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 13-E-03 ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE

Section 25 History

Section 1 Authority

This emergency 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 emergency 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. The Division of Insurance finds that immediate adoption of this regulation is imperatively necessary to ensure carrier compliance with the recent changes to Colorado law contained in HB 13-1266 to ensure consumer protection with regard to the advertising of accident and sickness insurance policies. Therefore, the Division finds that compliance with § 24-4-103, C.R.S. would be contrary to the best interest of the public.

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

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

2. The language "except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts" means it does not include disability, waiver of premium and double indemnity benefits included in life insurance, endowment or annuity

contracts or contracts supplemental to the above contracts that contain only provisions that:

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

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

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

1. "Advertisement" also includes;

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

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

E. "Health Benefit Plan" shall have the same meaning as defined in § 10-16-102(32), C.R.S.

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

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

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

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

1. An "invitation to inquire" 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]."

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

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

L. "Limited benefit health coverage" means, for the purposes of this regulation, 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(32),

C.R.S.

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

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

N. "Prominently" or "conspicuously" means, for the purposes of this regulation, 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.

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

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

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 health benefit plans, 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, when an accident and sickness insurance policy does not cover losses resulting from preexisting conditions, 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, cancellable 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 health benefit plans 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 (1) year after it was originally given, a confirmation must be obtained.

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

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

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

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

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

C. Any person or agency acting as a spokesperson, as defined in 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.

D. For purposes of Section 14 of this regulation and the multistate plan provisions of Section 1334 of the ACA, a contract between the Office of Personal Management and a multistate insurer does not constitute approval, endorsement or accreditation by the federal government.

Section 15 Identity of Insurer

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

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

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

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

2. That the advertiser is the same as is connected with or is endorsed by the governmental agencies or the other insurers, except as permitted by the provisions found in Section 14.D. of this regulation.

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 Filing Requirements

All filings shall be submitted in accordance with the requirements located in Appendix A of this regulation, and all filings shall be submitted electronically by licensed entities.

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 Incorporated Materials

42 U.S.C. 18054 (Patient Protection and Affordable Care Act), Section 1334, published by the Government Printing Office shall mean 42 U.S.C. 18054 (Patient Protection and Affordable Care Act), Section 1334, as published on the effective date of this regulation and does not include later amendments to or editions of 42 U.S.C. 18054 (Patient Protection and Affordable Care Act), Section 1334. 42 U.S.C. 18054 (Patient Protection and Affordable Care Act), Section 1334, may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Government Printing Office website at http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf . Certified copies of 42 U.S.C. 18054 (Patient Protection and Affordable Care Act), Section 1334 are available from the Division of Insurance for a fee.

Section 22 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 24 Enforcement

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

Section 24 Effective Date

This emergency regulation is effective June 20, 2013.

Section 25 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.

Emergency Regulation, effective June 20, 2013.

Appendix A

The marketing filing procedures for entities subject to this regulation, as determined by the commissioner, which must be followed for all new and annual form filing submissions, are as follows:

A. Carriers (including health care coverage cooperatives and CO-OPs) offering non-grandfathered

individual and small group health and catastrophic health benefit plans, and stand-alone dental plans offering pediatric EHB coverage, for sale inside or outside of the Exchange, must file:

1. The PPACA Marketing Checklist, which must be attached under the Supporting Documentation Tab in SERFF;

2. If a carrier uses a third party to submit a form filing on their behalf, a Letter of Authority, which must be attached under the Supporting Documentation Tab in SERFF.

B. Carriers (including health care coverage cooperatives and CO-OPs) offering non-grandfathered individual and small group health and catastrophic health benefit plans, and stand-alone dental plans offering pediatric EHB coverage, for sale inside of the Exchange, additionally must file:

1. A copy of the Carrier Logo, which must be submitted under the Supporting Documentation tab in the Plan Management (Binder) section of SERFF.

2. Carriers desiring to have a Marketing Brochure displayed on the Exchange website, which describes the features of all plans within a specific market (i.e. individual or small group), must attach a copy of the brochure under the Associate Schedule Item tab in the Plan Management (Binder) section of SERFF.

   a. Carriers may submit a copy of the brochure in English and Spanish.

3. Carriers desiring to have a Marketing Brochure displayed on the Exchange website, which describes the features of a specific plan, must attach a copy of the brochure under the Associate Schedule Item tab in the Plan Management (Binder) section of SERFF.

   a. Carriers may submit a copy of the brochure in English and Spanish.

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

Section 2 Scope and Purpose

Section 3 Applicability

Section 4 Definitions

Section 5 Rules

Section 6 Severability

Section 7 Enforcement

Section 8 Effective Date

Section 9 History

Section 1 Authority

This amended regulation is promulgated 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

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

Section 1 Authority

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

Section 2 Scope and Purpose

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

Section 3 Applicability

This regulation applies to all entities that provide life or a policy of sickness and accident insurance in this state including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident company, a life or annuity company, and any other entity providing a life policy, annuity, or a policy of sickness and accident insurance subject to the insurance laws and regulations of Colorado.

Section 4 Definitions

A. “Insurance coverage” shall mean life insurance policies and policies of sickness and accident insurance.

B. “Person” shall have the meaning in § 10-3-1104.5(2)(f), C.R.S.

C. “Policy of sickness and accident insurance” shall have the meaning in §10-16-102(30), 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. Persons may not use an applicant’s marital status, living arrangements, occupation, gender, medical history, beneficiary designation, or zip code or other territorial classification to establish, or aid in establishing, the applicant’s sexual orientation.

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

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

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

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

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

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

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

b. for urine specimens, a Western Blot test with bands present at 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 Appendix A.

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

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

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

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

Section 6 Severability

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

Section 7 Incorporated Materials

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

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

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in

the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation as amended is effective July 1, 2012.

Section 10 History

Originally issued as Regulation 87-2, effective January 1, 1988.

Renumbered as Regulation 4-2-9, effective June 1, 1992.

Amended Section IV(J), effective February 1, 1995.

Amended Regulation, effective March 2, 1999.

Amended Regulation, effective May 1, 2010.

Amended Regulation, effective July 1, 2012.

Appendix A

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

Published as of 7/22/2011

Human Immunodeficiency Virus Type 1 (Anti-HIV-1 Assay)

Tradename(s) (Labeling may be out of date)	Infec-tious Agent	Format	Current Sample
GS rLAV EIA	HIV-1	EIA	Serum / Plasma
Fluorognost HIV-1 IFA	HIV-1	IFA	Serum / Plasma
Cambridge Biotech HIV-1 Western Blot Kit	HIV-1	WB	Serum / Plasma
GS HIV-1 Western Blot	HIV-1	WB	Serum / Plasma
Avioq HIV-1 Microelisa System	HIV-1	EIA	Serum, Plasma, Drie blood spot, Oral Flui

HIVAB HIV-1 EIA	HIV-1	EIA	Dried Blood Spot
Maxim Biotech HIV-1 Urine EIA	HIV-1	EIA	Urine
INSTI™ HIV-1 Antibody Test Kit	HIV-1	Rapid Immunoassay	Plasma / Whole Bloo (veni-puncture and fingerstick)
Reveal Rapid HIV-1 Antibody Test15	HIV-1	Rapid Immunoassay	Serum / Plasma
Uni-Gold Recombigen HIV	HIV-1	Rapid Immunoassay	Serum / Plasma / Wh Blood (venipuncture fingerstick)
GS HIV-1 Western Blot	HIV-1	WB	Dried Blood Spot
Fluorognost HIV-1 IFA	HIV-1	IFA	Dried Blood Spot
OraSure HIV-1 Western Blot Kit	HIV-1	WB	Oral Fluid
Cambridge Biotech HIV-1 Western Blot Kit	HIV-1	WB	Urine

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

Tradename(s) (Labeling may be out of date)	**Infec-tious Agent**	**Format**	**Current Sample**

Human Immunodeficiency Virus, Type 1 (HIV-1) Reverse Transcription (RT) Polymerase Chain Reaction (PCR) Assay	HIV-1	PCR	Plasma
UltraQual HIV-1 RT-PCR Assay	HIV-1	PCR	Plasma
COBAS Ampliscreen HIV-1 Test	HIV-1	PCR	Plasma/ Cadaveric se or plasma
APTIMA HIV-1 RNA Qualitative Assay	HIV-1	HIV-1 Nucleic Acid (TMA)	Plasma/ Serum
Abbott RealTime HIV-1 Amplification Kit	HIV-1	PCR	Plasma
Roche Amplicor HIV-1 Monitor Test	HIV-1	PCR	Plasma
COBAS	HIV-1	PCR	Plasma

AmpliPrep/COBAS TaqMan HIV-1 Test			
Versant HIV-1 RNA 3.0 (bDNA)	HIV-1	Signal amplification nucleic acid probe	Plasma
ViroSeq HIV-1 Genotyping System with the 3700 Genetic Analyzer	HIV-1	HIV-1 Genotyping	Plasma
Trugene HIV-1 Genotyping Kit and Open Gene DNA Sequencing System	HIV-1	HIV-1 Genotyping	Plasma

Anti-HIV-1 Testing Service

Tradename(s) (Labeling may be out of date)	**Infec-tious Agent**	**Format**	**Current Sample**
Home Access HIV-1 Test System	HIV-1	Dried Blood Spot Collection Device	Dried Blood Spot

Anti-HIV-1 Oral Specimen Collection Device

Tradename(s) (Labeling may be out of date)	Infec-tious Agent	Format	Current Sample
OraSure HIV-1 Oral Specimen Collection Device	HIV-1	Oral Specimen Collection Device	Oral Fluid

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

Tradename(s) (Labeling may be out of date)	Infec-tious Agent	Format	Current Sample
GS HIV-2 EIA	HIV-2	EIA	Serum / Plasma

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

Tradename(s) (Labeling may be out of date)	Infec-tious Agent	Format	Current Sample
Abbott HIVAB HIV-1/HIV-2 (rDNA) EIA	HIV-1, HIV-2	EIA	Serum / Plasma / Cadaveric Serum
ABBOTT PRISM HIV O Plus assay	HIV-1, HIV-2	Chemi-luminescent Immunoassay (ChLIA)	Plasma / Serum/ Cadaveric Serum
GS HIV-1/HIV-2 Plus O EIA	HIV-1, HIV-2	EIA	Serum / Plasma / Cadaveric Serum

ADVIA Centaur HIV 1/O/2 Enhanced ReadyPack Reagents	HIV-1, HIV-2	Microparticle Chemi-luminometric Immunoassay	Plasma/Serum
Ortho VITROS HIV-1/HIV-2	HIV-1, HIV-2	EIA	Plasma/Serum
Multispot HIV-1/HIV-2 Rapid Test	HIV-1, HIV-2	Rapid Immunoassay	Plasma / Serum
SURE CHECK HIV 1/2 ASSAY	HIV-1, HIV-2	Rapid Immunoassay	Fingerstick & venou whole blood, serum, plasma
HIV 1/2 STAT-PAK ASSAY	HIV-1, HIV-2	Rapid Immunoassay	Fingerstick & venou whole blood, serum, plasma
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test	HIV-1, HIV-2	Rapid Immunoassay	Whole Blood, Plasm Oral Fluid
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test	HIV-1, HIV-2	Rapid Immunoassay	oral fluid, plasma, ve whole blood

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

Tradename(s) (Labeling may be out of date)	**Infec-tious Agent**	**Format**	**Current Sample**
ARCHITECT HIV Ag/Ab Combo	HIV-1, HIV-2	Chemi-luminescent Microparticle Immunoassay (CMIA)	Plasma / Serum

Bio-Rad GS HIV Ag/Ab Combo EIA	HIV-1, HIV-2	EIA	Plasma / Serum

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

Tradename(s) (Labeling may be out of date)	Infec-tious Agent	Format	Current Sample
Abbott HTLV-I/HTLV-II EIA	HTLV-1, HTLV-2	EIA	Serum / Plasma
ABBOTT PRISM HTLV-I/HTLV-II	HTLV-1, HTLV-2	Chemi-luminescent Immunoassay (ChLIA)	Serum / Plasma

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

Section 1 Authority

Section 2 Scope and Purpose

Section 3 Applicability

Section 4 Definitions

Section 5 Filing Requirements of MEWAs

Section 6 Authorized Insurance Arrangements

Section 1 Authority

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

Section 2 Scope and Purpose

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 Multiple Employer Welfare Arrangements (MEWAs) claiming exempt status from formal licensing requirements; and (2) clarify the responsibilities of licensed producers,

Section 3 Applicability

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

Section 4 Definitions

A. "Fully insured" means 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

MEWA seeking exemption from licensure requirements.

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

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(7)(b)(I), C.R.S.; or

E. Determined to be in compliance with §10-3-905.3(7)(c), C.R.S. and Section 5 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 Severability

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

Section 10 Enforcement

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

Section 11 Effective Date

This amended regulation shall be effective August 1, 2012.

Section 12 History

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

Amended regulation effective October 2, 2006

Amended regulation effective August 1, 2012

Regulation 13-E-01 RATE FILING SUBMISSIONS FOR LIMITED BENEFIT PLANS, STOP LOSS INSURANCE, SICKNESS, AND ACCIDENT INSURANCE, OTHER THAN HEALTH BENEFIT

PLANS

Section 1 Authority

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

Section 2 Scope and Purpose

The purpose of this emergency regulation is to provide health carriers the necessary guidance to implement the requirements of House Bill 13-1266 enacted during the 2013 General Assembly to ensure that health insurance rates on Limited Benefit Plans, Stop Loss Insurance, Sickness, and Accident Insurance, other than Health Benefit Plans, are not excessive, inadequate or unfairly discriminatory, by establishing the requirements for rate filings. The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary to ensure carrier compliance with the recent changes to Colorado law, and to provide the consumer protections provided by the enacted legislation. Therefore, compliance with the requirements of § 24-4-103(3-4), C.R.S. would be contrary to the public interest.

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 other than health benefit plans, including, but not limited to, dental, health coverage plans (not covering pediatric dental as an essential health benefit), limited benefit, limited service licensed provider networks, long-term care, long-term disability, Medicare supplement, non-profit hospital/medical/surgical, and health service corporations, prepaid dental, short-term disability, supplemental health, travel accident/sickness, vision, and stop loss carriers for employers with self-insured health plans.

Section 4 Definitions

A. "Accident only" means, for the purposes of this regulation, coverage for death, dismemberment, disability, or hospital and medical care caused by or necessitated as the result of accident or specified kinds of accident. "Accident Only" policies cannot include 'sickness' or 'wellness' benefits. If additional benefits are provided they must be fully disclosed and properly labeled.

B. "Benefits ratio" means, for the 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 the 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 the purposes of this regulation, the number of members, subscribers and dependents.

E. "Disability income policy" means, for the purposes of this regulation, a policy that provides periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury. Disability income policies cannot include annual doctor visits or outpatient coverage. If additional benefits are provided they must be fully disclosed and properly labeled. Short-term disability coverages must be filed separately from long-term disability income coverages. Group Disability Income policies must comply with §10-16-214(3)(C), C.R.S. Additional requirements are also addressed under Section 7 of this regulation.

F. "Dividends" means, for the purposes of this regulation, both policyholder and stockholder dividends.

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

H. "File and use" means, for the purposes of this regulation, a filing procedure that requires rates and rating data to be filed with the Division 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 specified in the rate filing. Carriers may bill members but not require the member to remit premium prior to the proposed implementation date of the rate change.

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

J. "Health benefit plan" shall have the same meaning as defined in § 10-16-102(32), C.R.S.

K. "Health coverage plan" shall have the same meaning as defined in § 10-16-102(34), C.R.S. and shall mean a contract, certificate or agreement entered into, offered, or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

L. "Health care services" shall have the same meaning as defined in § 10-16-102(33), C.R.S.

M. "Hospital indemnity" means, for the purposes of this regulation, a policy that provides a stated daily, weekly or monthly payment while the insured is "hospitalized" regardless of expenses incurred and regardless of whether or not other insurance is in force. Hospital Indemnity policies cannot include medical expense, wellness benefits or well-baby care. If additional benefits are provided they must be fully disclosed and properly labeled.

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

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

P. "Lifetime loss ratio":

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

   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.

Q. "Limited benefit health plans" means, for the purposes of this regulation, a policy, contract or certificate issued or offered on a group or individual basis as a supplemental health coverage policy 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 plans do not include short-term limited duration health benefit 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".

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

S. "Non-developed rates" means, for the purposes of this regulation, 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."

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

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

V. "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.

W. "Prior approval" means, for the purposes of this regulation, a filing procedure that requires a rate change to be affirmatively approved by the commissioner prior to: distribution, release to agents, collection of premium, advertising, or any other use of the rate. Under no circumstance shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing. The implementation date must be at least 60 days after the date of submission. After the rate filing has been approved by the commissioner, carriers may bill members but not require the member to remit premium prior to the proposed implementation date of the rate change.

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

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

Z. "Qualified actuary" shall meet the requirements outlined in Colorado Insurance Regulation 1-1-1.

AA. "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 the cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the contract. Rates for all heath coverages must be filed with the Division.

AB. "Rate filing" means, for purposes of this regulation, a filing that contains all of the items required in this regulation, and:

1. The underlying rating assumptions must be submitted for individual products, including the proposed base rates and all rating factors. Support for all changes in existing rates,

factors and assumptions must be provided, including the continued use of trend factors. Support for new product offerings must be provided; and;

2. The underlying rating factors and assumptions must be submitted for group products and proposed base rates. Support for all changes in existing rates, factors and assumptions must be provided, including the continued use of trend factors. Support for New Product Offerings must be provided. Groups must meet the definition as "valid groups" as defined in section 4.AN below.

AC. "Rate increase" shall have the same meaning as defined in § 10-16-102(57), C.R.S., and includes increases in any current rate or any factor, including trend factors, used to calculate premium rates for new or existing policyholders, members or certificate holders. Rate changes applicable to "New Business Only" are considered rate changes, and must be supported. Rate increases for "New Business Only" are subject to prior approval.

AD. "Rating Period" shall have the same meaning as defined in § 10-16-102(58), C.R.S.

AE. "Renewed" means, for the purposes of this regulation, a health coverage plan that is 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.

AF. "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).

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

AH. "Substantially different new benefit" means for the purposes of this regulation, a new benefit that results in a change in the actuarial value of the existing benefits by 10% or more. The offering of additional cost sharing options (i.e. deductibles and copayments) to what is offered as an existing product – does not create a new form. Actuarial value is the change in benefit cost as developed when making other benefit relativity adjustments.

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

AJ. "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. Trend factors include inflation factors, durational factors and the Index Rate for small group business. Rate filings must be submitted on an annual basis to support the continued use of trend factors.

AK. "Underwriting wearoff" means, for the purposes of this regulation, 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.

AL. "Unfairly discriminatory rates" means, for the purposes of this regulation, charging different rates for the same benefits provided to individuals, or groups, with like expectations of loss; or if after allowing for practical limitations, differences in rates 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.

AM. "Use of the rates" means, for the purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder including advertising, distributing rates or premiums to agents, and disclosing premium quotes. Rates must be filed with the Division and forms must be certified prior to use. 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.

AN. Valid group" means, for the purposes of this regulation, a group of persons who qualify for "group sickness and accident insurance" as defined in § 10-16-214(1), C.R.S. All groups must meet the qualifications as "valid groups". Non-employer groups, including, but not limited to, associations, trusts, unions, and organizations eligible for group life insurance shall be submitted to the Division for approval. Groups formed for the purpose of insurance are prohibited under Colorado law. Multi-state associations must also meet the requirements under §10-16-214(1), C.R.S. Bona fide associations must meet the requirements under §10-16-102(6), C.R.S. Trusts must meet the requirements under §10-7-201, C.R.S., and must be formed by one or more employers or by one or more labor unions, or by one or more employers and one or more labor unions. Union agreements must also be submitted to the Division.

AO. "Wellness and prevention program" shall have the same meaning as defined in § 10-16-136(7)(b), C.R.S., and apply to individual and small group health coverage plans.

Section 5 General Rate Filing Requirements

All rates associated with health coverage policies, riders, contracts, endorsements, certificates, and other evidence of health coverage, must be filed with the Division prior to issuance or delivery of coverage. 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.

a. 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.

b. A carrier who provides insurance coverage under the rates before the proposed implementation date will be considered to be using unfiled rates and the Division would take appropriate action as defined by Colorado law.

c. After the rate filing has been approved by the commissioner, carriers may bill members but not require the member to remit premium prior to the proposed implementation date of the rate change.

d. If the commissioner does not approve or disapprove the rate filing within 60 calendar days after the submission date, the carrier may implement the rates filed.

e. Under no circumstances shall the carrier provide insurance coverage under the filed rates until on or after the proposed implementation date specified in the rate filing.

2. Existing law also defines a rate increase as any increase in the current rate, including an increase in any base rate, or any rating factor, or continued use of trend factors, used to calculate premium rates, that results in an overall increase in the current rate to any existing policyholder or certificate holder renewing during the proposed rating period of the filing, and such a rate increase would be considered a prior approval filing. Rate increases as applied to 'new business only' are also subject to prior approval.

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

   The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a rate filing. Corrections of any deficiency identified after the 60th calendar day will be required on a prospective basis and no penalty will be applied for a non-willful violation identified in this manner if the rates are determined to be excessive, inadequate or unfairly discriminatory.

   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;

d. The rate filing is incomplete; or

e. The data in the filing failed to adequately support the proposed rates.

3. File and Use: Any rate filing not specified in Paragraph 1 of this subsection is classified as file and use. Existing law allows for file and use rate filings to be implemented upon submission to the Division and correction of any deficiency shall be on a prospective basis. All filings not returned on or before the thirtieth day after submission to the Division will be considered complete. Rates for all health coverages must be filed with the Division prior to use.

   To determine file and use, calculations should reflect the 12 months accumulative impact of trend and any changes to rating factors or base rates. If there is an annual cumulative decrease in rates for all policyholders during the filed rating period then the filing would be file and use.

   If new rates, rating factors, or a rate change has been implemented or used without being filed with the Division, corrective actions may be ordered, including, but are not limited to, civil penalties, refunds to policyholders, and/or rate credits. Use of unfiled rates may also be deemed excessive. Under no circumstances shall the carrier provide insurance coverage 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 to remit premium prior to the proposed implementation date of the rate change. All filings must be filed with the Rates and Forms Section of the Division.

4. New Policy Forms and Products: Carriers shall not represent an existing product to be a new policy form or product unless it fits the definition set forth in Section 4.R. If a policy form is not a new policy form or product and the rate is increasing, the rate filing will be considered a prior approval filing and the required supporting documentation required by law and regulation will need to be submitted with the filing.

