DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

LIFE, ACCIDENT AND HEALTH, Series 4-7

3 CCR 702-4 Series 4-7

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

Regulation 4-7-1 HEALTH MAINTENANCE ORGANIZATIONS

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109, 10-16-109, and 10-16-403(2)(b), C.R.S.

Section 2 Scope and Purpose

The purposes of this regulation are to provide the requirements for licensure as a health maintenance organization (HMO) and establish standards for HMO organization and operations.

Section 3 Applicability

This regulation applies to licensed HMOs or persons seeking to become licensed to operate an HMO in Colorado.

Section 4 Definitions

A. "NAIC" means the National Association of Insurance Commissioners.

B. “Material modification of the plan of operations” includes a change in service area, or the initial entrance or withdrawal from the Medicare, Medicaid or commercial market, or any other transaction or series of related transactions which the HMO could reasonably predict would involve a net increase or decrease of 20% or more in the number of HMO enrollees or result in a 20% increase or decrease in the HMO’s net worth over a 12 month period based upon projected financial statements.

Section 5 Authorization of Insurers and Nonprofit Hospital, Medical-Surgical and Health Service Corporations

A. Any licensed health carrier may apply to the Division of Insurance to become licensed as an HMO, as defined in article 16 of title 10, C.R.S. If a licensed health carrier is authorized to hold a certificate of authority to operate as an HMO, the requirements of part 4, article 16, title 10, C.R.S., will apply in addition to the other requirements for its health carrier certificate of authority.

B. Nothing herein shall be deemed to amend the intent or provisions of article 20 of title 10, C.R.S. Any HMO product offered by a licensed health carrier is not provided coverage and protection by the Colorado Life and Health Insurance Protection Association Act.

Section 6 Application for Licensure

Any person seeking licensure as an HMO shall submit two copies of an application to the Corporate Affairs Section of the Division of Insurance (Division). Applications shall include all items as required under § 10-16-401(4), C.R.S., and the following:

A. A list of all persons who will ultimately control the proposed HMO. If the proposed HMO is organized as a stock company, the application must identify all persons who directly or indirectly will own or control ten percent or more of the outstanding stock.

B. Biographical sketches of all the official persons of the organization, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association, officers, directors, organizers and controlling individuals. Biographical information shall be submitted on the NAIC Biographical Affidavit (form available upon request). A complete fingerprint set, as may be obtained from local law enforcement sources may be requested at the discretion of the Commissioner. Any person who has been involved with any

adverse administrative action within the prior five years shall disclose such activity in the biographical affidavit.

C. The addresses of company offices and the HMO functions to be performed by each office, including sufficient information to verify compliance with the provisions of § 10-3-128, C.R.S.

D. A statement as to whether the HMO will be seeking Federal qualification.

E. Current financial information and three (3) year financial projections, including balance sheets and income statements, conforming to the format of the NAIC convention blank. The projections shall also contain projected member-month enrollment at calendar year end and a detailed summary of all assumptions used to generate the projections.

F. A description of the method of marketing including, at a minimum, proposed advertisements, solicitation material, use of brokers and agents, use of HMO staff, and marketing research that will indicate the ability to meet the enrollment projections.

G. Proposed enrollment and/or application forms.

H. An actuarial opinion supporting the proposed premiums or rates to be charged and the underlying actuarial report reflecting the methodology and assumptions used in arriving at the rates used within the projections. The opinion and report must be prepared using generally accepted actuarial standards and principles.

I. A description of the geographic service area by county. Where the service area will be a part of a county, appropriate zip codes may be used to describe the service area.

J. A list of contracting providers, by specific geographic area and by specialty within each geographic area along with a map clearly indicating the service area. If there are no providers or specialty providers within a specific geographic service area, a separate description of the method of providing covered services in said service area, or part thereof, shall be provided.

K. An access plan for each separate network.

L. A description of the provider network arrangements, including copies of specimen contracts. This description should include the due diligence procedures to be performed by the HMO to ensure performance of the services by the participating providers.

M. A detailed description of the sources of funding of the HMO.

N. The filing fees as required by § 10-3-207, C.R.S.

O. An application for licensure as a foreign HMO must also include the following:

1. The most recent financial examination report conducted by the state of domicile.

2. The most recent market conduct report conducted by the state of domicile.

3. An original certificate of compliance or a certified copy of the certificate of authority from the state of domicile referencing the approved lines of authority.

