set forth in §10-16-104(1.3)(a)(II), C.R.S., and include a monthly case management service fee.

F. "Eligible child" shall have the same meaning as set forth in §10-16-104(1.3)(a)(III), C.R.S.

G. "Health benefit plan" shall have the same meaning as set forth in §10-16-102(21), C.R.S.

H. "Individualized family service plan" or "IFSP" shall have the same meaning as set forth in §10-16-104(1.3)(a)(IV), C.R.S.

I. "Limited benefit health insurance" means 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" .

J. "Registry" means 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.

Section 5 Rules

A. Eligible early intervention services specified in the eligible child's IFSP shall be considered to 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, 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. Subject to paragraphs 1, 2 and 3 of this subsection C., carriers shall pay benefits into the trust established by the Colorado Department of Human Services (CDHS) as provided in §27-10.5-709(1), C.R.S., within 30 days of receipt of an invoice issued by CDHS, as follows:

1. For an eligible child identified after the effective date of the amendment of this regulation;

2. For an eligible child already receiving early intervention services in accordance with §10-16-104(1.3), C.R.S.:

   a. Upon the first day of the policy's new calendar year or benefit year, as applicable, after the effective date of the amendment of this regulation;

   b. Payment into the trust is not required prior to the policy's new calendar year or benefit year, as applicable; therefore, the carrier's payment of the services may continue as initially established;

3. Upon the receipt of a new IFSP for an eligible child not previously utilizing private health coverage for reimbursement of early intervention services.

D. Carrier payment guidelines.

1. Eligible early intervention services do not include:

   a. Non-emergency medical transportation;

   b. Respite care;

   c. Service coordination other than case management services; and

   d. Assistive technology. However, assistive technology may be covered by the policy's durable medical equipment benefit provisions.

2. If the payment is not made into the trust, then monthly case management service fees shall be paid directly to the certified early intervention service broker that has been designated by the State until the maximum annual benefit has been paid.

3. As of January 1, 2009, the maximum annual benefit payable for all eligible early intervention and case management services is $5,935.00. Thereafter, on January 1 of each year, the maximum annual benefit payable shall be adjusted based on the consumer price index for the Denver-Boulder-Greeley metropolitan statistical area for the state fiscal year that ends in the preceding calendar year or by such additional amount to be equal to the increase by the General Assembly to the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program if that increase is more than

the consumer price index increase. 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 maximum annual benefit specified in paragraph 3. of this subsection D:

   a. Rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation;

   b. Services provided to a child who is not participating in Part C and services that are not provided pursuant to an IFSP; and

   c. Assistive technology that is covered by the policy's durable medical equipment benefit provisions.

5. When the trust is not utilized for early intervention services that were started prior to the effective date of the amendment to this regulation, carriers shall notify the policyholder and the certified early intervention service broker when the maximum annual benefit has been paid. At the beginning of the new plan year, the carrier shall be responsible for paying benefits up to the maximum annual benefit as established in accordance with paragraph 3. of this subsection D.

6. Qualified early intervention service providers that receive reimbursement in accordance with paragraph 5 of this subsection D. 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 covered person or the carrier.

E. The Division for Developmental Disabilities will notify the carrier within 90 days if a child is no longer eligible for early intervention services.

F. Short-term, accident, fixed indemnity, specified disease policies, disability income contracts, limited benefit health insurance 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.

G. The carrier shall return requests for verification of eligibility of coverage of the eligible child to the certified early intervention service broker 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 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 certificates of authority. Among others, the penalties provided for in §10-3-1108, C.R.S., may be applied.

Section 8 Incorporated Materials

The following is hereby incorporated by reference as written on or before the effective date of this regulation:

Section 303.23 of Title 34 (Early Intervention Program for Infants and Toddlers with Disabilities), Code of Federal Regulations.

This rule does not include later amendments to or editions of the incorporated material. A copy of this reference may be examined at any state publications depository library. For additional information regarding how to obtain a copy, please contact the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202.

Section 9 Effective Date

This regulation shall become effective on October 1, 2009.

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.

Regulation 4-2-29 CONCERNING THE RULES FOR STANDARDIZED CARDS ISSUED TO PERSONS COVERED BY HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is being promulgated pursuant to the authority granted to the Commissioner of Insurance in §10-1-109, C.R.S. and is adopted by the Commissioner of Insurance pursuant to the requirement in §10-16-135, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide health carriers the guidance necessary to implement Senate Bill 135 enacted in 2008 by the Colorado General Assembly and effective on July 1, 2009.