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

6. Required Submissions:

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

   b. All carriers must submit a compliant rate filing whenever the rates charged to new or renewing policyholders or certificate holders differ from the rates on file with the Division. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or change(s) in 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 will take appropriate action as defined by Colorado law.

c. All carriers must submit a compliant rate filing on at least an annual basis, at a minimum, to support the continued use of trend factors which change on a predetermined basis. The rate filing must contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate. The rate filing shall contain all of the items required in this regulation. The rate filing must demonstrate that the proposed rate is not excessive, inadequate or unfairly discriminatory. Note: Trend factors which change on a predetermined basis can be continued for no more than a period of twelve months. To continue the use of trend factors that change on a predetermined basis, a filing must be made for that particular form with an implementation date on or before the one-year anniversary of the implementation date of the most recent rate filing.

d. All carriers must submit a compliant rate filing when the rates are changed on an existing product even though the rate change pertains to 'new business only'. Colorado experience data for this existing product must be submitted. If Colorado data is partially credible, nationwide data must also be submitted. Detailed support must be provided for the rate change. Support must also be provided to ensure rates are not discriminatory. Assessing different rates for the same product based on issue dates may violate Colorado law.

e. All carriers must submit a compliant 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 is proposing to use, even if there is no change in the rating factors. The new filing must demonstrate that the rating assumptions are still appropriate.

f. Each line of business requires a separate rate filing. Rate filings should not be combined with form filings.

g. All carriers are expected to review their experience on a regular basis, no less than annually, and file rate revisions, as appropriate, in a timely manner to ensure that rates are not excessive or inadequate and to avoid filing large rate changes. Rates are deemed excessive if the actual loss ratio falls below the loss ratio as filed with the Division.

h. The Form Schedule tab in SERFF must be completed for all rate and form filings. This tab must list policies, riders, endorsements, or certificates referenced in the rate filing. Do not attach actual forms in a rate filing.

7. 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 are subsequently resubmitted, will be considered as new filings. If a filing is withdrawn, returned, or disapproved, those 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.

8. 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 electronically submitted rate filings must meet all relevant general requirements, including all necessary rate and policy forms. If a filing is returned as incomplete those rates may not be used or distributed.

9. 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.

10. Required Inclusions: Rate filings require the submission of an actuarial memorandum in the format as specified under Section 6 of this regulation. A response must be provided for each element under Section 6. The level of detail and the degree of consistency incorporated in the experience records of the carrier are vital factors in the presentation and review of rate filings. Every rate filing 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 upon by the carrier; the interpretation of any statistical data relied upon by the carrier; descriptions of methods used in making the rates; and any other similar information deemed necessary by the carriers. Actual experience must be submitted for changes to existing products. In addition, the commissioner may request additional information used by the carrier to support the rate change request.

11. Confidentiality: All rate filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. The Division does not consider such items as rates, rating factors, rate histories, or side-by-side comparisons of rates or retention components to be confidential. The entire filing, including the actuarial memorandum, cannot be held as confidential. There should be a separate SERFF component for the confidential exhibits, and must be indicated by the icon as confidential in SERFF. Non-confidential information, such as the actuarial memorandum, must be in a separate SERFF component.

    A "Confidentiality Index" must be completed if the carrier desires confidential treatment of any information submitted as required in this regulation. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected. It should be noted that HMOs are not afforded automatic confidential treatment of any rate filings and therefore must complete a Confidentiality Index.

B. Actuarial Certification

Each rate filing shall include a signed and dated statement by a qualified actuary, which attests that, in the actuary's opinion, the rates are not excessive, inadequate or unfairly discriminatory. (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).

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

"This policy DOES NOT include coverage of pediatric dental services as required under The Patient Protection and Affordable Care, Pub, L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub, L. 111-152. Coverage of pediatric dental services is available for purchase in the State of Colorado and can be purchased as a stand-alone plan. Please contact

your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-certified stand-alone dental plan that includes pediatric dental coverage."

Section 6 Actuarial Memorandum

The rate filing must contain an actuarial memorandum. To ensure compliance with this regulation, each of the following sections must be provided in the memorandum in the designated order shown below, or in an alternate template supplied by the Division. A response must be provided for each element under this section. The actuarial memorandum must be attached to the Supporting Documents tab in SERFF, and must be accompanied by a certification signed by, or prepared under the supervision of, a qualified Actuary, in accordance with the actuarial certification requirements of this regulation. Do not attach the actuarial memorandum, supporting documents, or actuarial certification to the Rate/Rule tab in SERFF.

A. Summary: The memorandum must contain a summary that includes, but is not limited to, the following:

1. Reason(s) for the rate filing: A statement as to whether or not this is a new product offering, a rate revision to an existing product, which includes rates applicable to "New Business Only", or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision should be clearly 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. (Agency/Broker, Internet, Direct Response, Other) If the block is closed, provide the closure date.

4. Premium classification: This section should state all attributes upon which the premium rates vary.

5. Product descriptions: This section should describe the benefits provided by the policy, rider or contract.

6. Policy/Rider or contract: A listing of all policy/rider or contracts impacted by the submission (for standardized Medicare supplement, the plans should be identified).

7. Age basis: This section must state 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.

A: SUMMARY	
1. Reason(s). Detail the reason for the filing: New Product Offering, a rate revision, change in rating methodology, change in benefits, trend only, etc.	
2. Requested Rate Action (This data should agree with the Rate/Rule tab in SERFF):	Rate Change Without Trend Factor: _____% Trend Factor applied*: _____% Rate Change With Trend Factor: _____% Minimum Change: _____% Maximum Change: _____% *Trend 'assumptions' used to project morbidity are NOT considered a rate change.

3. Marketing method(s):	☐ Agency / Broker ☐ Internet ☐ Direct Response ☐ Other: ☐ Closed Block _____ (Date Closed)
Market Type:	☐ Individual ☐ Group ☐ Small ☐ Large ☐ Small and Large ☐ Employer Only ☐ Non-Employer: Identify ALL non-employer Groups, and provide the SERFF Tracking Number of Division Approval ☐ Trust: _____ ☐ Blanket: _____ ☐ Union: _____ ☐ Association: _____ _____ _____

4.Premium Classification(s):	☐ Age ☐ Area Factor ☐ Gender ☐ Smoking and/or Tobacco ☐ Group Size Factor ☐ Tiers (describe)_____ ☐ Other _____
5. Product Description(s):	
6. Policy/Rider impacted:	Base Policy #_____ Rider #_____ Rider #_____ Rider #_____ Rider #_____ Rider #_____ Rider #_____ Rider #_____
7. Age Basis:	☐ Issue Age ☐ Renewal Age ☐ Attained Age ☐ Both Issue & Attained Age ☐ Other:

8. Renewability Provision	☐ Guaranteed Renewable ☐ Cancellable, ☐ Non-cancellable ☐ Optionally renewable ☐ **Other**
Additional Information:	

B. Assumption, Acquisition or Merger: The memorandum must state whether or not the products included in the rate filing are part of an assumption, acquisition or merger of policies from/with another carrier. If so, 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 the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption of the acquisition or assumption rate filing. Commissioner approval of the assumption or acquisition of a block of business is required. See Section 5.A.6.e. for acquisition or assumption rate filing requirements.

B: ASSUMPTION, MERGER OR ACQUISITION	
1. Is product part of assumption, acquisition, or merger (from or with another company)?	
Assumption:	☐ **Yes** ☐ **No**
Acquisition:	☐ **Yes** ☐ **No**
Merger:	☐ **Yes** ☐ **No**
2. If yes, provide name of company(s):	
3. Closing Date of assumption, merger or acquisition:	
4. SERFF or State Tracking Number of Assumption rate filing	
Additional Information:	

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.

C: RATING PERIOD	
Proposed Effective Date (this date must agree with the Implementation Date Requested field reflected on the General Information tab in SERFF):	**(MM/DD/YYYY)**
Rating Period:	

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 federal, state or local law(s) or regulation(s). All applicable benefit mandates should be listed, including those with no rating impact. This quantification must include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

E: EFFECT OF LAW CHANGES - Identify and quantify changes resulting from mandated benefits and other law changes:
Mandated Benefits ☐YES ☐NO **Other Law Changes:** ☐YES ☐NO
Additional information:

F. Rate History: The memorandum must include a chart showing at a minimum, all rate changes that have been implemented in the three years immediately prior to the filing date, including the implementation date of each rate change.

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

months.

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

3. The rate history should be provided on both a Colorado basis, as well as an average nationwide basis, if applicable. This information must be provided in the format required by the Division.

F: RATE HISTORY

Provide the State Tracking Number or SERFF Tracking Number of the Previous Rate Filing _____ and Effective Date: _____(MM/DD/YYYY)

Provide rate changes made in at least the last three years

☐ **N/A (Initial Filing)**

COLORADO

State Tracking Number or SERFF Tracking Number	Effective Date	% OF CHANGE			
		Minimum	Average	Maximum	Cumulative for past 12 Months

If data is presented in an exhibit, identify the exhibit.

NATIONWIDE		
Effective Date	**Average % of change**	**Cumulative for past 12 Months**
Additional Information:		

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

G: COORDINATION OF BENEFITS	
Provides actual loss experience net of any savings:	☐ Yes ☐ No
Additional Information:	

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.E and 7.F of this regulation.

2. Retention Percentage: The actuarial memorandum must list and adequately support each specific component of the retention percentage. The support for a health benefit plan must include a comparison of the most recent levels experienced for each component as shown in the plan's financial statements, with an explanation for any variations between retention loads used and actual experience for each component.

   a. If the product was not initially priced using a lifetime loss ratio standard, the retention

percentage is equal to the sum of all the 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, divided by earned premium.

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

Each of these specific components 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
Accident Only	60%
Dental	60%
Hospital Indemnity	60%
Limited Benefit Plans	60%
Long-Term Disability Income	60%
Short-Term Disability Income	60%
Short Term Limited Duration Individual Health Plans	60%
Specified or Dread Disease	60%
Stop Loss	60%
Travel Accident/Sickness	60%
Vision	60%
Long-Term Care	60%
Group Medicare	75%

Supplement	
Individual Medicare Supplement	65%

c. For individual products issued to HIPAA eligible individuals the premiums for these products are, at most, two times the premiums for the underlying, underwritten product.

H: Relation of Benefits to Premium		
Description	**Percentage**	**Support**
Commissions		Year 1 _____% Year 2 _____% Year 3 _____% Year 4 _____% Year 5+ _____% Other:
General expenses		
Premium taxes		
Profit/Contingencies		
Investment Income		
PPACA Fees		
Other Fees (explain)		☐ **Initial** ☐ **Annual**
Other (explain)		

Total Retention		

Targeted Loss Ratio: (This number should equal 1 minus the total retention percentage listed above.)	_____%
Actual Benefit Ratio: (This number should be based on the Experience Period.)	☐ **Colorado:** _____% ☐ **Nationwide:** _____%

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 provision percentage 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%.

J: PROVISION FOR PROFIT AND CONTINGENCIES	
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.	
1. Provision for Profit and Contingencies:	**% Pre-Federal Income Tax After tax**
2. Proposed load in excess of 7% after tax. **Provide detailed support:**	
Additional information:	

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 support for each rating assumption is found to be inadequate.

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

K: DETERMINATION OF PROPOSED RATES	
Include all underlying rating assumptions, with detailed support for each assumption. This explanation may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis.	
1. Explain, in detail, how rates and/or rate changes were developed:	
2. Provide adequate support for all assumptions and methodologies used:	
Additional Information:	

L. Trend: The memorandum 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. Trend factors do not renew automatically. Continued use of trend factors must be supported annually.

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

2. Provided loss data for an applicable plan that pays on an expense basis must be on an incurred basis with pharmacy data shown separately from medical data, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and incurred but not reported (IBNR) reserves) as of the valuation date. The plan

should indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

3. Provided claims experience for an applicable plan that pays on an expense basis should include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims, total medical incurred claims including estimated IBNR claims, actual pharmacy paid on incurred claims, total pharmacy incurred claims including estimated IBNR claims, average covered lives for medical, and average covered lives for pharmacy.

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

    a. Medical trend means, for the purposes of this section, the combined effect of medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology.

    b. Insurance trend means, for the purposes of this section, the combined effect of underwriting wearoff, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Note: medical trend must be determined or assumed before insurance trend can be determined. Underwriting 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.

L: TREND	
Itemized trend component	**Trend (%)**
MEDICAL TREND (total)	
Medical provider price increase	
Utilization changes	
Medical cost shifting	
Medical procedures and new technology	
INSURANCE TREND (total)	
Underwriting wear off	
Deductible leveraging	
Anti-selection	
PHARMACEUTICAL TREND (total)	
Price increases	
Utilization changes	
Cost shifting	
Introduction of new brand and generic drugs	
TOTAL AVERAGE ANNUALIZED TREND (required)	
Additional information:	

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. Partial credibility shall be based on either the number of Life Years OR the number of Claims over a three year period. Partial credibility must be used if the Colorado data is not fully credible. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers)

must be provided and the use of such data must be justified.

2. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is the square root (number of life years or claims/full credibility standard). The full credibility standard is defined above, and Colorado data must be provided.

3. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.

M: CREDIBILITY	
1. Credibility Percentage (Colorado Only): **If other, please specify**	%
The above credibility percentage is based upon:	☐ Life Years ☐ Claims ☐ Other (please specify)
2. Number of years of data used to calculate above credibility percentage:	
3. Discuss how and if aggregated data meets the Colorado credibility requirement and how the rating methodology was modified for the partially credible data, if applicable.	
Additional Information: (including collateral data, if used)	

N. Data Requirements: The memorandum must include, at a minimum, 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.

1. Pharmacy claims data for health benefit plans or an applicable plan that pays on an expense basis should also be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.

2. National or other relevant data shall be provided in order to support the rates, if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates; rating factors; rating methodology; trend; new benefit options; or new plan designs for an existing product.

3. If the purpose of the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience from the new product is available, experience from a comparable product must be provided, including experience data from other carriers that have been used to support the rates or, the statistical data used in rate development.

4. Support for new policy forms must be provided. If the new policy form is based on an existing policy form, the experience of the existing policy form must be used to support the new policy form, with an explanation as to the benefit differences and the differences in relativity factors between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles or co-payments) does not change the existing form into a "New Product", as defined in this regulation.

5. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. Data used to support the rates must be included in the filing.

    a. For both Renewal filings and new business filings, the experience period must include consecutive data no older than nine months prior to the effective implementation date.

    b. For New Business only filings, the experience period must include consecutive data on the existing product no older than nine months prior to the effective implementation date.

    c. For New Product Offerings, rates must be supported. This data can be from a comparable product at the company or from another carrier.

6. The loss data must be presented on an incurred basis, including accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Premiums and/or exposure data must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information on how the number of claims was calculated.

N: DATA REQUIREMENTS

Colorado-only basis for at least 3 years. **Include** national, regional or other appropriate basis, if the Colorado data is not fully credible. The experience period must include consecutive data no older than 9 months prior to the effective implementation date.

	COLORADO DATA							
Year*	Earned Premium	Incurred Claims	Total Estimated Incurred Claims	Estimated IBNR Claims	Loss Ratio	Average Covered Lives	Number of Claims	Colorado On Rate Level Premium
20XX								
20XX								
20XX								
20XX								
20XX								

***This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY**

Above data is for:	☐ Existing Product ☐ Comparable Product ☐ Other _____ (please specify)

	OTHER DATA					
Year	Earned Premium	Incurred Claims	Total Estimated Incurred Claims	Estimated IBNR Claims	Average Covered Lives	Number of Claims
20XX						
20XX						
20XX						
20XX						
20XX						
Above data is for: (Check all the apply)	☐ Existing Product ☐ Comparable Product ☐ National ☐ Other (please specify)_____					

Experience Period:	**From** **to**
Detailed description regarding support used for "New Product Offering":	
Additional Information:	

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 state this and provide detailed support for each of the rating factors.

O: SIDE-BY-SIDE COMPARISON only				☐ N/A- New Product
If the proposed rating factor(s) are new, the memorandum must specifically so state, and provide detailed support for each of the factors.				
Description	**Current Rate/ Rating Factor/ Rating Variable**	**Proposed Rate/ Rating Factor/Rating Variable**	**Percentage Increase/ Decrease**	**Detailed Support for Rating Factor Change**

If the above table is not used, please identify the location of the Side-by-Side Comparison in the rate filing:		
Description and detailed support for new rating factor(s):		
Additional Information:		

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. The comparison should be shown in chart form; listing projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should be included. 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.

P. BENEFITS RATIO PROJECTIONS			
PROJECTED EXPERIENCE FOR RATING PERIOD			
	Premiums	Incurred Claims	Benefits Ratio
Projected Experience Without Rate Change			
Projected Experience With Rate Change			
If priced using a lifetime loss ratio standard, the above projections should show the projected lifetime loss ratios and should include the entire lifetime of the product(s), or a time frame over which the lifetime loss ratio will be achieved. Above projections include (check only one box):		☐ Colorado ☐ Nationwide ☐ Blended CO/Nationwide ☐ Other (please specify)	
Additional Information:			

Q. Other Factors: The memorandum must clearly display or clearly reference all other rating factors and definitions used, including the area factors, age factors, gender factors, etc., and provide support for the use of each of these factors in the new rate filing. The same level of support for changes to any of these factors must be included in all renewal rate filings. In addition, the commissioner expects each carrier to review each of these rating factors every five years, at a minimum, 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.

Q: OTHER FACTORS	
Identify and provide support for other rating factors and definitions, including area factors, age factors, gender factors, etc.:	
Additional Information:	

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/reject basis are not required to be filed. Rate pages and rate manuals must be attached to the Rate/Rule Schedule tab in SERFF. All other documents must be attached to the Supporting Documents tab in SERFF.

S. Actuarial certification - An actuarial certification must be submitted with all rate filings. Actuarial Certification is a signed and dated statement made by a qualified Actuary which attests that, in the Actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

Section 7 Additional Rate Filing Requirement by Line of Business

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

A. Individual: Renewal rates for individual health coverage 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 rewards 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 that the wellness program is scientifically proven to improve health and that the incentives are not provided based on an individual's actual health status; and

    c. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:

        (1) Does not exceed 20% of the premium; and

        (2) Is not a subterfuge for discriminating based upon a health status-related factor.

    d. For purposes of small group plans, the incentives or rewards attributable to the individual (and all similarly situated individuals) shall be applied to that individual (and all similarly situated individuals), and shall not be distributed to the entire group.

7. The carrier shall include any information as required by the commissioner to ensure that the filed rates, in conjunction with the incentives and rewards available under the wellness program, are not excessive, inadequate, or unfairly discriminatory.

C. Large Group Health Coverage Plans: Large group health coverage plan contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing 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 to 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 must 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.

Groups must meet the requirements as "valid groups" as defined in Section 4.AN of this regulation. All 'Non-employer' groups must be approved by the Division. Detailed support must be provided explaining how each non-employer group meets the requirements of a valid group. Groups formed for the sole purpose of insurance are prohibited.

D. Valid Multi-State Association Groups: To be considered a valid multi-state group, a group shall meet the requirements of § 10-16-214(2)(b), C.R.S. All associations must be identified and the by-laws and articles of association for each association must be submitted to the Division for approval. Once the association has been approved by the Division, the filing must provide the SERFF Tracking Number of the approval filing when submitting all rate filings for the association, and include confirmation that the coverage requirements of the association are still being met.

E. 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. Additional Rrating requirements can be found in Sections 10.E, 13 and 14.F – J of that same regulation). Although the Modernized plans must be filed separately from the closed OBRA '90 Standardized plans, the experience for the Modernized plans and the OBRA '90 Standardized plans must be included in each filing type. The experience must be reported separately by plan for each type, as well as combined by plan for Modernized and Standardized, and totaled as all plans. This must be done for all Colorado plans. Nationwide data must be provided if Colorado data is not fully credible.

F. 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.

G. Disability Income: The filing must demonstrate that investment income has been considered in the development of the rate. Short-term disability rates must be filed separately from Long-term disability rates. Each must be supported separately. Group Disability Income plans must also meet the requirements under §10-16-214(3)(a)(V)(C),C.R.S.

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

Section 11 Effective date

This emergency regulation shall be effective June 15, 2013.

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 4-2-11 amended, effective February 1, 2013.

Emergency Regulation 13-E-01, effective June 15, 2013

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

Section 1 Authority

This regulation is promulgated pursuant to § § 10-1-109 and 10-16-107(5)(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 § 10-16-107(5), C.R.S., concerning women's access to obstetricians, gynecologists, and certified nurse midwives in managed care plans.

Section 3 Applicability

The provisions of this regulation shall apply to all carriers offering managed care plans that provide coverage for reproductive health or gynecological care.

Section 4 Definitions

A. "Carrier" shall have the same meaning as set forth in § 10-16-102(8), C.R.S.

B. "Managed care plan" shall have the same meaning as set forth in § 10-16-102(26.5), C.R.S. Examples of managed care plans include but are not limited to: preferred provider organization (PPO) plans, gatekeeper plans, health maintenance organization (HMO) plans, plans offered by limited service licensed provider (LSLPN) 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).

C. " 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 carrier, a representative of the carrier, 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. Notwithstanding any other provision in law, 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 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 carrier's procedures shall specify whether the request should be submitted to the carrier 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 one (1) working day of the date on which the request was made if it is an oral request, or within one (1) working day of the date on which it was received if it is a written request. Where a carrier allows a primary care provider to process referral requests, pursuant to paragraph 5.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 carrier'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 carrier 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 Colorado Insurance Regulation 4-2-17.

6. Carriers 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 carrier 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, gynecologist, or certified nurse midwife.

8. Carriers 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 midwife to provide such information shall not in any way result in financial or other penalties being imposed by the carrier on either the patient or the primary care provider.

D. If the managed care plan requires the designation of a primary care provider, the carrier shall inform each covered person that there is no requirement to obtain an authorization or referral for obstetrical or gynecological care by a participating obstetrician, gynecologist, or certified nurse midwife.

1. In the case of a group managed care plan, this notice must be included whenever the carrier provides the covered person with a summary plan description or other similar description of the plan's benefits.

2. In the case of an individual managed care plan, the notice must be included whenever the carrier provides the primary subscriber with a policy, certificate, or contract.

E. All carriers 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 that have been appealed shall not include patient identifying information. The log shall be made available upon request to the Division of Insurance.