4. An explanation of any limitations imposed by the state of domicile.

5. Disclosure of any administrative action currently pending or taken against the company within the last five (5) years.

Section 7 Organizational Changes

A. An HMO requesting a material modification in the plan of operations on file with the Division, shall provide two copies of the following:

1. The financial statement for the HMO prepared within 90 days prior to the date of request for a modification in the plan of operations.

2. To the extent applicable with regard to the modification, a list of providers under contract or who have committed to contracting with the HMO and a description of the provider network arrangements, including specimen copies of provider contracts. This description shall provide due diligence procedures to be performed by the HMO to ensure performance of the services by the participating providers.

3. Three year financial projections disclosing the impact of the modification in the HMO operations. Include balance sheets and income statements which conform to the format of the NAIC convention blank. The projections shall also contain projected member-month enrollment at calendar year end and a detailed summary of all assumptions used to generate the projections.

4. To the extent applicable with regard to the modification, a Memorandum and certification by a qualified actuary, supporting the proposed premiums or rates to be charged in the new service area(s) or for the new market.

    a. The certification shall include a statement that the rates are not excessive, inadequate or unfairly discriminatory.

    b. In the Memorandum, the actuary shall discuss the differences in provider agreements to the extent that the agreements affect the underlying premium or rate requirements.

    c. The Memorandum shall include justification and support for the difference, or lack of difference, between the rates to be charged for the new market or service area(s) and the existing rate(s).

    d. If the new operations include Medicaid business or other business in which the premium is set by the contract holder and not the HMO, the Memorandum shall provide justification that the premium received will be at least equal to the company's medical and administrative costs. If the actuary cannot provide such a justification the HMO shall provide an adequate explanation as to why the HMO would accept a premium which is not at least equal to the company's medical and administrative costs.

B. An HMO requesting to modify its approved plan of operations on file with the Division by withdrawing from the geographic service area or a market, shall provide two copies of the following:

1. A statement as to why the HMO is withdrawing from a service area or market.

2. Evidence that there will no longer be any enrollment in the portion of the service area at the time of the proposed withdrawal. Such elimination of enrollment in the affected area may be accomplished by nonrenewal according to Colorado statutes and regulations or by any other means acceptable to the Commissioner.

3. An affidavit that the HMO will honor existing coverage for any enrollee hospitalized on the date of such withdrawal from the portion of the geographic service until the date of discharge or arrangements are made for alternative coverage.

C. Changes to the basic organizational documents, such as articles of incorporation and related documents, shall be filed with the Corporate Affairs Section and approved by the Commissioner before filing appropriate documents with the Colorado Secretary of State.

Section 8 Fidelity Bond

Pursuant to § 10-16-405, C.R.S., the funds received from enrollees must be treated in a fiduciary capacity. In order to protect the HMO enrollees from misuse of enrollee funds, an HMO licensed in Colorado shall have fidelity coverage, meeting the requirements of Regulation 3-1-1 (3 CCR 702-3), for all officers, directors and employees who have access to the HMO funds.

Section 9 Reinsurance

A. An HMO may enter into reinsurance agreements under which its risks are indemnified by an insurer. Such agreements must conform to the provisions of §10-3-118 et seq., C.R.S., and Colorado Insurance Regulations 3-3-3 and 3-3-4 (3 CCR 702-3).

B. Section 10-3-118, C.R.S., provides that an HMO may assume risks from another HMO provided it is licensed or authorized to write the type of coverage assumed.

C. An HMO may only assume contract obligations from another HMO with the Commissioner's prior written approval. Any assumption transaction shall follow the provisions of § 10-3-701, et seq., C.R.S., and Colorado Insurance Regulation 3-3-1 (3 CCR 702-3). In all transactions subject to the provisions of § 10-3-701, et seq., the assuming HMO must be licensed in the ceding HMO's service area and must demonstrate the ability to service the proposed acquisition and continue to meet compliance with the availability, accessibility and quality of care requirements.

Section 10 Subordinated Debentures

A. An HMO may enter into loans or similar obligations, for cash or liquid securities received, which may be treated as surplus, pursuant to § 10-16-411(1), C.R.S. These arrangements shall be in a form acceptable to the Commissioner and must comply with the following:

1. Any such obligation must be approved by the Commissioner prior to entering into the final contract.

2. The contract must contain language that it shall not be paid in whole or in part, whether as to principal or interest, or converted, without the Commissioner's prior written approval.