Section 3 Applicability

This regulation applies to all individual and group health benefit plans issued or renewed on or after July 1, 2009 by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes, and to any person enrolling in an existing plan on or after July 1, 2009.

Section 4 Definitions

A. "Carrier" shall have the same meaning as set forth in §10-16-102(8), C.R.S.

B. "Clear and conspicuous" as used in this regulation means that 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 set forth in §10-16-102(21), C.R.S.

D. "Limited benefit health insurance" means 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. "Short-term health benefit plans" shall have the same meaning as §10-16-102(21)(b), CRS, subparagraphs (I) and (II).

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 insurance plans.

B. The card size shall be approximately 2.125 inches by 3.370 inches, which is consistent with standard-sized credit cards, and shall be either made of plastic, or laminated. Cards issued in connection with coverage provided by short-term health benefit plans do not have to be made of plastic or be laminated.

C. The colors used for the card and font shall be legible and conducive to black and white photocopying.

D. The following information shall 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 numbers, 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), or Indemnity (non-managed care plan));

6. Coverage levels for the following services. If all services are subject to the plan's deductible

and applicable coinsurance, a non-specific amount notation of “Deductible and coinsurance” is sufficient; otherwise, the required copayments shall 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 plans regulated in whole or in part by the State of Colorado’s Division of Insurance. This designation shall be placed on the card in a clear and conspicuous manner.

E. The following information shall 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 notification.

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; however, this date shall 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 paragraph 6. of subsection D., such as:

1. “PCP” to describe or refer to primary care physician benefits;

2. “SCP” to describe or refer to specialty care physician 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 subsection G. shall 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, 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 certificates of authority. 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 July 1, 2009.

Section 9 History

New regulation effective October 1, 2008.

Amended effective July 1, 2009.

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

Section 1 Authority

This regulation is being promulgated pursuant to the authority granted to the Commissioner of Insurance

in §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 implement Senate Bill 57 enacted in 2008 by the Colorado General Assembly and effective on January 1, 2009. In addition, it is to clarify the coverage mandated for prosthetics by §10-16-104(14), C.R.S. This regulation replaces Emergency Regulation 08-E-11 in its entirety.

Section 3 Applicability

This regulation applies to all individual and group health benefit plans issued or renewed on or after January 1, 2009 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 set forth in §10-16-102(8), C.R.S.

B. "Health benefit plan" shall have the same meaning as set forth in §10-16-102(21), C.R.S.

C. "Hearing aid" shall have the same meaning as set forth in §10-16-102(24.7), C.R.S.

D. "Limited benefit health insurance" means 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 set forth in §10-16-102(27.3), 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 or lifetime 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). These benefits are subject to the policy's general annual and/or lifetime maximum benefit amounts. 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 or lifetime 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, 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 certificates of authority. 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 February 1, 2009.

Section 9 History

1. Emergency Regulation 08-E-11 is effective January 1, 2009.

2. New regulation is effective February 1, 2009.

Regulation 4-2-31 ANNUAL HEALTH REPORTING AND DATA RETENTION REQUIREMENTS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-3-109, 10-16-111(4), 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, 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, Medicare supplement and excess loss insurance (pursuant to § 10-16-119, C.R.S.).

Reporting of information is waived for the following lines of business for each report:

A. Hospital Reimbursement Rate Report

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

Third party administration for fully self-funded plans, undeveloped rates that involve Medicare, Medicaid and Medicare Part D, and excess loss insurance (pursuant to § 10-16-119, C.R.S.).

Section 4 Definitions

A. "Average Reimbursement Rate" 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" means any entity that provides health coverage in this state including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a non-profit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to the insurance laws and regulations of Colorado.

C. "Diagnostic 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. "MS-DRG" (Medicare Severity Diagnosis Related Group) is a code within a system developed for Medicare as part of their payment system to classify each hospital case into one of approximately 500 groups that is published in the Federal Register Vol. 75, No. 157.

F. "Premium" means, for purposes of this regulation, the amount of money paid by the insured as a condition of receiving health care coverage. The premium paid normally reflects such factors as

the carrier's expectation of the insured's future claim costs and the insured's share of the carrier's claims settlement, operational and administrative expenses, and the carrier's cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.