F. Nothing in this regulation shall be construed to require a carrier 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 carrier to include in its plan of coverage specific obstetrical or gynecological services except to the extent otherwise required by law or regulation.

Section 6 Severability

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

Section 7 Enforcement

Non-compliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license.

Section 8 Effective Date

This amended regulation is effective on March 1, 2012.

Section 9 History

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

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

Amended regulation effective March 1, 2012.

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

This regulation is promulgated under the authority of § § 10-1-109(1), 10-16-109, and 10-16-118(1)(b), C.R.S.

Section 2 Scope and Purpose

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 § 10-16-118(1) (b) , C.R.S.

Section 3 Applicability

This amended regulation shall apply to all certificates of creditable coverage issued on or after March 1, 2012.

Section 4 Definitions

A. "Individual", as used in this regulation, means a person age nineteen years and older.

B. "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 (Division), 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 Division, a significant break in coverage may consist of as few as sixty-three (63) days.

C. "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 § 10-16-118(1) (b) , C.R.S. , shall be as set forth in the federal regulations incorporated into this regulation.

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.

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply to both group and individual plans that are subject to § 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. 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. However any health coverage plan subject to the jurisdiction of the Division must issue certificates of creditable coverage that reflect

the definition of a "significant break in coverage" found in section 4.B. of this regulation.

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

Colorado law prohibits group health benefit plans from imposing a pre-existing condition limitation period that exceeds six (6) months, except with respect to late enrollees as provided for in § 10-16-118(1)(c), C.R.S. All 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 benefit plans are considered group health benefit plans.

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

E. 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 § 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 § 10-16-118 (1) (c) , C.R.S.

Section 6 Severability

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

Section 7 Incorporated Materials

The following are hereby incorporated by reference as written on or before the effective date of this regulation. This rule does not include later amendments to or editions of the incorporated material. A copy of these references may be examined at any state publications depository library. For additional information regarding how to obtain a copy please contact the Colorado Division of Insurance, 1560 Broadway Suite 850, Denver, CO 80202.

A. Title 45 of the Code of Federal Regulations, section 146.113(a) (3) , (b) and (c) ;

B. Title 45 of the Code of Federal Regulations, section 146.115; and

C. Title 45 of the Code of Federal Regulations, section 148-124(b) .

Section 8 Enforcement

Non-compliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license.

Section 9 Effective Date

This amended regulation is effective on March 1, 2012.

Section 10 History

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

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

Amended, effective November 1, 1999.

Amended, effective October 1, 2004.

Amended regulation effective March 1, 2012.

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 SUPPLEMENT TO THE SUMMARY OF BENEFITS AND COVERAGE FORM

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-16-108.5(11)(b), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to coordinate the requirements of § 10-16-108.5(11), C.R.S. and certain

provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the "Affordable Care Act" (ACA). This regulation also sets out procedures for carriers to make available a Colorado Supplement to the Summary of Benefits and Coverage Form for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer.

Section 3 Applicability

This regulation shall apply to all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage on and after January 1, 2013.

Section 4 Definitions

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

B. "Glossary" means the form required by the Affordable Care Act as described in the final rule published on February 14, 2012 in Volume 77, No. 30 of the Federal Register (77 FR 8668, Summary of Benefits and Coverage and Uniform Glossary).

C. "Health benefit plan" shall have the same meaning as § 10-16-102(21), C.R.S.

D. "Summary of Benefits and Coverage" means the form required by the Affordable Care Act as described in the final rule published on February 14, 2012 in Volume 77, No. 30 of the Federal Register (77 FR 8668, Summary of Benefits and Coverage and Uniform Glossary).

Section 5 Rules

A. All carriers offering or providing health benefit plan coverage shall make available to a producer or consumer through electronic means or paper copy, along with a Summary of Benefits and Coverage form, a completed copy of the Colorado Supplement to the Summary of Benefits and Coverage Form shown in Appendix A for each policy or contract for a health benefit plan that either covers a Colorado resident or is selected by a Colorado resident or such resident's employer for which the employee or participant is eligible.

B. Carriers marketing or providing a Medicare supplemental plan shall meet the requirement of § 10-16-108.5(11)(a), C.R.S., by making available for each such plan a Medicare supplement outline of coverage as prescribed in Colorado Insurance Regulation 4-3-1, 3 CCR 702-4.

C. Carriers shall use the exact format found in Appendix A for the Colorado Supplement to the Summary of Benefits and Coverage Form. All boxes must be filled in. Carriers may modify box dimensions, reduce margins, or use a portrait rather than a landscape page layout format. A carrier may also add its logo to the form and print the form in color or black and white. Pursuant to § 10-3-1104(1), C.R.S., in completing the form, carriers shall not misrepresent the benefits, advantages, conditions, or terms of the policy.

D. Carriers shall follow the directions for completing the Colorado Supplement to the Summary of Benefits and Coverage Form found in Appendix B of this regulation.

E. Carriers shall provide a Colorado Supplement to the Summary of Benefits and Coverage Form that is specific with respect to the particular policy provisions of the policy as follows:

    1. Automatically, along with the applicable Summary of Benefits and Coverage form, other health benefit plan description materials, or enrollment application given to employees or members of a group, association or health care cooperative who have the option of

selecting such an employer-sponsored, group-sponsored, association-sponsored, or cooperative-sponsored plan when they initially become eligible for coverage and thereafter during any open enrollment period;

2. Automatically, along with the applicable Summary of Benefits and Coverage form, within seven (7) business days of a potential policyholder expressing interest in a particular plan or such plan being selected as a finalist from which the ultimate selection will be made;

3. Upon request, along with the applicable Summary of Benefits and Coverage form, and the glossary if requested, within seven (7) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier. The request may be made orally or in writing to the carrier;

4. Upon request, along with the applicable Summary of Benefits and Coverage form, and the glossary if requested, within seven (7) 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. The request may be made orally or in writing to the carrier;

5. As part of any written application materials that are distributed by the carrier for enrollment, along with the applicable Summary of Benefits and Coverage form. If written application materials are not distributed, it shall be provided no later than the first date on which the employee is eligible to enroll for coverage for the employee or dependent;

6. No later than thirty (30) calendar days prior to the first day of coverage under the new plan year when the policy has an automatic renewal, along with the applicable Summary of Benefits and Coverage form. If the policy has not been issued or renewed before such 30-day period, it should be provided no later than seven (7) business days after issuance of the new policy or the receipt of written confirmation of intent to renew whichever is earlier;

7. As soon as practicable following the receipt of the group application, but in no event later than seven (7) business days following receipt of the application, along with the applicable Summary of Benefits and Coverage form;

8. If there is any change in the information required to be on the Colorado Supplement to the Summary of Benefits and Coverage Form between the application for coverage and the first day of coverage, the carrier must update and provide a current form to the individual, employee and/or dependent no later than the first day of coverage.

F. Anti-duplication rule.

1. For group plans, if the employer, plan administrator, association or health care cooperative has provided the required form to the employee, dependent or member, the carrier is not required to provide a duplicate Colorado Supplement to the Summary of Benefits and Coverage Form.

2. For individual policies, the Colorado Supplement to the Summary of Benefits and Coverage Form may be provided to one address unless any dependents are known to reside at a different address.

G. A carrier shall develop a separate Colorado Supplement to the Summary of Benefits and Coverage Form for each of its health benefit plans.

H. The Colorado Supplement to the Summary of Benefits and Coverage Form should not include

attachments, except that a carrier may:

1. Attach a list of exclusions developed pursuant to subsection J. of section 5 of this regulation;

2. Attach information on premiums;

3. Attach information on riders; or

4. 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 § 10-16-704(9), C.R.S.).

J. A carrier shall make a list of policy exclusions available immediately upon request, but in no event more than seven (7) business days after the request, for each of its health benefit plans.

K. The Colorado Supplement to the Summary of Benefits and Coverage Forms developed for each health benefit plan shall be in standard, easy-to-read type sizes and fonts, of no less than 12 points.

Section 6 Severability

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

Section 7 Incorporated Materials

The relevant portions of the final rule published on February 14, 2012 in Volume 77, No. 30 of the Federal Register (77 FR 8668, Summary of Benefits and Coverage and Uniform Glossary) as published on the effective date of this regulation are incorporated by reference. Later amendments to this final rule are not included. Volume 77, No. 30 of the Federal Register may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202.

Section 8 Enforcement

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

Section 9 Effective Date

This regulation is effective on September 1, 2012.

Section 10 History

New regulation effective November 15, 1997.

Amended Sections 1, 2, 3, 4, 7, Appendix A, and Appendix B effective September 30, 1998.

Amended regulation effective January 1, 2004.

Amended regulation effective: January 1, 2005.

Amended regulation effective July 1, 2007.

Repealed and repromulgated effective September 1, 2012.

Appendix A

Colorado Supplement to the Summary of Benefits and Coverage Form

_____

Name of Carrier

_____

Name of Plan

_____

Policy Type

TYPE OF COVERAGE

1. Type of plan.	.
2. Out-of-network care covered? [1]	.
3. Areas of Colorado where plan is available.	.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note : The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

.	**Description**	**What this means.**
4. Deductible Period	[Calendar year]	[Calendar year deductibles restart each January 1.]
.	[Benefit year]	[Benefit year deductibles restart on a date other than January 1. Please see your policy or plan document to see the date the deductible starts over.]
.	[Per Accident or Sickness]	[Deductible restarts with each new accident and/or sickness. Please see your policy or plan document for a more complete description.]
5. Annual Deductible	[Individual/Family]	["Individual" means the

Type		deductible amount you and each individual covered by the plan will have to pay for allowable covered expenses before the carrier will cover those expenses. "Family" is the maximum deductible amount that is required to be met for all family members covered by the plan. 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").]
.	[Single Coverage/Non-single Coverage]	["Single" means the deductible amount you will have to pay for allowable covered expenses under this HSA-qualified health plan when you are the only individual covered by the plan. "Non-single" is the deductible amount that must be met by one or more family members covered by this HSA-qualified plan before <u>any</u> covered expenses are paid.]
6. What cancer screenings are covered?	.	.

LIMITATIONS AND EXCLUSIONS

7. Period during which pre-existing conditions are not covered for covered persons age 19 and older. [2]	.
8. How does the policy define a "pre-existing	.

condition" ?	
9. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	.

USING THE PLAN

.	**IN-NETWORK**	**OUT-OF-NETWORK**
10. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	.	.
11. Does the plan have a binding arbitration clause?	.	.

Questions: Call 1-800-[insert carrier's customer service number] or visit us at www.[insert carrier's web address].

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance

Consumer Affairs Section

1560 Broadway, Suite 850, Denver, CO 80202

Call: 303-894-7490 (in-state, toll-free: 800-930-3745)

Email: insurance@dora.state.co.us

Endnotes

1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that this 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 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.

Appendix B

Directions for Filling Out the

Colorado Supplement to the Summary of Benefits and Coverage Form

TOP OF FORM

Carrier and plan names : Fill in the 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.

Policy Type : Select one of the following choices only: (1) “Individual Policy” , (2) “Small Employer Group Policy” , (3) “Large Employer Group Policy” , (4) “Association Group Policy” , or (5) “Short-term Limited Duration Policy” .

TYPE OF COVERAGE

Question 1: Type of Plan . Enter type of plan. Select one of the following choices only: (1) “Medical expense policy” , (2) “Preferred provider organization (PPO)” , (3) “Health maintenance organization (HMO)” , (4) “Point of service (POS)” (i.e., an HMO plan with some out-of-network benefits), or (5) “Limited service licensed provider network (LSLPN) 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]; or (5) “Yes; plan makes no distinction between in-network and out-of-network care.” [e.g., traditional indemnity plans]. For HMOs that are marketing to small employers or employees of small employers outside of its geographic service area, the following statement must be added in bold, 10 point font caps:

“INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS.”

Question 3: 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.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Question 4: Deductible Period . Describe 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 Sickness” .

Question 5: Annual Deductible Type . For a non-HSA qualified plan, insert “Individual/Family” in the first column and provide the corresponding information in the “What this means.” column. For an HSA-qualified plan, insert “Single Coverage/Non-single Coverage” and provide the corresponding information in the “What this means.” column.

Question 6: What cancer screenings are covered? Provide a list of covered cancer screenings.

LIMITATIONS AND EXCLUSIONS

Question 7: Pre-existing Condition Exclusion Period for covered persons age 19 and older. Select one of

the following choices only: (1) "____ [insert the length of the limitation period] months for all pre-existing conditions." ; (2) "____ [insert the length of the limitation period] months 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. Carriers are reminded that Colorado law governs allowable pre-existing periods for all health benefit plans.

Question 8: 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 children under 19, special enrollees, or for pregnancy." ; (3) for individual plans: "A pre-existing condition is an injury, sickness or pregnancy for which a person, 19 or older, 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: "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."

Question 9: Exclusionary Riders . All group carriers must enter "No" . Depending on the policy, individual carriers should enter "Yes" or "No."

USING THE PLAN

Question 10: 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."

Question 10: Provider Charges . In each column, select one of the following choices only: (1) "Yes" or (2) "No." If the answer is "Yes" , a carrier may expand on the answer to note exceptions to this requirement.

Question 11: Binding Arbitration . Indicate, with a "Yes" or "No" , if the plan has binding arbitration.

QUESTIONS' FOOTER

Questions : Carrier must insert the appropriate telephone number and website information.

Regulation 4-2-21 EXTERNAL REVIEW OF BENEFIT DENIALS OF HEALTH COVERAGE PLANS

Section 1 Authority

Section 2 Scope and Purpose

Section 3 Applicability

Section 4 Definitions

Section 5 Notice and Disclosure of Right to External Review

Section 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 and adopted by the Commissioner of Insurance 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 provides a uniform list of required elements to be included on a specified uniform claim form in order to be considered a "clean claim".

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.

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.

D. When all of the information or documentation necessary to resolve the claim is initially provided with the appropriate claim form that includes all of the 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.

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 39-41: 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 (30) 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 required shall be requested within thirty (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. This applies even though the genesis of the request may be from other sources, e.g., if the carrier has other information that indicates the information in 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. The following circumstances are those for which additional information is generally required by most health carriers:

1. When the coverage is not primary, an explanation of benefits form from the primary payer;

2. When service/procedure codes indicate "unusual" procedural services or anesthesia, the medical records to justify medical necessity;

3. When surgical procedures utilize multiple surgeons or surgical assistants, the medical records to justify medical necessity;

4. When the procedure is a repeat procedure, the medical records to justify medical necessity;

5. When supplies and materials are ordered on an outpatient basis, the medical records and/or invoice to justify medical necessity or allowable fee; and

6. When services are billed using a "by report" or unlisted CPT code, the medical records to substantiate the claim.

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.

G. Medical information requested from institutional providers shall be limited to the following:

1. History and physical reports;

2. Consultant reports;

3. Operative reports;

4. Discharge summaries;

5. Emergency department reports;

6. Diagnostic reports; and

7. Progress reports.

Section 7 Severability

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

Section 8 Enforcement

Non-compliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license.

Section 9 Effective Date

This regulation is effective June 1, 2012.

Section 10 History

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

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

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

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

Amended Regulation effective June 1, 2012.

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
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
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 and Medicaid and Medicare Part D.

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. 77, No. 92.

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. 77, No. 92 published by Centers for Medicare & Medicaid Services shall mean Federal Register Vol. 77, No. 92 as published on the effective date of this regulation and does not include later amendments to or editions of Federal Register Vol. 77, No. 92. A copy of the Federal Register Vol. 77, No. 92 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A Certified copy of the Federal Register Vol. 77, No. 92 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://www.gpo.gov/fdsys/pkg/FR-2012-05-11/pdf/2012-9985.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 in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

This regulation shall become effective on December 1, 2012.

Section 11 History

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

Amended Regulation, Effective August 1, 2011.

Amended Regulation, Effective December 1, 2012.

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. It is being amended to change the compliance date to ensure that an unnecessary burden is not placed on health carriers doing business in Colorado by requiring they comply with CORE guidelines on a date earlier than the date required by the federal government.

Section 3 Applicability

This regulation applies to all health benefit plan providers and carriers operating in the state of Colorado. Deadlines imposed in this regulation may be extended by the Commissioner under the circumstances listed in subsection 5.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 January 1, 2013, shall be able to show the ability of their systems to allow real time data exchange including benefits eligibility, coverage determinations, and other appropriate provider-carrier transactions and interoperability following all CORE guidelines for data formats and system requirements.

B. Carriers licensed in this state after January 1, 2013, if not already having systems that allow real time data exchange including benefits eligibility, coverage determinations, and other appropriate provider-carrier transactions following all CORE guidelines, shall, within sixty (60) days of becoming licensed adjust their systems to follow all CORE guidelines for data formats and system requirements.

C. CORE Phase I certification shall be accepted as evidence of compliance with subsections 5.A. and 5.B. Those carriers using CORE certification to comply with the provisions of this rule shall be required to become CORE Phase II certified within one (1) year of completing certification for CORE Phase I.

D. All carriers and providers shall uniformly use the Council for Affordable Quality Healthcare-developed CORE data content and infrastructure rules in the exchange of HIPAA compliant healthcare information and infrastructure improvements.

E. When installing new operating systems after December 31, 2012, all carriers are required to use CORE certified systems for communications, those systems which meet CORE certification standards, or contract with a vendor who has applied by January 1, 2013 to be CORE certified.

F. Notwithstanding the above requirements, those systems used solely for internal integrated systems between a carrier and a provider group may be granted an exemption from this requirement so long as CORE certification standards of systems that provide information exchange functionality for carrier interactions related to consumers, out of network providers, and non-dedicated providers is maintained. No exemption exists until the Commissioner has reviewed a written request for exemption and has made a written finding that the exemption is granted.

G. A carrier or provider located in a rural area of the state, as determined by the Commissioner, may apply to the Commissioner for, and the Commissioner may grant, an extension of any of the deadlines imposed by this section if meeting a particular deadline would impose a financial hardship on the rural carrier or provider. The Commissioner may require the rural carrier or provider to submit documentation supporting the financial hardship claim.

Section 6 Severability

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

Section 7 Incorporated Materials

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

Section 9 Effective Date

This regulation shall become effective on July 1, 2012.

Section 10 History

New regulation effective October 1, 2010.

Amended regulation effective July 1, 2012.

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 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.

Regulation 13-E-02 CONCERNING PREMIUM RATE SETTING FOR INDIVIDUAL, SMALL AND LARGE GROUP HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated under the authority of § §10-1-109(1), 10-16-104.9, 10-16-107 and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this emergency regulation is to provide the necessary guidance to carriers to implement the requirements of House Bill 13-1266, enacted during the 2013 General Assembly and to ensure that health insurance rates comply with Colorado's health benefit plan rating laws. The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary to ensure carrier compliance with the recent changes to Colorado law, and to provide the consumer protections provided by the enacted legislation. Therefore, compliance with the requirements of § 24-4-103(3-4), C.R.S. would be contrary to the public interest.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing individual, small group, and/or large group health benefit plans; health benefit plans subject to the individual, small group, and large group laws of Colorado; and stand-alone dental plans that provide for pediatric dental as an essential health benefit. This regulation excludes Individual short-term policies as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. "Benefits ratio" means, for the purposes of this regulation, the ratio of the value of the actual policy benefits, not including policyholder dividends, to the value of the actual premiums, not reduced by policyholder dividends, over the entire period for which rates are computed to provide coverage. Additionally, the Division of Insurance (Division) will consider Quality Improvement (QI), as defined herein at Section 5.Z., in the benefits ratio calculation. 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.

B. "Carrier" means, for the purposes of this regulation, a carrier as defined in § 10-16-102(8), C.R.S., and includes, but is not limited to: licensed life and health insurance companies; non-profit hospital, medical-surgical, and health service corporations; Health Maintenance Organizations (HMOs); prepaid dental companies; and limited service licensed provider networks.

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

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

E. "Dividends" means, for the purposes of this regulation, both policyholder and stockholder dividends.

F. "Essential health benefit" and "EHB" shall have the same meaning as defined in § 10-16-102(22),

C.R.S.

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

H. "Exchange" shall have the same meaning as defined in § 10-16-102(26), C.R.S.

I. "File and use" means, for the purposes of this regulation, a filing procedure that requires rates and rating data to be filed with the Division concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates. Under no circumstance shall the carrier provide insurance coverage using the rates until on or after the proposed implementation or effective date specified in the rate filing. Carriers may bill members but not require the member to remit premium prior to the proposed implementation or effective date of the rate change.

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

K. "Filed rate" means the index rate as adjusted for plan design and the case characteristics of age, geographic location, tobacco use and family size only. The "filed rate" does not include the index rate as further adjusted for any other case characteristic. (See Section 5.A.3. of this regulation)

L. "Geographic area:" means, for the purposes of this regulation, the geographic area selected by Colorado and approved by the federal government, to be used by carriers in the state of Colorado.

M. "Health benefit plan" shall have the same meaning as defined in § 10-16-102(32), C.R.S.

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

O. "Index rate" shall have the same meaning as defined in § 10-16-102(39), C.R.S.

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

Q. "Multistate associations" shall have the same meaning as defined in § 10-16-102(68), C.R.S.

R. "New policy form or product" means, for the purposes of this regulation, a policy form that has substantially different new benefits or unique characteristics associated with risk or costs that are different from existing policy forms. For example: A guaranteed issue policy form is different than

an underwritten policy form; a managed care policy form is different than a non-managed care policy form; a direct written policy form is different from a policy sold using producers, etc.

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

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

U. "Premium" shall have the same meaning as defined in § 10-16-102(51), CRS.

V. "Premium rate" means, for the purposes of this regulation, all moneys paid by an individual, or an employer and eligible employees, as a condition of receiving coverage from a carrier, including any fees or other contributions associated with obtaining or administering the health benefit plan.

W. "Prior approval" means, for the purposes of this regulation, a filing procedure that requires a rate change be affirmatively approved by the commissioner prior: to distribution, release to producers collection of premium, advertising, or any other use of the rate. Under no circumstances shall the carrier provide insurance coverage using the rates until on or after the proposed implementation or effective date specified in the rate filing. The implementation date must be at least sixty (60) days after the date of submission. After the rate filing has been approved by the commissioner, carriers may bill members but not require the member to remit premium prior to the proposed implementation or effective date of the rate change.

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

Y. "Qualified actuary" means, for the purposes of this regulation, a member of the American Academy of Actuaries, or a person who has demonstrated to the satisfaction of the commissioner that the person has sufficient educational background and who has not less than seven (7) years of recent actuarial experience relevant to the area of qualifications, as defined in Colorado Insurance Regulation 1-1-1.