3. The contract must contain language that repayment may only be made from available funds in excess of the net worth required by the Division of Insurance.

B. No loan or advance made under the provisions of this section or interest accruing thereon shall form a part of the legal liabilities of the HMO until authorized for payment by the Commissioner, but, until such authorization, all statements published by the HMO or filed with the Commissioner shall show the amount thereof then remaining as a special surplus account.

Section 11 Guarantees for Uncovered Expenditures

An HMO may have financial arrangements under which uncovered expenditures are guaranteed by a third party in the event of insolvency or nonpayment by the HMO. Such arrangements require prior written approval by the Commissioner. At a minimum, the following criteria must be met:

A. The guarantor must demonstrate a net gain from operations or positive income for each of the five years prior to entering into the guarantee.

B. The guarantee must contain a provision that if the Commissioner determines that the HMO cannot meet its obligations as they become due and payable, the Commissioner may, without notice, call on the guarantor to immediately meet the HMO's applicable net worth requirements.

C. A guarantee may not provide for fees or interest charges for placing the guarantee, keeping the guarantee in place or terminating the guarantee. Agreements with such provisions will be considered subordinated debentures or loans.

D. The guarantor must maintain a minimum net worth equal to the greater of $5,000,000 (five million dollars) or 6 months of the operating expenses of the HMO in excess of the guaranteed amount. For the purposes of this Subsection, net worth shall be limited to tangible assets less liabilities.

E. The guarantor must demonstrate that it has the experience, financial strength and access to capital to serve as a guarantor.

F. The guarantor must agree to file audited financial statements with the Division of Insurance for each year the guarantee is in place. Upon initial filing for approval for the guarantee, the most recent audit report must be submitted.

Section 12 Provider Agreements

A. An HMO must establish that executed agreements between the HMO and the providers exist prior to licensure or granting of approval for an increase in geographic service area. Provider agreements must be maintained in Colorado in the HMO's administrative office or other designated office for examination and shall be made available to the Commissioner upon request.

B. In order to qualify as a covered expenditure, a provider, intermediary, IPA or other provider group contract or provider subcontract must have a "hold harmless" provision which substantially complies with the following:

1. Provider agrees that in no event, including but not limited to nonpayment by the HMO, insolvency of the HMO or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or persons (other than the HMO) acting on his/their behalf for services provided pursuant to this agreement. This provision does not prohibit the provider from collecting supplemental charges or copayments or fees for uncovered services delivered on a 'fee-for-service' basis to HMO subscribers/enrollees.

2. Provider agrees that this provision shall survive the termination of this agreement, for authorized services rendered prior to the termination of this agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollees. This provision is not intended to apply to services provided after this agreement has been terminated.

3. Provider agrees that this provision supersedes any oral or written contrary agreement now or existing hereafter entered into between the provider and the subscriber, enrollee, or persons acting on their behalf insofar as such contrary agreement relates to liability for payment of services provided under the terms and conditions of this agreement.

4. Any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the Commissioner has received written notification of proposed changes.

C. Every contract between an HMO and a provider shall contain a provision clearly setting forth the HMO's reimbursement arrangements with the participating provider, including any financial risk assumed by the participating provider. An HMO shall maintain evidence that it took reasonable steps to ascertain that the provider understands such arrangements and that the HMO has determined that the provider is capable of undertaking the financial risk assumed.

D. HMOs may only transfer financial risk to providers for services which the provider performs, or services which such provider controls, directs or influences. Out of network emergency services are not controlled, directed or influenced by the provider and financial risk for such services may not be transferred. Any individual arrangement may be submitted to the Commissioner to be reviewed on a case by case basis to determine its acceptability.

E. An HMO shall have available a continuous program and procedure for review of providers ensuring their ability to provide contracted services. At a minimum this program must include the following:

1. Financial review of intermediaries and providers accepting risk for services which they do not control, direct or influence directly from the HMO.

2. Review all provider subcontract specimen forms for compliance with applicable insurance statutes and regulations, availability of services and evaluation of risk transfers.