G. "Reimbursement rate" means 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.

H. "Trend," for the purposes of this regulation, means the rate of increase in costs for the reporting period.

I. "Stop Loss" means Individual or group policies providing coverage to a health plan, 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 most common inpatient procedures performed in Colorado for the previous reporting year. This will include more than twenty-five 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 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, 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 a fine 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 Diagnosis 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 so as to show clearly 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.

    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., companies 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 and shall be filed electronically via a form provided on the Division of Insurance's website www.dora.state.co.us/insurance .

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. 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 a fine for an incomplete report.

C. Annual Cost Reports filed by companies identified in Section 3 must contain, where applicable, all of the information in this subsection. For every company the report shall include the following information from the previous calendar year.

1. The information required in this report identified in Subsection 2 of this section must be itemized in the following categories by:

    a. Market group size: individual, small group, and large group; and

    b. Lines of business: comprehensive health insurance, Health Maintenance Organization (HMO) coverage, long term care, disability income, accident, specified or dread disease, hospital indemnity, vision, dental, Medicare supplement, and other.

2. The following information referred to below is to be reported from the carrier's financial annual statement or provided using the allocation method detailed in Subsection D:

    a. Earned premium, not reduced by dividends.

    b. Written premium, not reduced by dividends.

    c. Net reinsurance premiums.

    d. Dividends.

    e. Reserves on hand.

    f. Net investment income.

    g. The amount of surplus and the amount of surplus relative to the carrier's risk-based capital requirement.

    h. Net Income.

    i. The cost of providing or arranging health care services.

    j. Net reinsurance recoveries.

    k. Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses.

    l. Insurance producer commissions.

m. Payments to legal counsel.

n. Advertising and marketing expenditures.

o. General administrative expenses, including expenses that are not otherwise mentioned in this subsection.

p. Staff salaries not reported in the Supplemental Compensation Exhibit.

3. The following information may not be available on the annual statement and must be reported;

a. The number of policyholders covered. This represents the number of actual policies issued for a product. For group coverage, this represents the number of primary subscribers to the groups and not the number of groups.

b. The number of groups covered.

c. The number of lives covered. This represents the number of individuals, including dependents that are covered under the policies or groups covered under a product type.

d. Paid lobbying expenditures.

e. Charitable contributions.

f. Healthcare cost trend must be itemized by product type as follows:

(1) Major Medical: This subsection shall be applicable for product types that provide comprehensive medical coverage, including but not limited to covering basic healthcare services and prescription drugs.

(a) Medical trend, excluding pharmacy trend, itemized by provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology;

(b) Pharmacy trend, itemized by provider price increases, utilization changes, medical cost shifting and new brand and generic drugs.

(2) All other products: This subsection shall be applicable for all other product types not described in Subsection 3(f)(1) of this section. For each product type, the company shall report the trend applicable to the product for the prior year.

g. Provision for profit and contingencies.

h. Taxes itemized by category.

4. Executive salaries, is defined to include but is not limited to base salary, bonuses and stock options are to be reported from the carrier's Supplemental Compensation Exhibit of the annual financial statement. Carriers must provide;

a. the Supplemental Compensation Exhibit of the carrier's annual financial statement; and

b. the percentage of executive salaries that should be allocated to Colorado health

business.

D. The information provided in Subsection C of this section shall be provided on a Colorado only basis, with the exception of executive salaries which is defined in Subsection 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.state.co.us/insurance .

Section 7 Incorporated Materials

The MS-DRG is incorporated by reference, but this rule does not cover amendments to this law or model act that were promulgated later than the effective date of this rule. A copy of the MS-DRG codes may be examined at any state publications depository library. For additional information regarding how relevant portions of the these codes can be obtained or examined, contact the Director of Market Regulation, Colorado Division of Insurance, 1560 Broadway, Ste 850, Denver, CO 80202.

The Federal Register Vol. 75, No. 157 published by Centers for Medicare & Medicaid Services shall mean Federal Register Vol. 75, No. 157 as published on the effective date of this regulation and does not include later amendments to or editions of Federal Register Vol. 75, No. 157. A copy of the Federal Register Vol. 75, No. 157 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 Federal Register Vol. 75, No. 157 may be requested from Center for Medicare & Medicaid Services, Baltimore Headquarters telephone number 877-267-2323. A charge for certification or copies may apply. A copy may also be obtained online at http://edocket.access.gpo.gov/2010/pdf/2010-19092.pdf.