Z. "Quality improvement expenses" and "QI" mean, for the purposes of this regulation, expenses, other than those billed or allocated by a provider for health care delivery (i.e., clinical or claims costs), for all carrier activities that are designed to improve health care quality, and increase the likelihood of desired health outcomes, in ways that are capable of being objectively measured and produce verifiable results and achievements. These expenses must be directed toward enrollees, or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees participation other than allowable QI associated with self-insured plans. Qualifying QI shall be grounded in evidence-based medicine, widely accepted best clinical practices, or in criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. Qualifying QI activities should not be designed primarily to control or contain cost, though they may have cost-reducing or cost-neutral benefits if quality improvement remains the primary goal and are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

1. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;

2. Prevent hospital readmissions;

3. Improve patient safety and reduce medical errors, lower infection and mortality rates;

4. Increase wellness and promote health activities; or

5. Enhance the use of health care data to improve quality, transparency, and outcomes.

AA. "Rate" means, for the purposes of this regulation, the amount of money a carrier charges as a condition of providing health coverage. The rate charged normally reflects such factors as the carrier's expectation of the insured's future claim costs; the insured's share of the carrier's claim settlement; operational and administrative expenses; and the cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the contract. Rates for all health benefit plans and pediatric dental plans must be filed with the Division.

AB. "Rate filing" means, for the purposes of this regulation, a filing that contains all of the items required in this regulation, and:

1. For individual products, the proposed base rates and all rating factors. The underlying rating assumptions must be submitted. Support for all changes in existing rates, factors and assumptions must be provided, including the continued use of previously filed trend factors. Support for new product offerings must be provided; and

2. For group products, proposed base rates, the underlying rating factors and assumptions. Support for all changes in existing rates, factors and assumptions must be provided, including the continued use of previously filed trend factors. Support for new product offerings must be provided. Groups must meet the definition contained in § § 10-16-214(1) and 10-16-215, C.R.S.

AC. "Rate increase" shall have the same meaning as defined in § 10-16-102(57), C.R.S., and includes increases in any current rate or factor used to calculate rates for new or existing policyholders, members, or certificate holders. Rate changes applicable to "new business only" are considered rates changes, and must be supported. Rate increases for "new business only" are subject to prior approval.

AD. "Rating period" shall have the same meaning as defined in § 10-16-102(58), C.R.S.

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

AF. "Retention" means, for the purposes of this regulation, the sum of all non-claim expenses including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses as the percentage of total premium.

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

AH. "Substantially different new benefit" means, for the purposes of this regulation, a new benefit which results in a change in the actuarial value of the existing benefits by 10% or more. The offering of additional cost sharing options (i.e. deductibles and copayments) to what is offered as an existing product does not create a new benefit. Actuarial value is the change in benefit cost as developed

when making other benefit relativity adjustments.

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

AJ. "Trend factors" means, for the purposes of this regulation, rates or rating factors which vary over time or due to the duration that the insured has been covered under the policy or certificate, and which reflect any of the components of medical or insurance trend assumptions used in pricing. Medical trend includes changes in unit costs of medical services or procedures, medical provider price changes, changes in utilization (other than due to advancing age), medical cost shifting, and new medical procedures and technology. Insurance trend includes the effect of underwriting wear-off, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Rate filings must be submitted on an annual basis to support the continued use of trend factors. Underwriting wear-off does not apply to guaranteed issue products.

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

AL. "Use of the rates" means, for the purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder including advertising, distributing rates or premiums to producers and disclosing premium quotes. Rates must be filed with the Division and forms, as required by § 10-16-107.2, C.R.S., must be filed prior to use. It does not include releasing information about the proposed rating change to other government entities or disclosing general information about the rate change to the public.

AM. "Valid group" means, for the purposes of this regulation, a group of persons who qualify for "group sickness and accident insurance" as defined in § 10-16-214(1) and 10-16-215, C.R.S. All groups must meet the qualifications as "valid groups". Non-employer groups, including, but not limited to, associations, trusts, unions, and organizations eligible for group life insurance shall be submitted to the Division for approval. Groups formed for the purpose of insurance are prohibited under Colorado law. Multi-state associations must also meet the requirements under §10-16-214(1), C.R.S. Bona fide associations must meet the requirements under §10-16-102(6), C.R.S. Trusts must meet the requirements under §10-7-201, C.R.S., and must be formed by one or more employers or by one or more labor unions, or by one or more employers and one or more labor unions. Union agreements must also be submitted to the Division.

AN. "Wellness and prevention program," shall have the same meaning as defined in § 10-16-136(7)(b), C.R.S., and apply to individual and small group health benefit plans.

Section 5 General Rate Filing Requirements

All rates associated with health coverage policies, riders, contracts, endorsements, certificates, and other evidence of health coverage associated with health benefit plans and standalone pediatric dental plans must be filed with the Division prior to issuance or delivery of coverage. All rate filings shall be submitted electronically by licensed entities. Failure to supply the information required in Sections 5, 6, 7, 8 and 9 of this regulation will render the filing incomplete. Incomplete filings are not reviewed for substantive content. All filings that are not returned or disapproved on or before the 30th calendar day after receipt will be considered complete. Filings may be reviewed for substantive content, and if reviewed, any deficiency will be identified and communicated to the filing carrier on or before the 45th calendar day after receipt. Correction of any deficiency, including deficiencies identified after the 45th calendar day, will be required

on a prospective basis, and no penalty will be applied for a non-willful violation identified in this manner, other than as allowed by § 10-16-216.5, C.R.S. Nothing in this regulation shall render a rate filing subject to prior approval by the commissioner that is not otherwise subject to prior approval as provided by statute.

A. General Requirements

1. Prior Approval: Any proposed rate increase for health benefit plans or a rate increase of 5% or more annually for dental insurance is subject to prior approval by the commissioner and must be filed with the Division at least sixty (60) calendar days prior to the proposed implementation or use of the rates.

    a. If the commissioner approves the rate filing within sixty (60) calendar days after the filing date, the carrier may use the rates immediately upon approval for new business and upon renewal for existing business; however, under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation or effective date specified in the rate filing.

    b. A carrier who provides insurance coverage using the rates before the proposed implementation or effective date will be considered as using unfiled rates and the Division will take appropriate action as defined by Colorado law.

    c. After the rate filing has been approved by the commissioner, carriers may bill members, but not require the member to remit premium prior to the proposed implementation date of the rate change.

    d. If the commissioner does not approve or disapprove the rate filing within sixty (60) calendar days after the submission date, the carrier may apply the rates as of the implementation or effective date in the filing.

    e. Under no circumstances shall the carrier provide insurance coverage under the filed rates until on or after the proposed implementation date or effective date specified in the rate filing.

2. Existing law defines a rate increase as any increase in the current rate. This, for purposes of this regulation, includes an increase in any base rate, or any rating factor, or continued use of trend factors used to calculate premium rates which results in an overall increase in the current rate to any existing policyholder or certificate holder renewing during the proposed rating period of the filing and would be considered a prior approval filing. Rate increases as applied to "new business only" are also subject to prior approval.

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

    The commissioner may require submission of any 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, other than as allowed by § 10-16-216.5, C.R.S.

All filings must be filed with the Rates and Forms Section of the Division. The commissioner shall disapprove the rate filing if any of the following apply:

a. The benefits provided are not reasonable in relation to the premiums charged;

b. The rate filing contains rates that are excessive, inadequate, unfairly discriminatory, or otherwise does not comply with the provisions of Sections 5, 6, 7, 8, 9 and 10 of this regulation. In determining if the rate is excessive or inadequate, the commissioner may consider profits, dividends, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice;

c. The actuarial reasons and data do not justify the requested rate increase;

d. The rate filing is incomplete; or

e. The data in the filing failed to adequately support the proposed rates.

3. File and Use: Any rate filing not specified in Paragraph 1 of this subsection is classified as file and use. Existing law allows for file and use rate filings to be implemented upon submission to the Division and correction of any deficiency shall be on a prospective basis. All filings not returned on or before the 30th day after submission to the Division will be considered complete. Rates for all health coverages must be filed with the Division prior to use.

   To determine file and use, calculations should reflect the 12-month accumulative impact of trend and any changes to rating factors or base rates. If there is an annual cumulative decrease in rates for all policyholders during the filed rating period then the filing would be file and use.

   If new rates, rating factors, or a rate change has been implemented or used without being filed with the Division, corrective actions may be ordered, including, but not limited to, civil penalties, refunds to policyholders, and/or rate credits. Use of unfiled rates may also be deemed excessive. Under no circumstances shall the carrier provide insurance coverage using the rates until on or after the proposed implementation or effective date. A carrier who provides insurance coverage under the rates before the proposed implementation or effective date will be considered as using unfiled rates and the Division will take appropriate action as defined by Colorado law. Carriers may bill members but not require the member to remit premium prior to the proposed implementation or effective date of the rate change. All filings must be filed with the Rates and Forms Section of the Division.

4. New Policy Forms and Products **:** Carriers shall not represent an existing product to be a new policy form, or product unless if fits the definition set forth in Section 4.R. If a policy form is not a new policy form or product, and the rate is increasing, the rate filing will be considered a prior approval filing and the required supporting documentation required by law and regulation will need to be submitted with the filing. In the case of reasonable modifications, pursuant to § 10-16-105.1 C.R.S., if an existing policy form is modified and it is truly not a new policy form or product, the policy form must be revised to comply with the provisions of § 10-16-105.1 C.R.S.

5. Required Submissions:

   a. Rates on all health insurance policies, riders, contracts, endorsements, certificates,

and other evidence of health coverage, must be filed with the Division prior to issuance or deliverance of policies, certificates or evidence of coverage.

b. All carriers must submit a compliant rate filing whenever the rates charged to new or renewing policyholders, or certificate holders differ from the rates on file with the Division. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or change(s) in trend or other rating assumptions. Failure to file a rate filing that is compliant with this regulation in these instances will render the carrier as using unfiled rates and the Division will take appropriate action as allowed by Colorado law.

c. All carriers must submit a compliant rate filing on an annual basis, at minimum, to support the continued use of trend factors, which change on a predetermined basis. The rate filing must contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate. The rate filing shall contain all of the items required in this regulation. The rate filing must demonstrate that the rate is not excessive, inadequate or unfairly discriminatory. Note: Trend factors which change on a predetermined basis can be continued for no more than twelve (12) months. To continue the use of trend factors that change on a predetermined basis, a filing must be made for that particular form with an implementation or effective date on or before the one-year anniversary of the implementation or effective date of the most recent rate filing for that form.

d. All carriers must submit compliant rate filings when rates are changed on an existing product, even though the rate change pertains to new business only. Colorado experience data for this existing product must be submitted. If Colorado data is partially credible, nationwide data must also be submitted. Detailed support must be provided for the rate change. Support must also be provided to ensure rates are not discriminatory. Assessing different rates for the same product based on issue dates may violate Colorado law.

e. All carriers must submit compliant rate filings within sixty (60) calendar days after commissioner approval of the assumption or acquisition of a block of business. This rate filing should provide detailed support for the rating factors the assuming or acquiring carrier is proposing to use, even if there is no change in rating factors. The new filing must demonstrate that the rating assumptions are still appropriate.

f. Each line of business requires a separate rate filing. Rate filings should not be combined with form filings.

g. All carriers are expected to review their experience on a regular basis, no less than annually, and file rate revisions, as appropriate, in a timely manner to ensure that rates are not excessive, inadequate and unfairly discriminatory, and to avoid filing large rate changes. Rates are deemed excessive if the actual loss ratio falls below the loss ratio as filed with, and/or approved by, the Division.

h. The Form Schedule tab in SERFF must be completed for all rate and form filings. This tab must list policies, riders, endorsements, or certificates referenced in the rate filing. Do not attach the actual forms to a rate filing.

6. Withdrawn, Returned, or Disapproved Filings: Filings that have been withdrawn by the filer, returned by the Division as incomplete or disapproved as unjustified, and are subsequently resubmitted, will be considered as new filings. If a filing is withdrawn, returned, or disapproved, those rates may not be used or distributed. Nothing in this regulation shall render a rate filing subject to prior approval by the commissioner which is

not otherwise subject to prior approval as provided by Colorado law.

8. Submission of Rate Filings: All health benefit plans and stand-alone pediatric dental plan rate filings must be filed electronically in a format made available by the Division, unless exempted by rule for an emergency situation as determined by the commissioner. If the carrier fails to comply with these requirements, the carrier will be notified that the filing has been returned as incomplete. Complete electronically submitted rate filings must meet all relevant general requirements, including all necessary rate and policy forms. If a filing is returned as incomplete, those rates may not be used or distributed.

9. Carrier Specific: A separate filing must be submitted for each carrier. A single filing made for more than one carrier, or for a group of carriers is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/indemnity point-of-service plan.

10. Required Inclusions: Rate filings require the submission of an actuarial memorandum in the format specified in Section 6 of this regulation. A response must be provided for each element contained in Section 6. The level of detail and the degree of consistency incorporated in the experience records of the carrier are vital factors in the presentation and review of rate filings. Every rate filing 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 upon by the carrier; the interpretation of any statistical data relied upon by the carrier; descriptions of methods used in making the rates; and any other similar information deemed necessary by the carriers. Actual Colorado experience must be submitted for changes to existing products. In addition, the commissioner may request additional information used by the carrier to support the rate change request.

11. Confidentiality: All rate filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. The Division does not consider such items as rates, rating factors, rate histories, or side-by-side comparisons of rates or retention components to be confidential. The entire filing, including the actuarial memorandum, cannot be held as confidential. There should be separate SERFF component for the confidential exhibits, and must be indicated by the icon as confidential in SERFF. Non-confidential information, such as the actuarial memorandum, must be in a separate SERFF component.

12. A "Confidentiality Index" must be completed if the carrier desires confidential treatment of any information submitted, as required in this regulation. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected. It should be noted that HMOs are not afforded automatic confidential treatment of any rate filings; and, therefore, must complete a Confidentiality Index.

B. Actuarial Certification

Each rate filing shall include a signed and dated statement by a qualified actuary, which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

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

"This policy DOES NOT include coverage of pediatric dental services as required under federal law. Coverage of pediatric dental services is available for purchase in the State of Colorado, and

can be purchased as a stand-alone plan, or as a covered benefit in another health plan. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-qualified stand-alone dental plan that includes pediatric dental coverage."

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

Section 6 Actuarial Memorandum

The rate filing must contain an actuarial memorandum. To ensure compliance with this regulation, each of the following sections must be provided in the memorandum in the designated order shown below, or in an alternate template supplied by the Division. A response must be provided for each element under this section. The actuarial memorandum must be attached to the Supporting Documents tab in SERFF, and must be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the Actuarial Certification requirements of this regulation. Do not attach the actuarial memorandum, supporting documents, or actuarial certification to the Rate/Rule tab in SERFF.

Stand-alone dental plans must comply with the actuarial memorandum requirements found in Colorado Insurance Regulation 13-E-01.

A. Summary: The memorandum must contain a summary that includes, but is not limited to, the following:

1. Reason(s) for the rate filing: A statement as to whether or not this is a new product offering; a rate revision to an existing product, which includes rates applicable to "new business only", or; a new option being added to an existing form. If the filing is a rate revision, the reason for the revision should be clearly stated.

2. Requested Rate Action: The overall rate increase or decrease should be listed. The listed rate change, the average change in each rate component and the change in renewal date by effective month must be provided. The submission must also list the twelve (12) month renewal with changes by component and the averages by component.

3. Marketing Method(s): A brief description of the marketing method used for the filed form should be listed. (Agency/Broker, Internet, Direct Response, Other) All non-employer groups must be clearly identified, and must meet the definition of a "valid group" found in this regulation.

4. Premium Classification: This section should state all attributes upon which the premium rates vary. This section must comply with all new rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas.

5. Product Descriptions: This section should describe the benefits provided by the policy, rider or contract. This section must include EHB(s) and list any substitution of benefits or any additional benefits provided above the required EHB(s).

6. Policy/Rider or Contract: This section must include a listing of all policies/riders or contracts impacted by the submission.

7. Age Basis: This section must state whether the premiums will be charged on an attained age, renewal age or other basis.

8. Renewability Provision: All health benefit plans are guaranteed renewable.

A: SUMMARY	
1. Reason(s):	
2. Requested Rate Action:	
3. Marketing Method(s):	☐ Agency/Broker ☐ Internet ☐ Direct Response ☐ Other:
4. Premium Classification(s):	
5. Product Description(s):	
6. Policy/Rider Impacted:	
7. Age Basis:	☐ Renewal Age ☐ Attained Age ☐ Both Issue & Attained Age ☐ Other:
8. Renewability Provision:	
Additional Information:	

B. Assumption, Acquisition or Merger: The memorandum must state whether or not the products included in the rate filing are part of an assumption, acquisition or merger of policies from/with another carrier. If so, the memorandum must include the full name of the carrier/carriers from which the policies were assumed, acquired or merged, and the effective date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption of the acquisition, or assumption rate filing. Commissioner approval of the assumption or acquisition of a block of business is required. See Section 5.A.5.e. for acquisition or assumption rate filing requirements.

B. ASSUMPTION, MERGER OR ACQUISITION	
1. Is product part of assumption, acquisition, or merger (from or with another company)?	
Assumption:	☐ Yes ☐ No
Acquisition:	☐ Yes ☐ No
Merger:	☐ Yes ☐ No
2. If yes, provide name of company(s):	
3. Closing Date of assumption, merger or acquisition:	
Additional Information:	

C. Rating Period: The memorandum must identify the period for which the rates will be effective. At a minimum, the proposed effective date of the rates must be provided. If the length of the rating period is not clearly identified, it will be assumed to be for twelve (12) months, starting from the proposed effective date. This must be provided in an Excel spreadsheet.

1. Individual Market: The rating period must be twelve (12) months and premiums cannot change through the year.

2. Small Group Market: The rating period must be twelve (12) months. The rating period can only be filed annually but can be trended quarterly.

C. RATING PERIOD	
Proposed Effective Date:	(MM/DD/YYYY)
Rating Period:	

D. Effect of Law Changes: The memorandum should identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable 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.

D. EFFECT OF LAW CHANGES	
Identify and quantify changes resulting from mandated benefits and other law changes:	
Select N/A if no changes	☐ N/A
Additional Information:	

E. Rate History: The memorandum must include a chart showing, at a minimum, any rate changes that have been implemented in the three (3) years immediately prior to the filing date, including the implementation date of each rate change.

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

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

3. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable. This must be provided in an Excel spreadsheet.

E. RATE HISTORY					
Provide rate changes made in at least the last three (3) years (If available) ☐ N/A (Initial Filing)					
COLORADO					
State Tracking Number or SERFF Tracking Number	Effective Date	% OF CHANGE			
		Minimum	Average	Maximum	Cumulative for past 12 months

NATIONWIDE		
Effective Date	Average % of change	Cumulative for past 12 Months
Additional Information:		

F. Coordination of Benefits: The memorandum must reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

F: COORDINATION OF BENEFITS	
Provides actual loss experience net of any savings:	☐ Yes ☐ No
Additional Information:	

G. Relation of Benefits to Premium: The memorandum must adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period. This relationship will be presumed to be reasonable if the carrier complies with the following benefits ratio guidelines:

1. All rate filings justifying the relationship of benefits to premium using one of these guidelines must list the components of the retention percentage.

2. The Division-recommended benefit ratio guidelines are as listed below. Targeted loss ratios below these guidelines shall be actuarially justified.

Comprehensive Major Medical - Individual	80%
Comprehensive Major Medical - Small Group	80%
Comprehensive Major Medical - Large Group	85%

3. The benefit loss ratio guideline for conversion products shall be at least 125%. Adequate

support shall be submitted if the loss ratio is below the 125% guideline.

4. For individual products issued to HIPAA-eligible individuals the premiums for these products are, at most, twice the premiums for the underlying, underwritten product.

Targeted Loss Ratio: (This number should equal 1 minus the total retention percentage listed above.)	

G: Relation of Benefits to Premium		
Description	**Percentage**	**Support**
Commissions		
General expenses		
Premium taxes		
Profit/Contingencies		
Investment Income		
PPACA Fees		
Exchange Fees		
Other		
Total Retention		

H. Provision for Profit and Contingencies. The memorandum must identify the provision percentage for profit and contingencies, and how this provision is included in the final rate. Material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process. Detailed support must be provided for any proposed load.

H. PROVISION FOR PROFIT AND CONTINGENCIES	
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.	
1. Provision for Profit and Contingencies:	**% Pre-FIT After tax**
2. Proposed load in excess of 7% after tax. Provide detailed support:	
Additional information:	

I. Complete Explanation as to how the Proposed Rates were Determined: The memorandum must contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if support for each rating assumption is found to be inadequate.

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

I. DETERMINATION OF PROPOSED RATES	
Include all underlying rating assumptions, with detailed support for each assumption. This explanation may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis.	
1. Explain, in detail, how rates and/or rate changes were developed:	
2. Provide adequate support for all assumptions and methodologies used:	
Additional Information:	

Index Rate Development

1. Carriers must develop a market-wide index rate based on the total combined EHB claims experience of all enrollees in all non-grandfathered (NGF) plans in the single risk pool.

2. After setting the Index Rate, the carrier shall make a market-wide adjustment based on the expected aggregated payments and charges under the risk adjustment and reinsurance programs in Colorado.

3. The premium rate for any given plan shall not vary from the resulting adjusted market-wide Index Rate, except for the following factors: The actuarial value and cost-sharing structure of the plan; the plan's provider network; delivery system characteristics; utilization management practices; plan benefits in addition to EHB; and with respect to catastrophic plans, the expected impact of specific eligibility categories for those plans.

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

J. Trend: The memorandum must describe the trend factor assumptions used in pricing. These trend factor assumptions must each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported. Trend factors do not renew automatically. Continued use of trend factors must be supported annually. This must be provided in an Excel spreadsheet.

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

2. Provided loss data must be on an incurred basis, with pharmacy data shown separately from medical data, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

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

4. Data elements shall be aggregated into 12-month annual periods, with yearly "per member, per month" (PMPM) data, and year-over-year PMPM trends listed separately for medical

and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified. The trend assumptions shall be quantified into two categories, medical and insurance, as defined below:

a. Medical trend means, for the purposes of this section, the combined effect of medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology.