3. Procedures for review of the timely and accurate compensation of providers pursuant to contract.

4. Review of quality management, utilization review, credentialing and other health care management services, if being conducted by the intermediary, provider or subcontracting provider. The procedures and practices used must be the same as those approved for the HMO by the Executive Director of the Colorado Department of Public Health and Environment.

5. Procedures for assuring continuity of care and for making payments to subcontracting providers in the event of the insolvency of an intermediary or provider

6. The reviews in subsections 1 through 5, above, shall occur upon initial contracting with the intermediary, provider or subcontracting provider. Subsequent reviews shall be undertaken at least annually. Additional reviews should be undertaken as necessary based upon: (1) the results of previous reviews of the intermediary, provider or subcontracting provider; or (2) complaints from enrollees or providers or (3) other information which may impact the intermediary's ability to provide services or pay subcontractors.

Section 13 Administrative and Other Service Agreements

A. An HMO may contract for the performance of administrative functions. Any contract for administrative functions shall contain the following:

1. Ninety (90) days written notice of cancellation to the Commissioner;

2. A provision that the contract may not restrict the HMO's Board of Directors from appointing, removing or changing officers or employees of the HMO;

3. A statement of the administrator's compensation, duties and responsibilities;

4. State that all books, records, assets, and liabilities of the HMO shall, at all times, remain the property of the HMO; and

5. If the HMO contracts for Electronic Data Processing (EDP) and/or Management Information Systems (MIS), a provision providing appropriate access to the system upon examination by the Commissioner, and a mechanism under which the system is available to the HMO or its successor upon insolvency of the HMO, or termination or cancellation of the contract.

B. All management agreements and any material amendments thereto shall be filed with the Division of Insurance for review 30 days prior to the effective date. Agreements filed in compliance with §10-3-805(4)(a)(IV), C.R.S., need not be filed under this regulation. For purposes of this regulation, management agreements mean any agreements between the HMO and any entity or person not employed by the HMO for the purpose of managing the day to day operations of the HMO.

C. An HMO may offer administrative or other services to another person to the extent not inconsistent with the provisions of Article 16 of Title 10, C.R.S., provided that:

1. The provider network is sufficient to absorb any enrollment from such action and the availability, accessibility and quality of the services to the HMO's enrollees are not impaired;

2. The arrangement entered into may be terminated by the HMO if such obligation substantially interferes with the HMO's operations or its ability to maintain compliance with law; and

3. The contract shall constitute the HMO's entire service obligation and shall be filed with the Commissioner.

Section 14 Financial Reports

A licensed health carrier also licensed as an HMO shall include the following exhibits of the HMO convention blank detailing their HMO activities as appendices to its NAIC convention blank filing:

A. The income and loss statement for total business and Colorado business;

B. The enrollment report for total business and for Colorado business;

C. The schedule reflecting health care receivables for total business and Colorado business;

D. The claims payable analysis for total business and Colorado business;

E. The summary of transactions with providers for total business and Colorado business; and

F. Any other form of the NAIC blank the Commissioner requires to analyze the business of the HMO including, but not limited to, electronic filing.

Section 15 Property Acquisitions

Section 10-16-403(1), C.R.S., provides that an HMO may acquire property which may reasonably be required for its administrative offices or for such other purposes as may be necessary to accomplish the business of the organization. The following rules apply in order to meet the requirements of § 10-16-403(2), C.R.S., regarding the prior approval of property purchases. Any property acquired without filing a notification, other than as outlined herein, shall be nonadmitted for statutory accounting purposes.

A. For acquiring real property, e.g. hospitals, medical facilities, nursing care and intermediate care facilities, an HMO must file, at least 30 days prior to acquisition, notice of its intent to acquire property. The filing shall include a description of:

1. The nature of the real property;

2. The location of the real property;

3. Method of acquisition (build new facility, remodel existing facility, etc.);

4. How the property contributes to the accomplishment of the nature of the HMO's business; and

5. An estimate of the amount to be expended and source of funding (i.e. loans, operating funds, etc.).

B. Electronic data processing equipment and software shall be admitted and valued in accordance with the statements of statutory accounting principles contained in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

C. The HMO may acquire property which is other than real property and which is used in the direct delivery of health care services, such as pharmaceuticals and surgical supplies, durable medical equipment, furniture, medical equipment and fixtures, and leasehold improvements in health care facilities.