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, 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 certificates of authority. Among others, the penalties provided in § § 10-3-109, 10-3-1108 and 10-1-205, C.R.S., may be applied.

Section 10 Effective Date

This regulation shall become effective on August 1, 2011.

Section 11 History

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

Amended Regulation, Effective August 1, 2011.

Regulation 4-2-32 STANDARDIZED ELECTRONIC IDENTIFICATION AND COMMUNICATIONSYSTEMS GUIDELINES FOR HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § §10-1-109 and 10-16-135, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to define the standardized electronic identification and communication systems to be used by carriers and providers of health benefit plans in Colorado, as required by §10-16-135, C.R.S.

Section 3 Applicability

This regulation applies to all health benefit plan providers and carriers operating in the state of Colorado. Deadlines imposed in this regulation may be extended by the Commissioner under the circumstances listed in Section 5.F. 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(21), C.R.S.

F. "Provider" shall have the same meaning as in §10-16-102(36), 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 September 1, 2012, 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 September 1, 2012, 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 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 Section 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 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 August 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 September 1, 2012 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

A. 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.

B. 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, 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 9 Effective Date

This regulation shall become effective on October 1, 2010.

Section 10 History

New regulation effective October 1, 2010.

Regulation 4-2-33 MANDATORY OPEN ENROLLMENT PERIODS FOR CARRIERS ISSUING CHILD-ONLY PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-16-104.4, and 10-16-108.5, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to facilitate the implementation of SB11-128 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). It replaces Emergency Regulation E-11-03 in its entirety.

Section 3 Applicability

This regulation applies to carriers that issue child-only plans on or after September 1, 2011.

Section 4 Definitions

A. "Carrier" shall have the same meaning as defined in § 10-16-102(8), C.R.S.

B. "Child-only plan" shall mean an individual health benefit plan that is issued on or after September 1, 2011, that provides coverage to an individual under the age of nineteen (19). A "child-only plan" does not include coverage provided to a dependent under an individual or group health benefit plan.

C. "Qualifying Event" shall include birth, adoption, marriage, dissolution of marriage, loss of employer-sponsored insurance, loss of eligibility under the Colorado Medical Assistance Act in Parts 4, 5, and 6 of Title 25.5 of the Colorado Revised Statutes, loss of eligibility under the Children's Basic Health Plan in Article 8 of Title 25.5 of the Colorado Revised Statues, entry of a valid court or administrative order mandating the child be covered, or involuntary loss of other existing coverage for any reason other than fraud, misrepresentation or failure to pay premium.

Section 5 Rules

A. Enrollment Only Allowed During Certain Periods.

1. Carriers issuing child-only plans shall accept an application for child-only plan coverage only during the open enrollment periods set forth in subsection B. below unless the application is received within thirty (30) days after a Qualifying Event.

2. Enrollment outside the open enrollment periods shall be prohibited, except upon the occurrence of a Qualifying Event. The application for coverage must be received within thirty (30) days after the occurrence of such Qualifying Event.

B. Twice Yearly Open Enrollment Periods for New Applicants.

1. Beginning January 1, 2012, carriers offering child-only plans shall hold an open enrollment period each January and July, for the duration of the entire month. During these open enrollment periods, all children under the age of nineteen (19) shall be offered coverage on a guaranteed issue basis, without any limitations or riders based on health status. Carriers shall use such rates as are filed and approved in accordance with § 10-16-107(1.5), C.R.S. The open enrollment period shall be followed by a thirty (30) day waiting period for the child-only plan to take effect.

2. Notice of the open enrollment opportunity, open enrollment dates for new applicants, as well as the opportunity to enroll due to a Qualifying Event, and instructions on how to enroll a child in a child-only plan, must be displayed continuously and prominently on the carrier's web site throughout the year. Each carrier shall also provide a link to public programs administered by the Department of Health Care Policy and Financing.

3. Nothing contained in this regulation shall alter an applicant's ability to obtain a child-only plan,

outside the open enrollment period, upon the occurrence of a Qualifying Event.

C. As a condition of issuing coverage in the individual health market, a carrier shall have an approved child-only plan available to be issued pursuant to § 10-16-104.4 and this regulation.

D. A carrier may cancel coverage for a dependent in the individual market if the parent subscriber cancels his or her individual coverage. The carrier shall allow the dependent to apply for a child-only plan during the next open enrollment period with no surcharge.