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

J. TREND	
Itemized trend component	**Trend (%)**
MEDICAL TREND (total)	
Medical provider price increase	
Utilization changes	
Medical cost shifting	
Medical procedures and new technology	
INSURANCE TREND (total)	
Underwriting wear-off	
Deductible leveraging	
Anti-selection	
PHARMACEUTICAL TREND (total)	
Price increases	
Utilization changes	
Cost shifting	
Introduction of new brand and generic drugs	
TOTAL AVERAGE ANNUALIZED TREND (required)	
Additional information:	

K. Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three (3) years if the proposed rates are based on claims experience. Partial credibility shall be based on either the number of Life Years OR the number of Claims over a three (3) year period. Partial credibility must be used if the Colorado data is not fully credible. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard). This must be provided in an Excel spreadsheet.

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 companies), must be provided and the use of such data must be justified.

2. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the

data is the square root of (# life years or claims/full credibility standard). The full credibility standard is defined above, and Colorado data must be provided.

3. 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.

K. CREDIBILITY	
1. Credibility Percentage (Colorado Only): If other, please specify	%
The above credibility percentage is based upon:	☐ Life Years ☐ Claims ☐ Other (please specify)
2. Number of years of data used to calculate above credibility percentage:	
3. Discuss how and if aggregated data meets the Colorado credibility requirement and how the rating methodology was modified for the partially credible data, if applicable.	
Additional Information: (including collateral data, if used)	

L. Data Requirements: The memorandum must include, at a minimum, earned premium data, loss experience data, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. This must be provided in an Excel spreadsheet.

1. Pharmacy claims data should be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.

2. National or other relevant data shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

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

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

5. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. Data used as support rates must be included in the filing. For both renewal filings and new business filings, the experience period must include consecutive data no older than six (6) months prior to the filing (submission) date.

6. The loss data must be presented on an incurred basis, including the accrued and unaccrued

portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Premiums, and/or exposure data, must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information on how the number of claims was calculated.

L. DATA REQUIREMENTS								
Colorado-only basis for at least 3 years. **Include** national, regional or other appropriate basis, if the Colorado data is not fully credible. The experience period must include consecutive data no older than 6 months prior to the filing date.								
	COLORADO DATA							
Year*	Earned Premium	Incurred Claims	Total Estimated Incurred Claims	Estimated IBNR Claims	Loss Ratio	Average Covered Lives	Number of Claims	Colorado On Rate Level Premium
20XX								
20XX								
20XX								
20XX								
*This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY								
Above data is for:	☐ Existing Product ☐ Comparable Product ☐ Other _____(please specify)							

	OTHER DATA					
Year	Earned Premium	Incurred Claims	Total Estimated Incurred Claims	Estimated IBNR Claims	Average Covered Lives	Number of Claims
20XX						
20XX						
20XX						
20XX						
Above data is for:	☐ Existing Product ☐ Comparable Product ☐ National ☐ Other (please specify) (Check all the apply)					
Experience Period:	From to					
Additional Information:						

M. Side-by-side Comparison: Each memorandum must include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison shall include three (3) columns: the first containing the current rate, rating factor, or rating variable; the second containing the proposed rate, rating factor, or rating variable; and the third containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum must specifically state this and provide detailed support for each of the rating factors.

M. SIDE-BY-SIDE COMPARISON ☐ N/A			
If the proposed rating factor(s) are new, the memorandum must specifically so state, and provide detailed support for each of the factors.			
Description	**Current Rate/ Rating Factor/ Rating Variable**	**Proposed Rate/ Rating Factor/Rating Variable**	**Percentage Increase/ Decrease**
If the above table is not used, please identify the location of the Side-by-Side Comparison in the rate filing:			
Description and detailed support for new rating factor(s):			
Additional Information:			

N. Benefits Ratio Projections: The memorandum must contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison should be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should be included. This must be provided in an Excel spreadsheet.

N. BENEFITS RATIO PROJECTIONS			
PROJECTED EXPERIENCE FOR RATING PERIOD			
	Premiums	**Incurred Claims**	**Benefits Ratio**
Projected Experience Without Rate Change			
Projected Experience With Rate Change			
Additional Information:			

O. Other factors: The memorandum must clearly display or clearly reference all other rating factors and definitions used, including the area factors, age factors, gender factors, etc., and provide support for the use of each of these factors in the new rate filing. The same level of support for changes to any of these factors must be included in all renewal rate filings. In addition, the commissioner expects each carrier to review each of these rating factors every five (5) years, at minimum, and 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. See Section 8.C. of this regulation. This must be provided in an Excel spreadsheet.

O. OTHER FACTORS	
Identify and provide support for other rating factors and definitions, including area factors, age factors, gender factors, etc.:	
Additional Information:	

P. Rating Manuals: A rating manual must be submitted to the Division for each new product. All changes to the rating manual must be filed with the Division in an appropriate rate filing. Rate pages and rate manual must be attached to the Rate tab in SERFF.

Q. Actuarial Certification: An actuarial certification must be submitted with all filings. Actuarial Certification is a signed and dated statement made by a qualified Actuary which attests that, in the Actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

Section 7 Premium Rate Setting for Individual and Small Group Health Benefit Plans

A. Calculating Premium Rates Adjusted for Case Characteristics

1. Index Rate: Each carrier offering a health benefit plan to individuals and small groups in Colorado shall develop a single index rate for all individual and small group NGF plans it offers. The index rate for a market segment (individual or small group) shall be based on:

    a. The EHB claims experience of all enrollees in all NGF health benefit plans in a risk pool;

    b. Adjusted for risk adjustment/reinsurance payments and charges, and Exchange user fees;

    c. Index rates may be developed separately for supplemental stand-alone benefits, as all such similar benefits are pooled for setting the respective index rate; and

    d. The premium rate charged during a rating period shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this section.

2. Plan Design Adjustment: The index rate may be adjusted to reflect differences attributable to different plan designs. Differences in the rates for different benefit plans, for persons with the same case characteristics of age, geographic location and family size, shall be attributable to plan design only. Using this methodology, a carrier's rates for a plan with richer benefits should be higher than the rates for a plan with lesser benefits.

3. Acceptable Case Characteristic Factor Categories:

    a. Carriers will be allowed to adjust premiums only for the following factors: self-only or family enrollment, geographic area, age and tobacco. These factors apply to products offered both inside and outside the Exchange, and for both individual and small group products.

    b. Rates may vary based on whether a plan covers an individual or a family. PHS Act section 2701(a)(4) provides that, with respect to family coverage, the rating variation permitted for age and tobacco use must be applied based on the portion of the premium attributable to each family member covered under a plan.

    c. The per-member rating methodology under 45 CFR § 147.102(c)(1) must apply. Per-member rating requires that the age and tobacco use factors be apportioned to each family member, and no more than three (3) covered children under the age of 21 whose per-member rates can be taken into account in determining the family premium.

    d. The per-member rating methodology is to be utilized in the small group market. The presence of employee choice among various qualified health plans (QHPs) in the Small Business Health Options Program (SHOP) exchange makes composite rating intractable and will not be allowed.

    e. Geographic area rating factors must not vary by product; there is only one set of area factors for each rate filing. Geographic area rating factors are separate from

network factor rating adjustments, and may not vary by network.

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

Geographic Area	Rating Factor
Boulder MSA	0.89
Denver MSA	1.03
Greeley MSA	0.98
Colorado Springs MSA	1.02
Fort Collins MSA	1.01
Grand Junction MSA	0.95
Pueblo MSA	1.05
Northeast Non-MSA	1.01
Southeast Non-MSA	1.27
West Non-MSA	0.99
Resort Non-MSA	1.29

The Denver area factor does not have to be set to 1.0. Carriers typically scale their area factors so that they are revenue neutral when applied within their rating formulas. Health claims may be used in the process of developing area factors. As stated in the ACA, rating factors may not reflect differences in member health status. Area factors should be actuarially justified and verified to have been set based upon the above criteria.

Geographic Location: If a carrier uses geographic location to calculate rates, then it shall use the eleven (11) mandatory categories in the following table.

Rating Area	County
Rating Area 1	Boulder
Rating Area 2	El Paso, Teller
Rating Area 3	Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park
Rating Area 4	Larimer
Rating Area 5	Mesa
Rating Area 6	Weld
Rating Area 7	Pueblo
Rating Area 8	Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Mineral, Otero, Prowers, Rio Grande, Saguache
Rating Area 9	Logan, Morgan, Phillips, Sedgwick, Washington,

	Yuma
Rating Area 10	Archuleta, Delta, Dolores, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake Moffat, Montezuma, Montrose, Ouray, Rio Blanco, Routt, San Juan, San Miguel
Rating Area 11	Eagle Garfield, Pitkin, Summit

For a small employer in Colorado, the applicable area factor for each employee is based on the principal business location of the small employer, rather than the residence of each employee.

For an individual policy, the applicable area factor applied to rates for each member is based on the location of the primary policyholder rather than the residence of each family member.

f. Age Factors. Age factors and age bands must be determined based on an enrollee's age on the date of policy issuance or renewal and must not exceed the 3:1 age ratio. For individuals who are added to the plan or coverage on a date other than the date of policy issuance or renewal, the enrollee's age is determined as of the date such individuals are added or enrolled in the coverage.

Children: A single age band covering children 0 to 20 years of age, where all premium rates are the same.

Adults: One-year age bands starting at age 21 and ending at age 63.

Older adults: A single age band covering individuals 64 years of age and older, where all premium rates are the same. The following are age band examples:

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-20	0.635	35	1.222
21	1.000	36	1.230
22	1.000	37	1.238
23	1.000	38	1.246
24	1.000	39	1.262
25	1.004	40	1.278
26	1.024	41	1.302
27	1.048	42	1.325
28	1.087	43	1.357
29	1.119	44	1.397
30	1.135	45	1.444
31	1.159	46	1.500
32	1.183	47	1.563
33	1.198	48	1.635

34	1.214	49	1.706

g. Tobacco Use Rate.

(1) The tobacco use rate may not exceed the non-tobacco use rate contained in § 10-16-107(5)(a)(I)(D), C.R.S. Smokers may not be rated in total more than three (3) times the total rate for a younger adult smoker. If a carrier implements the tobacco rating factor with the result that an older smoker is rated up more than three (3) times of that of a younger smoker, the submission will be rejected by the Division.

(2) Carriers in the individual and small group market may remove the tobacco rating factor (as described in section 2705 of the PHS Act) for individuals participating in a wellness program.

(3) "Tobacco use" is defined at 45 CFR § 147.102(a)(1)(iv) as the use of a tobacco product or products four (4) or more times per week within, but no longer than, the past six (6) months by legal users of tobacco products (generally those 18 years and older). It includes all tobacco products and clarifies that the term tobacco use does not include religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives). Tobacco use must be defined by carriers in terms of the time since the individual's last use of a tobacco product.

h. Family Size Categories:

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

i. Health status and claims experience may not be used as case characteristics.

4. Additional Premium Adjustments: Small employer groups may be subject to premium adjustment for health status of no more than 35% above the modified community rate, for a period of no more than twelve (12) months, in certain instances. (See § 10-16-105.6 subsections (3) and (4), C.R.S.) Adequate and acceptably detailed information as to how the carrier determines the rating factor(s) for this adjustment must be included in each rate filing.

5. Wellness and Prevention Programs; A small employer carrier may make wellness and prevention programs available as provided for under Section 7.B. of Colorado Insurance Regulation 13-E-01.

B. Rating Period

1. The rating period for all small group health plans shall be twelve (12) months.

2. A carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

C. Administrative and Other Fees

Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Such charges must be built into the index rate and are not an allowable rate adjustment factor. Reasonable late payment penalties may be imposed by a small group carrier if the policy discloses the carrier's right to, the amount of, and circumstances under which late payment penalties will be imposed.

D. Calculating Actuarial Value

The ACA requires carriers offering NGF health plans inside and outside of the Exchange in the individual and small group markets to assure that any offered plan meets a distinct level of coverage, or actuarial value (AV), specified in section 1302 of the ACA: bronze, silver, gold, or platinum (also known as "metal tiers"). Carriers may also offer catastrophic-only coverage to certain eligible individuals.

AV standards will help consumers compare health benefit plans by providing information about relative plan generosity. The AV standard of a health benefit plan is determined using the following calculation:

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

AV must be calculated based on the provision of EHB to a standard population and is presented as a percentage. Additionally, AV determines a health benefit plan's metal level tier. The ACA directs that NGF individual and small group plans inside and outside the Exchanges meet specific AV targets (or be a catastrophic plan):

- Bronze = 60% AV

- Silver = 70% AV

- Gold = 80% AV

- Platinum = 90% AV

These targets allow for a de minimis range of -/+ 2% points

E. Actuarial Equivalent Service Limits for certain Health Benefits

The chart below identifies the benefits with a dollar limit under state law or the benchmark plan, the dollar amount of that limit, and the recommended actuarially equivalent service limit.

Benefit	Annual Dollar Limit	Actuarially Equivalent Service Limit
Early Intervention Services	$6,361	45 therapeutic visits
Autism – Applied Behavioral Analysis	$34,000 birth to age 8; $12,000 age 9-19	550 sessions birth to age 8; 185 sessions age 9-19 (25-minute session increments)
Outpatient Substance Abuse	$500	4 visits
Mammography	$105.50, with exclusions	Full cost of an annual mammogram (preventive or diagnostic)
Durable Medical Equipment (DME)	$2000, with exclusions	Exclude small dollar items; 4 units under $1000 each OR 1 unit over $1000 NOTE: Still under Federal Review
Pediatric Dental	$600	2 oral exams 2 fluoride applications 1 set of x-rays 1 cleaning 2 other services from the CHP+ procedure list, which generally includes, but is not limited to, the following: ▪ Sealants ▪ Space maintainers ▪ Amalgam and resin restorations ▪ Resin and stainless-steel crowns ▪ Extractions ▪ Root canals Palliative treatment/sedative fillings

F. Calculating the Actuarial Value of Unique Plan Designs

1. To satisfy actuarial value (AV) requirements, carriers are required to use the Actuarial Value Calculator (AVC) developed and made available by the United States Department of Health and Human Services unless the plan design is not compatible with the AVC (a

unique plan design). In order to assist with this calculation, the SERFF Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. In addition, upon submission of a QHP application, HHS recalculates this value to validate that a carrier's plan designs meet AV requirements.

2. The AVC will be integrated with SERFF so that the Division can evaluate plans for compliance with AV standards on an automated basis. Carriers will first complete the plans and benefits template and submit the information through SERFF; the Plans and Benefits Template will directly populate the AVC to determine a plan's AV and corresponding metal tier. A plan's results from the AVC will be displayed automatically in SERFF.

3. For standard plan designs, carriers will determine AV using an HHS-developed AV calculator. The AVC will guarantee plans with the same cost sharing structure will have the same actuarial value (regardless of plan discounts or utilization estimates.)

4. If a carrier determines that a material aspect of its plan design cannot be accommodated by the AVC, HHS allows for alternative calculation methods supported by certification by an actuary.

5. States will have the option to submit Colorado-specific data sets starting 2015.

G. Calculating the Actuarial Value of Health Benefit Plans that are not compatible with the AVC

1. Although the AVC has been designed to accommodate the vast majority of plan designs, there is the possibility that the Calculator will not be able to accommodate a small percentage of plan designs. Under 45 C.F.R. § 156.135(b), carriers with plan designs that are not compatible with the AVC will need to use an alternate method to calculate AV, as described below. For example, the following types of plan designs would not be compatible with the AVC.

   Example 1 : A plan with coinsurance rates that increase with out-of-pocket spending, such as a plan design with 10 percent coinsurance for the first $1,000 in consumer spending after the deductible, 20 percent coinsurance for the next $1,000 in consumer spending, and 40 percent coinsurance up to a $6,350 out-of-pocket maximum. This plan design would not be compatible because the current AVC can accommodate only a single coinsurance rate for each benefit.

   Example 2 : A plan with a multi-tiered provider or hospital network with substantial amounts of utilization expected in tiers other than the two lowest-priced tiers. This plan design would not be compatible because the current AVC does not take into account utilization beyond the second network tier when computing AV.

   Generally, a plan design that includes different cost sharing for services not included in the AVC would be considered compatible with the AVC. For example, advanced imaging is a single cost-sharing entry in the Calculator; a plan design would not be considered incompatible because it assigns different copayment amounts to different types of imaging (e.g., MRI versus CT). Similarly, because the AVC does not consider quantitative or qualitative limits for any benefit, the application of limits to a particular benefit would generally not necessitate one of the alternative methods for AV calculation.

2. To account for plan designs that are incompatible and ensure that requiring the use of the AVC allows for plan innovation, 45 C.F.R. § 156.135(b) provides two alternative methods of calculating AV for plans that cannot meaningfully fit within the parameters of the AVC. Carriers issuing such plans must:

a. Make adjustments to certain key plan design features to enter a modified plan design that fits into the parameters of the AVC, and have an actuary certify that the plan design was appropriately fit into the parameters of the AVC; or

b. Use the AVC to determine the AV for plan provisions that do fit within its parameters, and then have an actuary calculate appropriate adjustments to the Calculator-generated AV to account for remaining plan features. For example, a carrier with reference pricing for prescription drugs could use the AVC to determine the AV for the medical benefits in its plan and then make adjustments to reflect its prescription drug benefits.

Both of the AV calculation methods for evaluating incompatible plans designs must be certified by a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies. If a carrier uses either of the two alternate methods for calculating AV just described, the carrier must submit an actuarial certification.

3. Family Plan Design

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

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

H. Annual Limitations on Deductibles for Employer Sponsored Health Benefit Plans in the Small Group Market

1. Section 1302(c)(2) of the ACA places limits on the deductibles for health plans offered in the small group market as part of the EHB package that must be offered by carriers in the individual and small group markets and in qualified health plans. As provided in 45 C.F.R. § 156.130(b)(3), a health benefit plan may exceed the annual deductible limit if it cannot reasonably reach a given level of coverage (i.e. metal level) without doing so. For example, if the only way that a carrier can offer a bronze plan and a $2,000 deductible is by offering all other services at a 90 percent cost-sharing rate, the plan may exceed the deductible because this would be considered an "unreasonable" plan design. The health benefit plan could instead be offered at the bronze level of coverage with a $3,000 deductible and a 40 percent cost-sharing rate, which is consistent with what is commonly offered in the small group market today. When designing a bronze level plan with a deductible that exceeds the maximum, a carrier should increase the deductible by the smallest amount that achieves a reasonable plan design. Colorado will collect general compliance information through market-wide targeted audits or an alternative state-based enforcement of this provision.

2. The AVC standard population and claims data were developed using claims data that did not include any family cost-sharing information. Carriers issuing plans with deductibles and/or

out of pocket maximum costs that accumulate at the family rather than the individual level have several options depending on the specifics of the family plan.

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

I. Unique Plan Design

1. If carriers are still unable to obtain an AV from the SERFF Plans and Benefits Template that matches what they obtain via the stand-alone AVC, then they should designate that particular plan as a unique plan design using the *Unique Plan Design?* field of the SERFF Benefits Package worksheet.

2. For this plan, the carrier should complete the ***Issuer Actuarial Value*** data field with the value from the stand-alone AVC. The carrier should also upload a screen shot of the stand-alone AVC with that value as a supporting document for each plan for which this situation occurs. They should indicate the *HIOS Plan ID (Standard Component)* in the Description field when uploading the screen shot as a supporting document in SERFF as well as indicating the HIOS *Plan ID (Standard Component)* in the file name of the screen shot.

3. Justification for Unique AV Plan Designs will need to complete the following document: *QHP Instructions: Chapter 13a Unique AV Plan Justification document located on www.regtap.info .*

J. Determining Minimum Value (MV)

A group health benefit plan provides minimum value (MV) if the total allowed costs of benefits paid by the plan are no less than 60%.

An individual eligible for coverage in an employer-sponsored plan that provides MV is not eligible for premium tax credits.

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

1. MV Calculator;

2. A safe harbor established by HHS and IRS; or

3. Certification by an actuary if neither is suitable.

K. Cost Sharing Limitations

Section 1302(c)(1) of the ACA sets an annual limitation on cost sharing (commonly referred to as a maximum out-of-pocket limit) as part of the EHB package that NGF policies sold in the individual and small group markets must offer. As provided in 45 C.F.R. § 156.130(c), cost sharing for benefits provided outside of a health plan's network do not count towards the annual limitation on cost sharing when the health plan uses a provider network. For plan or policy years beginning after January 1, 2014, this limit will be the out-of-pocket limit for high deductible health plans (HDHP), adjusted by the Consumer Price

Index (CPI-U), and set by the Internal Revenue Service (IRS) pursuant to section 223(c)(2)(A)(ii) of the Internal Revenue Code.

1. Each carrier offering a health benefit plan to individuals or small groups in Colorado must develop a single index rates for all plans it offers. Carriers must apply all of their NGF business in the individual market and in the small group market as single risk pools. Carriers must use the total combined claims experience derived from providing EHBs within the individual or small group market in Colorado to establish an index rate (average rate) for that particular market.

2. All plans sold in and out of the Exchange must be pooled for index rate setting purposes. Colorado will not force a carrier to pool Grandfathered (GF) business with the NGF pool. (If a carrier has a GF pool with low levels of credible experience available, the carrier may use experience from their NGF pool for rate setting and trend setting of the GF pool.)

3. Additional benefits provided under the plan that are offered in addition to the EHBs must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to the EHBs.

L. Market Wide Index Rate

1. The market's risk pool index rate will be used to set the rates for all products of the carrier in that particular market. A carrier will then make a market-wide adjustment to the index rate based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in Colorado. A market-wide adjustment to the index rate will be made for Exchange user fees.

2. Market-wide index rate (average rate) shall be:

    a. Based on EHB claims experience of all enrollees in all NGF health benefit plans in the risk pool;

    b. Adjusted for risk adjustment/reinsurance payments and charges, and Exchange user fees; and

    c. Index rates may be developed separately for supplemental sand-alone benefits, and all such similar benefits are pooled for setting the respective index rate.

3. Rates on an individual or small employer policy issued on or after January 1, 2014, are only guaranteed through Dec 31st of that year. All members will receive new rates on January 1st of the following year. For example, an individual or small employer enrolling on October 1, 2014 would have their rates in effect until December 31, 2014, and would then be subject to the new rates implemented on January 1, 2015.

M. Market Wide Index Rate Development

1. Average Projected Benefit Cost Per-Member-Per-Month

    a. The index rate will initially be set by determining the average benefit cost of all NGF members in the pool in the state. Carriers are expected to consider all of the usual data adjustments and methods in developing the per-member-per-month (PMPM) cost, from their experience, including the following:

    b. Credibility: Carriers should determine the credibility levels of experience being used

and adjust appropriately. Carriers shall always discuss actuarial justification for credibility of the data being used.

c. Typical methods to deal with experience deemed to be less than 100% credible would be:

(1) Supplement the Colorado experience with similar national business,

(2) Supplement small employer business with other Colorado experience with similar characteristics (membership, network, plan designs).