1. Furniture, medical equipment and fixtures and leasehold improvements in health care facilities must meet the following conditions in order to qualify as an admitted asset

   a. useful life of at least two (2) years; and

   b. cost of more than $500.00.

2. The aggregate admitted value of all property other than real property is limited to the lesser of 5% of assets or 25% of surplus.

3. The Commissioner may waive the aggregate limitations of subsection 2 above. A request for waiver must include:

   a. A detailed list and cost of each item;

   b. An explanation of why the property is necessary for the conduct of the business of the HMO; and

   c. A statement as to why the request would not result in a deterioration of the liquidity or solvency of the HMO.

4. Property other than real property shall be carried at the lesser of cost at the time of request less accumulated depreciation or the market value at the time of valuation, unless it is an asset whose method of valuation is specified in the insurance laws, regulations, or nationally recognized insurance statutory accounting principles.

5. The admissibility of property other than real property is subject to review and restriction of admissibility when the net worth of an HMO, less the admitted value of property subject to this section, is below the statutory minimum net worth as required by § 10-16-411, C.R.S., or if such property will cause a hazardous financial condition as determined by Colorado Insurance Regulation 3-1-7 (3 CCR 702-3).

6. A licensed health carrier, also authorized to hold a certificate of authority directly to operate an HMO, is restricted to the property which is admitted under rules applicable for the certificate of authority of the licensed health carrier.

D. The admitted value of property, other than real property acquired and admitted prior to January 1, 2001, which is not used in the direct delivery of health care services, may be phased out over a period not to exceed three years. The rate for phasing out the admitted value of such property shall be documented in the HMO's records, available for examination by the Division.

Section 16 Confidentiality

A. Except as set forth in statute or regulation, documents filed with the Division of Insurance shall generally be considered public records under the Public Records Act, § 24-72-201, et. seq., C.R.S.

B. If an HMO considers a document to be confidential, it must submit the document under separate cover or in a file clearly labeled "CONFIDENTIAL" with a completed Vaughn Index explaining why the document is considered confidential.

C. Documents found to be confidential by the Division of Insurance, will be maintained in a separate, confidential file and will not be released to the general public for inspection or copying.

Section 17 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 18 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 19 Effective Date

This amended regulation shall become effective on October 1, 2012.

Section 20 History

Originally issued as regulation 74-21 effective 1974

Re-codified as Regulation 4-7-1 effective December 1, 1993

Amended regulation effective September 1, 1999

Amended regulation effective July 1, 2001

Amended regulation effective January 31, 2003

Amended regulation effective October 1, 2012

Regulation 4-7-2 CONCERNING THE LAWS REGULATING HEALTH MAINTENANCE ORGANIZATION BENEFIT CONTRACTS AND SERVICES IN COLORADO

Section 1 Authority

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

Section 2 Scope and Purpose

The purpose of this regulation is to provide reasonable standards for the terms and provisions contained in Health Maintenance Organizations' ("HMOs") benefit contracts and evidences of coverage.

Section 3 Applicability and Scope

This regulation shall apply to all HMOs that are required to obtain or maintain a certificate of authority in this state. This regulation shall apply to all benefit contracts and evidences of coverage that are issued or renewed on or after the effective date of this regulation. In the event of conflict between the provisions of this regulation and the provisions of any earlier regulation issued by the Commissioner, the provisions of this regulation shall be controlling as to HMOs.

Section 4 Definitions

No contract or evidence of coverage delivered or issued for delivery to any person by an HMO required to obtain a certificate of authority in this state shall contain definitions respecting the matters set forth below and in § 10-16-102, C.R.S., unless such definitions comply with the requirements of this section. Definitions other than those set forth herein and in § 10-16-102, C.R.S., may be used as appropriate providing that they do not contradict these requirements. As used in this regulation and for the purpose of any terms used in a benefit contract of evidence of coverage:

A. "Copayment" means, for the purposes of this regulation, the predetermined amount, whether stated as a percentage or a fixed dollar, an enrollee must pay, to receive a specific service or benefit.

B. "Deductible" means, for the purposes of this regulation, the amounts to be paid by the enrollee for covered services, other than a co-payment, before the enrollee is entitled to benefits from a health benefit plan.

C. "Emergency services" means, for the purposes of this regulation, health care services provided in connection with 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.