E. A carrier may deny coverage to an applicant for enrollment in a child-only plan if other creditable coverage as defined in § 10-16-102(13.7), C.R.S., is available. For purposes of this subsection E., creditable coverage does not include eligibility for a high-risk pool insurance plan, including but not limited to CoverColorado and Getting US Covered, but creditable coverage does include current enrollment in a high-risk pool insurance plan.

F. A carrier may impose a surcharge for up to twelve (12) months on an individual who enrolls in a child-only plan if the individual was previously enrolled in a child-only plan, subsequently dropped the coverage, and the lapse in coverage is greater than sixty-three (63) days. The surcharge may be up to an additional fifty percent (50%) of the amount that would be charged for the same child demonstrating continuous coverage.

G. Annual Report.

At the time a carrier submits the information required in § 10-16-111(4)(a), C.R.S., it shall submit a report, in a manner specified by the Commissioner, providing the following information:

1. The number of applicants for a child-only plan in each of the open enrollment periods for the previous calendar year;

2. The number of individuals enrolled in a child-only plan as of January 1 and December 31 for the previous calendar year; and

3. The number of applicants denied enrollment in a child-only plan and the specific reasons for the denials for the previous calendar year.

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 and shall remain in full force and effect.

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, refund of excess premiums plus interest, restitution, issuance of cease and desist orders, and/or suspensions or revocation of license or certificate of authority. 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 September 1, 2011.

Section 9 History

Emergency Regulation E-11-01 effective September 23, 2010.

New Regulation 4-2-33 effective January 1, 2011.

Emergency Regulation E-11-03 effective May 3, 2011.

Amended Regulation effective September 1, 2011.

Regulation 4-2-34 SECTION NAMES AND THE PLACEMENT OF THOSE SECTIONS IN POLICY FORMS BY HEALTH CARRIERS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, and 10-16-137(2), 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 health carriers.

Section 3 Applicability

The requirements and provisions of this regulation apply to health benefit plans, limited benefit health insurance, dental and vision policies issued or delivered on or after January 1, 2012.

This regulation does not apply to Medicare Supplement or disability income insurance.

Section 4 Definitions

A. "Health benefit plans" for the purposes of this regulation, shall have the same meaning as provided under § 10-16-102(21), C.R.S.

B. "Health carriers" for the purposes of this regulation, shall have the same meaning as provided under § 10-16-102(8), C.R.S.

C. "Limited benefit health insurance" means a health policy, contract or certificate offered or marketed 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; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan" as defined in § 10-16-102(21), C.R.S.

Section 5 Rules

Health carriers shall use the following section names in the listed order, for health benefit plans, limited benefit health insurance, dental and vision policy forms:

A. 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. 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.

B. Carriers may continue to use existing forms and instead publish a table of contents or directory which cross-references the proposed standards section names with those used in carrier's current forms.

Section 6 Severability

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

Section 7 Enforcement

Noncompliance with this Regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in § 10-3-1108, C.R.S. may be applied.

Section 8 Effective Date

This regulation is new and shall become effective on October 1, 2011.

Section 9 History

New regulation effective October 1, 2011.

Regulation 4-2-35 REQUIRED INFORMATION FOR CARRIERS TO PROVIDE ON EXPLANATION OF BENEFITS FORMS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-16-137(2), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to set forth the minimum required information for health carriers to provide on an explanation of benefits form sent to covered persons or providers.

Section 3 Applicability

The requirements and provisions of this regulation apply to health benefit plans, limited benefit health insurance, and dental plans issued or delivered on or after January 1, 2012.

This regulation does not apply to Medicare Supplement or disability income insurance.

Section 4 Definitions

A. "Health benefit plans" for the purposes of this regulation, shall have the same meaning as provided under § 10-16-102(21), C.R.S.

B. "Health carriers" for the purposes of this regulation, shall have the same meaning as provided under § 10-16-102(8), C.R.S.

C. "Limited benefit health insurance" for the purposes of this regulation, means a health policy, contract or certificate marketed 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 of certificates; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan" as defined in § 10-16-102(21), C.R.S.

Section 5 Rules

Health carriers shall include the following information on an explanation of benefits (EOB) form sent to covered persons or providers:

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, a notice will need to go out with 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); 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 plans, any annual limits for a specific benefit).

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 is effective October 1, 2011.

Section 9 History

New Regulation effective October 1, 2011.