2. Carriers shall always iscuss the impact of large claims on their business; apply methods for adjusting data by pooling large claims above a threshold and apply pooling charges. This consideration is separate from the Transitional Federal Reinsurance program impacts for individual plans in years 2014 - 2016.

3. Carriers must support and provide estimates for the IBNR claims portion of total incurred claims.

4. In developing the health cost trend, costs should be projected to the applicable rating period, assuming an actuarially justifiable health cost trend. For individual business index rates may not be trended monthly or quarterly through any rating period, and index rates must be the same for each month during a rating period. For small employer business, index rates may increase quarterly to reflect trend.

5. Adjustments for Demographic Mix, Benefit Mix, and Area: Other projected population changes from the experience period to the rating period should include considerations of newly uninsureds entering the market, grandfathered members moving into NGF products, and members moving from high-risk pools into commercial plans.

6. Adjustments for underwriting wear-off should be made due to members who were previously underwritten.

N. Allowable Market Level Adjustments

In each rate filing, carriers are expected to provide a calculation indicating the estimated federal medical loss ratio (MLR) calculation for each full calendar year containing any part of the rating period. For example, a filing for calendar year 2014 should contain an estimated MLR calculation for calendar year 2014.

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

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

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

P. The development of the plan cost and index rate should include market-wide adjustments for

Exchange user fees.

Carriers will need to make a market-wide adjustment to the index rate for Exchange user fees. This will ensure that Exchange user fees are spread evenly across the market, creating a level playing field inside and outside the Exchange, and further protecting against adverse selection.

Q. Plan Level Rating Adjustment

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

1. The actuarial value and cost-sharing design of the plan;

2. The plan's provider network and delivery system characteristics, as well as utilization management practices. This factor is intended to pass savings onto consumers where carriers negotiate robust provider discounts, construct efficient networks, or manage care more intensely;

3. Benefits provided by the product in addition to EHBs. The additional benefits must be pooled with similar benefits provided in other products to determine the allowed rate variation for products that offer these benefits;

4. Administrative costs other than Exchange user fees; and

5. With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

R. Benefit Factor Adjustments to the Index Rate

1. The adjusted index rate as developed from the process in Section 7.A. may be modified for each plan design by reflecting benefit cost adjustments due to the different benefit plan designs. Differences in the rates for different benefit plans, for persons with the same case characteristics of age, geographic location, family size, and tobacco use shall be attributable to plan design only. Benefit factors should not reflect the health status of members assumed to be enrolled in any particular plan, and should not reflect claims experience of members on a particular plan. The benefit cost relativity between plans should only reflect the true benefit differences due to different member cost sharing levels and plan design features. Using this method, a carrier's benefit factor for a plan design relative to the benefit factor for a richer (leaner) plan design should be higher (lower).

2. With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans should be reflected.

S. Retention Factor Adjustments to the Index Rate

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

At the minimum, carriers should provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financials, and identify and justify loads by specific retention components that include at least the following:

1. Administrative expenses;

2. Commissions and other acquisition expenses (may be separated);

3. Taxes;

4. PPACA Fees (Transitional Reinsurance, Health Insurer, CERF): these are market-wide adjustments as stated above];

5. Other assessments; and

6. Profit and contingencies.

T. Network Factor Adjustments

1. The adjusted index rate may be modified to reflect cost differences between different provider networks. Network factors may not be developed to reflect health status or claims experience of members included in the different networks. Factors should be set assuming each network has the same average member risk profile and levels of member health. Therefore, claims experience may not be directly used as the basis for setting a network factor. Network factors must reflect the following estimated cost differences between networks:

   a. Differences in reimbursement levels and discounts between providers;

   b. Differences in the utilization management of members, including tighter control of referrals, stricter managed care, disease management and wellness programs, etc;

   c. Other delivery system characteristics of a network; and

   d. Plan level network factor adjustments for any plan design and network may not vary by geographic area.

2. Carriers shall provide a table showing the network factor for each plan.

   (1) "Plan" is defined by HIOS Plan ID, which is the combination of "benefit design and cost sharing" (i.e. Silver Plan) with the network.

   (2) Plan level network factor adjustments may not vary by geographic area. As illustrated in the following table, all factors must be the same across areas (across rows in this table).

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

As defined on the SERFF Plans and Benefits Template: HIOS Plan ID = Benefit Design, Network, Geographic Area.

The combined effect of the geographic and network factors on the index rate for a particular plan is:

(Index Rate) x (Geographic Area Factor) x (Network Factor)

U. For the purposes of determining whether a carrier is meeting the federal MFR requirements, a carrier shall provide a list of other plans under its legal entity that will be pooled with the plan in the rate filing for purposes of determining whether the Federal minimum MLR will be met.

1. The carrier is required to provide the estimate of the MLR for the current calendar year and the following calendar year. The carrier is requested to indicate all adjustments allowed in the minimum MLR calculation that will be used to reach the minimum required MLR. Federal minimum MLR requirements are as follows:

    a. Large Group: 85%

    b. Small Group: 80%

    c. Individual: 80%, includes Student Health Plans

2. Allowable MLR adjustments from Colorado's benefit ratio are as follows:

    a. Tax: State and federal taxes may be subtracted from earned premium in the denominator;

    b. L&R: Licensing and regulatory fees may be subtracted from earned premium in the denominator;

    c. QI: Quality Improvement costs may be added to the numerator;

    d. SHP: Student Health Plan multiple of 1.15 to claims and QU may be made for 2013 only;

    e. ICD: ICD-10 implementation costs up to 0.3% of premium may be added to the numerator;

    f. Cred: Credibility adjustment percent based on the plan's size is added to the Base Loss Ratio; and

    g. Ded: Deductible adjustments based on average deductible, applied as a multiple to Cred.

V. Essential Health Benefits (EHBs)

1. Carriers are to provide EHBs and essential health care benefit packages.

2. Essential benefits include providing prescription drug coverage that covers at least the greater of:

    a. One drug in every United States Pharmacopeial Convention (USP) Model category and class; or

    b. The same number of prescription drugs in each category and class as the EHB benchmark plan. A drug is considered covered if the health benefit plan pays for all or part of the drug regardless of tiers and cost sharing. The specific drugs

covered on each carrier's formulary may vary as long as the minimum number in each category and class is met.

W. Stand-alone Dental (SADP)

1. QHPs in an Exchange may omit the pediatric dental EHB if a SADP in the Exchange offers pediatric dental EHB coverage.

2. SADPs are allowed a separate out-of-pocket maximum

    a. SADPs are required to demonstrate that the out-of-pocket maximum is reasonable for pediatric dental EHB.

    b. The Division will make the final determination as to what constitutes a reasonable out-of-pocket maximum for pediatric dental EHB.

    c. The cost sharing annual limit for a pediatric dental plan will be at or below $700 for a plan with a single child enrollee, or $1,400 for a plan with two or more child enrollees is considered reasonable and no higher limit will be approved

3. SADPs are not required to use the AVC, but will have a low and/or high plan (70% AV and 85% AV, respectively).

4. Pediatric dental plans provide coverage up to age 19.

5. The standardized rating regions that apply to the medical QHPs do not apply to SADP. Each dental carrier can determine its area adjustment factors and how to vary such factors by geographic locations. If zip codes are used to establish the area adjustment factors, no zip code smaller than a three (3)-digit zip code may be used when establishing an area.

6. The standard rating tiers and child factors applicable to the medical QHP do not apply to SADP. The dental carrier can develop a rating structure that conforms to federal and state laws.

7. The pediatric dental EHB offered by a stand-alone dental plan must be offered without annual and lifetime limits. Such limits may be used for benefits offered in addition to pediatric dental essential health benefits as well as for adult dental benefits.

X. Student Plans

1. 45 CFR §147.145 of the federal rate review final rule exempts student health insurance coverage from the guaranteed availability and guaranteed renewability requirements of the PHSA to the limited extent provided for in Public Health Service Act (PHS Act) sections 2702 and 2703, added by the ACA. However, coverage in a student health plan is guaranteed available and guaranteed renewable for students and their dependents.

2. Non-grandfathered student health insurance coverage is not subject to the single risk pool requirement of section 1312(c) of the ACA. The premium rate charged by a carrier offering student health insurance coverage may be based on a school-specific group community rate if, consistent with section 2701 of the PHS Act, the carrier offers the coverage without rating for age or tobacco use.

3. Pursuant to federal law, these plans are defined as "individual health insurance coverage."

Section 8 Rate Filings and Actuarial Certification

A. The provisions of and § 10-16-107, C.R.S. and this regulation shall apply to the filing of rates for individual, small and large group health benefit plans. Expected rate increases for individual, small and large group health benefit plans shall be submitted for approval to the Division of Insurance at least sixty (60) days prior to the proposed rate implementation and/or effective date.

B. Small group health benefit plan rate filings shall not be combined with either individual or large group health benefit rate filings. Additionally, they shall be filed separately by type of coverage (indemnity, preferred provider organization, or health maintenance organization).

C. Pursuant to § 10-16-107, C.R.S., all carriers who sell, or offer for sale, policies subject to the requirements of this regulation must submit an annual actuarial rate certification to the Division prior to March 1 of each calendar year. Note: this certification may be combined with the carrier's Annual Rate Report. Certifications shall be sent to the Colorado Division of Insurance, Attention: Rates and Forms Section. The certification must be signed by a qualified actuary and must contain at least the following:

1. The name of the carrier and the identification number assigned by the National Association of Insurance Commissioners;

2. A list of all plans of health benefits and policy forms to which the certification applies;

3. A statement that covers at least the points listed in the following illustration:

> "I am familiar with the small group rating laws and regulations of the state of Colorado. In my opinion, as of January 1 of the year of this certification, the premium rates and rating methodology to which this certification applies are neither excessive, inadequate nor unfairly discriminatory, and they meet the requirements of the insurance laws and regulations of Colorado;"

4. The name and title of the qualified actuary signing the certification, and the name of the firm with which he or she is associated; and

5. The original signature of the qualified actuary and the date of the signature. Signature stamps or signatures on behalf of the actuary are not acceptable.

D. Stand-alone dental plans offering the pediatric dental coverage mandated by PPACA as EHBs, must be "Exchange certified stand-alone dental plans". The "Product Name" on the General Information tab in SERFF must identify the filings as "PPACA Dental." New filings must be submitted in accordance with the PPACA rate filing requirements for Colorado.

Section 9 Additional Requirements for Large Group Health Benefit Plans

A. Large Group Health 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 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.

B. Valid Multi-State Association Groups: Valid multi-state associations 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.

C . Determining Minimum Value

1. A group health plan provides minimum value (MV) if the total allowed costs of benefits paid by the plan is no less than 60%.

2. An individual eligible for coverage in an employer-sponsored plan that provides MV is not eligible for premium tax credits

3. A group health plan may determine if it provides MV using the following methods:

    a. AV Calculator; or

    b. A safe harbor established by HHS and IRS; or

    c. Certification by an actuary if neither is suitable.

Section 10 Prohibited Rating Practices

The commissioner has determined that certain rating activities lead to excessive, inadequate or unfairly discriminatory rates, and are unfair methods of competition and/or unfair or deceptive acts or practices in the business of insurance. Therefore, in accordance with § § 10-16-107, 10-16-109, and 10-3-1110(1), C.R.S., the following are prohibited:

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

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

C. Pursuant to § 10-16-107(2)(b), C.R.S, individual health benefit plans rates shall not vary due to the gender of the individual policyholder, enrollee, subscriber, or member.

D. For large group health benefit plans, the use of any rating factors based upon zip codes which fail to

equitably adjust for different expectations of loss. It is the expectation of the commissioner that areas of the state with like expectations of loss must be treated in a similar manner. Also, policyholders utilizing the same provider groups 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; and

    b. The following zip codes in Adams County: 80614, 80640.

3. All zip codes in the 809 three-digit zip code group are considered part of the Colorado Springs metropolitan area and shall receive the same rating factor. In addition, the following zip codes in El Paso County, which lie outside the 809 three-digit zip code group shall be considered part of the Colorado Springs metropolitan area and shall receive the same rating factor as the 809 three-digit zip code group: 80809, 80817, 80819, 80829, 80831, 80840, 80841.

If a carrier uses area rating factors which are based in whole or in part upon the zip code, and does not follow these guidelines, the carrier may be found to have rates that are unfairly discriminatory. The commissioner would prefer that a carrier use federal MSA's, rather than zip codes, in their rating structure. The commissioner expects carriers to review the appropriateness of area factors at least every five (5) years and provide detailed support for the continued use of the factors in rate filings and upon request.

Section 11 Incorporated Materials

Colorado Insurance Regulation 13-E-01, 3 CCR 702-4 published by the Colorado Division of Insurance shall mean Colorado Insurance Regulation 13-E-01, 3 CCR 702-4 as published on the effective date of this regulation and does not include later amendments to or editions of Colorado Insurance Regulation 13-E-01, 3 CCR 702-4. Colorado Insurance Regulation 13-E-01, 3 CCR 702-4 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Colorado Division of Insurance Website at www.dora.state.co.us/insurance/. Certified copies of Colorado Insurance Regulation 13-E-01, 3 CCR 702-4 are available from the Division of Insurance for a fee.

45 CFR § 147.102 published by the Government Printing Office shall mean 45 CFR § 147.102 as published on the effective date of this regulation and does not include later amendments to or editions of

45 CFR § 147.102. A copy of the 45 CFR § 147.102 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A Certified copy of the 45 CFR § 147.102 may be requested from the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 CFR §156.135 published by Government Printing Office shall mean 45 CFR §156.135 as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR §156.135. A copy of the 45 CFR §156.135 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A Certified copy of the 45 CFR §156.135 may be requested from the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 CFR §147.145 published by Government Printing Office shall mean 45 CFR §147.145 as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR §147.145. A copy of the 45 CFR §147.145 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A Certified copy of the 45 CFR §156.135 may be requested from the Rulemaking Coordinator, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 12 Severability

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

Section 13 Enforcement

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

Section 14 Effective Date

This emergency regulation shall become effective on June 20, 2013.

Section 15 History

Emergency regulation 13-E-02 effective June 20, 2013.

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

1. Format: All required reports and documentation must be submitted through SERFF in a searchable PDF format. All tables in the Colorado Actuarial Memorandum must also be submitted in an Excel format (in addition to the searchable PDF).

2. Submission Requirements for New Rate Filings: Carriers must complete and submit the following information in SERFF in order for a rate filing submission to be considered complete:

    1. Carriers must complete all SERFF required data fields.

    2. Carriers must list all forms associated with the rate filing under the Form Schedule Tab.

a. Carriers must complete all data fields (Form Name, Form Number, Form Type, Action, Readability Score) under this tab.

b. Carriers are not required to attach copies of the actual form documents as part of a rate filing.

3. Carriers must attach a copy of the Rate Tables/Manual under the Rate/Rule Schedule Tab.

4. Carriers must attach copies of the following documents under the Supporting Documentation Tab in the Filing (Non-Binder) section in SERFF:

    a. If a carrier uses a third party to submit a form filing on their behalf, a Letter of Authority, which must be attached under the Supporting Documentation Tab in SERFF.

    b. A copy of the Colorado Actuarial Memorandum, which includes all elements contained in Section __ of this regulation.

    c. The following documents required by the Centers for Medicare and Medicaid Services:

        i. Part I – Unified Rate Review Template;

        ii. Part II – Consumer Justification Narrative must be completed for all rate increases, but is options for new plans;

        iii. Part III – Actuarial Memorandum.

5. Carriers must complete and upload the following templates, under the Template Tab in the Plan Management (Binder) section of SERFF:

    a. Business Rules Template;

    b. Plans and Benefits Template;

    c. Prescription Drug Template;

    d. Network Template;

    e. Rate Data Template; and

    d. Service Area Template.

6. Carriers must attach copies of the following documents under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF

    a. Carrier Attestation Form;

    b. State-Based Exchange Issuer Attestations: State of Detailed Attestation Responses;

    c. Cost Sharing – Small Group Deductible Justification (if applicable);

    d. Cost Sharing – Supporting Documentation and Justification for Exceeding Annual Limitation on Out-of-Pocket Maximum (Nesting) (if applicable);

    e. Cost Sharing – Supporting Documentation and Justification for Exceeding Annual

Limitation on Out-of-Pocket Maximum (Multiple Administrators) (if applicable);

f. EHB – Substituted Benefit (Actuarial Equivalent) Justification (if applicable);

g. Formulary – Inadequate Category/Class Count Justification (if applicable);

h. Limited Cost Sharing Plan Variation – Estimated Advance Payment Supporting Documentation and Justification (if applicable);

i. Partial Service Area Justification (if applicable); and

j. Unique Plan Design Supporting Documentation and Justification (if applicable).

Regulation 13-E-05 CONCERNING THE ELEMENTS OF CERTIFICATION FOR CERTAIN LIMITED BENEFIT PLANS, CREDIT LIFE AND HEALTH, PRENEED FUNERAL CONTRACTS, EXCESS LOSS INSURANCE FORMS, AND SICKNESS AND ACCIDENT INSURANCE, OTHER THAN HEALTH BENEFIT PLANS

Section 1 Authority

This emergency regulation is promulgated pursuant to § § 10-1-109(1), 10-3-1110, 10-15-105(1)(b)(I),(II), (III), 10-16-109, 10-16-107(2), 10-16-107.2(1),(2),(3), 10-16-107.3(1)(b), and 10-16-119(1), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to promulgate rules applicable to the filing of new policy forms, new policy form listings, annual reports of policy forms, and certifications of policy forms and contracts, other than health benefit forms.

Section 3 Applicability

This regulation applies to all insurers and other entities authorized to conduct business in Colorado who are required to fully execute and file a certification form and complete the Form Schedule Tab in the System for Electronic Rate and Form Filings (SERFF). This includes insurers and other entities who provide sickness and accident insurance, credit disability, credit - FMLA, credit – life, accident only,

specified disease, intensive care, organ & tissue transplant, dental, disability income, and short term care. This also includes insurers and other entities who provide hospital indemnity, travel, vision, long-term care, pre-need funeral contracts, accidental death and dismemberment, hospital/surgical/medical, prescription drug, and excess/stop loss insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act" (ERISA). This regulation does not change the certification requirements for pre-need funeral contract sellers who utilize Colorado's prototype pre-need funeral contracts. The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary to ensure carrier compliance with the recent changes to Colorado law as implemented by recently enacted legislation. Therefore, compliance with the requirements of § 24-4-103, C.R.S. would be contrary to the public interest.

This regulation does not apply to health benefit plans, life insurance, annuities, or stand-alone dental plans.

Section 4 Definitions

For the purposes of this regulation:

A. "Accident only" means, for the purposes of this regulation, coverage for death, dismemberment, disability, or hospital and medical care caused by or necessitated as the result of accident or specified kinds of accident. "Accident Only" policies cannot include 'sickness' or 'wellness' benefits. If additional benefits are provided they must be fully disclosed and properly labeled.

B. "Annual Report for credit insurance" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.K. of this regulation.

C. "Annual Report for health coverage plans" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.L. of this regulation

D. "Annual Report for preneed contracts" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.M. of this regulation.

E. "Certification of compliance" means, for the purposes of this regulation, the form that contains the necessary elements of certification, as determined by the commissioner, which has been signed by the designated officer of the insurer.

F. "Certification of compliance for excess loss insurance" means, for the purposes of this regulation, a certification form, which contains the elements of certification as determined by the commissioner, signed by a designated officer of the insurer, and used in conjunction with self-insured employer benefit plans under ERISA.

G. "Credit Insurance" for the purposes of this regulation, shall have the same meaning as defined in §10-10-103(2), C.R.S.

H. "Disability Income policy" means, for the purposes of this regulation, a policy that provides periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury. "Disability income policies" cannot include annual doctor visits or outpatient coverage. Short-term disability coverages may be filed separately from long-term disability income coverages. If additional benefits are provided they must be fully disclosed and properly labeled.

I. "Entity" means, for the purposes of this regulation, any organization that provides sickness and accident insurance, credit insurance, preneed funeral contracts, or excess loss coverage in this

state. For the purpose of this regulation, "entity" includes insurers providing health coverage through fraternal benefit societies, health maintenance organizations, nonprofit hospital and health service corporations, sickness and accident insurance companies, and any other entities providing a plan of health insurance or health benefits subject to the Colorado insurance laws and regulations.

J. "Excess Loss Insurance" means, for the purposes of this regulation, the excess loss insurance provided in conjunction with self-insured employer benefit plans under ERISA, and that comply with the requirements set forth in § 10-16-119, C.R.S.

K. "Health Benefit Plan" for the purposes of this regulation shall have the same meaning as defined in §10-16-102(32), C.R.S.

L. "Health Coverage" means, for the purposes of this regulation, services included in furnishing to any individual, medical, mental, dental, optometric care or hospitalization or nursing home care or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human physical or mental illness or injury.

M. "Health Coverage Plan" for the purposes of this regulation shall have the same meaning as defined in §10-16-102(34), C.R.S., and shall mean a contract, certificate or agreement entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

N. "Hospital indemnity" means, for the purposes of this regulation, a policy that provides a stated daily, weekly or monthly payment while the insured is "hospitalized" regardless of expenses incurred and regardless of whether or not other insurance is in force. "Hospital Indemnity" policies cannot include medical expense, wellness benefits or well-baby care. If additional benefits are provided they must be fully disclosed and properly labeled.

O. "Listing of New Policy forms for credit insurance" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF, including the documents and information listed in Section 5.N. of this regulation.

P. "Listing of New Policy Forms for health coverage" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.O. of this regulation.

Q. "Listing of New Policy Forms for preneed contracts" means, for the purposes of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.P. of this regulation.

R. "New Policy Form or Product" means, for the purposes of this regulation, a policy form that has "substantially different new benefits" or unique characteristics associated with risk or cost that are different from existing policy forms. For example: A guaranteed issue policy form is different than an underwritten policy form, a managed care policy form is different than a non-managed care policy form, a direct written policy form is different from a policy sold using producers, etc.

S. "Officer of an entity" means, for the purposes of this regulation, the president, vice-president, assistant vice-president, corporate secretary, chief executive officer (CEO), chief financial officer (CFO), chief operating officer (COO), assistant corporate secretary, funeral director, general counsel or actuary who is a corporate officer, or any officer appointed by the board of directors.