D. "Group" means, for the purposes of this regulation, a) a bona fide employer covering employees of such employer for the benefit of persons other than the employer; or b) an association, including a labor union, which has a constitution and bylaws and which is organized and maintained in good faith for purposes other than that of obtaining insurance.

E. "Group contract" means, for the purposes of this regulation, a contract for health care services, which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

F. "Group contractholder" means, for the purposes of this regulation, the person to which a group contract has been issued.

G. "HMO service area" means, for the purposes of this regulation, the geographical area within which the HMO is authorized to provide or arrange for health care services that are available and accessible to enrollees and may include contracted providers physically located across state or county lines.

H. "Individual contract" or "nongroup contract" means, for the purposes of this regulation, a contract for health care services issued to and covering an individual or a family that is not a group.

I. "Out-of-area services" means, for the purposes of this regulation, the health care services that an HMO covers when its enrollees are outside of the enrollee service area.

J. "Point-of-service plan contract" means, for the purposes of this regulation, a Health Maintenance Organization contract which includes coverage for both in-network services and coverage for services provided by non-contracted providers. The term "point-of-service plan contract" shall also apply to a plan contract where the indemnity coverage or service is underwritten by a non-HMO carrier in this state and is offered in conjunction with an HMO contract.

K. "Primary care physician" means, for the purposes of this regulation, a physician designated by the enrollee, subject to the policies and procedures of the HMO, who supervises, coordinates, and provides initial and basic care to members, initiates their referral for specialist care and maintains continuity of patient care.

L. "Subscriber" means, for the purposes of this regulation, the individual whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in the HMO.

M. "Supplemental health care services" means, for the purposes of this regulation, any health care services other than basic health care services as defined in § 10-16-102(4), C.R.S.

N. "Temporarily absent" means, for the purposes of this regulation, circumstances where the enrollee has left the HMO's service area but intends to return within a reasonable period of time, such as a vacation trip.

O. "Urgently needed services" means, for the purposes of this regulation, covered services which enrollees require in order to prevent a serious deterioration in their health while they are temporarily absent from the enrollee's service area.

P. "Variable Copayment" means, for the purposes of this regulation, a copayment that varies based on the enrollee's use of certain providers.

Q. "Variable Deductible" means, for the purposes of this regulation, a deductible that varies based on the enrollee's use of certain providers.

Section 5 Requirements for Benefit Contracts and Evidences of Coverage

Each enrollee shall be entitled to receive an individual contract and/or evidence of coverage. Each group contractholder shall be entitled to receive a group contract and/or evidence of coverage. Group contracts, individual contracts and evidences of coverage shall be delivered or issued for delivery to enrollees or group contractholders within a reasonable time after enrollment, but not more than fifteen working days from the later of the effective date of coverage or the date on which the HMO is notified of enrollment. The contract and/or evidence of coverage shall include the following:

A. HMO Information

The contract and/or evidence of coverage shall contain the name, address and telephone number of the HMO and shall describe how services may be obtained. A toll free or collect call phone number within the service area for calls, without charge to enrollees, to the HMO's administrative office shall be made available and disseminated to enrollees to adequately provide telephone access for member services, problems or questions.

B. Entire Contract

The contract shall contain a statement that the contract, evidence of coverage, all applications and any amendments thereto shall constitute the entire agreement between the parties.

C. Term of coverage

1. The contract and/or evidence of coverage shall contain the time and date or occurrence upon which coverage takes effect and include any applicable waiting periods.

2. The contract and/or evidence of coverage shall contain the time and date or occurrence upon which coverage will terminate.

D. Benefits and Services within the HMO's Service Area

The contract and/or evidence of coverage shall contain a specific description of benefits and services available within the HMO's service area.

E. Emergency Care Services

The contract and/or evidence of coverage shall contain a specific description of emergency services available twenty-four hours a day, seven days a week, including disclosure of how emergency care services will be accessible within the HMO's service area by affiliated providers and nonaffiliated providers.

F. Out of Area Benefits and Services

The contract and/or evidence of coverage shall contain a specific description of benefits and services available out of the HMO's service area including situations where balance billing could apply, variable deductibles, variable copayments and notice if individuals may need to travel into the HMO's service area to receive covered health benefits.

G. Cancellation or Termination

The contract and/or evidence of coverage shall contain the conditions upon which cancellation or termination may be effected by the HMO or the enrollee.