Regulation 4-2-36 PRESCREENING QUESTIONAIRE FOR INDIVIDUAL HEALTH BENEFIT PLANS

Section 1 Authority

Section 2 Scope and Purpose

Section 3 Applicability

Section 4 Rules

Section 5 Severability

Section 6 Enforcement

Section 7 Effective Date

Section 8 History

Appendix A Prescreening Questionnaire

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-16-107.2(2)(c)(III), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to implement a prescreening questionnaire for use by carriers marketing and issuing individual health benefit plans.

Section 3 Applicability

The requirements and provisions of this regulation apply to carriers issuing individual health benefit plans on or after January 1, 2012. Child-only policies are guaranteed issued pursuant to state and federal law and therefore this questionnaire shall not be used in connection with the issuance of child-only policies.

Section 4 Rules

The prescreening questionnaire provided in Appendix A, is not part of an application, and is required to be used by all carriers issuing individual health benefit plans.

Section 5 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 6 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 7 Effective Date

This regulation shall become effective on October 1, 2011.

Section 8 History

New regulation effective October 1, 2011.

Appendix A, Prescreening Questionnaire

Appendix A, Prescreening Questionnaire

DO NOT COMPLETE THIS QUESTIONNAIRE IF YOU ARE APPLYING FOR A CHILD-ONLY POLICY.

APPLICANT INFORMATION											
Last Name:		First Name:		Middle Initial:							
Current address:											
City:		State:		ZIP Code:		County:					
Phone:		Email Address:									
☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Common Law Marriage											
CARRIER RESPONSES SHOULD BE EMAILED OR FAXED TO:											
INFORMATION FOR EACH FAMILY MEMBER INTERESTED IN COVERAGE											
Spouse Information:											
Last Name:		First Name:		Middle Initial:							
Dependent Information: Please complete for dependents from age 19 up to age 26.											
Last Name:		First Name:		Middle Initial:							
Last Name:		First Name:		Middle Initial:							
Last Name:		First Name:		Middle Initial:							
Last Name:		First Name:		Middle Initial:							
Last Name:		First Name:		Middle Initial:							
Last Name:		First Name:		Middle Initial:							

prescreening questions: INDIVIDUAL HEALTH BENEFIT PLANs

Children under 19 years of age cannot be denied coverage based on a pre-existing condition. If a private health insurance carrier denies you or a family member over the age of 19 coverage based on this form, YOU MAY STILL BE ELIGIBLE FOR COVERAGE WITH COVERCOLORADO and the denial may serve as a denial for purposes of eligibility for coverage through CoverColorado.

Has any applicant (which includes the individual completing form, spouse and dependents) ever been diagnosed with any of the following conditions?

Condition/Disease/Disorder:	Yes:	No:	Condition/Disease/Disorder:	Yes:	No:
AIDS/HIV+			**Malignant Tumor, last 4 years**		
Alzheimer's Disease			**Multiple or Disseminated Sclerosis**		
Bipolar Disorder			**Muscular Dystrophy**		
Cirrhosis of the Liver			**Myasthenia Gravis**		
Cystic Fibrosis			**Paraplegia or Quadriplegia**		
Hemophilia			**Parkinson's Disease**		
Hepatitis, Chronic			**Primary Polycythemia**		
Hodgkin's Disease			**Schizoaffective Disorder**		
Huntington's Disease			**Schizophrenia**		
Lou Gehrig's Disease			**Stroke**		
Lupus Erythematosus Disseminate					

If you or any family member age 19 or older checked "Yes", please clearly indicate which family member checked yes for which condition: _____

_____

_____

Determining Your Coverage Options: PLEASE READ CAREFULLY

If you or any family member age 19 or older checked "Yes" to any condition on the above list: Please DO NOT proceed with a full-length application for any private health insurance carrier. Please submit this prescreening questionnaire to the insurance carrier of your choice and that insurance carrier will decide to issue coverage, ask you for additional information, or decide to deny coverage. If you receive a denial from a carrier based on your answers to this form, that denial may serve as your CoverColorado medical eligibility form. If you have medical documentation of the condition marked "Yes" on the list, you may also submit to CoverColorado a letter, on your doctor's letterhead, or a prescription form from your doctor reflecting your doctor's name, address, and phone number for purposes of eligibility in CoverColorado. The letter or prescription form must state the applicant's name and exact diagnosis, and must be signed and dated by your doctor and must accompany your CoverColorado application. The letter or prescription form will serve as your proof of medical eligibility, so a denial letter from a private health insurance carrier will not be necessary. Other eligibility requirements for CoverColorado may apply.