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

U. "Policy of Sickness and Accident" for the purposes of this regulation shall have the same meaning as defined in §10-16-102(30), C.R.S.

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

W. "Program" means, for the purposes of this regulation, the title of an entity's insurance program, product or preneed funeral contract.

X. "Signature" means for the purposes of this regulation, the original signature of an officer, or an electronic signature as defined in § 24-71.3-102, C.R.S.

Y. "Specified disease coverage" means, for the purposes of this regulation, payment of benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or principal sum.

Z. "Substantially different new benefit" means for the purposes of this regulation, a new benefit that results in a change in the actuarial value of the existing benefits by 10% or more. The offering of additional cost sharing options (i.e. deductibles and copayments) to what is offered as an existing product does not create a new form.

Section 5 Rules

A. At least 31 days prior to using any new form (except preneed funeral contract and excess loss insurance, which are filed concurrently) each entity, subject to the provisions of this regulation, shall file, in a format prescribed by the commissioner, a fully-executed certificate of compliance form, and complete the Form Schedule Tab in SERFF.

B. Preneed funeral contract and excess loss insurance form certifications shall file a fully-executed certification of compliance, and complete the Form Schedule Tab in SERFF, in a format prescribed by the commissioner, prior to, or concurrently with, the use of the form by each entity. For excess loss insurance, the actual forms to be used need to be submitted in the forms schedule tab.

C. No later than July 1 of each year, each preneed contract insurer or credit insurer shall file an Annual Report of policy forms including a fully-executed certificate of compliance and complete the Form Schedule Tab in SERFF.

D. Not later than December 31 of each year, each entity providing sickness and accident coverages shall file an Annual Report of policy forms, including a fully executed certificate of compliance and complete the Form Schedule Tab in SERFF. However, excess loss insurance, used in conjunction with self-insured employer benefit plans under ERISA does not require the filing of an Annual Report of policy forms.

E. Certification requirements.

1. The elements of certification are as follows:

a. The name of the entity;

b. A statement that the officer signing the certification form is knowledgeable of accident and sickness insurance or health care benefits (other than health benefit plans), preneed funeral contracts, excess loss insurance, or credit insurance, whichever is being certified;

c. A statement that the officer signing the certification form has carefully reviewed the policy forms, subscription certificates, membership certificates, preneed funeral contracts or other evidences of health care coverage identified on the Form Schedule Tab in SERFF, or in the case of excess loss insurance, the actual forms are attached;

d. A statement that the officer signing the certification form has read and understands each applicable law, regulation, and bulletin;

e. A statement that the officer signing the certification form is aware of applicable penalties for certification of a noncomplying form or contract;

f. A statement that the officer signing the certification form certifies:

(1) For Listings of New Policy Forms for health coverage or, in the case of excess loss insurance, the actual forms themselves, that the certifying officer has reviewed, signed and placed on file, and in the case of excess loss insurance, the excess loss for ERISA plan guide, and to the best of the officer's good faith, knowledge and belief, the new policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, provide all applicable mandated coverages and are in full compliance with all Colorado insurance laws and regulations, and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.

(2) For Annual Reports of all policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements or riders for any sickness, accident, limited benefit plans and/or health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms identified in the Form Schedule Tab in SERFF, provide all applicable mandated coverages and are in full compliance with all Colorado insurance laws and regulations, and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.

(3) For Listings of New Policies for credit insurance, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders, and to the best of the officer's knowledge, each policy form, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider in use complies with Colorado law.

(4) For Listings of New Contract Forms and Annual Reports for preneed funeral (§ 10-15-101 et seq., C.R.S.) contracts (prototype contracts are excluded from this requirement), the contract seller must certify that, to the best of the seller's knowledge, each preneed funeral contract or form of assignment is in full compliance with all Colorado insurance laws and regulations;

g. Annual Reports for health coverage shall contain a statement in the form certification that states: "Copies of the rates and the classification of risks or subscribers

pertaining thereto are on file with the commissioner."

h. The name and title of the officer signing the certification form and the date the certification form is signed;

i. The original signature of the officer. Signature stamps, photocopies or a signature on behalf of the officer are not acceptable. Electronic signatures must be in compliance with § 24-71.3-102, C.R.S., and applicable regulations.

2. The elements of certification must be included in:

a. Form Health (Colorado Health Coverage Certification Form for Listing of New Policy Forms);

b. Form Health Annual (Colorado Health Coverage Certification Form for Annual Reports);

c. Form CI (Colorado Credit Insurance Policy Certification Form for Annual Reports and Listings of New Policy Forms);

d. Form PN (Colorado Preneed Certification Form for Annual Reports and Listings of New Contracts); and

e. Form Excess Loss (Colorado Excess Loss Insurance for Self-Insured Employer Benefit Plans under ERISA Certification Form),

F. If the individual signing the certification is other than the president, vice-president, assistant vice-president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel or an actuary that is also a corporate officer, documentation shall be included that shows that this individual has been appointed as an officer of the organization by the board of directors. This documentation is to be submitted with every filing.

G. If an insurer or carrier uses the optional method of electronic dissemination of newly issued or renewed policy forms or endorsements, the insurer or carrier must comply with Colorado's Uniform Electronic Transactions Act (UETA) § 24-71.3-101 et seq., C.R.S. UETA guidance is provided by the Colorado Office of Information Technology and the Colorado Division of Insurance.

H. All filings submitted in the format prescribed by the commissioner, in SERFF, shall have the Form Schedule Tab completed with the form name, form number, edition date, form type, action, action specific data, and readability score where required by law. Only forms related to excess loss policies must be attached.

I. Rate changes that impact "New Business Only" must be filed as a 'rate change' to an existing product. ANY changes to the rating methodology, rating factors, rates, or assumptions must be identified, and the overall experience data for the existing product must be provided.

J. Insurers and other entities shall not represent an existing policy form or product to be a new policy form or product, if the policy form or product is not a new policy form or product. If a policy form or product is not a new policy form or product and the rate is increasing, the rate filing is prior approval. If an existing policy form is modified and it is truly not a new policy form it will need to comply with the provisions of § 10-16-105.1(5), C.R.S.

K. In order to file an "Annual Report for credit insurance" the insurer must complete the Form Schedule Tab in SERFF. The report must include all credit insurance policy forms, certificates of insurance,

notices of proposed insurance, applications for insurance, endorsements, and riders issued or delivered to any policyholder in Colorado. Such listing shall be submitted on or before July 1 of each year. Each annual report shall include a certification by an officer of the organization that, to the best of the officer's knowledge, each policy form, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider in use complies with Colorado law. Attaching the actual forms is not required.

L. In order to file an "Annual Report for health coverage plans" the insurer must complete the Form Schedule Tab in SERFF. The report must include all health coverage policy forms, application forms (including any health questionnaires used as part of the application process), endorsements or riders for any sickness, accident, and/or health coverage policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms. This annual report shall include a certification that the rates and classification of risks or subscribers pertaining to the policies, endorsements, riders, or applications are on file with the commissioner. Listing the readability score and attaching the actual form(s) is not required.

M In order to file an "Annual Report for preneed contracts" the insurer must complete the Form Schedule Tab in SERFF. The report must include all written contracts currently in use, but not limited to, forms of assignment, agreements, or mutual understandings, any series or combination of contracts, agreements, or mutual agreements, or mutual understanding, or any security or other instrument which is convertible into a contract, agreement, or mutual understanding whereby it is agreed that, upon the death of the preneed contract beneficiary, a final resting place, merchandise, or service shall be provided or performed in connection with the final disposition of the preneed contract beneficiary's body. Attaching the actual forms is not required.

N. In order to file a "Listing of New Policy forms for credit insurance" the insurer must complete the Form Schedule Tab in SERFF. The listing must include all policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery to any policyholder in Colorado with the form name, unique form number for new policies, edition date, form type, action, and action specific data. Attaching the actual forms is not required.

O. In order to file a "Listing of New Policy Forms for health coverage plans" the insurer must complete the Form Schedule Tab in SERFF. The listing must include any new policy forms, application forms (including any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health coverage policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, with a description of the form, unique form number for new forms, including the edition date for amended forms, the title of the program or product affected by the form, and the readability score where required by law. In order to file New Policy Forms for Excess Loss, actual forms must be attached to the Form Schedule tab in SERFF. Excess loss forms must include description of the form, the unique form number for new forms including the edition date for amended forms, and the title of the program or product affected by the form, and the readability score.

P. In order to file a "Listing of New Policy Forms for preneed contracts" the insurer must complete the Form Schedule Tab in SERFF. The listing must include all new written contracts, forms of assignment, agreements, or mutual understandings, any series or combination of contracts, agreements, or mutual agreements, or mutual understanding, or any security or other instrument which is convertible into a contract, agreement, or mutual understanding whereby it is agreed that, upon the death of the preneed contract beneficiary, a final resting place, merchandise, or service shall be provided or performed in connection with the final disposition of the preneed contract beneficiary's body. Additionally, the preneed funeral contract seller shall include a description of the form, the unique form number for new forms including the edition date for amended forms, and the title of the program or product affected by the form. All preneed funeral

contract sellers shall certify preneed contracts to the commissioner concurrent with the use of such preneed contracts. Attaching the actual forms is not required.

Q. New plan designs under an existing product or policy form must identify the difference in benefits, and must also state if the benefits have been previously offered under the policy form and then later removed.

Section 6 Readability

A. Pursuant to §10-16-107.3, C.R.S., entities writing health coverage plans, limited benefit health insurance, dental plans, or long-term care plans, must include the Flesch-Kincaid grade level or the Flesch Read Ease score in the electronic filing. The Flesch-Kincaid grade level shall not exceed the tenth grade level or the Flesch Read Ease score shall not be less than 50.

B. Entities may choose either the Flesh-Kincaid grade level formula or the Flesh Read Ease formula to generate a readability score. However, once a formula has been selected from these two formulas, the selected formula shall be used consistently for all text being scored for that particular policy.

C. At the option of the insurers and carriers, riders, endorsements, applications, and other forms made a part of the policy may be scored as a separate form or as part of the policy with which they may be used.

D. For the purposes of the readability score, only forms that are made part of the policy are required to comply with the readability score. Cancellation notices, renewal notices, disclosure forms, and notices of reductions in coverage do not require a readability score.

Section 7 Severability

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

Section 8 Enforcement

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

Section 9 Effective Date

This emergency regulation shall become effective on June 20, 2013.

Section 10 History

Originally issued as Final Regulation 1-1-6 effective June 1, 1994.

Amended Regulation 1-1-6 effective February 1, 2002.

Amended Regulation 1-1-6 effective June 1, 2003.

Sections 1, 2, 3, 8 and 9 amended effective February 1, 2004.

Amended Regulation effective January 1, 2012.

Emergency Regulation effective June 20, 2013.

Regulation 13-E-06 CONCERNING ESSENTIAL HEALTH BENEFITS

Section 1 Authority

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

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for the required inclusion of the essential health benefits in individual and small group health benefit plans in accordance with Article 16 of Title 10 of the Colorado Revised Statutes, and the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the "Affordable Care Act" (ACA). The Division of Insurance (Division) finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary to ensure carrier compliance with the recent changes to Colorado law as implemented by recently enacted legislation. Therefore, compliance with the requirements of § 24-4-103, C.R.S. would be contrary to the public interest.

Section 3 Applicability

This regulation shall apply to all carriers offering individual and small group health benefit plans subject to the individual and group laws of Colorado and the requirements of the ACA. The requirements of this regulation do not apply to grandfathered health benefit plans.

Section 4 Definitions

A. "Actuarial value" and "AV" means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a plan will cover, with calculations based on the provision of essential health benefits to a standard population.

B. "AV calculator" means, for the purposes of this regulation, the publicly available actuarial value (AV) calculator developed by the U.S. Department of Health and Human Services (HHS) and available

electronically on the Center for Consumer Information & Insurance Oversight (CCIIO) website.

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

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

E. "Essential health benefits" and "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.

F. "Essential health benefits package" shall have the same meaning as found at § 10-16-102(23), C.R.S.

G. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

H. "Federal law" shall have the same meaning as found at § 10-16-102(29), C.R.S.

I. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.

J. "Habilitative services" means, for the purposes of this regulation, services that help a person retain, learn or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's EHB benchmark plan.

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

L. "Premium adjustment percentage" means, for purposes of this regulation, the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance, as published in the annual HHS "Notice of benefits and payment parameters."

Section 5 Essential Health Benefits

A. Carriers offering non-grandfathered individual and small group health benefit plans inside or outside of the Exchange must include the essential health benefits package.

1. Carriers must provide benefits that are substantially equal to Colorado's EHB-benchmark plan in the following ten (10) categories:

a. Ambulatory patient services, which must include, at a minimum:

(1) Primary care to treat an illness or injury;

(2) Specialist visits;

(3) Outpatient surgery;

(4) Chemotherapy services;

(5) Radiation therapy;

(6) Home health care;

(7) Outpatient diagnostic laboratory, x-ray, and pathology services;

(8) Sterilization;

(9) Treatment of cleft palate and cleft lip conditions; and

(10) Oral anti-cancer medications.

b. Emergency services, which must include, at a minimum:

(1) Emergency room – facility and professional services;

(2) Ambulance services; and

(3) Urgent care treatment services.

c. Hospitalization services, which must include:

(1) Inpatient medical and surgical care;

(2) Organ and tissue transplants (transplants may be limited to specified organs);

(3) Chemotherapy services;

(4) Radiation services;

(5) Anesthesia services; and

(6) Hospice care.

d. Laboratory and radiology services, which must include:

(1) Laboratory tests, x-ray, and pathology services; and

(2) Imaging and diagnostics, such as MRIs, CT scans, and PET scans.

e. Maternity and newborn care services, including state and federally required benefits for hospital stays in connection with childbirth, which must include:

(1) Pre-natal and postnatal care;

(2) Delivery and inpatient maternity services; and

(3) Newborn well child care.

f. Mental health, substance abuse disorders, and behavioral health treatment services rendered on an inpatient or outpatient basis, which must include:

(1) Benefits for treating alcoholism and drug dependency;

(2) Benefits for mental health services;

(3) Behavioral health treatment;

(4) Benefits for biologically based mental illness and mental disorder treatment that are no less extensive than the coverage provided for a physical illness, pursuant to § 10-16-104(5.5), C.R.S.; and

(5) Outpatient hospital and physician services.

g. Pediatric services, including oral and vision care, which must include:

(1) Preventive care services;

(2) Immunizations;

(3) One (1) comprehensive routine eye exam per year, to age nineteen (19);

(4) Routine hearing exams to age nineteen (19);

(5) Hearing aids to age eighteen (18), pursuant to § 10-16-104(19), C.R.S.; and

(6) Children's dental anesthesia, pursuant to § 10-16-104(12), C.R.S.

h. Prescription drugs, which must include:

(1) Retail services;

(2) Mail services (home delivery);

(3) Contraceptive services; and

(4) Home infusion therapy.

(5) To meet the EHB requirement for prescription drug benefits, carriers must offer coverage that includes at least the greater of:

(a) One (1) drug in every United States Pharmacopeia (USP) category and class; or

(b) The same number of prescription drugs in each category and class as the EHB-benchmark plan.

i. Preventive services, listed in Attachment 1, which are not subject to deductibles, copayments, or coinsurance and chronic disease management services, and which must include:

(1) Office visits for preventive care services;

(2) Immunizations;

(3) Colorectal cancer screenings;

(4) Annual breast cancer screenings with mammography for women over forty (40), and for younger women based upon risk;

(5) Vision care, consisting of one (1) comprehensive exam every twenty-four (24) months (does not include hardware);

(6) Audiology/hearing tests (adult hearing aids not included);

(7) Nutritional counseling;

(8) Smoking cessation programs;

(9) Allergy testing and injections;

(10) Diabetes education and medically necessary equipment and supplies; and

(11) Annual prostate cancer screening for men fifty (50) years of age and over, and for men from age forty (40) to fifty (50) based upon increased risk.

j. Rehabilitative and habilitative services and devices, which must include:

(1) No more than twenty (20) visits per calendar year, per therapy, for physical, speech, and occupational therapy for:

(a) habilitative services; and

(b) rehabilitative services.

(2) Cardiac rehabilitation services;

(3) Pulmonary rehabilitation services;

(4) Durable medical equipment;

(5) Arm and leg prosthetics;

(6) Inpatient and outpatient habilitative services;

(7) Up to one hundred (100) days of skilled nursing services annually;

(8) Up to two (2) months of inpatient rehabilitation annually;

(9) Autism spectrum disorder services; and

(10) Physical, occupational, and speech therapy for congenital defects for children up to age six (6).

2. Carriers seeking to include pediatric dental EHB coverage within a health benefit plan, or carriers offering a stand-alone pediatric dental plan that meets EHB requirements, must include the following eligible services, subject to plan benefit limitations, in order to meet the EHB requirements for pediatric dental coverage:

a. Diagnostic and preventive procedures, which must include:

(1) Oral exams and evaluations;

(2) Full mouth, intra-oral, and panoramic x-rays;

(3) Bitewing x-rays;

(4) Routine cleanings;

(5) Fluoride treatments;

(6) Space maintainers;

(7) Sealants; and

(8) Palliative treatment.

b. Basic restorative services, which must include:

(1) Amalgam fillings;

(2) Resin and composite filings;

(3) Crowns;

(4) Pin retention; and

(5) Sedative fillings.

c. Oral surgery, consisting of extractions.

d. Endodontics, consisting of:

(1) Surgical periodontal services; and

(2) Root canal therapy.

e. Medically necessary orthodontia and medically necessary prosthodontics for the treatment of cleft lip and cleft palate.

f. Implants, denture repair and realignment, dentures and bridges, non-medically necessary orthodontia, and periodontics are not considered a part of the pediatric dental EHB.

3. Carriers must limit cost-sharing for EHB coverage in accordance with state and federal law.

a. Annual deductibles in the small group market for plans covering single individuals are limited to $2,000, and $4,000 in the case of family plans.

(1) Carriers may exceed the annual deductible limit only if the plan cannot reasonably reach an actuarial value for a given level of coverage; and

(2) Carriers must provide a justification for the reasons the annual limit was exceeded, signed by an actuary.

(3) For plan years after 2014, the annual deductible limit may only be increased to the extent it matches the annual premium adjustment percentage for individuals, and no more than twice the individual amount for family plans. Increases in annual deductibles must be in multiples of fifty (50) dollars, and if not, must be rounded to the next lowest multiple of fifty (50) dollars.

b. Cost-sharing (or maximum out-of-pocket limits) for individual and small group plans must not exceed the annual out-of-pocket limit set by federal law. For the 2014 plan year, this limit is $6,350 for self-only coverage, and $12,700 for family coverage. For managed care plans, out-of-network deductibles and out-of-pocket maximums do not count toward these cost sharing limits.

c. For plan years after 2014, cost sharing limits for individual and small group plans may not be increased beyond the annual premium adjustment percentage for

individuals, and no more than twice the individual amount for family plans. Increases in annual deductibles must be in multiples of fifty (50) dollars, and if not, must be rounded to the next lowest multiple of fifty (50) dollars.

d. Cost-sharing (or maximum out-of-pocket limits) for stand-alone pediatric dental plans must not exceed the annual out-of-pocket limit. For the 2014 plan year, this limit is $700 for a single-child plan, and $1,400 for a plan that covers two or more children. For managed care plans, out-of-network deductibles and out-of-pocket maximums do not count toward these cost sharing limits.

e. The Division will annually publish the federally established annual premium adjustment percentage, as determined by HHS, including guidance as to how it will be applied to stand-alone pediatric dental plans.

f. For plan years after 2014, the Division will determine what, if any, increase to the 2014 annual cost-sharing limitation for stand-alone pediatric dental plans will be considered reasonable.

4. Carriers must offer health benefit plans that meet state and federally defined levels of coverage.

   a. Carriers must offer plans that meet at least one (1) of the following metal tiers of coverage:

      (1) Bronze level: benefits actuarially equivalent to sixty percent (60%) of the full actuarial value of the benefits provided under the plan;

      (2) Silver level: benefits actuarially equivalent to seventy percent (70%) of the full actuarial value of the benefits provided under the plan;

      (3) Gold level: benefits actuarially equivalent to eighty percent (80%) of the full actuarial value of the benefits provided under the plan; or

      (4) Platinum level: benefits actuarially equivalent to ninety (90%) of the full actuarial value of the benefits provided under the plan.

   b. Carriers are allowed a de minimis range of +/- two percentage (2%) points for each metal tier.

   c. Carriers offering health benefit plans at any of the levels of coverage listed in Section 5.A.4.a. of this regulation must offer child-only plans at that same level.

   d. Carriers may offer a catastrophic individual health benefit plan that does not provide a bronze, silver, gold, or platinum level of coverage to certain qualified individuals.

5. Benefits that are excluded from EHB, even though they may be covered by the EHB-benchmark plan, include:

   a. Routine non-pediatric dental services;

   b. Routine non-pediatric eye exam services;

   c. Long-term/custodial nursing home care benefits; and

   d. Non-medically necessary orthodontia.

6. Although the EHB-benchmark plan provides coverage for abortion services, no health benefit plan must cover such services as part of the requirement to cover EHB.

7. Carriers offering stand-alone non-pediatric dental plans that are offered in conjunction with a health benefit plan, or are offered as a stand-alone policy, need not comply with the requirements of Section 5.A.2. of this regulation.

B. Carriers must use actuarial value (AV) to determine the level of coverage of a health benefit plan. The AV is the percentage of total average costs for covered benefits that a plan will cover, and must be calculated based on the provision of EHB to a standard population.

1. For standard plan designs, carriers must use the AV calculator developed by the HHS to determine AV.

2. Carriers offering plans with benefit designs that cannot be accommodated by the AV calculator may alternatively:

a. Decide how to adjust the plan benefit design (for calculation purposes only) to fit the parameters of the calculator, and have a member of the American Academy of Actuaries certify that the methodology to fit the parameters of the AV calculator was in accordance with generally accepted actuarial principles and methodologies; or

b. Use the AV calculator for the plan design provisions that correspond to the parameters of the calculator, and have a member of the American Academy of Actuaries calculate appropriate adjustments to the AV as determined by the AV calculator for the plan design features that deviate substantially, in accordance with generally accepted actuarial principles and methodologies.