H. Renewal

The contract and/or evidence of coverage shall contain the conditions for, and any restrictions upon, the enrollee's right to renewal.

I. Reinstatement

The contract and/or evidence of coverage shall contain the conditions for, and any restrictions upon, the enrollee's right to reinstate.

J. Claims

The contract and/or evidence of coverage shall contain procedures for filing claims that include:

1. any required notice to the HMO;

2. if any claim forms are required, how, when and where to obtain and submit them;

3. any requirements for filing proper proofs of loss;

4. any time limit of payment of claims;

5. notice of any requirement for resolving disputed claims including arbitration; and

6. a statement of restrictions, if any, on assignment of sums payable to the enrollee by the HMO.

K. Complaint System

In compliance with § 10-16-409, C.R.S., the contract and/or evidence of coverage shall contain a description of the HMO's method for resolving enrollee complaints, incorporating procedures to be followed by the enrollee in the event any dispute arises under the contract.

L. Coordination of Benefits

A group contract and/or evidence of coverage must contain a provision for coordination of benefits that shall be consistent with Colorado Insurance Regulation 4-6-2, 3 CCR 702-4. An individual contract and/or evidence of coverage may have an "insurance with other insurers provision." Additionally, an HMO must coordinate benefits with private passenger automobile coverage, as required under § 10-4-641, C.R.S.

M. Point-of-service plan contract

There is no requirement that "point-of-service" coverage be offered to groups or individuals. However, if an HMO offers a point-of-service plan, it must be offered to all individuals and/or groups that qualify for the point-of-service plan, based upon the HMO's underwriting standards. If

the point-of-service plan is offered to a group, it must be offered to all eligible members of that group. Additionally, an employer may set standards as to which employees are eligible for "point-of-service" coverage.

1. Point-of-service plan mandatory contract provisions.

   A point-of-service plan contract must, at a minimum:

   a. Provide all basic health care services required by law to be provided by an HMO as in-plan coverage services, including emergency and urgent care; and

   b. Provide incentives for enrollees to use in-plan covered services.

2. Point-of-service plan optional contract provisions.

   A point-of-service plan may:

   a. Limit or exclude specific types of services from coverage when obtained out-of-plan;

   b. Include annual out-of-pocket limits and annual and/or lifetime maximum benefit allowances for out-of-plan covered services that are separate from any limits and allowances applied to in-plan covered services; and

   c. Include those services that an enrollee obtains from a medical provider for which proper authorization or referral was not given.

3. Point-of-service plan limitations.

   An HMO may not expend more than 20% of its total annual net medical and hospital expenses (net of reinsurance and coordination of benefit recoveries) for indemnity benefits.

4. An HMO must comply with the form and rate filing requirements contained in statute and regulation. In complying with these statutes and regulations, the HMO will:

   a. Design the benefit levels for in-plan covered services and out-of-plan covered services to achieve the desired level of in-plan utilization; and

   b. Provide or arrange for adequate systems to:

      (1) Process and pay claims for out-of-plan covered services;

      (2) Meet the requirements of a point-of-service product as set by this section; and

      (3) Generate accurate financial and regulatory reports on a timely basis in order for the commissioner to evaluate experience with the point-of-service plan and monitor compliance with the point-of-service plan provisions.

5. Disclosure.

   All HMO benefit contracts and evidence of coverage must contain a clear and concise explanation of point-of-service health care services. The explanation must include:

   a. The method of reimbursement to enrollees, where applicable;

b. Applicable copayments, coinsurance and deductibles;

c. Exclusions;

d. The services that an enrollee is permitted to obtain on an allowed self-referral basis; and

e. Instructions regarding submission of claims for self-referred health care services.

N. Indemnity Benefits

Basic health care services are required to be offered through providers that are contracted or employed by the HMO. Coverage offered by non-contracted providers may be provided on an indemnity basis, as permitted by law.

Section 6 Prohibited Practices

Unfair discrimination

A. No HMO shall unfairly discriminate against any enrollee based on the age, sex, race, color, creed, national origin, ancestry, religion or marital status. However, nothing shall prohibit an HMO from setting rates or establishing a schedule of charges in accordance with relevant actuarial data.

B. No HMO shall expel or refuse to offer a continuation or conversion contract to individual members of a group based on the health status or health care needs of the individual enrollee or member.