If neither you nor anyone in your family checked "Yes" to any condition on the list above: You should proceed directly to a full-length application for any private health insurance carrier with which you may want coverage and submit ONLY the full-length application. Please DO NOT submit this Prescreening Questionnaire.

Applicant Signature:		Date:	
Spouse Signature:		Date:	
Dependent Signature:		Date:	
Dependent Signature:		Date:	
Dependent Signature:		Date:	
Dependent Signature:		Date:	

Contact Information for CoverColorado:

The individuals with medical conditions on the list above are medically eligible for healthcare coverage through CoverColorado. If you want additional information on CoverColorado please contact an enrollment specialist at the CoverColorado Administration Office at 303-863-1960 or 1-866-787-9129 (8 am – 5 pm MST, M-F), or at: CoverColorado, 425 South Cherry Street, Suite 160, Glendale, CO 80246, or website www.covercolorado.org.

Producer Name (if appropriate)		Date:	
Agency Name:			
Telephone:		Fax:	

Health Insurance Carrier Response:

(Completed by the health insurance carrier for those applicants submitting the Prescreening Questionnaire)

☐ Prescreening Questionnaire Accepted

Approval for health care coverage is not guaranteed and is based on medical history and health status. You will be contacted with a full-length insurance application packet. Please do not cancel other current health insurance coverage until written notification is received indicating that your full-length application has been approved.

Name of Accepted Applicant: _____

Name of Accepted Spouse: _____

Name of Accepted Dependent: _____

Name of Accepted Dependent: _____

Name of Accepted Dependent: _____

Name of Accepted Dependent: _____

☐ Prescreening Questionnaire Denied

Name of Denied Applicant: _____

Reason for Denial: _____

Name of Denied Applicant: _____

Reason for Denial: _____

Name of Denied Applicant: _____

Reason for Denial: _____

Carrier Name:		Phone Number:	
Carrier Signature:		Date:	

Regulation 4-2-37 REQUIRED INFORMATION FOR CARRIERS TO OBTAIN ON ALL FULL-LENGTH APPICATIONS FOR INDIVIDUAL HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-16-105.2(1.5), 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. It replaces Emergency Regulation E-11-04 in its entirety.

Section 3 Applicability

The requirements of this regulation apply to all carriers issuing individual health benefit plans. It applies to all applications received by the carrier on or after September 1, 2011. It does not apply to applications for limited benefit health insurance plans or to applications for short-term health benefit plans.

Section 4 Definitions

A. "Carrier" for the purposes of this regulation, shall have the same meaning as provided under § 10-16-102(8), C.R.S.

B. "Health benefit plan" for the purposes of this regulation, shall have the same meaning as provided under § 10-16-102(21), C.R.S.

C. "Limited benefit health insurance" for the purposes of this regulation, means a health policy, contract or certificate marketed 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 of certificates; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan" as defined in § 10-16-102(21), C.R.S.

D. "Short-term health benefit plans" shall have the same meaning as §10-16-102(21)(b), C.R.S.,

subparagraphs (I) and (II).

Section 5 Rules

A. All full-length applications for individual health benefit plans must contain the questions provided in Appendix A either as part of the application or 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 that must be used is attached in Appendix B.

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) calendars 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, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in § 10-3-1108, C.R.S. may be applied.

Section 8 Effective Date

This regulation shall become effective on September 1, 2011.

Section 9 History

Emergency regulation E-11-04 effective May 19, 2011.

New regulation effective September 1, 2011.

Appendix A: Required questions for full-length applications for individual health benefit plans.

1. Will an employer of fifty (50) 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. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve months prior to the date of this application?

____ Yes ____ No

3. If the answer to both questions 1 and 2 is "yes", the applicant may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

   If the answer to question 1 is "yes" and the answer to question 2 is "no", the applicant must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months.

   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.

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(40), C.R.S., with fifty (50) or fewer eligible employees;

2. The employer has not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit.

3. A false certification may cause the rescission of the employee's individual 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(21)(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 § 12-22-102(30), 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(22), 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(22), C.R.S. and devices as defined in § 12-22-102(8), 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.

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 History link that appears above the text in 3 CCR 702-4. 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]