C. Substitution of Benefits

1. Carriers are permitted to substitute EHB if the following conditions are met:

a. The substituted benefit must be actuarially equivalent to the benefit that is being replaced. Carrier must submit evidence of actuarial equivalence that is:

(1). Certified by a member of the American Academy of Actuaries;

(2). Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(3). Based on a standardized population; and

(4). Determined regardless of cost-sharing.

b. A benefit substitution may be made only within the same EHB category (substitutions across categories are not permitted); and

c. Prescription drug benefits cannot be substituted.

D. Prohibition on Discrimination

1. Carriers may not offer benefit plans that, either through their design or implementation, discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other medical conditions.

2. Carriers may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

3. Carriers may not offer plans with benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.

E. Drug/Formulary Review

Carriers must submit their formulary to the Division annually, by June 30 of each year. If the formulary changes by more than five percent (5%) in a calendar year, the carrier must submit a filing to the Division of Insurance supporting it has the required number of drugs in each category to comply with the EHB requirement.

Section 6 Incorporation by Reference

The United States Preventative Services Task Force "USPSTF A and B Recommendations," published by the United States Preventative Services Task Force shall mean "USPSTF A and B Recommendations" as published on the effective date of this regulation and does not include later amendments to or editions of the "USPSTF A and B Recommendations." The United States Preventative Services Task Force "USPSTF A and B Recommendations" may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the United States Preventative Services Task Force Website at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm . Certified copies of the United States Preventative Services Task Force "USPSTF A and B Recommendations" are available from the Colorado Division of Insurance for a fee.

Section 7 Severability

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

Section 8 Enforcement

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

Section 9 Effective Date

This emergency regulation shall become effective on June 25, 2013.

Section 10 History

Emergency regulation effective June 25, 2013.

Attachment 1

Covered Preventive Services [1]

All Persons	Chicken pox vaccination for all persons who have not had chicken pox.
	Colorectal screening for all high risk individuals,

	regardless of age. [1a]
	Immunizations in accordance with the Immunization Schedules of the Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention: for children age 0 to 6 years, for children age 7 to 18 years, a "catch-up" schedule for children and for adults. [4]
	Syphilis screening for all adults at increased risk. [4]
Females	Full cost of cervical cancer vaccine. [1b]
	Screening for chlamydial infection: all sexually active women aged 24 and younger and for older females who are at an increased risk. [4]
	Screening for chlamydial infection: all pregnant women aged 24 and younger and for older pregnant females who are at an increased risk. [4]
	Cervical cancer screening for all sexually-active females with a cervix. [4]
	Screening for iron deficiency anemia in asymptomatic pregnant females. [4]
	Screening for asymptomatic bacteriuria with urine culture for pregnant females at 12 to 16 weeks gestation or at

	first prenatal visit, if later. [4]
	Screening for hepatitis B virus (HBV) for pregnant females at first prenatal visit. [4]
	Rh(D) blood typing and antibody testing for all pregnant females during first prenatal visit and repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative females at 24-28 weeks' gestation. [4]
	Syphilis screening for all pregnant females. [4]
	Pregnant females: Augmented, pregnancy-tailored tobacco counseling. [4]
	Annual well-woman visits. [4, 5]
	Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at first prenatal visit for pregnant women identified to be at high risk for diabetes. [4]
	Breastfeeding support, supplies, and counseling. [4, 6]
	Annual counseling for sexually transmitted infections for all sexually active women. [4]
	Annual counseling and screening for human immune-deficiency virus infection for all sexually active women. [4]

	High risk human papillomavirus testing DNA testing in women with normal cytology results: screening to begin at age 30 and occur no more frequently than every 3 years. [4]
	Annual screening and counseling for interpersonal and domestic violence. [4]

All Children (Age 0-18 years)	Immunizations, including the influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. [1c, 4] Immunization deficient children are not bound by "recommended ages".
	Ages 12 to 18 years: screening for major depressive disorder. [4]
	Under age 5: Screening to detect amblyopia, strabismus, and visual acuity defects. [4]
	Oral fluoride supplementation for preschool children older than 6 months of age whose primary water source is deficient in fluoride. [4]
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
	Newborns: Screening for hearing loss. [4]
	Newborns: Screening for

	sickle cell disease. [4]
	Newborns: Screening for phenylketonuria (PKU). [4]
	Newborns: Prophylactic ocular topical medication against gonococcal ophthalmia neonatorum. [4]
	Newborns: Screening for congenital hypothyroidism (CH). [4]
	6 well-child visits. [2]
	Ages 6 to 12 months: Routine iron supplementation for asymptomatic children who are at increased risk for iron deficiency anemia. [4]
Age 13-35 months	3 well-child visits.
Age 3-6	4 well-child visits.
	Age 6: Obesity screening and comprehensive, intensive behavioral interventions. [4]
Age 7-12	4 well-child visits.
	Obesity screening and comprehensive, intensive behavioral interventions. [4]
Age 13-18	1 age appropriate health maintenance visit [3] every year.
	1 Td [4]
	Females: screening pap smears not to exceed 1 per year.
	1 hepatitis B vaccination if not given previously. [4]
	Obesity screening and comprehensive, intensive

	behavioral interventions. [4]
	Sexually Transmitted Infection (STI) prevention counseling for all sexually active adolescents. [4]
	HIV screening for all adolescents at increased risk and all pregnant females. [4]
	Females: Screening for gonorrhea infection for all sexually active females, including pregnant females, at increased risk. [4]
Age 18 and older	Tobacco use screening and tobacco cessation interventions by any provider furnishing primary care services to the patient in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4]
	Alcohol misuse screening and behavioral counseling interventions by any provider furnishing primary care services to the patient in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4]
	Obesity screening and intensive counseling and behavioral interventions. [4]
	Females: HIV screening for all pregnant females. [4]
	Sexually Transmitted

	Infection (STI) prevention counseling for adults at higher risk. [4]
	Blood pressure screening. [4]
	Depression screening. [4]
	Type 2 diabetes screening in asymptomatic adults with sustained with blood pressure (either treated or untreated) greater than 135/80 mm Hg. [4]
	Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care providers or by referrals to other specialists, such as dieticians or nutritionists. [4]
	HIV screening for all adults at increased risk and all pregnant females. [4]
	Females: Screening for gonorrhea infection for all sexually active females, including pregnant females, at increased risk. [4]
	Females: Referral for genetic counseling and evaluation for BRCA testing for females whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes. [4]

	Females: Breast cancer chemoprevention counseling. [4]
	Females: Folic acid supplements for all females planning or capable of pregnancy. [4]
Age 19-39	1 Td every ten years. [4]
	1 age appropriate health maintenance visit every three years.
	Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. [1c, 4]
	Females: screening pap smears not to exceed 1 per year.
	Males ages 20-34: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4] Males ages 35-39: Screening for lipid disorders in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4]
	Females ages 20-39: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4]

Age 40-64	1 Td every ten years. [4]
	Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. 1c, [4]
	Adults ages 50-64: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4]
	1 age appropriate health maintenance visit every 24 months.
	Females ages 40-64: 1 screening mammogram, with or without clinical breast exam, every 1 to 2 years (annually, if high risk). [4]
	Females: screening pap smears not to exceed 1 per year.
	Males: Screening for lipid disorders in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4]
	Females: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4]
	Females ages 55-64: Aspirin therapy. [4]
	Females ages 60-64: Routine osteoporosis screening for females at increased risk for

	osteoporotic fractures. [4]
	Males: Prostate screening as specified in state law.
	Males ages 45-64: Aspirin therapy. [4]
Age 65 and older	Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. [1c, 4]
	Females: screening pap smears not to exceed 1 per year.
	1 Td every ten years. [4]
	1 age appropriate health maintenance visit every year.
	Males: Screening for lipid disorders in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4]
	Females: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4]
	Females: 1 screening mammogram, with or without clinical breast exam, every 1 to 2 years (annually, if high risk). [4]
	Females ages 65-79: Aspirin therapy. [4]
	Females: Routine osteoporosis screening. [4]
	Adults ages 65-75: Colorectal screening in accordance with the "A"

	or "B" recommendations of the U.S. Preventive Services Task Force. [4]
	Males: Prostate screening as specified in state law.
	Males ages 65 to 75: One-time screening for abdominal aortic aneurysm (AAA) by ultrasonography for males who have ever smoked. [4]
	Males ages 65-79: Aspirin therapy. [4]

1 Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans and coverage includes all preventive services as set forth in § 10-16-104(18), C.R.S., in accordance with "A" and "B" recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. That list of recommendations can be found at the United States Preventative Services Task Force Website at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

1a Colorectal screening shall be provided to all individuals who are at a high risk for colorectal cancer including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

1b Age limitations as recommended by the U.S. Department of Health and Human Services' Advisory Committee on Immunization Practices.

1c "ACIP" means the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the federal Department of Health and Human Services.

2 "Well-child visit" means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12, is based on the recommendations of the American Academy of Pediatrics.

3 "Age appropriate health maintenance visit" means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutrition counseling (including folate counseling for women of child bearing age).

4 In-network providers: These services are not subject to any cost-sharing requirements (copay, deductible, or coinsurance). If the service or item is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such item or service, then no office visit copay or other cost-sharing requirement can be imposed. If the service or item is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of the service or item, then the office visit copay or cost-sharing requirement can be imposed on the office visit charge. If the service or item is billed separately from an office visit, then the office visit copay or other applicable cost-sharing requirement can be imposed with respect to the office visit charge.

Out-of-network providers: These services can be subject to the plan's out-of-network cost sharing requirements.

5 Annual visits, though several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.

6 Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

Regulation 13-E-07 CONCERNING THE ELEMENTS FOR FORM FILINGS FOR HEALTH BENEFIT PLANS AND CERTAIN DENTAL COVERAGE FORMS AND CONTRACTS

Section 1 Authority

This emergency regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109(1), 10-3-1110, 10-16-107.2(3), 10-16-107.3(1)(b), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to promulgate rules applicable to the form filing requirements for health benefit plans and stand-alone pediatric dental plans. The Division of Insurance (Division) finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary to ensure carrier compliance with the recent changes to Colorado law as implemented by recently enacted legislation. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing individual, small group, and/or large group health benefit plans, and all carriers marketing and issuing stand-alone dental plans that provide for pediatric dental as an essential health benefit subject to Colorado insurance laws. This regulation excludes certain limited benefit plans, credit life and health policies, preneed funeral contracts, excess loss insurance forms, and sickness and accident insurance other than health benefit plans.

Section 4 Definitions

A. "Annual Report for Health Coverage Plans" means, for the purpose of this regulation, completing the Form Schedule Tab in SERFF including the documents and information listed in Section 5.A.3. of this regulation.

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

C. "Certification" means, for the purpose of this regulation, a certification form, which contains elements of certification as determined by the commissioner, signed by a designated officer of the carrier.

D. "Connect for Health Colorado" shall have the same meaning as "Exchange" as found at § 10-16-102(26), C.R.S.

E. "Federal law" shall have the same meaning as found at § 10-16-(29), C.R.S.

F. "Grandfathered health benefit plan" shall have the same meaning as found at § 10-16-102(31), C.R.S.

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

H. "Listing of New Policy Forms for Health Coverage" means, for the purpose of this regulation, completing the Form Schedule Tab in SERFF, including the documents and information listed in Section 5.A.2. of this regulation.

I. "Officer" means, for the purposes of this regulation, the president, vice-president, assistant vice-president, corporate secretary, chief executive officer (CEO), chief financial officer (CFO), chief operating officer (COO), assistant corporate secretary, funeral director, general counsel or actuary who is a corporate officer, or any officer appointed by the board of directors.

J. "Pediatric dental plan" means, for the purpose of this regulation, a stand-alone dental plan that provides coverage of the required pediatric dental essential health benefits.

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

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

M. "Program" means, for the purpose of this regulation, the title of a carrier’s health coverage program or product.

N. "SERFF" means, for the purpose of this regulation, System for Electronic Rate and Form Filings.

O. "Signature" includes an electronic signature as found at § 24-71.3-102(8), C.R.S.

P. "Substantially different new benefit" means, for the purpose of this regulation, a new benefit that, in the minimum, results in a change in the actuarial value of the existing benefits by 10% or more. The

offering of additional cost sharing options (i.e. deductibles and copayments) to what is offered as an existing product does not create a new form.

Section 5 Rules

All policies, riders, contracts, endorsements, certificates and other evidence of health coverage associated with health benefit plans and pediatric dental plans must be filed with the Division of Insurance (Division). All form filings shall be submitted electronically by licensed entities. Failure to supply the information required in Section 5 of this regulation will render the filing incomplete.

A. General Requirements

1. For all filings, carriers must complete the Form Schedule Tab in SERFF with the form name, form number, edition date, form type, action, and readability score where required by law. Copies of the actual form documents must be attached for individual and small group health benefit plans.

2. In order to file a "Listing of New Policy Forms for Health Coverage" the carrier must complete the Form Schedule Tab in SERFF. The listing must include any new policy forms, application forms, endorsements or riders for any health benefit plan or stand-alone pediatric dental and/or health insurance policy, contract, certificate, summary of benefits and coverage, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, with a description of the form, unique form number for new forms, including the edition date for amended forms, the title of the program or product affected by the form, and the readability score where required by law.

3. In order to file an "Annual Report for Health Coverage Plans" the carrier must complete the Form Schedule Tab in SERFF. The report must include all policy forms, application forms, endorsements or riders, and/or health policy, contract, certificate, summary of benefits and coverage, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms. This annual report shall include a certification that the rates and classification of risks or subscribers pertaining to the policies, endorsements, riders, or applications are on file with the commissioner. Listing the readability score and attaching the actual forms is not required.

4. If a carrier uses the optional method of electronic dissemination of newly issued or renewed policy forms or endorsements, the carrier must comply with Colorado's Uniform Electronic Transactions Act (UETA) § 24-71.3-101, et seq., C.R.S. UETA guidance is provided by the Colorado Office of Information Technology and the Division.

5. Carriers shall not represent an existing policy form to be a new policy form, if the policy form is not being issued in connection with a substantially different new benefit. In the case of reasonable modifications, if an existing policy form is modified and it is not a new policy form, it will need to comply with the provisions of § 10-16-105.1(5), C.R.S., for reasonable modifications. For carriers who have opted to discontinue certain plans, new policy forms cannot have similar names or form numbers to any discontinued plan forms.

B. Certification Requirements

1. At least thirty-one (31) days prior to using any new form, each carrier, subject to the provisions of this regulation, shall file, in a format prescribed by the commissioner, a fully-executed "Colorado Health Coverage Certification Form for Listing of New Policy Forms (Form Health)", and complete the Form Schedule Tab in SERFF.

2. Not later than December 31 of each year, each carrier subject to the provisions of this regulation shall file an annual report of policy forms including a fully executed "Colorado Health Coverage Certification Form for Annual Reports (Form Health Annual)" and complete the Form Schedule Tab in SERFF.

3. Elements of certification: The elements of certification as determined by the commissioner, which must be included in the "Colorado Health Coverage Certification Form for Listing of New Policy Forms (Form Health)", and "Colorado Health Coverage Certification Form for Annual Reports (Form Health Annual)", are as follows:

   a. The name of the carrier;

   b. A statement that the officer signing the certification form is knowledgeable of the health coverage insurance being certified;

   c. A statement that the officer signing the certification form has carefully reviewed the policy forms, subscription certificates, membership certificates, or other evidences of health care coverage identified on the Form Schedule Tab in SERFF;

   d. A statement that the officer signing the certification form has read and understands each applicable law, regulation and bulletin;

   e. A statement that the officer signing the certification form is aware of applicable penalties for certification of a noncomplying form or contract;

   f. A statement that the officer signing the certification form certifies:

      (1) For the "Listing of New Policy Forms" for health benefit plans and stand-alone pediatric dental coverage, that the certifying officer has reviewed, signed and placed on file, and to the best of the officer's good faith, knowledge and belief, that the submitted forms provide all applicable mandated coverages and are in full compliance with all Colorado laws and regulations, and that copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner. The submitted forms must include:

         (a) New policy forms;

         (b) Application forms (to include any health questionnaires used as part of the application process used by large group plans only);

         (c) Endorsements and riders for any health benefit plan and/or stand-alone pediatric dental insurance policy; and

         (d) Contracts, certificates, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado.

      (2) For "Annual Report for Health Coverage Plan" for health benefit plans and stand-alone pediatric dental plans, the documents identified in the Form Schedule Tab in SERFF, provide all applicable mandated coverages, and are in full compliance with all Colorado laws and regulations;

   g. The name and title of the officer signing the certification form and the date the

certification form is signed;

h. The original or electronic signature of the officer. Signature stamps, photocopies or a signature on behalf of the officer are not acceptable. Electronic signatures must be in compliance with § 24-71.3-102, C.R.S. and applicable regulations; and

i. If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel or an actuary that is also a corporate officer, documentation shall be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors. This documentation is to be submitted with all filings.

C. Required Submissions

1. All policies, riders, contracts, endorsements, certificates, summary of benefits and coverage, and other evidence of health coverage, must be filed with the Division at least thirty-one (31) days prior to issuance or deliverance of policies, certificates or evidence of coverage.

2. All carriers must submit a compliant form filing prior to giving forms to new or existing policyholders which differ from the forms on file with the Division.

3. All carriers must submit a compliant form filing on an annual basis, containing the items required in this regulation.

4. Each type of insurance must have a separate form filing. Form filings must not be combined with rate filings.

5. A separate filing must be submitted for each carrier. A single filing made for more than one carrier, or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/indemnity point-of-service plan.

6. All grandfathered policy form filings must be submitted separately from non-grandfathered policy form filings.

D. To be considered a complete filing, new or revised form filings for individual and small group health benefit plans and stand-alone pediatric dental plans must comply with the form filing procedures contained in Appendix A of this regulation.

Section 6 Readability

A. Carriers writing health benefit plans must include the Flesch-Kincaid grade level or the Flesch Read Ease score in the electronic filing. The Flesch-Kincaid grade level shall not exceed the tenth (10th) grade level or the Flesch Read Ease score shall not be less than 50.

B. Carriers may choose either the Flesh-Kincaid grade level formula or the Flesh Read Ease formula to generate a readability score. However, once a formula has been selected from these two (2) formulas, the selected formula shall be used consistently for all text being scored for that particular policy form.

C. All riders, amendments, endorsements, applications, and other forms made a part of the policy by a carrier must either be scored as a separate form, or as part of the policy with which they will be used.

D. For the purposes of the readability score, amendments, riders, and endorsements that are made part of the policy, evidence of coverage, or certificate of coverage, are required to comply with the readability score. Cancellation notices, renewal notices, disclosure forms, and notices of reductions in coverage do not require a readability score.

E. Carriers must provide all policy forms in a manner that is accessible and timely to individuals living with disabilities, or with limited English proficiency.

Section 7 Severability

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

Section 8 Enforcement

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

Section 9 Effective Date

This emergency regulation shall become effective on June 28, 2013.

Section 10 History

Emergency Regulation effective June 28, 2013.

(This regulation incorporates certain portions of Colorado Insurance Regulation 1-1-6, which was repealed in full on June 28, 2013)

APPENDIX A FORM FILING REQUIREMENTS FOR NEW AND REVISED NON-GRANDFATHERED INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS AND STAND-ALONE DENTAL PLANS OFFERING PEDIATRIC DENTAL PLANS

1. Format: All required reports and documentation must be submitted through SERFF in a searchable PDF format.

2. Unless otherwise noted, carriers offering individual and small group health benefit plans, and stand-alone pediatric dental plans must follow the filing requirements in this appendix for plans offered inside and outside of Connect for Health Colorado.

3. Variability: Carriers may submit one base document, accompanied by a statement of variability, for all policy forms, per the following requirements:

    a. Cost sharing information, including copayments, coinsurance, deductibles, and maximum out-of-pocket amounts, should be bracketed as variable amounts to include the entire possible range of minimum amounts for plans at all metal levels (as defined in Colorado Insurance Emergency Regulation 13-E-06);

    b. Bracketed language must be complete and options must be identified in a statement of variability. Form filings that do not include an adequate explanation of bracketed ranges and language may be rejected;

    c. Special requirements for Summary of Benefits and Coverage (SBC) and Evidence of

Coverage (EOC) forms:

(1) Carriers must submit SBC forms that are in compliance with the requirements of Colorado Insurance Regulation 4-2-20 and federal law;

(2) The SBC and EOC documents attached under the Form Schedule Tab in the Filing (Non-Binder) section of SERFF, as required in paragraph 4.b. of this appendix, will be reviewed by the Division for compliance with state and federal law, and Colorado Insurance Regulation 4-2-20. The Division will allow carriers to use variable language in these documents at the level of the Benefits Package, as defined by the federal Plans and Benefits Template in the Plan Management (Binder) section in SERFF. For those counties where 10% or more of the population is literate exclusively in the same non-English language, the SBC must provide instructions, in that language, on how to obtain a copy of that document in that non-English language and access carrier language services.;

(3) The SBC and EOC documents attached under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF, as required in paragraph 4.e. of this appendix, will posted on the Connect for Health Colorado website. Connect for Health Colorado will allow carriers to use variable language in these documents at the Health Insurance Oversight System (HIOS) Standard Component Plan ID level. For plans offered through Connect for Health Colorado, the SBC must be submitted and made available in both English and Spanish. The EOC may be submitted in Spanish, but there is no requirement to do so; and

(4) Carriers offering stand-alone pediatric dental plans are not required to complete or file an SBC form. Stand-alone pediatric dental carriers must still submit EOC documents, and otherwise comply with the requirements of paragraphs 4.a through 4.e of this appendix;

4. Submission Requirements for New Form Filings: Carriers must complete and submit the following information in SERFF in order for a form filing submission to be considered complete:

a. Carriers must complete all SERFF required data fields;

b. Carriers must complete the Form Name, Form Number, Form Type, Action, Readability Score data fields on the Form Schedule Tab, and attach copies of the following documents:

(1) Summary of Benefits and Coverage;

(2) Evidence of Coverage;

(3) Uniform Application; and

(4) Policy forms, riders and endorsements;

c. Carriers must attached copies of the following documents under the Supporting Documentation Tab in the Filing (Non-Binder) section in SERFF:

(1) Letter of Authority (If a carrier uses a third party to submit a form filing on their behalf.);

(2) Colorado Health Coverage Certification Form for Listing of New Policy Forms (Form Health); and

(3) PPACA Uniform Compliance Summary;

d. Carriers must complete and upload the following Administrative Data Template, under the Template Tab in the Plan Management (Binder) section of SERFF:

e. Carriers offering plans through Connect for Health Colorado must complete and upload the following templates, under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF:

(1) Summary of Benefits and Coverage; and

(2) Evidence of Coverage.

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]