Section 7 Services

A. Out-of-Area Services and Benefits

1. Out-of-area services shall be subject to copayment or deductible requirements set forth in Subsection C of Section 8 of this regulation.

2. When an enrollee is temporarily absent from the HMO's service area, an HMO shall provide benefits for reimbursement for emergency care or urgent care services, or, at the HMO's discretion, transportation which is medically necessary and appropriate under the circumstances to return the enrollee to an HMO provider, subject to the following conditions:

a. The condition could not reasonably have been foreseen;

b. The enrollee could not reasonably arrange to return to the HMO's service area to receive treatment from the HMO's provider;

c. The temporary absence must be for some purpose other than the receipt of medical treatment; and

d. If the HMO requires notification, the HMO is notified as required by the evidence of coverage unless it is shown that it was not reasonably possible to communicate with the HMO in such time limits.

For urgently needed services, the HMO is notified prior to the commencement of care, unless it is shown that it was not reasonably possible to communicate with the HMO in such time limits.

B. Supplemental Health Care Services

In addition to the basic health care services as defined in § 10-16-102(4), C.R.S., an HMO may offer to its enrollees any supplemental health care services it chooses to provide. Limitations as to time and cost may vary from those applicable to basic health care services.

Section 8 Other Requirements

A. Description of Providers

1. An HMO shall provide its enrollees with access to a list of the names and locations of all of its current primary care physicians and hospitals in an enrollee's service area, no later than the time of enrollment or the time the contract and evidence of coverage are issued and upon request thereafter.

2. Any list of providers shall contain a notice regarding the availability of the listed primary care physicians. Such notice shall be in not less than ten-point type and be placed in a prominent place on the list of providers. The notice shall contain the following or similar language:

   "Enrolling in (name of HMO) does not guarantee services by a particular provider on this list. If you wish to be sure of receiving care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for (name of HMO). Also, we may add physicians on a periodic basis and will provide you with a listing of newly added doctors in your local area, if you request it."

B. Description of the Service Area

A HMO shall provide its enrollees with a description of the HMO's service area no later than the time of enrollment or the time the contract and evidence of coverage is issued and upon request thereafter. If the description of the HMO's service area is changed, the HMO shall provide, at such time, a new description of the HMO's service area to its enrollees.

C. Copayments or Deductibles

1. An HMO may require copayments and/or deductibles of enrollees as a condition for the receipt of specific health care services. Copayments and deductibles for basic health care services shall be shown in the contract and/or evidence of coverage or an addendum thereof as a percentage or as a specified dollar amount.

2. Copayments or deductibles can vary by provider as a means of encouraging an enrollee to obtain services from a particular provider.

D. Complaint System

1. A complaint system shall be established and maintained by an HMO to provide reasonable procedures for the prompt and effective resolution of written complaints.

2. An HMO shall provide complaint forms to be given to enrollees who wish to register written complaints. Such forms shall include the address and telephone number to which complaints must be directed and shall specify any required time limits imposed by the HMO.

3. The complaint system shall provide for (a) written acknowledgment of complaints and (b) complaints to be resolved or to have a final determination of the complaint by the HMO

complaint system within a reasonable period of time, but not more than ninety days from the date the complaint is registered. This period may be extended (a) in the event of a delay in obtaining the documents or records necessary for the resolution of the complaint, or (b) by the mutual written agreement of the HMO and the enrollee.

4. Membership may not be terminated solely as a result of filing a complaint against the HMO.

5. If an enrollee's complaints and grievances may be resolved through a specified arbitration agreement, the enrollee shall be advised in writing of his rights and duties under the agreement at the time the complaint is registered. Any such agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration. Any HMO that makes such binding arbitration a condition of enrollment must fully disclose this requirement to its enrollees in the contract and evidence of coverage.

Section 9 Severability

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

Section 10 Enforcement

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

Section 11 Effective Date

This regulation is hereby amended shall be effective for policies issued or renewed on January 1, 2014.

Section 12 History

Originally issued as Regulation 90-6, Effective October 1, 1990.

Amended Regulation, Effective December 1, 1992.

Amended Regulation, Effective July 1, 2000.

Amended Regulation, Effective January 31, 2003.

Amended Regulation, Effective October 1, 2009.

Amended Regulation, Effective August 1, 2012.

Amended Regulation, Effective January 1, 2014.

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]